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Newsletters

The LHD/ERISA Advisor

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

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.

U.S. Supreme Court Issues Ruling on 'Actual Knowledge' Required to Trigger ERISA's Limitations Period

On February 26, 2020, the Supreme Court issued its decision in *Intel Corp. Inv. Policy Comm. v. Sulyma*, __. U.S. __, 140 S. Ct. 768 (2020). The Court unanimously held that Christopher Sulyma ("Sulyma") did not necessarily have

Attorneys

Robert C. Bohner

Peter J. Felsenfeld

Peter E. Pederson

M. Annie Santos

Service Areas

Life, Health, Disability & ERISA Litigation

"actual knowledge" under 29 U.S.C. § 1113(2) of the information contained in the disclosures that he received, because he did not read, or could not recall reading, the disclosures. Rather, to meet § 1113(2)s "actual knowledge" requirement, the Court held that Sulyma must in fact have become aware of the information in the disclosures sent to him.

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 disclosed its investment decisions to participants through various documents available on Intel's website. The documents disclosed, among other things, the committee's decision to participate in alternative investments, such as hedge funds and private equity. While Sulyma accessed the Intel website, he testified that he did not recall reading the disclosures regarding his investments while working at Intel, and was not aware of the alternative investments and the impact on his retirement accounts until October 2015. He filed his lawsuit on behalf of himself and others similarly situated more than three years after the disclosures were made available to him.

The issue presented to the Court was 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," barred Sulyma's lawsuit.

While ERISA does not define the phrase "actual knowledge" in the statute, the Court found that its meaning is plain and that to have "actual knowledge" of a piece of information, one must in fact be aware of it. The Court found support for this interpretation in dictionaries, as well as congressional intent drawing the distinction between actual knowledge and constructive knowledge in other provisions of ERISA.

The Court noted, however, that the disclosures to Sulyma were "no doubt *relevant* in judging whether he gained knowledge of that information." The Court further stated that its decision did not foreclose "any of the 'usual ways' to prove actual knowledge at any stage in the litigation," such as by "inference from circumstantial evidence." For example, if electronic records showed that a plaintiff viewed the relevant disclosures and evidence suggested that the plaintiff took action in response, actual knowledge could be established. Additionally, the Court stated that its opinion also did not preclude defendants from contending that evidence of "willful blindness" supports a finding of "actual knowledge."

Intel did not argue that "actual knowledge" was established in any of these ways, it only argued that it need not offer any such proof in light of the disclosures provided. Viewing the facts in the light most favorable to Sulyma, there was a genuine dispute as to his actual knowledge, precluding summary judgment in Intel's favor.

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Ninth Circuit Affirms Judgment for Unum Life In ERISA Disability Benefits Case

In *Western v. Unum Life Insurance Company of America,* 798 F.App'x 154, 2020 U.S. App. LEXIS 8362 (9th Cir. March 17, 2020), the Ninth Circuit affirmed Unum Life's determination that an aerospace engineer diagnosed with chronic fatigue syndrome was not disabled under the terms of a group long-term disability policy.

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

Plaintiff Lonny Western ("Western"), an engineer for The Aerospace Company, was a participant in his employer's LTD plan, which was funded by a group insurance policy issued by Unum Life. Western stopped working in 2010 and subsequently submitted a claim for LTD benefits based on a diagnosis of chronic fatigue syndrome ("CFS").

After initially approving Western's LTD claim based on his subjective reports of impairment, Unum Life investigated and evaluated Western's claim. Despite the diagnosis of CFS reported by his doctor, Western did not mention fatigue when Unum Life asked him why he could not return to work throughout the course of his claim. Instead, Western repeatedly reported he was unable to return to work because of purported cognitive deficits, which he attributed to recurring fevers and CFS. Accordingly, Unum Life focused its evaluation on Western's functional capacity, rather than the validity of his CFS diagnosis, and concluded that the available medical information established that Western was not cognitively impaired. During the claim review process, two separate neuropsychological evaluations (one arranged by Western, one arranged by Unum Life) each confirmed that Western was not cognitively impaired, despite his assertions to the contrary. Unum Life also arranged for several of its medical consultants (including an infectious disease specialist, an internal medicine physician and a neuropsychologist) to review Western's medical information. Based on the findings and opinions

of those medical consultants and the neuropsychologists who evaluated Western, Unum Life determined that Western was not entitled to benefits under the LTD Plan.

Western filed suit against Unum Life seeking not only to recover the LTD benefits in dispute, but also seeking equitable relief pursuant to 29 U.S.C. § 1132(a)(3). The district court reviewed Unum Life's claim decision *de novo* and affirmed the decision. Following a bench trial, the court concluded that Western "failed to demonstrate that he is disabled as that term is defined in the LTD Policy." The court also found that Western's breach of fiduciary duty claim was "barred because it is redundant of his claim for benefits."

Western appealed to the Ninth Circuit. He argued, *inter alia*, that the district court applied a "de facto" deferential review favoring Unum Life's evidence, and should have focused its review on the validity of his CFS diagnosis and the "evidence relevant to the time period of the termination of benefits and afterwards."

A panel of three Ninth Circuit judges affirmed the district court's decision. The Ninth Circuit held that the court correctly applied a *de novo* standard of review and did not err in finding that Western was no longer disabled as of March 12, 2015. The panel noted that the court "appropriately focused its analysis on whether Western was disabled by cognitive deficits," and concluded that "the record supported its finding that he was not." The Ninth circuit also held that the court did not err by dismissing Western's claim for breach of fiduciary duty.

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Eighth Circuit Upholds Payment for Out-of-Network Air Ambulance Flight at 150 Percent of Medicare Rates

In *Mitchell v. Blue Cross Blue Shield of N.D.*, 2020 U.S. App. LEXIS 8818 (8th Cir. Mar. 20, 2020), the Eighth Circuit upheld the payment of 150% of Medicare rates for an out-of-network air ambulance flight, although the patient's health plan did not expressly provide for the use of such rates.

On January 15, 2014, Valley Medical Flight transported the patient via fixed-wing air ambulance when she presented to a rural medical center with an emergency cardiac condition that required treatment at a larger hospital. The patient was covered under a benefit plan (the "Plan") sponsored by her husband's employer and issued by Blue Cross Blue Shield North Dakota ("BCBSND"). The ambulance provider billed BCBSND $33,200, which included a $21,500 charge for the ambulance base rate (HCPCS A0430), an $11,250 mileage charge for the 90-mile flight (HCPCS A0435), and a $450 charge for IV fluids (A0398). In March 2014, BCBSND partially allowed the claim and paid a total of $6,759.98, leaving the patient and her husband responsible for the remainder. BCBSND based the payment amount on 150% of the 2013 Medicare rates for rural air ambulance. In addition, BCBSND denied the separate $450 charge for IV fluids because it was included in the "payment made for a related procedure," namely the air ambulance base rate.

The members then sued BCBSND under ERISA, contending that the payment was arbitrary and capricious, because the Plan did not state that out-of-network services would be reimbursed at 150% of Medicare rates, and that the rate of payment was so low as to violate BCBSND's fiduciary duty to act in the interest of plan members. With regard to out-of-network reimbursement, the plan simply provided that the "allowance" or "allowed charge" was the "maximum dollar amount that payment for a procedure" was based on "as determined by BCBSND." Because the plan did not contain express language calling for the use of Medicare rates on air-ambulance claims, BCBSND relied on a 2014 letter, which had been sent to participating providers, but not plan members. The letter stated that BCBSND would cover air ambulance base rates and mileage charges at 150% of the 2013 Medicare rural air ambulance rate.

The district court affirmed BCBSND's payment of Medicare rates for the base rate and air mileage charges, but overturned BCBSND's denial of the $450 charge for IV fluids, finding that BCBSND's position was an improper post-hoc rationale. The members appealed.

The Eighth Circuit concluded that BCBSND had acted reasonably in basing the ambulance provider's payment on 150% of Medicare rates. First, the plan granted BCBSND discretion, and payment of 150% Medicare rates did not contravene any plan language or render any of its terms superfluous. Second, although BCBSND had not provided the plaintiffs

advance notice that payment would be based on 150% of Medicare rates, it ultimately disclosed the basis for the payment during the claim review process. Third, the use of the Medicare rates did not amount to a prohibited post-hoc rationale because those rates had been set forth in the letter BCBSND sent to participating providers just two days before the flight. Fourth, while the plaintiffs contended that BCBSND's payment rate subjected them to excessive balance bill liability—in violation of BCBSND's duty to act for the exclusive purpose of providing benefits to plan members—no rule prohibited the plan sponsor from granting BCBSND broad discretion to determine the allowed amount for the flight. Setting air ambulance reimbursement in accordance with an objective external standard, namely Medicare rates, did not violate any duty BCBSND had to act in the members' interests. The court found that indexing the allowed amount to an external benchmark, such as the "usual and customary amount," or Medicare rates, permits a court to evaluate the reasonableness of the claims administrator's payment decisions.

The court then reversed the district court's determination that BCBSND had adopted a prohibited post-hoc rationale for its denial of the separate charge for IV fluids administered during the flight. After Valley Medical Flight initially submitted its claim, BCBSND issued an EOB explaining that the plan did not cover the separate medical supply charge because it was included in the base rate for air ambulance services. BCBSND therefore had not raised this ground for the denial for the first time in the litigation, and the basis for the denial was consistent with the plan's definition of ambulance services.

This case can be cited for the proposition that a health plan's claims administrator may validly exercise its discretion to base reimbursement for out-of-network services on Medicare rates, even when the plan does not call for the application of such rates, at least when the claims administrator has previously notified participating providers that such rates will be used.

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Ninth Circuit Affirms $6.5 Million Bad Faith Verdict Against Disability Insurer

In *McClure v. Country Life Ins. Co.*, 795 Fed. Appx. 548 (9th Cir. 2020), the Ninth Circuit affirmed a $6.5 million bad faith verdict against a disability insurer that included a $1.29 million award for emotional distress damages even though the plaintiff had provided no medical evidence demonstrating emotional trauma.

In this case, plaintiff Benjamin McClure ("McClure") sought benefits under an individual disability income policy issued by County Life Insurance Company ("Country Life") after suffering a head injury. McClure claimed that post-concussive syndrome prevented him from performing the material duties of his profession as the manager of an insurance company call center. In addition, McClure claimed that he suffered from a history of depression, which rendered him vulnerable to emotional injury.

Country Life initially accepted McClure's claim and paid benefits for approximately 13 months, but then terminated benefits upon finding that McClure was no longer totally disabled under the subject policy. McClure sued Country Life and its affiliate CC Services, Inc., ("CCS") (collectively "Defendants") in Arizona District Court, alleging causes of action for breach of contract and bad faith. McClure claimed at trial that Defendants denied his claim without reviewing his most recent medical records, including records from the physicians who had attested to his disability.

A federal jury returned a verdict in favor of McClure on both causes of action. On the bad faith allegations, the jury found that CCS employees were compensated, in part, based on the profitability of CCS, which in turn depended on the decisions those employees made concerning disability benefits.

The jury ultimately awarded McClure approximately $200,000 in past and future disability benefits and $2,500,000 in punitive damages against each defendant. In addition, the jury awarded $1,290,000 in damages for emotional distress—even though McClure provided no medical records or medical testimony establishing that the denial of benefits caused his allegedly worsening mental health condition.

The district court, in denying Defendants' motion for a new trial, held that proof of causation did not require such evidence. In addition, the court held that the award was appropriate in light of a jury instruction stating that McClure was entitled to emotional distress damages if the adverse benefits decision exacerbated a pre-existing mental condition. In sum, the evidence at trial "painted a picture of emotional pain brought on by the uncertainties of the family finances and of their

future, resulting from the termination and the coverage battle with Defendants, all of which came at a time when McClure was vulnerable and experiencing severe depression."

The Ninth Circuit affirmed every aspect of the ruling, finding there was sufficient evidence to support the jury's conclusions. The *McClure* case is a cautionary tale for insurers, as it indicates Ninth Circuit courts may allow a jury to infer significant emotional distress damages where there is scant evidentiary support.

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First Circuit Affirms Offset of Claimant's LTD Benefits by Amount of His VA Benefits

The claimant, Martinez, was a disabled veteran who suffered from multiple sclerosis. In September 2010, Martinez became a participant in his employer's group LTD benefits plan (the "Plan"). When his health deteriorated in November 2012, Martinez submitted a claim for LTD benefits, which were insured by Sun Life. Under the Plan, Martinez was entitled to monthly benefit payments, less any "Other Income Benefits." While on claim, Martinez applied for and was awarded VA Benefits under the Veterans' Benefits Act. Martinez notified Sun Life of the award of VA Benefits. Thereafter, Sun Life informed Martinez that his VA Benefits were considered "Other Income Benefits" subject to offset under the Plan. Sun Life cited the entire "Other Income Benefits" provision, highlighting two specific sections: "The amount the Employee is eligible for under any other act or law of like intent" and "Disability or retirement benefits under the United States Social Security Act, or any similar plan or act . . . ."

Martinez appealed Sun Life's decision, asserting various reasons for the exclusion of VA Benefits as "Other Income Benefits" under the Plan, including that such benefits were not "compulsory" under the "Other Income Benefits" provision relating to "[t]he amount the Employee is eligible for under Compulsory Benefit Act or Law." In its letter denying Martinez's appeal, Sun Life cited a number of federal cases supporting its decision, including a Tenth Circuit decision which held that service-connected disability benefits are awarded under a "Compulsory Benefit Act or Law" pursuant to the same policy language as set forth in the Plan. Martinez then filed suit in Massachusetts District Court, asserting, *inter alia*, a claim for benefits under ERISA § 1132(a)(1)(B).

Following summary judgment in favor of Sun Life, Martinez appealed to the First Circuit. On appeal, the First Circuit reviewed, *inter alia*, whether Sun Life's alleged failure to clearly disclose at the administrative level that it was relying upon the "Compulsory Benefit Act or Law" provision for the offset, now precluded it from relying on this rationale in litigation. This argument was premised on ERISA's statutory notice provision, which requires that an insurer "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1).

The First Circuit held that Sun Life's communications to Martinez during the administrative process complied with this mandate. In so holding, the First Circuit reasoned that although Sun Life highlighted other rationales for the offset in its letters, the "Compulsory Benefit Act or Law" provision was included, albeit not emphasized, in Sun Life's communications to Martinez. This included Sun Life's appeal denial letter, which featured a lengthy discussion of the Tenth Circuit's decision in *Holbrooks v. Sun Life Assurance Co. of Canada*, 570 F. App'x 831 (10th Cir. 2014), which relied on the "Compulsory Benefit Act or Law" provision to offset VA Benefits.

The court further stated that despite Martinez's argument that Sun Life failed to include the rationale at the administrative level, Martinez clearly understood that the "Compulsory Benefit Act or Law" provision was pertinent, because he addressed the alleged non-compulsory nature of VA Benefits explicitly in his appeal letter.

The First Circuit further explained that even if Sun Life had not adequately disclosed its rationale to Martinez, barring the company from raising the "Compulsory Benefit Act or Law" provision during litigation would not be the proper remedy. Typically, a plan is barred from asserting defenses to coverage not articulated to the insured only when the lack of notice results in prejudice to the insured. Given that this case was strictly one of contract interpretation—a question of law—and Martinez had a full opportunity to present his arguments on the construction of the Plan's provisions, the court found no prejudice to Martinez. Accordingly, the First Circuit agreed with the district court's decision to entertain Sun Life's arguments premised on the "Compulsory Benefit Act or Law" provision.

Finally, after thorough analysis on the issue of whether the term "Compulsory Benefit Act or Law" was ambiguous, the First Circuit held it was not and that VA Benefits, being compulsory benefits under the Veterans' Benefits Act once eligibility is established, were properly offset under the "Compulsory Benefit Act or Law" section of the Plan's "Other Income Benefits" provision.

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First Circuit Holds Decision to Deny Accidental Death and Dismemberment Benefits Not an Abuse of Discretion

In *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 13 (1st Cir. 2020), the First Circuit held that a claims administrator's decision to deny accidental death and dismemberment benefits was not an abuse of discretion where substantial evidence in the record indicated that the participant's pre-existing medical condition caused and/or contributed to the motor vehicle accident which led to his death.

The now-deceased Joseph Arruda ("decedent") was a covered participant in an ERISA-governed Plan established by his former employer, which provided basic life and accidental death and dismemberment ("AD&D") insurance benefits. The decedent's wife, Denise Arruda ("Arruda"), was the designated beneficiary for any death benefits.

On May 22, 2014, the decedent was driving to work when his car crossed all lanes of traffic, collided with an oncoming car, and rolled over. Decedent briefly survived the accident, but succumbed to his significant injuries and was pronounced dead at the scene.

Arruda submitted a claim for AD&D benefits to Zurich American Life Insurance Company ("Zurich"), the insurer and claims administrator for the Plan with discretionary authority "to determine eligibility for benefits and to construe the terms of the plan."

The Plan provided AD&D benefits "[i]f an Insured suffers a loss of life as a result of a Covered Injury." The Plan defined Covered Injury to mean "an Injury directly caused by accidental means which is independent of all other causes." The Plan, however, expressly excluded a Covered Loss that "is caused by, contributed to, or results from . . . illness or disease, regardless of how contracted, medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease . . . ."

Zurich obtained Decedent's medical records, which revealed that Decedent had a medical history related to heart disease, as well as several other conditions. About four months prior to the accident, the decedent had an implantable cardioverter defibrillator ("ICD") placed in his chest to monitor his heart rate and rhythm. The Chief Medical Examiner's report concluded that the primary cause of death was hypertensive heart disease, with contributing factors of an upper cervical spine fracture due to blunt impact. The death certificate also listed the primary cause of death as "hypertensive heart disease." The State Police report concluded that the decedent "had suffered a catastrophic medical event which caused him to be unable to control his vehicle."

Two independent medical doctors retained by Zurich reviewed the records and concluded that the decedent's heart condition caused or contributed to his losing control of his vehicle and the fatal crash.

Based on all this information, Zurich denied Arruda's claim stating, first, that the decedent's death was not "independent of all other causes," and second, that the death was excluded from coverage because it was "caused by, contributed to, or results from" an "illness or disease."

Arruda submitted an appeal and the opinion of her own medical expert that the decedent did not experience "a natural death at the wheel" as he was briefly alive after the accident; the decedent's death was due to neck injuries and blunt force trauma; the "exact reason [decedent] traveled across several traffic lanes and into the other vehicle is unclear"; and that the ICD "showed no abnormal heart rhythms recorded prior to the collision."

Zurich retained a third independent medical expert who ruled out several other possible causes of decedent's loss of control of the vehicle and opined that the "accident was caused by several possible pre-existing illnesses or diseases, singly or in combination," including, but not limited to, the decedent's "cardiac arrhythmia resulting from pre-existing heart disease."

Arruda filed a lawsuit seeking benefits under 29 U.S.C. 1132 (a)(1)(B). The district court entered summary judgment in Arruda's favor. The First Circuit reversed.

The First Circuit found that evidence and reports in the record "were all consistent that [decedent's] crash was caused, at least in part, or was contributed to by his pre-existing medical conditions." The court further found that the contrary opinions of Arruda's expert did not render Zurich's decision arbitrary or capricious.

Finally, the First Circuit held that Zurich's interpretation of the Plan language was reasonable. While the court noted that other circuits—namely the Fourth and Ninth Circuits—have chosen to adopt a "substantial factor" test to aid their interpretation of whether a pre-existing illness cause or "contributed to" a covered loss under an insurance policy, because the standard of review was for discretionary, the court found the substantial factor test to be "in tension with our circuit law on the abuse of discretion test." In that regard, the court noted that under the abuse of discretion standard of review, the courts do not determine "best reading" of the ERISA plan, but rather whether the administrator's interpretation was reasonable.

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New York Court Rejects Claim that Health Insurer Violated the Parity Act

In *Julie L. v. Excellus Health Plan, Inc.*, 2020 U.S. Dist. LEXIS 47734 (W.D.N.Y. March 19, 2020), a New York district court rejected the plaintiff's claims that a health insurer improperly imposed stricter medical necessity requirements for treatment at residential mental health centers than for stays at inpatient skilled nursing facilities.

The case arose under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (the "Parity Act") (29 U.S. C. § 1185a), which seeks to eliminate disparities in health insurance coverage for mental health as compared to other medical or surgical conditions. The Parity Act requires group health plans to provide the same aggregate benefits for mental healthcare and substance abuse treatment as they do for medical and surgical benefits.

The Parity Act technically amended ERISA, and is enforced by seeking equitable relief through 29 U.S.C. § 1132(a)(3).

In recent years, several claimants have alleged that plans violated the Parity Act by applying more stringent medical necessity criteria when evaluating claims for mental health/substance abuse treatments than they would for medical/surgical treatments. A cluster of recent lawsuits has alleged that plans denied benefits for intermediate level treatment at residential mental health treatment facilities based on criteria that applies to acute-level medical care, and further, that the plans would not apply those same standards when evaluating coverage for subacute treatment in the medical/surgical context.

That was the case in *Julie L.*, where the plaintiff's parents sued a group health plan (the "Plan") on behalf of their minor child, who had a history of mental health problems, after the plan denied coverage for her treatment at two wilderness therapy programs in Idaho. The parents alleged, *inter alia*, that the Plan covered skilled nursing facilities in the medical context for "subacute" symptoms, but in the mental health context the Plan covered analogous residential treatment facilities only for more serious "acute" symptoms—often involving the serious risk of harm to self or others—in violation of the Parity Act.

The court disagreed that the Plan imposed stricter requirements for residential mental health treatment. In so holding, the court analyzed the specific Plan language and noted that it required all benefits to be "medically necessary," and further, it imposed the same set of medical necessity criteria to both mental health residential treatment programs and skilled nursing facilities. Critical to the coverage determination for both was whether the patient's symptoms could be treated in a less intensive setting.

In addition, the court noted that the Plan imposed neutral requirements for the types of mental health and skilled nursing facilities that would be covered. Residential treatment facilities must be defined under New York's Mental Hygiene Law, while skilled nursing facilities must be accredited by a national accrediting agency or Medicare.

"In light of the above, there is no evidence that the Plan, on its face, imposes more stringent requirements on admission to residential treatment facilities in comparison to [skilled nursing facilities]," the court concluded in granting the Plan's motion for summary judgment.

The *Julie L.* case demonstrates that Parity Act challenges are usually plan specific, hinging on both specific plan language and how plan administrators have applied coverage grants and exclusions in the mental health and medical surgical contexts.

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Ninth Circuit Rules Coverage under ERISA Disability Plan Excluded Due to Underlying Medical Condition

In *Estate of Maurice v. Life Ins. Co. of N. Am*., 792 Fed. Appx. 499 (9th Cir. Cal. Feb. 5, 2020), the Ninth Circuit held that coverage was excluded under an ERISA-governed disability plan ("Plan"), because the evidence in the record demonstrated that the covered participant's underlying diabetes substantially contributed to an infection that led to the amputation of his foot—and ultimately his death—after he stepped on a piece of glass.

The Plan at issue provided accidental death benefits if "[a] sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss" and is "not contributed to by disease, Sickness, mental or bodily infirmity," and " not otherwise excluded under the terms of this Policy." The Plan excluded "any Covered Injury or Covered Loss, which, directly or indirectly, in whole or in part, is caused by or results from … illness or disease." *Estate of Maurice v. Life Ins. Co. of N. Am.*, 2018 U.S. Dist. LEXIS 93807, at *2-3 (C.D. Cal. June 4, 2018).

The evidence in the record before the district court showed that the deceased had cut his foot on glass in May of 2008. The deceased, who had diabetes, developed a serious infection and complications as a result of his injury. Despite several surgeries and a partial amputation of his foot, the deceased ultimately had his left leg amputated in 2015, and died several months later. The death certificate listed the immediate cause of death as ventricular fibrillation, with congestive heart failure and aortic stenosis, and listed diabetes mellitus as a significant condition contributing to death.

The claim administrator and insurer for the Plan, LINA, determined that no AD&D benefits were payable, in part, because decedent's pre-existing diabetes significantly contributed to his death and was thus excluded by the terms of the Plan. The district court, under a *de novo* standard of review, ruled that the exclusion did not apply, because the evidence in the record failed to demonstrate that the decedent's amputation was "significantly contributed to" by an underlying sickness or disease; LINA appealed.

On appeal, the Ninth Circuit reserved. The court reasoned that the Plan did not provide coverage "if a preexisting condition substantially contributed to the disability." Citing its recent decision in *Dowdy v. Metro. Life Ins. Co.*, 890 F.3d 802, 809 (9th Cir. 2018), the Ninth Circuit explained:

> "The word 'substantial' is used to denote the fact that [the condition] has such an effect in producing the harm as to lead reasonable men to regard it as a cause, using that word in the popular sense, in which there always lurks the idea of responsibility, rather than in the so-called [**3] 'philosophic sense,' which includes every one of the great number of events without which any happening would not have occurred. [internal citations omitted]. … For a court to distinguish between a responsible cause and a 'philosophic,' insignificant cause, there must be some evidence of a significant magnitude of causation. Such evidence need not be presented with mathematical precision, but must nonetheless demonstrate that a causal or contributing factor was more than merely related to the injury, and was instead a substantial catalyst."

Reviewing the evidence presented in the underlying record, the Ninth Circuit noted that the decedent's own medical expert opined that his diabetes prevented the cuts on his foot from healing properly, increased the risk of infection, and made it more difficult to fight the "bacterial onslaught" that allowed the infection to reach the bone. The evidence showed that the only way to stop the infection from spreading further was to amputate the decedent's leg. The court found that the effects of decedent's pre-existing diabetes were extensive and well-documented.

In sum, the Ninth Circuit found the conclusion "inescapable" that decedent's diabetes "substantially contributed" to the amputation of his leg and ultimate death, and was therefore a loss excluded from coverage.

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District Court Holds that Plan Administrator Was ERISA Fiduciary

In *Technibilt Grp. Ins. Plan & Technibilt, Ltd v. Blue Cross & Blue Shield of North Carolina* (W.D. N.C., Feb. 3, 2020), a North Carolina district court held that a plan administrator was an ERISA fiduciary for the purpose of timely submitting claims to a stop loss carrier.

The case involved a group health benefit plan (the "Plan") offered by a shopping cart manufacturer for its employees and their dependents. The manufacturer had obtained an excess stop-loss policy as reinsurance for the plan.

The reinsurance policy only covered claims *paid* during the policy period and not those *incurred* during the policy period. An outside health insurer who provided claim processing services for the Plan failed to submit certain claims for payment within the applicable policy year, and the reinsurance policy refused to cover them.

The Plan brought an action under ERISA against the health insurer, alleging it had breached its fiduciary duties by failing to process and pay the medical expense claims before the end of the policy period. In response, the health insurer filed a motion to dismiss the complaint. The health insurer argued that the Plan lacked standing to bring an action for breach of fiduciary obligations under ERISA. It also maintained that the Plan did not fit into the enumerated categories which allowed for standing to bring an ERISA action.

The district court rejected this argument, finding that the claims asserted directly by the Plan were pursued in a fiduciary capacity as the Plan was necessarily seeking relief for the benefit of the Plan.

Next, the district court rejected the health insurer's claim that it was not, as a matter of law, an ERISA fiduciary that could breach any fiduciary duty by its failure to process and pay the patient's claims before the end of policy period. The district court found that the Plan had sufficiently alleged facts that the health insurer was a functional fiduciary because it alleged the health insurer exercised discretionary control over if and when claims were paid for Plan participants. Additionally, the district court was not persuaded by the health insurer's argument that even if it was a fiduciary, the Plan had not sufficiently alleged it had breached any fiduciary duty. The district court held this was not a proper matter to be determined as a matter of law on a motion to dismiss.

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Eleventh Circuit Rules Against Insurer in LTD Case

In *Kaviani v. Reliance Std. Life Ins. Co.*, 2020 U.S. App. LEXIS 3006 (11th Cir. Jan. 31, 2020), the Eleventh Circuit held that an insurer had failed to give sufficient credence to a claimant's self-reports of pain and unreasonably disregarded corroborative evidence while evaluating an ERISA-governed LTD claim.

The case serves as a cautionary tale to insurers denying claims based on self-reported complaints of pain. In *Kaviani*, a dentist insured under a group disability plan ("Kaviani") sought benefits based on neck and back pain three years after a car accident. Between the accident and filing the claim, Kaviani continued working as a dentist, although he asserted the pain was exacerbated by his continued dental work and that it caused him to practice dentistry unsafely. Kaviani underwent significant treatment for several months immediately following the accident, but then sought no pain-related medical care for approximately a year and a half. At that point, Kaviani underwent additional testing which caused his

treating physician to opine that Kaviani should change professions. Kaviani submitted his resignation and then worked for an additional 30 days before filing his LTD claim.

In support of his claim, Kaviani submitted medical records documenting various treatments for pain, as well as a functional capacity exam ("FCE") and a report by an independent medical examiner ("IME"). He also submitted statements from numerous physicians and colleagues attesting to his infirmities. During the claim review process, Reliance had two physicians examine Kaviani's file, both of whom determined that Kaviani's self-reports of pain were not supported by the medical evidence.

Reliance denied the claim, finding that Kaviani had failed to demonstrate he was unable to perform the material duties of his regular occupation, dentistry. Reliance concluded that Kaviani's reports of pain were not credible because (1) Kaviani did not file for LTD benefits until three years after the accident, (2) following his initial treatments after the accident he did not receive additional treatments for a year anda half, and (3) he continued to work for 30 days after giving notice of his resignation. Kaviani exhausted his administrative remedies, and then filed suit in a Florida district court.

Applying a discretionary standard of review, the district court granted Kaviani's motion for summary judgment, finding that Reliance had "cherry-picked" evidence by which to deny the claim and ignored "unfavorable findings of disability." The Eleventh Circuit affirmed.

In so holding, the court noted that while Reliance was not required to defer to the FCE and IME reports, it could not reject them without a reasoned basis. "Although a plan administrator has substantial discretion in adjudicating disability claims, it cannot ignore uncontradicted record evidence of disability. We agree with the district court that Reliance did just that when it rejected Kaviani's claim for LTD benefits."

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Court Applies "Reasoned Approach" in Upholding Insurer's Denial of LTD Claim

In *Creed v. Hartford Life & Acc. Ins. Co.,* 2020 U.S. Dist. LEXIS 17613, (S.D. Ohio February 4, 2020), the court applied a "reasoned explanation" approach to hold that the evidence supported an insurer's decision to deny an LTD claim.

The court's reliance on a "reasoned explanation" standard stemmed from Ohio case law's description of the arbitrary and capricious standard of review. Specifically, the court noted that under Ohio law, "[a]n outcome is not arbitrary and capricious where the evidence supports a reasoned explanation for that particular outcome." *Citing Kirkham v. Prudential Ins. Co. of Am.*, 2011 U.S. Dist. LEXIS 53690, at *9 (S.D. Ohio March 11, 2011); *Killian v. Healthsource Provident Administrators, Inc.,* 152 F. 3d 514 (6th Cir. 1998).

In *Creed*, the court found that Hartford's "reasoned explanation" for the denial was based on updated medical records and opinions, an interview with the claimant ("Creed"), video surveillance, and an employability study. In contrast, Creed failed to proffer any evidence of his own within the Administrative Record showing he was disabled from his occupation for which he was reasonably qualified by education, training, or experience. Instead, Creed simply argued that Hartford's evidence was irrelevant or insufficient.

The court analyzed each basis for Hartford's denial based on the "reasoned explanation" approach.

First, the court's review of the medical records found that while Creed disagreed with the opinions of three of his doctors and two independent non-treating physicians finding he was capable of working, albeit with restrictions, Creed did not provide any evidence to contradict their conclusions. The court found both the quality and the quantity of the medical opinions provided by Hartford—combined with the lack of conflicting evidence from Creed—formed a reasoned basis for Hartford's decision to terminate LTD benefits.

Second, the court dismissed Creed's argument that his interview established he was incapable of working absent any evidence supporting his statements. Moreover, according to the court, the interview could not be read in a vacuum because Hartford based its determination on medical evidence and surveillance.

Third, the court found that the video surveillance of Creed, which showed him moving in ways he claimed he could not, further supported Hartford's reasoned explanation for its decision to terminate benefits.

Finally, the court rejected Creed's argument that Hartford's employability analyses were flawed because they (1) were not authored by an outside vocational expert and (2) suggested job availability in locations too far from his residence. As to the first point, the court relied upon Sixth Circuit precedent which does not require plan administrators to obtain vocational expert reports when making disability determinations. Citing *Judge v. Metro. Life Ins. Co.,* 710 F. 3d 651, 661-62 (6th Cir. 2013.). As to the second, the court noted that no doctor put driving restrictions on Creed and further found "a claimant's commute to a particular job is not a consideration for determining disability." Citing *Nelson v. Unum Life Ins. Co. of Am.,* 421 F. Supp. 2d 558, 568 (E.D.N.Y. 2006), aff'd, 232 F. App'x 23 (2d Cir. 2007).

Because the evidence submitted by Hartford provided a reasoned explanation for each of the grounds it relied upon in denying Creed's LTD claim, the court concluded the denial was "well-taken" and granted Hartford's motion for judgment on the Administrative Record, and denied Creed's cross-motion.

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