In This Edition:

- Pre-Emption of Colorado’s Unreasonable Delay/Denial of Insurance Claims Statute  
  Page 2

- Mental Health of Insured Irrelevant When Applying Suicide Exclusion  
  Page 3

- Fourth Circuit Now Requires ERISA Plan Administrator to Seek Readily Available Records that Might Have Confirmed Claimant’s Theory of Disability or Otherwise Inform Claimant in Clear Terms That Such Records are Necessary  
  Page 4

- U.S. Supreme Court Recently Heard Newest Challenge to ACA  
  Page 6
Effective August 5, 2008, the Colorado General Assembly enacted C.R.S. §10-3-1116, creating a statutory cause of action for unreasonable delay or denial of insurance claims, which is in addition to Colorado’s previously-existing bad faith tort. Included in the statute are the following provisions, mandating de novo review and a jury trial in cases involving claims for health, life, and disability benefits:

(2) An insurance policy, insurance contract, or plan that is issued in this state that offers health or disability benefits shall not contain a provision purporting to reserve discretion to the insurer, plan administrator, or claim administrator to interpret the terms of the policy, contract, or plan or to determine eligibility for benefits.

(3) An insurance policy, insurance contract, or plan that is issued in this state shall provide that a person who claims health, life, or disability benefits, whose claim has been denied in whole or in part, and who has exhausted his or her administrative remedies shall be entitled to have his or her claim reviewed de novo in any court with jurisdiction and to a trial by jury.

Under the federal Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. §1001 et seq., applicable to employee welfare benefit plans, a legal challenge to a denial of benefits is reviewed de novo unless the plan grants the claims administrator discretion to interpret the plan and decide claims, in which case the standard of review is arbitrary and capricious. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). The Colorado courts have come to different conclusions in determining whether Colorado’s unreasonable delay/denial statute is preempted by ERISA when applied to employee welfare benefit plans.

ERISA contains an express preemption provision, stating “[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insular as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. §1144(a). However, ERISA also contains a “savings clause,” saving from ERISA preemption state statutes regulating insurance: “[E]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” 29 U.S.C. §1144(b)(2)(A). To be deemed a law regulating insurance, the statute at issue must (1) be “specifically directed toward entities engaged in insurance,” and (2) “substantially affect the risk pooling arrangement between the insurer and the insured.” Kentucky Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329, 342 (2003). The Colorado unreasonable delay/denial statute states that it is a law regulating insurance, in an apparent effort to avoid express pre-emption under ERISA. C.R.S. §10-3-1116(7).

In addition to express pre-emption, “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.” Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004). This theory is commonly referred to as “conflict preemption,” which applies even if the state law can arguably be characterized as regulating insurance under the savings clause. Id. at 217-18.

Shortly after the enactment of the Colorado unreasonable delay/denial statute, two federal district court cases in Colorado considered whether the statute’s prohibition on arbitrary and capricious review pre-empted ERISA. See McClennahan v. Metro. Life Ins. Co., 416 Fed. Appx. 693, 2011 U.S. App. LEXIS 5826 (10th Cir. 2011), (unpublished order and judgment); Kohut v. Hartford Life & Accident Insurance Co., 710 F. Supp. 2d 1139 (D. Colo. 2008). Each case arose in the context of a claim for long-term disability benefits, and the parties briefed the applicable standard of review. In each case, the court held the Colorado statute was a law regulating insurance under the two-part test
describe in Miller, and therefore saved from express pre-emption under ERISA’s savings clause. Although not addressed in Kohut, the court in McClenahan also considered whether the Colorado statute is pre-empted under a theory of conflict pre-emption. The court rejected the insurer’s argument that the Colorado statute conflicts with the federal statute’s remedial scheme by eliminating the arbitrary and capricious standard of review, on the basis that ERISA does not actually contain any standard of review requirement.

Several years later, the Colorado Court of Appeals held that a statutory unreasonable delay/denial claim, also arising from the denial of long-term disability benefits, was pre-empted under a theory of conflict pre-emption. Timm v. Prudential Ins. Co., 259 P.3d 521, 526-527 (Colo. App. 2011). In Timm, the court noted that ERISA provided a remedy for the unreasonable withholding of benefits, which did not include consequential or punitive damages, and held that Colorado’s bad faith statute conflicted with that comprehensive remedial scheme by providing for double recovery of benefits. The court distinguished McClenahan, which found that conflict preemption did not apply, as dealing only with the standard of review for benefits denial, as opposed to the provision of a remedy greater than that permitted under ERISA.

On February 19, 2015, another division of Colorado’s federal district court weighed in on the issue of pre-emption under C.R.S. §10-3-1116, this time in the context of a claim for life insurance benefits. See Shafer v. Metropolitan Life Ins. Co., 2015 U.S. Dist. LEXIS 19822 (D. Colo. Feb. 19, 2015). The court in Shafer agreed with Kohut and McClenahan that the Colorado statute is a law regulating insurance and therefore saved from express pre-emption. The court also agreed with McClenahan that the requirement of de novo review does not conflict with ERISA’s remedial scheme, given that de novo is the default standard of review in an ERISA case. However, the court found that the right to a jury trial in C.R.S. §10-3-1116(3) conflicts with ERISA’s remedial structure, which provides only equitable relief and does not include the right to a jury trial. Although the statute contains a severance provision in C.R.S. §10-3-1116(6), the court read that section as permitted severance only of an entire subsection, and not of a portion of a sentence within a subsection. The court therefore held that ERISA pre-empts C.R.S. §10-3-1116(3) in its entirety, and stated it would review the claim under an arbitrary and capricious standard of review pursuant to the plan language.

Of note, C.R.S. §10-3-1116(2), which Shafer seems to indicate would not be pre-empted by ERISA, also bars arbitrary and capricious review, but is on its face applicable only to health and disability benefits. By contrast, C.R.S. §10-3-1116(3) applies to health, life, and disability benefits. Because Shafer involved a life insurance claim, the former section did not apply.

By: Gillian Dale, Esq. & Cristin J. Mack, Esq. Hall & Evans, LLC Denver, Colorado

Mental Health of Insured Irrelevant When Applying Suicide Exclusion

A creative attempt to avoid an age-old life insurance exclusion failed recently in South Carolina. On July 10, 2014, the U.S. District Court for the District of South Carolina in Robinson v. American General Life Insurance Co., 2014 U.S. Dist. LEXIS 93742 (D.S.C. July 10, 2014), dismissed with prejudice the claims of a beneficiary related to the denial of life insurance benefits following an insured’s suicide. The policy contained a standard suicide exclusion providing that liability under the policy was limited to the return of premiums “[i]n the event of the suicide of the insured, while sane or insane, within two years.” The insured died of a self-inflicted gunshot wound, and the insurer tendered the premiums paid to the beneficiary. The plaintiff’s theory was that the medical malpractice of third-parties treating the insured for depression led to the self-inflicted gunshot wound and that the insured did not have the mental capacity to commit suicide. The insurer moved for judgment on the pleadings, arguing that the complaint and
accompanying “expert” affidavits, which outlined the alleged medical malpractice, established the applicability of the suicide exclusion as a matter of law.

The court granted the motion for judgment on the pleadings, holding that the complaint and accompanying affidavits plainly admitted that the insured died from suicide and that his mental health and treatment were irrelevant to the claims. In reaching this conclusion, the court looked to South Carolina’s statutory law on suicide exclusions, S.C. Code Ann. § 38-63-225(A), and found that to avoid liability the insured need only establish (1) that it returned the premiums paid, and (2) that the suicide occurred within two years of the issuance of the policy. The complaint on its face established the date of the policy and the date of death, which fell within the two-year period. Further, the complaint admitted that the insurer tendered the premiums paid to the beneficiary. Accordingly, the case hinged on whether death by self-inflicted gunshot wound was not a suicide due to the plaintiff’s contention that the insured did not want to die and would not have died but for the medical malpractice of third parties. The court framed the legal question as “whether insanity may be used to avoid a suicide exclusion in a life insurance policy.”

The court rejected the plaintiff’s contention that the insured’s death was not suicide because the insured lacked the requisite intent required under a South Carolina criminal statute prohibiting assisted suicide, S.C. Code Ann. § 16-3-1090(A)(2). The court noted that the plaintiff’s own experts called the insured’s death a suicide, thereby rendering the plaintiff’s argument a “failed attempt to avoid the ‘suicide’ exclusion.” The court also rejected the argument that the cause of death was the medical malpractice of third parties, finding that while the argument may have supported a theory of recovery against the third parties, it did not serve to avoid the exclusion in the policy. By using the language “sane or insane” in the policy, the court found that the insurer made irrelevant, as a matter of law, any argument that the insured “did not want to die” and “did not voluntarily kill himself due to mental illness.”

The court relied in part on a South Carolina Supreme Court holding from eighty years ago, Gibson v. Reliance Life Insurance Co., 172 S.C. 94, 172 S.E. 772 (1932), holding that suicide exclusions including the phrase “sane or insane” are valid, self-executing, and must be applied according to their plain terms. The court holding reaffirms this established South Carolina law that suicide exclusions, including the phrase “sane or insane,” are valid, enforceable, and cannot be avoided by allegations of mental incapacity. Importantly, this ruling helps prevent the erosion of the suicide exclusion which would have surely resulted had the plaintiff’s arguments been adopted as almost every case of suicide involves some degree of mental illness.

By: D. Larry Kristinik, Esq. & Sarah B. Nielsen, Esq.
Nelson Mullins Riley & Scarborough LLP
Columbia, South Carolina

Fourth Circuit Now Requires ERISA Plan Administrator To Seek Readily Available Records That Might Have Confirmed Claimant’s Theory Of Disability Or Otherwise Inform Claimant In Clear Terms That Such Records Are Necessary

In Harrison v. Wells Fargo Bank, N.A., --- F.3d ---, 2014 WL 6845461 (4th Cir., Dec. 5, 2014), the plaintiff, Nancy Harrison (“Harrison”), brought suit against her employer, Wells Fargo, arguing that it improperly terminated her short-term disability (“STD”) benefits while she was undergoing a series of treatments for thyroid disease. The U.S. District Court for the Eastern District of Virginia upheld Wells Fargo’s decision, finding that its plan administrator, Liberty Life Assurance Company (“Liberty Life”), did not abuse its discretion in denying Harrison’s claim. However, the U.S. Court of Appeals for the Fourth Circuit reversed the judgment of the district court and instructed it to remand Harrison’s claim to Wells Fargo for a full and fair review of Harrison’s claims. In reversing the district court, the Fourth Circuit adopted the
narrow principle that once a plan administrator is on notice that readily-available evidence exists that might confirm an ERISA claimant’s theory of disability, “it cannot shut its eyes to such evidence where there is little in the record to suggest the claim deficient.”

Harrison worked for Wells Fargo as an Online Customer Service Representative. In May 2011, her doctor discovered that she had an enlarged thyroid and a large mass extending into her chest that was causing her to suffer chest pain and tracheal compression. She underwent a bronchoscopy on June 9, 2011, and a thyroidectomy on August 17, 2011. She was unable to work and received STD benefits under the Wells Fargo plan. Although she needed a second surgical procedure to remove the remaining mass in her chest, her benefits were terminated on September 10, 2011 as Wells Fargo adjudged three weeks to be the normal period of recovery from her thyroidectomy.

One week after the August 17, 2011 thyroidectomy, Harrison notified Wells Fargo that she was scheduled for another more serious procedure, a median sternotomy, on October 31, 2011, where her chest would be opened to remove the remaining mass. Moreover, while Harrison was facing her surgeries, her husband died unexpectedly, triggering a recurrence of depression and post-traumatic stress disorder (“PTSD”) related to the death of her mother and children in a house fire in 2004. Nevertheless, on September 10, 2011, Wells Fargo found that she had fully recovered from the thyroidectomy, deemed her fit to return to work, and discontinued her STD benefits.

In her first level appeal, Harrison’s primary care physician provided documentation of her continued chest pain and emotional trauma. Harrison also noted that she had an appointment with a psychologist with regard to her mental health condition and provided contact information for her primary care physician, thoracic surgeon, and psychologist. A nurse case manager reviewed her file and Liberty Life upheld its denial on November 28, 2011.

In her second level appeal, Harrison provided documentation from her primary care physician and thoracic surgeon, as well as a detailed letter from her sister who was her primary caretaker outlining her continuing pain, disability, and severe panic attacks. Wells Fargo conducted two independent peer reviews, one of Harrison’s physical disability claim and another of her psychological claim.

While the doctor reviewing Harrison’s psychological claim contacted Harrison’s primary care physician, he did not contact her psychologist. He concluded that while there was evidence in the record to suggest that the loss of her husband could have triggered PTSD caused by the death of her mother and children, “[i]n the absence of psychiatric/psychological records or telephone conference with her psychologist, an opinion as to whether her psychiatric status limited her functional capacity cannot be provided.” Ultimately, Wells Fargo rendered its final decision on May 4, 2012, upholding the denial decision.

Harrison proceeded to bring an action against Wells Fargo under ERISA and contended that Wells Fargo abused its discretion in denying her STD benefits. The district court found that there was insufficient evidence of disability under the Plan to conclude that Wells Fargo had abused its discretion in denying Harrison’s claim. Harrison thereafter appealed to the Fourth Circuit.

On appeal, Harrison argued that Wells Fargo abused its discretion in rejecting her claim between her surgical procedures at a time when she continued to have pain and other complications from the mass in her chest. She further argued that the denial was flawed because Liberty Life neither considered records from her psychologist nor specifically explained to her that such records were necessary to perfect her claim.

In considering the factors as set forth in Booth v. Wal-Mart Stores, Inc. Assoc’s Health and Welfare Plan, 201 F.3d 335, 342-43 (4th Cir. 2000), the Fourth Circuit held that Wells Fargo failed to meet its statutory and Plan obligations to Harrison:

By failing to contact Dr. Glenn [Harrison’s psychologist] when it was on notice that Harrison was seeking treatment for mental health conditions and when it had his contact
information, as well as properly signed release forms from Harrison, the plan administrator chose to remain willfully blind to readily available information that may well have confirmed Harrison’s theory of disability.

While the court acknowledged that the primary responsibility for providing medical proof of disability undoubtedly rests with the claimant, “a plan administrator cannot be willfully blind to medical information that may confirm the beneficiary’s theory of disability where there is no evidence in the record to refute that theory.” In those situations, it is necessary for there to be “some back and forth between administrator and beneficiary.” “A searching process does not permit a plan administrator to shut its eyes to the most evident and accessible sources of information that might support a successful claim.” The Court further recognized the rule from sister circuits that plan administrators are required to notify a claimant of specific information that they were aware was missing and that was material to the success of the claim.

The Court distinguished Harrison’s claim from those claims in its prior decisions, LeFebre v. Westinghouse Elec. Corp., 747 F.2d 197, 207 (4th Cir. 1984), overruled by implication on other grounds by Black & Decker Disability Plan v. Nord, 538 U.S. 822 (2003), Berry v. Ciba-Geigy Corp., 761 F.2d 1003 (4th Cir. 1985) and Elliott v. Sara Lee Corp., 190 F.3d 601 (4th Cir. 1999). In those cases, there was sufficient evidence in the existing record to refute claimant’s theory of disability. In the case sub judice, however, Wells Fargo was repeatedly put on notice that Harrison was seeking psychiatric treatment and its reviewer made clear to the plan administrator that the record was not sufficient to render a decision. Wells Fargo had Harrison’s psychologist’s contact information; however, its reviewing physician did not take the additional step of contacting Harrison’s psychologist directly. Moreover, although Wells Fargo was on notice that Harrison was receiving psychological treatment, it never made clear to Harrison that records from her psychologist were missing and needed, noting only vaguely in a long letter that she should provide relevant medical information without mentioning her psychologist by name. Furthermore, nothing in the record specifically refuted Harrison’s claim of disability.

The Court was careful to recognize that plan administrators possess limited resources and that there are practical constraints on their ability to investigate the volume of presented claims. In that regard, “[n]othing in our decision requires plan administrators to scour the countryside in search of evidence to bolster a petitioner’s case” and “there is no open-ended duty for plan administrators to ‘look all over . . . for a doctor whose testimony might contradict the medical reports from reliable physicians that ha[ve] been submitted.’” (internal citation omitted). However, the Court concluded that Wells Fargo abused its discretion “when it neither sought readily available records from [Harrison’s psychologist] that might have confirmed her theory of disability nor informed her in clear terms that those records were necessary.”

Accordingly, the Court reversed the judgment of the district court and remanded the case to the district court with instructions to return the claim to Wells Fargo for a full and fair review of Harrison’s claims.

By: Scott M. Trager, Esq.
Semmes, Bowen & Semmes
Baltimore, Maryland

U.S. Supreme Court Recently Heard
Newest Challenge to ACA

On March 4, 2015, the United States Supreme Court heard a challenge to the Affordable Care Act (“ACA”) which targets the federal subsidies that have helped over four million people afford health insurance.

The case is King v. Burwell, U.S. Supreme Court case no. 14-114, 759 F.3d 358 (4th Circuit 2014). The issue to be decided is whether the subsidies should be available to all Americans who qualify for them or only to those who purchased health insurance through exchanges “established by the state.” These four words are at the heart of the case because the ACA says citizens qualify for tax credits when they
buy insurance on an online marketplace “established by the state.”

What’s behind the issue? Only 14 states have set up their own exchanges – or marketplaces. The remaining 36 states have left the task of setting up the exchanges to the federal government, which the ACA permits. This presents the high court with the question of whether people can secure ACA subsidies even if they buy policies on the federal exchange.

The IRS has ruled that consumers are able to receive tax credits no matter where they live, and proponents of the ACA argue that the IRS is simply acting in a way that is consistent with the ACA.

Opponents of the ACA argue that the IRS’ interpretation conflicts with the plain and simple language of the statute, and that nothing in the ACA or its legislative history supports the notion that Congress meant to create the legal fiction that the federal government acts on behalf of a state when it establishes an exchange.

The stakes are enormous. If citizens in the 34 states that have not established exchanges are ineligible for the premium subsidies they are now receiving, the ACA could be in peril. Without the premium subsidies, health care coverage would not be affordable for millions of people.

Depending on the court’s ruling, will some or all of the states without exchanges act to establish them? Will the ACA unravel? Or, will the court find the tax credits at issue are essential to the Act’s goals of making affordable health care coverage available and ensuring functional insurance markets?

Stay tuned. The Supreme Court’s decision will likely come by June of 2015.

By: Robert C. Paschal, Esq.
Young Moore and Henderson, PA
Raleigh, North Carolina