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Newsletters

The LHD/ERISA Advisor

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Welcome to the first edition of *The LHD/ERISA Advisor*, a Hinshaw newsletter focusing on legal developments in the life, health, and disability areas. *The Advisor* will provide an analysis of the most current cases and trends on both ERISA-governed and individual policy claims. We sincerely hope the newsletter will provide useful context and support for your litigation and claim decisions going forward.

Because this is a new venture, our editors Peter Felsenfeld and Misty Murray welcome your comments and suggestions about how we can tailor *The Advisor* to best meet your needs. Our goal is to provide the most practical information possible, so please let us know what would be helpful to you. For now, we hope you enjoy our premier issue!

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Life, Health, Disability & ERISA Litigation

SCOTUS Reviews "Blissful Ignorance" as Statute of Limitations Defense

On December 4, 2019, the U.S. Supreme Court heard oral argument in *Intel Corp. Inv. Policy Comm. v. Sulyma*, 139 S. Ct. 2692 (2019). The question presented is whether the three year limitations period in 29 U.S.C. § 1113(2), which runs from "the earliest date on which the plaintiff had actual knowledge of the breach or violation," bars suit where all the relevant information was disclosed to the plaintiff more than three years prior to the filing of the lawsuit, but the plaintiff chose not to read—or could not recall having read—the information.

Christopher Sulyma ("Sulyma") was employed by Intel Corporation ("Intel") from 2010 through 2012 and participated in two of Intel's ERISA-governed retirement plans. Intel's investment committee managed the retirement plan funds. The committee disclosed its investment decisions to Sulyma and other participants through various documents available on Intel's websites. The documents disclosed, among other things, the committee's decision to participate in certain alternative investments that impacted plan performance. Sulyma accessed some of this investment information on the websites, but testified that he was not actually aware of the alternative investments while working at Intel. Rather, Sulyma claimed he did not become aware of the alternative investments and impact on his retirement accounts until October 2015, when he filed suit against Intel on behalf of himself and others similarly situated. Sulyma asserted a claim for breach of fiduciary duty, among others.

Intel argued the suit was untimely because Sulyma had actual knowledge of the alleged breach more than three years before he filed suit through the disclosures on Intel's website. The district court granted summary judgment in favor of Intel. Sulyma appealed to the Ninth Circuit on the grounds that the district court incorrectly interpreted the level of "actual knowledge" required by Section 1113(2).

The Ninth Circuit agreed with Sulyma and noted that ERISA does not define "knowledge" or "actual knowledge," but interpreted Section 1113(2) as requiring that the defendant show "the plaintiff was actually aware of the nature of the alleged breach more than three years before the plaintiff's action is filed." While the court noted that the "exact knowledge required will...vary depending on the plaintiff's claim," the Ninth Circuit emphasized that "for a plaintiff to have sufficient knowledge to be alerted to his or her claim, the plaintiff must have actual knowledge, rather than constructive knowledge."

In reaching this holding, the Ninth Circuit rejected the Sixth Circuit's reasoning in Brown v. Owens Corning Inv. Review Comm., 622 F.3d 564 (6th Cir. 2010) that "[w]hen a plan participant is given specific instructions on how to access plan documents, their failure to read the documents will not shield them from having actual knowledge of the documents' terms, " and that such constructive knowledge was sufficient to trigger the three-year statute of limitations period under Section 1113(2). While the Ninth Circuit recognized that there are "strong policy reasons" to conclude that "actual knowledge" may have a broader meaning under ERISA—including knowledge that a plaintiff can glean from corporate disclosures—the Ninth Circuit was ultimately not persuaded that the proffered policy reasons had force in this context.

The Supreme Court's decision will determine the burden of proof that defendants will be required to meet in order to show that a participant had actual knowledge of an alleged breach of fiduciary duty sufficient to trigger the three-year statute of limitations, and whether participants can avoid the three-year time bar by ignoring the disclosures sent to them.

| Return to Top of Page |

Ninth Circuit Affirms Dismissal in Fibromyalgia Disability Case

In *Demko v. Unum Life Ins. Co. of America,* 2019 U.S. App. LEXIS 31102 (9th Cir. Oct. 15, 2019), the Ninth Circuit affirmed Unum Life's determination that a Hollywood executive diagnosed with fibromyalgia was not disabled from performing her own occupation.

Disclaimer: Hinshaw represented Unum Life in all phases of the ERISA litigation.

Plaintiff Kelly Demko ("Demko") was diagnosed with fibromyalgia in 2009, but thereafter continued to work as a human resources executive for Amblin Entertainment. In January 2016, Demko stopped working and submitted a claim for long-term disability (LTD) benefits under her employer's LTD plan, claiming her fibromyalgia had become disabling, with "all over deep pain, foggy feeling, [and] severe depression."

In the months before she stopped working, Demko's medical records revealed that her fibromyalgia-related complaints were generally stable and well-controlled, and her diagnostic findings and physical examinations were normal, with no exacerbation or change in her condition. Additionally, Demko's prescribed treatment plan was conservative and lacked the more aggressive pain management and other treatment techniques one would expect for a patient with the disabling complaints Demko reported to Unum Life Insurance Company of America ("Unum Life"). Furthermore, Demko's psychiatrist reported that her cognitive functioning was normal, and her primary care physician routinely recorded normal mental status and cognitive functioning examination results.

Unum Life also contacted Demko's employer, who reported that Demko's work performance and work schedule had not changed in any way before she stopped working. The employer told Unum Life that Demko had stopped working because she was "terminated due to violation of company policy."

The district court reviewed Unum Life's claim decision *de novo*. In affirming the decisions, the court concluded that Demko did not show that her medical conditions rendered her totally disabled under the plan, and added that "mere subjective" complaints are insufficient to establish total disability.

Demko appealed to the Ninth Circuit. A panel of three judges affirmed the district court's decision, concluding that the court did not err in finding that Demko "was able to perform her job normally until she was terminated for non-medical reasons." The Ninth Circuit also rejected Demko's objections to the district court's evaluation of the evidence. The panel noted, *inter alia,* that the court had accorded Demko's treating physicians the "greatest weight" and did not rely heavily on the opinions offered by Unum Life's doctors, and also held that "an independent medical examination was not required, particularly when Demko proffered insufficient evidence to establish disability." Additionally, the panel held that "the district court duly considered Demko's subjective complaints, and reasonably concluded that they did not establish the requisite level of disability."

| Return to Top of Page |

Ninth Circuit Reverses Award of Attorneys' Fees

In *Gorbacheva v. Abbott Laboratories Extended Disability Plan, et al.*, 29 U.S. App. LEXIS 36542 (N.D. Cal. Dec. 10, 2019), the Ninth Circuit reversed a district court's award of attorneys' fees to an ERISA claimant as excessive because she had rejected a reasonable settlement offer.

Under ERISA, a claimant may receive attorneys' fees if he or she obtains *some degree of success* on the merits. The *Gorbacheva* court granted the defendant's motion for summary judgment on an ERISA disability claim because it determined that the plan administrator had not abused its discretion by denying a claim based on an ambiguous medical record. It also awarded attorneys' fees to the plaintiff because she had obtained an earlier remand for further consideration of her ERISA claim.

The Ninth Circuit determined that an award of fees would be appropriate for this limited success. However, it found the district court's award of all fees incurred in achieving the remand to be unreasonable because plaintiff had previously declined defendant's offer to remand the matter so that the plan could consider additional evidence. As the Ninth Circuit noted, the district court's remand order "was nearly identical to the settlement offer and contained no additional benefit."

Thus, the Ninth Circuit held the district court had abused its discretion by awarding plaintiff attorneys' fees for hours expended after she had rejected the plan's offer. The court remanded the matter to allow the district court to re-calculate the fee award to include only those fees incurred prior to her rejection of the settlement offer.

| Return to Top of Page |

Ohio State Court Affirms Dismissal of Bad Faith and Punitive Damages Claim

In *Shah v. Metropolitan Life Ins. Co.*, 2019 U.S. Dist. LEXIS 25695 (S.D. Ohio Feb. 19, 2019), the U.S. District Court for the Southern District of Ohio dismissed a plaintiff insured's bad faith and punitive damages claims where there was a genuine dispute as to his right to benefits in light of the policy's coverage for disability caused by accident, but not by injury.

An interventional cardiologist—who was covered by an individual disability policy—claimed to suffer from neck, shoulder, and back pain, which worsened over time and was apparently caused by cervical disc disease and radiculopathy. The claimant ("Shah") took the position that he qualified for benefits under the portion of his policy providing benefits for disability caused by "accident."

Defendant Metropolitan Life Insurance Company ("MetLife") denied the claim, asserting the development of the insured's chronic condition over time constituted a sickness, as opposed to an acute, traumatic event that would qualify as an accident under the policy.

After Shah sued for breach of contract, bad faith, and punitive damages, MetLife filed a motion for partial summary judgment, seeking dismissal of the bad faith and punitive damages portions of the complaint. MetLife argued the "genuine dispute" doctrine required dismissal of these requests, even if the court assumed the denial was a breach of contract, based on case law holding that unless it appears the claim denial was arbitrary or capricious, extra-contractual relief should be dismissed.

The court found MetLife had considered all the information provided to them, and that a jury could not reasonably find the carrier lacked good faith in its processing of the claim.

Accordingly, the court granted MetLife's motion for partial summary judgment.

| Return to Top of Page |

Ohio District Court Rejects MSPA and ERISA Discrimination Claims

Seeking to control healthcare costs, many group health plans have adopted amendments that lower reimbursement rates for the treatment of end-stage renal disease ("ESRD"), which requires long-term dialysis treatment or a kidney transplant, resulting in higher-than-average medical expenses. In several recent lawsuits, large dialysis providers have challenged these amendments, contending that they result in violations of the Medicare Secondary Payer Act.

The Medicare Secondary Payer Act ("MSPA"), provides that employer-based group health plans must act as the primary payer for an individual's dialysis treatment during the first 30 months in which the individual is eligible for Medicare based on ESRD. According to 42 U.S.C. 426-1(b)(1), an individual with ESRD becomes eligible for Medicare on the first day of the fourth month of dialysis treatment, but many working-age individuals with ESRD also have employer-based coverage under a group health plan. In 1980, Congress enacted the MSPA, 42 U.S.C. §1395y(b), which requires that Medicare act as the secondary payer and employer-based coverage act as the primary payer for all dialysis treatments provided during the first 30 months in which an individual is eligible for Medicare due to ESRD.

The MSPA contains several provisions intended to ensure that employer-based plans pay on a primary basis for the duration of the 30 month "coordination period." The MSPA's private right of action allows for suit against a group health plan if: a) the plan fails to make a primary payment due under the MSPA; and b) Medicare then steps in and makes a payment that the primary plan was required to make. 42 U.S.C. § 1395y(b)(3)(A).

Additionally, the MSPA forbids employer-sponsored plans from discriminating on the basis of whether an individual with ESRD has Medicare coverage. Specifically, under the MSPA's "take into account" provision, a "group health plan … may not take into account that an individual is entitled to or eligible for benefits under" Medicare due to ESRD during the coordination period. 42 U.S.C. 1395y(b)(1)(C)(i). And, the MSPA's "differentiation" provision states that a group health plan "may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner." § 1395y(b)(1)(C)(ii). Plan provisions prohibited by the non-differentiation rule include benefit limitations that apply

to persons who have ESRD, but not to other enrollees. 42 C.F.R. §§ 411.161(b).

Dialysis providers have filed several lawsuits challenging plan amendments that lower the rate of reimbursement for dialysis, contending that they run afoul of the MSPA. A recent case, *DaVita, Inc. v. Marietta Mem'l Hosp. Emple. Health Ben. Plan*, 2019 U.S. Dist. LEXIS 160793 (S.D. Ohio Sep. 20, 2019), involved ESRD-related amendments to the group health plan sponsored by Marietta Memorial Hospital ("Marietta"). The hospital amended its plan to classify all ESRD providers as out-of-network, which reduced the reimbursements the plan paid for ESRD services. DaVita, Inc., which has a 37% share of the market for dialysis services, sued Marietta, contending that its practice of reimbursing all ESRD providers at out-of-network rates had a disparate impact on individuals with ESRD, because they make up a disproportionate number of individuals receiving dialysis.

On Marietta's motion to dismiss under Federal Rule 12(b)(6), the *Marietta* court—like several other courts considering this issue—concluded that Marietta's ESRD amendments complied with the MSPA's nondiscrimination provisions. A group health plan violates the MSPA's "take into account" provision only "through disparate treatment based on Medicare eligibility—that is, when a group health plan treats those eligible for Medicare differently than those who are not." A health plan violates the non-differentiation provision only "when it treats those with ESRD differently than those who do not have ESRD." Marietta's plan amendments did not violate either of the MSPA's nondiscrimination provisions because the provisions "apply to all enrollees receiving dialysis," not just those who were eligible under Medicare due to ESRD.

The court also rejected DaVita's ERISA claims. The plan and Marietta had not discriminated among participants based on whether they had ESRD, an alleged violation of 29 U.S.C. § 1182(a)(1), because individuals with ESRD were provided the same benefits as those without ESRD. Similarly, the court rejected DaVita's argument that the amendments improperly classified ESRD providers as out-of-network providers. Again, because the plan amendments did not run afoul of the MSPA, the plan had properly paid DaVita at out-of-network rates.

Finally, the court determined that DaVita had no private right of action under § 1395y(b)(3)(A). The provider did not allege that Medicare ever "had to step in to make payments that the Plan…failed to make." Medicare only began making payments after the patient voluntarily ended her coverage under the plan and enrolled in Medicare.

DaVita has appealed the *Marietta* ruling. The ruling from the U.S. Court of Appeals for the Sixth Circuit bears watching by health payers and their counsel.

| Return to Top of Page |

California Federal Court Rules Claim Denial was Unequivocal

In *Daneman v. Guardian Life Ins. Co. of Am.*, 2019 U.S. Dist. LEXIS 42881 (C.D. Cal. March 11, 2019), the U.S. District Court for the Central District of California held that an insurer's statement in a claim denial letter that it would reconsider the claim should the claimant submit additional information did not render the denial "equivocal."

The *Daneman* claimant ("Daneman") filed a claim under an individual disability policy in 2013, asserting his disability began in 2006. The insurer, Guardian Life Insurance Company of America ("Guardian Life") denied the claim based on Daneman's failure to receive medical care, and because the coverage had lapsed. Thereafter, Daneman repeatedly provided additional support for his claim; Guardian Life repeatedly denied the claim, each time expressing a willingness to review additional information.

After Daneman sued, Guardian Life filed a summary judgment motion, based in part on Daneman's violation of the statute of limitations. Daneman argued that the carrier's stated willingness to reconsider its denial rendered the rejection of the claim equivocal, which prevented the limitations period from running.

The court rejected Daneman's argument, finding that a statement of willingness to consider does not render a denial equivocal. In doing so, the court cited case law establishing that an insurers' use of language such as defending a denial "based upon the information available to us at this time," referring to the right of the insured to seek a review by the California Department of Insurance, or a general invitation to submit "any other information that might affect the decision," did not render a denial equivocal.

| Return to Top of Page |

Fifth Circuit Defines Meaning of "Regular Occupation" Under LTD Policy

In *Nichols v. Reliance Standard Life Ins. Co.*, 924 F.3d 80 (5th Cir. 2019), the U.S. Court of Appeals for the Fifth Circuit held that when an LTD policy funding an ERISA plan defines "regular occupation" as the way the claimant's job is performed in the national economy, that language is to be honored in assessing entitlement to disability benefits.

In *Nichols*, the claimant ("Nichols") worked at a chicken processing plant as a "Hazard Analysis Critical Control Point Coordinator," where she was routinely exposed to temperatures around 40 degrees. She stopped working, claiming that she had developed Raynaud's phenomenon, a circulatory disorder that could cause gangrene if she continued working in the cold. She sought LTD benefits under a policy issued to her employer by Reliance Life Insurance Company ("Reliance") and governed by ERISA.

The policy defined "total disability" as meaning that the claimant could not perform the duties of her "regular occupation." In turn, "regular occupation" was defined as the way the claimant's job "is normally performed in the national economy" and not the way it is "performed for a specific employer or in a specific locale." The policy provided Reliance with discretion in making claims decisions.

Nichols made a claim for LTD benefits. Reliance denied Nichols' claim, finding through consultation with the Department of Labor's Dictionary of Occupational Titles (DOT) that her occupation was best described as that of a "sanitarian," the duties of which did not involve routine exposure to the cold. It further found that Nichols' need to be exposed to the cold was "job site specific." Reliance upheld its decision after Nichols appealed, and Nichols then filed suit. Reliance moved for summary judgment. The district court found that Reliance abused its discretion, denied Reliance's motion for summary judgment, and reversed the company's decision to deny benefits. Reliance appealed.

The Fifth Circuit reversed, finding both that a claims administrator need not consider each of a claimant's job duties to determine her regular occupation, and that in any event, Reliance's classification was "easily based" on substantial evidence, to wit, a DOT classification, so there was no abuse of discretion. Based on Fifth Circuit precedent, the *Nichols* court noted that DOT entries may serve as evidence of material duties of a claimant's regular occupation if they are in the administrative record, even though the duties identified by the DOT do not match each duty the claimant actually performs. The court also found that Nichols' and the district court's argument "missed the mark" in asserting that "common sense says that an occupation involving inspection and packaging of meat products would require exposure to refrigeration and low temperatures." It found that "any requirement to work in the cold is specific to a subset of sanitarians who work in poultry processing plants."

As a caution to practitioners, the *Nichols'* court stated in a footnote that the "regular occupation" analysis in the Fifth Circuit may differ from that of the Second and Third Circuits.

| Return to Top of Page |

Florida Federal Court Holds Claimed Future Benefits Cannot Be Used in Diversity Jurisdiction Determination

In *Parrott v. Northwestern Mut. Life Ins. Co.*, 2019 U.S. Dist. LEXIS 128827 (M.D. Fla. Aug. 1, 2017), a U.S. District Court for the Middle District of Florida held that parties cannot include future disability benefits in the "amount in controversy" calculation for the purposes of establishing diversity jurisdiction when the complaint seeks such benefits, but the plaintiff concedes that they are not available as a matter of law.

That was the factual scenario in *Parrott*, where the plaintiff's complaint sought both past due and future benefits under an individual disability policy. The defendant insurer, Northwestern Mutual Life Insurance Company ("Northwestern Mutual"), removed the complaint on the basis that the damages requested exceeded $75,000. The plaintiff ("Parrott") sought to remand, conceding in his motion that he was not entitled to future benefits under state law.

As Parrott admitted, under Florida law, recovery under an individual disability income insurance policy is generally limited to the installments which have accrued at the institution of the action. There is an exception when an insurer repudiates the policy. Parrott, however, alleged breach—not repudiation—and he was thus limited to past benefits.

Northwestern Mutual argued that the future benefits sought in the complaint must be included in the court's calculation of amount in controversy regardless of their recoverability, because Parrott's withdrawal of the demand constituted a post-removal event.

The court rejected the argument, holding that because Parrott could never recover the future benefits, they should not be used to evaluate whether the $75,000 jurisdictional minimum had been satisfied. "Thus, the actual issue presented can be simply stated: if it appears to a legal certainty that Parrot can't recover future benefits under the policy, then the amount in controversy doesn't exceed $75,000, and the action should be remanded," the court said.

The *Parrott* case presents an interesting study on how to calculate the amount in controversy when a plaintiff's complaint seeks future benefits that are not available under the subject policy.

| Return to Top of Page |

Courts Say Abuse of Discretion Standard is "Highly Deferential" to Plan Administrator's Denial of Benefits

In *Rittinger v. Healthy Alliance Life Ins. Co.,* 914 F.3d 952 (5th Cir. Jan. 31, 2019), and *Roebuck v. USAble Life*, 380 F. Supp. 3d 852 (E.D. Ark. Mar. 30, 2019), the courts found no abuse of discretion where the ERISA plan administrators denied claims benefits, one involving an LTD claim and one in the healthcare context. While both courts found in the plan administrator's favor, the Fifth Circuit's decision especially emphasized the abuse of discretion standard's highly deferential nature, which required the administrator to demonstrate merely "more than a scintilla of evidence" in support of its position.

In *Rittinger*, the Fifth Circuit held that the ERISA plan administrator, Anthem, did not abuse its discretion in concluding that the plan excluded coverage for the claimant's (Rittinger) bariatric surgery. The plan in question excluded "bariatric surgery, regardless of the purpose it is proposed or performed," but nevertheless covered "excessive nausea/vomiting." Rittinger underwent bariatric surgery and suffered complications that resulted in follow-up surgery and intensive care. Anthem denied coverage and affirmed the denial in response to Rittinger's first-level internal appeal. In her second-level appeal, Rittinger argued that the "excessive nausea/vomiting" exception applied because she had suffered from Gastroesophageal Reflux Disease (GERD) and esophagitis, which were linked to nausea and vomiting, and underwent surgery to address those problems. Anthem affirmed the denial of coverage.

In Rittinger's ensuing lawsuit, the district court found that Anthem abused its discretion in denying the second-level appeal because it failed to give sufficient weight to Rittinger's evidence linking her GERD/esophagitis to her nausea and vomiting. The Fifth Circuit disagreed and reversed. The court explained that this "highly deferential standard of review" required affirmance of the administrator's decision where it is "supported by substantial evidence" – "more than a scintilla, less than a preponderance" – and "is not arbitrary or capricious." The Fifth Circuit concluded that Anthem cleared this "very low" threshold because Rittinger's intake medical record documented chief complaints of "morbid obesity and abdominal pain" and affirmatively noted "no vomiting" and "no nausea." The court further noted that nausea and vomiting did not appear in the administrative record until after the coverage dispute arose, when Rittinger and her friends submitted affidavits stating that she suffered from nausea and vomiting. Finding that "Anthem was not duty-bound to defer to shifting medical opinions" and was entitled to exercise its discretion in siding with one medical view over a competing view, the Fifth Circuit held that Anthem did not abuse its discretion in denying coverage.

The *Roebuck* court reached a similar conclusion in the LTD context. There, the claimant ("Roebuck"), a nurse engaged in the sedentary evaluation of health insurance claims, applied for disability benefits following a motor vehicle collision that caused pain in her neck, lower back, and wrist. USAble's medical consultant reviewed voluminous records from Roebuck's treatment providers and found them inconsistent and unclear on the issue of whether Roebuck was capable of sedentary work. A subsequent functional capacity evaluation (FCE) resulted in a finding that Roebuck was capable of working full-

time, prompting USAble to deny benefits. Roebuck appealed and submitted 1,300 pages of medical records purporting to support her disability. USAble referred the new information to a second medical consultant, who similarly concluded that Roebuck's claimed disability was unsupported. USAble upheld the initial denial, and Roebuck sued.

In finding that USAble's denial of benefits was supported by substantial evidence, the court pointed to Roebuck's FCE, citing Eighth Circuit law to the effect that such an evaluation "alone constitutes more than a scintilla of evidence when the FCE concludes a benefits claimant does not meet an ERISA plan's 'disability' definition." The court found that Roebuck's FCE's conclusion that she was "able to tolerate the Sedentary level of work for the 8-hour/40-hour work week" provided "objective clinical evidence" that she was able to work. The court further based its holding on the findings of USAble's medical consultants, noting the lack of evidence that their compensation was tied to their findings, and further emphasizing that USAble was not required to give special weight to the opinions of Roebuck's treating physicians.

Finally, the court noted that USAble's dual role as plan administrator and insurer created a conflict of interest which must be considered in evaluating whether it abused its discretion. However, the court found that USAble's conflict was "reduced close to or to the vanishing point" because USAble retained an "independent" FCE provider, its in-house consultants considered Roebuck's medical records, and it thoroughly explained its claim decision. As such, the court held that USAble did not abuse its discretion and entered judgment in its favor.

| Return to Top of Page |

Failure to Plead "Special Relationship" Results in Dismissal of Breach of Fiduciary Duty Claim

In *Tifer v. New York Life Ins. Co.*, 2019 U.S. Dist. LEXIS 119702 (N.D. Fla. July 18, 2019), a U.S. District Court for the Northern District of Florida dismissed a state law claim for breach of fiduciary duty against an insurer because the plaintiff insured had failed to plead the existence of a "special relationship" that might sustain such a claim.

The case illustrates the factors that courts may consider when determining whether a fiduciary relationship exists between insureds and insureds under certain state laws.

The complaint in *Tifer* asserted claims for breach of contract and breach of fiduciary duty arising from allegations that defendant insurer had failed to pay all benefits due under an individual disability income policy. The defendant insurer, New York Life Insurance Company ("NYL") moved to dismiss the breach of fiduciary claim, arguing that Florida law does not recognize a fiduciary duty from an insurer to a first-party insured.

Plaintiff Tifer ("Tifer") acknowledged that NYL had correctly stated the general rule. However, citing a 2017 Florida district court decision in *Asokan v. Am Gen. Life Ins. Co.*, he countered that an exception exists where there is a special relationship of trust between the parties. Relevant factors to determine the existence of such a relationship may include "the extent of insurance company's involvement in the client's decision to purchase insurance, and whether the insurance company held itself out has having experience in the field and the insured relied upon that expertise," the *Asokan* court stated.

Tifer argued that a determination regarding these factors creates a question of fact that precludes dismissal at the pleading stage. The court rejected this argument.

While explicitly withholding judgment on whether *Asokan* had been correctly decided, the court found that Tifer's complaint failed to allege any facts tending to establish a special relationship between insurer and insured when Tifer purchased the subject policy. Additionally, the court stated that Tifer could not allege such facts for the first time in opposition to a motion to dismiss.

Accordingly, the court granted NYL's motion to dismiss plaintiff's state law claims for breach of fiduciary duty.

| Return to Top of Page |

First Circuit Clarifies ERISA's Timing Requirements for Appealing Adverse Benefits Determination

In *Fortier v. Hartford Life & Accident Ins. Co.*, 916 F.3d 74 (1st Cir. 2019) the U.S. Court of Appeals for the First Circuit clarified ERISA's timing requirements with respect to appealing an adverse benefits determination and rejected a claimant's attempts to salvage an untimely appeal under equitable doctrines.

Specifically, the court held that a claimant's 180-day appeal period commences upon notification of the benefits decision, not when benefits terminate, as the plaintiff ("Fortier") had argued. In addition, the court held that the doctrines of "substantial compliance" and the notice-prejudice rule, both of which ERISA plaintiffs sometimes invoke to excuse late appeals, were inapplicable.

The dispute in *Fortier* arose from Hartford Life & Accident Insurance Company's ("Hartford") notification to the claimant that her LTD benefits would terminate after 24 months, pursuant to the plan's Mental Illness Limitation. Under 29 C.F.R. § 2560.503-1(h)(3)(i), a group health plan must provide a claimant 180 days after notification of an adverse benefit determination to file an appeal. Hartford, whose plan incorporated the 180 day period, declined to consider the *Fortier* claimant's appeal because it was filed two months late.

Fortier filed a complaint in district court under ERISA Section 502(a) and argued that her appeal was timely filed because Hartford received it within 180 days of the benefit termination date or, in the alternative, that equitable doctrines required Hartford to process her appeal. The court rejected both arguments.

With respect to timing, the court held that the plain language of § 2560.503-1(h)(3)(i) establishes that notice—not the termination of benefits—is the key event triggering ERISA's appeal deadline. Fortier's equitable arguments fared no better. The court held that the "substantial compliance" doctrine only applies to an insurer's failure to comply precisely with notice requirements. According to the court, applying the doctrine to a claimant's late appeal would render it virtually impossible for plan administrators to enforce administrative deadlines.

Furthermore, the court held that New Hampshire's notice-prejudice rule was inapplicable in the context of ERISA appeals. "Indeed, no federal court has applied any state's common law notice-prejudice rule to excuse a late administrative appeal. "

Ultimately, the court affirmed the district court's granting of Hartford's motion to dismiss on the grounds that the claimant had failed to exhaust her administrative remedies. The case is potentially significant to plan administrators because of its strict enforcement of ERISA's timing requirements regarding appeals.

| Return to Top of Page |