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In a May 18, 2015 opinion, the Supreme Court of the United States made it easier for pension plan participants and beneficiaries to maintain breaches of fiduciary duty claims against plan fiduciaries related to the investments in the plan. The Court unanimously held that an ERISA fiduciary has a “continuing duty to monitor” the investments in ERISA-governed plans and to “remove imprudent ones.” In creating a rolling six-year window within which claims can be filed, the Court determined that so long as the alleged breach of the continuing duty occurred within six years of the filing of the suit, the claim is timely.

By way of background, beneficiaries of the Edison 401(k) Saving Plan brought suit against the plan’s fiduciaries in 2007 asserting, among other things, that they suffered alleged losses as a result of the fiduciaries having offered six expensive mutual funds when less costly and identical funds were available for inclusion in the plan. Importantly, three of the mutual funds were added to the plan in 1999, while the three others were added in 2002. The district court, along with the Ninth Circuit, concluded that, as to the funds added in to the plan in 1999, the plaintiffs did not timely file their claims within ERISA’s six-year statute of limitation. With regard to the funds added in 2002, plaintiffs’ claims were found to be timely.

Justice Breyer, writing for the unanimous Supreme Court, noted that ERISA’s fiduciary duty is rooted in the common law of trusts. He pointed out that the common law of trusts provides that a trustee has a continuing duty to monitor investments separate and apart from the duty of prudence in initially selecting an investment for the plan. Unlike the district and circuit courts, the Supreme Court rejected the fiduciaries’ argument that the duty to monitor is triggered only where there is a change in the circumstances surrounding an investment, such that a prudent fiduciary would review the investment. Rather, the Supreme Court, drawing on the common law of trusts, held that ERISA fiduciaries - like trustees - have a continuing duty to monitor investments and to remove imprudent ones.

The Supreme Court declined to offer any guidance on the scope of the ERISA fiduciary’s duty to monitor. The matter was remanded to the Ninth Circuit to determine what kind of investment monitoring is sufficient. Specific guidance and directives will be forthcoming from the district and circuit courts as they ascertain the sufficiency of the monitoring processes of ERISA plan fiduciaries. Nonetheless, the Tibble opinion is instructive, and ERISA fiduciaries would be well served to heed the Supreme Court’s advice, albeit in dicta:

1. Remove bad investment options from the plan – the common law of trusts on which the Supreme Court so heavily relied specifically provides for both a duty to monitor investment and to “remove imprudent ones.”

2. Don’t use expensive investments where more economical and comparable investments are available – do not lose sight of the fact that this is what landed the Edison International fiduciaries in the soup in the first place.

3. Systematically and regularly review plan investments – again borrowing from the common law of trusts, the Court noted that trustees are required to “systematically consider all the investments of the trust at regular intervals.”

My own personal advice to ERISA fiduciaries – stay calm and start monitoring.

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In 2008, Colorado enacted C.R.S. §§10-3-1115 and 1116, establishing penalties for the unreasonable delay or denial of a claim for benefits submitted by any first-party claimant. A first-party claimant is defined as “an individual, corporation, association, partnership, or other legal entity asserting an entitlement to benefits owed directly to or on behalf of an insured under an insurance policy,” and
includes “a public entity that has paid a claim for benefits due to an insurer's unreasonable delay or denial of the claim.” The statutory claim does not apply to workers compensation insurance, title insurance, or life insurance.

A claimant who successfully establishes an unreasonable delay or denial of a claim for benefits under this statute can recover two times the covered benefit plus reasonable attorneys’ fees and costs. By contrast, an insurer that prevails in an action under the statute can recover attorneys’ fees and costs only if the court finds the action was frivolous. The statute disclaims any intent to bar a common law bad faith claim, but does preclude duplicative damages by stating that damages awarded under the statute are not recoverable in any other action.

Recently, Magistrate Judge Michael E. Hegarty of the United States District Court for the District of Colorado issued a ruling addressing the scope of Colorado’s unreasonable delay / denial statute. The case was originally filed in the El Paso County District Court, but was removed by the defendant insurer, to federal court where the parties consented to the jurisdiction of the Magistrate Judge for all purposes including ruling on dispositive motions.

The underlying claim arose under an insurance policy issued to a television production company providing benefits of $1 million to any eligible cast or crew member accidentally killed during the production of a reality television show being produced by the company. In June of 2012, plaintiff Melvin Bernstein’s wife, Terry Flanell-Bernstein, was killed during the production of the pilot for the television show. In May of 2013, the insurer sent a letter to Mr. Bernstein’s attorney informing him of the existence of the accidental death policy, and a claim was then submitted where the full benefits of $1 million were paid to Mr. Bernstein.

In the lawsuit, Mr. Bernstein argued that the insurer had unreasonably delayed the payment of the accidental death benefits because it failed to notify him prior to May of 2013 of the existence of the policy. The defendant insurer moved to dismiss the claim, arguing that the plain language of the statute applies only after a claim has been submitted, and noted that Mr. Bernstein did not allege any delay after his claim was submitted. The insurer further argued that the statute does not impose any obligation to notify potential claimants of the existence of insurance policies which may provide them benefits and does not create any right of action for failing to notify potential claimants of the existence of such policies.

Judge Hegarty issued his Order on Motion to Dismiss on October 22, 2014, finding that the language of the statute was unambiguous and did not apply to the facts alleged in the complaint. Judge Hegarty noted that Mr. Bernstein alleged an unreasonable delay in payment of benefits only during the period he was unaware of the policy, and he was therefore not asserting an entitlement to benefits during that time period. Judge Hegarty further noted that the statute prohibited the unreasonable delay or denial of a claim for benefits, while undisputed, it was not submitted during the time in question.

Judge Hegarty rejected Mr. Bernstein’s effort to invoke Colorado’s common law bad faith tort in an effort to expand the scope of the statute to cover pre-claim conduct. Judge Hegarty instead agreed with the insurer that the bad faith tort was distinguishable from the bad faith statute, and declined to construe the statute as encompassing a broader scope of conduct than specifically articulated in its express language. Judge Hegarty further rejected Mr. Bernstein’s argument that the case law he cited relating to Colorado’s bad faith tort, which referred to the entire course of conduct and all dealings between the insurer and the insured, included conduct which took place before the submission of a claim for benefits.

Judge Hegarty therefore granted the motion to dismiss and ordered the clerk to direct judgment in favor of the defendant insurer. Mr. Bernstein did not appeal the ruling.

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Johnson v. United of Omaha, 75 F.3d 893 (8th Cir. 2014)

At first blush this recent Eighth Circuit ERISA disability case reversing the district court’s grant of summary judgment to the claimant and granting the administrator’s motion appears solely to follow existing circuit precedent -- no deference required to treating physician, reasonable reliance upon outside physician reviewer, and the right to rely upon objective evidence of disability. However, the Court addressed two other significant issues worth a more careful review: first, it analyzed and resolved the interplay between a summary plan description (SPD) and the plan document where the grant of discretionary authority was set forth in the SPD, but it was incorporated within the operative plan document; second, it rejected the district court’s finding that the administrator engaged in “procedural irregularities” during both the short- and long-term disability claims review process on the grounds that they did not affect the ultimate claim decision.

The facts relative to Ms. Johnson’s disability claim are largely undisputed. Ms. Johnson worked in a sedentary, clerical job for Colorado Real Estate and Investment Company as a Rent Roll Specialist. Her job consisted primarily of using a computer to administer the company’s rental operations and to collect rental payments. She was provided disability insurance under a United of Omaha group policy issued to Colorado Real Estate. As such, the employee benefit plan was governed by the Employee Retirement Income Security Act (“ERISA”).

Ms. Johnson stopped work in February 2009 and submitted a claim for short-term disability supported by statement from her treating physician, Dr. MacDonald, who attested that Johnson could not work because of depression, anxiety attacks, and fibromyalgia. 775 F.3d at 985. Claims administrator United of Omaha (“United”) denied her claim. After she appealed, United requested that an in-house physician review her records, which included those related to her spinal surgery five years prior to her stopping work, in 2004. United upheld its decision on appeal.

Johnson then requested long-term disability benefits from United. Her treating physician identified her primary diagnoses as depression and chronic pain syndrome and opined that Johnson could not sit or stand “for any length of time.” Id. The physician also restricted Johnson from working at a computer, noting that she should “[a]void sources of stress” and not use her hands in any repetitive motions. Johnson v. United of Omaha Life Ins. Co., Case No. 8:11CV296, 2013 WL 942511 at *5 (D. Neb. Mar. 11, 2013). United denied Johnson’s long-term disability claim. On appeal, the company obtained an external file review from Dr. Boscardin, an orthopedic surgeon, who disagreed with virtually all aspects of Ms. Johnson’s claim. The Eighth Circuit summarized the key components of Dr. Boscardin’s report:

Dr. Boscardin determined that, although Johnson experienced chronic pain associated with her neck and spine, Johnson’s complaints were “self-reported” and not supported by “conclusive, objective evidence.” For instance, Dr. Boscardin noted Johnson’s “physical exam does not reveal any specific atrophy, loss of strength, or sensation abnormalities” and Johnson’s “Imaging Studies are not specific to explain her ongoing complaints.” Also, he noted, “[t]he medication and its ingestion also leaves me unsettled in that someone complaining of pain at eight to ten level is not requiring a greater degree of medication.” Dr. Boscardin concluded he did not believe Johnson “can’t work with a computer, cannot stand for any length of time, and can sit for only one hour a day,” and he found Johnson’s medical records “do not support significant functional limitation beyond a sedentary level.”
“[o]verall” agreed with Dr. Boscardin’s report but offered no response on Johnson’s work capacity and physical restrictions and limitations. 775 F.3d at 986; 2013 WL 942511, at *11.

The district court found that the de novo standard of review applied because the plan did not grant discretion to United and the existence of procedural irregularities in United’s handling of the claims but decided to apply the abuse-of-discretion standard. The court granted Johnson’s motion for summary judgment and denied United’s motion, finding that United’s decision was unreasonable because United relied solely on Dr. Boscardin’s findings, ignored Johnson’s allegations of fibromyalgia and mental illness, and did not consider Johnson’s condition in its entirety. 775 F.3d at 986.

On appeal, the Eighth Circuit reversed the District Court on all three issues.

(i) The abuse of discretion standard of review applies

In finding that the plan did not contain a grant of discretionary authority to United, the district court relied on Jobe v. Medical Life Insurance Co., 598 F.3d 478 (8th Cir. 2010) and Ringwald v. Prudential Insurance Co. of America, 609 F.3d 946 (8th Cir. 2010), reasoning that inclusion of the grant language in the SPD was insufficient to trigger the abuse of discretion standard. The Eighth Circuit disagreed, holding that (a) the policy expressly incorporated the certificate, (b) the SPD was the final part of a consecutively-paginated booklet, and most importantly, (c) “a reasonable participant would understand the policy to have integrated the SPD along with the discretionary clause. . . .” which the Jobe and Ringwald courts both emphasized as critical to their decisions and thus found that there was no conflict between the two documents in this case. 773 F.3d at 988 (emphasis added).

(ii) Any “procedural irregularities” did not affect the ultimate decision

The district court identified several instances of “irregularities” it attributed to United: lost or misplaced medical records, untimely processing of claims, refusal to re-submit additional medical evidence to a reviewing physician, and giving “the run-around” to Johnson and her counsel. Id. at 988; 2013 WL 942511, at *14 and n.10 thereto.

Under Eighth Circuit law, the de novo standard “might” apply when there was (1) a serious procedural irregularity which (2) caused a serious breach of the plan administrator’s fiduciary duty. 775 F.3d at 986-88. The issue of whether the Supreme Court’s decision in Metropolitan Life v. Glenn, 554 U.S. 105, 115–17, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008) impacts the “procedural irregularity” component of the Eighth Circuit’s pre-Glenn sliding scale standard of review analysis has not been definitively resolved. 775 F.3d at 987, and n.1 thereto (citing Woo v. Deluxe Corp., 144 F.3d 1157, 1160 (8th Cir. 1998) and Waldoch v. Medtronic, 757 F.3d 822, 830 n.3 (8th Cir. 2014)). The Eighth Circuit did not quarrel with the district court’s findings, but concluded that they would not have changed the outcome in the case and did not “trigger a total lack of faith in the integrity of the decision making process.” 775 F.3d at 988 (citing Layes v. Mead Corp., 132 F.3d 1246, 1251 (8th Cir.1998) (internal quotation marks omitted). Implicitly, the Court found dispositive the substance of Johnson’s claim rather than every detail of United’s processing of the claim.

(iii) United’s determination was reasonable

Applying the abuse of discretion standard -- whether United’s decision was “reasonable” and proof by “more a scintilla but less than a preponderance” -- the Court held that United did not abuse its discretion in several respects:

- United reasonably relied upon reviewing physician Dr. Boscardin, who found no objective evidence supporting Johnson’s restrictions and limitations, noting that United was not obliged under ERISA to accept her physician’s opinions) (citing Black & Decker Disability Plan v. Nord, 538 U.S. 822, 123 S. Ct. 1965, 155 L.Ed.2 1034 (2003).
- While the record showed that Johnson had undergone spinal surgery in 2004, she did not receive medical treatment for that condition for four years, from January 2005 until the day she quit her job in February 2009.
Johnson admitted that depression was not the reason she stopped work. Thus, even if she was diagnosed with and treated for the condition, there was no proof indicating that it was impairing her ability to work.

Treating physician Dr. MacDonald’s opinions on Johnson’s restrictions were not based on any objective testing but rather on Johnson’s self-report. Though not mentioned specifically, Dr. MacDonald’s lack of any specialty designation in orthopedic surgery or chronic pain appeared to factor into the Court’s decision.

Dr. McClellan was provided an opportunity to comment upon Dr. Boscardin’s report and agreed with Dr. Boscardin’s overall assessment of Johnson’s condition. 775 F.3d at 989.

The Court’s decision on the merits of the case focused on the claimant’s proof of disability and the administrator’s actions in considering all such information and relying upon a qualified medical reviewer. Accordingly, the practical take-away is that under ERISA, the administrator “got it right.”

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Fourth Circuit Holds that Continuing Breach Theory of Statute of Limitations does not Apply to Disability Insurance Policy

In Curry v. Trustmark Insurance Company, 2015 WL 493834, 2015 U.S. App. LEXIS 1910 (4th Cir., Feb. 6, 2015), the Fourth Circuit considered the statute of limitations as it relates to a disability insurance policy (the “Policy”) and specifically rejected the continuing breach theory, which in this case meant that Plaintiff Martin Curry’s (“Curry”) entire suit was time-barred. Curry filed a lawsuit contending that Trustmark Insurance Company (“Trustmark”) breached the Policy by refusing to pay benefits to him. The district court granted summary judgment on procedural grounds, i.e., disposing of the claim based on Maryland’s statute of limitations. With respect to the portion of the action that fell within the limitations period, the district court ruled against Curry on the merits. The Fourth Circuit affirmed and further found that the lawsuit was time-barred in its entirety.

Factually, Curry was a chiropractor who operated his own practice. Pursuant to the Policy, Trustmark would pay monthly benefits if a physical disability prevented Curry from working as a chiropractor. In order to determine Curry’s eligibility for benefits, the Policy also required him to submit written and continuing proof of loss and, if necessary, to submit to an independent medical examination (“IME”). In 2003, Curry injured his back while performing an adjustment on a patient. He underwent spinal surgery and applied for disability benefits in early 2004. Trustmark began paying benefits to the plaintiff, subject to his providing information regarding the extent of his injury, condition, and expected recovery. For the next three (3) years, Trustmark paid Curry the monthly benefits under the Policy, all while attempting to establish his continued disability. However, the information provided by Curry was inconsistent and incomplete. Consequently, in July 2007, Trustmark notified the plaintiff that it had discontinued his benefits, effective June 26, 2007, until it received the information it requested under the Policy. For the next year, the parties exchanged correspondence regarding the discontinuation of benefits and the scope of the information requested by the Insurer. During that period, Trustmark extended three (3) additional months of benefits. Finally, in the spring of 2008, Trustmark requested that Curry undergo an IME to determine his continued eligibility for benefits; however, he refused to submit to the IME unless Trustmark paid him additional benefits that he argued were owed to him. When Curry failed to attend the IME, Trustmark denied any additional benefits, effective June 30, 2008, and closed the claim on September 29, 2008.

On July 27, 2011, Curry filed suit against Trustmark, alleging breach of contract. In ruling on Trustmark’s motion for summary judgment, the district court determined that the cause of action for breach of contract accrued anew each month benefits were not paid. Consequently, although the court concluded that Curry’s action for breach between September 25, 2007 and July 27, 2008 was untimely
under Maryland’s three (3) year statute of limitations, it addressed on the merits all alleged monthly breaches occurring after July 27, 2008. Because it found no breach of contract in Trustmark’s requirement that Curry submit to an IME and provide continuing proof of loss as a prerequisite for payment of his benefits, the district court granted summary judgment in favor of Trustmark.

On appeal, the Fourth Circuit observed that the Maryland three (3) year statute of limitations typically begins to run from the date of the alleged breach. Actions arising from alleged breaches of a continuing contractual obligation, however, are not wholly barred by the statute of limitations merely because one or more of those alleged breaches occurred earlier in time. Rather, where a contract provides for continuing performance over a period of time, each successive breach of that obligation begins the running of the statute of limitations anew, with the result being that accrual occurs continuously and a plaintiff may assert claims for damages occurring within the statutory period of limitations. In this case, the district court determined that Trustmark breached the contract each time it failed to pay benefits for a period during which Curry was disabled. Because it concluded that each failure to pay monthly benefits was a separate and independent breach, the district court found timely the claims for payment that were not due until after July 27, 2008.

The Fourth Circuit disagreed. Although it found no authoritative Maryland precedent applying the continuing breach theory to an insurance disability policy, the Court of Appeals of Maryland had opined, in the context of a tort action that a similar theory does not apply to the continuing effects of a single earlier act. Maryland federal courts had also rejected a broad application of a continuing breach theory of accrual. In the insurance context, both the Tenth and Eleventh Circuits rejected the idea that disability policies are installment contracts giving rise to continuing breaches for each monthly unpaid benefit. Further, in this situation, the issue was whether the disability benefits were owed in the first place. While Curry contended that he was disabled under the Policy and owed benefits, it did not provide him with an unconditional right to receive benefits in perpetuity—rather, his receipt of benefits was subject to his providing adequate continuing proof of loss, and Trustmark maintained that it did not owe Curry additional benefits because he failed to provide continuing proof of loss. Because the alleged breach arose from Trustmark’s denial that it owed Curry benefits at all, no installment contract existed, and the continuing breach theory was not applicable. The Court was not persuaded by Curry’s argument that his claim accrued only after Trustmark formally closed his claim for benefits on September 29, 2008. The Court held that the cause of action for breach of contract arose, and the statute of limitations began to run, when Trustmark terminated Curry’s monthly benefit payments on June 30, 2008. Thus, the Fourth Circuit affirmed the decision of the district court granting summary judgment in favor of Trustmark, albeit on different grounds than the district court.

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On March 10, 2015, the Fourth Circuit Court of Appeals in Wactor v. Jackson National Life Insurance Co., No. 13-2367, 2015 WL 1020653 (4th Cir. Mar. 10, 2015), upheld a ruling from the U.S. District Court for the District of South Carolina that notice of cancellation was not required for a life insurance policy. The policy in Wactor had been in force for nearly 19 years, until it was cancelled in February 2010 due to a missed premium payment. After the insured passed away on June 12, 2010, his widow, who was the sole beneficiary, sought payment of the $200,000 death benefit. Prior to his death, the decedent had missed premium payments on at least 22 occasions. In each of these instances, the insurer mailed a grace-period notice to the insured, and the insured paid the premium within the 31 day grace period provided under the policy. After a missed payment on January 25, 2010, the insurer mailed a grace-period notice, and, after not having received a payment within the grace period, the insurer mailed a lapse notice. The
beneficiary contended that these two notices were never received. The policy was silent as to whether notice of cancellation was required. The claim for the death benefit was denied based on the lapse of the policy due to non-payment of premium. The beneficiary then initiated the lawsuit.

The insurer moved for summary judgment, relying on the prior cancellation of the policy. The beneficiary argued that there was a factual dispute as to whether the lapse notice was ever received by the insured. The district court rejected this argument, recognizing that “neither South Carolina law nor the terms of the policy require any notice prior to cancelling the policy.” In reaching this conclusion, the court disregarded expert testimony that notice of cancellation actually had to be received by the insured. The court found that this opinion was an inadmissible legal conclusion. The beneficiary also argued that the insurer had waived its right to cancel the policy due to its prior course of conduct with the insured. The district court rejected this argument, finding that the insurer had never accepted a premium payment after the grace period and thus had not created any expectation that there would be coverage past the expiration of the grace period. The Fourth Circuit upheld the grant of summary judgment and deemed the district court’s reasoning to be sound.

The decision in Wactor reiterates the principle of South Carolina law that, absent a requirement set forth in the policy, notice of cancellation is not required to be provided to an insured before a life insurance policy can be terminated for non-payment of premiums. The timely payment of premiums continues to be recognized as an obligation of the insured, and one which is not easily overcome by a beneficiary when a lapse occurs prior to the death of the insured.

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