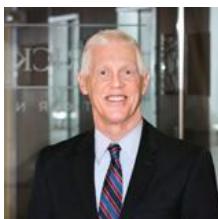




Life, Health & Disability e-Report First Circuit

Winter 2019

Life, Health, Disability and ERISA Litigation Group:



Joseph M. Hamilton
Joe spoke at the ABA Tort Insurance Practice Mid-Winter Symposium on alternative dispute resolution for life, health and disability claims.



J. Christopher Collins
Chris will be presenting at the Eastern Claims Conference in March on the interplay between total and residual disability

Welcome to the Winter 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 HOLDS THAT IN A DE NOVO ERISA BENEFITS CASE, IT REVIEWS THE DISTRICT COURT'S FACTUAL FINDINGS ONLY FOR CLEAR ERROR

In *Doe v. Harvard Pilgrim Health Care, Inc.*, 904 F.3d 1 (1st Cir. 2018), the First Circuit Court of Appeals joined several other circuits in holding that when a district court examines the denial of ERISA benefits under the de novo standard of review, the First Circuit would review the district court's factual findings only for clear error.

The underlying case involves coverage of residential mental health treatments. Doe is 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. A dispute arose among the parties regarding the payment of a portion of the residential mental health treatment provided to Doe.

The district court had held in favor of Harvard Pilgrim and dismissed the complaint. See 2017 WL 4540961 (D. Mass. 2017). The district court also addressed Doe's attempt to expand the administrative record.



[Joan O. Vorster](#)

On appeal, the court first addressed the denial of Doe's request to expand the administrative record. The court found the district court erred in its determination and that for a variety of reasons, including the fact that submissions made by the parties to the district court made clear that the parties were continuing to engage in an administrative review process after the date Harvard Pilgrim contended that a final administrative decision had been made. Thus, the court held that the administrative record should have been supplemented with records propounded by Doe.



[Elizabeth L.B. Greene](#)

The court then turned to deciding the standard of review of the district court's decision denying benefits. Doe argued it should be de novo. Harvard Pilgrim argued it should be clear error.

Equating its role to reviewing an appeal from a bench trial, the court held that it would review the factual findings of the district court in the denial of an ERISA benefits claim de novo. While not specifically stated by the court, in all likelihood, it would also apply the clear error standard if the benefit claim had been allowed by the district court and the appeal was filed by the plan. In doing so, the First Circuit joined the Third, Sixth and Ninth Circuits, which have employed a similar analysis.

This ruling will result in appeals of district court decisions in de novo benefit claims becoming much more challenging.



[Kevin Kam](#)

Kevin will be attending the DRI's Life, Health, Disability and ERISA Conference in Chicago in spring

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DENIAL OF LTD CLAIM FOR MULTIPLE PHYSICAL AND PSYCHOLOGICAL CONDITIONS NOT ARBITRARY AND CAPRICIOUS

In [Faberlle-Hernandez v. Triple-S Vida, Inc.](#), 2018 WL 4719060 (D. Puerto Rico 2018), the U.S. District Court of Puerto Rico held that Triple-S's decision to deny LTD benefits was not arbitrary and capricious.

Hernandez was employed as a secretary. She was covered under an employee benefit plan provided by her employer, which included long-term disability benefits. She applied for LTD benefits, claiming a number of conditions including fibromyalgia, disc protrusions, degenerative disc disease, radiculopathy, and depression. Triple-S had Hernandez's medical records reviewed by a clinical consultant and a physician, board certified in family medicine and neuromusculoskeletal medicine. Both found that Hernandez, with minimal restrictions and limitations, could perform a sedentary occupation. A vocational consultation opined that Hernandez was able to work as a secretary.

In connection with Hernandez's administrative appeal, Triple-S referred the file to a physiatrist and a psychiatrist. Both found there was insufficient evidence to demonstrate that Hernandez was impaired to work due to a mental or physical condition. Suit followed.

Hernandez alleged that Triple-S's decision was unreasonable because previous medical reports and evaluations unequivocally revealed that she was in physical pain and sufficiently limited in movement so as to preclude her from performing any kind of work. A psychiatrist had also stated that Hernandez suffered from major depression.

Relying on First Circuit decisions, the court noted that while the plan administrator could not arbitrarily refuse to credit reliable evidence, the administrator was not obligated to accept or even to give particular weight to the opinion of a treating physician. There was no evidence that Triple-S ignored the treating physician's opinions or reports. It considered them. That being said, the court held that Triple-S reasonably relied on outside medical experts. The court held that the fact that Hernandez could point to evidence

contradicting Triple-S's conclusions was not enough, by itself, to render the decision arbitrary and capricious.

The court entered summary judgment in favor of Triple-S and dismissed the case.

COURT UPHOLDS REDUCTION OF LTD BENEFITS BASED UPON RECEIPT OF VA BENEFITS

In Martinez v. Sun Life Assurance Co. of Canada, 2018 WL 5045183 (D. Mass. 2018), appeal docketed, No. 18-2127 (1st Cir. Nov. 13, 2018) the U.S. District Court of Massachusetts upheld Sun Life's determination that Martinez's disability benefit from the Veterans Administration was properly offset from his LTD benefit.

Martinez was covered by an employee benefit plan provided by his employer that was funded by a group policy issued by Sun Life. Martinez filed a claim for LTD benefits due to multiple sclerosis and began receiving benefits. Several years later, Martinez's claim for VA disability benefits based on the multiple sclerosis was approved. After Sun Life learned of the VA award it informed Martinez it would offset his VA benefit from the LTD benefit as "Other Income Benefits" under the plan. Martinez challenged this determination and ultimately filed suit.

Martinez's primary claims were that the offset constituted discrimination under the Uniformed Services Employment and Reemployment Rights Act of 1994, 30 U.S.C. §4311, and the Veterans' Benefits Act, 38 U.S.C. §5401(a)(1). Martinez also brought claims alleging breach of fiduciary duty and for declaratory and injunctive relief.

The court denied Martinez's claims and entered judgment in favor of Sun Life. The court held that the language of the benefit plan did not distinguish between service members and non-service members and that Sun Life properly considered the VA benefit to be "Other Income Benefits" under the benefit plan. Therefore, offsetting the benefits was simply applying the plain language of the plan, not an act of discrimination.

The court rejected the claim under the Veterans' Benefits Act as well. That statute protects veterans' benefits from seizure. The court held that Sun Life was not attempting to seize the VA benefits, but rather seeking to recover the LTD benefits that would have been subject to the VA offset.

For similar reasons, the court rejected the breach of fiduciary duty claims and the requests for injunctive and declaratory relief.

FAILURE TO TIMELY PROVIDE CHANGE IN PLAN PROVISIONS BARS DENIAL OF CLAIM

In Lavery v. Restoration Hardware Long Term Disability Benefits Plan, 2018 WL 3733936 (D. Mass. 2018), appeal docketed, No. 18-2027 (1st Cir. Oct. 19, 2019) the U.S. District Court of Massachusetts allowed an employee's claim for LTD benefits.

Lavery was covered under a disability plan provided by his employer, Restoration Hardware. The plan was funded by a group policy issued by Aetna Life Insurance Company ("Aetna"). Aetna also administered claims.

Lavery filed a claim for disability benefits after he was diagnosed with malignant melanoma. The issue in the case was whether Lavery's claim was barred by the pre-existing condition provision of the plan.

Aetna denied the claim on two grounds. First, it contended that a visit by Lavery to his primary care physician for a lesion on his back satisfied the provisions of the pre-existing condition clause. At that visit, the physician suspected that the lesion might be a basal cell carcinoma and recommended that Lavery consult with a dermatologist. Lavery did so about six weeks later, at which time the lesion was biopsied and found to be a melanoma.

The court rejected Aetna's argument on this point. The court noted that there was internal conflict within Aetna regarding whether the visit to the primary care physician triggered the pre-existing condition exclusion. On at least two occasions, Aetna personnel had found it did not trigger the exclusion. The court found that the unexplained reversals of the recommendations to award benefits in the absence of new information and in the face of detailed explanations to award benefits warranted a finding that Aetna acted unreasonably.

Aetna's second argument was that, based on a retroactive change in plan provisions, Lavery's coverage did not come into force until later than originally believed. In that case, there was no dispute that the preexisting condition exclusion applied, because Lavery's appointment with the dermatologist was within the look back period.

Lavery argued that the retroactive change in the plan should not apply to him because he did not receive notice of the change until the following year. The court noted that while it was well established that ERISA did not prevent employers from changing welfare plans at any time and for any reason, courts have blocked attempts to apply plan modifications retroactively to affect benefits that had already become due.

The court held that if Lavery had received an earlier notice of the change in coverage he could have waited to see the dermatologist until after the look back period expired and therefore avoided the pre-existing condition exclusion. The court held that Lavery was able to show prejudice due to his reliance on the original terms of the plan that were in effect at the time he sought treatment from the dermatologist. Therefore, the court rejected this argument by Aetna as well.

The court entered summary judgment in favor of Lavery and ordered Aetna to allow the claim.

LTD BENEFITS AWARDED FOR FIBROMYALGIA CLAIM UNDER DE NOVO REVIEW

In [Kamerer v. Unum Life Insurance Company of America](#), 334 F.Supp.3d 411 (D. Mass. 2018), the U.S. District Court of Massachusetts, applying the de novo standard of review, found the plaintiff to be disabled from her occupation due to fibromyalgia.

Kamerer was covered by an employee welfare benefit plan provided by her employer. The LTD coverage was provided through a group policy issued by Unum Life Insurance Company of America and an individual disability policy provided by Provident Life and Accident Insurance Company. Kamerer's occupation was a systems consultant.

Kamerer was paid benefits from 2004 to 2015. She was unable to work due to fibromyalgia and depression.

Benefits were discontinued in 2015 after an IME and a medical review concluded that Kamerer was not disabled due to fibromyalgia, although it was determined that she continued to be disabled due to depression. Because the

plan provided benefits for a mental illness for only 24 months and Kamerer had received those benefits, benefits were discontinued.

The issue before the court was whether Kamerer met her burden of demonstrating that she was disabled from fibromyalgia. While noting several First Circuit decisions that held it was not arbitrary and capricious for an insurer to require objective evidence of a subjective condition such as fibromyalgia, because the standard of review was *de novo*, the court held that even if Kamerer did not provide objective evidence that her symptoms precluded her from fulfilling the physical requirements of her occupation, she could satisfy her burden of proof "if the totality of the evidence" demonstrated that she was unable to fulfill the physical requirements.

While the defendants relied upon independent medical examination as well as several medical reviews of Kamerer's medical records to conclude that she was no longer unable to perform the duties of her occupation due to fibromyalgia, the court elected to conclude that because Kamerer had been diagnosed with fibromyalgia and that one physician and a psychologist had opined she could not physically perform her duties, and she was taking medication, this was sufficient to satisfy her burden that she was disabled from fulfilling the duties of her occupation.

The court then went on to address the mental health limitation contained in the benefit plan. Kamerer had argued that the defendants should have the burden of proof to demonstrate that the mental health limitation applied to her claim. The court agreed, finding that the defendants were required to demonstrate that Kamerer's condition was "due to" or "caused by" mental illness. The court found that while Kamerer's psychological condition may be playing a role in her physical wellbeing, it did not rise to the level of a "but for" causation.

The court granted summary judgment in favor of Kamerer and ordered benefits to be reinstated and to be paid for past benefits.

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

COURT REMANDS LTD CLAIM

In Ampe v. The Prudential Insurance Company of America, 2018 WL 5045184 (D. Mass. 2018), the U.S. District Court of Massachusetts remanded an LTD claim for further review after determining that the decision denying Ampe's LTD claim was arbitrary and capricious.

Ampe was employed as an engineer for Massachusetts Institute of Technology's Lincoln Laboratories. MIT had a self-insured employee benefit plan. Prudential served as a third party administrator.

In 2011, Ampe fell and struck his head. He was diagnosed with a post-concussive syndrome and experienced physical, cognitive and emotional changes. He continued to work until 2015. He stopped working after a series of declining annual performance reviews. MIT told Ampe it would not provide further accommodations and recommended he apply for LTD benefits. Ampe applied for benefits which were ultimately denied by MIT based upon Prudential's recommendation. Suit followed.

Applying the arbitrary and capricious standard of review, the court found that MIT's decision was arbitrary and capricious for two reasons.

The court first held that it was concerned that Prudential gave conclusive weight to its medical reviewer's opinions based upon a file review, without giving any substantive consideration to the records and opinions of Ampe's treating physician and the doctors who had examined Ampe to evaluate his

neuropsychological symptoms. The court noted that it was troubled by a reference to somatization which it characterized as "a discredited clinical diagnosis" without any explanation of how it reached that conclusion. The court also stated that while it was not in a position to address the medical validity of post-concussion syndrome as a diagnosis, the court found there was enough support in the medical literature to make a denial of benefits based upon "one skeptical doctor's file review open to question." To support the view the court referenced, in a footnote, the Wikipedia page on post-concussion syndrome.

Secondly, the court found that Prudential's benefit denial failed to analyze Ampe's conceded limitations against the demands of his occupation as an engineer. More particularly, the court held that Prudential failed to address and properly weigh Ampe's complaints of severe headaches and fatigue.

Finding that the record did not compel the conclusion that Ampe was disabled or disabled, the court ordered "a more considered examination of the medical evidence on remand..."

COURT FINDS NO JURISDICTION BASED UPON ERISA, BUT DOES FIND DIVERSITY JURISDICTION

In [Flinn v. Minnesota Life Insurance Company](#), 2018 WL 5982021 (D. Mass. 2018), the U.S. District Court of Massachusetts denied Flinn's motion to remand the case for lack of jurisdiction, but also found that jurisdiction was based upon diversity, not ERISA.

Flinn sought life insurance benefits under an employee welfare benefit plan provided by his wife's employer, and funded by a group policy issued by Minnesota Life. The life insurance benefits were paid by Minnesota Life with a check made payable to Flinn, but sent to Attorney Joan Oliveira at Oliveira's business address. Subsequently, Oliveira diverted the funds to herself. While Flinn filed suit against her, Oliveira filed for bankruptcy. Flinn then filed suit against Minnesota Life claiming that the benefits had been wrongfully released to Oliveira.

Flinn brought claims of negligence, constructive trust, breach of fiduciary duty, and violations of Massachusetts Consumer Protection Act, Chapter 93A. Minnesota Life removed the case to federal court and moved to dismiss it on grounds of ERISA preemption.

The court denied Minnesota Life's motion to dismiss. The court based its decision on its conclusion that Flinn was not seeking the benefits under the plan, but that Minnesota Life violated its state law obligations to ensure that Flinn received the benefits check. The court held that whether Flinn's claims were meritorious depended not on the terms of the plan or ERISA, but on state law and other federal statutes regulating Minnesota Life's duties. The court found that Flinn's claims did not relate to the benefit plan. The court reasoned that Flinn's claim was a simple allegation that Minnesota Life violated Massachusetts Law when the benefits were sent to someone masquerading as his representative. The court held that because Flinn's claim did not question the administration of the plan, it did not threaten the uniformity of national benefits law.

Joan Vorster and Kevin Kam represented Minnesota Life Insurance Company.

HEALTH INSURER'S DENIAL OF SURROGATE PREGNANCY EXPENSES NOT ARBITRARY OR CAPRICIOUS

In [Roibas v. EBPA, LLC](#), 2018 WL 4690354 (D. Me. 2018), the U.S. District Court of Maine upheld a health insurer's decision denying expenses related to a surrogate or gestational pregnancy.

Melissa True was covered under an employee benefit plan provided by her employer which provided reimbursement of medical expenses covered by the plan. EBPA was a third party administrator of the plan.

True entered into an agreement with Roibas to be a gestational carrier, that is to carry the fertilized egg of Roibas and his partner. The agreement between True and Roibas provided that Roibas would pay the medical expenses related to the pregnancy and birth to the extent they were not covered by True's health insurance.

True submitted her claim to the benefit plan but was denied under a surrogacy exclusion contained in the plan. Suit followed.

Applying the arbitrary and capricious standard of review, the court entered summary judgment for EBPA on the grounds that EBPA's decision to deny True's claim as "expenses for surrogacy" was not arbitrary and capricious.

The court found that the term "expenses for surrogacy" was ambiguous. However, the court also noted that in the First Circuit when a term is ambiguous, if the administrator has discretionary authority to construe the plan's terms, the court must defer to the administrator's reasonable interpretation of that term. The court found that EBPA's interpretation of the term was not arbitrary and capricious. It found the plain meaning of "surrogacy" encompasses carrying a child for another couple. The court rejected True's argument that expenses related to a "gestational carrier" should receive benefits under the meaning of the plan. The court stated it was hard to believe that the drafters of the plan would have intended to cover pregnancy expenses for a plan participant who served as a gestational carrier (carrying the fertilized egg of another couple) but deny those benefits to a participant who as a surrogate carrier (where the egg is the carrier's but fertilized by a third party).

The court denied EBPA's request for attorney's fees.

PUTATIVE CLASS ACTION BENEFIT CLAIM AND BREACH OF FIDUCIARY CLAIM UNDER ERISA DISMISSED

In [Cotton v. Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.](#), 2018 WL 6416813 (D. Mass. 2018), the U.S. District Court of Massachusetts dismissed two counts of a putative class action brought against Blue Cross Blue Shield.

The complaint alleged that Blue Cross Blue Shield improperly denied claims for the cost of treating the plaintiffs' childrens' mental health issues in wilderness therapy programs. The complaint contained a claim pursuant to 29 U.S.C. §1132(a)(1)(B) of ERISA to recover benefits, a claim for a breach of the Mental Health Parity and Addiction Equity Act, and a breach of fiduciary duty pursuant to ERISA. Blue Cross Blue Shield moved to dismiss the benefit claim and the breach of fiduciary claim. The court allowed the motion.

The plaintiffs argued the benefit claim should proceed because the exclusion under which Blue Cross Blue Shield denied their benefit claims was ambiguous. The court rejected this, finding that the language of the exclusion was unambiguous and specifically disclaimed coverage for the type of treatment sought by the plaintiffs.

With respect to the breach of fiduciary duty claim, plaintiffs argued that in accordance with CIGNA Corp. v. Amara, 563 U.S. 421 (2011), they could plead a fiduciary duty claim in the alternative to a benefits claim. The court noted that while the First Circuit had yet to specifically address the issue, it was confident that the First Circuit would adhere to its position as set forth in LaRocca v. Borden, Inc., 276 F.3d 22 (1st Cir. 2002) in which it held that if a plaintiff can pursue a benefit claim under the benefit plan, there is an adequate remedy such that it bars a further remedy for breach of fiduciary duty.

ERISA CLAIM FOR MENTAL HEALTH TREATMENT PROGRAM SURVIVES MOTION TO DISMISS

In [Vorpahl v. Harvard Pilgrim Health Insurance Company](#), 2018 WL 3518511 (D. Mass. 2018), the U.S. District Court of Massachusetts allowed a suit to continue alleging that a ERISA governed health plan violated the Mental Health Parity Act ("Parity Act").

Vorpahl and two other parents brought suit, on behalf of a putative class, against Harvard Pilgrim contending that Harvard Pilgrim owed benefits and breached its fiduciary duty by denying payment for their children's mental health treatment at an outdoor youth treatment program, also known as a wilderness program. Harvard Pilgrim denied benefits based upon an exclusion in the plan.

Harvard Pilgrim moved to dismiss. The plaintiffs argued the motion should be denied because the exclusion in the benefit plan did not cover the treatment provided; that the exclusion violated the Parity Act; and that the exclusion violated the Affordable Care Act.

The court rejected the plaintiffs' argument that the exclusion did not apply to the treatment. The court held the exclusion did contemplate the services that were provided to the plaintiffs' children. The court also allowed the motion with respect to the Affordable Care Act for two reasons. First, the court found that the provision cited by the plaintiffs, 42 U.S.C. §300gg-5 did not prohibit an insurer from discriminating against a provider by denying coverage for service by a provider who is licensed to provide that service. Secondly, the court held that the section of the Act cited by the plaintiffs did not provide a private right of action.

With respect to the Parity Act, however, the court was persuaded by case law from other jurisdictions allowing such a suit to proceed. The court held the issue is whether Harvard Pilgrim's exclusion for wilderness programs was an exclusion that applied equally to medical/surgical benefits and mental health or substance abuse disorder benefits. While stating that it was a close call, the court held that the allegations in the complaint were sufficient to allege that the mental health treatment was categorically excluded by the plan while corresponding medical treatment was not. The court thus allowed that claim to proceed.

COURT DENIES MOTION TO EXPAND ADMINISTRATIVE RECORD

In [Fisher v. Harvard Pilgrim Health Care of New England, Inc.](#), 2018 WL 3421323 (D. Mass. 2018) the U.S. District Court of Massachusetts denied the plaintiff's attempt to expand the administrative record.

Fisher was denied medical benefits related to her eating disorder when Harvard Pilgrim found they were not medically necessary. Suit followed.

Harvard Pilgrim provided a copy of the proposed administrative record. Fisher sought to expand the record.

The court first noted that the final administrative decision on a benefit claim acts as a temporal cutoff point such that post-denial evidence may not be admitted into the administrative record. As a result, the court denied Fisher's attempt to include any documents or communications originating after her claim was finally decided.

The court also denied Fisher's attempt to add documents that existed prior to the final administrative decision because she did not demonstrate that those records were before Harvard Pilgrim when the decision was made.

The remaining requests were denied because they related to treatment periods that were covered by Harvard Pilgrim and were not relevant to the medical necessity determination made on the pending claim. The court held that absent evidence that Harvard Pilgrim actually considered the documents from prior, covered treatment periods they would not be relevant because they would not have been relied on or generated in the course of making the adverse benefit determination at issue.

Finally, the court held that to the extent materials were not before the decision maker, the motion should also be denied because Fisher failed to show a "very good reason" to include them as required by the First Circuit.

LTD CLAIM DISMISSED FOR FAILURE TO EXHAUST ADMINISTRATIVE REMEDIES

In [Fortier v. Hartford Life and Accident Insurance Company](#), 2018 WL 3542863 (D.N.H. 2018), appeal docketed, No. 18-1752 (1st Cir. Aug. 14, 2018) the U.S. District Court of New Hampshire dismissed a plan participant's suit for long-term disability benefits for failing to timely administratively appeal Hartford's termination of benefits.

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

Fortier raised several arguments to excuse her late appeal. She first alleged that Hartford failed to comply with its LTD insurance "Product Manual" which, in Fortier's view, required additional information to be provided in the adverse determination letter. The court rejected this on the grounds it was unclear whether the manual even applied or was in effect when Hartford made the decision to terminate Fortier's benefits. In addition, the court held that the manual could not be used to override the plan's plain language.

The court also rejected Fortier's argument that her 2011 appeal satisfied the requirement to appeal the 2013 determination. She argued that because the

basis of the 2011 termination was the same as the basis for the 2013 termination, her appeal in 2011 must render her later appeal timely. The court rejected this, holding that the plan required Fortier to timely appeal all terminations.

The court next rejected Fortier's attempt to use the substantial compliance doctrine, again noting that Fortier provided no support that the doctrine, which applies to insurers and plan administrators, should be extended to excuse a beneficiary's failure to timely appeal an adverse benefit determination.

The court next rejected Fortier's attempt to apply the notice-prejudice rule, noting that there were no New Hampshire cases applying that rule in the ERISA context and that the majority of courts that have considered the issue have held that the notice-prejudice rule does not apply to save untimely ERISA appeals.

Lastly, the court rejected Fortier's argument that an appeal would have been futile noting that Fortier's attempt to draw a negative inference from her successful 2011 appeal was misplaced. There was nothing in the record which demonstrated that Hartford would have denied a timely appeal in 2014.

ERISA SUIT DISMISSED WITH PREJUDICE FOR FAILURE TO EXHAUST ADMINISTRATIVE REMEDIES

In Anderson v. Liberty Mutual Insurance, 2018 WL 3521176 (D. Me. 2018), the U.S. District Court of Maine dismissed a beneficiary's claim for accidental death benefits for failing to exhaust internal remedies and because Liberty's denial for failure to provide requested documents was reasonable.

John Anderson was covered under a life insurance welfare benefit plan provided by his employer that included accidental death benefits. The plan was funded by a group life insurance policy issued by Liberty to the employer. Liberty also administered claims under the plan.

Anderson died operating a snowmobile when it collided with a tree. A proof of death form was submitted to Liberty. Thereafter Liberty made attempts for a year to obtain information necessary to process the accidental death benefit claim. Finally, Liberty sent a letter to the beneficiary's attorney stating that if the documents were not received within 30 days the claim would be closed. The documents were not received. The beneficiary was notified of the denial and that he could request a review by submitting a written request within 60 days. No request was submitted. Instead, the beneficiary filed suit in state court. The case was removed by Liberty to federal court.

Liberty filed a motion for judgment on the record to dismiss the complaint. The court allowed it.

The beneficiary raised a number of defenses to Liberty's motion. The court first held that the suit would be barred for failure to exhaust administrative remedies unless an exception to the exhaustion doctrine applied, or there was some material defect in Liberty's notice or procedures relating to the denial.

The court first held that the beneficiary had not attempted to make any showing of futility or inadequacy with respect to the administrative appeal. So, those exceptions did not apply.

The court then rejected the beneficiary's argument that Liberty's denial letter was defective because it was sent to their attorney rather than to the beneficiary personally. The court held that notice to the attorney is notice to the claimant.

The beneficiary then argued that Liberty was required to show prejudice by any delay. While noting that Maine had a notice-prejudice rule for liability

policies, and that it was unclear whether it applied to ERISA, the court held that even assuming the notice-prejudice applied, the beneficiary raised it too late.

The court next addressed the beneficiary's argument that the notice from Liberty regarding the administrative appeal was misleading. The court rejected the argument stating that the beneficiary did not produce any evidence that he failed to exhaust because he relied upon allegedly misleading language as the reason he did not timely request an internal appeal.

The court next rejected the beneficiary's argument that Liberty improperly closed the claim by imposing an arbitrary deadline to submit proof of claim. The court noted that other courts have upheld denials for failure to provide reasonably requested documents, and found that Liberty's request was reasonable.

The last issue addressed is whether the dismissal of the complaint should be with prejudice. The court held it should be with prejudice because the time within which the administrative appeal should have been filed had expired by the time the beneficiary filed suit.

TORT AND CONSUMER PROTECTION CLAIMS NOT BARRED BY CONTRACTUAL LIMITATIONS PERIOD

In **Brown v. Savings Bank Life Insurance Company**, 93 Mass. App. Ct. 572 (2018), the Massachusetts Appeals Court upheld the dismissal of a contract claim based upon a contractual limitations period set forth in a life insurance policy, but held tort claims and a claim for violation of the Massachusetts Consumer Protection Statute, General Law Chapter 93A, were not barred by that limitations period.

Michelle and Daniel Brown were insured under term life insurance policies issued by the Savings Bank Life Insurance Company of Massachusetts ("SBLI"). The premium for the policies was scheduled to increase dramatically after the tenth year. In advance of that, SBLI's agent began communicating with both Michelle and Daniel about replacement policies.

Daniel let his policy lapse. While he applied for a new term policy, the application was denied. Before new insurance was in place, he died. Michelle brought suit against SBLI claiming breach of contract, negligence, misrepresentation, and a violation of Chapter 93A.

SBLI moved for summary judgment. The trial court allowed the motion, finding that the contract claim was barred by the contractual limitation period and the remaining claims failed as a matter of law. Michelle then appealed.

The key language of the policy was "Any suit brought on or in respect to this policy shall be brought against us no later than two years after the date the alleged cause of action accrues . . ."

On appeal, Michelle conceded that the contractual claim was late. However, she contested the applicability of the contractual limitations period to the tort and Chapter 93A claims. The court agreed.

The court noted that the timeframe for bringing a tort claim under Massachusetts law is three years, and four years for Chapter 93A claims. The question was whether those claims were "in respect to this policy." The essence of Michelle's claim was her allegation she had been deceived and misled by statements made by SBLI's representative that Daniel should buy a new policy without telling him to continue to pay the premiums on the old

policy or offering the option to reinstate the old policy once lapsed while the application for a new policy was pending.

Holding that an insurance contract is a contract of adhesion which must be construed against the drafter, the court held that the language of the limitation period in the policy did not put an average member of the public on notice that independent tort and tort-based consumer protection claims must be brought within two years. The court also held that a contractually short limitations period for tort-based consumer protection claims violated public policy, but that contractually-based consumer protection claims could be barred.

The court then addressed the Superior Court's ruling dismissing the tort and consumer protection claims as failing as a matter of law. The court held that the tort claims as well as the tort-based consumer protection claims were viable taking the evidence in the light most favorable to Michelle.

INDIVIDUAL LIFE INSURANCE POLICY LAPSED DUE TO FAILURE TO PAY PREMIUM

In [Fraser v. Prudential Insurance Agency, LLC](#), 2018 WL 6716093 (D. Mass. 2018), the U.S. District Court of Massachusetts entered summary judgment in favor of Prudential and found Fraser's life insurance policy had lapsed.

Prudential issued Fraser a whole life insurance policy in 1991 which required monthly premiums to be paid on the first day of each month. In April 2010, Fraser missed the monthly payment and failed to pay it during the grace period provided by the policy. Prudential sent Fraser a notice informing him that the policy had lapsed but told him that if Prudential received payment by June 2, 2010 the policy would be reinstated without the need for underwriting. Fraser failed to make that payment on time and was then notified that in order to reinstate the policy he would have to complete an application.

When the policy lapsed, Prudential reported to the Internal Revenue Service the taxable gain that Fraser had earned as a result of an outstanding loan balance he had on the policy.

Fraser, on a pro se basis, sued Prudential claiming that it had improperly canceled the policy and wrongfully reported the taxable gain to the IRS. Both parties filed motions for summary judgment which were referred to a magistrate judge.

The magistrate judge recommended summary judgment be entered in favor of Prudential. The district court adopted that recommendation.

The magistrate first found that the insurance policy was unambiguous as to the applicable terms. The court found that Fraser received all appropriate notices from Prudential regarding the lapse of his policy; that Prudential was obligated to notify the IRS because loans against a life insurance contract's cash value have the same effect as paying the proceeds directly to the policyholder; and that Fraser failed to make timely payments to Prudential to keep the policy in force.

The case is also interesting due to the pro se nature of Fraser's representation. The court pointed out that even as a pro se plaintiff, Fraser was required to adhere to the filing requirements of Federal Rule of Civil Procedure 56. The court also issued an order precluding Fraser from filing any motions against Prudential that had previously been addressed by the court without leave of court. Noting Fraser's history of filing motions in the case, the court stated the "time has come to end these time consuming, distracting and meritless motions."

MASSACHUSETTS APPEALS COURT UPHOLDS INTERPRETATION OF "YOU" IN LIFE INSURANCE POLICY

In [Dickerson v. MassMutual Life Insurance Co.](#), 2018 WL 5116579 (Mass. App. 2018), the Massachusetts Appeals Court upheld summary judgment entered in favor of MassMutual regarding the interpretation of the word "you" in a policy.

Dickerson was the beneficiary of a life insurance policy owned by and insuring his wife. The policy required the wife to make quarterly premium payments to keep the policy in force. The policy also provided that written notification would be sent to "you" if the policy entered a grace period resulting from a failure to pay the premium.

After making an initial premium payment, the wife made no other payments. MassMutual notified her that the policy had entered the grace period and would terminate if payment was not received by a date certain. No further payment was received. The wife subsequently died. Dickerson made a claim for benefits which was denied by MassMutual because of the lapse on the policy.

Dickerson sued MassMutual claiming that the policy required MassMutual to also give him and the broker involved in the sale of the policy notice that the policy was entering the grace period. MassMutual moved for summary judgment which was allowed by the Superior Court. The case centered around the interpretation of the word "you" in the policy.

The Appeals Court found that while the term "you" was undefined in the policy, the term was used throughout the policy and clearly referred to the owner of the policy, the wife. The court also noted that interpreting the term to refer to Dickerson, his wife, and the broker in each instance in which the term "you" was used would lead to nonsensical interpretations. The court noted that terms of an insurance policy, when unambiguous, must be given their usual and ordinary meaning. The court upheld the entry of summary judgment in favor of MassMutual.

COURT DISMISSES AFFIRMATIVE DEFENSE OF UNCLEAN HANDS DIRECTED TOWARDS LIFE INSURER

In [Farm Family Life Insurance Company v. Barker](#), 2018 WL 3475531 (D. Mass. 2018), a magistrate judge issued a report and recommendation, which was later adopted by the district court, see 2018 WL 4268891 (D. Mass. 2018), that the affirmative defense of unclean hands raised by the policyholder be stricken.

Barker was the trustee of a trust which had ownership of a life insurance policy issued by Farm Family to Dorothea Barker. The policy provided for a surrender value. When the policy was issued it contained an inaccurate table of guaranteed cash surrender values. The table was inconsistent with the provisions of the policy, the annual statements issued by Farm Family each year, and the illustration issued by Farm Family on or before the time the policy was issued.

Barker sought to obtain the surrender value contained in the faulty table of policy values which showed a value of more than \$8,000,000. Farm Family countered that the cash surrender value was less than \$200,000, as demonstrated by the annual statements, the policy language and the illustration.

As one of her affirmative defenses, Barker raised the unclean hands doctrine. The court found that the defense should be stricken. The court held that the

alleged inequitable conduct must affect the party asserting the defense and relate directly to the conflict at issue. Barker claimed a replacement table of values that was inserted by Farm Family when she sought a copy of her policy satisfied the doctrine. The court disagreed. The court found that Barker set forth no facts to establish any link between the replacement table and Farm Family's refusal to pay the amount sought by her. Because Farm Family did not base its claim upon the erroneous nature of the original table or the replacement table, the court held that Farm Family was not relying on its alleged wrongful conduct; that the alleged wrongful conduct did not relate to Farm Family's claim for a declaratory judgment; and that such conduct did not harm Barker.

DID YOU KNOW?

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