

NOT FOR PUBLICATION

In the
United States Court of Appeals
For the Eleventh Circuit

No. 25-11338

JUDSON PANKEY,

Plaintiff-Appellant,

versus

AETNA LIFE INSURANCE COMPANY,

Defendant-Appellee.

Appeal from the United States District Court
for the Middle District of Florida
D.C. Docket No. 6:23-cv-01119-WWB-UAM

Before GRANT, LAGOA, and ABUDU, Circuit Judges.

PER CURIAM:

The parties cross-moved for summary judgment. The district court granted summary judgment for Appellee Aetna Life

Insurance Company (“Aetna”) thereby affirming the claims administrator’s decision to terminate Appellant Judson Pankey’s long-term disability (“LTD”) benefits. Pankey argues that the district court erred in concluding that Aetna’s decision was not arbitrary and capricious. After careful review of the record, and with the benefit of oral argument, we affirm.

I. FACTUAL AND PROCEDURAL HISTORY

A. The LTD Plan

Pankey worked as a Senior Vice President and Senior Project Manager for CPH Engineers, Inc. (“CPH”). As a CPH employee, Pankey received LTD coverage under an employee benefit plan (the “Plan”) governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* (“ERISA”). The Plan was funded through Group Policy No. GP-474696-GI, a group disability policy issued by Aetna. The Hartford served as the claims administrator.¹

The Plan includes the following “Test of Disability”:

Test of Disability

From the date that you first became disabled and until monthly benefits are payable for 24 months you meet the test of disability on any day that:

- You cannot perform the **material duties** of your **own occupation** solely because of an

¹ The Hartford is not a party to this appeal, and like the district court below, we use the term “Aetna,” even when referring to The Hartford’s actions.

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illness, injury or disabling pregnancy-related condition; and

- Your earnings are 80% or less of your **adjusted predisability earnings**.

After the first 24 months of your disability that monthly benefits are payable, you meet the plan’s test of disability on any day you are unable to work at any **reasonable occupation**² solely because of an **illness, injury** or disabling pregnancy-related condition.

(emphasis in original). Thus, the Plan distinguishes between an initial 24-month “own occupation” period and a subsequent open-ended “any reasonable occupation” period.

The Plan advises that claimants would no longer be “considered as disabled [or] eligible for long term monthly benefits” when the first of thirteen listed events occurred, including:

- The date you no longer meet the LTD test of disability, as determined by **Aetna**.
- The date you fail to provide proof that you meet the LTD test of disability.

(emphasis in original).

² The Plan defines “reasonable occupation” as “any gainful activity” for which “you are, or may reasonably become, fitted by education, training, or experience”; and which “results in, or can be expected to result in, an income of more than 60% of your **adjusted predisability earnings**.” (emphasis in original).

To meet the Test of Disability's earnings component, the Plan requires claimants to provide proof of income. The relevant provision advises, in part, that Aetna may require proof:

- That the person has sent **Aetna** copies of documents showing the effective dates and amounts of other income benefits.
- Of income you receive from any work for pay or profit.

If you do not provide the proof that **Aetna** may require, **Aetna** has the right to suspend or adjust this plan's benefits by the estimated amount of the other income benefits.

(emphasis in original).

The Plan clarifies when benefits are paid:

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

The group policy also includes a discretionary clause for claim terminations, which provides as follows:

Claim Determinations; ERISA Claim Fiduciary.

For the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), We are a fiduciary with complete authority to review all denied claims for benefits under this Policy. This includes, but is not limited to, the denial of certification of the **medical necessity** of hospital or medical treatment. In

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exercising such fiduciary responsibility, We shall have discretionary authority to determine whether and to what extent eligible employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under this Policy, the Certificate or any other document incorporated herein. We shall be deemed to have properly exercised such authority unless We abuse our discretion by acting arbitrarily and capriciously. We have the right to adopt reasonable policies, procedures, rules, and interpretations of this Policy to promote orderly and efficient administration.

(emphasis in original).

B. Pankey's Physical Disability and Initial Benefits

In September 2011, Pankey experienced “severe to profound sensorineural hearing loss,” which affected his ability to hear and engage in normal conversation or speech. As a result, he stopped working for CPH. Aetna then wrote to Pankey, acknowledging that he was “totally disabled” from performing his position’s responsibilities. Aetna thus notified Pankey that he could receive monthly benefits effective December 26, 2011, and for up to 24 months, as long as he remained “totally disabled” from his occupation. In defining “total disability,” Aetna identified the Plan’s Test of Disability, as well as the events upon which Pankey would no longer be considered disabled or eligible for LTD benefits.

Pankey received benefits for the 24-month “own occupational” period, until December 26, 2013. Once that period ended, Pankey was approved for any-reasonable-occupation benefits.

Pankey also began receiving monthly disability payments from the Social Security Administration (“SSA”) in May 2012.

C. Aetna’s Termination of Pankey’s Benefits³

On July 21, 2021, Aetna requested that Pankey provide several documents as “continuing proof” of his disability. Specifically, Aetna sought a completed Attending Physician’s Statement (“APS”) from Pankey’s healthcare provider, a completed Claimant Questionnaire, and copies of his relevant tax returns or Schedule K-1 forms. Pankey neither responded nor submitted the requested documentation. Nor did he respond to Aetna’s three subsequent requests for the materials—made on July 26, 2021, December 9,

³ For the purposes of this appeal, we focus on the facts leading up to Aetna’s decision to terminate Pankey’s benefits, as reflected in its March 8, 2023, termination letter. Even so, we note that the administrative record documents the parties’ substantial correspondence regarding Pankey’s LTD benefits and reflects that Aetna has terminated and reinstated those benefits on several occasions since 2013. For these terminations, Aetna cited Pankey’s repeated failure to provide requested materials, including questionnaires, medical records, and tax returns. Aetna reinstated Pankey’s benefits once he had furnished the appropriate materials, pursuant to its requests.

The parties repeatedly clashed over Aetna’s requests for financial information to satisfy the Plan’s Test for Disability. In particular, Aetna sought to verify that Pankey was not receiving work earnings from an entity called Brown Little Development. Pankey expressed concerns about the confidentiality of his tax returns and maintained that Brown Little Development was a passive real estate investment. Though he never provided his personal tax returns, Pankey did furnish Schedule K-1 forms and business tax returns for Brown Little Development to fulfill Aetna’s requests.

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2021, and May 2, 2022—even though Aetna warned that his failure to do so could result in the termination of his benefits.

After Pankey continued to withhold the requested documentation, Aetna notified him on July 15, 2022, that it was terminating his claim for LTD benefits. Aetna’s letter attributed this decision to “the fact that [it] didn’t have enough proof of loss” to evaluate Pankey’s disability. To that end, the letter included the Plan’s provisions for the Test of Disability and the end of LTD benefits eligibility, before setting forth the guidelines for an analyst to recommend terminating or denying a claim:

- Information was requested from a physician or claimant;
- Ongoing Disability cannot be determined without the requested information;
- The claimant is aware of what information is needed; and
- The information has not been received after at least two (2) follow ups.

Even so, Aetna offered Pankey another opportunity to submit the requested materials, emphasizing that:

If you have additional information that you believe may change our decision, please submit the required information to my attention. Specifically, you should send a completed [APS], completed Claimant Questionnaire, and tax returns/Schedule K1 forms from 2020 & 2021. If you would like this

information considered, we must receive it as soon as possible, but no later than 180 days from the date of this letter. We'll review the information and let you know if it changes our original claim determination.

(emphasis in original).

In January 2023, Pankey appealed the termination of his LTD benefits. Because Pankey did not furnish an updated Claimant Questionnaire or recent tax returns or Schedule K-1 forms with his appeal, Aetna twice renewed its request for those documents—first on February 3, 2023, and again on February 20, 2023.⁴ But Pankey did not provide the requested documents in response to either of those letters, so the termination of his benefits was upheld on appeal in a letter dated March 8, 2023.

D. The District Court Action

On June 14, 2023, Pankey sued Aetna for benefits, pursuant to 29 U.S.C. § 1132(a)(1)(B), alleging that he was insured under a group policy Aetna issued to his employer and that Aetna, acting as the claims administrator, was responsible for the final review of claims and the payment of benefits. Pankey contended he “was and is disabled as defined by the Plan” and therefore entitled to benefits, but that Aetna terminated those benefits thereby

⁴ Pankey provided Aetna a January 4, 2023, letter from his doctor, Lisa Spiegel; a 2023 SSA Statement; a Claimant Questionnaire dated February 19, 2018; a 2019 Schedule K-1 form; an Other Income Questionnaire from 2016; a copy of the LTD claim file; and documentation of his Social Security Status.

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breaching the Plan. After Aetna filed its Answer and the administrative record, the parties cross-moved for summary judgment in their respective favor.

In his motion for summary judgment, Pankey stated that the parties did not dispute his physical disability, but instead whether the specific information Aetna requested “was required to be submitted.” Pankey contended that Aetna’s decision to terminate his benefits was “both wrong and arbitrary and capricious[,]” because Pankey had either provided the information Aetna requested or, alternatively, the Plan was unclear and Aetna had not shown that tax returns or Schedule K-1 forms for Brown Little Development were needed to satisfy the Test of Disability. In addition, Pankey argued that Aetna’s actions should be limited to reducing his benefits, rather than terminating them outright.

Aetna, in its motion for summary judgment, contended that the claims administrator had discretion to terminate Pankey’s benefits given his failure to provide proof that he satisfied the Plan’s Test of Disability. Aetna asserted that Pankey had “ignored seven requests, made over the course of nearly two years” to submit the requested materials. Without this information, Aetna contended that Pankey could not be considered eligible for benefits under the Plan. Hence, Aetna argued, the termination was proper and summary judgment in its favor was proper as Pankey could neither establish that the termination was arbitrary and capricious, nor demonstrate that a conflict of interest affected Aetna’s decision.

The magistrate judge issued a report and recommendation recommending that the district court find Aetna's termination decision was arbitrary and capricious and that the district court grant Pankey's motion for summary judgment and deny Aetna's motion for summary judgment.

Aetna timely filed its objections to the report and recommendation. The district court sustained these objections and rejected the report and recommendation in several aspects.⁵ As a preliminary matter, the district court found that the Plan's provisions "clearly afford[ed]" Aetna discretion to reasonably determine whether Pankey had submitted sufficient proof of eligibility. The district court determined that, if Aetna had discretion to develop its own Test of Disability, it "necessarily follows that it must also have discretion to evaluate the sufficiency of proof" that Pankey meets the test. The district court then found it reasonable for Aetna to interpret the Plan "to allow for the termination of benefits absent sufficient proof." Because Aetna's interpretation both "[fell] within

⁵ The district court also identified factual obstacles to the recommendation's conclusion that Aetna's termination decision was arbitrary and capricious. The district court noted that Aetna had previously terminated Pankey's benefits because he had not provided his tax returns. The benefits were later restored after Pankey provided financial documents related to Brown Little Development, including Schedule K-1 forms for the entity. To the extent the instant situation reflected a "change in circumstance," the district court focused on the undisputed fact that Pankey had not provided updated Schedule K-1 forms for 2020 or 2021.

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its discretion” and was “reasonable,” the district court gave it deference.

Turning to the parties’ cross-motions for summary judgment, the district court clarified that its review was limited to Pankey’s claim for benefits pursuant to 29 U.S.C. § 1132(a)(1)(B). The district court distilled the parties’ summary judgment arguments down to the central question of whether Aetna’s termination decision was arbitrary and capricious and ultimately determined that Pankey had not made such a showing. To support that conclusion, the district court recognized both Aetna’s authority under the discretionary clause and Pankey’s “continuing obligation” to satisfy the Plan’s Test of Disability. The district court emphasized that Pankey had not provided documents Aetna had specifically requested to gauge his eligibility, and it determined that Pankey had not demonstrated that Aetna’s decision was “tainted” by a conflict of interest. Given those considerations, the district court concluded that Aetna’s interpretation and application of the Plan was reasonable and granted Aetna’s motion for summary judgment and denied Pankey’s motion for summary judgment.

Pankey timely appealed the district court’s order.

II. STANDARD OF REVIEW

We review “‘a district court’s grant of summary judgment *de novo* applying the same legal standards used by the district court.’” *S-Owners Ins. Co. v. Easdon Rhodes & Assocs. LLC, et al.*, 872 F.3d 1161, 1163 (11th Cir. 2017) (quoting *Galvez v. Bruce*, 552 F.3d 1238, 1241 (11th Cir. 2008)). We review *de novo* a district court’s

“interpretation of contract language.” *Id.* at 1164 (citing *Nat’l Fire Ins. Co. v. Fortune Constr. Co.*, 320 F.3d 1260, 1267 (11th Cir. 2003)).

“We review *de novo* a district court’s ruling affirming or reversing a plan administrator’s ERISA benefits decision, applying the same legal standards that governed the district court’s decision.” *Blankenship v. Metro. Life Ins. Co.*, 644 F.3d 1350, 1354 (11th Cir. 2011).

We can affirm a district court’s ruling “on any ground supported by the record.” *Krutzig v. Pulte Home Corp.*, 602 F.3d 1231, 1234 (11th Cir. 2010) (citing *Bircoll v. Miami-Dade Cnty.*, 480 F.3d 1072, 1088 n.21 (11th Cir. 2007)).

III. ANALYSIS

On appeal, Pankey contends the district court erred in concluding that Aetna’s termination of his benefits was not arbitrary and capricious.

To determine whether Aetna’s termination decision was arbitrary and capricious, we apply the framework established in *Blankenship v. Metropolitan Life Insurance Company*, 106 F.4th at 1355. That framework involves six steps:

- (1) Apply the *de novo* standard to determine whether the claim administrator’s benefits-denial decision is “wrong” (i.e., the court disagrees with the administrator’s decision); if it is not, then end the inquiry and affirm the decision.
- (2) If the administrator’s decision in fact is “*de novo* wrong,” then determine whether he was vested

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with discretion in reviewing claims; if not, end judicial inquiry and reverse the decision.

- (3) If the administrator’s decision is “*de novo* wrong” and he was vested with discretion in reviewing claims, then determine whether “reasonable” grounds supported it (hence, review his decision under the more deferential arbitrary and capricious standard).
- (4) If no reasonable grounds exist, then end the inquiry and reverse the administrator’s decision; if reasonable grounds do exist, then determine if he operated under a conflict of interest.
- (5) If there is no conflict, then end the inquiry and affirm the decision.
- (6) If there is a conflict, the conflict should merely be a factor for the court to take into account when determining whether an administrator’s decision was arbitrary and capricious.

Id.

Under our precedent, we can “skip step one,” if, “at step two,” we determine that the plan administrator was “vested with discretion in reviewing claims.” *Goldfarb v. Reliance Standard Life Ins. Co.*, 106 F.4th 1100, 1106 (11th Cir. 2024) (citations omitted). We do so here. Through its discretionary clause, the Plan plainly grants Aetna the “discretionary authority to determine whether and to what extent eligible employees and beneficiaries are entitled to benefits[.]” In addition, and looking ahead to step four, we need not consider whether Aetna operated under a conflict of interest,

because Pankey does not argue so on appeal. See *Access Now, Inc. v. Sw. Airlines Co.*, 385 F.3d 1324, 1330 (11th Cir. 2004) (“[T]he law is by now well settled . . . that a legal claim or argument that has not been briefed before the court is deemed abandoned and its merits will not be addressed.”); see also *Cagle v. Bruner*, 112 F.3d 1510, 1517 (11th Cir. 1997) (determining whether there was a conflict of interest as a preliminary matter). So, our core query takes place at step three, where we consider the reasonableness of Aetna’s decision to terminate Pankey’s benefits.⁶

Under the Plan, Pankey is entitled to disability benefits if he satisfies the Test of Disability. As relevant here, Pankey could meet this test “on any day [he is] unable to work at any reasonable occupation solely because of an illness, injury or disabling pregnancy-related condition.” And in defining “reasonable occupation,” the Plan highlighted “gainful activity” that “results in, or can be expected to result in, an income of more than 60% of . . . adjusted predisability earnings.” As such, the Test of Disability involved both a physical and financial component. Neither Pankey nor Aetna disputes that Pankey is physically disabled. Instead, the

⁶ Our review of whether that decision was arbitrary and capricious is limited to “whether [Aetna’s] interpretation of the plan was made rationally and in good faith.” *Cagle*, 112 F.3d at 1518 (citing *Blank v. Bethlehem Steel Corp.*, 926 F.2d 1090, 1093 (11th Cir. 1991)). We consider: “(1) the uniformity of [Aetna’s] construction; (2) the reasonableness of its interpretation; and (3) possible concerns with the way unexpected costs may affect the future financial health of [Aetna].” *Id.* Other relevant considerations include “the internal consistency of a plan, the relevant regulations formulated by administrative agencies, and the factual background of the determination.” *Id.* at 1518 n.6.

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parties diverge on the test's financial component and Aetna's related authorities.

Pankey needed to provide proof that he meets the Test of Disability's financial component. The Plan likewise authorizes Aetna to determine whether a claimant satisfies that test. Other provisions in the Plan underscore this allocation of authority, cautioning that Pankey would not be "considered as disabled" or "eligible" for long-term disability benefits if he did not meet the Test of Disability "as determined by Aetna." And because Aetna had clear authority to determine whether a claimant satisfies the Test of Disability, it follows, both logically and textually, that Aetna could weigh the sufficiency of proof provided by Pankey. Indeed, the Plan's language conditions benefits payments on Pankey's submission of "necessary proof" and allows Aetna to modify benefits if Pankey "[did] not provide the proof that Aetna may require[.]" Moreover, the Plan grants Aetna discretionary authority to "determine whether and to what extent eligible employees and beneficiaries are entitled to benefits" and to "adopt reasonable policies, procedures, rules, and interpretations" of the terms. Taken together, these provisions make clear that Aetna's interpretation of the scope of its authority was reasonable. Under the Plan, Aetna could determine what information was necessary to evaluate continued eligibility, request supporting documentation, and assess the sufficiency of Pankey's proof.

Based on its reasonable understanding of the Plan, Aetna requested documentation on Pankey's income and occupational

status, to evaluate whether he continued to satisfy the Test of Disability. Though Aetna initially sought Pankey's tax returns, Pankey concedes that Aetna permitted him to fulfill its requests with Schedule K-1 forms instead. That accommodation aligns with Aetna's discretion under the Plan and indicates that Aetna was not acting in bad faith. And Aetna's rationale for seeking updated financial information is persuasive: Pankey needed to prove a continuing disability, so Aetna was entitled to scrutinize whether his income or relationship with Brown Little Development had changed over time. Aetna's periodic requests for updated information were, therefore, reasonable to administer the Plan and verify Pankey's continued entitlement to benefits. Those requests may have been unwelcomed, but they were not arbitrary and capricious.

Nor was Aetna's ultimate decision to terminate Pankey's benefits unreasonable. Despite making seven requests, Aetna did not receive the requested tax returns or Schedule K-1 forms or the Claimant Questionnaire. These documents were needed to evaluate whether Pankey satisfied the Test of Disability, so his refusal to provide them justified termination under the Plan.

Pankey does not dispute his refusal to comply with Aetna's requests. Instead, he argues that Aetna administered the Plan inconsistently. But we are not persuaded, because that contention finds no support. Indeed, Pankey's own refusal to furnish an updated Schedule K-1 form and Claimant Questionnaire was inconsistent with the parties' prior course of conduct. Further, the

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record establishes that Pankey regularly refused to cooperate with Aetna's reasonable requests. Even after Aetna had terminated his benefits, Pankey was afforded multiple opportunities to cure the deficiencies, yet he refused to do so. On this record, we cannot conclude that Aetna's decision to terminate Pankey's benefits was arbitrary and capricious. We therefore affirm the district court's judgment.

IV. CONCLUSION

For the reasons discussed, we conclude that the district court did not err in granting Aetna's motion for summary judgment and denying Pankey's motion for summary judgment. We thus affirm the district court's order.

AFFIRMED.