UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	2:14-cv-03861-SVW-PLA	Date	August 8, 2016
Title	*Margueritte Kibel v. Aetna Life Insurance Company*		

Present: The Honorable	STEPHEN V. WILSON, U.S. DISTRICT JUDGE	
Paul M. Cruz		N/A
Deputy Clerk		Court Reporter / Recorder
Attorneys Present for Plaintiffs:		Attorneys Present for Defendants:
N/A		N/A

Proceedings: IN CHAMBERS ORDER GRANTING DEFENDANT'S MOTION FOR RECONSIDERATION [46] AND DENYING PLAINTIFF'S MOTION FOR RECONSIDERATION [45]

I. Introduction

Plaintiff Margueritte Kibel ("Plaintiff" or Kibel") filed suit against Aetna Life Insurance Company ("Aetna" or "Defendant") on May 20, 2014. Dkt. 1. The Court conducted a bench trial on December 16, 2014. Dkt. 38.

Following the bench trial, the Court issued findings and conclusions regarding Defendant's denial of benefits. Dkt. 42. The Court found that as of March 26, 2001, Plaintiff was diagnosed with relapsing-remitting multiple sclerosis.[1] *Id.* at 2. She began working at City National Bank in March 2011. *Id.* But sometime in the latter half of 2011 Plaintiff collapsed and fell again a few months later. *Id.* at 3. Plaintiff returned to her doctors to evaluate her symptoms. *See id.* Eventually, on April 4, 2012, Plaintiff took an official leave of absence. *Id.* at 4. She sought long-term disability benefits and a waiver from premium payments on her life insurance policy, on February 18, 2013. *Id.* at 5. But Aetna denied

[1] Multiple sclerosis is an inflammatory disease affecting the central nervous system. The disease causes a person's own immune system to attack the nerves' protective sheath, called myelin, in a process referred to as demyelination. In its relapsing-remitting form, multiple sclerosis is characterized by attacks of worsening neurologic function (relapses) followed by periods of partial or complete recovery (remissions). Dkt. 42 at 2.

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Plaintiff's disability claim, on May 16, 2013. *Id.* at 6. Within six days of the denial, Plaintiff sent a letter to Aetna, expressing her intent to appeal. *Id.* Aetna denied Plaintiff's appeal for long-term disability benefits on March 12, 2014. *Id.* at 9. The Court found that before Aetna closed its review, deciding her waiver of life insurance premium claim, Plaintiff submitted a new MRI showing "significant interval progression of [the] disease" over the past four months. *Id.* Finally, on March 20, 2014, Aetna denied Plaintiff's request for life insurance benefits. *Id.* at 10. Based on the information in the record, the Court concluded that Aetna owed Kibel long-term disability benefits beginning March 19, 2014, but upheld Aetna's denial of benefits in all other respects. *Id.* at 18.

After the Court issued its findings of fact and conclusions of law, both parties moved for reconsideration. Dkts. 45, 46. Plaintiff argues that the Court erred in finding that she was not disabled under the "own occupation" criteria of the Plan prior to March 19, 2014 and seeks to introduce testimony by Plaintiff's neurologist, Dr. Anderson. *See* Dkt. 45. Defendant, in turn, argues that the Court improperly considered an MRI dated March 19, 2014 that postdated Aetna's denial of Plaintiff's appeal and improperly determined that benefits were proper as of that date even though Plaintiff was no longer covered by the Plan. *See* Dkt. 46.

For the reasons stated below, the Court GRANTS Defendant's motion for reconsideration [46] and DENIES Plaintiff's motion for reconsideration [45].

II. Legal Standard

Under Federal Rules of Civil Procedure 59(e) and 60(b), a court may reconsider a motion if "the district court (1) is presented with newly discovered evidence, (2) committed clear error or the initial decision was manifestly unjust, or (3) if there is an intervening change in controlling law." *Sch. Dist. No. 1J, Multnomah Cty., Or. v. ACandS, Inc.*, 5 F.3d 1255, 1263 (9th Cir. 1993); *see also 389 Orange Street Partners v. Arnold*, 179 F.3d 656, 665 (9th Cir. 1999). Clear error occurs when the court "is left with the definite and firm conviction that a mistake has been committed." *Smith v. Clark Cty. Sch. Dist.*, 727 F.3d 950, 955 (9th Cir. 2013). Additionally, Local Rule 7-18 provides:

> A motion for reconsideration of the decision on any motion may be made only on the grounds of (a) a material difference in fact or law from that presented to the Court before such decision that in the exercise of reasonable diligence could not have been known to the

> party moving for reconsideration at the time of such decision, or (b) the emergence of new material facts or a change of law occurring after the time of such decision, or (c) a manifest showing of a failure to consider material facts presented to the Court before such decision. No motion for reconsideration shall in any manner repeat any oral or written argument made in support of or in opposition to the original motion.

L.R. 7-18. The Local Rules also provide that the Court can order a new trial on the basis of legal error: "If the ground for the motion is an error of law occurring at the trial, the error shall be specifically stated." L.R. 59-1.1.

III. Discussion

A. Plaintiff's Motion for Reconsideration

Plaintiff argues that the Court made two manifest errors in its findings of facts and conclusions of law. First, Plaintiff's occupation was a "light occupation" but some of the evidence relied upon by Defendant only supported a finding that she could perform a "sedentary occupation." *See* Dkt. 45-1 at 4–13. Accordingly, Plaintiff asserts that the Court erred by not properly crediting a report by Aetna's doctor, Dr. Vaughn Cohan, stating that: "It is my opinion that the claimant would be capable of performing work at a sedentary level" *Id.* at 7–10. Next, Plaintiff argues that the Court erroneously required Plaintiff to "prove" that she was unable to perform her own occupation. *Id.* at 13–14. Finally, Plaintiff asserts that the Court can hear testimony from Dr. Andersson rather than relying on the opinions of others that have been erroneously attributed to Dr. Anderson. *Id.* at 14–16.

Defendant asserts that these arguments are simply a means of asking the Court to rethink the arguments already raised by Plaintiff and rejected by the Court. Dkt. 50 at 1–2. Defendant asserts that the Court devoted four pages to a discussion of sedentary versus light classifications and ultimately reached its conclusion under the proper standard. *Id.* at 3. The Court also already considered Plaintiff's fatigue argument. *Id.* at 3–4. Defendant asserts that the Court properly made credibility determinations regarding the various medical reports. *Id.* at 4–6. Defendant contends that the Court should deny Plaintiff's request to hear testimony from Dr. Andersson because the Court already determined not to hear Dr. Andersson's testimony after consideration of the parties' supplemental trial briefing and his records speak for themselves. *Id.* at 6–8. Finally, Defendant asserts that a new trial on some or all of the issues presented is

not called for because Plaintiff is not seeking to correct a manifest error or present new evidence, only attempting to advance the same arguments that the Court has already rejected. *Id.* at 8.

The Court finds that Plaintiff's arguments are not suitable for a motion for reconsideration because Plaintiff repeats arguments already made in other submissions and does not demonstrate that the Court failed to consider material facts. The Court's findings of fact and conclusions of law includes a significant discussion of the discrepancies in the record between a sedentary classification and a light classification. *See* Dkt. 42 at 14. Plaintiff's assertion that the Court "assumed that Aetna's occupational classification error did not make a difference," Dkt. 45-1 at 4, is both incorrect factually and raises the same argument that Plaintiff has already made in her responding trial brief. *See* Dkt. 32 at 13–15.

Second, though the Court may have used the word "prove" on several occasions, the Court clearly applied the applicable standard. *See* Dkt. 42 at 10 ("In an ERISA action, the plaintiff carries the burden of showing, by a preponderance of the evidence, that he was disabled under the terms of the Plan during the claim period."). Plaintiff cites to no portion of the record where this supposed distinction affected the outcome of the Court's evaluation.

Finally, as Defendant argues, the Court could have called Andersson to testify prior to the trial if the Court deemed it appropriate at the time. The fact that he is willing to testify in a manner that will "resolve [] ambiguity," Dkt. 45-1 at 2, now does not meet the applicable standard for a motion for reconsideration under local rules or Rule 59. The Court and the parties were aware that Dr. Andersson could testify regarding his notes and impressions, but the Court determined that this testimony was not necessary under the applicable *de novo* standard of review. *See Opeta v. Nw. Airlines Pension Plan for Contract Employees*, 484 F.3d 1211, 1217 (9th Cir. 2007) (discussing the standard for admitting evidence outside the administrative record under *de novo* review).

Under the *de novo* standard of review "[t]he court simply proceeds to evaluate whether the plan administrator correctly or incorrectly denied benefits . . . ." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006) (en banc). The record that was before the plan administrator serves as the "primary basis for review." *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc). But the court may consider new evidence, outside the administrative record, "to enable the full exercise of informed and independent judgment." *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 943 (9th Cir. 1995). But even under this non-deferential review, "a district court

should not take additional evidence merely because someone at a later time comes up with new evidence" and "[i]n most cases" only the evidence that was before the plan administrator should be considered." *Id.* at 944.

Plaintiff's request for the Court to take additional testimony from Dr. Andersson is deficient for two reasons. First, Plaintiff fails to connect her factual argument to the reconsideration standard. The Court is not empowered to change a finding of fact because Plaintiff raises new factual arguments in light of the Court's ruling. Plaintiff fails to point to a change in fact or law that has developed subsequent to the Court's ruling. And Plaintiff does not assert that the Court failed to consider evidence of Dr. Andersson's medical opinions already in the record.[2] Accordingly, Plaintiff's argument is improper under Local Rule 7-18.

Second, even assuming that the Court could hear additional evidence in support of Plaintiff's factual argument, Dr. Andersson's proposed testimony would be improper under *Opeta*. Plaintiff does not cite to anything facially ambiguous in Dr. Andersson's medical records. Instead, Plaintiff's offer of proof attempts to create ambiguity by explaining that "mild fatigue" can include "extremely disabling" fatigue. *See* Dkt. 51 ¶¶ 3–5. The offer of proof also attempts to introduce a new medical conclusion that Plaintiff could not work in her own occupation on a full-time basis from February 2012 through February 2013. *Id.* ¶ 6. This is a medical conclusion that does not attempt to clarify anything within the administrative record. There could be no meaningful limits on the review of extrinsic evidence if the Court were to accept this sort of evidence, even under the non-deferential *de novo* standard of review.

Accordingly, the Court DENIES Plaintiff's motion for reconsideration.

B. Defendant's Motion for Reconsideration

Defendant asserts that the Court should reconsider its findings of fact and conclusions of law because the court committed clear error in finding Aetna owed Plaintiff benefits as of March 19, 2014. Dkt. 46. First, Defendant argues that the Court should not have considered the March 19, 2014 MRI because, even though the parties stipulated to include the MRI in the administrative record, the MRI was

[2] The absence of evidence which the Court has failed to considered is confirmed by Plaintiff's offer of proof, describing the evidence that she seeks to introduce. *See* Dkt. 51.

not in front of Aetna on March 12, 2014 when it made its decision to uphold its denial of benefits. *Id.* at 5–6. In the alternative, Defendant argues that even if Plaintiff could have met the applicable disability standard as of March 19, 2014, that she was no longer eligible for benefits at that time. *Id.* at 6–8.

Plaintiff does not substantively contest that the Court erred in concluding that Plaintiff was entitled to coverage based on a finding of disability as of March 19, 2014. Plaintiff argues that Defendant considered the March 19, 2014 MRI, so that it was properly in the administrative record. Dkt. 49 at 1. But Plaintiff does not argue that coverage began on March 19, 2014. *See generally id.* Instead, Plaintiff maintains that she proved that she was not capable of performing her occupation from February 2012 to February 19, 2013, a period of time when she was a "covered person" within the meaning of the Plan. *Id.* at 2–3. Plaintiff essentially contends that the Court erred in not interpreting Dr. Cohan's assessment that Plaintiff was capable of a "sedentary level" of work between February 29, 2012 and February 28, 2014 as precluding her ability to perform a "light level" of work during that time period. *See id.*

The Court finds that Defendant's motion for reconsideration is warranted based on the Court's manifest failure to consider the terms of the Plan. The Court found that Plaintiff met her burden of establishing disability as of March 19, 2014. Dkt. 42 at 11, 17. But without citation to the language of the Plan, the Court concluded that "[t]herefore, Aetna owed Ms. Kibel long-term disability benefits as of that date." *Id.* at 11; *see also id.* at 17 ("Thus, as of that date, Aetna owed Ms. Kibel long-term disability benefits.").

But the fact that Plaintiff demonstrated, by a preponderance of the evidence, that she was physically unable to perform her job as of March 19, 2014 does not logically require that she was covered under the Plan. The Court did not apply the factual conclusion that Plaintiff was disabled as of March 19, 2014 to the language of the Plan.

Under the Plan, long term disability coverage ends on the date of termination or 12 months after an employee is no longer actively at work due to illness or injury. *See* AR 19, 908–09, 1052. The Booklet Certificate provides that coverage ends under the Plan when:

- The plan is discontinued;
- You voluntarily stop your coverage;

- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer; or
- **Your employment stops for any reason**, including job elimination or being placed on severance. **This will be either the date you stop active work, or the date before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue**, for purposes of remaining eligible for coverage under this Plan, **as described below**:
  - **If you are not actively at work due to illness or injury, your coverage may continue until stopped by your employer, but not beyond 12 months from the start of the absence.**
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage may continue until stopped by your employer, but not beyond 12 months from the start of the absence.
  - If you are eligible as a permanently and totally disabled employee, your coverage may be deemed to continue for Life Insurance while you remain eligible.

AR 19 (emphasis added). The Plan further provides that LTD coverage ends:

- **On the date you are no longer an eligible colleague**
- **On the date you resign or terminate employment with the Bank for any reason**
- On the date you are placed on severance and are no longer actively at work
- When you fail to make the necessary payroll contributions for supplemental LTD coverage (basic coverage will continue)
- At the end of the month in which you cancel your supplemental LTD coverage because of a qualified family status change event (basic coverage will continue)
- At the end of the calendar year, unless your coverage will continue pursuant to the rules established for the annual enrollment period (basic coverage will continue)
- If you are on a leave of absence for at least 180 days and are found ineligible for LTD benefits
- When long-term disability insurance for all colleagues ends.

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AR 1052 (emphasis added).

Because Plaintiff took a leave of absence in April 2012, Dkt. 42 at 5, and was terminated in February 2013 her coverage under the Plan would have ended at the latest in April 2013.[3] *See* AR 19. The March 19, 2014 MRI found significant deterioration had occurred since the November 22, 2013 MRI. AR 714. Accordingly Plaintiff was not eligible for coverage regardless of her disability status as of March 19, 2014. Based on an application of the text of the Plan to the Court's legal conclusion that Plaintiff was disabled as of March 19, 2014, the Court has a definite and firm conviction that a mistake has been committed.

Thus, Defendant's motion for reconsideration is GRANTED.

IV. Order

For the aforementioned reasons, Plaintiff's motion for reconsideration [45] is DENIED and Defendant's motion for reconsideration [46] is GRANTED.

IT IS SO ORDERED.

[3] Aetna asserts that an eligible colleague must work over 30 hours per week, but the provision that Aetna cites to refers to eligibility to *enroll* in the benefits program, not eligibility for coverage. *See* AR 901. Even if eligible colleagues were required to work over 30 hours per week, Aetna does not attempt to reconcile this requirement with the fact that the Plan contemplates coverage for individuals who are no longer employed and not actively at work. *See* AR 19; *see also Harris v. Aetna Life Ins. Co.*, No. CA 6:12-2601-TMC, 2013 WL 5935144, at *4 (D.S.C. Nov. 5, 2013) (describing Aetna's argument under a similar plan that coverage ended one year after an employee was injured at work and unable to return).

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