Life, Health, Disability & ERISA Litigation Report

September 8, 2024 | 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.

FIRST CIRCUIT ALLOWS A CLAIM CHALLENGING PREMIUM INCREASESFOR LTC COVERAGE GOVERNED BY ERISA

In Parmenter v. Prudential Insurance Company of America, 93 F.4th 13 (1st Cir. 2024), the First Circuit Court of Appeals held a plan participant may bring a claim of breach of fiduciary duty regarding premium increases for long-term care coverage.

Parmenter obtained long-term care insurance coverage through a benefits plan provided by her employer, Tufts University. The policy was issued by Prudential. The plan documents noted that increases in premium were subject to the approval of the Massachusetts Commissioner of Insurance. Other provisions of the plan appeared to allow Prudential to change the premium rate unilaterally.

After having coverage for years, Prudential raised the rates significantly in 2019 and 2020, in both cases without obtaining approval from the Massachusetts Commissioner of Insurance. Parmenter sued Prudential and Tufts complaining both had breached their fiduciary duties: Prudential by increasing the premium without first securing the approval of the Commissioner of Insurance and Tufts by failing to monitor Prudential. The district court dismissed the claims on a motion to dismiss. The appeal followed.

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The court first examined the breach of fiduciary claim against Prudential. The court found that Prudential owed Parmenter a fiduciary duty with regard to exercising its discretion to increase premiums.

Regarding whether Parmenter had alleged a sufficient breach of the fiduciary duty, the court concluded it could not make that determination because of an ambiguity in the policy. The court noted that it was not appropriate to resolve the meaning of the ambiguous contract based solely on the pleadings. Based on these holdings, the court reversed the dismissal of Prudential.

As to Tufts, the court found Parmenter's allegation that Tufts breached a fiduciary duty by failing to stop Prudential from breaching the plan terms did not state an actionable claim. It therefore upheld the dismissal of Tufts.

MASSACHUSETTS APPEALS COURT UPHOLDS INSURERS INTERPRETATION OF LIFETIME TOTAL DISABILITY BENEFIT RIDER

In Kligler v. Paul Revere Life Insurance Company, 104 Mass. App. Ct 1107, 2024 WL 2288878 (Mass. App. Ct. 2024), the Massachusetts Appeals Court upheld a summary judgment entered in favor of Paul Revere.

After receiving his first disability policy from Paul Revere in 1990, approximately a year later Kligler submitted an application requesting a new policy with additional benefits, including a lifetime total disability benefit rider. Under Kligler's prior policy, benefits were payable only to age 65.

In 2014, Kligler submitted a claim to Paul Revere. The claim was approved, and Paul Revere began paying total disability benefits to Kligler when he was 62 years old. Under the terms of the rider, Kligler was only entitled to a monthly benefit of 30% of what he had been receiving prior to age 65. Kligler challenged that determination and argued that he was entitled to two benefits of $13,300 each, a double total disability benefit. He also brought a claim alleging a violation of the Massachusetts Consumer Protection Act, Chapter 93A.

Kligler argued that the language of the policy schedule allowed him to recover two total disability payments of $13,300 each. All claims were dismissed on summary judgment. Kligler appealed. In its decision, the Appeals Court found that Kligler's policy was unambiguous. It found that

after age 65 Kligler's disability benefit was provided solely through the rider and that Paul Revere properly calculated his benefit under the terms of that rider.

Joseph M. Hamilton represented The Paul Revere Life Insurance Company

APPLYING DE NOVO REVIEW, COURT UPHOLDS DENIAL *OF* DISABILITY CLAIM

In Demeritt v. Unum Life Insurance Company of America, 2024 WL 2990553 (D. N.H. 2024), the U.S. District Court of New Hampshire upheld Unum Life's determination that Demeritt was not entitled to long-term disability benefits.

Demeritt was employed as a network engineer, a sedentary occupation. In 2021 Demeritt stopped working, claiming to be disabled due to narcolepsy. After receiving short-term disability benefits, Demeritt applied for long-term benefits. Unum Life denied the benefits and upheld it on appeal.

Applying the de novo standard of review, the court held that Demeritt did not meet his burden of proof to demonstrate that he was qualified for benefits. In support of his claim, Demeritt had submitted letters from his treating neurologist, along with letters from co-workers and his supervisor.

After analyzing the evidence, the court found the analysis and opinions of Unum's medical consultants were more persuasive than those of Demeritt's. In particular, the court found the opinion of Unum Life's in-house neurologist, Dr. Jacqueline Crawford, persuasive. The court did note that the opinions of Unum Life's other medical consultant were consistent with Dr. Crawford's analysis.

The court entered summary judgment in favor of Unum Life.

DISCONTINUANCE OF LONG-TERM DISABILITY BENEFITS NOT ARBITRARY OR CAPRICIOUS

In Bernitz v. USAble Life and Fullscope RMS, 2024 WL 3106249 (D. Mass. 2024), the U.S. District Court of Massachusetts allowed USAble Life's motion for summary judgment regarding a claim for long-term disability

benefits.

Bernitz filed for disability benefits with USAble Life in 2014 due to back pain. USAble Life approved the claim and paid benefits for several years.

In 2018, the Social Security Administration ("SSA") denied Bernitz's application for disability benefits and determined that he could perform his past work as a vice president and program manager. The SSA decision noted Bernitz's activities including taking college classes, driving, exercising with a personal trainer, traveling to Hawaii and national parks, and spending a month in San Diego house hunting.

In 2019, surveillance of Bernitz found him working with a personal trainer, including using a treadmill, free weights with barbells, weight machines, and other exercises.

Subsequently, USAble Life found Bernitz able to do his occupation and discontinued benefits.

Bernitz appealed and submitted numerous documents in support of his claim, including a functional capacity evaluation, medical reports, and a neuropsychological evaluation. Those submissions were thoroughly reviewed by USAble Life's medical resources.

Applying the arbitrary and capricious standard of review, the court found that USAble Life made its decision based on substantial evidence and upheld it. The court noted USAble Life relied on sufficient information, including the SSA's denial of Bernitz's application for benefits, his significant weight loss, his extensive travel, and the surveillance.

The court also noted that on appeal USAble Life had adequately addressed all evidence Bernitz put forward in support of his appeal. The court found that USAble Life was entitled to give its medical resources more weight. The court allowed USAble Life's motion for summary judgment.

COURT ORDERS AMENDED FINAL DETERMINATION LETTER IN ERISA DISABILITY CLAIM

In Rogers v. Unum Life Insurance Company of America, 2024 WL 1466728 (D. Mass. 2024), the U.S. District Court of Massachusetts denied cross-motions for summary judgment regarding a claim for long-term disability benefits and ordered Unum Life to provide an amended final

determination.

Rogers, a materials scientist, filed a claim for long-term disability benefits for a variety of medical conditions. While Rogers received short-term disability benefits, he was denied long-term benefits. After the determination was upheld on appeal, Rogers filed suit.

Unum Life's determination was based on a review of Rogers' medical records, a vocational review, an IME, and review of his file with the Social Security Administration for disability benefits. One of Rogers' arguments was that Unum Life's medical consultants did not adequately explain the basis of their disagreement with Rogers' treating physicians, as required by Unum Life's claims manual.

The court performed an extensive review of the medical records and found that Unum Life's last letter to Rogers regarding its determination did not adequately address Unum Life's disagreements with Rogers' physicians. Consequently, the court denied both motions for summary judgment without prejudice and ordered Unum Life to provide "an amended final determination letter that includes specific reasons why each attending physician's opinion is not well supported by medically acceptable clinical or diagnostic standards or is inconsistent with other substantial evidence in the record."

Joseph M. Hamilton represented Unum Life Insurance Company of America.

ERISA PLAN HAS BURDEN TO TRACK FUNDS SOUGHT FOR RECOVERY

In Verizon Sickness and Accident Disability Benefit Plan v. Rogers, 2024 WL 323057 (D. R.I. 2024), the U.S. District Court of Rhode Island addressed some relatively novel issues regarding the reimbursement of disability benefits.

Rogers was paid approximately $45,000 in benefits by Verizon for a disability due to injuries sustained in an automobile accident. Rogers sued regarding the automobile accident and recovered a $100,000 settlement.

After the settlement funds were received, Rogers' attorney, Richard Sands, paid out approximately $62,000 to Rogers, paid some liens, and then transferred approximately $32,000 to his firm's general operating account. When Verizon sought to recover its disability payments under the terms of the benefit plan, Rogers disappeared. Verizon then sought to

recover the disability benefits from the funds paid to Sands.

The court acknowledged that Verizon, under the terms of the plan, had an equitable lien against the settlement proceeds. As an equitable lien, the remedy required recovery from a specific, identifiable pool of funds to which Verizon established an entitlement. If the funds were not in the attorney's possession, or had been dissipated, Verizon could not simply seek compensation from the attorney's assets. That would be a legal recovery, not an equitable one. Sands claimed the settlement funds had been dissipated by being used to pay his operating expenses and therefore were no longer in his possession, thus no equitable recovery.

The first question the court addressed was who had the burden of proof as to whether the funds had been dissipated. While noting that there was no controlling authority stating where the burden of proof lies on the issue, the court concluded from its analysis of other cases that the burden should be on Verizon.

With regard to whether the funds still existed, the court noted that the typical process to determine that was using a method called the "lowest intermediate balance." That method looks at the cash in the attorney's bank account into which the settlement funds were deposited, and at the running balance of the account between the time of the deposit and the time of the claim. If the account had at any time during that period shown a balance of $0, it meant that all the settlement funds were spent. If the balance did not drop to $0, complete dissipation had not been shown.

The court found Verizon had the burden of proof to show the lowest intermediate balance as well, but had failed to do so. Verizon had not conducted any discovery. By failing to carry the burden that the funds still existed, judgment was entered for Sands.

ERISA PLAN NOT BARRED FROM COLLECTING SSA OVERPAYMENT

In Cutway v. Hartford Life & Accident Company, 2024 WL 231453 (D. Me. 2024), the U.S. District Court of Maine entered judgment in favor of Hartford in a dispute over Hartford's recovery of an overpayment of disability benefits.

Cutway was covered under an ERISA governed disability plan provided by his employer. Disability benefits were subject to a setoff for other benefits

such as a Social Security disability benefit. In 2019, Cutway received a notice from SSA that he was awarded disability benefits. However, the notice from the SSA stated the benefit was $49 per month, even though the actual benefit was $1,587 per month. While Hartford was told the actual benefit payment in a phone call with Cutway, it elected to offset only $49 per month until it received a new notice of award from SSA.

In December 2021, Hartford determined that the $49 amount must be inaccurate, and that Cutway was receiving monthly checks in the amount of $1,587. Hartford issued a notice stating it had overpaid benefits in the amount of $52,292 and began offsetting those benefits. Cutway filed suit.

The court ruled in favor of Hartford, finding that the equities supported Hartford. The court relied on the terms of the policy, which Hartford properly applied; the administrative record, which supported the finding that Cutway was informed of and understood or should have understood that he was being overpaid disability benefits due to the receipt of unreduced disability payment along with Social Security benefits; and Hartford's repeated efforts to get accurate information from Cutway about the monthly benefit he received from SSA. While finding that Hartford was not entirely blameless, its lack of care did not exceed Cutway's own lack of care in the management of his funds. Therefore, the court did not find that Hartford acted arbitrarily or capriciously in its determination.

MOTION TO REMAND TO STATE COURT DENIED BECAUSE CLAIMS GOVERNED BY ERISA

In Tutungian v. Massachusetts Electric Co., 2024 WL 1541094 (D. Mass. 2024), the U.S. District Court of Massachusetts denied Tutungian's motion to remand the case to state court. Tutungian filed a Complaint in Massachusetts state court. The Complaint concerned Tutungian's entitlement to supplemental and life insurance coverage. Mass. Electric removed the case to federal court and Tutungian moved to remand.

Finding that Tutungian's claims concerned his right to benefits under an ERISA plan provided by Mass. Electric, the court held that because ERISA completely preempts common law claims, the court had subject-matter jurisdiction over the dispute. Therefore, the motion to remand was denied.

REVOCATION ON DIVORCE STATUTE DOES NOT BAR EX-WIFE FROM RECOVERING LIFE INSURANCE PROCEEDS

In Metropolitan Life Insurance Company v. Belizaire-Jeudy, 2024 WL 1538112 (D. Mass. 2024), the U.S. District Court of Massachusetts dismissed an interpleader action filed by MetLife, finding MetLife had not demonstrated the potential for adverse claims on the proceeds of a life insurance policy based on the Massachusetts' revocation on divorce statute.

In 2015, George Jeudy acquired life insurance through his employer in the amount of $5,000 of basic coverage and $335,000 in supplemental coverage. His wife, Cherlene, was named primary beneficiary and his two children contingent beneficiaries. In 2019, George and Cherlene divorced. The divorce agreement required George to "obtain and maintain in full force and effect life insurance policies with a value of $150,000 with [Cherlene] designated as beneficiary for her benefit and for the benefit of the minor Children."

George died in 2022 and Cherlene made a claim for the insurance proceeds. MetLife filed an interpleader based, in part, on Massachusetts General Law, c.190B, §2-804, which operates as a revocation of the designation of a spouse as a beneficiary in a life insurance policy after a divorce, unless there is an express agreement that the designation continues.

MetLife contended that it could not determine whether Cherlene or her children were entitled to the proceeds of the policy and that interpleader was appropriate. The court disagreed. The court found the divorce agreement adequate to satisfy the exception to the revocation on divorce statute.

The court was not concerned that the divorce agreement referred to a policy of a smaller dollar amount than what George had with MetLife, or that the agreement required him to "obtain and maintain" the coverage. Rather, the court focused on the existence of coverage and the requirement in the agreement that George had to maintain coverage.

The court then went on to find the appropriate remedy in the case was to dismiss MetLife's interpleader action, thereby effectively awarding the benefits to Cherlene.

REVOCATION ON DIVORCE STATUTE BARS EX-WIFE FROM RECOVERING LIFE INSURANCE PROCEEDS

In Sevelitte v. The Guardian Life Insurance Company of America, 2024 WL 639314 (D. Mass. 2024), the U.S. District Court of Massachusetts held, for the second time, that the divorced spouse of the deceased was not entitled to the proceeds of a life insurance policy.

Joseph Sevelitte purchased a life insurance policy in 1986. He named his then wife, Renee, as beneficiary. There was no contingent beneficiary. In 2013, Joseph and Renee divorced, and he later married Robyn. Joseph died in 2020.

A dispute arose regarding who was entitled to the proceeds of the policy. While Guardian was attempting to resolve the dispute, Renee filed suit in state court bringing multiple claims against Guardian. Guardian removed the case to federal court, added Robyn as a party, and brought a counterclaim for interpleader. The parties then brought dispositive motions.

The district court ruled in favor of Robyn based on the application of Massachusetts General Law, Chapter 190B, § 2-804. That statute operates as a revocation of the designation of a spouse as a beneficiary in a life insurance policy after a divorce, unless there is an express agreement that the designation continued. The district court found that no such designation had been made. See 2022 WL 1051351 (D. Mass. 2022).

Renee appealed. The First Circuit vacated the district court's determination, finding that the divorce agreement was ambiguous, and that Renee had made a plausible claim that the language could support her and therefore the court sent the case back to the district court.

On remand, the parties again filed motions for summary judgment and again the district court ruled in favor of Robyn. The court performed a thorough review of the divorce agreement and found it was undisputed that the agreement, read as a whole, and considering the context in which it was executed, and illuminated by uncontested extrinsic evidence that Robyn submitted, did not counter the presumption under the Massachusetts statute that Renee's status was revoked upon her divorce from Sevelitte. The court ordered benefits paid to Robyn.

J. Christopher Collins represented The Guardian Life Insurance

Company of America.

COURT DISMISSES FAILURE TO NOTIFY CLAIM AGAINST LIFE INSURER

In Hickman v. Pruco Life Insurance Company, 2024 WL 2262792 (D. Mass. 2024), the U.S. District Court of Massachusetts granted Pruco's motion to dismiss the Complaint.

Hickman purchased a life insurance policy insuring the life of her business partner. Hickman was the owner and beneficiary of the policy. The policy was paid through annual premium payments. In 2022, Hickman missed a payment and the policy lapsed. Pruco sent a letter to Hickman letting her know the policy had lapsed. It also advised her she could apply for reinstatement. Hickman did neither. Instead, she sent a Chapter 93A demand letter and subsequently filed suit.

The primary issue raised by Hickman was that Pruco had not complied with Mass. Gen. Law c.175, §110B, which prevents a life insurance policy from lapsing sooner than three months after non-payment of an annual premium, unless the insurer provides a reminder to the insured between 10 to 14 days before the premium is due. If that notice is given, the policy can be allowed to lapse one month after the payment date. Pruco contended, and Hickman disputed, that the appropriate notices were sent.

In response to the Chapter 93A demand, Pruco attached the notifications to Hickman. After Hickman filed suit, Pruco moved to dismiss.

The court first addressed what documents it could consider in deciding the motion to dismiss. The court determined that it could take judicial notice of the policy since it had been incorporated by reference into the Complaint. It also found that it could take into consideration Pruco's response to the Chapter 93A demand letter. The notices attached to that letter were authenticated by an affidavit from Pruco. After considering those documents, the court found that the facts alleged by Hickman did not sustain her failure to notify claim.

Similarly, the court found that Hickman failed to articulate a compensable Chapter 93A claim, breach of the covenant of good faith and fair dealing and denied Hickman's request for declaratory judgment.

COURT DISMISSES BREACH OF FIDUCIARY DUTY CLAIM BY BENEFICIARY AGAINST LIFE INSURER

In Gatto v. MetTower, 2024 WL 1857005 (D. Mass. 2024), the U.S. District Court of Massachusetts held that Metropolitan Life Insurance Company had no fiduciary duty to the beneficiary of a life insurance policy, and dismissed the claim.

Josephine Gatto purchased a single premium whole life policy from MetLife in 1987. In 1992, she executed The Josephine Gatto Irrevocable Trust. Shortly thereafter, she named that trust the revocable beneficiary of her policy. Joseph Gatto was the sole trustee and beneficiary of the trust.

The policy matured in 2016. By that time, Ms. Gatto had been determined incompetent and was placed under a guardianship. She died 12 days after the policy matured. After MetLife unsuccessfully attempted to reach Ms. Gatto, it placed the value of the policy in an unclaimed funds account. Four years later MetLife sent another letter to Ms. Gatto informing her that the funds would be transferred to the Massachusetts Unclaimed Property Division. That was done in 2020.

In 2021, Joseph Gatto received a notice from the IRS regarding a tax deficiency of $17,000 resulting from the policy. This was the first he had learned of the policy's existence. He made a demand of the funds on MetLife, which directed him to the Unclaimed Property Division. He then sued.

Gatto brought claims of breach of fiduciary duty, breach of contract, and Chapter 93A against MetLife. The essence of the claim was he alleged MetLife breached its fiduciary duty, as well as breached the contract, when it failed to ascertain whether Ms. Gatto was alive or competent and failed to communicate with him as the trustee of the designated beneficiary. MetLife argued and the court agreed that MetLife owed no fiduciary duty to Gatto or the trust. It noted the Massachusetts standard that a fiduciary duty only arises in special circumstances, none of which existed.

The court also dismissed the breach of contract claim on the grounds that the death proceeds were only payable to a beneficiary if the policy owner died before the maturity date. Because Josephine died after the maturity date, the amounts were owed to her, not the trust. Thus, the trust had no claim on the policy.

For the same reasons, the court dismissed the Chapter 93A claim.

Mirick O'Connell's Life, Health, Disability & ERISA Litigation Group represents clients throughout New England. With offices in Boston, Westborough and Worcester, our attorneys are within an hour of all the major courts in Massachusetts, Hartford, Connecticut, Rhode Island, and southern New Hampshire. In addition, our attorneys are admitted to practice not only in Massachusetts, but in Connecticut, New Hampshire and Rhode Island as well. We have repeatedly and successfully represented clients in each of these jurisdictions. So remember, we are not here for you just in Massachusetts – think New England!