MIRICK O'CONNELL

ATTORNEYS AT LAW

Life, Health & Disability e-Report
First Circuit

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Life, Health, Disability and ERISA Litigation Group:

Joseph M. Hamilton

Joe spoke in February at the American Conference Institute's Litigating Disability Insurance Claims in Philadelphia on total and residual disability claims.

Joan O. Vorster

Welcome to the Winter 2018 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 OPENS DOOR TO RIGHT TO JURY TRIAL IN MASSACHUSETTS CONSUMER PROTECTION ACTIONS

In a case that should be of interest to all insurers, the First Circuit Court of Appeals in Full Spectrum Software, Inc. v. Forte Automation Systems, Inc., 858 F.3d 666 (1st Cir. 2017), held that the plaintiff's claim for a violation of Massachusetts General Law, Chapter 93A, the Massachusetts consumer protection statute, was triable to a jury as a matter of right.

Chapter 93A provides a cause of action by a consumer or a business against another business for unfair or deceptive acts or practices. The Massachusetts Supreme Judicial Court has long held that there is neither a statutory right nor a constitutional right to a jury trial under the Massachusetts state constitution for a claim under Chapter 93A. See Nei v. Burley, 388 Mass. 307 (1983). However, the district court in this case allowed the plaintiff's request for a jury trial over the defendant's objection. After the jury found a violation of Chapter 93A by the defendant, the appeal followed.

The First Circuit framed the question as whether the plaintiff had the right to have the Chapter 93A claim heard by a jury pursuant to the Seventh Amendment of the U.S. Constitution. The court stated the analysis it would

Elizabeth L.B. Greene

David L. Fine

J. Christopher Collins

Chris spoke in January at the ABA's TIPS Conference in Florida regarding ERISA equitable claims. Chris also hosted a "Legal Year in Review" webinar for the International Claims Association in February.

Kevin Kam

Kevin is a co-author of the First Circuit chapter of the 2018 Edition of the ERISA Survey of

employ was whether the statute was analogous to common law causes of action ordinarily decided in English courts in the late 18th century. Then, it examined the remedies sought to determine whether they were legal or equitable in nature. Finally, it needed to determine whether Congress had assigned resolution of the claim to a non-Article III body that does not use a jury as a fact finder.

The court found the only question at issue was the first. That is, whether Chapter 93A was analogous to causes of action tried in courts of law in late 18th century England. The court found the plaintiff's claim was one for deception, which was not analogous to any 18th century action at law. However, in such a case the court held that the other two factors controlled. Since both dipped in favor of a jury claim, the court upheld the district court's decision.

The court did review its prior decisions as well as Massachusetts case law, which found there was no right to a jury under Chapter 93A. However, the court noted that it had never addressed the question of whether there was a right to a jury trial in federal court for Chapter 93A claims pursuant to the Seventh Amendment.

While it upheld the district court's ruling, the court noted that the defendant had not developed a meritorious argument for why the district court erred in submitting the claim to a jury. The court also noted that because of the scope of Chapter 93A, whether the jury was permitted as a matter of right might be based upon the type of claim alleged. The court closed by noting it left for another day a fuller consideration of the extent to which the Seventh Amendment may apply to Chapter 93A claims. However, be advised that plaintiffs litigating claims in federal court may now push more frequently for a jury trial of the Chapter 93A claim.

EQUITABLE RELIEF DENIED FOR LAPSED LIFE INSURANCE COVERAGE

In Coastal Medical, Inc. v. Reliance Standard Life Insurance Company, 2017 WL 3130387 (D.R.I. 2017), the U.S. District Court of Rhode Island denied the plaintiffs' attempts to obtain benefits from lapsed life insurance coverage.

Carnevale was employed by Coastal Medical, which provided a life insurance plan for its employees. The plan was funded by a group policy issued by Reliance. Under the terms of the plan, in order to maintain coverage, an employee was required to be actively working at least twenty hours per week. If the employee became ineligible, the coverage could be continued for one year if illness or disability caused the ineligibility. Otherwise, the employee could convert his group coverage into an individual plan.

Carnevale became totally disabled and stopped working in October 2013. As such, he became ineligible for the coverage. Reliance advised Carnevale of his possible eligibility for a waiver of premium, but because he became disabled after age 60, premiums were required. Reliance did not notify Carnevale or Coastal that coverage would only last one year after Carnevale became ineligible.

Carnevale died in June 2015. Coastal continued to pay premiums until his death. After the claim was filed, Reliance determined that Carnevale was not covered at the time of his death and therefore denied the claim. Suit followed.

Coastal was a plaintiff because the benefit plan, in part, operated as a funding mechanism for Coastal to buy back Carnevale's shares in the company upon his death. Coastal brought suit alleging a number of bases for recovery, all of which the court rejected.

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Coastal first alleged that Reliance provided a defective Summary Plan Description because it did not reference Carnevale's conversion rights. The court found the SPD did provide adequate notice and noted that ERISA does not require that the SPD even include notification of conversion rights.

Coastal next argued that Reliance waived the lack of coverage by billing and accepting premiums. The court also rejected this, finding that waiver cannot be employed to create coverage. The court held accepting Coastal's argument would rewrite the terms of the plan so as to continue coverage for ineligible employees indefinitely by paying premiums. The court stated that would create coverage beyond what the parties had originally bargained for, and the court could not do it.

Coastal next argued that Reliance should be estopped on the grounds that it continued to bill Coastal after the policy lapsed. Noting the requirements to establish equitable estoppel, the court stated that estoppel was limited to statements that interpreted the plan and cannot extend to statements that would modify the plan. The court held Coastal's theory requested the court to modify a clear provision, rather than interpret an ambiguous one, and therefore estoppel did not apply.

Finally, Coastal argued that Reliance had breached a fiduciary duty owed to Carnevale. The court noted that the plan delegated to Coastal the obligation of apprising its employees of their conversion rights. The court further found that when inquiries were made to Reliance, it provided complete and accurate answers.

The court entered summary judgment in favor of Reliance.

COURT UPHOLDS RECORDING OF IME AND PRESENCE OF ATTORNEY

In a Massachusetts trial court decision, Amica Mutual Insurance Company v. Amanda Olmo, 2017 WL 2466110 (April 11, 2017), a Superior Court judge found, in a personal injury case, that Amica was not entitled to summary judgment for Olmo's failure to attend an IME.

The case arose from an automobile insurance claim. Amica, in accordance with the policy and a Massachusetts statute, notified Olmo that it intended to conduct an IME of her. Olmo refused to attend the IME unless it could be video recorded and her attorney could attend. The examining physician refused to allow the attorney to be present or to permit the recording of the examination. As a result, Olmo refused to attend the IME and Amica denied the claim due to lack of cooperation. Suit followed.

Ruling on cross-motions for summary judgment, the court noted that Amica's denial relied upon Olmo's alleged failure to cooperate with Amica in the investigation, settlement and defense of the claim as provided by the policy and a Massachusetts statute which allowed an IME to be performed. The court noted that the failure of an insured to submit to an IME is merely evidence of noncooperation, not per se noncooperation. The court held the claimant was not required to unconditionally submit to an examination no matter what the circumstances or without any preconditions. The court then went on to address the issue of recording the IME and having the attorney present.

The court concluded that nothing in the record indicated that recording the IME would have impeded the examination or made it less effective. The court also said Olmo had an interest in obtaining an objective record of the examination in light of the adversarial nature of it. The court, citing another trial court decision, found that an attorney could be present but only upon a showing of good cause such as factors suggesting a biased or adversarial examination; allegations of

past impropriety on the part of the examining physician; or whether the claimant had any needs or disabilities warranting an attorney's presence. The court found that the examination was adversarial in nature because it formed the basis of Amica's decision. In addition, the court found the record indicated that a significant amount of the examining physician's medical practice was dedicated to providing medical examinations for insurance companies. Interestingly, the court also noted Olmo's allegation that the IME physician routinely opined to insurers that the insured was not injured. Thus, the court said if it were to apply a good cause standard, Olmo had done so.

As a result, the court entered summary judgment in favor of Olmo and found that she had not failed to cooperate by refusing to attend the IME without it being recorded or having her attorney present.

This case is relevant to instances in which an IME is sought in a case governed by state law. Generally speaking, federal courts in Massachusetts do not routinely permit the attendance of attorneys at IMEs or the recording of them.

ERISA PLAN IN PLACE AT DATE OF DISABILITY CONTROLS

In Tullie v. The Prudential Life Insurance Company of America, 2017 WL 5997405 (D.R.I. 2017), the U.S. District Court of Rhode Island held that the benefit plan in effect at the time Tullie became disabled controlled her claim, and that the de novo standard of review applied.

Tullie was covered by a benefit plan provided by her employer which included disability coverage. The plan was funded by a policy issued by Prudential, which also administered claims under the plan. After receiving benefits for a short time, Prudential discontinued benefits. Suit followed.

At the outset of the case the court was asked to determine the applicable plan document, as well as the standard of review. At the time Tullie became disabled, the plan document in effect was from 2005. However, during the time Tullie received benefits, the plan was amended.

The court found that the earlier plan, the 2005 plan, was the operative document. The court noted that the plan included a provision that any amendment to it would not affect a claim incurred before the date of the change.

Turning to the standard of review, Prudential referred to several provisions of the plan document which it contended gave it discretionary authority. However, after reviewing that language, the court concluded that the provisions cited by Prudential were inapplicable to Tullie's claim. Therefore the court held that the de novo standard of review would be applied in the case.

THIRD PARTY ADMINISTRATOR DISMISSED FROM ERISA BENEFITS SUIT

In Brown v. Lilly Del Caribe, Inc., 2017 W.L. 3446782 (D. Puerto Rico 2017) the U.S. District Court of Puerto Rico allowed a third party administrator's motion for summary judgment, dismissing the TPA from the suit.

Brown was covered by an employee welfare benefit plan through his employer which provided disability benefits. Benefit decisions were made by the employer's Employee Benefits Committee ("EBC"), not the TPA. After benefits were initially denied to Brown, Sedgwick Claims Management Services replaced another company as the TPA.

Sedgwick processed Brown's administrative appeal, but the decision was made by the EBC, which upheld the denial of benefits. Brown then filed suit and

included Sedgwick as a defendant. Sedgwick then filed a motion for summary judgment.

The court held that a proper party defendant in an action concerning ERISA benefits is any party that controls administration of the plan. However, the mere performance of mechanical administrative tasks generally is insufficient to confer control of the plan.

The court held that because Sedgwick did not perform anything except ministerial functions regarding the claim, Sedgwick could not be held liable under ERISA for the denial of the claim. Therefore, the motion for summary judgment was allowed and Sedgwick was dismissed from the case.

DENIAL OF HEALTH INSURANCE BENEFITS UPHELD ON DE NOVO REVIEW

In Doe v. Harvard Pilgrim Healthcare, Inc., 2017 WL 4540961 (D. Mass. 2017), the U.S. District Court of Massachusetts, on de novo review, upheld Harvard Pilgrim's partial denial of benefits for residential mental health treatments.

The denial of residential mental health treatments has resulted in several reported decisions within the First Circuit in the last few years. This is the latest. In this 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 inpatient 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 court first found that de novo review applied to Harvard Pilgrim's decision. The Court did not find language in the plan which would allow for the arbitrary and capricious standard of review.

The court then addressed Doe's attempt to expand the administrative record. Doe attempted to introduce records that she had provided to Harvard Pilgrim after litigation had begun, when the parties discussed a potential settlement of the case. In addition to denying that request on the grounds that information could not be submitted after the final administrative appeal, the court also noted that it did not wish to discourage insurers from engaging in an out-of-court resolution by reopening the administrative record to documents post-dating the administrative decision.

As to the merits of the case, noting that Doe had the burden of proof to demonstrate that continued residential treatment was the "most appropriate" level of care for her condition at the time benefits were denied, the court found Doe had not done so. The court found that based upon the guidelines employed by Harvard Pilgrim, Doe had failed to show her mental health would have been in a worse position if she had transitioned to a lower level of care, rather than continued residential treatment.

The court also addressed Doe's claim that Harvard Pilgrim did not conduct a full and fair review of her claim. Doe contended the review was inappropriate because Harvard Pilgrim did not obtain all of her medical records. The court found Harvard Pilgrim made appropriate efforts to obtain those records, and that even if the court accepted Doe's arguments that Harvard Pilgrim did not review all of her records, she had failed to show she was prejudiced by any error.

The court entered summary judgment in favor of Harvard Pilgrim. This case is currently on appeal.

DENIAL OF LTD BENEFITS UPHELD ON DE NOVO REVIEW

In Davis v. Sun Life Assurance Company, 2017 WL 3841630 (D. Mass. 2017), the U.S. District Court of Massachusetts adopted the Report and Recommendation of the Magistrate Judge and entered summary judgment in favor of Sun Life.

Davis was an in-house counsel for her employer. The employer provided a welfare benefit plan which included disability benefits. The plan was funded by a group policy issued by Sun Life. The claims were administered by Sun Life as well.

In May 2012, Davis submitted a claim to Sun Life seeking partial disability benefits, claiming to be disabled since December 2011. Shortly thereafter, Davis was terminated when her employer learned, through a phone call from Sun Life, that, unbeknownst to the employer, Davis had been working part-time. Davis was terminated as of June 20, 2012. Davis then contacted Sun Life and requested to change her claim to total disability as of June 20. Davis based her claim on a number of conditions including sleep apnea, arthritis, fibromyalgia, and chronic pain. After reviewing the medical information and other information provided by Davis, Sun Life denied the claim, and upheld the denial after an administrative appeal.

Reviewing the decision de novo, the court found that Davis was suffering from a variety of co-morbid conditions for years leading up to the filing of her claim. While recognizing that Davis's ability to perform the material and substantial duties of her position would not be without difficulties, the court found the Administrative Record was largely devoid of medical records preceding and through the elimination period that supported the alleged worsening of many of Davis's conditions. The court also noted that the lion's share of the medical opinions upon which Davis relied were not rendered until a year after the elimination period.

The opinion is quite lengthy and goes into significant detail regarding the parties' positions. In the end, the court held that Davis had not met her burden to prove she was disabled. The case is currently on appeal.

CHEMICAL SENSITIVITY CLAIM DENIED FOR FAILURE TO PROVIDE OBJECTIVE EVIDENCE OF IMPAIRMENT

In Parnagian v. MetLife Disability Insurance Company, 2017 WL 4366968 (D. Mass. 2017), the U.S. District Court of Massachusetts upheld MetLife's denial of disability benefits.

Parnagian was covered under an employee welfare plan provided by her employer. The plan was funded by a group policy issued by MetLife. Claims were also administered by MetLife.

Parnagian stopped working due to chemical sensitivities which were allegedly causing headaches, fatigue, muscle and joint pain, and focus issues. MetLife denied the claim initially, and on administrative review. On both occasions, MetLife had the claim reviewed by physicians. Suit followed.

The parties agreed that the arbitrary and capricious standard of review applied to the benefit decision. The Plan provided that Parnagian was required to prove that she could not perform the essential elements and substantially all the duties of her job. To do so, she needed to provide "objective evidence satisfactory to the Claims Administrator."

Parnagian argued that because her condition could not be diagnosed via objective medical criteria, MetLife erred in denying her claim based upon the

absence of such proof. The court, however, noted the distinction the First Circuit has drawn between requiring objective evidence to support the diagnosis of a disease that does not manifest itself in an objectively-verifiable manner, and the justified requirement that a claimant's limitations be objectively verifiable. That is, while it would be unreasonable to rule out a disease because of the absence of objective clinical findings, the distinct inquiry of whether an impairment renders a claimant disabled under the plan may require objective evidence.

Given the extensive medical review conducted by MetLife, the court held Parnagian did not provide objective evidence that would render MetLife's decision an abuse of discretion. The court held that MetLife's decision was based on evidence that was reasonably sufficient to support the conclusion.

The court entered summary judgment in favor of MetLife.

COURT CONSIDERS APPLICABILITY OF NOTICE-PREJUDICE RULE IN ERISA CASE BUT REJECTS APPLICATION OF THE AMERICANS WITH DISABILITIES ACT

In Fortier v. Hartford Life and Accident Insurance Company, 2017 WL 4011147 (D.N.H. 2017), the U.S. District Court of New Hampshire ruled on several issues which arise in ERISA benefit claims.

Fortier was a participant in an employee welfare benefit plan provided by her employer. The Plan provided disability benefits and was funded by a group policy issued by Harford, which also administered claims under the Plan. Fortier had been receiving LTD benefits, but the benefits were discontinued on the grounds that Fortier's claim was subject to the 24-month limitation for mental illness claims contained in the Plan. Fortier filed an administrative appeal, but Hartford refused to consider it on the grounds it was late. Suit followed, which included a claim for violation of the Americans with Disabilities Act ("ADA"), as well as a benefit claim.

Hartford brought a motion to dismiss. The court first addressed whether Fortier had exhausted her administrative remedies. The court concluded that because the appeal was sent past the 180 days provided in the plan to request an administrative appeal, she had failed to exhaust her administrative remedies. The court rejected Fortier's argument that the appeal was within 180 days of the termination of the LTD benefit, finding that the appeal must be filed within 180 days of Fortier receiving notice of the adverse benefit determination. The court also rejected Fortier's arguments that the plan language was ambiguous, and rejected the argument that the adverse benefit determination was defective.

Fortier also argued that New Hampshire's notice-prejudice rule required Hartford to show prejudice regarding the late administrative appeal before her claim could be dismissed. The court noted that neither the Supreme Court nor the First Circuit has decided this issue. The court then reviewed case law from other jurisdictions and concluded it would defer ruling on the issue until the summary judgment stage.

Lastly, the court considered and dismissed Fortier's ADA claim. While noting the First Circuit has not yet ruled on this issue the court held that based upon the rationale provided in decisions rendered in other jurisdictions there was no cause of action under the ADA against a benefit plan for imposing a limitation on benefits for mental illness.

CLAIM FOR ERISA BENEFIT DISMISSED FOR FAILURE TO

PLEAD EXHAUSTION OF ADMINISTRATIVE REMEDIES

In Quinones v. Sepulveda Perez, 268 F.Supp.3d 318 (D. Puerto Rico 2017), the U.S. District Court of Puerto Rico dismissed a claim brought by the plaintiffs against The Prudential Insurance Company of America on the grounds of preemption and failure to exhaust administrative remedies.

Alvarez was covered by a life insurance benefit plan provided by her employer. The plan was funded by a group policy issued by Prudential. After Alvarez's death, her husband collected the benefit. Subsequently, Alvarez's parents sued Prudential for breach of contract claiming the benefit was improperly paid to the widower.

Prudential removed the case to federal court and moved to dismiss. The court first noted the longstanding precedent in the First Circuit that breach of contract claims are preempted when the essence of the action is a recovery of a benefit due under an ERISA plan. The court then went on to state that even if the plaintiffs had properly pleaded an ERISA claim, it was non-cognizable because they did not allege efforts to exhaust administrative remedies before bringing suit. Therefore, the court dismissed their claims against Prudential with prejudice.

While it is a defense to a benefit claim that administrative remedies have not been exhausted, courts do not typically require that the complaint allege the exhaustion of those remedies.

COURT ALLOWS A PREJUDGMENT ATTACHMENT AND INJUNCTION IN STOLI FRAUD CASE

In Transamerica Life Insurance Company v. Caramadre, 2017 WL 3822731 (D.R.I. 2017), the U.S. District Court of Rhode Island allowed Transamerica and Western Reserve Life Assurance to obtain a prejudgment attachment and an injunction preventing the defendant from transferring assets of his company.

The case arises out of a complex fraud scheme concocted by Caramadre which has had a long procedural history including the Rhode Island Supreme Court and the First Circuit Court of Appeals. In addition to a civil case brought by Transamerica and Western Reserve, a criminal prosecution was initiated against Caramadre which culminated in him pleading guilty to mail, wire and identity fraud, including the fraudulent receipt of millions of dollars by making material misrepresentations and omissions to terminally ill clients. As part of the plea, Caramadre owes restitution of approximately $1M to both Transamerica and Western Reserve. In addition, Caramadre owes over $46M in restitution to the victims of his scheme.

Given the guilty plea, Caramadre's lack of assets and the fact that several claims in the civil litigation have been resolved on summary judgment in favor of Transamerica and Western Reserve, the court found sufficient grounds to impose an attachment and a preliminary injunction.

The case is a good reminder to insurers that when seeking to recover benefits they should proactively seek security through the litigation.

DID YOU KNOW?

Did you know that Mirick O'Connell's Life, Health, Disability and ERISA Litigation Group represents clients throughout New England? With offices in Boston, Westborough and Worcester, our attorneys are within an hour of all the major Courts in Massachusetts; Hartford, Connecticut; Providence, Rhode Island; and southern New Hampshire. In addition, our attorneys are admitted to

practice not only in Massachusetts, but in Connecticut, New Hampshire and Rhode Island as well. We have repeatedly and successfully represented our clients in each of these jurisdictions. So remember, we are not here for you just in Massachusetts; think New England!

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

Joseph M. Hamilton
jhamilton@mirickoconnell.com

Joan O. Vorster
jvorster@mirickoconnell.com

J. Christopher Collins
ccollins@mirickoconnell.com