

Life, Health and Disability News

Winter 2010

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Villains, Victims & Sinners: Morality and the Law of Suicide Exclusions

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Modern insurance law governing suicide exclusions has been shaped by early criminal law and turn of the century morality. Insurance policies have excluded coverage for death by suicide since the eighteenth century. In interpreting suicide clauses in these early policies, courts looked for guidance to the criminal law. Under English and American common law, suicide was a criminal act of moral turpitude, punishable as “felonious suicide.” To constitute felonious suicide, the act of self-destruction had to be conducted by a morally responsible agent, able to distinguish between right and wrong, with the specific intent to die. Of course, a defendant charged with felonious suicide had to be tried *in absentia*. So courts conducted post-mortem trials to determine the deceased’s intent, mental capacity, and moral accountability. If convicted of felonious suicide, the defendant forfeited all property to the State, leaving family

members bereft of their inheritance.

The criminal law concept of felonious suicide shaped how early common law courts interpreted suicide exclusion in insurance policies. In eighteenth and nineteenth century insurance law, as in criminal law, the requirement of *mens rea* was foundational. To fall within the policy’s suicide exclusion, the act of self-destruction had to be performed by a morally responsible agent who understood the nature of his actions and intended to die. An individual suffering from delusions might bring about his death through an act of self-destruction, but the insured could not be held morally or legally accountable for his actions under early insurance law any more than he could be held morally or legally accountable under criminal law.

By the twentieth century, many courts had liberated the law of suicide exclusions from its criminal origins. Courts adjudicating coverage matters adopted an objective test for suicide. These courts found that, by excluding coverage for suicide whether “sane or insane,” the insured’s mental capacity at the moment of

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death was irrelevant. Rather, the suicide exclusion applied when, to an objective observer, the insured took his own life. Under the objective test for suicide, there is no post-mortem inquiry into the insured's mental capacity or ability to direct his actions.

Outdated legal concepts tend to fade away gradually, particularly when those concepts involve deeply engrained moral beliefs such as suicide. As a result, even today, vestiges of felonious suicide continue to influence the judicial interpretation of suicide exclusions. Like the early common law courts, these minority jurisdictions continue to conduct a post-mortem inquiry into the insured's subjective state of mind at the moment of death. Rather than speak of the insured's morality and criminal accountability, however, these courts attempt to reconstruct the insured's state of mind using scientific terminology borrowed from psychiatry and biochemistry, and guided by expert opinion. Though framed in the language of science, these "modern" judicial decisions nevertheless reflect a judicial proceeding akin to a trial for felonious suicide.

Courts do a social disservice by attempting to reconstruct the insured's mental state at the moment of death, which itself can never truly be known. That approach unnecessarily conflates contractual interpretation with principles of moral responsibility, but disguised with the language of modern science. When an insurance policy excludes suicide whether "sane or insane," the judicial inquiry should be an objective one. Suicide whether "sane or insane" should not be concerned with the insured's mental capacity or moral accountability. Suicide is simply the act of killing one's self. It is determined by an objective standard, and

not a subjective inquiry into the insured's state of mind.

Early Law: Felonious Suicide

Since the 1700's, insurance policies have limited coverage for death by suicide. In interpreting suicide clauses in these early policies, courts were guided by the criminal law of felonious suicide as well as commonly accepted societal *mores*. Under early English and American common law, an insane man might bring about his death through an act of self-destruction, but in the absence of mental capacity, he could not be held morally or legally accountable for the criminal act of suicide. As recounted in one insurance decision from 1902:

"By common law, suicide was a felony. In such cases courts have held, as the term imports, that one so insane as not to understand the moral character of the act, incapable of forming guilty intent, could not, while in that condition, commit suicide; that self-destruction was not suicide."

Seitinger v. Modern Woodmen of America, 106 Ill.App. 449, 1902 WL 2410, at *2 (4th Dist. 1902), *aff'd*, 204 Ill. 58, 68 N.E. 478 (1903).

The Supreme Court in *Life Ins. Co. v. Terry*, 82 U.S. 580 (1872) drew upon principles of felonious suicide in interpreting a policy that excluded coverage when the insured dies "by his own hand." *Id.* at 591. Adducing the concept of legal capacity from criminal law, the Court held that if the insured intentionally takes his life while "in the possession of his ordinary reasoning faculties," whether out of jealousy, anger, or a desire to escape the ills of life, then the policy's exclusion applies. *Id.* But if the insured intention-

ally takes his life when "his reasoning faculties are so far impaired that he is not able to understand the moral character, the general nature, consequences, and effect of the act" or when impelled "by an insane impulse," the exclusion does not apply and the policy's beneficiary may recover. *Terry* reflects the nineteenth century sensibility that only morally responsible agents, capable of exercising free will, should be held legally accountable for their acts of self-destruction.

Insurance companies responded to *Terry* by drafting clauses that excluded suicide whether the insured was "sane or insane." The purpose of this language was to exclude coverage for all acts of self-destruction, regardless of the insured's mental capacity.

The Supreme Court in *Bigelow v. Berkshire Life Ins. Co.*, 93 U.S. 284 (1876) interpreted a suicide exclusion that contained the "sane or insane" language. The insured in *Bigelow* died when he intentionally discharged a pistol to his head. Although he knew that he was killing himself, "he was unconscious of the great crime he was committing." *Id.* at 288. "His darkened mind did not enable him to see or appreciate the moral character of his act, but still left him capacity enough to understand its physical nature and consequences." *Id.*

Departing for the first time from the criminal law paradigm, the *Bigelow* Court held that insurers properly may exclude coverage for intentional self-destruction, "whether it be the voluntary act of an accountable moral agent or not." *Id.* at 286. An insane man "could not commit felony; but, conscious of the physical nature, although not of the criminality of the act, he could take his own life, with a settled purpose to do

so.” *Id.* at 287. By including the mental states “sane or insane,” the policy’s suicide clause encompassed any act of intentional self-destruction, and not just acts of felonious suicide. The question of the insured’s mental capacity at the moment of death became, for the most part, irrelevant:

“As the line between sanity and insanity is often shadowy and difficult to define, this company thought proper to take the subject from the domain of controversy, and by express stipulation preclude all liability by reason of the death of the insured by his own act, whether he was at the time a responsible moral agent or not.”

Id. at 287.

The parties in *Bigelow* did not dispute that the insured’s self-destruction was intentional. His mental illness was not so severe that he was totally unable to direct his actions. The Court acknowledged, however, that a phase of insanity might be so extreme that the insured loses all semblance of an individual will. But the Court declined to decide that hypothetical issue:

It is unnecessary to discuss the various phases of insanity, in order to determine whether a state of circumstances might not possibly arise which would defeat the condition [of suicide, sane or insane]. It will be time to decide that question when such a case is presented. For purposes of this suit, it is enough to say that the policy was rendered void, if the insured was conscious of the physical nature of his act, and intended by it to cause his death, although, at the time, he was incapable of judging between right and wrong, and of understanding the moral consequences of what he was doing.

Id. at 287. *Bigelow* left unanswered the fundamental question of whether the sui-

cide exclusion would apply if the insured was so insane as to lack all semblance of an individual will. *Bigelow’s* unanswered question lead to the creation of two divergent bodies of insurance law: the majority view, which adopted an objective test for suicide, and the minority view, which maintained the subjective test for suicide (akin to a criminal prosecution for felonious suicide).

Objective Test for Suicide

The issue left undecided in *Bigelow* was directly addressed and decided by the Illinois Supreme Court twenty-seven years later in *Seitinger v. Modern Woodmen of America*, 204 Ill. 58, 68 N.E. 478 (1903). The policy in *Seitinger* excluded coverage if the insured “shall die by his own hand, whether sane or insane.” *Id.* at 479. The parties stipulated that the insured “took his own life, and that at the time he did so he was wholly insane, totally unconscious of the manner of his death, and by reason of his total insanity was incapable of forming an intention of taking his life, and did not comprehend the physical nature and results of his act.” *Id.*

Seitinger explained that the terms “sane or insane” exclude coverage for all acts of self-destruction, without differentiating varying degrees of insanity:

“Nothing can be clearer than that the words “sane or insane” were introduced in the certificate by the insurer for the purpose of excepting from its operation any self-destruction, whether the insured was of sound mind or in a state of insanity. There is no qualification of the varying degrees of insanity, but the language is simply ‘sane or insane.’”

Id. at 481. “[T]o permit, in cases of this kind, the discussion and proof and a differentiation of the degrees of insanity would be to do violence to words having a

generally accepted significance, and to do that which the parties themselves never contemplated.” *Id.* at 481-482. *Seitinger* held that the insured died by suicide “sane or insane,” and that no death benefit was payable. That the insured was “totally insane” and “incapable of forming an intention to take his life” was completely irrelevant to the court’s decision. *Id.* at 482.

Seitinger is one of the early cases marking the departure from a subjective test for suicide to an objective one. If to an objective observer the insured committed a fatal act of self-destruction, then the act is regarded as “suicide, whether sane or insane.” The *Seitinger* court refused to look *post-mortem* into the insured’s possible subjective intentions and mental capacity at the moment of death.

Seitinger reflects the current prevailing view of the majority of the states that have addressed coverage exclusions for suicide “sane or insane.” See *Couch on Insurance*, §138:38, 3rd ed. 2009 (“What appears to be the majority view is that the applicability of a suicide clause with the words ‘sane or insane’ is not dependent upon the insured’s consciousness or realization of the physical nature or consequences of his or her act, or his or her conscious purposes to kill himself or herself.... That is, there can be no looking into the condition of the mind of the insured when he or she committed the fatal act, rendering it irrelevant whether the insured was under the influence of drugs and alcohol at the time of his or her death.”).

When a life insurance policy limits coverage for suicide while “sane or insane,” all questions about the insured’s subjective state of mind are removed from controversy. The insured’s state of mind is completely irrelevant.

For example, if a hypothetical insured

jumped to his death from the Golden Gate Bridge, and there was no dispute that he jumped rather than accidentally slipped, then to an objective observer the insured died by suicide whether sane or insane. It is irrelevant that the insured was unable to comprehend the consequences of his actions, failed to appreciate the meaning of death, or due to delusions thought the jump survivable. See also *Knott v. Globe Indemnity Co.*, 242 Ill. App.7, 1926 WL 3908, at *2 (1st Dist. 1926) (“[T]he test is not the capacity of the assured to form an intention to commit the act, or his consciousness of the physical consequences thereof, but the nature or character of the act itself viewed from the standpoint of being done by one in the possession of all his faculties.”).

Under the objective test, the cause of the insured’s state of mind that ultimately led to suicide also is irrelevant. In *Charney v. Illinois Mut. Life Cas. Co.*, 764 F.2d 1441 (11th Cir. 1985), the insured, a veterinarian, experienced an adverse psychiatric reaction (severe depression) to his new hypertension medication, resperine. Unaware of the cause of his depression, he went to his office and injected himself with a fatal dose of euthanasia solution, dying instantly. The court held that the insured’s death fell within the policy’s limitation for “suicide, sane or insane.” The court explained that the cause of the insured’s depression was irrelevant in determining the applicability of the policy’s suicide clause:

“Even assuming that the [insured] was rendered insane by resperine, there is nothing in the contract that suggests the cause of insanity would make any difference in the policy’s coverage. The cause of Dr. Charney’s insanity, if he was insane, is simply irrelevant.”

Id. at 1442-1443 (citing *Bigelow*, 93 U.S. at 284).

Recently, a district court applied the objective test in *Ohio Nat’l Life Assur. Corp. v. Soldat*, No. 07 C 4266, slip. op. (N.D. Ill. Oct. 29, 2009), finding that the insured died by suicide sane or insane. The insured in *Soldat* drove his car at a high rate of speed head-on into a concrete wall without swerving or breaking. The policy’s beneficiary argued that the insured was experiencing a drug-induced psychosis caused by an adverse reaction to medication. The beneficiary claimed that the insured should not be held accountable for his death. But for the adverse reaction to medication, he never would have killed himself.

Every act of self-destruction can be deconstructed to relieve the actor of personal responsibility. One might suffer from a severe mental illness due to uncontrollably low levels of serotonin in the brain, or one might suffer from hallucinations due to a hereditary mental illness. If there is a medical explanation for why an insured took his life, so be it. Then the insured was not morally accountable for the act of self-destruction.

But under the objective test, the court does not sit in judgment in order to decide whether the insured was morally accountable for his act of self-destruction. Rather, the court’s task is to determine whether the insured’s death, viewed from an objective reasonable person standard, was self-inflicted. Because the insured in *Soldat* caused his death by driving into a concrete wall, the district court held that the insured died by suicide whether “sane or insane.” The insured’s actual state of mind was irrelevant.

Vestiges of Felonious Suicide

Although the majority of jurisdictions have adopted an objective test for suicide, a minority continues to adhere to a

subjective test. Under the subjective test, the court must determine whether the insured understood the physical nature and consequences of his actions. This test requires a post-mortem determination of the insured’s mental capacity, akin to an early common law inquiry assessing guilt for felonious suicide.

For example, the policy in *Searle v. Allstate Life Ins. Co.*, 38 Cal.3d 425, 437, 696 P.2d 1308, 1315 (1985) excluded coverage for death by suicide whether sane or insane. The insured died by a self-inflicted gunshot wound. The *Searle* court held that the inclusion of the terms “sane or insane” in the policy’s suicide exclusion does not discharge the insurer from the burden of proving suicidal intent. Suicidal intent, in turn, could be negated by proof that the insured suffered from a mental condition that deprived him of the ability to comprehend the nature and consequences of his self-destructive act. The subjective test adopted in *Searle* ensures that most suicide coverage disputes will be decided by the finder of fact, and will entail significant expert testimony. Indeed, during the trial in *Searle*, testimony was presented by an expert psychiatrist and expert psychologist. They testified that the insured was in a psychotic state at the time of his death and that he did not understand the nature and consequences of his actions.

But courts applying the subjective test for suicide—though using the language of medicine and science—actually are engaged in the same inquiry that guided early common law courts in felonious suicide cases. In each instance, the fact finder must decide whether the insured was a morally accountable agent and therefore legally responsible for his actions, or alternatively, whether the insured was deprived of all semblance of free will and therefore not legally responsible for his

actions. The infusion of expert testimony creates the illusion that the fact finder is engaged in a scientific inquiry when, in reality, the inquiry remains a moral one. The language of moral accountability from early felonious suicide cases merely has been replaced by the language of psychoscience.

Another vestige of the law of felonious suicide can be found in the standard of proof. Even Illinois law, which has adopted the objective test for suicide, still imposes a heightened burden of proof on insurers which seek to avoid coverage by applying a suicide exclusion. The insurer must prove suicide by “clear and convincing evidence.” See, e.g., *Soldat*, slip. op. at pg. 21 (citing *Kettlewell v. Prudential Ins. Co. of America*, 4 Ill.2d 383, 385, 122 N.E.2d 817, 818 (1954)).

The clear and convincing evidence standard is an outdated relic from the criminal law of felonious suicide. The sole authority cited in *Kettlewell* for applying the clear and convincing evidence standard was *Cooley’s Briefs on Insurance*, 2nd ed. vol. 6 pg. 5475 (1928). *Cooley’s Briefs on Insurance*, originally authored in 1904, reflected nineteenth century notions that suicide was an immoral criminal act. Indeed, *Cooley’s Briefs on Insurance* defined “suicide” as an act of “moral turpitude.”

The standard of proof reflects how society values the parties’ competing interests. When one party represents interests of transcending value, society protects those interests by placing a heightened burden of proof on the opposing party. Our society places a particularly high value on personal liberty, so guilt in criminal cases must be established by proof beyond a reasonable doubt. See, e.g., *Speiser v. Randall*, 357 U.S. 513, 525-526 (1958).

Certain civil proceedings also impli-

cate transcending social values. Involuntary commitment proceedings, while civil in nature, seek to deprive individuals with severe mental illness of their liberty, though the infringement on liberty is more limited than in criminal cases. Proof of mental incompetence must be established by clear and convincing evidence. See, e.g., *In Re Stephenson*, 67 Ill.2d 544, 555, 367 N.E.2d 1273, 1278 (1977).

By contrast, in insurance coverage disputes, no transcending social interests favor one party over the other. These disputes simply determine which party should bear the risk of economic loss.

Civil disputes involving competing economic interests should be decided according to the preponderance of the evidence:

“In a civil suit between two private parties for money damages...we view it as no more serious in general for there to be an erroneous verdict in the defendant’s favor than for there to be an erroneous verdict in the plaintiff’s favor. A preponderance of the evidence standard therefore seems peculiarly appropriate....” *In Re Winship*, 397 U.S. 358, 371 (1970) (Justice Harlan, concurring).

No transcendent social interest mandates applying a heightened standard of proof in insurance coverage disputes involving suicide clauses. There are no transcendent social interests justifying a heightened clear and convincing standard in cases involving exclusions for acts of suicide. That some courts continue to require proof of suicide by clear and convincing evidence is another manifestation of culturally ingrained notions of felonious suicide.

Conclusion

Suicide clauses in insurance policies should not be adjudicated like criminal

proceedings. There should be no *post-mortem* speculation about the insured’s mental state at the moment of death, or forensic theories about the cause of his mental state. By excluding coverage for suicide “sane or insane,” insurance companies contracted out of this class of risks entirely. Suicide while sane or insane is simply the act of killing one’s self. It is properly determined by an objective standard based on a preponderance of the evidence, and not through a forensic inquiry that casts judgment on the moral accountability of the insured’s actions.

Committee Spotlight: Life, Health, Disability & ERISA Annual Claims Seminar April 28-20, 2010

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It is my honor to chair this year's Life Health, Disability and ERISA Claims Seminar as it returns to Chicago April 28 - 30, 2010. After a summer of hard work by committee leadership and an in-house advisory committee, topics have crystallized and speakers have been slated. This year's program promises to provide practical guidance for claims and legal professionals. The program will provide unparalleled presentations by distinguished inside and outside counsel, as well as judiciary and medical experts. The expert faculty will focus on practical pointers, checklists and best practices that can be utilized daily.

The 2010 seminar offers more continuing legal education than ever before. Wednesday includes three parallel tracks

of focused programming (Life, Health and ERISA). Attendees may choose to attend one track or move between them at one hour increments. Thursday will include an internationally recognized rheumatologist, Sanford Roth, M.D., commenting on the legal and medical differences of Fibromyalgia, Chronic Fatigue Syndrome and Somatosensory Disorders. On Friday, Mark Schmidtke returns by popular demand for an in-depth discussion of complex ERISA issues. These are just a few highlights among topics that include material misrepresentation, Post-*Glenn* analysis, STOLI and removal.

Networking opportunities will abound in the Windy City. Join colleagues for dine-arounds led by in-house counsel and committee leadership in some of Chicago's finest restaurants. Attend one of the counsel meetings being held by several insurance companies, including: Guardian/Berkshire, Combined Life Insurance, Assurant Employee

Benefits, Sun Life, Standard Insurance, American General Life, Hartford, Met Life, and Reliance Standard. Meet the Chief Counsel for the Illinois Department of Insurance, who will speak at a breakfast meeting for inside counsel. If you are not in Chicago for this seminar, you will have missed the preeminent seminar for the life, health, disability and ERISA industry.

I hope to see you in Chicago this spring. Look for the program brochure in the near future. There are still opportunities to be involved in the seminar's marketing. If you are interested in participating in the marketing committee, please do not hesitate to contact me at dgerber@goldbergsegalla.com.

EDITORIAL INFORMATION

Life, Health and Disability News is published quarterly by DRI's Life, Health and Disability Committee. Articles should be submitted via e-mail to Publications Vice Chair Warren von Schleicher of Smith, von Schleicher & Associates in Chicago. Case summaries go to Newsletter Editor Vaughan Finn of Shipman & Goodwin in Hartford. Submissions are encouraged and welcome.

Twombly and Iqbal: Motions to Dismiss are Alive and Well

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In *Bell Atlantic Corp. v. Twombly*, 127 S.Ct. 1955 (2007), an antitrust case, the Supreme Court held that the complaint was insufficient to state a claim for relief. In doing so, it set aside a familiar test from *Conley v. Gibson*, 78 S.Ct. 99 (1957), universally cited over the past fifty years, and announced a new approach for analyzing motions under Rule 12. Under *Conley*, claims were not to be “dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.” *Id.* at 102. The bar for surviving a motion to dismiss is now higher.

Questions regarding the impact of *Twombly* outside the antitrust context were largely answered in the May 28, 2009 decision in *Ashcroft v. Iqbal*, 129 S.Ct. 1937 (2009). *Twombly*, buttressed by *Iqbal*, has given new vitality to Rule 12 motions. Parties seeking dismissal of claims based upon marginal, conclusory allegations now have a stronger prospect of success. *Twombly* has become “the citation du jour in Rule 12(b)(6) cases.” *Smith v. Duffey*, 576 F.3d 336, 339 (7th Cir. 2009).

The full effect of these cases on routine civil cases remains to be seen. But already they are the standard guideposts for federal trial and appellate courts in analyzing the adequacy of a claim. Literally

hundreds of recent cases have discussed Rule 12 motions in their new language.

In 1986, several Supreme Court decisions revitalized summary judgment. In one, *Celotex Corp. v. Catrett*, 106 S.Ct. 2548, 2555 (1986), the Court stated:

Summary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are designed “to secure the just, speedy and inexpensive determination of every action.” ... Rule 56 must be construed with due regard not only for the rights of persons asserting claims and defenses that are adequately based in fact to have those claims and defenses tried to a jury, but also for the rights of persons opposing such claims and defenses to demonstrate in the manner provided by the Rule, prior to trial, that the claims and defenses have no factual basis.

The message in 1986 was clear - summary judgment is not an exceptional procedure, but the means by which the Rules of Civil Procedure guarantee to a litigant protection from an unnecessary trial. *Twombly* and *Iqbal* appear to be inspired by the same sentiment, perhaps due to the growing complexity and cost of litigation. Rule 12 is not a “procedural shortcut” either, but rather the proper device for challenging sketchy claims, or those based upon conclusions only.

Twombly

Twombly, a 7-2 decision authored by Justice Souter, began its legal analysis with a

discussion of the elements of a claim under Section 1 of the Sherman Act, particularly the requirement that the claimant show a conspiracy, something more than parallel activity by competitors. It then addressed the language of Rule 8(a)(2), requiring that the pleading show “that the pleader is entitled to relief,” stating:

While a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations, ... a plaintiff’s obligation to provide the “grounds” of his “entitle[ment] to relief” requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do. ... (on a motion to dismiss, courts “are not bound to accept as true a legal conclusion couched as a factual allegation”). Factual allegations must be enough to raise a right to relief above the speculative level. ... “[t]he pleading must contain something more ... than ... a statement of facts that merely creates a suspicion [of] a legally cognizable right of action, on the ASSUMPTION THAT ALL THE allegations in the complaint are true (even if doubtful in fact) ... “Rule 12(b)(6) does not countenance ... dismissals based upon a judge’s disbelief of a complaint’s factual allegations.”

Twombly, 127 S.Ct. at 1964-1965 (citations omitted). Footnote 3 added that a claimant normally need not plead in detail the factual basis of his claim. However,

Rule 8(a)(2) still requires a “showing,” rather than a blanket assertion, of entitlement to relief. Without some

factual allegation in the complaint, it is hard to see how a claimant could satisfy the requirement of providing not only “fair notice” of the nature of his claim, but also “grounds” on which the claim rests.

Id. The *Twombly* complaint was deficient because not enough was pleaded “to raise a reasonable expectation that discovery will reveal evidence of illegal agreement.”

Id. The Court continued:

The need at the pleading stage for allegations plausibly suggesting (not merely consistent with) agreement reflects the threshold requirement of Rule 8(a)(2) that the “plain statement” possess enough heft to “sho[w] that the pleader is entitled to relief.”

Id. at 1966.

The Court discussed the expense of defending antitrust cases. In response to the contention that the cost of litigation could be tempered by controlling discovery, the Court responded:

It is no answer to say that a claim just shy of plausible entitlement to relief can, if groundless, be weeded out early in the discovery process through “careful case management,” ... given the common lament that the success of judicial supervision and checking discovery abuse has been on the modest side.

Id. at 1967.

Twombly noted frequent criticisms of the *Conley* rule, and observed that it was often not followed to the letter, concluding:

[T]his famous observation has earned its retirement. The phrase is best forgotten as an incomplete, negative gloss on an accepted pleadings standard: once a claim has been stated adequately, it may be supported by showing any set of facts consistent with the allegations in the complaint.

Id. at 1969. In closing, *Twombly* stated: [W]e do not require heightened fact pleading of specifics, but only enough facts to state a claim to relief that is plausible on its face. Because the plaintiffs here have not nudged their claims across the line from conceivable to plausible, their complaint must be dismissed.

Id. at 1974.

Iqbal

Plaintiff, a Pakistani imprisoned following September 11, 2001, sought damages for improper treatment while imprisoned. Among the defendants were former Attorney General Ashcroft and FBI Director William Mueller, and it is those claims that were the subject of the appeal. Both the district court and court of appeals denied these defendants’ motions to dismiss. The court of appeals considered *Twombly*, but concluded that control of discovery could adequately protect these defendants from discovery abuse. In a 5-4 decision, the Supreme Court reversed, and remanded for consideration to determine whether leave to amend should be granted. (One of the dissenters was Justice Souter, the author of *Twombly*).

The Court first discussed the elements of a claim for damages against federal officers, and the unusual procedural setting, which allowed appeal from the denial of a motion to dismiss. The Court then summarized and affirmed its holding in *Twombly*:

To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to “state a claim to relief that is plausible on its face.” ... A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the de-

fendant is liable for the misconduct alleged. ... The plausibility standard is not akin to a “probability requirement,” but it asks for more than a sheer possibility that a defendant has acted unlawfully. ... Where a complaint pleads facts that are “merely consistent with” a defendant’s liability, it “stops short of the line between possibility and plausibility of ‘entitlement to relief.’”

Two working principles underlie our decision in *Twombly*. First, the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions. Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice. ... (Although for the purposes of a motion to dismiss we must take all the factual allegations in the complaint as true, we “are not bound to accept as true a legal conclusion couched as a factual allegation.”) Rule 8 marks a notable and generous departure from the hyper-technical, code-pleading regime of a prior era, but it does not unlock the doors of discovery for a plaintiff armed with nothing more than conclusions. Second, only a complaint that states a plausible claim for relief survives a motion to dismiss. ... Determining whether a complaint states a plausible claim for relief will, as the Court of Appeals observed, be a context-specific task that requires the reviewing court to draw on its judicial experience and common sense. ... But where the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged – but it has not “show[n]” – “that the pleader is entitled to relief.” Fed. Rule Civ. Proc. 8(a)(2).

In keeping with these principles a court considering a motion to dismiss can choose to begin by identifying

pleadings that, because they are no more than conclusions, are not entitled to the assumption of truth. While legal conclusions can provide the framework of a complaint, they must be supported by factual allegations. *Iqbal*, 129 S.Ct. at 1949-1950, quoting in part from *Twombly*.

The Court then went through the allegations, eliminating those which were “not entitled to the assumption of truth.” The plaintiff’s allegations that Mr. Ashcroft was the “principal architect” of policies by which he had been mistreated, and that Mr. Mueller was “instrumental” in the carrying out of those policies, were insufficient. The Court did not “reject those bald allegations on the ground that they are unrealistic or nonsensical,” but rather because of their “conclusory nature” which “disentitles them to the presumption of truth.” *Id.* at 1951. The remaining allegations were insufficient to “plausibly suggest an entitlement to relief” because they provided no basis for concluding that the actions of these defendants were intended to discriminate against him because of race, religion or national origin, as opposed to national security measures necessitated by the September 11th attacks.

In so ruling, the Court expressly rejected three arguments. Plaintiff first contended that *Twombly* should be limited to antitrust actions. The Court emphasized that *Twombly* was the result of the language of Rule 8(a)(2), and is not so limited. Plaintiff further argued that the rights of these defendants could be protected by managing discovery. Quoting *Twombly*, the Court noted the limited success of such approaches. The Court was particularly concerned because of potential disruption in the defendants’ performance of their government duties. Further, such an approach was unrealis-

tic:

It is quite likely that, when discovery as to the other parties proceeds, it would prove necessary for petitioners and their counsel to participate in the process to ensure the case does not develop in a misleading or slanted way that caused prejudice to their position. Even if petitioners are not yet themselves subject to discovery orders, they would not be free from the burdens of discovery.

Id. at 1953.

Plaintiff’s third argument was that his allegations of general discriminatory intent were sufficient because of the language of Rule 9(b), which states that “[m]alice, intent, knowledge, and other conditions of a person’s mind may be alleged generally.” The Court responded that the Rules “do not require courts to credit a complaint’s conclusory statements without reference to its factual context.” The word “generally” should be seen as a “relative term,” and in the context of this action, the complaint was insufficient because it did not specifically describe the plaintiff’s theory of liability against these defendants. *Id.* at 1954.

Twombly & Iqbal Applied

Motions to dismiss will now be analyzed in the new language of *Twombly* and *Iqbal*. *E.g., Harris v. Mills*, 572 F.3d 66 (2d Cir. 2009); *Moss v. U.S. Secret Service*, 2009 WL 2052985 (9th Cir. July 16, 2009). Replacement of the *Conley* test puts a new burden on the pleader to explain that his entitlement to relief against specific defendants is not only possible under any set of circumstances, but plausible. In *Pace v. Swerdlow*, 519 F.3d 1067, 1076 (10th Cir. 2008) the court commented on the importance of *Twombly*:

The insistence on *factual* allegations tending to suggest actionable rather

than innocent conduct is not mere formalism. Rather, the Supreme Court emphasized that it serves at least two vital purposes -- to ensure that a defendant is placed on notice of his or her alleged misconduct sufficient to prepare an appropriate defense, ... and to avoid ginning up the costly machinery associated with our civil discovery regime on the basis of “a largely groundless claim.”

As illustrated by *Iqbal*, the line between “threadbare recitals” of the elements of a claim, and satisfactory specific allegations, is sometimes difficult to see. Pleadings must offer some explanation for drawing a particular conclusion when there are equally plausible alternatives which do not impose liability - as *Iqbal* puts it, the pleader must *show* a basis for relief, not simply *claim* it.

The requirement of “plausibility” does not empower a court to reject specific factual allegations as improbable, unless they are utterly fantastic. What must be plausible are the allegations explaining why the pleader is entitled to relief, i.e., the claim must state a basis, rather than a mere possibility, for recovery.

Most cases recently dismissed under Rule 12 perhaps would have been dismissed under the *Conley* standard as well. But the analysis is fundamentally different. No longer can a claimant brush aside a motion to dismiss by responding that the details will come later, after discovery. No longer can the possible dangers of Rule 11 be avoided by pleading conclusions and theory rather than fact.

These two decisions offer a number of points to be considered both by claimants and those framing a Rule 12(b)(6) motion:

a. Like summary judgment, the requirements of Rule 8 and Rule 12 must be viewed from the perspective of both

claimants and those who properly seek early dismissal. Rule 8 is intentionally worded. Rule 12 is not a “procedural shortcut,” but an integral component of the Federal Rules of Civil Procedure, upon which defendants may justifiably rely.

b. Complaints which merely recite the elements of a claim may be subject to dismissal. Rule 8 “demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation.” *Iqbal*, 129 S.Ct. at 1949. When pleading certain matters, *Iqbal* admonishes the pleader to go beyond the minimal requirements of Rule 9, depending on the context.

c. The “plausibility” rule is based upon the language of Rule 8, which requires that pleadings “show”, not simply “claim”, an entitlement to recovery. While debate will continue about what exactly is a “plausible” showing, *Iqbal* calls upon the court to utilize “its judicial experience and common sense.” *Iqbal*, 129 S.Ct. at 1950.

d. Specific factual allegations must be taken as true, even if doubtful. But conclusory allegations of law are not to be considered in ruling on a motion to dismiss. Depending on the context, conclusory allegations of fact will often be treated as conclusions of law. In both these cases, the pleader failed to set out specifically why potentially benign conduct gave rise to liability, relying on conclusions instead. This problem may often arise with claims in which it is necessary to allege such matters as conspiracy, bad faith, willfulness or intent, or complex matters such as antitrust or RICO claims.

e. Compromise solutions to protect a defendant through modification of discovery may be impractical, and should not be a basis for rejecting a defendant’s right to dismissal of inadequately pleaded

claims. Minimal complaints should not be treated as a “key to unlock the doors of discovery.” Defendants are entitled to protection from speculative fishing expeditions. (However, if the case is not dismissed, a Rule 12 motion may alternatively be the basis for limiting the scope of discovery.)

f. As *Iqbal* illustrates, a pleading must show not only an entitlement to relief, but provide sufficient allegations to explain why a particular defendant is liable for a claim. See, e.g. *Shonk v. Fountain Power Boats*, No. 08-1450, 2009 WL 2132659 (4th Cir. July 16, 2009), in which claims against some defendants were dismissed because of the plaintiff’s inability to separate the grounds of recovery against those defendants.

To be sure, detailed factual allegations are not required. Further, *pro se* complaints require greater indulgence. *Erickson v. Pardus*, 127 S.Ct. 2197 (2007). And, as the subsequent history of *Iqbal* illustrates, deficiencies may be cured by amendment. On July 28, 2009, the Second Circuit remanded *Iqbal* to the district court to determine whether leave to amend should be granted. *Iqbal v. Ashcroft*, No. 05-6352-cv, 2009 WL 2244481 (2d Cir. July 28, 2009).

Nor do these cases remove the potential risk of an unsuccessful motion to dismiss. A motion denied by the trial court may simply encourage pursuit of a marginal claim. A greater danger is that the law of the case will be decided by the trial or appellate court based upon imaginative factual allegations that cannot ultimately be proven. Sometimes claims may more effectively be challenged from the record, by summary judgment, without the risk of creating adverse law.

But undoubtedly these cases provide not only a new vocabulary, but valuable support for attacking those complaints

which say little more than, “I was injured by defendant’s misconduct,” or which fill factual gaps with conclusions. Such allegations should no longer be enough “to unlock the doors of discovery.”

Taking A Wrong Turn: *Krolnik v. Prudential*

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It is one thing to get lost when one has no map available. It is quite another thing to get lost when one has a map and either fails to consult it or ignores it altogether. The latter appears to be what happened to the Seventh Circuit in *Krolnik v. The Prudential Ins. Co. of America*, 570 F.3d 841 (7th Cir. 2009) as it ignored directions charted by previous cases discussing admissible evidence in ERISA *de novo* cases, and instead headed for destinations yet unknown.

For over fifteen years, the Seventh Circuit has followed the basic principle that in *de novo* ERISA cases, a district court has discretion to determine whether or not to consider evidence outside of the administrative record and that as a general matter, the district court should restrict itself to the evidence that was before the claim administrator. The Court has repeatedly held that additional evidence should only be admitted where the court needs additional evidence to make an informed evaluation of the parties' claims and defenses. In *Krolnik*, without any acknowledgement that its decision might be inconsistent with previous circuit holdings, the panel ruled that the phrase "*de novo* review" is misleading and that courts should instead start thinking about such a case as an "independent decision" with the further ruling that

evidence outside of the administrative record may be admissible, apparently without the restrictions mandated by previous Seventh Circuit decisions.

Seventh Circuit Precedent

The Seventh Circuit, like virtually every other circuit, has long held that where an ERISA benefit decision is subject to deferential review, a court is limited to review of the administrative record compiled by the claim administrator. See, e.g., *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir. 1999). That position remains unchanged after *Krolnik*. 570 F.3d at 843 ("When review is deferential . . . then review is limited to the administrative record."). Prior to *Krolnik*, the Seventh Circuit also held that in *de novo* cases, a court's review is generally limited to the administrative record although a district court does have discretion to admit additional evidence where such evidence is necessary for the court to conduct an adequate review.

The Seventh Circuit first addressed the scope of admissible evidence in *de novo* cases in *Casey v. Uddeholm Health Benefits Plan*, 32 F.3d 1094 (7th Cir. 1994). In that case, the plaintiff sought review of a decision to deny certain health care benefits under an ERISA plan following an attempt to commit suicide. The Seventh Circuit held that the benefit decision hinged on a determination of the claimant's mental state, that there was a disputed issue of material fact, and overturned the district court's summary judgment

and remanded for trial. Discussing the evidence that would be admissible at trial, the Seventh Circuit adopted a body of law already established in other circuits:

[A] district court may review evidence beyond that which was before the plan administrator only when circumstances clearly establish that additional evidence is necessary, but . . . as a general matter the district court should restrict itself to the evidence before the plan administrator.

Id. at 1099. The Court then went on to hold that even where the administrative record is "relatively undeveloped," a trial court may still "limit the evidence to the record before the plan administrator, or it may permit the introduction of additional evidence necessary to enable it to make an informed and independent judgment." *Id.*

This remained the law in the Seventh Circuit until the Court again picked up the theme in *Patton v. MFS/Sun Life Financial Dist., Inc.*, 480 F.3d 478 (7th Cir. 2007). In that case, the claimant sought disability benefits which were denied. Reviewing the administrator's decision *de novo*, the district court declined to allow discovery for the purpose of developing evidence outside of the administrative record and granted summary judgment to the plan. The Seventh Circuit ruled that there was a dispute in the medical evidence and remanded to the district court for discovery and trial. Providing guidance to the district court on remand, the Seventh Circuit reiterated its holding in *Casey* that "the district court ha[s] discre-

tion to ‘limit the evidence to the record before the plan administrator or . . . [to] permit the introduction of additional evidence necessary to enable it to make an informed and independent judgment.’” *Id.* at 490.

The Court also listed several factors for the district court to consider in determining the breadth of discovery and the scope of admissible evidence at trial, the “most central being the court’s need to hear the evidence in order to make an informed evaluation of the parties’ claims and defenses.” *Id.* Later in the opinion, the Court repeated that the question of whether additional evidence was “necessary” to an “informed and independent judgment” was the “most important” factor. *Id.* at 491. Reemphasizing this point, the Court held:

A court should not automatically admit new evidence whenever it would help to reach an accurate decision. *Any* relevant, probative evidence increases the likelihood of an accurate decision, but always at a price of increased cost, both in the form of more money and additional time . . . The record calls for additional evidence only where the benefits of increased accuracy exceed the costs, a balance familiar to the district court.

Id. at 492 (emphasis in original).

District Court Decision in Krolnik

Krolnik sought to overturn a decision by Prudential to terminate his long term disability benefits after he received the maximum benefit amount for a mental disability. *Krolnik v. The Prudential Ins. Co. of America*, 2007 U.S. Dist. Lexis 96847 (E. D. Wis. 2007). He launched a wide volley of discovery requests, including requests to depose a variety of doctors and Prudential employees, discovery of Prudential’s claims handling procedures,

charts, and documents of other disability claimants, and depositions of Prudential’s consulting doctors. Noting that Krolnik bore the burden of demonstrating that the benefits of the discovery outweighed the associated costs, the district court concluded that Krolnik failed to satisfy this burden. On summary judgment, Krolnik submitted medical affidavits, but the district court declined to consider them and granted summary judgment to Prudential.

Seventh Circuit Decision in Krolnik

The Seventh Circuit criticized both the district court’s discovery decision and its decision not to consider the medical affidavits. The Court characterized Krolnik’s discovery requests as being limited to “generat[ing] evidence about his medical conditions, and the extent (if any) to which his mental condition affects his ability to work,” when even a cursory reading of the district court’s discovery order reveals that Krolnik’s discovery was far broader. The Seventh Circuit also described the excluded evidence as “[doctor] affidavits describing his condition and prognosis,” without any mention of whether the affidavits contained information that duplicated what was already in the record or even whether Krolnik had the opportunity to submit the information during the claim review process. Despite these obvious defects, the Court held that the district judge should have allowed the discovery and admitted the additional evidence.

The Seventh Circuit panel began its analysis by stating that “*de novo review*” is a misnomer and that courts and lawyers should stop referring to “review” and start referring to such a case as an “independent decision.” The Court also stated that such a proceeding is not unlike a

breach of contract action where a judge “won’t ask what evidence the insurer considered,” but instead “will decide for itself where the truth lies.” According to *Krolnik*, in such cases, “the court decides on the record made in the litigation.” 570 F.3d at 843.

With a nod to *Patton* and *Casey*, the panel allowed that some ERISA *de novo* cases might still be limited to the administrative record: “Medical evidence presented to the plan or its insurer may be placed in the judicial record, and when this evidence is ample it may in principle constitute the whole record.” *Id.* The Court also stated that “[i]f the administrative record contains comprehensive medical evidence, then duplicative discovery may be limited to avoid ‘undue burden or expense.’” However, the Court also held that “[d]iscovery may be curtailed to the extent that the Rules of Civil Procedure allow” and “we cannot imagine any justification for refusing to admit evidence that one party has procured at its own expense.” *Id.*

Ultimately, the Seventh Circuit remanded the matter for trial. The Court characterized the dispute as whether Krolnik could work even with his physical and mental problems. The Court instructed the district court to make an “independent decision” in which it “must weigh *all* of the medical evidence” and that at trial, Krolnik would be free to offer medical evidence of his own and cross-examine the physicians whose reports supported Prudential’s decision.

Conclusion

Casey and *Patton* have provided clear guidance to parties and the trial courts in the Seventh Circuit and this body of law was well settled prior to *Krolnik*. Now *Krolnik* seems to undercut those decisions to some extent, leaving parties and

district courts with more questions than answers. A few that come to mind are: What happens to the administrative record? Prior to *Krolnik*, ERISA *de novo* cases started with the administrative record and the only question was what additional evidence would be admitted.

Does the statement in *Krolnik* that a district court is instructed to decide cases based on “the record made in the litigation” imply that the administrative record is not considered? That reading of *Krolnik* would not seem consistent with the Court’s later acknowledgement that in some cases a court might be able to make its decision based solely on the administrative record. The latter statement was made in deference to *Patton* and *Casey* and to say otherwise would have required an *en banc* decision which the panel in *Krolnik* was apparently trying to avoid.

Does discovery extend beyond the medical evidence in dispute? *Krolnik* sought far more than medical discovery, yet the only discovery even mentioned by the Seventh Circuit in *Krolnik* related to medical evidence. Even pre-*Krolnik* cases were allowing additional medical testimony in some *de novo* cases, but what about all of the other discovery that *Krolnik* was seeking related to the claim process and to files of other claimants? Are these now discoverable? Presumably not if a court determines that such discovery creates “undue burden or expense,” but anyone who has litigated any civil cases knows that convincing a court that discovery creates “undue burden and expense” is often difficult.

What happened to the pre-*Krolnik* “presumption” that *de novo* cases would be tried on the administrative record in which the burden was on the proponent of the additional evidence to show that it was necessary for the court’s review?

Does *Krolnik* create a new “presumption” that places the burden on the party opposing the evidence? If so, what exactly is the burden and do pre-*Krolnik* factors still apply?

If these cases go to trial, what additional evidence will be admitted? *Krolnik* submitted medical “affidavits.” Are affidavits now admissible at trial? What if the affidavits merely reiterate what is already in the administrative record? If “duplicative” discovery is prohibited, can “duplicative” evidence be barred from the trial? Moreover, what about evidence that a claimant had an opportunity to submit during the claim review process? Under *Patton*, one factor determining admissibility was “whether the parties had a chance to present their evidence in the ERISA administrative proceeding.” Does this still apply such that this kind of evidence would be inadmissible? If a claimant has an opportunity to cross-examine the reviewing doctors whose reports supported the benefit denial, does this mean that claim administrators must plan on presenting those doctors as witnesses or risk the unenviable choice of relying on deposition testimony to rebut live testimony from a treating doctor?

Finally, what about the claim review process? The underlying consideration for limiting evidence to the administrative record, not mentioned anywhere by the panel in *Krolnik*, is to prevent federal judges from becoming substitute plan administrators. The Department of Labor has dictated a comprehensive claim review process that ERISA plan administrators are bound to follow – regardless of the type of judicial review applied in a later court proceeding – and that is designed to get all of the relevant evidence before the administrative decision maker. The last thing that a federal court should do is create a situation where claimants

stonewall the claim review process and then essentially create a whole new claim review process when they get to court.

Despite the verbiage in *Krolnik*, one would hope that all of the pre-*Krolnik* factors and case law are still applicable in the Seventh Circuit. The fact remains that one circuit panel cannot overturn another panel and *Casey* and *Patton* are still binding law. Maybe one can make them all consistent if one reads *Krolnik* as merely overturning discovery and admissibility decisions that went too far, much like the situation in *Patton*. To be sure, even if consistent with prior law, *Krolnik* did nothing to make that law clearer or easier to apply in the trial courts and likely created opportunities for more issues and more disputes. In the end, there was a map in the Seventh Circuit that was drawn in *Casey* and made more detailed in *Patton*, but which the Court chose to ignore in *Krolnik*. By taking the wrong turn, as it were, *Krolnik* did nothing but work to the detriment of ERISA plan participants and administrators.

Supreme Court

Legal Conclusions In A Complaint Must Be Supported By Factual Allegations

The United States Supreme Court ruled that, in evaluating a Complaint, a court need not accept as true “threadbare recitals of a cause of action’s elements, supported by mere conclusory statements.” *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1940 (2009) (citing *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555, 127 S. Ct. 1955 (2007)). The plaintiff was a Pakistani who was incarcerated after September 11, 2001. He alleged in his Complaint that former Attorney General Ashcroft and F.B.I. Director Mueller “adopted an unconstitutional policy that subjected respondent to harsh conditions of confinement on account of his race, religion, or national origin.” *Id.* at 1942. The Complaint also alleged that “the policy of holding post-September 11th detainees in highly restrictive conditions of confinement until they were ‘cleared’ by the FBI was approved by Defendants ASHCROFT and MUELLER in discussions in the weeks after September 11, 2001.” *Id.* at 1944. The Court ruled, “[t]o survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to ‘state a claim to relief that is plausible on its face.’ [citations omitted]. A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” *Id.* at 1949.

The Court discussed at length the requirement of Fed. R. Civ. P. 8(a)(2) that a pleading contain a “short and plain

statement of the claim showing that the pleader is entitled to relief.” *Id.* The Court remanded the matter to the Second Circuit to decide in the first instance whether to remand to the district court to allow the plaintiff to amend his “deficient complaint.” *Id.* at 1953.

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First Circuit

No Coverage When Insured Failed To Report A Claim During A Period Of Coverage

In *Gargano v. Liberty Int’l Underwriters, Inc.*, 572 F.3d 45 (1st Cir. 2009), three successive one year policies provided professional liability coverage for claims against the insured attorney, with the requirement that the claims must have been both made against the attorney and reported by him to the insurer within the coverage period under the policy to be covered. The insured had purchased coverage from three separate insurers for three successive years from September 1, 2004 through September 1, 2007. During the first of those policy years, September 1, 2005 to September 1, 2006, another attorney brought an action against the insured for concealing the attorney’s role in the initial representation of the workers compensation claimant in a workers compensation proceeding. This concealment deprived the plaintiff attorney of his share in the fee awarded.

The insured did not report the claim against him during the first or the second policy years. He reported the claim during the third policy year under the policy providing coverage for the period from September 1, 2006 to September 1, 2007. The court ruled that there was no cover-

age under any of the policies as the claim was made against the insured during the first policy period but not reported during its coverage period of September 1, 2004 to September 1, 2005. *Id.* at 49. The insured did not report the claim during the coverage period under the second policy from September 1, 2005 to September 1, 2006. When he reported the claim during the third policy year of September 1, 2006 to September 2007, it was not a claim made during that period of coverage as the claim had been made in March of 2005 during the period of coverage under the first policy.

The court ruled that, “[e]ven accepting as true all of the well-pleaded facts of the complaint, Mr. Gargano and his firm have failed to state a claim of breach of contract or deceptive business practices in violation of Massachusetts law, because the claim they made for coverage did not fall within the coverage period on any of the three professional liability insurance policies. Each was a ‘claims made and reported’ policy, stating explicitly that its coverage applied only to claims first made against the insured during the policy period and reported to the company during the policy period.” *Id.*

The court went on to rule against the insured on his “failure to deliver the policy” argument. *Id.* at 49-50. The court ruled that, “neither delivery nor actual possession by the insured is essential to the making of an insurance contract unless the contract expressly sets out a requirement of delivery.” [Citations omitted.] ...Here, Gargano paid the premiums, he admits the formation of a contract, and the terms of the policies at issue do not set forth a delivery requirement.” *Id.* at 50.

Further, the court ruled that the insured could not claim “ignorance of the terms of policies that were delivered to

his insurance agent or broker. [Citations omitted.]...Under Massachusetts law, the agent's knowledge of the policy's terms is imputed to the insured in this circumstance. [Citations omitted.] Additionally, '[a]lthough an insured is entitled to rely on his broker as his agent, an insured cannot abandon all responsibility for ascertaining the terms of the coverage his broker obtained.'" [Citations omitted.]

The court did not cite the coverage provisions under the policies. However, typically, professional liability policies cover any negligent act, error or omission by the insured. The court did not discuss how the insured's concealment in the worker's compensation proceeding of the role of the first attorney and suborning the claimant to conspire in this concealment could be a negligent act, error or omission. Nevertheless, the decision is significant for both the holding on the requirement for timely reporting under a "claims made" policy and, even more so, for the ruling that the insured is bound by the terms of the policy even if it is not delivered.

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Courts Must Inquire Into Steps Taken By Administrator To Insulate Its Decision From A Conflict Of Interest In *Denmark v. Liberty Life Assurance Co.*, 566 F.3d 1 (1st Cir. 2009), the court ruled that, under *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008), structural conflicts of interest, where the same entity is the adjudicator and the payor of the claim, should be "accorded weight – albeit not necessarily dispositive weight – in the standard-of-review equation...courts are duty-bound to inquire into what steps a plan administrator has taken to insulate

the decision making process against the potentially pernicious effects of structural conflicts." *Id.* at 9 (citing *Glenn*, 128 S. Ct. 2349-50). The court went on to rule that, under *Glenn*, where a "conflict has in fact infected a benefit denial decision, such a circumstance may justify a conclusion that the denial was itself arbitrary and capricious (and thus an abuse of discretion)." *Id.* at 9 (citing *Glenn*, 128 S. Ct. 2351).

The trial court had permitted the plaintiff to conduct limited discovery on the insurer's relationship with the provider of an IME in a fibromyalgia disability claim and "its correspondent physicians as part of an effort to show that [the insurer's] actions were influenced by a conflict of interest." *Id.* at 4-5. The insurer had acknowledged in discovery "that it had paid upwards of \$2,000,000 to [the provider's] physicians between 2001 and 2003, and identified 1,204 files that it had referred to [the provider] during that interval. But [the insurer] refused, on burdensomeness grounds, to answer interrogatories regarding the proportion of those files in which claims ultimately had been allowed." *Id.* at 5. As a sanction, the trial court "drew an inference that [the provider] had found against the claimants in all cases..." *Id.* However, the trial court also found "the denial of LTD benefits [was] supported by substantial evidence and, thus, within the plan administrator's discretion." *Id.* The trial court explained that it found "no significantly probative evidence that the conflict [posed by the insurer's role of making benefit determinations and paying claims] had in fact influenced [the insurer's] decision making." *Id.*

As the United States Supreme Court had decided *Glenn* after the trial court had ruled in this action, the Court remanded the case to permit the trial

court to reconsider its decision in light of *Glenn*. The Court ruled that "[r]emand will allow full consideration of how heavily this conflict should weigh in the balance. That is highly desirable because, in performing a multi-factor analysis, 'any one factor will act as a tiebreaker when the other factors are closely balanced.'" *Id.* at 9 (citing *Glenn*, 128 S. Ct. 2351).

The court went on to give guidance on the scope of discovery, citing its decision in *Liston* which had noted that "some very good reason is needed to overcome the strong presumption that the record on review is limited to the record before the administrator." *Id.* at 10 (citing *Liston v. Unum Corp. Officer Severance Plan*, 330 F.3d 19, 23 (1st Cir. 2003)). The court found that *Glenn* contemplates "some discovery on the issue of whether a structural conflict has morphed into an actual conflict...But any such discovery must be allowed sparingly and, if allowed at all, must be narrowly tailored so as to leave the substantive record essentially undisturbed." *Id.* at 10 (citing *Glenn*, 128 S. Ct. 2351). The court ruled further that, in the future, "[c]onflict-oriented discovery will be needed only to the extent that there are gaps in the administrative record. If, say, the plan administrator has failed to detail its procedures, discovery may be appropriate, in the district court's discretion." *Id.* at 11.

The Court scrupulously avoided discussing the insurer's refusal to answer interrogatories about the outcome of the claims involving examinations performed by the subject physicians. It also avoided discussing the resulting sanction the trial court had applied except to note that the trial court was "free to abrogate or modify the discovery sanction previously imposed if it sees fit to do so." *Id.* at 10. The court, however, allowed the trial court discretion in affording the parties

“a limited opportunity to flesh out the record (even if that entails further, appropriately circumscribed, discovery).” *Id.* The court seems to be suggesting that there may be further limited inquiry into the IME practices of the insurer.

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Third Circuit

Third Circuit Takes A Less Restrictive View Of Pre-Existing Condition Limitations

The President has commented that “pre-existing condition” limitations in insurance policies are unfair, at least in the context of health care plans. Some decisions from the Third Circuit also show that court’s dislike for these provisions. However, a recent decision from the Third Circuit has taken a broader view of pre-existing conditions exclusions and upheld the denial of benefits.

In *Doroshow v. Hartford Life & Accident Ins. Co.*, 574 F.3d 230 (3d Cir. 2009), the defendant denied the claim for long term disability benefits based on the policy’s exclusion for pre-existing conditions. The language excluded benefits for disabilities “caused by, contributed to, or resulting from...a preexisting condition.” *Id.* at 231. A pre-existing condition was defined in the policy as “one ‘for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to [the participant’s] effective date of insurance.’” *Id.*

Mr. Doroshow had a family history of Amyotrophic Lateral Sclerosis (ALS). A few years before he enrolled in the disability plan, he saw a doctor for motor neuron symptoms which could be

related to ALS. During the “look back” or treatment free period before his coverage became effective, the claimant saw a specialist who concluded that his symptoms were “not felt to be ALS.” [emphasis added] *Id.* at 235. Approximately one year later, however, the insured was definitively diagnosed with ALS. Because the claimant received “advice” regarding ALS during the treatment free period, the claim for benefits was denied. The district court upheld the denial of benefits, and the plaintiff appealed to the Third Circuit.

Looking to the language of the policy, the Court of Appeals considered whether the plaintiff received “advice.” This term was not defined in the policy, so the court looked to its ordinary dictionary meaning and thus defined “advice” to mean “an opinion or recommendation offered as a guide to action.” *Id.* at 234.

Citing to earlier Third Circuit decisions, the plaintiff argued that he did not receive “advice” since the doctor concluded during that earlier visit that he did *not* have ALS. The earlier decisions were *McLeod v. Hartford Life & Accident Ins. Co.*, 372 F.3d 618 (3d Cir. 2004) and *Lawson ex rel. Lawson v. Fortis Ins. Co.*, 301 F.3d 159 (3d Cir. 2002).

In *Lawson*, the insured complained to her doctor about upper respiratory symptoms that were diagnosed as an upper respiratory tract infection. When her symptoms continued, her doctors performed additional testing and discovered that she had leukemia, and that her earlier symptoms stemmed from that condition. The Third Circuit ruled against the insurer, agreeing with the district court that “in order to be treated for leukemia, there must have been some awareness that the disease existed at the time treatment or advice was rendered.” *Doroshow*, 574 F.3d at 237 (citing *Lawson*, 301 F.3d

at 162).

In *MacLeod*, the court went even further. There, the insured saw a doctor during the treatment free period for numbness in his arm. He had a history of bulging discs in his spine. Several months later, after the insurance went into effect, the insured’s symptoms were related to the new diagnosis of MS. The plan included an even broader exclusion than the one in *Lawson*, defining a pre-existing condition as “any accidental bodily injury, sickness...or *any manifestations, symptoms, findings, or aggravations* related to or resulting from such accidental bodily injury, sickness, mental illness...*for which you received Medical Care during [the look-back period].*” *McLeod*, 372 F.3d at 621. Clearly, the insured received care for a symptom that was a manifestation of MS even though it had not yet been diagnosed. Nevertheless, the court held that the exclusion did not bar coverage. According to the court, there cannot be treatment “for” a condition if it is not suspected or diagnosed. Thus, the court held that a pre-existing condition exclusion does not apply where there is “a misdiagnosis or an unsuspected condition manifesting non-specific symptoms” rather than a “suspected condition without a confirmatory diagnosis.” *Doroshow*, 574 F.3d at 235-236 (citing *Lawson*, 301 F.3d at 166).

Returning to *Doroshow*, the Third Circuit distinguished the earlier decisions in *Lawson* and *MacLeod* and concluded that the exclusion applied to bar the claim. While stating that “generally...ruling out a condition [does not] constitute[] advice or treatment for that condition,” Mr. Doroshow’s medical history made that conclusion “compelling.” *Doroshow*, 574 F.3d at 235. The claimant had a family history of ALS. A few years earlier, ALS was considered as a possible diag-

nosis. ALS is the most common motor neuron disease. Therefore, even though his doctor “ruled out” ALS during the treatment-free period, an opinion which turned out to be wrong, he still received “advice” for that condition. Accordingly, the claim was barred by the pre-existing conditions exclusion.

The dissenting opinion in *Doroshov* accused the majority of “casting aside” precedent. This dissent fails to recognize that each claim is factually different, and they do not often fit into easily defined categories. When applying a pre-existing condition limitation, it is important to look at the claimant’s entire medical history, including treatment received prior to the treatment-free period. If those records disclose that the condition on which the disability claim is based was at least suspected, and the claimant consulted with a doctor for related symptoms during the treatment-free period, the exclusion will most likely apply.

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Fifth Circuit

Definition Of “Common Carrier” For Accidental Death Coverage

In *Nat’l Union Fire Ins. Co. of Pittsburgh, PA. v. McMurray*, No. 08-11039, 2009 WL 2710076 (5th Cir. Aug. 27, 2009), Mr. & Mrs. Joe McMurray were married and went on a honeymoon cruise with Oceania Cruises. Mr. McMurray purchased the cruise using his Platinum Select Citibank MasterCard which included a \$1,000,000 accidental death benefit. Among the covered hazards was death occurring while the insured was “riding as a passenger in or on...

any Common Carrier.” *Id.* at *1. The policy defined “common carrier” as “any licensed land, water or air conveyance operated by those whose occupation or business is the transportation of persons for hire.” *Id.* During the cruise, the McMurrays purchased a separate white-water rafting excursion operated by Rios Tropicales in Costa Rica. The cost was charged to Mr. McMurray’s cruise account and added to his MasterCard bill. During the rafting trip, Mr. McMurray was thrown from the raft and drowned. Mrs. McMurray’s claim was denied on the ground that Rios Tropicales was not a “common carrier.” National Union filed this Declaratory Judgment action, and the district court granted summary judgment to the insurer. The Fifth Circuit affirmed. The court determined that the provided transportation was merely incidental to Rios Tropicales’ primary purpose of entertainment, so it was not a common carrier. It rejected Mrs. McMurray’s argument that a rafting trip necessarily involves transportation from one place to another. The policy did not define what it means to be in the “occupation or business” of “transportation” for hire. So the courts looked to Texas common law. Undefined terms are not per se ambiguous and will be given their plain, ordinary meaning, if it can be determined with some clarity. Nor did the policy use the phrase “primary purpose.” However, the plain and ordinary meaning of “occupation or business” encompasses a primary purpose requirement. “An entity’s occupation or business is transportation for hire only if transportation is the primary function of the entity in question. Transportation is incidental to the primary purpose of entertaining rafting participants. Accordingly, Rios Tropicales is not a common carrier under the policy.” *Id.* at *3.

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Drug Exclusion Enforceable Even Where Evidence Is Circumstantial
In *Dutka v. AIG Life Ins. Co.*, 573 F.3d 210 (5th Cir. 2009), the insured, an employee of Continental Airlines, was flying a private plane with two passengers on a reconnaissance flight of deer hunting sites. He needed to fly at a low altitude and, during the flight, failed to maintain an adequate air speed. His plane stalled and crashed, killing everyone. His beneficiaries sought Accidental Death Benefits under his employer’s ERISA plan. Toxicology tests of the insured found alcohol, cocaine and the narcotic Propoxyphene in the insured’s system at the time of his death. AIG denied benefits, based on an exclusion for losses “caused in whole or in part by, or resulting in whole or in part from...the Insured Person being under the influence of drugs or intoxicants.” *Id.* at 212. Applying an abuse of discretion standard, the district and appellate courts affirmed the insurer’s decision. The court acknowledged that the evidence supporting the denial had its shortcomings; however, it concluded the decision was not arbitrary and capricious. Specifically, the court said that although the blood tests were conducted over 50 days after the accident and the insurer’s medical expert’s opinion regarding drug influence was not unequivocal, the toxicology report did disclose the presence of these drugs at the time of the insured’s death. Thus, the doctor’s opinion that the insured was under the influence of drugs and alcohol, although circumstantial, was sufficient. There was no direct proof that the drugs actually caused the crash, which there

rarely is. Here, however, the investigation determined that on the day of the crash there were good visual meteorological conditions and no evidence of airplane mechanical difficulties. Additionally, failing to maintain proper airspeed at a low altitude is recognized to be a fundamental piloting error. All these facts made it reasonable to conclude that the accident resulted, at least in part, from the pilot being under the influence of drugs.

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Sixth Circuit

Illegal Act Exclusion Requires Causal Relationship Between Conduct And Loss

In *Shelby County Health Care Corp. v. Majestic Star Casino, LLC*, Nos. 08-6078 and 08-6419, 2009 WL 2997985 (6th Cir. Sept. 22, 2009), the insured, covered under an ERISA employer-sponsored medical plan, was involved in a single vehicle accident resulting in approximately \$400,000 in medical bills. The insured assigned his claim for benefits to the plaintiff. The claim was denied under an exclusion for any losses “resulting from... [c]harges for or in connection with an injury... arising out of the participation in... or being engaged in... the commission or attempted commission of an illegal or criminal act.” *Id.* at *2. Here, the police report stated that the insured was driving under the influence of alcohol (a blood test was taken but no results were available at the time of the claim denial), and operating the vehicle without a valid license or proof of insurance. The Plan relied on the last two offenses (acknowledging that it did not have sufficient

information to determine whether the insured actually was legally intoxicated) to argue the insured engaged in “illegal acts” which fell within the exclusionary language. The district court judge disagreed and entered judgment for the plaintiff. The Sixth Circuit affirmed. Applying a *de novo* standard of review (the administrator’s decision is accorded no deference or presumption of correctness), the court found the term “illegal,” which the Plan did not define, to be ambiguous as to what level of wrongdoing was required to constitute an “illegal act” for application of this exclusion. The Plan argued that these acts were illegal because they were prohibited by Mississippi law, even if such conduct was not criminal. Thus, “illegal” is a much broader term than “criminal.” Yet, the court noted, even assuming that such conduct constituted “illegal acts,” they did not “cause” the accident and resulting injuries. The fact that the insured engaged in an illegal act was insufficient to establish a causal connection, as required by the exclusionary language.

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Sixth Circuit Upholds Contractual Accrual Date

In *Rice v. Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450 (6th Cir. 2009), the Sixth Circuit held that the plaintiff’s claim was barred by a three-year period of limitations contained in an ERISA-regulated disability policy. The Sixth Circuit held that the plaintiff’s cause of action accrued on the date that proof of claim was required to be given to the insurer, not the date that the insurer denied the claim. In so doing, the Sixth Circuit enforced contractual language stating that “[n]o legal

action may be brought more than three years after proof of claim is required to be given.” *Id.* at 453. Thus, the Sixth Circuit not only enforced a contractual period of limitations but also enforced a contractual provision stating when the cause of action accrued.

In *Rice*, the plaintiff claimed that he became disabled on May 22, 2002. The insurer denied the plaintiff’s claim on December 23, 2002, and upheld this denial on February 3, 2003. The plaintiff filed a second appeal, which was denied on September 24, 2003.

The plaintiff then filed suit against the insurer. This initial litigation was resolved by a stipulation to dismiss the litigation without prejudice and remand the claim to the insurer for re-adjudication. After reconsideration, the insurer again denied the plaintiff’s claim on April 20, 2005. The plaintiff then filed a second complaint on September 8, 2007.

In attempting to avoid the three-year period of limitations in the policy, the plaintiff argued in the district court that the cause of action did not accrue until April 20, 2005, when the insurer denied the claim for the second time. The Sixth Circuit held that the plaintiff had waived this argument by not presenting it to the district court. The Sixth Circuit went on to hold, however, that the litigation was untimely. The court noted that the policy stated that “no legal action may be brought more than three years after proof of claim is required to be given.” The policy required that proof of claim be given within 270 days from the alleged onset of the disability. Thus, because the plaintiff alleged that he became disabled on May 22, 2002, the cause of action accrued on February 16, 2003, and the period of limitations expired on February 16, 2006. The Sixth Circuit held that the parties were free to contract for the

date on which an ERISA claim accrues.

The Sixth Circuit also rejected the plaintiff's argument that the period of limitations was tolled during the time the first litigation was pending. The court held that a dismissal with prejudice does not toll the period of limitations.

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Ninth Circuit

Modicum Of Evidence Not Enough To Support Conflicted Administrator's Decision

In *Montour v. Hartford Life & Accident Insurance Co.*, No. 08-55803, 2009 WL 2914516 (9th Cir. Sept. 14, 2009), the Ninth Circuit attempted to clarify how a reviewing court should approach the standard of review in cases that involve a structural conflict. When doing so, the court first noted that "[t]he weight the court assigns to the conflict factor" still "depends on the facts and circumstances of each particular case." *Id.* at *5. However, it also clarified that "a modicum of evidence in the record supporting the administrator's decision will not alone suffice" when there is a structural conflict. *Id.* at *1. Instead, the court explained that:

the extent to which a conflict of interest appears to have motivated an administrator's decision is one among potentially many relevant factors that must be considered. Other factors that frequently arise in the ERISA context include the quality and quantity of the medical evidence, whether the plan administrator subjected the claimant to an in-person medical evaluation or relied instead on a paper review of the claimant's existing medical records,

whether the administrator provided its independent experts 'with all of the relevant evidence[.]' and whether the administrator considered a contrary SSA disability determination, if any. *Id.* at *5. Consequently, a district court's failure to address – and "appropriately balance" – the pertinent factors allowed the Ninth Circuit to do so.

When presented with that opportunity, the Ninth Circuit found that the administrative record it revealed "a common theme...of presenting evidence of capability in the best possible light, while failing to subject evidence of capability to the same skepticism and rigorous analysis applied to evidence of disability." *Id.* at *8. It also noted the absence of any extrinsic evidence of an effort to "assure accurate claims assessment," as well as the administrator's decision to "hire doctors to review [the plaintiff's] files rather than to conduct an in-person medical evaluation." *Id.* at *9. In addition, the court seems to have been troubled by the administrator's "failure to grapple with the SSA's contrary disability determination," stating that a "complete disregard for a contrary conclusion without so much as an explanation raises questions about whether an adverse benefits determination was 'the product of a principled and deliberative reasoning process.'" *Id.* at *10. Accordingly, the Ninth Circuit concluded that the administrator's "conflict of interest improperly motivated its decision" and, in turn, held that the administrator had abused its discretion. *Id.* at *12.

The lesson to be learned from this case therefore seems to involve the manner in which the administrator deals with any evidence that contradicts its benefit determination. If that evidence is ignored and/or discredited without explanation, there is a genuine risk that a court may find the claim decision to have been improperly

motivated by a conflict of interest. However, if competing evidence is acknowledged and fairly explained, it should be harder for a court to substitute its judgment for that of the administrator.

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Tenth Circuit

Denial Of Health Coverage Was Arbitrary And Capricious When Denial Was A Pretext For Avoiding Large Claim

In *Phelan v. Wyoming Associated Builders*, 574 F.3d 1250 (10th Cir. 2009), the Tenth Circuit reviewed a breach of fiduciary duty claim brought against a trade association. The plaintiff's former employer was a member of the defendant trade organization, which maintained a trust to provide health insurance benefits to the employees of its members. The plaintiff was diagnosed with bone cancer, and was about to submit a large claim to the trust relating to his cancer treatment. The trade organization terminated the membership of the plaintiff's employer in the trust, claiming that the employer had submitted a payment that was both late and in the wrong form. The plaintiff's benefits claim was then denied, and he brought claims against the trade organization and his employer, including a claim for breach of fiduciary duty under ERISA, 29 U.S.C. §1132(a)(3).

The district court found that the trade organization's stated reasons for terminating the employer's membership in the trust were a pretext for avoiding payment on the plaintiff's claim, and that the termination was arbitrary and capricious. The court ordered retroactive reinstatement of the employer's health care cover-

age, effectively restoring the plaintiff's health benefits at the time of his claim.

On appeal, the trade organization first argued that because reinstatement had the retroactive effect of requiring the trade organization to cover the plaintiff's claim, it was in reality a legal remedy rather than an equitable remedy, and was therefore not authorized under ERISA. The Tenth Circuit disagreed, finding that the relief ordered would have the prospective effect of allowing the employer to maintain its health care coverage into the future, and noting that at the time the plaintiff filed the lawsuit the relief requested was entirely prospective. The Tenth Circuit further observed that the relief ordered was not specific to the plaintiff's injuries, but instead reinstated coverage for all of the employer's employees, so long as the employer continued to pay the required premiums. In addition, payment of the plaintiff's specific claims depended upon a number of contingencies, including his own timely submission of the claims. The fact that the plaintiff was a victim of the unlawful activity, and therefore a beneficiary of the remedy, did not make the relief legal rather than equitable.

The trade organization also argued on appeal that the termination decision was based on the failure to properly pay premiums and was therefore not arbitrary or capricious. The Tenth Circuit found that, while the trade organization's interpretation of the plan requirement for receipt of premiums to mean posting with the bank was within the realm of reasonableness, the decision was not reasonable under the circumstances. Specifically, the payment was mailed to the bank the day before it was due and arrived on the due date, but was not posted to the bank account on the date of receipt because the bank closed early due to a snowstorm. In light

of the district court's determination that, as a factual matter, the plan interpretation was a pretext to avoid the plaintiff's claim, the Tenth Circuit agreed that the decision lacked good faith. The Tenth Circuit found that "[e]xploiting ambiguous rules for the purpose of denying coverage is arbitrary and capricious." *Id.* at 1259.

The Tenth Circuit similarly rejected the trade organization's argument that the premium payment was properly rejected because it was made in the form of a personal check rather than a cashier's check. The court emphasized that this requirement was not found in the policy language, but was instead an unwritten internal rule of the third party administrator, and the record was unclear as to whether the employer had been informed of this requirement. The Tenth Circuit again emphasized the district court's finding that the true reason for the termination was to avoid paying the plaintiff's claim, and concluded that reinstatement of coverage was an appropriate equitable remedy for the arbitrary and capricious decision to terminate coverage.

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Pre-Existing Illness Contributing To Death Bars Recovery Of Accidental Death Benefits

In *Brown v. Life Ins. Co. of N. Am.*, No. 07-CV-1039, 2009 WL 2325142 (W.D. Ark. July 28, 2009), the insured, covered by an employer-sponsored Accidental Death Policy, collapsed and died at work while mowing the lawn. Medical records established he was obese and suffered from Type II diabetes, hypertension,

hyperlipidemia and was taking a variety of medications. Although he had no previous history of a heart condition, medical tests did show that in 2003 he had mild heart enlargement and depressed pulmonary flow rates suggesting possible early stage mild obstructive deficiency. His wife told the ER doctors that the day before his death her husband had been complaining of arm pain all day but had not sought medical treatment. The ER doctor indicated on the death certificate (no autopsy was performed) that death was due to natural causes and the immediate cause of death was his diabetes with hypertension as a significant contributing condition. The policy provided benefits if death was "caused by an accident..., which, directly and from no other causes, result in a covered loss." *Id.* at *3. Benefits were excluded for loss caused by "sickness, disease, or bodily infirmity..." *Id.* at *1. Based on this information, the claim was denied. The widow retained a doctor who opined that death was due to an accident, although he agreed that the insured's underlying health problems far more predisposed him to having a heart attack. The Workers' Compensation Board also found the death to be a work-related accident, so the insurer re-opened the file and asked an independent cardiovascular doctor to review the reports. The doctor found that the death was due to a heart attack brought about by the insured's health problems and not by an accident. The insurer upheld its denial, and this lawsuit followed.

The district court, applying a *de novo* standard, upheld the denial. The judge acknowledged a split of opinion on the issue of how to interpret "injuries caused by an accident..., which, directly and from no other causes, result in a covered loss." *Id.* at *3. The narrow approach (6th and 10th Circuits) holds that the loss must

result directly from an accidental bodily injury, independently of all other causes. The “middle ground” approach (4th, 9th and 11th Circuits) holds that recovery is barred only if the pre-existing conditions substantially contributed to the loss. The Eighth Circuit has not ruled on this issue. However, under either rule, this claim is barred. The insured’s underlying medical problems, at a minimum, substantially contributed to the fatal heart attack.

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District of Columbia

ERISA Participant May Not Maintain Action Under ERISA § 1132(a)(3)

In *Wright v. Metropolitan Life Ins. Co.*, 618 F. Supp. 2d 43 (D.D.C. 2009), the plaintiff, Peter Wright, brought an ERISA action against Metropolitan Life Insurance Company (“MetLife”). The plaintiff alleged, *inter alia*, that MetLife wrongfully denied him benefit coverage under § 1132(a)(1)(B) of ERISA when it terminated his long-term disability (“LTD”) benefits following receipt of those benefits for approximately 30 months. Wright further contended that MetLife did not properly provide him with requested documents relevant to his ERISA claim, which he argued was in violation of 29 C.F.R. § 2560.502-1(g). Wright was diagnosed with rheumatoid arthritis and was approved for LTD benefits on or about August 23, 2002. MetLife determined that Wright was no longer entitled to receive further LTD benefits as of January 10, 2005.

Prior to MetLife’s denial of his claim,

Wright requested several documents from MetLife related to his claim. In response to the request, MetLife provided a copy of the Plan. However, Wright submitted subsequent document requests to MetLife seeking, for example, “its ‘claim handling practices, policies and procedures,’ its ‘agreements with third parties performing any outside reviews,’...‘service agreements’ between [Wright’s employer] and MetLife, all e-mails and related information in MetLife’s computer system or in hard copy form pertaining to [Wright’s] claim, and all surveillance materials compiled by MetLife.” *Id.* at 49. MetLife produced the additional documentation, including Wright’s updated claim file and all medical documentation and correspondence on file related to his claim. MetLife then advised Wright that it had provided all the information relevant to his claim under its ERISA-imposed obligations.

After exhausting his administrative remedies, Wright brought an action seeking judicial review of MetLife’s termination of his LTD benefits, arguing that MetLife violated its fiduciary duty to him under § 1123(a)(3) of ERISA, as well as wrongfully denying him benefits under § 1123(a)(1)(B). Wright also maintained that MetLife’s failure to provide him with a copy of its internal “claims manual provisions or handling instructions under which [his] claim was reviewed” violated 29 C.F.R. § 2560.503-1(g). *Id.* at 51.

The United States District Court for the District of Columbia, applying a deferential standard of review, held that Wright could not maintain both a claim for breach of fiduciary duty under § 1132(a)(3) and a claim for denial of benefits under § 1123(a)(1)(B) because awarding him relief under § 1132(a)(1)(B) would fully redress his alleged injury. *Id.* at 56.

The court further rejected Wright’s allegation that MetLife did not produce Plan-related documents upon his request and that Wright was not entitled to an award of statutory penalties. The administrative record indicated that MetLife responded to Wright’s numerous requests by providing a number of documents contained in his claim file. Moreover, MetLife advised Wright that it was not the plan administrator and that he would need to submit his request for all additional Plan-related documents to the plan administrator. There was no indication in the record, and Wright never alleged, that his employer failed to produce any documents that he requested. Thus, the court found Wright’s allegations of non-production unpersuasive as MetLife was not the plan administrator according to the express provisions of the Plan.

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ERISA Claims Brought By Retirement Plan Participant Dismissed

In *Clark v. Feder Semo & Bard, P.C.*, No. 07-470, 2009 WL 2053605 (D.D.C. July 16, 2009), the plaintiff, Denise M. Clark, brought an action against her employer, Feder Semo & Bard, P.C. (“FSB”), its retirement plan and the plan’s trustees, asserting ERISA violations that allegedly led to the underfunding of the plan and present value of her retirement benefits. After the defendants filed a counterclaim against Clark for contribution and indemnity under ERISA and federal common law, she filed a third-party complaint against Much Shelist Denenberg Ament & Rubenstein, P.C. (“MSDAR”), a law firm hired by FSB to provide legal services related to the retirement plan, and Pension Advisory Fund, Ltd.

(“PAF”), an actuarial consulting firm hired by FSB to provide actuarial services related to the retirement plan. MSDAR and PAF moved to dismiss Clark’s third-party claims.

The plaintiff alleged that the defendants violated ERISA by reducing or eliminating her accrued benefits under the retirement plan, failing to disclose the retirement plan’s lack of insurance, and breaching their fiduciary duties. Although Clark later conceded that PAF was not a fiduciary under ERISA, she contended that MSDAR knowingly participated in fiduciary breaches such that it functioned as a co-fiduciary with respect to the retirement plan. Clark argued that MSDAR’s role in providing legal services to the retirement plan went beyond the normal advisory role of a law firm and that it exercised sufficient discretion with respect to the plan to become an ERISA fiduciary.

The court, citing 29 C.F.R. § 2509.75-5, stated that “[a]ttorneys and actuaries ‘performing their usual professional functions’ will typically not be considered fiduciaries under ERISA. According to the Department of Labor, an attorney or other consultant to a retirement plan is a fiduciary only if he or she ‘(a) exercises discretionary authority or discretionary control respecting the management of the plan, (b) exercises authority or control respecting management or disposition of the plan’s assets, (c) renders investment advice for a fee, direct or indirect, with respect to the assets of the plan, or has any authority or responsibility to do so, or (d) has any discretionary authority or discretionary responsibility in the administration of the plan[.]’” *Id.* at *4 (citing 29 C.F.R. § 2509.75-5).

The court found that Clark’s allegations that FSB simply “followed” MSDAR’s advice did not establish that

MSDAR’s actions with respect to the plan rose to the level of discretionary authority. Clark’s other factual allegations similarly failed to establish that MSDAR’s actions fell outside the scope of normal legal services. Because the court determined that neither MSDAR nor PAF were fiduciaries of the retirement plan under ERISA, any claim for recovery against them under ERISA had to be made on a nonfiduciary basis.

Under ERISA, nonfiduciaries are subject only to “appropriate equitable relief,” not money damages. The court held that, “Clark’s boilerplate request for ‘other legal and equitable relief’ [did] not convert what was plainly a legal action for damages into one for equitable relief.” *Id.* at *5. The court concluded that Clark was unable to proceed against MSDAR and PAF as nonfiduciaries. Accordingly, the court dismissed the ERISA claims brought by Clark against MSDAR and PAF.

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Court Upholds Denial Of Health Coverage For Failure to Exhaust

In *Cox v. Graphic Com’s Conference of the Int’l Brotherhood of Teamsters, et al.*, 603 F. Supp. 2d 23 (D.D.C. 2009), Madeline Cox filed suit against her employer, George Tedeschi, president of her employer, Graphic Communications Conference of the International Brotherhood of Teamsters (“Graphic Communications”), and Graphic Communications National Health and Welfare Fund (“Fund”) in the United States District Court for the District of Columbia pursuant to ERISA. Ms. Cox alleged that the denial of her health care benefits following her retirement from Graphic Communications was discriminatory based

upon her retirement prior to age 60. The defendants filed a Motion to Dismiss, or in the alternative, a Motion for Summary Judgment.

Ms. Cox alleged that she worked for Graphic Communications for thirty-two years as an Executive Secretary. On March 6, 2006, she informed Mr. Tedeschi that she intended to retire as of March 31, 2006 and that she expected her employer to continue paying for her health insurance. Mr. Tedeschi explained that the employer would not continue to pay for her health insurance because she was retiring at age 55, and the company’s policy was not to continue to pay for health insurance for employees who left employment prior to age 60. Ms. Cox retired and, consistent with Mr. Tedeschi’s representations, the employer sent her a letter indicating that her health insurance coverage would terminate on April 1, 2006. Several days later, Ms. Cox was sent a “Termination of Health Insurance Coverage” notice. Ms. Cox did not appeal this notice. A year later, Ms. Cox’s attorney filed a Notice of Claim of Plan Benefits asking that her health insurance be reinstated. Her request was refused and, in May 2008, she filed suit.

The United States District Court for the District of Columbia dismissed Ms. Cox’s allegations that she was wrongfully denied employer-paid health insurance coverage at the time of her retirement because she failed to exhaust her administrative remedies related to these claims. The court reasoned that exhaustion of administrative remedies under ERISA must occur before bringing suit. In this case, Ms. Cox never appealed the termination of her coverage. The plaintiff argued that an appeal would have been “clearly useless” and that a decision in her favor was “unlikely.” *Id.* at 31. The court rejected this argument, stating that the exhaus-

tion requirement may only be waived in the most exceptional circumstances and that the “plaintiff must show that ‘it is certain that their claim will be denied...’” *Id.* at 31 (citing *Smith v. Blue Cross & Blue Shield United of WI*, 959 F.2d 655, 659 (7th Cir. 1992)).

Ms. Cox also argued that Mr. Tedeschi discriminatorily denied her health benefits in violation of Section 510 of ERISA. The court agreed with the defendants’ argument that the District of Columbia Human Rights Act (“DCHRA”) applied to these claims. The court reasoned that, “[w]hile the Court of Appeals for the D.C. Circuit has not directly addressed which statute of limitations period should apply to claims under Section 510, this Court has previously applied the one-year limitations period...” in *Watts*. *Id.* at 33 (citing *Watts v. Parking Mgmt.*, 2006 WL 627153, *3-6 (D.D.C. Mar. 12, 2006), *aff’d*, 210 Fed. App’x (2006)). Therefore, because Ms. Cox filed her suit well beyond the one-year limitations period, these claims were time barred, and defendants’ Motion for Summary Judgment was granted.

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Court Awards Prejudgment Interest In ERISA Case Based on Prime Rate
In *Finks v. Life Ins. Co. of N. Am.*, No. 08-1272, 2009 WL 1473939 (D.D.C. May 27, 2009), Cynthia Finks filed suit against the Life Insurance Company of North America (“LINA”) seeking long term disability benefits under ERISA. Ms. Finks alleged that, on or about September 7, 2006, she became disabled as a result of chronic Lyme Disease. As a result, she alleged that she was entitled to monthly disability benefits as well as

prejudgment interest. After suit was initiated by Ms. Finks, LINA approved her claim for disability benefits and paid her \$121,217.52, which represented LINA’s calculation of disability benefits and interest. However, Ms. Finks asserted that she was entitled to additional monies in prejudgment interest. LINA argued that it properly calculated the amount of interest due to Ms. Finks based upon the prime rate that was in effect for the entire period that the benefits would have been paid, without compounding the interest. Ms. Finks argued that the proper rate would be varying prime rates that were in effect during each of the months she was owed a disability payment.

The United States District Court for the District of Columbia found that the decision to award prejudgment interest fell within the sound discretion of the court. *Id.* at *1 (see *Forman v. Korean Air Lines Co. Ltd.*, 84 F.3d 446, 450 (D.C. Cir.1996); *McKesson Corp. v. The Islamic Republic of Iran*, 116 F. Supp. 2d 13, 40 (D.D.C.2000)). “Because no exceptional or unusual circumstances exist that would make an interest award inequitable..., an award of prejudgment interest [was] appropriate.” *Id.* at *1 (see *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 13 (D.C. Cir. 2006) (holding that prejudgment interest on unpaid ERISA benefits is presumptively appropriate)). The court further found that the decision as to whether to compute prejudgment interest is also within the court’s discretion. *Id.* at *1 (see *Forman*, 84 F.3d at 450). “In calculating a prejudgment [interest] award..., the Court has three primary objectives: 1) preventing the unjust enrichment of the defendant; 2) ensuring that the plaintiff is made whole; and 3) promoting settlement while deterring any unfair benefit from litigation delay.” *Id.* at *1 (see *Moore*, 461 F.3d at 13).

The court went on to state that “the most appropriate prejudgment interest rate is the prime rate, i.e., the rate that banks charge for short-term unsecured loans to credit-worthy customers.” *Id.* at *2 (citing *Forman*, 84 F.3d at 450). The court also concluded that application of the varying prime rates that were in effect at the time Ms. Finks would have received her monthly disability benefits would satisfy the objective of making the plaintiff whole. However, the court found that, in keeping with D.C. case law, compounding the interest was not appropriate.

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Court Awards Market Rate Attorneys’ Fees Even Though Actual Fees Paid Were Discounted For Reasons of “Public Spirit”

In *Flynn v. Dick Corp.*, 624 F. Supp. 2d 125 (D.D.C. 2009), members of a union fund applied for attorneys’ fees after obtaining summary judgment under the mandatory attorney fees provision of § 502(g)(2)(D) of ERISA. The defendant, Dick Corporation, opposed the plaintiffs’ application for attorneys’ fees, arguing that the hourly rate charged and the time spent claimed in the application were unreasonable. The defendant challenged the rates billed as claiming an improper enhancement for counsel’s purported “public spirited” representation of the fund.

“ERISA provides for the mandatory award of reasonable attorney’s fees in a successful action to enforce an employer’s obligation to make contributions to a multi-employer plan: ‘the court shall award the plan... (D) reasonable attorney’s fees and costs of the action, to be paid by the defendant.’” *Id.* at 129-130

(citing 29 U.S.C. § 1132(g)(2)(D)). “The usual method of calculating reasonable attorney’s fees is to multiply the hours reasonably expended in the litigation by a reasonable hourly fee, producing the ‘lodestar amount’”. *Id.* at 130.

The United States District Court for the District of Columbia, citing *Board of Trustees of Hotel and Restaurant Employees Local 25 and Employers’ Health and Welfare Fund v. JPR, Inc.*, 136 F.3d 794 (D.C. Cir. 1998), found that the reasonable hourly fee under § 502(g)(2) may, in the court’s “sound discretion,” be set at market rates if the fees actually paid by the client were discounted for public spirited reasons. Under this analysis, the court is to determine whether an attorney had a public-spirited reason for representation and whether the fee charged significantly differed from the market value of the attorney’s services and whether public-spiritedness was a principal, though not necessarily the only, reason for the discount.

The *Flynn* court found that the plaintiffs sufficiently demonstrated the public spiritedness of their counsel’s discounted fees as their counsel had a long history of representing labor organizations and multi-employer funds and it had reasons for providing such organizations with representation at a discounted rate. The court also concluded that the size, scope or financial status of the fund were not factors to be considered in the public-spiritedness determination. Thus, the court used market rates in considering the plaintiffs’ application for attorney’s fees.

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Pre-Existing Illness Is Not An “Accidental Bodily Injury” Even If Worsened by Accident

In *Dove v. Prudential Ins. Co. of Am.*, No. 07-1311-EFM, 2009 WL 1379574 (D. Kan. May 18, 2009), Prudential was the insurer and administrator of an ERISA AD&D plan which provided discretionary authority. “Accidental Bodily Injury” was defined as “an injury that results solely and directly from a Covered Accident...” *Id.* at *1. “Dismemberment” included the “loss of...sight,” defined as the “total and permanent loss of sight.” *Id.* The plan excluded any “loss directly or indirectly, result[ing] from...sickness...disease of any kind, or medical or surgical treatment for any sickness, illness or disease...” *Id.* The insured suffered an accident while playing basketball resulting in, according to his doctor, a ruptured right eye globe. He filed a claim for dismemberment (loss of sight). Prudential’s investigation determined that the insured had long-standing problems with this eye, including glaucoma and cataracts, and was actually blind in the eye prior to the accident. Accordingly, the claim was denied under the exclusion for disease. Finding no conflict under *Glenn* because the insurer took appropriate steps to reduce any bias, the district court affirmed the denial. The administrative record contained documents which established permanent blindness prior to the accident and that the insured’s vision problems were not all due to the accident. Thus, the loss did not result “solely and directly from a covered accident.” *Id.* at *7. Accordingly, the determination was supported by substantial evidence.

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Loss Of Sight Must Be Irrevocable For Accidental Dismemberment Benefit

In *Scallion v. Hartford Life and Accident Ins. Co.*, No. 08-2001, 2009 WL 2366559 (W.D. La. July 31, 2009), the insured suffered a laceration to his left cornea requiring surgery. He then filed claims under two Accidental Death and Dismemberment Policies, alleging permanent and irrevocable loss of vision in that eye. Hartford received conflicting medical information from the treating doctor. One report indicated that the insured’s loss was not irreversible, while another report said the loss of vision was permanent and the insured suffered irreparable loss of all vision. The insurer sought additional medical records and instead received a response from the doctor indicating his second statement was made in error and that, in fact, the insured did have light perception which could be improved with further surgery. Accordingly, the claim was denied. The district court, finding that Hartford was vested with full discretionary authority, reviewed the decision under the arbitrary and capricious standard. The administrative record provided substantial evidence to support Hartford’s decision. The Fifth Circuit followed the vast majority of courts, which hold that a loss of sight is not irrevocable if the insured’s sight is “capable of being recovered by surgery or any other artificial means.” *Id.* at *7. Accordingly, the decision to deny benefits was affirmed.

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Employee's Claims For Failure To Disclose Retirement Benefits Were Preempted By ERISA

In *Patten v. John Hancock Life Ins. Co.*, No. AW-08-2426, 2009 WL 2514105 (D. Md. Aug. 14, 2009), the plaintiff, Ralph F. Patten, Jr., sued John Hancock Life Insurance Company over the cancellation of his retirement benefits. Patten was an employee of Hancock for 12 years until he was terminated, at which time Hancock advised him in writing that he was not entitled to receive retirement benefits if he chose to accept post-terminal commission payments. Patten objected and requested arbitration to secure his retirement benefits. The first phase of the arbitration resulted in a finding in favor of Hancock; however, the Fourth Circuit reversed the ruling. During the second phase of arbitration, Hancock disclosed that Patten was entitled to receive retirement benefits. Patten then filed a complaint against Hancock alleging fraud/misrepresentation, negligent fraud/misrepresentation and breach of the covenant of good faith and fair dealing. Hancock filed a motion to dismiss.

Hancock argued that all counts of the complaint related to an employee benefits plan under ERISA and were therefore preempted. Patten argued that his claims were not preempted by ERISA because he was not seeking benefits and that "Hancock's 'purposeful failure to disclose the pension benefits...caused Patten to incur substantial expense in arbitration.'" *Id.* at *2.

The United States District Court for the District of Maryland granted Hancock's motion to dismiss. The Court concluded that Patten's retirement benefits were considered an employee benefit plan

as defined by ERISA because they provided retirement income to an employee. The court found that Patten's claims related to his attempts to secure payment of his retirement benefits and that the case law supported the conclusion that his claims were preempted by ERISA. Therefore, the court held that Patten's complaint failed to state a claim for relief as ERISA preempted his state law claims, and he made no attempt to explain how ERISA entitled him to relief. Finally, the court noted that Patten had already recovered his retirement benefits in the prior arbitration and that he should have raised any ERISA claims in that proceeding.

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Court Abstains From Hearing ERISA Claim Based on Younger Doctrine

In *Kaplan v. CareFirst, Inc.*, 614 F. Supp. 2d 587 (D. Md. 2009), the United States District Court for the District of Maryland addressed when a federal court may abstain from hearing a federal cause of action pursuant to the *Younger* doctrine. The plaintiff, Leon Kaplan, disputed post-termination payments allegedly due following his termination from defendant, CareFirst, Inc. In federal court, Kaplan raised a federal claim under § 502(a)(1)(B) of ERISA, and related breach of contract claims under Maryland law. CareFirst moved to dismiss Kaplan's Complaint, asserting that the court should abstain from hearing the case under the *Younger* doctrine.

CareFirst hired Kaplan as its Executive Vice President of Operations in December 2000 pursuant to the terms of an employment agreement which contemplated

the award of substantial post-termination payments in the event he was fired without cause and covered some amounts payable under ERISA-governed plans. Kaplan was terminated by CareFirst on April 30, 2008. However, because CareFirst was in the midst of an administrative proceeding concerning the legality of its proposed post-termination benefits and compensation payable to its former CEO, William Jews, CareFirst delayed issuing post-termination payments to Kaplan until the Insurance Commissioner had ruled in the Jews matter.

On August 11, 2008, Jews filed a federal Complaint seeking a declaration that ERISA preempted the Final Order of the Maryland Insurance Administration ("MIA") and that the Insurance Commissioner's application of § 14-139(c) of the Insurance Article violated the United States Constitution. On January 19, 2009, the United States District Court for the District of Maryland dismissed Jews' action on the grounds that the *Younger* doctrine required the court to abstain in deference to the pending administrative appeal in state court.

In the *Kaplan* matter, the Insurance Commissioner conducted an investigation in order to analyze the terms and conditions of the compensation and severance provisions of the claimant's employment agreement and to determine whether the post-termination payment complied with § 14-139(c). The Insurance Commissioner issued an Order authorizing CareFirst's payment to Kaplan of \$2.7 million and agreed that CareFirst would violate § 14-139(c) if it were to pay Kaplan the remaining \$4 million. Kaplan subsequently submitted a request for an administrative hearing challenging the Order, and a hearing was scheduled for July 20, 2009. Kaplan thereafter filed his federal Complaint seeking recovery of

his ERISA plan benefits under § 502(a)(1)(B).

Although the procedural posture of *Kaplan* was slightly different than that of *Jews*, the court held that the *Younger* analysis was the same: (1) whether there is an ongoing state judicial proceeding; (2) whether the proceeding implicated important state interests; and (3) whether there is an adequate opportunity to raise federal claims in the state proceeding. *Kaplan*, 614 F. Supp. 2d at 592.

The court found all three factors were satisfied. Specifically, it concluded that the MIA proceedings were “ongoing” for purposes of *Younger* and that no proceedings of substance had occurred in the federal court. *Id.* at 594. It was also established that Maryland has a substantial interest in regulating the insurance industry and executing its insurance statutes through the authority of the MIA. Finally, the court recognized that the state court was fully competent to hear *Kaplan*’s ERISA benefits claim, along with his administrative appeal and state law claims.

Kaplan further contended that his federal Complaint had to be heard in a federal forum because it was distinct from the pending administrative proceeding in which he was challenging the legality of § 14-139(c). While the court acknowledged that the remedy sought by *Kaplan* pursuant to ERISA § 502(a)(1)(B) was a federal concern, the exclusively “federal” nature of his claim did not necessitate that his claim be pursued solely in a federal court. The court noted that § 502(a)(1)(B), unlike other ERISA enforcement provisions, explicitly grants concurrent jurisdiction to the state courts. Accordingly, there is an exception to the broad preemptive power of ERISA for laws that “regulate insurance.” *Id.* at 597. Thus, the court was not required to entertain *Ka-*

plan’s federal suit where there was already an ongoing proceeding at the state level, with which continuance of the federal suit would interfere.

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Death Resulting From Driving While Intoxicated Not An Accident Under ERISA

In *Sheffield v. Metropolitan Life Ins.*, No. 07-CV-14678, 2009 WL 2591491 (E.D. Mich. Aug. 24, 2009), the insured, who was covered under an employer-sponsored ERISA Life and Accidental Death plan, was driving at approximately 2 a.m. when his vehicle veered over into the opposite lane of traffic and onto the shoulder, striking a boulder and causing the vehicle to flip over. The insured died from the resulting blunt force trauma. A toxicology report determined the insured’s blood-alcohol level was .15%, almost twice Michigan’s legal limit of 0.08%. The police report indicated this was a single vehicle accident on a cloudy but dry night with no other vehicles or other factors involved. Accordingly, MetLife, as plan administrator, paid the life benefit but denied accidental death benefits. The plan provided coverage “if the accident was the sole cause of the injury; and...the injury was the sole cause of [the death].” *Id.* at 1. Additionally, the plan excluded coverage for losses that resulted from or were caused by, or contributed to by, injuring oneself on purpose. MetLife’s basis for denial was that the death did not result solely from an accident and that the death was caused or contributed to by the insured’s intentional self-inflicted injury. The beneficiary sued and the

district court, applying an arbitrary and capricious standard, affirmed the Administrator’s decision. Citing *Lennon v. Metropolitan Life Ins. Co.*, 504 F.3d 617 (6th Cir. 2007), the district judge stated that the dangers of driving while intoxicated are widely publicized, and it is common knowledge that death or serious injury can result when engaging in such conduct. These factors support a finding that the decision was not arbitrary and capricious.

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Pre-Existing Disease Bars Recovery Under Accidental Bodily Injury Policy

In *Cumbest v. Gerber Life Ins. Co.*, No. 1:07cv968WJG-JMR, 2009 WL 3011217 (S.D. Miss. Sept. 16, 2009), benefits under an employer-sponsored ERISA plan were denied on the basis that the loss was did not constitute an “accidental bodily injury which: (i) is direct and independent of any other cause;...” or “caused by or result[ing] from: ... (d) medical or surgical treatment.” *Id.* at *8. The parents of the insured argued her death resulted from an earlier automobile accident which caused a small liver laceration resulting in a slow bleed, drop in blood pressure and decrease in respiration ultimately causing her heart to stop beating. The brain did not receive sufficient oxygen, resulting in irreversible damage. Life support was removed, and the insured died. These findings were supported by an independent review conducted at the parents’ request. The autopsy report, however, found that her condi-

tions resulted from recent prescription drug intake (which would be excluded under the Plan terms) and the liver injury resulted from resuscitation efforts by the emergency medical team responding to her parents' 911 call. An independent review by the Plan Administrator also determined that death resulted from a heart attack that was unrelated to the auto accident, which caused only minor injuries. The district court, applying an abuse of discretion standard, ruled in favor of the Plan. The Plan terms, following the *Sekel* decision, contemplated that if disease was a contributing factor or the cause of death, there was no coverage. This was true even if the preexisting condition contributed to, but was not the proximate cause of death. Here, death was caused by or contributed to by a cardiac arrest. The fact that the Plan accepted its doctor's view over the claimant's doctor's opinion was justified. The task of weighing conflicting medical opinions is given to ERISA Plan Administrators and accepting its own doctor's findings, so long as they are reasonably supported by the evidence, is permissible. This report constituted "substantial evidence in support of [the Plan's] determination that [the insured's] death was...not covered under the terms of the policy." *Id.* at *12.

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Alcohol Exclusion Enforced For Unexplained Drowning When Insured Was Intoxicated

In *Sanford v. Zurich Am. Ins. Co.*, No. 1:08CV107, 2009 WL 2986343 (N.D. Miss. Sept. 15, 2009), the insured, covered under two employer ERISA Accidental Death policies, drowned in a

boating accident. There were no witnesses to the event. The investigators were able to determine only that the insured and another person were traveling aboard a pontoon boat in a lake. They were last seen "dancing and playing" on the boat. The vessel was found the next day adrift and unmanned. Both bodies were later recovered from the lake. An autopsy toxicology test determined the insured's blood-alcohol level was 0.161%. Additionally, beer and vodka were found on the boat. Police concluded that the insured had fallen overboard and drowned. The official cause of death was listed as freshwater drowning with a contributing cause of ethyl alcohol intoxication. The subsequent benefit claim was denied under an exclusion stating that "[n]o benefits will be paid for a Covered Loss contributed to, either directly or indirectly, by a Covered Person's being: 1) Intoxicated. a) A covered person will be conclusively presumed to be intoxicated if the level of alcohol in his/her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be intoxicated if operating a motor vehicle. b) An autopsy report...shall be considered proof of the Covered Person's intoxication." *Id.* at *2. Mississippi's legal limit is .08%.

The beneficiary challenged the denial, arguing that the insured could not swim, and if she fell into the water she would surely have drowned unless saved by someone else. Different theories regarding the death were proposed, such as that she might have been thrown into the lake by the boat operator's negligence, horseplay or by a large wave. The district court, acknowledging that there were a number of possible explanations, followed the Plan's highly deferential "abuse of discretion" standard and found there clearly was substantial evidence supporting the

insurer's conclusion that intoxication was a contributing factor. The insured's intoxication need not be the only or even the predominate cause of death. Accordingly, the decision was affirmed.

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Intentionally Self-Inflicted Injury Exclusion Barred Recovery For Drug Overdose

In *Schmidt v. Metropolitan Life Ins. Co.*, No. 08-0726-CV-W-FJG, 2009 WL 2982918 (W.D. Mo. Sept. 14, 2009), the insured, covered by two employer-sponsored Accidental Death plans died as the result of a drug overdose. The evidence indicated that the insured and his wife were separated but attempting to resolve their differences. One evening, they were at home and began arguing. The insured grabbed medication prescribed for his wife (Methadone, Tamae and Diazepam, all of which are "controlled substances") from his wife's purse and locked himself in the bathroom for thirty minutes.

He came out and tried to retrieve a gun unsuccessfully. He then left the house stating that he would kill himself. Later, the insured was found dead in a field with a pill bottle nearby. Subsequently, the police recovered six pill bottles from the house, all of which were empty. The autopsy determined the insured died from a "combined drug toxicity." The manner of death was ruled an "accident." The claim for accidental death benefits was denied under one plan provision stating, "[y]our loss must not in any way result from or be caused or contributed to, wholly or partially, by:...(5) intentional self-inflicted

destruction or intentionally self-inflicted injury, while sane or insane.” *Id.* at *2. The second plan provided that the death must not result from “...the insured person’s act of aggression, participation in a felonious enterprise or illegal use of drugs.” *Id.* at *3. The district court reviewed this decision under a *de novo* standard. First, the judge rejected the Death Certificate’s conclusion that the death was accidental because it did not consider the language in the ERISA-governed plans at issue. The court then looked to the four factor test to determine whether the drug overdose fell within the intentionally self-inflicted injury exclusion – “1) [w]as the ingestion intentional?; 2) [d]id the insured know the ingestion would likely cause injury?; 3) [d]id the ingestion cause [the] injury?; and 4) [d]id the loss result from the injury?” *Id.* at *6 (see *Fee v. Sheet Metal Workers Local 263*, No. C99-0124, 2000 WL 34027918, *4 (N.D. Iowa July 28, 2000), *aff’d*, 6 Fed. App’x 560 (8th Cir. 2001); *Holsinger v. New England Mutual Life Ins. Co.*, 765 F. Supp. 1279, 1282 (E.D. Mich. 1991); *McClain v. Metropolitan Life Ins. Co.*, 820 F.Supp. 169, 178 (D.N.J.1993)). The third and fourth criteria were clearly satisfied here. So too, the record reflected that the insured deliberately ingested the prescribed drugs. The insurer need not establish that the insured actually knew that taking the drugs would result in death - a general cognizance that injury could result was sufficient so long as there was some causal relation between the injury caused and the death. Taking a massive amount of the above-described drugs prescribed to someone else constitutes an intentionally self-inflicted injury. Accordingly, taking these controlled drugs was illegal, and the insurer’s denial under both plans was affirmed.

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“Control Test” Applies To Defendants Sued Under Section 1132(a)(1)(B)

In *Worsley v. Aetna Life Ins. Co., et al.*, No. 3:07cv500-RJC, 2009 WL 1794430 (W.D.N.C. June 23, 2009), Mark Worsley filed suit against Aetna Life Insurance Company, Duke Energy Carolinas, LLC, Duke Energy Corporation, Duke Energy Long-Term Disability Insurance Plan, Duke Energy Corporation Benefits Committee (“Benefits Committee”) and Duke Energy Corporation Claims Committee (collectively referred to as “Duke Energy”), alleging that Aetna had wrongfully terminated his long-term disability benefits pursuant to ERISA.

Mr. Worsley was an employee of Duke Energy for over twenty-five years when he became disabled. In April 2001, he applied for disability benefits under the Duke Energy Long-Term Disability Insurance Plan (“Plan”) which was issued by Aetna. Aetna approved his claim and began paying Mr. Worsley monthly disability payments. However, in May 2006, Aetna terminated his disability benefits, stating that he was no longer disabled. Mr. Worsley appealed the termination but Aetna upheld it. Mr. Worsley filed suit against Aetna and Duke Energy, seeking to recover his benefits and rights under the Plan. Duke Energy moved for dismissal, arguing that, while Aetna was a proper defendant in this case as it had a significant role in administering and paying long term disability benefits, Duke Energy was not a proper defendant be-

cause 29 U.S.C. § 1132(d) allows only the Plan itself to be named as a defendant. The magistrate judge issued a Memorandum and Recommendation (“M & R”) finding that Duke Energy should not be dismissed as it was a proper defendant. Duke Energy filed objections to the M & R.

The United States District Court for the Western District of North Carolina stated that the circuits were split on the issue of whether parties other than the plan itself could be named as defendants under 29 U.S.C. § 1132(a)(1)(B). While the Fourth Circuit has not specifically addressed the issue, the court found that it appeared that the Fourth Circuit was aligned with those circuits which permit a plaintiff to recover benefits against the pension plan as well as any fiduciaries who control the administration of the plan. The court reasoned that this “control test” originates from the text of ERISA and “extends the scope of the term fiduciary to any person or entity who actually exercises discretionary authority, control or responsibility over the plan.” *Worsley*, 2009 WL 1794430, at *4. Application of the control test to ERISA defendants is fact-specific and “hinge[s] upon the amount of discretion the potential defendant exercised over the plan.” *Id.*

The District Court found that Mr. Worsley alleged in his Complaint that Duke Energy Corporation Benefits Committee was identified as the designated plan administrator and that administrative duties were designated by the Benefits Committee to the Duke Energy Corporation Claims Committee. If proven by the plaintiff to be true, Duke Energy would be a proper defendant as it exercised discretionary authority over the Plan. Duke Energy’s Motion to Dismiss was denied.

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Filing A Complaint With “Ill Will And Insincerity” Results In Award Of Attorneys’ Fees For The Defendant In *Admiral Metals Servicer Co., Inc. v. Micromatic Products Co., Inc. et al.*, Mass. Lawyers Weekly No. 11-100-09, 16 pages, (Appeals Court, June 11, 2009), the plaintiff knew at the time he filed the action against the defendants that one of the defendants, an individual, was not personally liable for the co-defendant corporation’s debts. The defendant had prevailed on a motion for summary judgment and then filed a motion for attorneys’ fees under M.G.L. c. 231, Section 6 (f) and Mass. R. Civ. P. 11. The court ruled that the plaintiff’s commencement and prosecution of the action was not the product of a genuine professional judgment, and was not based on reasonable inquiry and an absence of bad faith.

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Calculation Of Disability Benefits Must Be Based On Insured’s Gross, Not Net, Pay

In *Smith v. Jefferson Pilot Fin. Ins. Co.*, 607 F. Supp. 2d 266 (D. Mass. April 8, 2009), “Basic Monthly Earnings” was defined in the policy as the “average monthly base salary.” *Id.* at 267. The policy was unclear as to the period on which the average monthly base salary was to be based. The insurer, according to the court, had several different interpretations of the above policy term. The court

ruled that the insurer must calculate the benefits based on an average of the Insured’s gross monthly pay over his entire period of employment.

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Treble Damages Awarded Under False Claims Act Where Insurer Required Disability Claimants To File For SSDI

In *Loughren v. UnumProvident Corp., et al.*, 604 F. Supp. 2d 269 (D. Mass. 2009), the evidence at trial suggested that the insurer had such a general policy. There was testimony about a manual so instructing its claim approvers to require its claimants to file for SSDI. Otherwise, the insurer threatened to reduce the monthly benefits by the amount of SSDI that might have been awarded if the claimant had filed and prevailed on a SSDI claim. The court wrote, “[t]he Court finds [the insurer’s] conduct extremely troubling.” *Id.* at 274.

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Hospital Did Not Owe Duty Of Care To Police Officer Injured Responding To Accident Involving Patient

In *Leavitt v. Brockton Hosp., Inc.*, 454 Mass. 37 (2009), the court ruled that “[w]e have not previously recognized, and do not now recognize, a duty to a third person of a medical professional to control a patient (excluding a patient of a mental health professional...) arising from any claimed special relationship between the medical professional and the patient.” *Id.* at 42. The court further ruled that the in-

jury to the police officer “was not ‘caused’ by the hospital because it falls outside the scope of foreseeable risk arising from any negligent conduct that would make the hospital’s alleged misconduct tortious.” *Id.* at 44.

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Drug Toxicity Resulting From Prescription Medication Was Sickness Not An Accidental Bodily Injury
In *Flores v. Monumental Life Ins. Co.*, No. CIV-08-1067-F, 2009 WL 1138050 (W.D. Okla. Apr. 27, 2009), Sandra Flores, insured under an individual Accidental Death Insurance Policy, fell on May 16, 2006 and underwent surgery for an injured arm and elbow. She was subsequently transferred to a rehabilitation center ten days later and died shortly thereafter. The medical examiner determined that Ms. Flores died from Verapamil toxicity. She had been taking this drug for a long time to control high blood pressure. Had she not been taking this drug, she would not have died when she did. Ms. Flores’ policy provided benefits for death directly resulting from an “Injury,” which was defined as “bodily injury caused by accident.” *Id.* at *2. The policy further stated that the Injury “must be the direct cause of the Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.” *Id.* at *2. “Sickness” was defined as “an illness or disease which results in a covered Loss...” *Id.* at *2. The lawsuit alleged, alternatively, that Ms. Flores died as a result of her fall or that an overdose of the drug Verapamil caused her death.

The court, granting summary judgment to the insurer, noted that the threshold issue was whether the claim comes within the policy's coverage language (was the death the direct result of an "injury" that caused her death "independent of all other causes") and concluded that it did not. *Id.* at *5. It was undisputed that Ms. Flores died of Verapamil toxicity, that she took this drug by prescription to control longstanding hypertension and that, had she not been taking the drug, she would not have died when she did. Accordingly, Ms. Flores' high blood pressure and her treatment were at least contributing causes to her death. Thus, her death fell outside the policy's coverage provisions.

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Injury Resulting From Medical Treatment Not An Accidental Bodily Injury

In *Hinkle v. Assurant, Inc.*, No. 08-cv-04124-JF, 2009 WL 1312685 (E.D. Pa. May 12, 2009), the insured underwent surgery for a kidney cyst. The surgeon committed malpractice by severing the wrong blood vessel resulting in the insured's death. Assurant denied the claim under the insured's ERISA-based AD&D policy on the basis that the death was not accidental and indirectly resulted from disease and thus excluded. Assurant relied on *Senkier v. Hartford Life & Accident Ins. Co.*, 948 F.2d 1050 (7th Cir. 1991). There, the Court of Appeals held that a death caused by a medical mishap during treatment was not an "accident." In *Senkier*, a catheter was inserted in the

course of treating Crohn's Disease. The catheter detached, entering and fatally puncturing the heart. The policy excluded "sickness or disease" as well as "medical or surgical treatment of a sickness or disease." *Senkier*, 948 F.2d at 1051. The court said "[m]edical treatment is often risky and when the risk materializes and the patient dies we do not call it dying in or because of an accident; it is death from sickness." *Senkier*, 948 F.2d at 1053. The district court judge in *Hinkle*, citing *Senkier*, upheld the denial as not arbitrary and capricious. The judge noted that not all courts agree with *Senkier*, and when courts are in disagreement on an issue, a decision one way or another is not improper. However, the judge went on to say that "[i]f I were free to do so, I would reject both of these defense theories. In my view, the operating surgeon did not intentionally sever the wrong blood vessel, hence the decedent was indeed the victim of an accident; and the benign cyst did not cause the insured's death in any way. But I can grant relief...only if the denial of coverage is...arbitrary and capricious." *Hinkle*, 2009 WL 1312685, at *1.

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Severance Of One Finger Does Not Constitute "Loss Of A Hand"

In *King v. Mutual of Omaha Ins. Co.*, No. 7:09cv00011, 2009 WL 2596509 (W.D. Va. Aug. 21, 2009), Mr. King was covered under two employer-sponsored ERISA Accidental Death and Dismemberment plans. He worked at a steel fabrication company. His hands became caught in a hydraulic sprocket on a conveyor, seri-

ously mangling and crushing them. After multiple surgeries to correct these fractures, some of the joints healed but others did not. One finger on the insured's left hand was amputated. His physician opined that Mr. King "will never have normal use of his hands." *Id.* at *1. Mr. King sought Dismemberment benefits for the "loss of Both Hands." *Id.* The plans defined this event as "'complete Severance of at least four whole fingers from one hand' and 'Severance' as 'the complete separation and dismemberment of the part from the body.'" *Id.* Both plans also excluded any loss "which...is not permanent." Based on these plan definitions, the insurer denied benefits. The district court, applying an abuse of discretion standard, held that even though the insured would have permanent stiffness and deficits in sensation and motor function in both hands, these facts were insufficient to satisfy the specific terms of the plans. The complete severance of a single finger was not the severance of a hand within the plans' plan language.

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Overpayment Recovery Permitted Under ERISA

In *Board of Trustees for the Hampton Roads Shipping Ass'n-Int'l Longshoremen's Ass'n v. Stokley*, No. 2:08cv253, 2009 WL 1492040 (E.D. Va. May 27, 2009), the court denied the defendant's Motion to Dismiss claims seeking recovery of overpayment under two separate plans. The defendant received benefits under a pension plan, which he was obligated to repay because he had returned to work, and benefits under another plan, which the plaintiff administrator

concluded had been paid erroneously. Both plans contained specific provisions requiring participants to repay overpaid benefits, and the defendant's application for pension benefits specifically obligated repayment if he returned to work.

The court dismissed one claim, alleging a contract arising from the benefit request signed by the defendant, because it was preempted by ERISA. However, it held that the plaintiff could go forward with claims based upon the plan provisions themselves, and a claim for unjust enrichment. The court concluded that ERISA allowed the administrator to enforce specific plan provisions providing for recovery of overpayment, and that the restitution remedy sought was equitable in nature, and thus available under 29 U.S.C. § 1132 (a)(3)(B).

The court discussed earlier Fourth Circuit decisions, and observed that the Court of Appeals had not addressed such a claim subsequent to *Sereboff*. It looked to recent decisions from other courts to support its conclusion that tracing of assets is not required, even if the benefits were commingled with other funds. The right to recover overpayments turned on the explicit terms of the plans, rather than the separate repayment agreement.

The court also held that the applicable contract statute of limitations, from Virginia law, was five years, so the action was not time barred.

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Breach Of Fiduciary Duty Claim Acrued When Plaintiff Had Actual Knowledge

In *Hunter v. Custom Business Graph-*

ics, et al., No. 2:08-cv-494, 2009 WL 2138675 (E.D. Va. July 1, 2009), Thomas Hunter, a participant in an employee pension plan, brought an action against his employer, Custom Business Graphics ("CBG"), and a co-worker who exercised discretionary authority over the administration and control of the plan, alleging violations of ERISA arising out of the defendants' alleged failure to make required contributions. The defendants filed a motion for summary judgment.

The plaintiff alleged that the defendants violated ERISA by failing to remit employee "Salary Reduction and Other Elective Simplified Employee Pension" ("SARSEP") contributions in a timely manner; failed to make the required employer contribution by virtue of funding the employer contribution from the employee's earned commission; and failed to make contributions at the same percentage for all employees, in violation of the express terms of the SARSEP. The defendants argued that the plaintiff's ERISA claims were barred by ERISA's three-year statute of limitations, codified at 29 U.S.C. § 1113.

The court acknowledged that the Fourth Circuit had not provided a precise definition of what it considers "actual knowledge of the breach of violation" under § 413 of ERISA. *Id.* at *4. Rather, in *Shofer v. Hack Co.*, 970 F.2d 1316, 1318 (4th Cir. 1992), it had only stated that "[t]he ERISA statute of limitations begins to run when a plaintiff has knowledge of the alleged breach of a responsibility." *Id.* The court looked to *Trace v. Retirement Plan for Salaried Employees*, 419 F. Supp.2d 845 (2006), where it was found that the relevant inquiry must focus upon the alleged violations and when the plaintiff became aware of the facts constituting the violation.

The court determined that the alleged

violations were that: (1) the defendants failed to make the required employer contribution by virtue of funding the employer contribution from the employee's earned commission; and (2) the defendants failed to make contributions at the same percentage for all employees, in violation of the express terms of the SARSEP.

As to the former, the filings indicated that the plaintiff first learned of the essential facts in 1996, at which time he had actual knowledge that CBG was funding the employer contribution from the employee's earned commission. However, the plaintiff took no affirmative actions to rectify his SARSEP situation until he first met with his accountants and subsequently filed the lawsuit in 2007. While he had acquired the essential fact for the alleged violation in 1996, he did nothing about it for 11 years.

The plaintiff alternatively contended that each contribution improperly made into the SARSEP by CBG constituted a separate violation which served to trigger a new statute of limitations. The court disagreed, holding that the alleged breach or violation occurred when the defendants decided *how* to contribute into the SARSEP – each subsequent contribution which was part of that initial plan did *not* constitute a new violation. Thus, the plaintiff's breach of fiduciary claim was subject to ERISA's three-year statute of limitations. Accordingly, the court granted the defendants' motion for summary judgment with respect to the plaintiff's breach of fiduciary claim.

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Medical Mishap Resulting From Treatment For Accidental Injury Is An Accidental Bodily Injury

In *Sellers v. Zurich Am. Ins. Co.*, 615 F. Supp. 2d 816 (E.D. Wis. 2009), the insured, during training exercises at work, accidentally tore the patellar tendon in his left knee, requiring surgery. The surgeon inserted a metal wire to stabilize his knee. The wire ultimately broke, requiring surgical removal. The insured thereafter suffered an acute pulmonary embolism with infarct and died. A doctor opined that the embolism was a direct consequence of the surgery to remove the wire. A claim under the insured's ERISA AD&D plan was denied on the basis that the death was not a direct result of the accident. The insurer cited the policy definitions for injury as "an accidental bodily injury which is a direct result, independent of all other causes..." and the exclusion for "any claim that is caused by, or contributed to, or results from...illness or disease." *Id.* at 819. This included medical treatment for illness or disease. Under *Senkier*, the death resulted from the surgery and embolism, which produced an intervening cause of death. Complications of the surgery resulting in death is due to an illness.

The district court found this reasoning to be arbitrary and capricious. The death need not necessarily be a direct result of, or solely caused by, the injury. *Senkier* stands for the rule that death due to complications of medical treatment for an illness or disease is death due to illness or disease, not that death due to complications for treatment of an accidental bodily injury is death due to illness or disease. *Id.* at 821. In *Senkier*, death resulted from a medical mishap during the treatment of Crohn's Disease, whereas in this case,

the death resulted from a medical mishap during treatment for an accidental injury.

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DEADLINE FOR NEXT ISSUE

The deadline to submit articles and case summaries for the next issue of *Life, Health and Disability News* is April 30, 2010.

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