Life, Health, Disability & ERISA Fall Update

December 3, 2025 | J. Christopher Collins, Joseph M. Hamilton | Articles

Greetings! We are pleased to provide you with a summary of decisions rendered by the First Circuit Court of Appeals, the U.S. District Courts within the circuit, and state appellate courts within the same geographic area. For your convenience, we have included hyperlinks with direct access to the full decision for each case. Decisions reproduced with permission of Westlaw.

Massachusetts Appeals Court Upholds Reduction in Disability Benefits Pursuant to a Lifetime Rider

For the second time within the last 12 months, the Massachusetts Appeals Court has upheld an insurer's interpretation of a rider in a disability policy which provides for a reduction of benefits after age 65.

In Landvater v. Massachusetts Mutual Life Insurance Company, 105 Mass. App. Ct. 1111, 2025 WL 274070 (2025), an unpublished decision, the court upheld a judgment entered in favor of MassMutual based upon a motion for judgment on the pleadings. Landvater asked the Appeals Court to reverse MassMutual's determination that her total disability benefit after age 65 was reduced based on the provisions of a lifetime total disability benefit rider.

Landvater became totally disabled at age 62. The rider provided for a reduction of the total disability benefit after age 65 by virtue of a 10% reduction for each year the disability began after age 55. Consequently, after age 65, Landvater's benefit was reduced from $10,125 per month to $3,037.50.

Landvater claimed the language of the rider was ambiguous and that a reasonable interpretation was that her monthly payment could only be reduced by 10% at most. Landvater based her analysis on the placement



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of a comma in the rider.

Like the trial court, the Appeals Court rejected the argument. Reviewing the policy as a whole, the court concluded that the terms were unambiguous and that there was but one reasonable interpretation of the language of the rider. The court noted that while the language could be improved, "difficulty in comprehension does not equate with ambiguity," citing an earlier Appeals Court decision.

In another unpublished disposition last year, the Appeals Court in *Kligler v. The Paul Revere Life Insurance Company*, 104 Mass. App. Ct. 1107 (2024) also found that a reduction in benefits based upon the lifetime rider was appropriate and rejected the argument that the rider or the policy was ambiguous. While *Kligler* made a slightly different argument, it is noteworthy that the Appeals Court has now twice upheld challenges to the interpretation of essentially the same rider.

First Circuit Determines Wrongful Death Claim is Preempted by ERISA

In Cannon v. Blue Cross and Blue Shield of Massachusetts, 132 F. 4th 86 (1st Cir. 2025), the First Circuit Court of Appeals affirmed a decision of the U.S. District Court of Massachusetts that dismissed a wrongful death claim against a health care insurer on the grounds that it was barred by ERISA.

Blaise Cannon was insured as a covered dependent of his domestic partner under Blue Cross' group health insurance policy. In 2020, Blaise sought coverage for an inhaler to treat his asthma. The claim was denied by Blue Cross. Blaise did not take an appeal from the denial.

Blaise subsequently died from asthma related complications. His partner, Scott Cannon, brought six state law claims against Blue Cross, including one for wrongful death pursuant to Mass. General Law. c. 229, §3. The district found all claims to be preempted by ERISA. Cannon appealed the dismissal of the wrongful death claim.

The First Circuit made short work in its analysis. The court found that the wrongful death claim was statutorily preempted under ERISA, 29 U.S.C. §1441(a) because it was a law relating to an employee benefit plan. The court repeated a ruling it had previously made that an impermissible connection with ERISA exists when the court must evaluate or interpret the terms of the ERISA regulated plan to determine liability under the state law cause of action.

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The court also found that Cannon's claim was preempted under 29 U.S.C. §1132(a) of ERISA, that preempts any state law cause of action that conflicts with the congressional attempt to make ERISA remedies exclusive.

The court affirmed the grant of summary judgment to Blue Cross.

Court Upholds Discontinuance of LTD Benefits on De Novo Review

In DeSilva v. Guardian Life Insurance Company of America, 2025 WL 999920 (D. Mass. 2025) the U.S. District Court of Massachusetts upheld Guardian's determination that DeSilva had been working in his occupation and therefore, was not entitled to further disability benefits.

DeSilva was covered by an ERISA plan funded by a group policy issued by Guardian. In 2016, DeSilva was in an automobile accident that resulted in a persistent back injury. He was approved for benefits. In 2021, Guardian informed DeSilva that his claim was being closed because he could work in his occupation. On the administrative appeal Guardian concluded that while DeSilva was unable to work full-time, he had been working since he became disabled and, therefore, was not entitled to additional benefits because he was earning more than the maximum allowable amount under the benefit plan.

The case was referred to a Magistrate Judge for a report and recommendation. That Magistrate recommended that Guardian's motion for summary judgment be allowed. DeSilva objected. The District Court overruled DeSilva's objections and adopted the Magistrate's recommendation in full.

The Court first found that the de novo standard of review applied to Guardian's determination based upon the language contained in the plan. Guardian had argued for the arbitrary and capricious standard.

Regarding the merits of the claim, DeSilva argued that whether he had been "working" was an ambiguous term in the ERISA plan and thus should be interpreted in his favor. The Court, noting that federal common law applied such that it would use common sense principles of contract interpretation, held that the Magistrate determination that "working" meant "engaged in activity regularly for wages or salary" was appropriate and that the term was not ambiguous.

The Court next rejected DeSilva's argument that Guardian should be estopped from raising the claim that he was working. The Court found

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that first, DeSilva had failed to allege an estoppel claim in his Complaint. The Court also noted that Guardian had long been skeptical of DeSilva's representations regarding his income and activities and, therefore, the basis of an estoppel was not present.

The Court next found that DeSilva failed to meet his burden of showing that he was not working for purposes of the plan. As found by the Magistrate, DeSilva owned a business, leased space, employed an assistant, maintained his business-related social media accounts, received and reviewed mail, and regularly went to the office to speak with his assistant to ensure the business was running smoothly. The Court found these facts sufficient to show that DeSilva did not meet his burden.

Lastly, the Court found that Guardian did not have an obligation to define "working" because the word had a plain, ordinary and natural meaning in the context. The Court also rejected DeSilva's conflict of interest argument against Guardian. The Court found that fact was not applicable where the de novo standard review was applied.

Summary judgment was entered for Guardian.

Court Denies Motion to Dismiss ERISA Benefit Claim as Premature

In Gillespie v. Cigna Health Management, Inc., 2025 WL 307268 (D. Me. 2025), the U.S. District Court of Maine denied Cigna's motion to dismiss Gillespie's benefit claim on the grounds that further information was needed to decide the claim.

Gillespie was covered under a health plan provided by his employer. Cigna was, at least, the claim administrator for the plan. Gillespie had both legs amputated. His doctor recommended a microprocessor prosthetic device for him. Cigna denied the request based upon an exclusion contained in the plan. Gillespie conceded that the plan language barred coverage of the device but asserted that the exclusion violated Maine insurance law which required health plans to provide such devices based upon a medical provider's recommendation.

Cigna moved to dismiss the complaint on the grounds that the plan was self-funded by Gillespie's employer and therefore the Maine law was preempted by ERISA. The court agreed that if the plan was insured then it was subject to state insurance laws, and the Maine law would apply. However, if the plan was self-funded then it could not be deemed to be insurance which meant that ERISA preempted the state law. Thus,

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the question before the court was whether the plan was self-funded.

Based on the allegations contained in the Complaint and the documents submitted to the court, the court found that it could not make that determination, and therefore, denied the motion without prejudice to Cigna filing a motion for summary judgment. The court also allowed limited discovery solely on the issue of whether the plan was self-funded.

Court Awards Life Insurance Benefits to Primary Beneficiary

In The Lincoln Life Insurance Company v. Bonds, 2025 WL 470760 (D. Mass. 2025), the U.S. District Court of Massachusetts resolved an interpleader action by awarding the benefits to the primary beneficiary named in the policy.

Elijah Pinckney had life insurance under a benefit plan provided by his employer. Pinckney originally named his mother, Aretha Bonds, as primary beneficiary and his girlfriend, Carshana Graham, as the contingent beneficiary. A year later, a beneficiary change was submitted to Lincoln electronically naming Graham as the primary beneficiary and Bonds as the contingent beneficiary. Later that year, Pinckney was murdered. Graham submitted a claim for the benefits, but Bonds challenged it, claiming that Graham had fraudulently changed the beneficiary and that Graham may have been involved in Pinckney's murder.

Lincoln filed an interpleader action in federal court. After a discovery battle, motions for summary judgment were filed.

The court awarded the benefits to Graham on the grounds that Bonds failed to submit any evidence to warrant a trial on Bonds' allegations. Bonds failed to submit any admissible evidence to support the claim that Graham fraudulently changed the beneficiary designation.

Regarding the allegation concerning Graham's involvement in Pinckney's murder, she similarly failed to provide any admissible evidence and indeed two individuals had been charged with Pinckney's murder and were incarcerated awaiting trial.

Given the lack of evidence, the court ordered the benefits be paid to Graham.

Court Determines Benefit Plan is not a Church Plan

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In Peterson v. The Lincoln National Life Insurance Company, 2025 WL 1063242 (D. Mass. 2025), the U.S. District Court of Massachusetts held that a benefit plan provided by a nursing home affiliated with the Catholic Church was not a "church plan."

Peterson was a participant in a plan provided by her employer, Notre Dame Healthcare Center, Inc. ("Notre Dame Health"). Notre Dame Health was a 501(c)(3) not-for-profit corporation that provided nursing and hospice care for the elderly and poor. The organization is affiliated with the Sisters of Notre Dame. The benefit plan was funded by a group policy issued by Lincoln National.

Peterson filed a claim for benefits which was denied by Lincoln National. Peterson exercised her right to administrative review of the denial. Lincoln National upheld its decision.

Peterson then filed suit in Massachusetts state court bringing state law claims. Lincoln National removed the case to federal court and argued that the state law claims were preempted by ERISA. Peterson claimed that the plan was not governed by ERISA because it was a church plan. The parties filed cross motions on the issue of whether the benefit plan was a church plan.

The court made its determination by reviewing the facts of the case with the governing statute. The issue for the court was whether Notre Dame Health Plan was entitled to the exemption provided by 29 U.S.C. §1002 (33)(A) and (C)(i)., and §1003 (b)(2).

As a preliminary matter the court found Lincoln National bore the burden of proving the plan was not a church plan. The court held that burden fell on Lincoln National because it had removed the case to federal court and was therefore required to prove the court had jurisdiction.

After analyzing the facts and statute, the court held the plan was governed by ERISA. The court found the statute did not expand the definition of a church plan to encompass entities or organizations that are merely associated with a church. The court held that for it to be a church plan, Notre Dame Health would either need to be a church or a principal-purpose organization. The court found both parties agreed that Notre Dame Health was neither and therefore was not a church plan.

The court held that the state claims would be preempted, but Peterson was allowed to amend the complaint to add a claim for a ERISA benefits.

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Court Denies Claim for Supplemental Life Insurance Based on Lack of Evidence of Insurability

In Slim v. Life Insurance Company of North America, 2025 WL 1413973 (D.P.R. 2025), the U.S. District Court of Puerto Rico entered summary judgment in favor of LINA on a benefit claim for supplemental life insurance benefits.

Slim was covered by an employee benefit plan that provided guaranteed and supplemental life insurance for him and his spouse. The plan was funded by a group policy issued by LINA to Slim's employer. When applying for coverage in 2021, Slim requested not only the guaranteed issue amount of life insurance for his wife, but an additional $250,000 of coverage. It appears premiums were deducted for that coverage.

In 2023, Slim's wife died. He submitted a claim for both the basic and supplemental benefits. LINA approved the basic coverage but denied the supplemental benefits due to Slim's failure to submit and have approved Evidence of Insurability which was required by the benefit plan. Slim filed suit.

On cross motions for summary judgment, the court considered Slim's claim which was a claim for benefits pursuant to 29 U.S.C. §1132(a)(1)(B). Earlier in the case the court had concluded that Slim had failed to state a claim for breach of fiduciary duty and dismissed it.

Applying the arbitrary and capricious standard of review the court found Slim failed to establish a benefit claim because of the failure to submit evidence of insurability. While Slim submitted an evidence of insurability form dated November 2021, there was no proof that LINA had ever received it or approved it. Thus, the court entered summary judgment in favor of LINA on the benefit claim. It similarly dismissed Slim's employer as not being a proper defendant to a benefits claim.

In support of his claim, Slim relied on the First Circuit's decision in *Shields v. United of Omaha Life Ins. Co.*, 50 F.4th 236 (1st Cir. 2022). In that case, while the First Circuit upheld the dismissal of a benefit claim for supplemental life insurance benefits, it found a breach of fiduciary claim existed against the insurer for failure to confirm evidence of insurability after it received premium for the coverage. The district court in *Slim* found Shields did not apply because there was no fiduciary claim in the case. Query whether Slim will appeal this ruling to contest the dismissal of his breach of fiduciary duty claim earlier in the case.

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Court Allows for Fair Credit Reporting Act Claim to Proceed Against MIB Group

In Michalski v. MIB Group, Inc., 2025 WL 92591 (D. Mass. 2025), the U.S. District Court of Massachusetts denied MIB's motion to dismiss a claim brought against it for an alleged violation of the Fair Credit Reporting Act, 15 U.S.C. § 1682, et seq. ("FCRA"). However, the court did allow the motion to dismiss against an insurer, Fidelity Security Life Insurance Company.

Michalski applied for life insurance with Fidelity. The application was denied after Fidelity obtained information from a MIB consumer report that Michalski had a history of a malignant tumor of the genital tract. MIB, previously known as the Medical Information Bureau, shares health and financial information regarding insurance applicants to its member insurance companies.

After being denied by Fidelity, Michalski applied to a second insurer for life insurance. That was also denied based upon MIB's consumer report. Following that, Michalski requested a copy of his file from MIB. Upon finding reference to the tumor, Michalski filed a dispute with MIB regarding what he contended to be inaccurate information. MIB notified Fidelity of the dispute. Both Fidelity and MIB informed Michalski that they would not be making any changes to the report. Michalski then sued, alleging violation of the FCRA.

Both Fidelity and MIB filed motions to dismiss arguing Michalski lacked standing to bring the claim and for judgment on the pleadings.

The court did find Michalski lacked standing to sue Fidelity. The court based its determination on its finding that Michalski's Complaint did not state sufficient allegations to conclude that Fidelity did not comply with the FCRA after it was notified of Michalski's dispute.

However, the court did find that Michalski had standing to pursue his claims against MIB and that MIB was not entitled to a motion for judgment on the pleadings. The court held that alleged procedural violations of the FCRA can be enough to satisfy standing requirements against a credit reporting agency, which MIB is. Regarding the motion for judgment on the pleadings, the court found the Complaint stated sufficient allegations that MIB failed to provide all information in its files in response to Michalski's request, as well as failing to provide the sources for the original service provider that treated Michalski.

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