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# Life, Health, Disability & ERISA Litigation

**Fall 2020 | 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 ACCIDENTAL DEATH UPHELD

In **Arruda v. Zurich American Insurance Company**, 951 F.3d 12 (1st Cir. 2020), the First Circuit Court of Appeals reversed a decision by the U.S. District Court of Massachusetts and held that Zurich's decision to deny accidental death benefits was not arbitrary and capricious.

Arruda was a participant in an employee benefits 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 implanted in his chest. In May 2014, while driving, 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. 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

## FIRST CIRCUIT UPHOLDS REDUCTION OF LTD BENEFITS BASED UPON RECEIPT OF VETERANS BENEFIT

In **Martinez v. Sun Life Assurance Company of Canada**, 948 F.3d 62 (1st Cir. 2020), the First Circuit Court of Appeals upheld the U.S. District Court of Massachusetts' decision that Sun Life properly determined that Martinez's disability benefit from the Veterans Administration was an offset from his LTD benefit.

Martinez was covered by an employee benefits 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.

The district court denied Martinez's claims and entered judgment in favor of Sun Life. Martinez appealed.

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 attributed 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 illnesses 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 district court held that Zurich's decision was arbitrary and capricious. Zurich appealed.

The First Circuit held that Zurich's determination that Arruda's death was caused or contributed to by pre-existing medical conditions was supported by substantial evidence and was not arbitrary and capricious. The court found that the record before Zurich of the causes that contributed to Arruda's death were all consistent that his crash was caused, at least in part, or was contributed to, by his pre-existing medical conditions. Taking all of those materials and medical opinions as a whole, the court held that Zurich's conclusion was not undermined because Arruda's expert, Dr. Laposata's, opinion differed. As the court noted, in the First Circuit "the existence of contradictory evidence does not, in itself, make the administrator's decision arbitrary." The court seemed to be particularly convinced that the third party reviewer used by Zurich on appeal, Dr. Taff, could be relied upon by Zurich because he carefully ruled out other possible causes of Arruda's accident, gave a detailed account of the Arruda's medical history, acknowledged potentially conflicting evidence, and came to a reasoned conclusion. The court also noted that a reviewing court should not find an insurer's decision to be arbitrary when the insurer relies on several independent experts.

There was a dissent to the decision.

On appeal, Martinez first argued that Sun Life failed to clearly disclose in its letters to him that it relied upon the provision of "Other Income Benefits" that addressed "Compulsory Benefit Act or Law." The court held that Sun Life did adequately disclose its rationale to Martinez and even if it did not, Martinez had a full opportunity to present his arguments on the construction of the plan. Thus, there was no prejudice to Martinez.

The court then went on to find that the meaning of "Compulsory Benefit Act or Law" included veterans disability benefits because the Veterans Administration was required by law to provide that benefit to Martinez once it determined that he was eligible. Therefore, Sun Life was correct in offsetting the benefit.

Finally, the court upheld the district court's determination that Sun Life's offset of the veterans benefits did not discrimination against employees who had served in the armed forces.
The court affirmed the decision by the district court.

## LIFE, HEALTH, DISABILITY & ERISA LITIGATION GROUP ATTORNEYS


**JOSEPH M. HAMILTON**
Group Co-Chair
jhamilton@mirickoconnell.com

**J. CHRISTOPHER COLLINS**
Group Co-Chair
ccollins@mirickoconnell.com

**JOAN O. VORSTER**
Partner
jvorster@mirickoconnell.com

**ELIZABETH L.B. GREENE**
Partner
egreene@mirickoconnell.com

**LAUREN E. SPARKS**
Associate
lsparks@mirickoconnell.com


## AUTOEROTIC ASPHYXIATION NOT ENCOMPASSED WITHIN ACCIDENTAL DEATH COVERAGE

In **Wightman v. Securian Life Insurance Co.**, 2020 WL 1703772 (D. Mass. 2020), the U.S. District Court of Massachusetts upheld Securian's decision that a death due to autoerotic asphyxiation was not unintended, unexpected and unforeseen and also constituted a self-inflicted injury.

Colin Wightman was enrolled in a group life insurance plan provided by his employer, and funded by a policy issued by Securian. The claim was governed by ERISA. His wife was the beneficiary. In 2016, Wightman died in his apartment. He was found by his wife naked and hanging from the bathroom door with a belt looped around his neck. Previously, Wightman had been interested in autoerotic asphyxiation, had told his wife of his interest, and had received mental health treatment for it.

The medical examiner determined Wightman's death to be an accident due to autoerotic asphyxiation. Wightman's wife submitted a claim for benefits under the life insurance coverage. Securian paid benefits, but denied accidental benefits. Securian denied the benefits on the grounds that a death by autoerotic asphyxiation was not encompassed within the coverage, which required the accidental bodily injury to be unintended, unexpected and unforeseen. Securian also found that the claim was not payable based on the plan's exclusion for intentional self-inflicted injury or an attempted self-inflicted injury. Suit followed.

The court applied the de novo standard of review. The court first agreed with Securian that Wightman's death was not an accidental bodily injury covered under the policy. The court applied the analysis employed by the First Circuit in Wickman v. Nw. Nat'l Ins. Co., 908 F.2d 1077 (1st Cir. 1990). Applying that analysis, the court found that while Wightman did not expect to suffer the injury he experienced, the loss of oxygen and subsequent death was not unexpected, unintended or unforeseen. Therefore, Wightman's expectation was not reasonable.

The court also agreed with Securian that the claim was barred due to the exclusion for intentional self-inflicted injuries. The court found that when an individual purposely places a belt around his neck, purposely employs that belt to cutoff blood flow, and ultimately dies from the very strangulation which he initiated, that person has died from one continuous self-inflicted injury.

The court entered summary judgment in favor of Securian.

## COURT QUESTIONS JURISDICTION OVER INTERPLEADER COMPLAINT

In **National Western Life Insurance Company v. Borrero-Sotomayor**, 2020 WL 3125332 (D. Puerto Rico 2020), the U.S. District Court of Puerto Rico ordered National Western to amend its complaint to address subject matter jurisdiction issues or risk dismissal.

National Western had issued a life insurance policy for Dobal, who passed away in 2019. The policy proceeds were approximately $80,000.

National Western filed an interpleader action stating that three sets of possible recipients of the policy proceeds existed, including Vazquez, a named beneficiary, Borrero, also a beneficiary, and Dobal's unidentified children. The only defendant served was Vazquez.

In response to a motion by National Western to interplead the policy proceeds, the court raised the issue of subject matter jurisdiction. The court stated that jurisdiction needed to be established either through diversity or statutory interpleader. National Western asserted jurisdiction based upon both.

The court held that National Western had not shown diversity among the parties because the citizenship of Vazquez or Borrero, or any other defendant, had not been alleged. If any of the defendants were citizens of the same state as National Western, there would be no diversity.

Similarly, the court held National Western could not invoke jurisdiction pursuant to statutory interpleader. That requires minimal diversity among two or more adverse claimants. Because National Western had failed to allege the citizenship of the defendants, diversity could not be established.

## LIFE INSURANCE BENEFICIARY DISPUTE RESOLVED BY COURT

In **Ross v. Jackson National Life Insurance Company**, 2020 WL 2850290 (D. Mass. 2020), the U.S. District Court of Massachusetts resolved a dispute regarding the entitlement to life insurance proceeds.

Howard Ross was the son, and only child, of Milton and Rose Ross. Mr. and Mrs. Ross obtained a last to die life insurance policy from Jackson National. The beneficiary for that policy was listed as "Howard S. Ross, Trustee of the Milton D. Ross and Rose K. Ross Irrevocable Insurance Trust."

After the death of both parents, a dispute arose over payment of the proceeds of the policy. Ross, an attorney representing himself, demanded that the proceeds be paid to him personally. Jackson National refused and asked Ross to return a copy of the trust agreement with the trust tax identification number. Ross stated he did not have a copy of the trust agreement. Ross then filed suit.

The court held that because the designated beneficiary, the trust, apparently did not exist, and because Rose Ross was the second insured to die, the insurance proceeds were payable to her estate. Therefore, the court ordered the insurance proceeds be paid to Ross as the personal representative of Rose Ross's estate. The court did allow $7,655 to be placed in escrow because of a dispute regarding a premium owed on the policy.

Ross also sought to bring a claim against Jackson National for a violation of the Massachusetts Wiretapping statute, Chapter 272, §99 on the grounds that Jackson National illegally recorded its conversations with him. That is, without asking his consent or disclosing it was doing so. The court rejected the claim on two grounds. First, it found Ross was informed that the calls may be recorded and that this was sufficient. In addition, because the calls were being recorded at Jackson

Finally, the court noted that the motion to interplead could not be granted because Federal Rule of Civil Procedure 67 only allows deposit if there is a genuine dispute over entitlement to the money. Because there only appeared to be one defendant declaring entitlement to the policy funds, there was no genuine dispute regarding the proceeds.

The court gave National Western twenty days to amend the complaint to address these issues.

National's offices in Michigan, which is a one-party consent state, under the terms of the Massachusetts statute the recordings took place in Michigan and therefore were outside the reach of the wiretapping statute.

## PLAN NOT ARBITRARY OR CAPRICIOUS IN FINDING CHRONIC FATIGUE AND FIBROMYALGIA ENCOMPASSED WITHIN SELF-REPORTED SYMPTOMS LIMITATION PROVISION

In **Ovist v. Unum Life Insurance Company of America**, 2020 WL 1931958 (D. Mass. 2020), the U.S. District Court of Massachusetts adopted the report and recommendation that Unum Life's decision limiting Ovist's benefits to 24 months under the self-reported symptom provision of the ERISA plan was proper. The report and recommendation is found at 2020 WL 1931755 (D. Mass. 2020).

Ovist, a college professor, became disabled due to chronic fatigue and fibromyalgia. Unum Life determined that Ovist was disabled but informed her at the outset that her benefits would be limited to 24 months in accordance with the self-reported symptoms provision of the plan. When Unum Life ended benefits, Ovist brought suit.

After cross motions for summary judgment were filed, the case was referred to a magistrate judge for a report and recommendation. The magistrate recommended that Unum Life's motion be allowed and the District Court adopted that recommendation.

The key dispute in the case was whether fibromyalgia was encompassed within the self-reported symptom provision. Ovist, relying primarily on Weitzenkamp v. Unum Life Ins. Co. of Am., 661 F.3d 323 (7th Cir. 2011), argued that because the trigger-point test is used to diagnose fibromyalgia, it qualified as a clinical examination accepted in the practice of medicine and thereby fell outside of the self-reported symptom limitations provision.

The magistrate rejected this argument and held that while the trigger-point was used as an objective evaluation tool for the diagnosis of fibromyalgia, that was not dispositive as to whether a claimant was entitled to benefits under the self-reported symptoms limitation provision. Rather, the court agreed with the decision reached in Decorpo v. Unum Life Ins. Co. of Am., 2013 WL 4794345 (D. N.H. 2014), where the court found that a claimant's reaction to the trigger-point test, complaints of pain, are based on the claimant's self-reporting and therefore the disability was encompassed within the self-reporting symptoms limitation provision. Therefore, the court found that Unum Life was not arbitrary or capricious in its decision.

The magistrate also rejected Ovist's contention that Unum Life had the burden to show the limitation provision applied because it was an equivalent to an exclusion of benefits. The magistrate noted that the provision was given that Unum Life paid benefits. Thus, the provision was a limitation, not an exclusion, and therefore the burden was on Ovist to show her entitlement to benefits beyond the payments that she received.

The case is currently under appeal.

**Joseph M. Hamilton represented Unum Life Insurance Company of America.**

## DETERMINATION THAT CLAIMANT WAS ABLE TO WORK IN "ANY OCCUPATION" NOT ARBITRARY OR CAPRICIOUS

In **Gammon v. Reliance Standard Life Insurance Company**, 444 F.Supp.3d 221 (D. Mass. 2020), the U.S. District Court of Massachusetts upheld Reliance Standard's determination that Gammon was not totally disabled because she was able to engage in a full-time occupation.

Gammon was covered by a long-term disability plan provided by her employer, which was governed by ERISA. Under the plan, Gammon could receive up to 36 months of total disability benefits if she was unable to perform the material

## DETERMINATION THAT CLAIMANT COULD RETURN TO WORK AS A LEGAL SECRETARY NOT ARBITRARY OR CAPRICIOUS

In **Jette v. United of Omaha Life Insurance Company**, 2020 WL 4559986 (D.Mass. 2020), the United States District Court of Massachusetts upheld United of Omaha's determination that Jette was not totally disabled to return to work as a legal secretary.

Jette was covered by a long-term disability plan provided by her employer, which was governed by ERISA. The plan was funded by a group policy issued to the employer by United of Omaha. Claims were also administered by United of Omaha.

duties of her regular occupation. After that, benefits would only be payable if she was unable to work full-time in any occupation. The plan also provided 24 months of benefits for a disability caused by a mental or nervous disorder.

After paying 36 months of benefits, Reliance Standard found Gammon was capable of working. Suit followed.

The court, applying the arbitrary and capricious standard of review upheld Reliance Standard's decision. As a threshold matter, the court denied Gammon's request for a jury, noting that this request had been repeatedly rejected by the courts, including the First Circuit. **Recupero v. New England Tel. & Tel. Co.**, 118 F.3d 820, 831-832 (1st Cir. 1997).

Given the standard of review, the court stated it was particularly important to give considered deference in cases like Gammon's because that approach promoted efficiency by encouraging resolution of benefit disputes through internal administrative proceedings rather than costly litigation.

The court made several additional interesting findings:

- The court found Reliance Standard was correct in not considering a 2018 examination from Gammon's treating physician because the relevant time period at issue was 2016, when benefits were terminated. The court held the proper records to consider were what existed in 2016. Whether Gammon's physical state may have changed since 2016 was not relevant because Reliance Standard's decision to deny benefits in 2016 could not have been arbitrary and capricious based on her state in 2018.

- The court also considered the Social Security Administration decision awarding benefits to Gammon. While finding that the SSDI report was murky and was subject to several interpretations, the court found Reliance Standard's interpretation that the SSA found Gammon to be physically capable of work, but not psychologically capable, was a reasonable one.

- The court also credited Reliance Standard's surveillance. While limited, only covering a few days, the court gave weight to it because it contradicted Gammon's assertion that she could not drive and was not able to do activities of daily living. The court held that while the surveillance did not establish that Gammon could work a full-time job, it contradicted her assertions and raised questions regarding her credibility.

The court noted that while the evidence presented would make it challenging for it to determine which side was right, the court found that was not the court's job. The court was to determine whether Reliance Standard's conclusion that Gammon was capable of work was reasonable and supported by substantial evidence on the record. The court found that it did.

Summary judgment was entered in favor of Reliance Standard.

## DETERMINATION OF LTD BENEFITS REMANDED FOR FURTHER REVIEW

In 2013, Jette applied for short-term disability benefits due to a back injury. Those benefits were approved. She subsequently requested long-term disability ("LTD") benefits. These were paid until January 2016. After Jette's appeal of the decision was denied she filed suit.

Applying the arbitrary and capricious standard of review, the court found that United of Omaha's decision was not arbitrary and capricious.

The court found that there was no dispute that Jette's regular occupation was a legal secretary and that the occupation fell within the sedentary exertion level. The court noted that the record contained several opinions that Jette could perform sedentary work, including United of Omaha's consulting physician, an independent medical examiner, and one of Jette's own doctors.

The court rejected Jette's argument that her physician had been misled to opine that she was able to engage in sedentary work. The court also rejected Jette's argument that the IME report supported her position. While the IME physician found Jette credible, he specifically opined that Jette could perform seated activities with occasional standing and walking and agreed with the restrictions provided by Jette's treating physician.

The court also rejected Jette's argument that because no medical professional explicitly stated that Jette could perform her job, the decision must be reversed. The court noted that the opinions of Jette's own doctor, the IME and the consulting physician were consistent with Jette's capacity to engage in sedentary work. Because Jette's occupation was sedentary, she was not disabled.

The court noted that while Jette had been awarded Social Security disability benefits, United of Omaha was not bound by that decision. The court also noted that when Social Security made its decision it did not have the benefit of United of Omaha's medical consultant's report, the treating physician's opinion, or the IME report.

Lastly, the court rejected Jette's argument that United of Omaha had not provided her with a full and fair review. Jette argued that she had been denied a full and fair review because she had not been provided with the IME report prior to United of Omaha making its final decision. The court held, consistent with other courts, that the insurer did not have a duty to disclose an IME report prior to making its decision unless the report was finding a new reason to deny benefits.

The court entered summary judgment in favor of United of Omaha.

## THIRD PARTY ADMINISTRATOR FOUND TO BE PROPER DEFENDANT

In **Prokhorova v. Unum Life Insurance Company of America**, 2020 WL 3713022 (D. Mass. 2020), the U.S. District Court of Massachusetts found that the discontinuance of disability benefits was arbitrary and capricious and ordered a further review of the claim on remand.

Prokhorova, a pediatrician, incurred a thoracic disc herniation in 2007. Unum Life paid benefits until May 2015. Benefits were discontinued at that time after an independent medical examination concluded that there was no support for work activity restrictions. The decision was upheld on appeal and Prokhorova filed suit.

Applying the arbitrary and capricious standard of review, the court vacated the denial of benefits and ordered a remand to Unum Life. The court based its decision on its conclusion that the termination of the benefits resulted from a flawed process, was not the product of reasonable decision making, and that the structural conflict of interest may have played a role in the decision.

The court based its decision on several issues. First, it was critical of the reliance on the IME because the evaluating physician relied on MRIs that he had performed, but only had the reports, not the actual MRIs that were performed by Prokhorova's treating physician in Miami. Based upon the Miami MRIs, Prokhorova's treating physician concluded that Prokhorova continued to be disabled due to the continued presence of the herniation. Evidence of the herniation was not seen in the MRIs performed by the IME physician.

The court was also critical of the IME MRI because it was performed on a machine less powerful that used in Miami, and because it found that Unum Life did not address the results of the Miami MRIs or give a basis for rejecting the opinion of Prokhorova's treating physician.

Finally, the court was critical that Unum Life initially determined that Prokhorova's occupation entailed medium work when it reviewed the claim based upon Prokhorova's job description. On appeal, Unum Life focused on Prokhorova's duty as it was performed in the national economy because to continue to receive benefits she needed to be disabled from any occupation. The court labeled this as an argument "conjured up in litigation."

The court ordered the claim remanded to Unum Life for further review.

**Joseph M. Hamilton represented Unum Life Insurance Company of America.**

## IN ERISA BENEFIT SUIT

In **Willitts v. Life Insurance Company of America**, 2020 WL 2839091 (D. Mass. 2020), the U.S. District Court upheld the denial of further short term disability benefits, dismissed common law claims on ERISA preemption grounds, and held the third party administrator, LINA, was a proper party to the case.

Willitts filed a claim for STD benefits under the benefit plan provided by his employer. The plan was administered by LINA pursuant to a claims consulting agreement. Willitts filed a claim for STD benefits for depression and anxiety. After paying STD benefits for a period of time, LINA determined that Willitts was not entitled to further benefits. That determination was upheld on appeal. Suit followed.

The court first determined that the benefit plan was governed by ERISA and that the plan explicitly granted discretionary authority to LINA to determine whether a claimant was eligible for benefits.

Given that the benefit claim was governed by ERISA, the court dismissed Willitts' common law claims of breach of contract, breach of the implied covenant of good faith and fair dealing, breach of fiduciary duty, fraud, intentional infliction of emotional distress, and unjust enrichment.

LINA had also moved to be dismissed on the grounds that it was not a proper party to the case because it only provided claims administration services and the employer self-funded the plan. However, the court found that the plan provided that LINA was the plan administrator and the named fiduciary for adjudicating claims for benefits and deciding any appeals. The key factor in the court's determination was the plan document naming LINA as the plan administrator. Perhaps it would have been a better course to have simply named LINA the claim administrator.

Going to the merits of the case, the court found that LINA's determination was not arbitrary or capricious. The court held that LINA had a reasonable basis to deny benefits based upon the fact that there was no documentation of work tasks or activities that Willitts was unable to perform or documentation of performance deficits at work. The medical records submitted by Willitts were based solely on self-reported symptoms and did not include any objective medical evidence to support the disability claim.

The court granted summary judgment in favor of LINA.

## LIMITED DISCOVERY ALLOWED IN CLAIM FOR LIFE INSURANCE BENEFITS

In **Shields v. United of Omaha Life Insurance Company**, 2020 WL 1956811 (D. Me. 2020), the U.S. District Court of Maine partially allowed a motion to conduct discovery in an ERISA case.

Shields was denied the payment of supplemental life insurance benefits after the death of her husband. The plan

## COURT AWARDS INTEREST AT STATE CONTRACT RATE IN ERISA BENEFIT CLAIM

In **McCarron v. Deloitte, LLP**, 2020 WL 3412576 (D. Mass. 2020), the U.S. District Court of Massachusetts ordered that interest at the Massachusetts statutory rate for contract claims, 12%, be awarded in an ERISA benefit claim.

McCarron was in a dispute with Deloitte regarding payment of claims under a group health insurance plan. The plan was

required that any life insurance above the guaranteed issued amount of $100,000 have evidence of insurability. The employer was assigned the responsibility of gathering evidence of good health from its employees. The employer failed to obtain that from Shields' husband. However, Shields' husband had premiums deducted from his paycheck for the supplemental life insurance for ten years, and he was listed in the bi-annual census provided by the employer to United of Omaha.

After the husband's death, United of Omaha denied the supplemental life insurance claim because of the lack of evidence of insurability. Shields brought suit alleging that United of Omaha waived its right to require evidence of insurability and alleged breach of fiduciary duties. Shields then sought discovery.

Shields requested the court allow her to conduct discovery to show how and by whom the bi-annual audits of the employer were received, to whom they were circulated, and what attention they were given to support her waiver and breach of fiduciary duty claims. While recognizing that discovery in an ERISA case was an exception, rather than the rule, the court found that Shields had met her burden of demonstrating a need for the discovery.

The court based its ruling on the allegations made by Shields in her complaint and found that she had at least made a colorable claim for waiver and estoppel, that the information that she sought was not in the record, and the information might be critical to her ability to prove her claim of waiver.

governed by ERISA. After lengthy litigation, Deloitte awarded benefits to McCarron. The issue then came before the court as to whether interest should be awarded to McCarron, and, if so, at what rate.

Deloitte argued that no interest should be awarded because McCarron did not request it in her complaint. The court rejected that argument, noting that prejudgment interest could be awarded by the court, even if not demanded in the complaint.

As to the rate of interest, the court noted that ERISA contained no explicit provision, and therefore, the court had broad discretion.

Citing a recent decision by the Court of Appeals for District of Columbia that interest is awarded so as to deny the fiduciary the benefit of retaining interest upon wrongfully withheld benefits, to allow the beneficiary to be fully compensated for loss of the use of money, and to promote settlement and deter attempts to benefit unfairly from the inevitable delay of litigation, the court concluded that the federal statutory rate, proposed by Deloitte, was not sufficient to meaningfully accomplish any of the goals for the award of prejudgment interest. It did find, however, that the Massachusetts state rate of 12% did achieve those objectives and ordered payment of interest at that rate be made starting from the date that McCarron's benefits were denied.

Subsequently, the court addressed the issue of post-judgment interest. See **2020 WL 4559926 (D. Mass. 2020)**. There, the court held in response to McCarron's claim for post-judgment interest that such interest was set at the lower federal rate, and that McCarron was not entitled to post-judgment interest at the Massachusetts state rate. The court also held that post-judgment interest did not begin until the court entered the final judgment.

## CONTRACTUAL LIMITATION PERIOD IN INSURANCE CONTACT UPHELD

In **Chambers v. Tufts Associated Health Maintenance Organization, Inc.**, 2020 WL 2197932 (Mass. Sup. Ct. 2020), the Business Litigation Session of the Massachusetts Superior Court held, among other things, that a two year contractual limitation period contained in a health insurance policy was enforceable.

Chambers sued Tufts on two grounds. First, he contested the deductible provision of his family's health insurance coverage. Chambers contended that he only needed to satisfy the individual deductible of $2,000 before receiving coverage, rather than having to cover the $4,000 family deductible. The court rejected this claim, noting that the policy clearly required a family with multiple members to satisfy the $4,000 deductible before coverage would kick in.

Chambers also argued he had never seen the policy and therefore the provision should not be enforced against him. The court also rejected this stating that the summary document that he received specifically informed him that if he wanted more details about the coverage he could access the policy on Tufts' website.

The court also rejected Chambers' argument that the policy should not be enforced because the summary differed from the policy. The court held the words of the policy were clear. Therefore, the policy must be construed in its usual and ordinary sense and parole evidence was not admissible to create an ambiguity.

The court next addressed the policy provision requiring that lawsuits challenging a benefit decision be filed within two years. The court noted that the Supreme Judicial Court in Massachusetts has long held that insurance companies may impose contractual limitations periods that are shorter than the statutory limitations periods. While agreeing with Chambers that an insurance contract may be a contract of adhesion, the court stated the general rule is even that type of contract is enforceable unless it is unconscionable, offended public policy, or is shown to be unfair in the particular circumstances. The court found that Chambers had not shown that the two-year contractual limitations provision met that standard.

The court entered summary judgment in favor of Tufts.

## MOTION TO DISMISS PURPORTED CLASS ACTION REGARDING ALLEGED VIOLATION OF MENTAL HEALTH PARITY ACT GRANTED

In **N.R. v. Raytheon Company**, 2020 WL 3065415 (D. Mass. 2020), the U.S. District Court of Massachusetts granted Raytheon's motion to dismiss the purported class action complaint.

N.R. is a child of a Raytheon employee. Raytheon provided a health insurance plan, self-funded, to its employees. N.R., at five years old, was diagnosed with autism spectrum disorder ("ASD"). The physician who diagnosed N.R. with ASD recommended that N.R. receive speech therapy services. N.R. received the treatment but Raytheon denied coverage for the services as not covered by the benefit plan.

After exhausting the administrative appeals, N.R. sued Raytheon alleging that the speech therapies were medically necessary mental health services and should have been covered under Raytheon's mental disorders benefit and that a plan restriction regarding coverage of only restorative speech therapies violated the Mental Health Parity and Addiction Equity Act of 2008. Included in N.R.'s Complaint were counts of breach of fiduciary duty, a claim for benefits under ERISA, and equitable relief under 29 U.S.C. §1132(a)(3).

Raytheon brought a motion to dismiss. The court allowed the motion.

With regard to the breach of fiduciary duty claim under 29 U.S.C. §1132(a)(2), the court dismissed that count finding that N.R. did not allege any facts to suggest that the benefit plan suffered losses because of any actions of the fiduciaries. Rather, the allegations were that the refusal to cover speech therapy benefits resulted in the plan's unjust retention of funds that should have been used to provide therapy.

The court next dismissed the claim for benefits under 29 U.S.C. §1132(a)(1)(B) finding that N.R. sought relief only pursuant to the Mental Health Parity Act and did not allege any right to benefits under the terms of the plan.

Finally, with respect to the claim for equitable relief, the court held that N.R. appeared to be seeking such relief on the grounds of violations of the Mental Health Parity Act. Raytheon defended its denial of the claim on the grounds that the plan limited coverage for all speech therapy to that which is restorative regardless of what condition the speech therapy was intended to treat. Because the plan did not differentiate between mental health conditions and medical conditions, the exclusion applied. The court agreed and dismissed that claim.

N.R. also included a claim for penalties under 29 U.S.C. §1132(a)(1)(A) for the failure to provide plan documents. The court dismissed that claim as well because N.R. had failed to plead facts sufficient to suggest that the document requests were directed to the plan administrator.

## MOTION TO DISMISS PURPORTED CLASS ACTION REGARDING RESIDENTIAL MENTAL HEALTH TREATMENT DENIED

In **Steve C. v. Blue Cross and Blue Shield of Massachusetts**, 2020 WL 1514545 (D. Mass. 2020), the U.S. District Court of Massachusetts denied Blue Cross' motion to dismiss a purported class action complaint.

Steve C.'s daughter, Jane, had struggled with mental disorders since she was a young child. She was diagnosed with depression, anxiety, and obsessive-compulsive disorder. Jane's health care providers identified a private boarding school and licensed residential treatment center in Utah for adolescent girls as a beneficial treatment program. Steve and Jane were covered by Steve's employer's mental health plan, governed by ERISA, and funded by a policy issued by Blue Cross and Blue Shield.

Treatment at the residential center was covered for the first sixteen days, but Blue Cross denied further benefits ultimately on the grounds that the treatment was not medically necessary, the treatment center was excluded as an educational, vocational or recreational setting, and the treatment center was not a covered provider. Suit followed. Blue Cross brought a motion to dismiss the complaint, which brought claims seeking payment of the benefits as well as a breach of fiduciary duty.

The court first addressed whether the plaintiffs had standing to sue Blue Cross. Blue Cross alleged that it was not a proper defendant because HMO Blue had the responsibility of administering the relevant policy. The plaintiffs argued that Blue Cross and HMO Blue should be considered part of the same control group. The court denied the motion on the grounds that even if it agreed with Blue Cross' argument, the role of HMO Blue did not address the plaintiffs' claim that the Blue Cross policy violated the mental health parity act. Therefore, this argument was rejected.

The court next denied Blue Cross' motion to dismiss the plaintiffs' claim for recovery of benefits on the grounds that the case required the court to make a factual determination concerning whether the residential treatment facility was a covered institution within the meaning of the policy.

The court also denied Blue Cross' motion to dismiss the claim alleging a violation of the mental health parity act, finding that the complaint effectively pleaded that Blue Cross provided coverage for subacute medical and surgical treatment, but denied coverage for comparable mental health treatment.

Next, the court found that the plaintiffs could seek alternative relief under both 29 U.S.C. §1132(a)(1)(B) and §1132(a)(3) at the early stage of the proceeding.

Finally, the court denied Blue Cross' motion to dismiss the plaintiffs' claim for attorney's fees. Although finding that the request for the fees was not an independent cause of action, because the court did not dismiss either of the other counts of the complaint it would not dismiss the demand for attorney's fees at that stage. The court did state that it would deny the demand for fees if the other two counts of the complaint were ultimately dismissed.

# MOTION TO DISMISS PURPORTED CLASS ACTION REGARDING DENIAL OF PROTON BEAM THERAPY GRANTED

In Weissman v. United Healthcare Insurance Company, 2020 WL 1446734 (D. Mass. 2020), the U.S. District Court of Massachusetts granted United Healthcare's motion to dismiss the purported class action complaint, but did give Weissman permission to amend the complaint within 21 days.

Weissman was covered by an ERISA benefits plan which provided medical coverage, through her employer, IPG. United Healthcare administered the plan.

Weissman was diagnosed with cervical cancer and traditional treatments did not resolve it. Her physicians determined that proton beam therapy in conjunction with other treatments would be the most effective treatment. United Healthcare denied the treatment as experimental or investigational because there was not enough strong clinical evidence to suggest that the therapy would change the outcome. Weissman went ahead with the treatment and paid for it herself. Suit then followed. The defendants brought a motion to dismiss.

The court first addressed Weissman's claims against United Healthcare. Weissman brought three claims against United Healthcare pursuant to 29 U.S.C. §1132(a)(3), alleging breach of fiduciary duties. The first claim alleged that United Healthcare breached its fiduciary duties by drafting and implementing a policy which acted as a blanket denial of proton beam therapy. The court held that Weissman could not bring a claim challenging the establishment of the plan itself.

The court then went on to find that the complaint was inadequate because it solely sought relief pursuant to §1132(a)(3) when relief was available for the denial of benefits under §1132(a)(1)(B). The court stated that while, at the pleading stage, a claimant could bring claims under both §1132(a)(1)(B) and 1132 §(a)(3), relief could not be awarded under both. The court held it was inappropriate for Weissman to seek relief solely under §1132(a)(3) but could repackage the complaint as one seeking alternative relief.

Next, the court dismissed the claim of breach of fiduciary duty by United Healthcare using medical personnel that were allegedly unqualified. The court found that the complaint lacked sufficient allegations to support such a claim.

Finally, the court dismissed the breach of fiduciary duty claim against the IPG plan. The court found the complaint did not allege fiduciary acts on the part of the plan that would have constituted a breach of fiduciary duty. The court also noted that the proper party defendant in an action concerning ERISA benefits is the party that controls the administration of the plan, which was United Healthcare.

The court granted the motion to dismiss but gave Weissman 21 days to amend the complaint.

## 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!



MIRICK O'CONNELL
ATTORNEYS AT LAW

Worcester | Westborough | Boston
800.922.8337
www.mirickoconnell.com