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On January 20, 2016, the United States Supreme Court held that an ERISA plan could not satisfy its reimbursement rights from a participant’s general assets. ERISA plans’ reimbursement rights are now so limited that participants, who are the insureds for plans funded by insurance, should be expected to seek to avoid reimbursing funds. So, insurers of ERISA plans will have to take prompt actions to enforce a plan’s reimbursement rights, including possibly intervening in an insured’s lawsuit against third parties.

The Montanile Facts and Holdings

In Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan, 136 S. Ct. 651 (2016), the Supreme Court considered the common circumstances that arise when a health plan pays medical expenses after an insured is in an accident. After a drunk driver hit Montanile, he sued the driver and received a $500,000 settlement. The plan had paid about $120,000 for his initial medical care. After subtracting costs and attorneys’ fees, Montanile’s attorneys held about $240,000 from the settlement.

The Board of Trustees (the “Board”) as the plan’s fiduciary sought reimbursement. Montanile’s attorney informed the Board that he would distribute the remainder of the settlement funds to Montanile unless the Board objected within 14 days. The Board did not do so. Montanile’s attorney distributed the funds. Six months later, the Board sued Montanile. By that time, though, Montanile had spent almost all of the settlement funds.

The District Court held that the plan was entitled to reimbursement from Montanile’s general assets. The Court of Appeals for the Eleventh Circuit affirmed, holding that the plan can recover out of a participant’s general assets when the insured dissipates specifically identified funds. The Supreme Court agreed to review the case to resolve the law as to when an ERISA fiduciary can enforce an equitable lien against a defendant’s general assets.

The Supreme Court reversed the Eleventh Circuit and remanded the case for further proceedings. Based on the plan language, the Supreme Court held that “[t]he Board had an equitable lien by agreement that attached to Montanile’s settlement fund when he obtained title to that fund” and that his “commingling a specifically identified fund – to which a lien attached – with a different fund of the defendant’s did not destroy the lien. Instead, that commingling allowed the plaintiff to recover the amount of the lien from the entire pot of money.” On the other hand, the Supreme Court held that “recovery out of Montanile’s general assets – in the absence of commingling – would not have been ‘typically available’ relief” under ERISA.

The Court also said that, “[b]ecause the lower courts erroneously held that the plan could recover out of Montanile’s general assets, they did not determine whether Montanile kept his settlement fund separate from his general assets or dissipated the entire fund on nontraceable assets . . . . A remand is necessary so that the district court can make that determination.” See Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan, 2016 WL 850877 (Mar. 4, 2016) (vacating judgment in favor of plan and remanding to district court for determination of “whether Montanile mixed the settlement fund with his general assets”).

What Are the Practical Consequences in Light of Montanile?

In light of Montanile, plan insureds, and their lawyers, will have incentives to spend, hide, and otherwise avoid reimbursing funds. Two recent cases that reached the Federal Circuit Courts of Appeal illustrate some of the problems.

In Central States, Southeast and Southwest Areas Health and Welfare Fund v. Lewis, 745 F.3d 283 (7th Cir. 2014), a plan insured’s lawyer had notice of the plan’s lien but distributed the settlement proceeds from a lawsuit to the insured and himself. The Seventh Circuit affirmed the order requiring the participant and his lawyer to restore $180,000 to the lawyer’s client trust fund account, the finding against the participant’s lawyer of civil contempt for not doing so, and the order to submit information to the General Counsel of the State Bar of Georgia for
possible disciplinary proceedings against the lawyer. Under the holding in Montanile, it is doubtful this monetary relief would have been appropriate.

In Airtran Airways, Inc. v. Elem, 767 F.3d 1192 (11th Cir. 2014), cert. granted, vacating judgment, 136 S. Ct. 979 (2016) (remanding “for further consideration in light of Montanile”), the plan participant and her lawyer “conspired to hide and disburse settlement funds she received after a car accident.” In AirTran Airways, the Eleventh Circuit held the settlement funds were “specifically identifiable,” and the plan participant’s dissipating the funds thus could not destroy the lien that attached before the dissipation. Id. at 1198. The Eleventh Circuit affirmed a judgment in favor of the plan for over $100,000 for medical care and awarded attorney’s fees and costs in favor of the plan. Because the funds could not be traced, however, under the holding in Montanile, the monetary relief would not have been appropriate. See Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan, 2016 WL 850877 (Mar. 4, 2016) (recognizing that the result in Airtran Airways was wrong under the Supreme Court’s Montanile holding).

The Supreme Court’s Montanile opinion perhaps raises more questions than it answers. In circumstances where an insured should reimburse a plan, when can an insurer recover? Recovery is appropriate when the funds at issue can be identified, but identifying money often is not practical. Based on the opinion, an insurer can still recover if it can identify a bank account where the funds are held, even if commingled with other funds. Or an insurer can still recover if it can trace the funds to other assets: examples might be stocks, a car, or other identifiable asset. But how does one “trace” liquid assets? Perhaps more important, how can an insurer avoid having the funds spent on non-traceable assets?

What Should an Insurer Do in Light of Montanile?

The result in Montanile will embolden some insureds to avoid reimbursing plans. For insurers, the dollars lost might be big. What should an insurer do?

A first step should be to make sure the plan documents, which probably means the insurance policy and the certificate, have strong, helpful language. The plan documents should not only provide for subrogation and reimbursement, but also require insureds to notify plan fiduciaries of claims against third parties and otherwise to cooperate. The plan documents should provide that not cooperating has consequences, such as offsets against future benefits or terminating coverage for misconduct, but imposing these consequences might raise other issues. The plan documents might specify that the participant and his lawyer are plan fiduciaries as to any recovery (i.e., plan assets) that should be returned to the plan.

As the fiduciary in Montanile protested, without being able to recover from general assets, recovery from an insured will be hard and costly. An insurer will first have to decide if the amount at issue is worth pursuing. A $500 reimbursement would rarely be worth the effort; a $500,000 reimbursement would almost always be. In between these two, an insurer would have to make a judgment call.

Once an insurer has notice of a potential claim worth pursuing, the insurer needs to take steps to avoid having the funds dissipated. In Montanile, the insured had signed a reimbursement agreement affirming his obligation under the plan language to reimburse the plan from any recovery. That step was a good one, but apparently did not work. Having the insured’s lawyer sign such an agreement is advisable. If the insured or the lawyer will not sign, or the insurer is concerned that the lawyer will not comply with an agreement he or she signs, then intervening in a pending lawsuit or filing a separate lawsuit, before the settlement funds are even received, would need to be considered.

In light of the Supreme Court’s Montanile decision, insurers of plans governed by ERISA must be diligent to protect their rights of subrogation and reimbursement. If one hesitates, remedies may be lost.

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On June 24, 2015, plaintiff Troy Baker filed a complaint in the United States District Court for the District of Montana, seeking payment of long-term disability benefits pursuant to an insurance policy issued by Hartford Life and Accident Insurance Co. ("Hartford") to Mr. Baker’s employer, Gensco, Inc. ("Gensco"). Mr. Baker was employed by Gensco as a delivery driver when he was injured on the job in September of 2006. He did not return to work following the injury, and apparently did not discover the long-term disability policy until several years later. He then applied for long-term disability benefits, which were granted in June of 2011 for the two-year “own occupation” period, from December of 2006 to December of 2008. Hartford informed Mr. Baker that he was not eligible for continued benefits under the “any occupation” period applicable after benefits were paid for two years. Mr. Baker appealed the denial of benefits from December of 2008 forward, and Hartford upheld the denial decision on January 26, 2012.

Approximately three and one-half years later, Mr. Baker filed his complaint, including a single claim for denial of benefits pursuant to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1132(a)(1)(B), naming Hartford and Gensco as defendants. The defendants filed a motion to dismiss and brief in support, pursuant to Fed. R. Civ. P. 12(b)(6), arguing that Mr. Baker’s claim was barred by the policy’s time limit for filing lawsuits. The policy stated that legal claims could not be brought more than three years after the date proof of loss was required to be given under the policy, and further specified that proof of loss was required to be given within 90 days after the start of the period for which Hartford was liable for payment. According to Mr. Baker, he became eligible for benefits on December 19, 2006, meaning he was required to submit proof of loss by March 19, 2007, and was required to bring a legal action by March 19, 2010.

The case was complicated by the fact that Mr. Baker did not even apply for benefits until 2011, after the deadline for filing a lawsuit had passed. The defendants therefore argued that the latest conceivable accrual date for the lawsuit was the denial of the administrative appeal, and Mr. Baker did not file his lawsuit until more than three years after that denial.

In response to the motion to dismiss, Mr. Baker invoked the Third Circuit’s decision in Mirza v. Ins. Adm’r of Am., Inc., 800 F.3d 129 (3d Cir. 2015), which relied on the Department of Labor’s implementing regulations under ERISA and held a plan’s limitations period is not effective if the claims administrator did not specifically inform the claimant of the deadline in the denial letter. Mirza instead applied the most closely analogous limitations period, which Mr. Baker argued was Montana’s eight-year statute of limitations for contract claims.

In reply, the defendants disputed that DOL regulations relating to initial claim denials required notification of the time limit for a lawsuit, but noted in any event that the applicable regulation related to final denials of administrative appeals, and did not require notification of any time limit. The defendants further noted that several courts within the Ninth Circuit had rejected arguments that the regulations required initial claim denials to state the time limit for filing a civil action. The defendants argued in the alternative that if the regulations did require notification of the time limit for a lawsuit, the court should disregard the contractual limitation period only if the claimant established he was entitled to equitable tolling. Because Mr. Baker did not exercise reasonable diligence in submitting his claim, he was not entitled to equitable tolling, and the contractual limitations period was applicable. Finally, defendants argued the mostly closely analogous limitations period was the three-year period for recovery of a loss under a policy, but even if the eight-year contract statute of limitations applied, Mr. Baker did not file his lawsuit within eight years of the date his proof of loss was due.

The court permitted Mr. Baker to file a sur-reply addressing the issue of when the eight-year statute of limitations, if applicable, would begin to run. Mr. Baker responded that his cause of action accrued on the date his administrative appeal was denied, and
he therefore had eight years from that date to file his lawsuit.

On January 20, 2016, United States Magistrate Judge Richard W. Anderson issued his findings recommending that the motion to dismiss be granted. Judge Anderson found the case law supporting Mr. Baker’s position had been abrogated by the United States Supreme Court decision in *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S.Ct. 604, 610 (2013), which held that a contractual limitations period in an ERISA plan is enforceable, even if it starts to run before the cause of action accrues, as long as it is reasonable. Judge Anderson noted that under the terms of the policy at issue, the time limit for a lawsuit began running 90 days after proof of loss was due, or March 19, 2007. Judge Anderson declined to reach the issue of whether the ERISA regulations required notification of the time limit for a lawsuit in the claim denial, or whether the eight-year statute of limitations should be applied, because even if the eight-year statute of limitations did apply, Mr. Baker was required to file his lawsuit by March 19, 2015. Mr. Baker did not file his lawsuit until over three months later, and his claim was therefore barred and the defendants entitled to dismissal.

Mr. Baker did not object to the recommendation, and on February 18, 2016, Chief Judge Dana L. Christensen issued an order adopting in full the recommendation and dismissing Mr. Baker’s complaint.

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The 8th Circuit Upholds the Obligation of an Applicant to Provide Evidence of Insurability for Supplemental Coverage

A physician applies for life insurance coverage and is told by the agent that he doesn't need to provide evidence of insurability for supplemental coverage. His wife then cancels life insurance coverage she had insuring his life. The insured then finds out he has been diagnosed with cancer but doesn’t tell the insurer. The policy is issued and the insured dies shortly thereafter. *Huang v. Life Ins. Company of North America*, 801 F.3d 892 (8th Cir. 2015).

On November 12, 2009, Dr. Ping Lui applied for basic and supplemental life insurance through his employer, $46,858.49 in basic coverage and approximately $180,000 in supplemental benefits through a policy issued by Life Insurance Company of North America (“LINA”). He designated his wife, Yafei Huang, as beneficiary of his coverage.

At the time he applied, his employer gave him a summary plan description and an application, the latter of which asked him to confirm whether he had been diagnosed or told or treated by a medical professional for a number of cancer-related conditions. The application also contained an “AGREEMENTS AND AUTHORIZATION” section whereby Dr. Lui certified that his answers were “true and complete” and agreed to “report any change in [his] health that happens before [his] insurance is effective.” 801 F.3d at 895.

Shortly after Dr. Lui applied for coverage, he was diagnosed with cancer, but did not disclose that diagnosis to LINA. The company issued the coverage on March 1, 2010. Seven weeks later, on April 23, 2010, Dr. Lui died of cancer.

LINA paid the basic life benefits but denied Ms. Huang’s request for supplemental benefits on January 19, 2011 on the grounds that Dr. Lui failed to provide notice of his change in health before March 1, 2010 as required. Along with its denial letter, LINA enclosed a copy of the application Dr. Lui had signed. (LINA also learned that prior to applying for coverage, Dr. Lui’s treating physician noted some physical symptoms two months prior to completing his application, but no specific diagnosis was made.)
Ms. Huang asserted in her administrative appeal that a LINA agent told Dr. Lui at the time of the application signing that he could obtain supplemental benefits by submitting the application without having to provide proof of good health, and in reliance on that representation she allowed her $100,000 policy through her employer insuring Dr. Lui's life to lapse. Ms. Huang sued LINA, alleging six theories of recovery. The district court granted summary judgment in relevant part:

- On count I, in her favor, reforming the plan language to comply with Missouri law (not appealed):

  “No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the insured [replacing “claimant”]. In the event of death or legal incapacity, the beneficiary must receive the copy.”

  LINA did not appeal this ruling.

- On count II (claim for plan benefits), in LINA’s favor holding that LINA’s interpretation of the plan to permit it to produce the application to Ms. Huang during the claims process – versus to the applicant prior to his death – was reasonable.

- On count V, also in LINA’s favor, holding that no breach of fiduciary duty claim could be sustained because Ms. Huang’s representation was too vague to support such a cause of action and that the representation was not untrue given that Dr. Lui did qualify for coverage at the time he applied and there was no assertion that he was told the conditions set forth in the application did not need to be followed. The court also found that Dr. Lui did not reasonably rely on the representation (noting that it made no sense to allow other insurance to lapse and not review the application's requirements), and that the terms of the application were sufficiently clear to put him on notice that he had to tell LINA if his health changed. Second, the court rejected Ms. Huang's contention that the size and formatting of the application was confusing and therefore constituted a breach of fiduciary duty under ERISA.

  801 F.3d at 897. Ms. Huang appealed to the Eighth Circuit, which affirmed the district court’s rulings.

**Count I:** Noting that LINA had been granted discretion to interpret the plan, the court recited the Eighth Circuit “abuse of discretion” standard, that a plan administrator’s decision will not be overturned if it is supported by substantial evidence. Applying that standard, the court found that LINA’s interpretation of the plan requiring it to supply a copy of the application during the claims process – as opposed to the insured during his lifetime – was reasonable since the plan did not require that the statement be given to the insured while he was alive.

Ms. Huang also argued that ERISA does not preempt state laws that regulate insurance, including Missouri Revised Statutes section 376.697(3) and state case law requiring that the statement be provided during the insured’s lifetime. The court also rejected that theory, noting that the Missouri statute utilized the word “or” which meant that the insurer could deliver the statement either to the insured or, alternatively, to his beneficiary after death. 801 F.3d at 898-99.

**Count II:** Although the court acknowledged that a claimant may be able to state a breach of fiduciary duty claim under *Cigna Corp. v. Amara*, 563 U.S. 421 (2011) and obtain equitable relief in the form of surcharge, Ms. Huang’s claim required proof of detrimental reliance. Such reliance was required because Ms. Huang was alleging that she and Dr. Lui relied upon the LINA representative’s statements in letting her life insurance coverage lapse. However, any such reliance must be reasonable and in this case the district court correctly found that any reliance was not reasonable:

  “[T]he questions in the application seeking health information were routine questions to identify health concerns that might trigger further inquiry. The ongoing duty to report changes in health post-application simply ensured the answers to the questions in the application remained current until the time of policy issuance. There is nothing unclear or unusual about these written requirements. . . .”
801 F.3d at 900. The court also found Ms. Huang's description of the circumstances surrounding the statement to be impossibly vague, citing to *Murphy v. FedEx Nat'l LTL, Inc.*, 618 F.3d 893 (8th Cir. 2010).

**Count V:** Ms. Huang alleged that the application and the summary plan description were so vague as to constitute a breach of fiduciary duty on LINA's part. The court held that no such claim could be sustained, pointing out that the duty upon an applicant to notify LINA of a change in his health was “sandwiched conspicuously between a line where Lui was required to write his name and social security number and a signature block where Lui and Huang signed and dated the policy[,]” and the wording was not hidden or printed in a smaller font. *Id.* at 901.

The court's opinion highlights the importance of ensuring that any state-mandated disclosure language is included within the plan document and the application and statement of good health; and ensuring that plain and conspicuous language be used to describe the applicant's duty to disclose changes in health discovered after the application has been signed and before the insurance coverage becomes effective.

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**Northern District of West Virginia Holds That Discovery Is Not Mandated in Every Case Merely Because a Structural Conflict of Interest Exists**

In *Lockard v. Unum Life Ins. Co. of Am.*, 2015 WL 4730089 (N.D. W. Va., Aug. 10, 2015), the United States District Court for the Northern District of West Virginia considered Plaintiff Belinda Lockard's ("Plaintiff" or "Lockard") motion to conduct limited discovery ("Plaintiff's Motion"). Specifically, plaintiff's motion sought leave to take depositions and serve defendant, Unum Life Insurance Company of America ("Defendant" or "Unum"), with interrogatories and requests for production of documents for the limited purpose of determining the existence and extent of any conflict of interest on Unum's part.

Lockard previously submitted a claim for long-term disability ("LTD") benefits under the plan, which delegated to Unum the discretionary authority under ERISA to make benefit determinations. Unum initially denied her claim for LTD benefits, Lockard then appealed Unum's decision, and Unum ultimately denied Lockard's appeal. Lockard then filed suit against Unum, and after the court entered a scheduling order, filed her motion to conduct limited discovery.

The court acknowledged that many courts have found that the Supreme Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), created an exception to the general rule prohibiting extra-record discovery in ERISA cases. In fact, as stated by the United States District Court for the District of Maryland in *Clark v. Unum Life Ins. Co. of Am.*, 799 F. Supp. 2d 527, 533 (D. Md. 2011), the *Glenn* exception allows for additional discovery outside of the administrative record “when an administrator has a structural conflict of interest and information not contained in the record is necessary to enable the court to determine the likelihood that the conflict influenced the particular benefits decision at issue.” The court, relying on several Fourth Circuit opinions issued in the wake of *Glenn*, noted that when an administrator acts in a dual role, courts should consider the inherent conflict of interest under the eighth factor set forth in *Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 201 F.3d 335, 342-43 (4th Cir. 2000) (“the fiduciary’s motives and any conflict of interest it may have”). Moreover, in *Helton v. AT&T Inc.*, 709 F.3d 343, 352 (4th Cir. 2013), the Fourth Circuit reaffirmed the principle that while an abuse of discretion standard of review under ERISA is normally limited to the administrative record, there is no “absolute bar” preventing the introduction of extrinsic evidence.

Lockard relied on the Fourth Circuit's decision in *Helton* to support her motion for extra-record discovery, as she contended that the requested discovery was necessary in order to adequately assess the conflict of interest factor under *Booth*, and
that the evidence sought to be discovered was known to Unum when it rendered its benefit determination. Unum, on the other hand, argued that the requested discovery was not necessary in order for the court to perform an analysis under *Booth* because it admitted that it operated under a structural conflict of interest when it adjudicated Lockard's benefits claim. In that regard, Unum contended that its structural conflict of interest was readily apparent on the face of the administrative record and the court could take that conflict into account when reviewing its decision for abuse of discretion.

The court agreed with Unum and decided to consider the merits of plaintiff's claim after the parties submitted their dispositive motions. At that time, the court could consider Unum's undisputed structural conflict of interest as one of the factors identified in *Booth*. The court further found that the plaintiff failed to identify anything in the administrative record – or anything suspected to exist outside of the record – that could serve to demonstrate the necessity of ordering limited discovery. The court held that while *Glenn* opened the door for extra-record discovery in ERISA cases, discovery was not mandated in every case, regardless of the circumstances, merely because of the existence of a structural conflict of interest. The court chose not to give the plaintiff carte blanche to conduct discovery on Unum's conflict of interest which would serve to convert the emphasis of the litigation from the reasonableness of an administrator's claim decision to an exhaustive scrutiny of the general fairness of the administrator's business practices.

The court found that the nearly 700-page administrative record was sufficiently detailed to reveal any significant defects that might have made it vulnerable to bias and that it was able to sufficiently weigh the *Booth* factors, including Unum's motives and conflict of interest, without requiring the requested discovery. Accordingly, the court concluded that discovery outside of the administrative record was not necessary for it to assess the appropriate factors when reaching its decision on the reasonableness of Unum's claims determination.

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