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Circuits Split Over Equitable Defenses to ERISA Reimbursement Claims

In this challenging economic climate, subrogation and reimbursement claims by employers with self-funded health plans are gaining heightened attention. Injured employees, plaintiffs’ attorneys, and employers seeking to protect health plan assets are litigating subrogation and reimbursement claims more strenuously. Consequently, the law in this area is quickly evolving. Recently, a circuit split developed which may affect the amount of health plan benefits an employer can recover.

Health Plan Reimbursement Claims

A typical health plan reimbursement claim involves the following fact pattern. Employer offers a self-funded health plan for the benefit of its employees. Employee, a participant in Employer’s health plan, is injured in a non-work-related accident, often a motor vehicle accident. The medical expenses for Employee’s accident-related injuries are paid by the health plan.

Employee sues the at-fault tortfeasor, and claims medical expenses, including all of the expenses paid by the health plan, as an element of her damages. Employee either settles the tort lawsuit, or obtains a judgment, which generally takes into account all of her alleged damages, including medical expenses.

The health plan’s language permits Employer to obtain full reimbursement of benefits paid for Employee’s injuries sustained from the tortfeasor’s conduct, from any monies recovered in Employee’s lawsuit against the tortfeasor. The health plan allows full reimbursement from any settlement funds or judgment, irrespective of whether the Employee is “made whole,” and regardless of the Employee’s personal injury attorney’s fees.

Employee and her personal injury attorney resist Employer’s reimbursement claim. Employer ultimately is required to bring

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suit to recover the plan benefits under section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a) (3), which allows an ERISA plan fiduciary to obtain “appropriate equitable relief” to enforce the terms of the plan.

**Zurich American Insurance Company v. O’Hara**

The Eleventh and Third Circuits have taken contrasting views of “appropriate equitable relief” under § 502(a)(3). In *Zurich American Insurance Company v. O’Hara*, 604 F.3d 1232 (11th Cir. 2010), Zurich brought suit against an employee, O’Hara, to recover $262,611 in self-funded health plan benefits from a settlement fund of $1,286,457. O’Hara had been injured in a head-on motor vehicle accident.

The plan language expressly allowed Zurich to obtain full reimbursement of plan benefits, and provided that “no court costs or attorneys’ fees may be deducted from the Plan’s recovery without the Plan’s express written consent; any so-called ‘Fund Doctrine’ or ‘Common Fund Doctrine’ or ‘Attorney’s Fund Doctrine’ shall not defeat this right.” 604 F.3d at 1234.

The plan further provided that “[R]egardless of whether a covered person has been fully compensated or made whole, the Plan may collect from covered persons the proceeds of any full or partial recovery that a covered person or his or her legal representative obtain, whether in the form of a settlement or judgment ....” Id.

O’Hara argued that enforcement of the plan’s reimbursement provisions was not “appropriate” because “he was not made whole by his third-party recovery.” Id. at 1236. Specifically, O’Hara argued “as a matter of equity and in order to effectuate ERISA’s policy of protecting plan beneficiaries, the make-whole rule must be applied because allowing Zurich to recoup the medical expenses it paid on his behalf unduly punishes him by requiring him to forfeit a substantial portion of the compensation he received for his other losses, including future wages and bodily integrity, and unjustly enriches Zurich.” Id.

Under the make-whole doctrine, an employee who has settled with a third-party tortfeasor is liable to reimburse the plan “only for the excess received over the total amount of his loss.” Id. at 1236. In the Eleventh Circuit, “the make-whole doctrine is a default rule that applies only in the absence of specific and unambiguous language precluding it.” Id. (citing *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997)).

The court rejected O’Hara’s argument, holding that “[a]pplying federal common law to override the Plan’s controlling language, which expressly provides for reimbursement regardless of whether O’Hara was made whole by his third-party recovery, would frustrate, rather than effectuate, ERISA’s purpose to protect contractually defined benefits.” Id. at 1237.

Moreover, the court held that “[a]pplying federal common law to deny an employer its right to reimbursement pursuant to a written plan would also frustrate ERISA’s purposes by discouraging employers from offering welfare benefit plans in the first place.” Id. The court emphasized that “[a]lthough O’Hara himself will be in a better position if the subrogation provision is not enforced, plan fiduciaries must ‘take impartial account of the interests of all beneficiaries.’” Id.

Although O’Hara did not challenge the district court’s finding that the plan precluded deduction of O’Hara’s attorney’s fees from Zurich’s recovery, the court nevertheless held that “because the Plan clearly and unambiguously disclaimed the ‘common fund doctrine,’ the district court correctly found that Zurich was owed the entire amount it paid on O’Hara’s behalf without a deduction of attorney’s fees.” Id. at n.4.

The court concluded that “[b]ecause full reimbursement according to the terms of the Plan’s clear and unambiguous subrogation provision is necessary not only to effectuate ERISA’s policy of preserving the integrity of written plans but to protect the interests and expectations of all plan participants and beneficiaries, such relief is both ‘appropriate’ and ‘equitable’ under ERISA § 502(a)(3).”

**U.S. Airways v. McCutchen**

In *U.S. Airways, Inc. v. McCutchen*, 663 F.3d 671 (3d Cir. 2011), the court held that “applying the traditional equitable principle of unjust enrichment, ... the [district court] judgment requiring McCutchen to provide full reimbursement to US Airways constitutes inappropriate and inequitable relief.”

The court emphasized that “the amount of the judgment exceed[ed] the net amount of McCutchen’s third-party recovery, and left him with less than full payment for his emergency medical bills, thus undermining the entire purpose of the Plan.”

The court also commented that full reimbursement “amounts to a windfall for U.S. Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery. Equity abhors a windfall.” The court did not decide what would constitute “appropriate equitable relief,” but remanded to the district court to make that determination.

McCutchen expressly disagreed with O’Hara and other circuit court opinions that do not allow common law equitable principles to limit reimbursement recoveries, where full reimbursement was required under the clear and unambiguous plan language.

Other circuits have found reimbursement claims under § 502(a) (3) to seek “equitable” relief, without next asking whether the relief sought is “appropriate.” The court stated that “[b]y categorically excluding the equitable limitations that § 502(a) (3)’s reference to equitable remedies necessarily contains, the ... O’Hara court[] departs from the text of ERISA.”

**Points of Comparison between O’Hara and McCutchen**

O’Hara and McCutchen are irreconcilable on whether common law equitable principles can limit ERISA reimbursement recoveries. Both cases claim to balance the equities, and yet, reach different conclusions. It bears emphasis that in *McCutchen*, the plan’s reimbursement amount exceeded the net sum of the employee’s third-
party recovery, apparently putting the employee in a worse position than before he brought the personal injury lawsuit. The court’s holding was heavily influenced by the “injustice” of these facts.

O’Hara emphasized that reimbursement of plan assets “inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan.” If plan assets were not recovered, “the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments.” Plan fiduciaries must “ensure that the assets of employee health plans are preserved in order to satisfy present and future claims.”

“Because maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions like the one at issue in this case ... denying [the plan] its right to reimbursement would harm other plan members and beneficiaries by reducing the funds available to pay those claims.” These considerations are the most consistent with the policies underlying ERISA.

McCutchen, in contrast, emphasized that it is “unjust” to require a plan participant to fully reimburse a health plan where the amount of the reimbursement exceeds the net amount of the participant’s third-party recovery, and further, full reimbursement constitutes a “windfall” to the plan. On the first point, it is not clear whether the court would find full reimbursement “unjust” if the benefits paid under the plan were significantly less than the third-party recovery. That factual distinction would exist in many, if not most reimbursement cases.

Second, the “windfall” argument seems misplaced, given that the reimbursement claim enforces a contractual right which protects plan assets. It rings particularly hollow when the plan participant is able to recover “medical expenses” as an element of damages in the underlying tort case, even when they are paid by the health plan. If the member gets to keep that money, which equitably ought to be returned to the plan, he is the one who obtains a “windfall.”

It is important to keep abreast of this split when assessing the mercurial legal landscape in this area, and if called upon to address it, to carefully note the factual and analytical distinctions between these cases. For a detailed analytical comparison of O’Hara and McCutchen, see Schwade v. Total Plastics, Inc., 2012 U.S. Dist. LEXIS (M.D. Fla. Feb. 22, 2012).

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Insurer May Not Retain Premiums When Rescinding Policy, Even if Insurance Was Procured by Fraud


PHL Variable Life Insurance Company sued Jolly and the Faye Keith Jolly Trust for negligent misrepresentation of Jolly’s assets in the application for a $10 million life insurance policy. The company sought to rescind the policy and to retain the premiums paid by the Trust, the policy owner. PHL also sought to recover the amount of commissions paid to the broker.

After Jolly defaulted, the district court rescinded the policy based on the default, but denied PHL’s claims for damages and retention of the premiums, which had been paid into the registry of the court. There was no evidence that the Trust, which was not in default, had participated in any misrepresentation of Jolly’s assets. The district court awarded summary judgment in favor of the Trust on the damages claims.

On appeal, PHL argued that by signing the application and representing that its contents were “full, complete and true to [my] best knowledge and belief,” the Trustee had stated falsely that it had knowledge of Jolly’s assets. According to the Eleventh Circuit’s opinion, PHL relied on Georgia cases “holding that a declaration made ‘to the best of my knowledge and belief’ in an insurance application may be false when the applicant relies on information provided by someone with no knowledge of the truth of the matter represented, such as the insurer’s agent, or when the applicant makes the declaration despite knowing that it is actually false.”

Those cases, the court held, did not apply “because PHL has submitted no evidence that [the Trustee] failed to read the application or that [the Trustee] knew that Jolly’s statements were false.”

PHL also argued that even if the Trust had made no misrepresentation, PHL nonetheless was “equitably entitled to retain the policy premiums because the default judgment against Jolly established that the insurance policy was obtained by fraud.” The Eleventh Circuit rejected this argument, noting that “Georgia law provides no support for this proposition.” Rather, “Georgia law generally requires an insurer seeking to rescind an insurance contract to return any premiums paid under the contract, even where the insured person originally obtained the policy by fraud.”

Without elaboration, the court noted that “there may be some exceptions to this general rule,” but concluded that “none apply here.”

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(Image and table are not relevant to the context and have been omitted.)
As an employee of Bristol-Meyers Squibb, Dickens participated in the company’s long-term disability plan, under which benefits were funded by a group insurance policy issued by Aetna.

Based on diagnoses of depression and anxiety, Dickens applied for LTD benefits under his employer’s plan, and he also applied for Social Security disability benefits, both of which were granted.

Four years later, Aetna terminated the payment of benefits under the ERISA plan, based on its conclusion that the medical evidence no longer showed that Dickens suffered from a debilitating illness. The Social Security Administration continued to pay benefits.

Dickens sued, and the federal district court concluded that Aetna had abused its discretion by neglecting to address relevant evidence relating to the award of SSDI benefits and by failing to address the Social Security award in "any meaningful fashion."

The court remanded the claim to Aetna for further consideration, stating that because the plan’s definition of disability was similar to that of the Social Security Administration, Aetna was obliged to accord substantial weight to the Social Security disability determination.

Because the court found that Aetna had accorded no weight to the SSDI decision, it deemed the decision to be "arbitrary and unreasonable." The district court did not enter a final judgment, however, and it “express[ed] no opinion as to whether [Dickens] is disabled under the LTD Plan’s definition.”

Despite the absence of a final judgment, Aetna filed a notice of appeal. Dickens did not challenge the appellate court’s jurisdiction, and the issue was raised for the first time by the Fourth Circuit Court of Appeals sua sponte during oral argument.

Aetna contended that, although the district court’s order was an interlocutory one, it was among “that small class [of decisions] which finally determine claims of right separable from, and collateral to, rights asserted in the action, too important to be denied review and too independent of the cause itself to require that appellate consideration be deferred until the whole case is adjudicated.” Cohen v. Beneficial Indus. Loan Corp. 337 U.S. 541, 546 (1949).


The Fourth Circuit had not previously considered whether an order remanding a claim to an ERISA fiduciary is a collateral order. Other circuit courts of appeal have come to different conclusions, with the First, Sixth, Eighth, and Tenth Circuits holding that such orders are not appealable. The Seventh and Ninth Circuits, however, have recognized ERISA remand orders as constituting final appealable decisions.

The Fourth Circuit concluded that the order remanding Dickens’ claim satisfied two but not all of the three tests for a collateral order, and thus, it dismissed the appeal, because if an order “fails to satisfy any of [the three] requirements, it is not an immediately appealable collateral order,” citing S.C. State Bd. of Dentistry v. FTC, 455 F.3d 436, 441 (4th Cir. 2006).

“[W]e are not convinced,” the court said, “that the Order itself – or any subsequent award or denial of benefits by Aetna – would be effectively unreviewable, the third collateral order requirement.” Aetna argued that the order requiring it give substantial weight to the Social Security decision effectively meant that it would have no choice but to award LTD benefits to Dickens. But the court noted that while Aetna was directed “to reweigh and reconsider the relevant evidence, Aetna was not, however, directed to render a finding of disability.”

Even if LTD benefits were awarded to Dickens on remand, Aetna “will nonetheless be entitled to appeal from a final judgment,” the court said, noting that other circuit courts have interpreted remand orders as having retained jurisdiction over the case. “This approach,” the court said, “allow[es] either party to challenge the ensuing eligibility determination by motion before the same court,” citing Bowers v. Sheet Metal Workers’ Nat’l Pension Fund, 365 F.3d 535, 537 (6th Cir. 2004).

Consequently, the Fourth Circuit concluded that “we are satisfied to construe the Order as retaining jurisdiction in the [district court] for appropriate further proceedings following disposition of the court's remand to Aetna. We thus conclude that Aetna is unable to satisfy the third collateral order requirement.”
Three-Year Limitation Period, Beginning When Proof of Loss Was Submitted, Bars Action to Recover LTD Benefits under ERISA Plan

Belrose v. Hartford Life & Accident Ins. Co.,

Belrose, a full-time employee of Camber Corporation, underwent arthroscopic knee surgery in September 2002. As a participant in his employer’s ERISA plan, Belrose began receiving short-term disability benefits under a group insurance policy issued by Hartford.

Shortly after his surgery, Belrose was diagnosed with aortic valve disease, coronary angina, and coronary artery disease. He began receiving long-term disability benefits under the plan as a result of his heart condition in December 2002.

Belrose continued to receive long-term disability benefits under the plan until Hartford terminated the benefits in October 2005. Belrose appealed the decision, but it was upheld and a final denial was issued in June 2006.

Belrose sued under ERISA, and Hartford moved to dismiss on the ground that the complaint was time-barred by the plan’s contractual limitations period.

The plan provided a three-year limitations period commencing on the date Belrose submitted his proof of loss. Belrose argued that because his proof of loss was required in September 2002, the plan required him to file an action against Hartford by September 2005, which was before his benefits were terminated in October 2005, and before the termination decision was upheld on appeal in July 2006. Thus, Belrose argued that the limitations period under the plan was in violation of public policy.

The Fourth Circuit Court of Appeals ruled that the plan’s commencement date was irrelevant, stating: “Regarding the date of accrual of a limitations period in an ERISA plan, we have held that despite the terms of accrual which may be contained within the plan, “[a]n ERISA cause of action does not accrue until a claim of benefits has been made and formally denied.”” (Quoting White v. Sun Life Assur. Co. of Canada, 488 F.3d 240, 246 (4th Cir. 2007)).

The court rejected Belrose’s argument that applying federal law in this instance was impermissible “blue penciling” of the contract. The court reasoned that it was not rewriting the contract terms, but merely applying the uniform federal law governing ERISA cases, despite contractual provisions to the contrary.

Belrose nevertheless maintained that the three-year limitations period was a violation of Virginia public policy, because Virginia law provides for a five-year statute of limitation for actions brought under a contract. The court dismissed this argument as well, quoting the Supreme Court of Virginia and the Virginia Code, which permits a one-year contractual limitation period in the insurance context. See Bd. of Supervisors of Fairfax County v. Sentry Ins., 239 Va. 622, 391 S.E.2d 273, 275 (Va. 1990) (upholding “contractual statutes of limitations for periods shorter than that fixed by statute when they were not against public policy and the time period was not unreasonably short”).

The court thus concluded that the plan’s three-year limitations period began in June 2006, when the benefits termination was final, and that Belrose’s claim, brought in 2010, was consequently time-barred.

Payment of Life Insurance Premiums with Stolen Money Does Not Authorize Defrauded Party to Recover Benefits

Speedway Motorsports, Inc. v. Pinnacle Bank,

In 2004, Speedway hired Oasis Trading Group, of which David Blihovde was a member, to provide consulting services about opportunities in the petroleum products business. Beginning in 2006, Blihovde allegedly sent fraudulent invoices to Speedway and misappropriated the payments. By 2010, Blihovde allegedly had obtained more than $5 million from Speedway by fraud.

In 2007, Blihovde obtained a policy of insurance on his life. When Blihovde died in 2010, the insurer paid the death benefits to Blihovde’s designated beneficiaries, who were his former wife, Deborah, his two adult children by Deborah, and a minor child by a subsequent marriage.

In a lawsuit involving multiple claims against multiple parties, Speedway sued Deborah and the two adult children, asserting that they had been unjustly enriched by their receipt of the death benefits, and that Speedway was equitably entitled to the proceeds of the policy, at least up to the amount of premiums paid with funds that Blihovde had acquired by fraud.

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The trial court dismissed the complaint, relying on O.C.G.A. § 33-25-11(a), which provides:

Whenever any person residing in this state shall die leaving insurance on his or her life, such insurance shall inure exclusively to the benefit of the person for whose use and benefit such insurance is designated in the policy, and the proceeds thereof shall be exempt from the claims of creditors of the insured unless the insurance policy or a valid assignment thereof provides otherwise.

Speedway argued in the trial court and on appeal that it was not a "creditor," as that term was used in the statute, because, as the unwitting victim of fraud, it never voluntarily undertook to extend credit to Blihovde.

The Georgia Court of Appeals said that the term “creditor” appears in several sections of the Georgia Code, “but it does not always have precisely the same meaning.” Its “generic meaning,” the court said, “refer[s] to any person to whom another ‘is liable and bound to pay … an amount of money.’” In its “more circumscribed and ordinary meaning,” the term “creditor” refers to “the holder of an obligation arising [by contract].”

The court reviewed previous versions of what is now § 33-25-11(a), back to the Code of 1933, all of which used the term “creditors,” and affirmed the trial court’s dismissal of Speedway’s claim. “Given this statutory history,” the court said, “and given our conclusion that the 1933 statute, to which the current statute traces its lineage, used ‘creditor’ in the ‘generic sense,’ including voluntary and involuntary creditors alike, we conclude that Speedway is a ‘creditor,’ as that term is used [in the statute].”

Benefits Not Payable for Disabling Condition That Develops after Final Claim Decision

Lamb, a truck driver, was insured under a long-term disability plan sponsored by his employer, Wal-Mart. In June 2008, Lamb claimed disability due to a staph infection in his right elbow. Hartford approved the payments of benefits during the plan’s 12-month “own occupation” period, which ended in June 2009.

During the “own occupation” period, Lamb visited his physicians several times with complaints that included degenerative joint disease, difficulties with vision, a rotator cuff tear, radiculopathy, and pain in his back, knees, shoulder, and groin. The physicians provided updated information regarding Lamb’s functional restrictions and limitations.

In June 2009, Hartford obtained an employability analysis, which took into consideration Lamb’s functional capabilities, education, training, and work history. The analysis identified five semi-skilled and unskilled occupations that were a “fair match” for Lamb, meaning that he would be required to complete training in tools and/or materials to prepare for those jobs. Lamb’s treating physician also reported in June 2009 that Lamb was capable of sedentary work.

When Hartford denied Lamb’s claim for total disability benefits beyond the “own occupation” period, he submitted additional medical records. The records showed that in August 2009, two months after the payment of benefits ended, Lamb’s treating physician determined that he had necrosis in his left hip and required a total hip replacement. The physician reported that Lamb was not capable of even sedentary work, due to pain in his hips.

After reviewing this additional information, Hartford upheld its original decision because, as of June 2009, the end of the “own occupation” period, Lamb no longer met the definition of total disability.

Lamb sued. Using the six-step analysis applied by the Eleventh Circuit, the district court held that Hartford’s decision was not de novo wrong. The court rejected Lamb’s claim that his hip problems should have qualified him for additional benefits, stating that the hip problems were not apparent to Lamb or his treating physicians until well after the date his “own occupation” benefits had terminated.

Lamb argued that his hip problems should “relate back,” because the medical records indicated problems with his hips during the “own occupation” period, but the court rejected this argument, stating that allowing symptoms to “relate back” would open legal floodgates, and insurance fraud would be rampant. Hartford’s decision
Johnson suffered fatal injuries while driving during the early morning hours when he lost control of his vehicle, traveled off the roadway, struck a highway sign, and overturned several times. The roadway was illuminated by streetlamps and was dry under clear weather conditions. The responding officer determined that Johnson was driving too fast, estimating that he was exceeding the speed limit by 15 miles per hour.

The coroner concluded that Johnson died from internal injuries resulting from the crash. As part of the investigation, it was determined that Johnson’s blood had an alcohol level of 0.289%, and that his ocular fluid had an alcohol level of 0.311%.

Johnson was a participant in an employee welfare benefit plan as defined by ERISA, providing life and accidental death benefits funded by insurance policies issued by American United Life (“AUL”). AUL promptly paid life insurance benefits to Johnson’s wife, but denied her claim for accidental death benefits on the basis that the death was not accidental due to the intoxicants found in Johnson’s system. AUL upheld its decision on administrative appeal, and litigation ensued.

AUL was not conferred decision-making discretion under the plan, so the federal district court applied the de novo standard of review. Because the policies required their terms to conform to North Carolina law, the court applied N.C. Gen. Stat. § 58-3-30 to determine “the meaning of the term ‘accident’” in the policies.

Under that statute, “‘Accident’ . . . shall be defined to imply ‘result’ language and shall not include words that establish an accidental means test.” Although the statute does not identify the “‘result’ language” to which it refers, the court noted that “under a results test, if death is the unanticipated and unexpected result of an intentional, voluntary act, then the death is an accident.” Thus, Mrs. Johnson had the burden to “prove that the crash was ‘unanticipated and unexpected.’” Rather than

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affirmatively pointing to evidence in the record to support such a finding, Mrs. Johnson relied "on the alleged absence of evidence that Mr. Johnson did anticipate or expect to die or, more accurately, to crash."

Because Mrs. Johnson "failed to point to any evidence that would establish what her husband expected or anticipated when he drove a vehicle down a highway at an unlawful speed while severely intoxicated," her motion for summary judgment was denied. Her failure to point to record evidence on a matter for which she bore the burden of proof authorized summary judgment in AUL’s favor.

"Where (as here) an individual with an intoxication level approaching four times the legal limit drives a car down a highway 30% above the speed limit," the court said, "a crash is in no commonly understood sense an 'unanticipated and unexpected result,' unless some unusual circumstance (absent here) would make it so." The court noted, however, that "[n]o other record, e.g., one involving a driver with a lower intoxication level that nevertheless exceeded the limit, a car crash might fall within the definition of 'accident' under § 58-3-30 ...."

Denial of Accidental Death Claim Based On Alcohol Exclusion Was De Novo Correct


Smith was covered by an ERISA-governed accidental death insurance policy provided by his employer. Smith died in a one-car collision, and a toxicology report showed that his blood ethyl alcohol content was 0.206 grams per 100 ml at the time of death.

Smith’s wife, as his beneficiary, claimed accidental death benefits. Hartford denied the claim, based on an exclusion for “loss caused or contributed to by the injured person’s intoxication.” Intoxication was defined to mean “that blood alcohol content or the results of other means of testing blood alcohol level, meet or exceed the legal presumption of intoxication under the law of the state where the accident took place.”

Mrs. Smith sued, and the federal district court relied on the six-step analysis applied by the Eleventh Circuit to review ERISA benefits decisions: (1) determine whether the benefits-denial decision is de novo wrong; (2) if the decision was wrong, determine whether the administrator had discretion; if not, reverse the decision; (3) if there was discretion, determine whether the decision was reasonable; (4) if the benefits decision was not reasonable, reverse it; if it was reasonable, then determine if there was a conflict of interest; (5) if there is no conflict, affirm the decision; (6) if there was a conflict, consider it as merely one factor in determining whether the benefits-denial was arbitrary and capricious.

Citing Buce v. Allianz Life Insurance Company, 247 F.3d 1133 (11th Cir. 2001), the court declared that, because the federal common law of ERISA supersedes state law, Georgia’s “accidental means” doctrine was inapplicable. Rather, the court considered the standard established by Wickman v. Northwestern National Insurance Company, 908 F.2d 1077 (1st Cir. 1990), that the court must consider whether the insured “knew or should have known that serious bodily injury or death was a probable consequence substantially likely to occur as a result of his volitional act ....”

Based on Wickman and its progeny, the court determined that Hartford’s denial was not de novo wrong, the first step in the analysis. Although there was insufficient evidence to determine Smith’s state of mind on the night of the collision, the court held that, objectively, death was the foreseeable result of driving while intoxicated to an extent greater than twice the legal limit.

In making this determination, the court rejected studies proffered by Mrs. Smith showing that death from drunk driving is not “substantially probable.” Because those studies had not been submitted to Hartford, they were not part of the administrative record considered by the court in its reasonableness determination. Furthermore, such statistics have been refuted under similar circumstances as failing to take into account the degree of intoxication of the driver and the fact that the risk of being involved in a fatal crash increases as blood alcohol levels rise.

Mrs. Smith also argued that Hartford denied the claim simply because of Smith’s blood alcohol content, without conducting an investigation to determine whether intoxication actually caused the crash. While agreeing that the law disfavors per se rules in intoxication cases, the court disagreed that Hartford had made a per se decision, citing the myriad documents reviewed by Hartford regarding the incident, coupled with the fact that nothing else in the record pointed to any other factor which might have contributed to the crash.

The court went on to say that, even if Hartford’s decision were de novo wrong, Hartford was granted discretion under the plan, and its determination was reasonable. The court found nothing in the record to indicate that Hartford was influenced by its conflict of interest. Thus, the court granted Hartford’s motion for summary judgment.
Action to Recover LTD Benefits Dismissed for Failure to Exhaust Administrative Remedies

Venning v. Metropolitan Life Ins. Co.,

Venning suffered a head injury that caused chronic headaches, speech impairment, mental disorientation, and deficiencies in concentration. He received short-term disability benefits under an employee welfare benefit plan administered by MetLife. Long-term disability benefits had been paid for one year before MetLife denied his claim. Without appealing the adverse claim decision, Venning filed a legal action to recover long-term disability benefits under the plan.

MetLife moved for summary judgment, arguing that Venning’s claim was barred because he failed to exhaust his administrative remedies before initiating a lawsuit. Venning argued that his failure to exhaust should be excused, based on the following policy language: “If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in state or Federal Court.” Venning contended that this language meant the appeal process was optional, and that he was not provided with sufficient notice of the exhaustion requirement.

Venning relied on Watts v. BellSouth Telecommunications, Inc., 316 F.3d 1203 (11th Cir. 2003), which stated that ERISA’s exhaustion requirement may be waived if a plaintiff can show (1) that the relevant plan documents, objectively speaking, could reasonably be interpreted as permitting him to file a lawsuit without exhausting his administrative remedies, (2) that he so interpreted them, and (3) that, as a result of that misinterpretation, he failed to exhaust the administrative process.

The court held – assuming the plan was susceptible to the interpretation that there was no exhaustion requirement – that Venning failed to meet the second and third requirements of Watts. Although he asserted that he “reasonably interpreted the plan as permitting him to file suit without appealing,” Venning failed to point to any record evidence supporting this claim.

Venning also asserted that MetLife denied him access to a full and fair review required by ERISA, because the company failed to provide him access to all documents used in the claim determination. The court found this assertion to be completely unsupported by the record, however, because Venning did not identify a single document that was submitted to MetLife in support of his claim and that was omitted from the claim file.

The court granted summary judgment to MetLife.

Death Was Not Due Solely to Accident, Because Prescription Medication Was a Contributing Cause

Slagle v. Life Ins. Co. of N. Am.,

Slagle was insured by an ERISA-governed accidental death and dismemberment policy, which provided:

We agree to pay benefits for loss from bodily injuries:
   a) caused by an accident which happens while an insured is covered by this policy; and
   b) which, directly and from no other causes, result in a covered loss.

We will not pay benefits if the loss was caused by:
   a) sickness, disease, or bodily infirmity; or
   b) any of the Exclusions listed in the policy.

Slagle died after fainting in a parking lot and hitting his head on the ground, resulting in an intracranial hemorrhage. At the time of his death, Slagle was taking Coumadin, an anticoagulant medication, to reduce the risk of stroke associated with two conditions with which he had been diagnosed – hypertension and atrial fibrillation.

Hospital records stated that Slagle’s death was caused by subarachnoid, subdural, and intracranial hemorrhages, and that other significant conditions were hypertension and atrial fibrillation. Slagle’s death certificate described the immediate cause of death as “acute intracerebral and subarachnoid hemorrhage and systemic arterial hypertension and anticoagulation,” and stated that other significant conditions contributing to death were “blunt force trauma of the head with subdural hematoma.” The death certificate described the death as due to an accident.

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When Slagle’s wife claimed accidental death benefits, LINA submitted her husband’s medical records to an independent medical reviewer. The reviewer determined that atrial fibrillation substantially contributed to Slagle’s death, because he had been anticoagulated with Coumadin, which prevented his blood from clotting adequately and which contributed substantially to the intracranial hemorrhages.

Based on this report, LINA determined that benefits were not payable, based on the policy exclusion for loss resulting from sickness, disease, or bodily infirmity. LINA also determined that fainting was not an accident, as that term is generally understood and as defined by the policy.

Mrs. Slagle sued to recover accidental death benefits, and the parties filed cross-motions for summary judgment.

The federal district court first considered whether a policy provision stating that benefits "will be paid as soon as we receive proper written proof of loss" granted discretionary authority to LINA to make claim decisions. The court rejected LINA’s argument that discretion was granted, distinguishing "proper written proof" from language in other policies requiring that proof be "acceptable to the plan" or "satisfactory to us.” The court held that discretion was not granted by the phrase "proper written proof.”

LINA next argued that discretionary authority was granted by the summary plan discription, which stated that the claims administrator “shall have full and final discretionary authority as set forth in this paragraph to determine claims and appeals.” The court held that this language – although an express and unambiguous grant of discretion – was invalid because it conflicted with the language of the policy, which prohibited changes other than in writing signed by an officer of the insurance company. Thus, the court applied the de novo standard of review.

Turning to LINA’s reasoning in support of its claim decision, the court rejected the argument that fainting and dizziness are internal bodily processes, not external events constituting an accident. Finding that the term "accident" was ambiguous and construing it against LINA, the court determined that, under a broad reading, fainting constituted an accident within the terms of the policy. The court also rejected LINA’s argument that Slagle’s fainting was due to a sickness or disease, because the administrative record did not establish that Slagle fainted due to atrial fibrillation, rather than some other cause, such as hunger or fatigue. For these reasons, the court determined that Slagle’s fall was an “accident” as described by the policy.

The court then considered LINA’s argument that the sickness, disease, or bodily infirmity exclusion applied. The court rejected the argument that atrial fibrillation contributed to death because it required anticoagulation therapy, which, in turn, reduced blood clotting and led to intracranial hemorrhages. The court reasoned that anticoagulation is not a disease, but the result of treatment, and that LINA was wrong to apply the disease exclusion.

Finally, the court considered LINA’s argument, asserted for the first time during the litigation, that benefits were not payable because Slagle’s death was not caused “directly and by no other causes” by an accident. The court concluded that Slagle’s anticoagulation therapy – a non-accidental cause – substantially contributed to his death, because it prevented his blood from clotting appropriately. Thus, the court held that LINA’s claim decision was de novo correct.

Administrator’s Procedural Errors Allow Claimant To Submit Post-Appeal Supporting Documentation

Cole v. Aetna Life Ins. Co.,

After working 31 years as a registered nurse at a hospital, Cole submitted a claim for long-term disability benefits under her employer’s welfare benefit plan, which was fully insured by Aetna. She received benefits for disability from her own occupation, but Aetna then determined that Cole was not disabled under the “any occupation” test.

Cole appealed and submitted additional documents on appeal, including an independent medical report which concluded that she did not have a functional impairment that would preclude her from working in any occupation. Aetna notified Cole of its decision to uphold the original claim decision, but in the letter Aetna erroneously listed documents pertaining to another claimant as being among those it had reviewed in affirming the denial.

Cole then retained counsel and requested that Aetna reopen her claim. She submitted further documents, but Aetna denied her request for reconsideration. Cole filed suit, asserting an ERISA claim, and she then filed a motion to remand the claim to Aetna, seeking further review based on claims that Aetna had committed procedural errors.

Under 29 C.F.R. § 2560.503-1(h) (1), every employee benefits plan must have a procedure under which a participant can appeal an adverse benefit determination, and have a full and fair review of the claim and decision.
A full and fair review must include (1) 180 days to appeal the decision; (2) an opportunity for the claimant to "submit written comments, documents, records, and other information relating to the claims for benefits"; (3) access, upon request, to all information relevant to the claim; (4) a "review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination"; (5) a review that does not afford deference to the initial adverse benefit determination; (6) identification of medical experts consulted; and (7) consultation by a medical consultant who was not consulted in connection with the adverse benefit determination. See 29 C.F.R. § 2560.503-1(h)(2) & (3).

Additionally, 29 C.F.R. § 2560.503-1(j) requires the plan administrator to provide written notification of the outcome of the review, including "[t]he specific reason or reasons for the adverse determination." In cases where there is a procedural ERISA violation, the Fourth Circuit has held that the appropriate remedy is to remand the matter to the plan administrator so that a "full and fair review" can be accomplished. Gagliano v. Reliance Standard Life Ins. Co., 547 F.3d 230, 240 (2008).

In holding that Aetna failed to give Cole proper notification of the claim decision, the federal district court scrutinized the composition of Aetna's denial letter. The court said that about one-third of the letter was standard LTD policy language, and another one-third consisted of a list of documents that purportedly were included in Aetna's review, but that were completely unrelated to Cole's claim. The final one-third was specific to Cole and her medical condition, but the language was taken almost verbatim from the report of Cole's independent medical examiner, which was supplemented as part of the appeal.

The court interpreted the erroneous list of documents and the copied language from the medical report as indicating "a lack of familiarity" by Aetna with regard to Cole's claim. As a result, the court held that Cole had not been provided a full and fair review. Further, the court ruled that Aetna failed to provide specific reasons for the adverse determination, despite the fact that the independent medical examiner's report was consistent with Aetna's original denial, confirming that Cole was not disabled from "any occupation."

For those reasons, the court remanded Cole's claim to Aetna, and held that Cole could submit further documentation in support of her claim for LTD benefits, including documents created after her first appeal.

A Message from the Editors

We were pleased to see many colleagues at the Life, Health, Disability and ERISA Claims Seminar in Chicago last month, presented by the Life, Health and Disability Committee of The Defense Research Institute. Kent Coppage is the Program Chair for next year's seminar, which will be in Boston on April 24-26, 2013.

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