MIRICK O'CONNELL
ATTORNEYS AT LAW

Life, Health & Disability e-Report
First Circuit

Fall 2019

Life, Health, Disability and ERISA Litigation Group:

Joseph M. Hamilton
Joe gave the Disability Litigation Update at DRI's Life, Health, Disability and ERISA Seminar in April. Joe and Chris Collins spoke on the topic of residual disability claims at the Eastern Claims Conference this past spring.

J. Christopher Collins
Chris was a speaker at the Legal Update for the New England Claims Association at its April meeting. In May, Chris also spoke

Welcome to the Fall 2019 edition of Mirick O'Connell's Life, Health and Disability e-Report - First Circuit. This newsletter provides a summary of decisions rendered by the First Circuit Court of Appeals, the United States District Courts within the circuit, and state appellate courts within the same geographic area. We hope the newsletter will be beneficial to you.

For your convenience, we have included hyperlinks with direct access to the full decision for each case. Decisions reproduced by permission of Westlaw.

Should you wish to learn more about Mirick O'Connell's Life, Health, Disability and ERISA Litigation Group, please visit our website at www.mirickoconnell.com, or contact Joseph M. Hamilton, Joan O. Vorster or J. Christopher Collins.

FIRST CIRCUIT REJECTS NOTICE-PREJUDICE RULE

In **Fortier v. Hartford Life and Accident Insurance Company**, 916 F.3d 74 (1st Cir. 2019), the First Circuit Court of Appeals, for the first time, rejected the application of the notice-prejudice rule to an ERISA benefit claim.

Fortier was employed by Dartmouth-Hitchcock Clinic. The clinic had an employee benefit plan providing disability coverage which was funded by a group policy issued by Hartford.

Fortier was paid LTD benefits from 2009 until September 2011. Her benefits were discontinued at that time based upon the mental illness limitation contained in the policy. Fortier appealed. Hartford reinstated benefits based upon its policy that the 24-month limitation for mental illness benefits begins to run from the date Hartford informs the beneficiary of the limitation. In its decision, Harford informed Fortier that no benefits would be payable beyond September 2013.

In 2013, benefits were again discontinued and Fortier was notified of her right to administratively appeal that decision. Fortier did submit an appeal but it was beyond the 180-day appeal period provided by the plan. Hartford notified

at Professional Disability Associates' annual seminar in Portland, ME.

Joan O. Vorster
Joan attended DRI's Life, Health, Disability and ERISA Seminar in Chicago in April.

Elizabeth L.B. Greene

Kevin Kam
Kevin assisted in updating the First Circuit chapter of the ABA's ERISA Survey of Federal Courts.

Jillian I. May, paralegal
Jillian is the newest member of the Life, Health, Disability and ERISA Litigation Group, joining the team in June.

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Fortier that the appeal was untimely and therefore the appeal would not be considered. Suit followed.

The district court entered summary judgment in favor of Hartford, finding that the administrative appeal was late. Fortier then appealed to the First Circuit.

On appeal, Fortier again argued that even if her appeal was untimely, it should be excused under either the substantial compliance doctrine or New Hampshire's notice-prejudice rule.

The court first rejected Fortier's argument that the adverse benefit determination 180-day time limit starts on the date of the termination of benefits, not from the date of notice. The court stated that the Department of Labor Regulations clearly state that a plan must provide claimants at least 180 days to appeal following the receipt of a notification of an adverse benefit determination. Therefore, Fortier's 180-day time limit began at the receipt of Hartford's letter notifying her that her benefits would end in September 2013, even though the letter was sent in July 2013.

The court then went on to reject Fortier's argument that the doctrine of substantial compliance excused her late filing. The court noted that the doctrine has only been applied to excuse an insurer's failure to comply precisely with ERISA's notice requirements under certain circumstances. The court adopted the Seventh Circuit's reasoning that the substantial compliance doctrine does not apply to a claimant's late appeal.

Finally, the court, for the first time, specifically rejected the application of a state's notice-prejudice rule to an ERISA benefit claim. Fortier argued that New Hampshire's common law notice-prejudice rule should apply. The court joined the Seventh and Ninth Circuits which have held that state common law notice-prejudice rules do not apply to ERISA appeals. In fact, the court noted that no federal court has applied any state's common law notice-prejudice rule to excuse a late administrative ERISA appeal.

The district court's judgment was affirmed.

FIRST CIRCUIT DISTINGUISHES LIFE INSURANCE WAIVER DECISION FROM LTD BENEFIT DECISION

In **Santana-Diaz v. Metropolitan Life Insurance Company**, 919 F.3d 691 (1st Cir. 2019), the First Circuit Court of Appeals upheld the district court's decision denying further disability benefits to Santana.

Santana was covered under an employee benefit plan provided by his employer which was funded by a group insurance policy issued by MetLife. The benefit plan provided total disability benefits for only 24 months for depression. Santana was notified of this. He responded by claiming to also suffer from asthma, arthritis, hypertension, high cholesterol and problems related to diabetes. MetLife had the medical information reviewed by outside independent physicians who all concluded that the evidence did not show Santana had any functional or physical limitations due to a medical condition. Santana then sued, but the district court found in favor of MetLife.

On appeal, applying the arbitrary and capricious standard of review, the court addressed four arguments raised by Santana.

Santana first argued that MetLife failed to consider physical conditions documented by his treating physicians. He claimed that MetLife cherry-picked evidence it preferred while ignoring contrary evidence. The court found that MetLife did not do so. The court pointed to the record where MetLife did consider the evidence that Santana alleged that MetLife overlooked.

Santana next argued that MetLife acted arbitrarily by reinstating his life insurance benefits but denying his LTD benefits. Santana pointed to the life decision that stated MetLife had considered not only Santana's depression, but also degenerative disc disease, diabetes, shoulder pain, high blood pressure, asthma and hypothyroidism. Santana argued that this showed MetLife did not consistently apply his conditions for the LTD benefits. The court rejected it. It found there was no evidence that the criteria to qualify for life insurance were the same as the LTD benefit. The court also noted that the life insurance decision did not state that the life insurance was reinstated due to Santana's diabetic conditions.

Next Santana argued that MetLife failed to provide him with sufficient information as to the showing he needed to make to qualify for LTD benefits. The court found that MetLife told Santana that he was required to submit objective medical information that would establish that his condition qualified him for LTD benefits and rejected this argument.

Lastly, Santana argued that MetLife acted arbitrarily and capriciously by considering the functional limitations of his condition. The court held that considering functional limitations in connection with the physical disability claim did not constitute an arbitrary criteria. On the contrary, the court held when an illness does not lend itself to objective clinical findings, the proper approach is to consider the physical limitations imposed by that illness.

The court affirmed summary judgment in MetLife's favor.

LATE ERISA DISABILITY CLAIMS TIME BARRED

In **Lyman v. Unum Group**, 378 F.Supp.3d 81 (D. Mass. 2019), the U.S. District Court of Massachusetts entered summary judgment in favor of the defendants, finding that the short-term and long-term disability claims filed by Lyman were late and therefore barred under the terms of the employee welfare benefit plan.

Lyman was covered by an ERISA governed plan issued to the Massachusetts Teachers Association (the "MTA"), which was funded by group disability insurance policies issued by Unum Life Insurance Company of America ("Unum Life"). Unum Life administered claims under the plan.

The policies stated that proof of any claim must be provided no later than 90 days after the elimination period. The policies also provided that if it was not possible to give proof within 90 days, it must be given no later than one year after the time the proof of loss was required.

It was undisputed that Lyman filed her claims for both STD and LTD benefits beyond 90 days after the elimination period. Lyman argued, however, that she should have been given an additional year to file her claim because it was not "possible" to make timely claims. Lyman argued it was not possible for her to file timely claims because of misrepresentations made to her by Unum Life, and due to her medical condition. She also argued that Unum Life was required to show prejudice by the late filings, and absent a showing of prejudice, her claim should have been allowed to proceed.

The court found that Unum Life was given discretion by the benefit plan. Thus, the court held it was required to review Unum Life's decision in a deferential manner. The court held that Unum Life's decision was not arbitrary or capricious.

The court first addressed Lyman's contention that Unum Life made misrepresentations to her as to whether she had coverage under the plan, which caused her to file her claim late. The court rejected this argument with regard to the STD benefits because the alleged misrepresentation occurred

after the STD claim was due. Therefore, any misrepresentation would have no impact on the filing of the STD claim.

With regard to the LTD claim, while Unum Life provided evidence that no misrepresentations were made to Lyman, even assuming it to be true, the court found that after the alleged communication occurred with Unum Life, Lyman admitted receiving the necessary forms from the MTA and still failed to complete them in a timely manner.

With regard to her medical condition, the court found that Unum Life did not abuse its discretion in finding that it was possible for Lyman to file timely claims despite her medical condition. In its review of Lyman's claim, Unum Life provided a detailed review of the circumstances regarding the filing of the claim, including during that timeframe Lyman was looking into finding other jobs, applying for unemployment compensation, and visiting and providing care to her sister out-of-state who had been in a motor vehicle accident.

Lastly, the court rejected Lyman's argument that the notice-prejudice rule should apply. Lyman relied on Massachusetts General Law, Chapter 175, §112. The court noted there have been numerous decisions within the District of Massachusetts which held the statute did not apply in the ERISA context. The court also rejected Lyman's argument that while the notice-prejudice rule may not apply to a late filed administrative appeal, it should still apply to the initial claim. The court, noting the First Circuit's recent decision in Fortier v. Hartford Life & Accident Ins. Co., 916 F.3d 74 (1st Cir. 2019) stated that any state law prejudice requirement does not apply in the ERISA context.

Joseph M. Hamilton and Kevin Kam represented Unum Group and Unum Life Insurance Company of America.

PRE-EXISTING CONDITION PROVISION BARS LTD CLAIM

In **Holzman v. The Hartford Life and Accident Insurance Co.**, 353 F.Supp.3d 121 (D. Mass. 2019), the U.S. District Court of Massachusetts entered summary judgment in favor of Hartford, finding that Holzman's claim was barred by the pre-existing condition provision of an employee welfare benefit plan. Holzman was covered by an ERISA governed plan provided by his employer and funded by a group disability insurance policy issued by Hartford. Hartford administered claims under the plan.

The plan included a pre-existing condition provision, which barred disabilities that occurred within the first year of coverage if the disability was due to, contributed to, or resulted from a pre-existing condition. A pre-existing condition was defined to include any sickness for which the employee saw a physician or health care provider for a consultation, medical advice or that recommended, prescribed or provided treatment within the 90 days prior to the start of coverage.

Holzman did receive medical care within the 90-day "Look Back Period." He saw a physician twice for facial paralysis which was diagnosed as Bell's palsy.

After he became covered under the plan, Holzman was diagnosed with salivary duct cancer. He then filed a claim for LTD benefits. The claim was denied on the grounds that it was precluded by the pre-existing provision. Holzman sued.

The issue before the court was essentially whether Hartford's interpretation of the pre-existing condition provision that medical care received for the facial paralysis, which was a manifestation of his latent cancer, was appropriate.

Holzman argued that the pre-existing provision was ambiguous and therefore in accordance with the First Circuit's decision in Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264 (1st Cir. 1994) the provision should be interpreted against Hartford. Holzman argued the pre-existing provision required some awareness

on the part of a treating physician or the insured that he was receiving treatment for a disabling condition in order for the provision to apply.

The court rejected Holzman's argument that his interpretation of the provision should apply. Noting that because the standard of review was arbitrary and capricious, the court held that contra proferentem did not apply. Thus, so long as Hartford's interpretation was rational, it must be upheld. Noting that the First Circuit in Hughes had found that the interpretation of the provision used by Hartford was reasonable, it was not arbitrary and capricious.

DENIAL OF LTD BENEFITS NOT ARBITRARY OR CAPRICIOUS

In **Carter v. Aetna Life Insurance Company**, 2019 WL 80434 (D. Me. 2019), the U.S. District Court of Maine found that Aetna was not arbitrary and capricious in denying a claim for LTD benefits. The case also provides a good overview of the applicable law regarding reviewing a case under the arbitrary and capricious standard of review where the claim administrator has a structural conflict of interest.

Carter was covered under an employee welfare benefit plan provided by his employer. He worked as an estimating analyst for General Dynamics. The position had a sedentary physical demand level. Carter submitted a claim for disability due to chronic neuropathic pain, chronic spinal disorder and a chronic pain syndrome. Aetna denied the claim initially and upheld the denial in the administrative appeal. Suit followed.

Carter conceded that the arbitrary and capricious standard of review applied and the court consequently applied that standard of review. Carter's attack on the decision primarily focused on an independent review of his claim by a physician specializing in physical medicine and rehabilitation and pain management. That physician found that Carter had sedentary level work ability and that he did not have any ongoing neurological or cognitive deficits that would prevent employability. Carter attacked the reviewer's report, claiming it misstated his physical therapist's conclusions, omitted sections of treatment notes and other facts from his treating physician, and ignored other facts from the medical records. Carter contended that Aetna erred in relying on the reviewer's report and that this demonstrated that Aetna did not perform an independent assessment of Carter's medical records.

Noting that Aetna had a structural conflict of interest, the court did not find this to be a factor given Aetna's evidence of its efforts to reduce any bias by instituting policies designed to isolate claim and appeal assessments from financial considerations and obtaining an independent review. The court also noted it was Carter's burden to demonstrate that Aetna's structural conflict actually influenced its decision to deny his claim. The court held Carter did not meet that burden by not raising it in his briefs.

The court went on to hold that, applying the arbitrary and capricious standard, it must uphold Aetna's decision if there was any reasonable basis for it. The court found that Aetna did have substantial evidence and a reasonable basis to deny Carter's claim. This was based not only on the independent review, but also Carter's treating physician's failing to be able to provide any objective physical changes to explain why Carter could no longer work, and his treating physician's statement that he understood how the independent reviewer's conclusions were reached.

With regard to Carter's attacks upon the independent reviewer's report, the court found, with one exception, that they were either belied by the record or overstated the perceived insufficiencies. The court was in agreement that the reviewer's summation of Carter's physical therapist's conclusions was inaccurate. However, the court went on to state that a mere inaccuracy by a

medical reviewer does not render the review of the claim arbitrary and capricious.

The court held that the record did not support the allegation that the reviewer drew inferences unsupported by the documentation in the record, and found the reviewer had weighed conflicting opinions from the medical professionals who treated Carter.

The court granted Aetna's motion for summary judgment.

COURT UPHOLDS DENIAL OF STD BENEFITS UNDER DE NOVO REVIEW FOR FAILURE TO PROVIDE OBJECTIVE EVIDENCE

In **Bowden v. Group 1 Automotive, Long Term Disability Plan**, 2019 WL 917427 (D. Mass. 2019), the U.S. District Court of Massachusetts, applying the de novo standard of review, upheld the decision to deny Bowden short-term disability benefits.

Bowden was employed as a car salesman. His employer provided an employee welfare benefit plan which included short-term and long-term disability benefits. The plan was funded by a policy issued by Aetna, which also administered claims.

Bowden submitted a STD claim after stopping work with complaints of dizziness. Bowden underwent a series of medical examinations and tests from a variety of specialists including a cardiologist; an ear, nose and throat specialist; and a neurologist. None could find a reason for his complaints. He did receive a diagnosis of anxiety and adjustment disorder from a psychiatrist. He was also awarded Social Security disability benefits.

After paying STD benefits for a short period, Aetna closed the claim on the grounds that Bowden had not met his burden to prove he was totally unable to fulfill his duties due to subjective dizziness.

The court applied a de novo review. Bowden argued that Aetna failed to weigh the medical evidence properly. The court disagreed, finding that Bowden failed to provide objective evidence of his inability to work. The court also found ample evidence in the administrative record that the information provided by Bowden's treating physicians was considered. The court undertook a thorough analysis of why the medical evidence did not support Bowden's claim.

The court also conducted a lengthy analysis regarding the Social Security Administration's decision. The court noted that while SSA determinations are not binding on disability insurers, it is relevant evidence of disability. The court did note that the Social Security Acts' criteria were more generous to claimants than the plan's definition of disability. Finding that Aetna's denial letter stated that there was a lack of medical evidence to support Bowden's impairment and offering to review any additional information he wanted to submit, the court was satisfied that Aetna clearly informed Bowden why it denied his claim.

PLAN FAILED TO GIVE DISCRETIONARY AUTHORITY

In **Hughes v. Life Insurance Company of North America**, 2019 WL 2717111 (D. R.I. 2019), the U.S. District Court of Rhode Island held that the de novo standard of review applied in that ERISA benefits case.

Hughes was a participant in an employee welfare benefit plan provided by his employer that included long-term disability benefits. After benefits were denied

by LINA, Hughes filed suit. Hughes then filed a motion to determine the standard of review for the case.

The court, citing the First Circuit's decision in Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc., 813 F.3d 420 (1st Cir. 2016), stated that the existence of discretion from a plan to a fiduciary must be "unambiguous and specific."

LINA argued that the plan granted such discretion by the following language: "The Plan Administrator has appointed the Insurance Company as the named fiduciary for deciding claims for benefits under the Plan, and for deciding any appeals of denied claims."

The court found this was a situation similar to that faced by the First Circuit in Stephanie C. The court held that the language upon which LINA relied only gave it the power to decide benefits and appeals. It did not bestow discretion. Therefore, the court held that the de novo standard of review would apply.

COURT ALLOWS MINIMAL DISCOVERY IN ERISA CASE

In **Knight v. Prudential Insurance Company**, 2019 WL 615357 (D. Me. 2019), the U.S. District Court of Maine allowed limited discovery in an ERISA action.

Knight had disability coverage through an employee benefit plan provided by her employer. The plan was self-funded, but Prudential administered claims under the plan. After paying Knight short-term disability benefits for a degenerative spinal condition, Prudential denied further benefits.

Suit was filed. Knight then requested leave to conduct discovery regarding: (1) internal guidelines, memorandum, rules, regulations and policies concerning Knight's condition; (2) documents concerning income paid to the medical reviewing service; and (3) documents regarding Prudential's alleged incentives, such as performance indicators and criteria for claims specialists.

Citing the First Circuit's decision in Glista v. Unum Life Ins. Co. of Am., 378 F.3d 113 (1st Cir. 2004), the court allowed Knight to conduct discovery regarding any internal guidelines, etc. Prudential had regarding Knight's condition.

The court denied requests for discovery as to the financial incentives for medical reviewers. The court noted that Knight provided no evidence to support the assertion that Prudential's choice of physician was suspect, especially given the lack of any structural conflict of interest. The court stated it would hold to the general rule prohibiting discovery.

Finally, the court addressed Knight's argument that he should be allowed to conduct discovery for performance incentives. Knight suggested that Prudential set performance targets or otherwise tracked performance in a way that impedes a full and fair assessment of a claim. The court noted that without a structural conflict of interest, the potential for incentives to influence the claims process was not as significant as it otherwise would be. Therefore it held that a discovery request for general incentives and criteria for the claims specialist was not reasonable. However, the court did allow discovery of documents that set forth or related to any policy or benchmarks that might exist as to Prudential's expectations regarding the number or percentage of claims to be denied.

DENIAL OF ACCIDENTAL DEATH BENEFITS UPHELD ON DE NOVO REVIEW

In **McGuiggin v. Zurich American Insurance Company**, 2019 WL 1333268 (D. Mass. 2019), the U.S. District Court of Massachusetts held that Zurich's decision to deny accidental death benefits was correct.

McGuiggin's 20 year old son was insured under the life insurance benefit plan provided by McGuiggin's employer. The benefit plan was funded by a group policy issued by Zurich, which also administered claims.

McGuiggin's son was found dead in his dormitory room. The autopsy performed by the medical examiner concluded that the cause of death was acute fentanyl intoxication and that the manner of death was an accident that occurred due to substance abuse or snorting illicit drugs. The autopsy found the presence of various substances including fentanyl.

McGuiggin filed a claim with Zurich for the accidental death benefit. Zurich denied the claim, ultimately relying on an exclusion in the policy that the death would not be a covered loss if it was "caused by, contributed to or results from: . . . (8) being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage."

McGuiggin sued, and argued that the exclusion applied only to prescription drugs and not to illicit drugs.

The court first determined the standard of review. While the benefit plan included language granting Zurich discretionary review, McGuiggin contended that she never received a copy of the policy and that the discretionary authority to Zurich was never disclosed or made available to her. While Zurich disagreed, the court found the record did not establish that McGuiggin was provided notice of Zurich's discretionary authority and therefore applied the de novo standard of review.

Despite reviewing the case under the de novo standard, the court upheld Zurich's decision.

McGuiggin argued that the word "prescription" in the exclusion modified all three of the words that followed it: drug, narcotic, and hallucinogen. The court rejected that argument. The court found the only reasonable reading of the exclusion was that "prescription" only modified the word "drug." The court held that the reading McGuiggin suggested was not grounded in the ordinary meaning and usage of the words. The court held that while "prescription drug" is a commonly used term, the terms "prescription narcotic" and "prescription hallucinogen" are not. The court also noted that McGuiggin had not cited a single decision construing similar policy language in the manner she urged the court to adopt.

Thus, the court held that the exclusion applied to any loss caused by being under the influence of any prescription drug or any narcotic or any hallucinogen unless a prescription from a physician authorized use of the relevant substance in the manner it was used. As such, the exclusion precluded coverage for the son's fatal overdose.

The court entered summary judgment in favor of Zurich.

DENIAL OF ACCIDENTAL DEATH BENEFITS ARBITRARY AND CAPRICIOUS

In **Arruda v. Zurich American Insurance Company**, 366 F.Supp.3d 175 (D. Mass. 2019), appeal docketed, No. 19-1247 (1st Cir. March 11, 2019), the U.S. District Court of Massachusetts held that Zurich's decison to deny accidental death benefits was arbitrary and capricious.

Arruda was a participant in an employee benefit plan provided by his employer that included accidental death coverage. The coverage was funded by a policy issued by Zurich.

Arruda had a history of heart disease. In 2014, he had a defibrillator pacing device implanted in his chest. Medical records indicated that since then, from a cardiac standpoint, he had been doing well.

On May 22, 2014, while driving to a work event, Arruda's car crossed a highway median into oncoming traffic and struck another car causing Arruda's car to hit a curb and flip multiple times. Arruda was pronounced dead on the scene. Arruda's widow filed a claim for accidental death benefits. After a lengthy investigation, Zurich denied the benefits. Zurich also upheld the decision on appeal and suit followed.

The policy provided the benefit if the death was the result of a covered injury. A covered injury was defined as an injury directly caused by accidental means, which is independent of all other causes and results from a covered accident. A covered accident was defined as an accident that results in a covered loss. The policy also contained an exclusion that a loss would not be a covered loss if it was caused by, contributed to or resulted from illness or disease.

In its decision, Zurich relied on an opinion from a Dr. Bell that Arruda's death was caused by his heart disease. A similar opinion was rendered by a Dr. Angell. The autopsy report also concluded that the cause of death was hypertensive heart disease. Similarly, a Massachusetts State Police report and an EMS report respectively contributed the death to a medical episode while driving and cardiac arrest. Finally, a Dr. Taff found that Arruda's accident was caused by several pre-existing illness or diseases. He also concluded that Arruda died from accidental bodily injuries.

Arruda's widow submitted a report from a former medical examiner, Dr. Laposata, that concluded Arruda's death resulted from injuries sustained in the auto accident. While Dr. Laposata could not explain what caused Arruda to travel across traffic lanes and hit another vehicle, she found no evidence that he experienced incapacitation by heart disease. The widow also submitted a log book report which tracked Arruda's defibrillator. The log showed no measured "events" prior to the accident.

The court concluded that Zurich's decision was arbitrary and capricious. The court rejected the reports from the Massachusetts State Police and the EMS on the grounds that there is no evidence that either the State Trooper or the authors of the EMS report had expertise in that area of medicine. The court also rejected Dr. Angell's report because his credentials were not contained in the record and Zurich could not identify the physician. The court held the "unauthenticated report by Dr. Angell must be given no weight."

The court then went on to find that Zurich's position that the cause of death was heart disease was unreasonable. Neither Dr. Bell's report or the autopsy report cited any evidence to support the conclusion that heart disease was the cause of death, other than that Arruda had a history of heart disease. The court also pointed to Dr. Taff's report that the immediate cause of Arruda's death was a combination of multiple blunt force impact bodily injuries and positional asphyxia.

Finally, the court found that Dr. Laposata's report fully supported the contention that heart disease was not the cause of death.

The court also rejected Zurich's position that Arruda's pre-existing illness caused the accident, noting that Dr. Taff has stated that there was no way to scientifically prove what medical condition occurred during the pre-collision phase of the accident that resulted in the fatal bodily injuries.

Based on this, the court found that Zurich's determination was unreasonable. The court found that Zurich had made a speculative leap from the proposition that because Arruda suffered from heart disease, the blunt trauma accident which killed him was caused by that pre-existing condition.

Finally, while Zurich also noted that there was marijuana found in Arruda's blood and the policy excluded deaths resulted from being under the influence of a drug, the court found the evidence of causation to be conclusory and speculative.

The court entered judgment in favor of the widow and also awarded attorney's fees.

REQUEST FOR ATTORNEY'S FEE DEFERRED AFTER DENIAL OF CLAIM ON REMAND

In **Host v. First Unum Life Insurance Company**, 2019 WL 343255 (D. Mass. 2019), appeal docketed, No. 19-1228 (1st Cir. March 5, 2019), the U.S. District Court of Massachusetts denied, without prejudice, Host's motion for attorney's fees related to an earlier order by the court remanding his claim for further consideration.

Earlier in the case, on cross-motions for summary judgment, the court remanded the case and required Unum Life to conduct a more thorough inquiry into the relationship between Host's alleged disability and his loss of income. After remand, Unum Life again found Host not eligible for benefits, and Host is challenging that determination.

In the meantime, Host submitted a motion for the attorney's fees he had incurred through the time of the court's order for remand. While the court found that Host was eligible to receive attorney's fees, because obtaining a remand was deemed to be some degree of success on the merits, the court found that what might be a reasonable fee may be colored by subsequent events. The court found that the value of the remand opportunity might be affected by Host's ultimate success or lack of success obtaining benefits. Thus, the court denied the motion without prejudice pending the outcome of Host's challenge of the second denial.

Joan O. Vorster and Kevin Kam represented First Unum Life Insurance Company.

DISTRICT COURT UPHOLDS DENIAL OF CLAIM FOR MEDICAL BENEFITS BECAUSE TREATMENT WAS NOT MEDICALLY NECESSARY

In **Fisher v. Harvard Pilgrim Health Care of New England, Inc.**, 380 F. Supp.3d 155 (D. Mass. 2019), appeal docketed, No. 19-1623 (1st Cir. June 19, 2019), the U.S. District Court of Massachusetts upheld Harvard Pilgrim's denial of Fisher's claim on the grounds that the treatment at issue was not medically necessary.

Fisher was receiving treatment for an eating disorder. Harvard Pilgrim paid the medical expenses until Fisher began receiving treatment through a partial hospitalization program. Harvard Pilgrim concluded that Fisher did not meet the medical necessity guidelines for such a program. Fisher challenged that determination. Harvard Pilgrim reviewed the claim again, including having peer-to-peer telephone conferences between Harvard Pilgrim's medical consultants and Fisher's treating physicians. Harvard Pilgrim upheld the denial. Suit followed.

The court applied the de novo standard of review, finding that the benefit plan did not grant Harvard Pilgrim discretionary review.

Fisher alleged a number of procedural defects on the part of Harvard Pilgrim. One was that Harvard Pilgrim allegedly failed to provide adequate notice of the reasons for its denial. While the court found that the final denial letter did satisfy the requirement, the first denial did not. However, the court found that error was not prejudicial to Fisher.

The second dispute concerned Fisher's contention that Harvard Pilgrim did not provide her with sufficient information as to what she would need to submit to Harvard Pilgrim to overturn the decision to deny her claim. Fisher relied on a section of the Department of Labor's Claim Regulations which requires the administrator to notify the claimant of any additional material or information necessary for the claimant to "perfect" the claim. Fisher interpreted this to mean Harvard Pilgrim had an obligation to provide her with information that was needed to overturn Harvard Pilgrim's initial decision. The court rejected that interpretation. The court held that perfecting the claim refers to completing a claim, and the administrator is not required to make suggestions to the claimant as to what information may be helpful in appealing the determination.

Fisher also claimed that Harvard Pilgrim erred by not obtaining her medical records. The court found that while medical records may be obtained in the course of reviewing a claim, it was not required, and without more Harvard Pilgrim could not be deemed to have committed an error.

Lastly, the court addressed whether the disputed treatment was medically necessary. The court found that while Fisher provided information that the partial hospitalization program would be beneficial, she did not provide evidence that it was medically necessary.

The court entered summary judgment in favor of Harvard Pilgrim.

DID YOU KNOW?

Did you know that Mirick O'Connell's Life, Health, Disability and ERISA Litigation Group represents clients throughout New England? With offices in Boston, Westborough and Worcester, our attorneys are within an hour of all the major Courts in Massachusetts; Hartford, Connecticut; Providence, Rhode Island; and southern New Hampshire. In addition, our attorneys are admitted to practice not only in Massachusetts, but in Connecticut, New Hampshire and Rhode Island as well. We have repeatedly and successfully represented our clients in each of these jurisdictions. So remember, we are not here for you just in Massachusetts; think New England!

For more information on Mirick O'Connell's Life, Health, Disability and ERISA Litigation Group, contact:

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