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Recent ERISA Cases You Should Know About (and some ERISA 101)

By

Roy Dickinson

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ABOUT THE SPEAKER

Roy Dickinson graduated from the O.U. College of Law in 1988 and has practiced in Oklahoma since then. Roy's current practice focuses primarily on ERISA litigation, but he has extensive experience in litigating injury and death claims, with a focus for many years on Railroad grade crossing trial practice. He lives and works in Norman, Oklahoma.

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1. *Caldwell v. Unum* 786 Fed.Appx. 816 (10th Cir. 2019) (Not for publication). ERISA Life insurance (AD&D). Insured's death resulted from auto crash caused by insured driver's speeding. Claim denial based on policy crime exclusion upheld.

Driver exceeding speed limit by about 50 m.p.h. lost control of vehicle, crashed and died. Insurer denied claim based on policy's crime exclusion—*which did not define crime*. Applying arbitrary and capricious standard of review, the Court of Appeals refused to follow or apply a recent Supreme Court decision[1] finding that the use of the word crime without further clarification of *exactly what is a crime* is prima facie ambiguous, bizarrely stating that that didn't matter, and agreed with the district court that the insured's interpretation of the exclusion was reasonable, completely ignoring the principle that ambiguous terms are to be construed against the insurer[2]. The Dissent is notable for its strong criticism of the majority's decision to disregard the ambiguity argument and the refusal to consider the claims manual, which explained that speeding was not a crime to be excluded under the policy.

2. *Harper v. Aetna,* 451 F.Supp.3d 1200, (N.D. Okla 2020). Life insurance claim. Denial of death benefits from an auto crash death, based on intoxication exclusion in policy. Issues of note: 1. Reduced standard of review based on insurer's "structural" conflict of interest; 2. applicability and interpretation of intoxication exclusion; 3. Evidence of intoxication. The court considered Aetna's conflict of interest as payor and decisionmaker and found the conflict to be "severe" and reduced the standard of review from "arbitrary and capricious" to "substantial

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[1] United States v. Stitt, 139 S. Ct. 399, 202 L. Ed. 2d 364 (2018).

[2] Well settled: where there is an ambiguity or conflict in the policy's terms, "a policy of insurance is to be construed strictly against the insurer and in favor of the insured." *Flores v. Monumental Life Insurance Co.,* 620 F.3d 1248, 1250 (10th Cir. 2010), *quoting Spears v. Shelter Mut. Ins. Co.,* 2003 OK 66, 73 P.3d 865, 868 (Okla. 2003).

evidence", but nonetheless determined that Aetna's exclusion precluding entitlement to benefits for an accident occurring while under the influence of illegal drugs was supported by substantial evidence. The "evidence" was a post-mortem toxicology report showing, among other things, the presence of methamphetamine (but note that the decedent had a prescription for Aderall), even though the conclusion that the decedent was "under the influence" was based upon admittedly incorrect calculation of the amount of illegal substances in the decedent's blood and an assumption by the toxicologist, performed by Aetna's in-house registered nurse and claims analyst. Apparently Plaintiff had submitted no rebuttal evidence dealing with the flawed analysis in the record.

The case is instructive on the issue of the effect of conflict of interest on the standard of review. It also demonstrates the importance of presenting evidence during the administrative review, and the perils of not doing so. Typically ERISA policy exclusion cases focus on the exclusionary language. There was no evidence (apparently) demonstrating that the decent was "under the influence" of drugs other than the (incorrectly calculated) mere presence of drugs in the post mortem toxicology report.

3. James C. v. Aetna 2020 WL 6382043, (D. Utah 2020)

Claim under medical plan for behavioral health benefits. Claims were submitted post-treatment. Plan had precertification requirement for the services. Plan had a $3 or 500 penalty for failure to pre-certify—but claim was denied in its entirety under the precertification penalty clause, despite never evaluating the claim's medical necessity. The court found that the denial was arbitrary and capricious and vacated the benefit denial—but did not award the benefits to

Plaintiff, instead remanded the claim to the administrator to conduct a medical necessity analysis. The court awarded Plaintiff attorney's fees under ERISA'S prevailing party provision.

4. Eschler v. The Lincoln Nat'l Life Ins. Co., No. 2:20-CV-467 DB, 2020 WL 6450509 (D. Utah Nov. 3, 2020).

Life Insurance claim. Decedent enrolled for life insurance after she became pregnant. She subsequently died during childbirth. Prior to her death, decedent enrolled for the coverage and her employer began deducting premiums. Issues: exhaustion or administrative remedies is jurisdictional (good discussion of judicial discretion and cases); §1132 (a)(3) claim for equitable relief (survived motion).

Defendant denied beneficiary's claim for benefits, citing a Plan provision requiring a new enrollee to provide evidence of insurability (EOI) which did not happen. Plaintiff failed to exhaust administrative and was unable to persuade the court that the exhaustion requirement should be avoided based upon an argument of inadequate notice that exhaustion was mandatory.. The court found that Plaintiff's claim for benefits under §1132 (a)(1)(B) was barred. The court did allow Plaintiff's additional claim for equitable relief based on breach of fiduciary duty §1132 (a)(3) to proceed and found the claim was not barred by failure to exhaust administrative remedies. The Complaint alleged Defendant failed to adequately notify of the need to submit evidence of insurability, Following CIGNA Corp. v. Amara, 563 U.S. 421, 131 S. Ct. 1866, 179 L. Ed. 2d 843 (2011), the court acknowledged the right to seek an equitable surcharge under ERISA's "other equitable relief "clause. §1132 (a)(3).

5. Lyn M. v. Premera Blue Cross, 966 F.3d 1061 (10th Cir. 2020).

Behavioral health claim. Appeal from grant of summary judgment to insurer. Administrator failed to notify insured of discretionary grant (which provides for a lower standard of review). Remanded. Dissent says this is a "new" standard. I think the dissent is on to something, and it's a good thing for ERISA claimants.

Insured's child admitted to long-term care facility for mental illness-and suicidal attempts and ideation. Insurer paid for ten days of admission and denied remainder of claim. The Court of Appeals found that insurer failed to inform insured of Plan's grant of discretionary authority, and therefore the de novo standard of review, not arbitrary and capricious, should have been applied by the trial court, singe the insurer's coverage documents provided to insured did not disclose discretionary grant. Defendant's argument that the document could have been obtained upon request held insufficient.

6. Mary D. v. Anthem Blue Cross Blue Shield, 778 F. App'x 580 (10th Cir. 2019)(not for publication).

Behavioral health claim for dependent child. Denial of claim upheld. Very stringent medical necessity criteria, which sealed the claim's fate. This is a fact specific case, and plows no new ground.

7. Moon v. Tall Tree Administrators, LLC, 814 F. App'x 371 (10th Cir. 2020)(not for publication). Surrogate pregnancy health benefit exclusion upheld. Demonstrates that a Plan can draft around fact-specific situations and avoid coverage.

8. Phillips v. Boilermaker-Blacksmith Nat'l Pension Tr., 2020 WL 6059733 (D. Kan. Oct. 14, 2020). Class action over retirement benefits, Fight over production of defendant's settlement agreement in previous case with similar issues. Production ordered. Fact-specific and probably of some use to ERISA class-action practitioners in limited circumstances.

9. Rachel S. v. Life & Health Benefits Plan of the Am. Red Cross, 2020 WL 6204402 (D. Utah Oct. 22, 2020).

Behavioral health claim. Eating disorder, numerous suicide attempts. Insurer disregarded numerous incidences of self-harm and ideation to justify denial of claim for residential treatment. After appeals exhausted, claimant sought review by "independent" review organization (IRO), denial upheld. Trial court applied arbitrary and capricious standard of review to IRO decision to despite no discretionary grant in plan for IRO decisions—expressing concern with "disruption" of review process for reviewing courts in the future.

Other issue was use of internal guidelines which differed from plan definition of medical necessity and the insurer's failure to even cite the medical necessity in articulating its denial. Court held denial was arbitrary and capricious **but** didn't award benefits.

10. Rodriguez v. Zurich Am. Ins. Co., 2020 WL 569351 (N.D. Okla. Feb. 5, 2020). AD&D claim. Judge Egan upheld (as usual) denial of benefits. Decedent slipped on ice, was injured, lost leg, then died. Prior to accident decedent has suffered from a myriad of chronic medical conditions and organ failure and history of fall leading to injury. Decent had a 1,000,000. Life policy and a $500,000 accidental death and dismemberment coverage. Insurance denied the AD&D claim due the the serious medical history, attributing the preexisting conditions to have contributed to the death, and finding that fell within the policy's coverage exclusion.

The court allowed limited discovery, but then denied Plaintiff's request to supplement the administrative record as outside the administrative record at the time defendant considered the claim.

Long discussion of sliding scale in conflict cases. “Standard” v. “inherent” conflict. Court found the conflict to be “severe” and thus subject to greater judicial scrutiny and burden shifted to defendant to prove interpretation of plan was reasonable and the application of terms was supported by substantial evidence. Court found evidence supporting denial was “overwhelming”. Despite increased scrutiny, the court affirmed the denial. Case has a good discussion of conflict issues.

11. Smith v. Standard Life Ins. Co., 2020 WL 5880971 (W.D. Okla. Oct. 2, 2020). ERISA post-decision attorney’s fee case. While underlying case, a suit to recover benefits after insurer denied claim based on insured’s failure to submit evidence of insurability (EOI) was pending, defendant amended its benefit plan and tendered payment of the claim in full to Plaintiff. Plaintiff argued that the amendment was causally connected to the filing of the lawsuit and this constituted “some degree of success” on the merits in the underlying case entitling him to an attorney’s fee. The court analyzed the request, citing Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242, 130 S. Ct. 2149, 176 L. Ed. 2d 998 (2010) and related cases. Defendant disputed a causal connection between the lawsuit and the Plan’s amendment (with a straight face) but provided no evidence to refute Plaintiff’s assertion that the lawsuit catalyzed the change. The Court found that Plaintiff was entitled to an attorney’s fee under Hardt, having had “some degree of success on the merits” but then took that all away, under the five-factor analysis[3] applicable to a prevailing party in ERISA cases under Cardoza v. United of Omaha Life Ins. Co., 708 F.3d 1196 (10th Cir. 2013), and ruled that Plaintiff was not entitled to a fee award.

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[3] (1) the degree of the opposing party's culpability or bad faith; (2) the opposing party's ability to satisfy an award of fees; (3) whether an award of fees would deter others from acting under similar circumstances; (4) whether the party requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions. Smith v. Standard Life Ins. Co., No. CIV-15-1126-D, 2020 WL 5880971, at *1 (W.D. Okla. Oct. 2, 2020)

12. Stachmus v. Guardian Life Ins. Co. of Am., 2020 WL 1528168 (E.D. Okla. 2020). Life insurance case—question regarding beneficiary designation and failure to exhaust administrative remedies. Father had originally designated his son (Plaintiff) as a 50% beneficiary and grandson a 50% beneficiary in 2011. In 2012 he amended the designation to Plaintiff-son to 90% and 10% to plaintiff's step-sister. Father died in September 2013, and ex-wife and her son (Plaintiff's stepmother and stepbrother) submitted claim for benefits, a 2011 power of attorney giving step sister (Andrea) POA, and a beneficiary change with a beneficiary change form with the insured's purported signature dated about a week before death giving the ex-wife and her children 100% of the benefits. Defendant's claims examiner sent a letter to the claimant's stepmother asking if the insured was incapacitated at the and were paid by defendant insurer. The stepsister Andrea (new designee) responded, stating that the insured was not incapacitated when he instructed her to make the beneficiary changes. Defendant then paid the ex-wife/stepchildren 100% of the benefits. Shortly after this, the Plaintiff wrote defendant expressing his belief that he was a 90% beneficiary and inquiring about payment. Defendant cited the 2013 changes and denied the claim. Plaintiff appealed and the denial was upheld on appeal. Suit was commenced, alleging the Defendant breached its fiduciary duty to conduct an adequate investigation, and, it appears, that defendant should have investigated whether the beneficiary change was made under duress or fraudulent. The court refused to apply state/common law principles, holding they were preempted by ERISA, and asserted that Plaintiff had a duty to bring evidence of fraud or duress to the claim administrator. The court also rejected the argument that the change was not done in accordance with Plan required written confirmation

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duties. Plaintiff submitted a claim well over two years later (Plan apparently limited claim submission to two years). It appears an appeal is pending.

13. Tracy O. v. Anthem Blue Cross Life & Health Ins., 807 F. App'x 845 (10th Cir. 2020) (unpublished). Behavioral health claim for dependent child's residential treatment. Child had long history of serious mental illness and was suicide risk. Court, applying arbitrary and capricious standard of review, upheld denial of claim.

Despite the child's therapist expressly stating the child needed the residential treatment due to suicide risk, the insurer denied the claim, asserting that outpatient treatment was sufficient and residential treatment was not "medically necessary". Claimant sought a voluntary "independent" medical review which upheld the denial. Litigation commenced. Despite a clear difference of opinion between treating physicians who opined residential treatment was necessary and Defendant's doctor and the IRO doctors who didn't, the court found the denial was reasonable since it was supported by the different opinion of the non-treating doctors.

14. Unum Life Ins. Co. of Am. v. Brester, 2018 WL 10129414 (N.D. Okla. Mar. 30, 2018). Life insurance interpleader case involving Oklahoma's "slayer statute". Case also involved Plaintiff's failure to exhaust administrative remedies. Court dismissed beneficiary's counter claims asserting breach of fiduciary duty, finding them preempted by ERISA.

The opinion is vague as to facts, but it is clear that Plaintiff, a minor, was a 25% beneficiary of an employee benefit life insurance policy. H.K. alleged a co-beneficiary was not entitled to benefits due to Oklahoma's slayer statute and sought to recover her portion of those benefits. Defendant moved to dismiss the slayer statute claim based on preemption, and the remaining claims because Plaintiff failed to exhaust administrative remedies. The court, without

explaining too much, dismissed all Plaintiff's claims. There is a good discussion about "conflict preemption" in the Order.

15. Williamson v. Unum Life Ins. Co. of Am., No. CIV-19-481-R, 2019 WL 6683116 (W.D. Okla. Dec. 6, 2019). Disability benefit case, interlocutory conflict discovery ruling.

Plaintiff moved for limited discovery to inquire into UNUN's inherent conflict of interest. Motion was denied. Plaintiff's counsel (me) felt confident that matter would be decided differently on appeal, but the matter was subsequently resolved to the *mutual satisfaction* of the parties. Murphy v. Deloitte & Touche Grp. Ins. Plan, 619 F.3d 1151 (10th Cir. 2010 allows for limited discovery based un a threshold showing of the propriety of the discovery. Despite a demonstration of the Defendant's well-established history of biased claims determinations, the evidence in support of that fact was not recent enough to satisfy the court that limited discovery was warranted.

Roy Dickinson
Attorney at Law
1408 Winding Ridge Rd.
Norman, OK 73072
(405) 321-3288
(405) 973-2204 (fax)
roy.d@coxinet.net
Dickinsonlegal.com