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Life, Health, Disability & ERISA Litigation

Winter 2021 | First Circuit e-Report | Download PDF

Greetings! We are pleased to provide you with a summary of decisions rendered by the First Circuit Court of Appeals, the U.S. District Courts within the circuit, and state appellate courts within the same geographic area. For your convenience, we have included hyperlinks with direct access to the full decision for each case. Decisions reproduced with permission of Westlaw.

DENIAL OF HEALTH INSURANCE BENEFITS AND ATTORNEY'S FEE UPHELD ON APPEAL

In **Doe v. Harvard Pilgrim Health Care, Inc.**, 974 F.3d 69 (1st Cir. 2020), the First Circuit Court of Appeals upheld the decision of the U.S. District Court of Massachusetts that Harvard Pilgrim appropriately denied benefits for residential mental health treatment. The First Circuit also upheld the district court's decision denying an award of attorney's fees for an earlier remand of the case.

Doe was a dependent beneficiary in a group health benefit plan provided by Doe's father's employer. The plan was funded by a policy issued by Harvard Pilgrim. The plan provided coverage for in-patient care, intermediate care, and outpatient mental health care only to the extent medically necessary. The plan utilized strict guidelines to determine whether residential mental health treatment was necessary. Doe sued after her claim for residential mental health treatment was partially denied.

The case has a somewhat convoluted procedural history. The district court initially upheld Harvard Pilgrim's decision in 2017. Doe appealed and the First Circuit remanded the case on the grounds that the administrative record should have been expanded. The district court then did so and, after allowing additional briefing and argument, again found that Doe had not met her burden to show that she was entitled to coverage for residential treatment during the disputed period. Doe appealed again.

Noting that in its prior decision it had held that under the de novo standard of review, the district court's factual findings would be reviewed only for clear error, the First Circuit found

COURT REJECTS GIVING ADDITIONAL WEIGHT TO TREATING PHYSICIANS

In **Ehlert v. Metropolitan Life Insurance Company**, 2020 WL 6871021 (D. Mass. 2020), the U.S. District Court of Massachusetts found MetLife's decision denying long-term disability benefits to Ehlert was not arbitrary or capricious.

Ehlert was covered by an employee benefit plan providing disability benefits. The plan was funded by a group policy issue by MetLife. MetLife also administered claims made under the plan.

Ehlert was employed as an actuary. She initially claimed to be disabled due to fatigue, short-term memory and cognitive issues, and headaches. Her claim was denied and the denial was upheld on administrative appeal. Ehlert then sued.

There was extensive medical information provided by Ehlert in support of her claim. Similarly, MetLife had the claim reviewed multiple times, including by a psychiatrist, a physician board certified in occupational and environmental medicine, and an infectious disease expert.

MetLife's decision was examined under the arbitrary and capricious standard of review. Ehlert argued that she met her burden of

none. While Doe attacked Harvard Pilgrim's expert reports, the First Circuit found that there was no clear error for the district court to rely on those reports or read them in the manner suggested by Doe.

Doe also argued that the district court should have had a bench trial and required the various experts to testify and be subject to cross-examination. The First Circuit stated that such a proposal had long ago been rejected in its decision in **Orndorf v. Paul Revere Life Ins. Co.**, 404 F.3d 510 (1st Cir. 2005). The court reiterated that it has consistently held that the record before the district court should match the record reviewed by the administrative decision maker absent special circumstances.

Lastly, the First Circuit upheld the district court's denial of Doe's request for attorney's fees for the period leading up to the First Circuit's initial decision remanding the case back to the district court. The First Circuit reviewed the five-factor test it has repeatedly utilized to consider an award of attorney's fees and found the district court made no legal or clear factual error in the exercise of its discretion that attorney's fees were not warranted.

The First Circuit affirmed the decision of the district court.

NO VIOLATION OF CHAPTER 93A FOR MERE BREACH OF CONTRACT

In **Ivers v. Lincoln National Life Insurance Company**, 2020 WL 4673569 (D. Mass. 2020), the U.S. District Court of Massachusetts dismissed a complaint alleging breach of contract and a violation of the Massachusetts Consumer Protection Act, Chapter 93A.

Ivers purchased a deferred variable annuity contract from Lincoln National. When he was prevented from depositing additional amounts into guaranteed minimum interest rate accounts he sued Lincoln National, pro se.

Lincoln National moved to dismiss the complaint on the grounds that the plain terms of the annuity contract gave it the unequivocal right to discontinue new allocations or transfers to interest rate accounts. The court dismissed the contract claim.

Turning to the Chapter 93A claim, the court noted that even if Ivers demonstrated a breach of contract, it is well established that a mere breach of contract does not rise to the level of a Chapter 93A violation. Rather, the breach of contract must have an extortionate quality that gives it the "rancid flavor of unfairness." Because Ivers' complaint alleged no such conduct and there was no breach of contract, it failed to state a viable Chapter 93A claim.

The court dismissed the complaint in its entirety.

proving that she was unable to perform the duties of her own occupation as a result of Lyme Disease and that MetLife failed to provide her with a full and fair review of her claim.

After undertaking an exhaustive review of the medical evidence, the court referenced the First Circuit's holding that the mere existence of contrary medical evidence does not render the plan administrator's decision to credit one medical opinion over another to be arbitrary and capricious. In fact, the court noted that the First Circuit has held the deference due to a plan administrator's determination may be especially great when the medical evidence is sharply conflicted.

The court rejected Ehlert's argument that she was not provided a full and fair review. While Ehlert argued that MetLife selectively assessed her claim and glossed over the opinions of her treating physicians, the court found that MetLife's consulting physicians had reached out to Ehlert's treating physicians and where possible had teleconferences to discuss her case. The court also noted that lengthy and comprehensive reports were submitted by MetLife consultants.

The court also found that MetLife gave sufficient weight to the functional capacity evaluation. The court noted that the FCE was not the only evidence bearing on Ehlert's functional limitations and it did not stand undisputed.

The court also was critical of the vocational report submitted in support of Ehlert's claim. The vocational consultant commented on the fact that MetLife's consultants had not done an examination of Ehlert. The court found that view was entitled to no weight because the First Circuit has held that an insurer is not required to physically examine a claimant and that benefit determinations may be based on reviews of the medical records.

Finally, the court disagreed with Ehlert that her award of Social Security disability benefits was significant evidence of her inability to perform her occupation. The court noted while such determinations are relevant to an insurer's decision they need not be given controlling weight. Because MetLife had addressed the Social Security decision, the court did not find MetLife to be arbitrary and capricious.

The court found that MetLife made a carefully considered decision to deny the LTD benefits, and that the decision was reasonable and supported by substantial evidence. Summary judgment was entered in favor of MetLife.

LIFE, HEALTH, DISABILITY & ERISA LITIGATION TEAM

JOSEPH M. HAMILTON
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TEAM NEWS

***Joe Hamilton**, along with Chris Collins, will be presenting the Annual Legal Update at the New England Claims Association conference in April 2021.*

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Chris Collins *recently authored the First Circuit ERISA chapter for the upcoming third edition of Misrepresentation in the Life, Health, and Disability Application Process to be published by the ABA. Chris also recently served as Co-Chair of the 18th Annual Mass Bar Association's In-House Counsel Conference and moderated a panel on the relationship between outside and in-house counsel.*

Elizabeth Greene *was recently spotlighted by the American Bar Association Journal for her many years of service to the Central Massachusetts chapter of the American Heart Association/American Stroke Association.*

Lauren Sparks *recently authored the Massachusetts chapter for the upcoming third edition of Misrepresentation in the Life, Health, and Disability Application Process to be published by the ABA.*

We are pleased to welcome ***Nancy E. Gunnard*** to the Life, Health, Disability and ERISA Litigation Team.

LIMITED DISCOVERY ALLOWED IN CASE APPLYING DE NOVO STANDARD OF REVIEW

In **Waldron v. Massachusetts Institute of Technology**, 2020 WL 7055969 (D. Mass. 2020), the U.S. District Court of Massachusetts allowed limited discovery in an ERISA case.

Waldron sued to recover additional long-term disability benefits under an employee welfare benefit plan provided to him by MIT. The plan was self-funded, but, while Waldron was receiving benefits, MIT retained Prudential to administer the claim. In 2019, Prudential terminated benefits. Waldron submitted an administrative appeal to MIT, which accepted Prudential's recommendation and denied the appeal. Suit followed.

The parties stipulated that the standard of review in the case was de novo. Waldron then sought to obtain discovery. While the parties resolved many of the discovery issues, the court addressed the remaining disputes.

Waldron first sought to add to the Administrative Record correspondence between him and the human resources manager at MIT. The court rejected that request on the grounds that those materials were not before either Prudential or MIT when making its decision regarding Waldron's eligibility for continued benefits.

Waldron also sought to obtain documents regarding MIT's decision to refer his claim to Prudential for administration. The court denied this request on the

INSURANCE AGENT OWES NO FIDUCIARY DUTY TO INSURED

In **Garcia v. United of Omaha Life Insurance Company**, 2020 WL 3895918 (D.R.I. 2020), the U.S. District Court of Rhode Island dismissed an insurance agent from a claim seeking life insurance benefits.

Marta Garcia obtained a life insurance policy from United of Omaha through one of United of Omaha's agents, Debbie Benn. Because Garcia was not proficient in English, Benn completed the application and apparently made some errors. After Garcia's death, the beneficiary of the policy sought payment. United of Omaha informed the beneficiary that the life insurance policy was rescinded. Suit followed.

United of Omaha removed the case from Rhode Island state court to federal court on diversity grounds. Benn and her agency were residents of Rhode Island, as was the plaintiff. However, United of Omaha argued removal was proper because Benn and her agency had been fraudulently joined. One basis to show fraudulent joiner is when there is no possibility, based upon the complaint, that the plaintiff can state a cause of action against a non-diverse defendant. The court found this to be true and allowed a motion to dismiss Benn and the agency.

The court first found that no breach of contract claim could lie against Benn and the agency because they were not parties to the contract. The court noted, however, that had the plaintiff alleged negligence against Benn, it may have survived the motion to dismiss.

grounds that the materials sought were too far afield from the question the court would address. That is, whether there was sufficient evidence to support a finding of disability.

Finally, Waldron sought to add Prudential's claim standards, manuals or guidelines to the Administrative Record on the grounds that the standards would have been employed by Prudential in reaching its decision. The court did not find Waldron's argument persuasive except for allowing him to obtain any guidelines governing Prudential's vocational assessments because it was possible that the court's decision in the case would turn on Prudential's assessment of Waldron's vocational capabilities.

The court also found that plaintiff's claim for breach of fiduciary also failed because the plaintiff alleged only that Benn acted as an insurance agent. The general law is that under ordinary circumstance an insurance agent does not owe a fiduciary duty to an insured. Only when there are special circumstances such as when the agent has a long-standing relationship with the client, or holds herself out as the client's insurance advisor is such a relationship found. Because the plaintiff did not allege any special circumstances that claim also failed.

COURT ALLOWS CHANGE OF VENUE FOR INTERPLEADER

In **Metropolitan Life Insurance Co. v. Oliver**, 2020 WL 6136364 (D. Mass. 2020), the U.S. District Court of Massachusetts allowed a motion to transfer venue of an interpleader action to the Middle District of Florida.

MetLife filed the action in federal court in Massachusetts. The dispute involved the proceeds of life insurance benefits payable under an ERISA governed employee benefit plan. The plan was funded by a group life insurance policy issued by MetLife.

After suit was filed, the parties stipulated to MetLife depositing the contested funds with the district court and dismissing MetLife from the action with prejudice.

After MetLife's dismissal, two of the defendants filed motions to transfer the case. One defendant requested a transfer to the Northern District of New York. The other requested a transfer to the Middle District of Florida.

Applying the provisions of 28 U.S.C. §1404(a), the court found a transfer of the case to the Northern District of New York was appropriate. The court noted that the plan appeared to have been administered in the Northern District of New York.

The court decided that although there were witnesses in both jurisdictions that had relevant information, the court found that the convenience of parties and witnesses and the interest of justice weighed in favor of New York. Witnesses in New York were found to most likely have the most relevant information regarding the decedent's mental capacity in the time period at issue. This related to claims of undue influence upon the decedent. The court found although the decedent resided in Florida in the last few years of his life, that fact provided little local interest to Florida where the decedent was a life-long resident of New York. In fact, the decedent identified New York, not Florida, as his address in his beneficiary designation form.

Although finding the question to be a close one, the court found the most appropriate venue was the Northern District of New York.

MASSACHUSETTS PROHIBITS CHANGE OF BENEFICIARY OF LIFE INSURANCE POLICY PENDING DIVORCE

In **Genworth Life and Annuity Insurance Company v. Elmer**, 2020 WL 4720048 (D.Mass. 2020), the United States District Court of Massachusetts resolved an interpleader action regarding the proceeds of a life insurance policy.

David Elmer owned a life insurance policy issued by Genworth. He named his wife, Christine, as sole beneficiary. Christine and David filed for divorce in 2015. In 2018, while the divorce proceedings were still ongoing, David died. The day before he died, David signed a Durable Power of Attorney naming his son, Eric, as his agent. Eric then filled out a beneficiary designation on David's behalf naming himself and his two brothers as new beneficiaries.

COURT ASSESSES TRIPLE DAMAGES UNDER RICO AGAINST PERPETRATORS OF FRAUD SCHEME

In **Western Reserve Life Assurance Co. of Ohio v. Caramadre**, 2020 WL 5665139 (D.R.I. 2020), the U.S. District Court of Rhode Island entered final judgment in a complex insurance fraud case. The court awarded triple damages pursuant to the federal RICO statute and attorney's fees.

The case involved a suit by two insurers against individuals responsible for a stranger-initiated annuity transaction scheme. The two individuals involved, Joseph Caramadre and Raymour Radhakrishnan, both pled guilty to committing mail fraud, wire fraud, identity fraud, obtaining signatures by false pretenses, forgery, and conspiring to defraud and obtain significant sums of money from two insurance companies. In an earlier decision, 2017 WL 752145 (D.R.I. 2017), the court found both individuals civilly

After David's death, Eric submitted a claim for benefits. Genworth took the position that the power of attorney did not give Eric the ability to change the beneficiary. Genworth filed an interpleader and deposited the proceeds with the court.

On cross-motions for summary judgment between Christine and the sons, the court held that under the supplementary rules of the Massachusetts Probate and Family Court no party to a divorce action could directly or indirectly change the beneficiary of a life insurance policy, except with the written consent of the other party or by order of the court. Given this, the court held that up to the time of his death David could not change the beneficiary of his life insurance and therefore the insurance proceeds would go to the wife.

liable under a Rhode Island law targeting any person who causes injury by reason of a commission of a crime. The court also found liability for a RICO violation stemming from a criminal enterprise. Subsequently, the insurers moved for summary judgment, primarily to obtain a ruling on the amount of damages payable to them.

The court calculated the damages and also found that pursuant to 18 U.S.C. §1964(c), part of the RICO statute, insurers could recover triple damages plus reasonable attorney's fees. Because the court had previously found that Caramadre and Radhakrishnan violated §§1962(c) and (d) by engaging in a multi-year pattern of racketeering activity the court found the insurers were entitled to the triple damages and attorney's fees.

ABOUT US

Mirick O'Connell's Life, Health, Disability & 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, 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 clients in each of these jurisdictions. So remember, we are not here for you just in Massachusetts - think New England!

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