APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

MICHAEL D. ELLIS, Plaintiff - Appellee, v. LIBERTY LIFE ASSURANCECOMPANY OF BOSTON, a New Hampshire corporation, Defendant - Appellant.	No. 19-1074 (D.C. No. 1:15-CV-00090-LTB-KMT) (D. Colo.)

ORDER

Before **HARTZ** and **EID**, Circuit Judges.

Appellee's petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular

active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court

CHRISTOPHER M. WOLPERT, Clerk

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

MICHAEL D. ELLIS, Plaintiff - Appellee, v. LIBERTY LIFE ASSURANCE COMPANY OF BOSTON, a New Hampshire corporation, Defendant - Appellant.	No. 19-1074

Appeal from the United States District Court for the District of Colorado

(D.C. No. 1:15-CV-00090-LTB-KMT)

Byrne J. Decker, Ogletree, Deakins, Nash, Smoak & Stewart, P.C., Portland, Maine (Kristina N. Holmstrom (Ogletree, Deakins, Nash, Smoak & Stewart, P.C., Phoenix, AZ on the briefs) for Defendant-Appellant.

Shawn McDermott, McDermott Law, LLC, Denver, Colorado (Timothy Garvey, McDermott Law, LLC,

Denver, Colorado on the briefs) for Plaintiff-Appellee.

Before **HARTZ** and **EID**, Circuit Judges.*

HARTZ, Circuit Judge.

In 2014, Liberty Life Assurance Company of Boston rejected the claim for long- term disability benefits by Michael Ellis. As part of its employee-benefit plan, Comcast Corporation, for whom Ellis worked in Colorado from 1994 until 2012, had obtained from Liberty in 2005 a Group Disability Income Policy (the Policy). Ellis sought review of Liberty's denial of benefits in the United States District Court for the District of Colorado under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 et seq. The district court, reviewing the denial de novo, ruled that Liberty's denial was not supported by a preponderance of the evidence. Liberty appeals. It contends that the court should have reviewed its decision under an abuse-of-discretion standard but that it should prevail even under a de novo standard. Ellis

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* The late Honorable Monroe G. McKay, United States Senior Circuit Judge, heard oral argument and participated in the panel's conference of this appeal, but passed away before its final resolution. The practice of this court permits the remaining two panel judges, if in agreement, to act as a quorum in resolving the appeal. *See United States v. Wiles*, 106 F.3d 1516, 1516, n* (10th Cir. 1997); 28 U.S.C. § 46(d).

defends the district court's choice of a de novo standard but argues he should prevail under either standard of review.

The central issue on appeal is what standard of review the district court should have applied. A plan administrator's denial of benefits is ordinarily reviewed by the court de novo; but if the policy gives the administrator discretion to interpret the plan and award benefits, judicial review is for abuse of discretion. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The Policy provided that it was governed by the law of Pennsylvania, which is where Comcast is incorporated and has its principal place of business. Among its terms was one that gave Liberty discretion in resolving claims for benefits. A Colorado statute enacted in 2008, however, forbids such grants of discretion in insurance policies. The parties dispute both whether the statute applies to the Policy under Colorado law and whether Colorado law governs. We hold that in this dispute the law of Pennsylvania, rather than that of Colorado, is controlling. The uniformity and administrative-efficiency objectives of ERISA counsel us to adhere to the Policy's choice of law. Liberty's denial of benefits is therefore properly reviewed for abuse of discretion. Under that standard the denial must be upheld. Exercising jurisdiction under 28 U.S.C. § 1291, we reverse the decision of the district court.

I. BACKGROUND

A. The Policy

Under the Policy, employees of Comcast are eligible for long-term disability benefits upon providing proof of disability due to injury or sickness and the expiration of an elimination period of at least six months, subject to proof of continuing disability and the need for regular attendance of a physician.[1] As relevant to the dispute before us, *disability* or *disabled* means that the employee "is unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation." Aplt. App., Vol. II at 296.

B. Ellis's Medical History

On February 1, 2012, while undergoing treatment for pneumonia, Ellis experienced severe chest pain as a result of a pulmonary embolism (blood clot in the lungs). He was administered nitroglycerin, but soon afterwards he had an abnormally slow heartbeat, followed by an approximately 24-second heart stoppage. He briefly returned to work after this incident, but his last day of employment with Comcast was February 29, 2012.

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[1] The Policy language states, in relevant part:

When Liberty receives Proof that a Covered Person is Disabled due to Injury or Sickness and requires the Regular Attendance of a physician, Liberty will pay the Covered Person a Monthly Benefit after the end of the Elimination Period, subject to any other provisions of this policy. The benefit will be paid for the period of Disability if the Covered Person gives to Liberty Proof of continued:

1. Disability;
2. Regular Attendance of a Physician; and
3. Appropriate Available Treatment. Aplt. App., Vol. II at 309.

Ellis submitted a claim for short-term disability benefits, which Liberty approved in March 2012. He reported "poor concentration, dizziness, slowing of physical and mental skills" and was referred to a neurologist in June 2012. Aplt. App., Vol. I at 268. The neurologist who began treating Ellis, Dr. Alan Zacharias, recommended physical and cognitive therapy but also noted that Ellis had an "[u]nremarkable brain MRI," had no evidence of a primary neuromuscular disease, and was alert and attentive. *Id.* at 269. Based on this report and documentation from two other providers, Liberty terminated short-term benefits in July 2012.

In October 2012, Ellis's lawyer sent a letter to Liberty asking it to reinstate benefits without a formal appeal. Part of this submission was a neuropsychological evaluation by Dr. Dennis Helffenstein, whom the lawyer had asked to evaluate Ellis. He opined that Ellis's testing "identified significant cognitive deficits suggesting bilateral frontal and bilateral temporal involvement. The pattern is consistent with cerebral hypoxia.[2] There is absolutely no way Michael could do his job at this time from a cognitive standpoint." Aplee. Supp. App., Vol. II at 578. Liberty reinstated short-term disability benefits through the maximum duration and advanced the claim for long-term- disability consideration.

To assess Ellis's eligibility for long-term benefits, Liberty's claim consultant asked Dr. John Crouch and Dr.

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[2] According to the National Institute of Neurological Disorders and Stroke, "[c]erebral hypoxia refers to a condition in which there is a decrease of oxygen supply to the brain even though there is adequate blood flow." National Institute of Health, *Cerebral Hypoxia Information Page*, https://www.ninds.nih.gov/disorders/all-disorders/cerebral-hypoxia-information-page. Possible causes include "cardiac arrest." *Id.*

Gilbert Wager (Liberty's consulting neuropsychologist and internal-medicine specialist, respectively) to review Ellis's records. The reports from both doctors expressed doubt that a 24-second heart stoppage could cause cerebral hypoxia or neurological injury. Dr. Wager explained that "[t]his scenario is unlikely, as permanent neurological injury is not a feature of an episode of cardiogenic syncope. In general, it takes about 4 minutes or longer of cerebral anoxia to cause neuronal cell death and permanent neurological damage upon loss of spontaneous circulation." Aplt. App., Vol. I at 246.

Dr. Crouch requested Dr. Helffenstein's raw data to assess the validity and reliability of Ellis's claimed cognitive and psychiatric deficits. After receiving the raw data, Dr. Crouch stated in an addendum to his report that "multiple measures of response bias were administered and yield[ed] Normal findings, suggesting that [Ellis's] impairments [were] valid/reliable." *Id.* at 187. Liberty also placed Ellis under surveillance in December 2012; the only video captured of Ellis revealed him "walking in a slow pace while utilizing a cane." Aplee. Supp. App., Vol. II at 482. Liberty approved long-term benefits in April 2013 but noted that the cause of Ellis's cognitive impairments was still unclear.

In May 2013 Liberty requested updated information from Dr. Dan Hadley, Ellis's primary-care physician, and Dr. Zacharias, his neurologist. Dr. Hadley completed a restrictions form stating that Ellis could not work in a situation requiring more than 10-20 minutes of minimal concentration. Dr. Zacharias did not specify a work-related restriction and instead signed a restrictions form directing Liberty to "see neuropsych testing that supports his impairment." Aplt. App., Vol. I at 239.

Liberty completed a vocational report in July 2013 that

identified several alternative occupations fitting Ellis's training, education, experience, and physical capacities. The case manager who completed the report indicated that she was asked to "presume[] sedentary work capacity, and not to include any cognitive and/or mental restrictions and limitations." Aplee. Supp. App., Vol. II at 455. Liberty also had a three- day surveillance conducted in August 2013, but no clear video of Ellis was obtained.

When Liberty asked Dr. Crouch for an updated clinical review of Ellis's records, he reported in September 2013 that "based on available information, it is unlikely that the claimant could perform the job duties of alternate occupations comparable to his prior job." Aplt. App., Vol. I at 189. But he said that an independent neuropsychological reevaluation was warranted if one had not been recently performed. Dr. Bob Gant, a neuropsychologist, was retained by an outside vendor at Liberty's request and evaluated Ellis in October 2013. He determined that Ellis's neuropsychological test results were invalid because of "[c]lear evidence of symptom exaggeration and suboptimal effort." *Id.* at 202. He said:

> Mr. Ellis reported an unusual and elevated degree of neurological complaints which are likely to be vague and illogical. This was confirmed by other tests utilized during this examination which indicated that the degree of neurologic impairment reported by Mr. Ellis was highly atypical and illogical. Such a presentation includes symptoms that are illogical or inconsistent with symptoms of a bona fide neurologic disorder or they occur very rarely in neurologically impaired patients.

Id. at 203–04. Dr. Gant questioned whether Ellis even had cognitive impairment:

> [W]ithin reasonable medical probability [Ellis] has not suffered cognitive impairment related to the asystole event which lasted 24 seconds on February 1, 2012. In fact, I am not certain that the patient suffers from cognitive impairment. It is likely that elements of secondary gain and/or impairment related to somatic exaggeration is responsible for [his] presentation.

Id. at 196.

In November 2013, Dr. Crouch reviewed Dr. Gant's report and stated that the results from Dr. Gant's evaluation "are insufficient to support the presence of valid/reliable" cognitive impairment. *Id.* at 194. Dr. Crouch also agreed that it was "medically impossible for a 24 second asystole event to cause cerebral hypoxia." *Id.* at 194. Liberty terminated Ellis's disability benefits in December 2013.

Ellis appealed the denial in June 2014. He included as additional evidence in support of his appeal a March 2014 letter from his speech therapist, letters from the Social Security Administration from December 2013 declaring him eligible for disability benefits, and imaging from a Single Photon Emission Completed Tomography (SPECT) scan together with an assessment report interpreting the images. The SPECT scan, which shows blood flow and oxygen perfusion to the brain, was interpreted by Dr. S. Gregory Hipskind, a nuclear neurologist to whom Ellis had been referred by Dr. Helffenstein. He read the scan as abnormal—consistent with "a diffuse, toxic/hypoxic encephalopathic process." *Id.* at 220. Dr. Helffenstein had also conducted a second evaluation in May 2014 and his

written report, completed in July 2014, later supplemented Ellis's appeal.

The report said that Ellis had demonstrated notable improvement in his results but had "reached maximum medical improvement from a neuropsychological standpoint" and was "totally and permanently disabled from competitive employment." *Id.* at 144–45.

In September 2014, Liberty had Dr. Timothy Belliveau, another of its consulting neuropsychologists, review Ellis's medical records and neuropsychological evaluations. Dr. Belliveau opined that the test data from Dr. Helffenstein's 2012 exam and Dr. Gant's 2013 exam probably indicated symptom over-reporting. Dr. Belliveau concluded that "[c]onsidered as a whole, and in the context of the claimant's documented medical history, the neuropsychological test data provide insufficient support for the presence of cognitive or psychological impairment due to a presumed brain injury in February 2012." *Id.* at 109. In light of Dr. Belliveau's review, Liberty upheld its denial.

C. ERISA

The Policy is part of an employee-benefits plan governed by ERISA. Such plans may provide a variety of healthcare, retirement, life-insurance, disability, and other benefits. Congress enacted ERISA both to "ensure that employees would receive the benefits they had earned" and to encourage employers to offer these plans by "creat[ing] a system that is not so complex that administrative costs, or litigation expenses, unduly discourage employers from offering ERISA plans in the first place," *Conkright v. Frommert*, 559 U.S. 506, 516–17 (2010) (brackets and internal quotation marks omitted), and by providing tax incentives, see Ronald J. Cooke, 1 ERISA Practice and Procedure § 1:3 (2d ed. 2019).

ERISA requires every benefit plan to be fully described in written "plan documents" that govern the management of the plan by plan administrators. *See* 29 U.S.C. § 1102(a)(1). The documents must "specify the basis on which payments are made to and from the plan," *id.* § 1102(b)(4), and the plan administrator must act "in accordance with the documents and instruments governing the plan," *id.* § 1104(a)(1)(D); *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001). From those documents, employees can "learn their rights and obligations under the plan at any time." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995).

Plan administrators are subject to federal standards imposing fiduciary duties. *See Miller v. Monumental Life Ins. Co.*, 502 F.3d 1245, 1249 (10th Cir. 2007). To avoid plan administrators having to "master the relevant laws of 50 states and to contend with litigation [that] would undermine the congressional goal of minimiz[ing] the administrative and financial burden[s] on plan administrators," *Egelhoff*, 532 U.S. at 149–50 (internal quotation marks omitted), ERISA contains a broad preemption provision stating that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statutory scheme, 29 U.S.C. § 1144(a). *See Aetna Health v. Davila*, 542 U.S. 200, 208 (2004) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans"; and its preemption provisions "are intended to ensure that employee benefits regulation would be exclusively a federal concern." (internal quotation marks omitted)); *Miller*, 502 F.3d at 1249. ERISA is one of the rare federal statutes recognized as "preempting the field." *See Nelson v. Great Lakes Educ. Loan Servs*., Inc., 928 F.3d 639, 652 (7th Cir. 2019). Nevertheless, state laws that regulate insurance, banking, or securities are

generally exempted from ERISA preemption. *See* 29 U.S.C. § 1144(b)(2)(A); *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 341–42 (2003). But see *Aetna Health*, 542 U.S. at 217 ("[E]ven a state law that can be arguably characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.").

An employee covered by an ERISA-governed benefit plan who believes the plan administrator wrongfully denied benefits can bring suit in state or federal court. *See* 29 U.S.C. §§ 1132(a)(1)(B), (e). The plan administrator's decision is reviewed by the court de novo unless the terms of the benefit plan give the administrator discretion to interpret the plan and award benefits. *See Firestone Tire*, 489 U.S. at 115. The Supreme Court has observed that granting plan administrators deference in interpreting plans promotes efficiency by encouraging resolution of disputes without litigation and promotes predictability "as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review." *Conkright*, 559 U.S. at 517.

II. ANALYSIS

A. Choice of Law

The principal dispute in this appeal is whether Liberty, the administrator of Ellis's ERISA plan, has discretion in determining whether to award or deny benefits. The Policy states: "Liberty shall possess the authority, in its sole discretion, to construe the terms of this policy and to determine benefit eligibility hereunder. Liberty's decisions regarding construction of the terms of this policy and benefit eligibility shall be conclusive and binding." Aplt. App.,

Vol. II at 329. Ellis does not dispute that the Policy grants Liberty the requisite discretion. But Colorado law provides:

> 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.

C.R.S. § 10-3-1116(2). On the other hand, the Policy has a choice-of-law provision stating that it is governed by Pennsylvania law, and Pennsylvania has no statute limiting discretion. Therefore, we must decide whether the Colorado statute applies to this dispute. We review the choice-of-law issue de novo. *See Boone v. MVM, Inc.*, 572 F.3d 809, 811 (10th Cir. 2009).[3]

The choice-of-law question could be avoided if ERISA preempts the Colorado statute. Liberty raised preemption in district court. But several circuits have held that similar

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[3] Ellis claims that Liberty did not argue the choice-of-law issue below and therefore essentially conceded that Colorado law applies. But Ellis was untimely in not raising this concern until oral argument. *See Lenox MacLaren Surgical Corp. v. Medtronic, Inc.*, 762 F.3d 1114, 1122–23 n.7 (10th Cir. 2014). And in any event Liberty did preserve the issue by arguing in its briefing to the district court that "the Policy expressly provides that [it] is governed by the laws of the state of Pennsylvania . . . Plaintiff's Opening Brief does not suggest, nor can it, that Pennsylvania has a statute prohibiting 'discretionary clauses.'" Aplt. App., Vol. II at 444–45. The district court clearly thought that Liberty had argued that Pennsylvania law governed, because it referred to Liberty's argument in the paragraph of its opinion devoted to the choice-of-law issue.

statutes are saved from ERISA preemption because they come within the exception to preemption for laws that regulate insurance. *See Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan*, Plan No. 625, 856 F.3d 686, 692–95 (9th Cir. 2017); *Fontaine v. Metro. Life Ins. Co.*, 800 F.3d 883, 886–89 (7th Cir. 2015); *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 604–07 (6th Cir. 2009). Perhaps for that reason, Liberty has not pursued the issue on appeal. In any event, there is no need to resolve that preemption issue here because our analysis leads to the conclusion that the Colorado statute does not apply for other reasons.[4]

Our analysis will proceed as follows: (1) Because Ellis's claim for benefits is a federal cause of action, federal law governs the elements of the claim. (2) But when federal law is silent on the specific question at issue (here, whether the Policy's grant of discretion to Liberty is enforceable), the federal court may incorporate state law instead of constructing a uniform federal rule. In our view, the enforceability question should be answered by state law; that is, federal law should incorporate a state rule of decision to resolve the question. (3) When federal law incorporates a state rule of decision, the choice of *which* state's law to incorporate is a matter of federal law. (4) As a matter of federal law, to effectuate ERISA's goals of uniformity and ease of administration, the law of the State selected by a choice-of-law provision in the plan documents should ordinarily provide the rule of decision for claims brought under the plan.

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[4] Similarly, because we conclude that we must follow Pennsylvania law, we need not address whether the Colorado statute applies to the Policy—that is, whether the Policy was issued after enactment of the statute and whether the Policy was issued in Colorado.

First, the Supreme Court has made clear that claims to enforce rights under an ERISA plan, even if styled as claims under state law, are federal claims. In *Metropolitan Life Insurance Co. v. Taylor*, the Court declared that ERISA so "completely pre- empt[ed]" claims within the scope of § 1132(a) that "any civil complaint raising this select group of claims is necessarily federal in character." 481 U.S. 58, 63–64 (1987).

Such actions "are to be regarded as arising under the laws of the United States . . . ." *Id.* at 65 (internal quotation marks omitted). The Court concluded that the plaintiff's suit seeking only state-law contract and tort remedies for failure of his employer and the plan administrator to provide benefits in accordance with his ERISA plan was "necessarily federal in character by virtue of the clearly manifested intent of Congress." *Id.* at 67; see *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (stating, in case where plan participant brought state common-law claim for tortious breach of contract, that "Congress' specific reference to § 301 of the [Labor Management Relations Act] to describe the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § [1132](a)."). The federal character of the ERISA suit is preserved even when (as will be further discussed below) a state-law rule of decision is incorporated for resolution of the claim. Thus, in *Unum Life Insurance. Co. v. Ward*, 526 U.S. 358, 376–77 (1999), the Court, holding that the California notice-prejudice rule was not preempted and should be applied in resolving a claim under § 1132(a), said, "The notice-prejudice rule supplied the relevant rule of decision for th[e] § [1132](a) suit." In sum, federal law governs the resolution of Ellis's

claim.

To say that federal law governs, however, is not to say that state law is irrelevant. In resolving a federal claim, questions may arise that cannot be answered by statutory interpretation. The court then must either adopt a federal common-law rule of decision or incorporate state law. The Supreme Court in *Kamen v. Kemper Financial Services*, 500 U.S. 90, 92 (1991), addressed this matter when it had to decide in a shareholder- derivative action under the Investment Company Act (ICA) whether to require the representative shareholder "to make a demand on the board of directors even when such a demand would be excused as futile under state law." First, the Court stated that federal law clearly governs "the contours of the demand requirement in a derivative action founded on the ICA," explaining that "[b]ecause the ICA is a federal statute, any common law rule necessary to effectuate a private cause of action under that statute is necessarily federal in character." *Id.* at 97. That did not mean, however, "that the content of such a rule must be wholly the product of a federal court's own devising." *Id.* at 98. On the contrary, absent a special reason the federal rule of decision should be state law that is incorporated into the federal remedial scheme:

> Our cases indicate that a court should endeavor to fill the interstices of federal remedial schemes with uniform federal rules only when the scheme in question evidences a distinct need for nationwide legal standards, or when express provisions in analogous statutory schemes embody congressional policy choices readily applicable to the matter at hand. Otherwise, we have indicated that federal courts should

> incorporate state law as the federal rule of decision, unless application of the particular state law in question would frustrate specific objectives of the federal programs.

Id. at 98 (citations, brackets, and internal quotation marks omitted). The Court held that a court considering a derivative action under the ICA "must apply the demand futility exception as it is defined by the law of the State of incorporation." *Id.* at 108–09.

Similarly, in *United States v. Kimbell Foods, Inc.*, the Court wrote:

> Controversies directly affecting the operations of federal programs, although governed by federal law, do not inevitably require resort to uniform federal rules. Whether to adopt state law or to fashion a nationwide federal rule is a matter of judicial policy dependent upon a variety of considerations always relevant to the nature of the specific governmental interests and to the effects upon them of applying state law.

440 U.S. 715, 727–28 (1979) (citation and internal quotation marks omitted); see *Davilla v. Enable Midstream Partners L.P.,* 913 F.3d 959, 965–66 (10th Cir. 2017) (incorporating, "as a matter of so-called 'federal common law,'" Oklahoma law as rule of decision in federal-law-governed trespass action).

Two Supreme Court opinions will illustrate the process of determining whether the courts should adopt a uniform federal common-law rule or incorporate a state rule of decision. Quite recently *Rodriguez v. FDIC*, 140 S. Ct. 713 (2020), rejected a uniform federal rule (the

Bob Richards rule, named for the case that originated it, *In re Bob Richards Chrysler-Plymouth Corp.*, 473 F.2d 262 (9th Cir. 1973)), which had been adopted by several circuit courts for determining how the members of an affiliated group of corporations that filed a consolidated tax return are to share a federal tax refund after it is delivered to the group's designated agent. *See id.* at 716. The affiliated group in Rodriguez was just a bank and its corporate parent. *See id.* Serious problems with the bank required the Federal Deposit Insurance Corporation (FDIC) to take it over in receivership. *See id.* Soon afterwards, the parent entered bankruptcy. *See id.* In the parent's bankruptcy proceedings the FDIC and the trustee for the parent's bankruptcy estate both claimed a large federal-income-tax refund that had been issued to the affiliated group. *See id.* The circuit court applied the Bob Richards rule. But the Supreme Court said that a uniform rule was hardly "necessary to protect uniquely federal interests." *Id.* at 718 (internal quotation marks omitted). It recognized that "[t]he federal government may have an interest in regulating how it receives taxes from corporate groups," or "in regulating the delivery of any tax refund due a corporate group," or it "may wish to ensure that others in the group have no recourse against federal coffers once it pays the group's designated agent." *Id.* "But what unique interests could the federal government have in determining how a consolidated corporate tax refund, once paid to a designated agent, is distributed among group members?" *Id.* at 717–18. The Court noted that "corporations are generally creatures of state law and state law is well- equipped to handle disputes involving corporate property rights," and it added that the fact that the controversy arose in the context of "federal bankruptcy and a tax dispute doesn't change much." *Id.* at 718 (citation and

internal quotation marks omitted). The Court held that the state rule of decision should govern, although it left for the circuit court to determine what that rule was. *See id.*; *see also United States v. Turley*, 878 F.3d 953, 956–57 (10th Cir. 2017) (in dispute arising from a lease between a private lessor and the United States Postal Service, we recognized that "obligations to and rights of the United States under its contracts are governed exclusively by federal law," but rather than constructing a uniform federal rule, we incorporated Oklahoma law because "lease contracts for the postal service do not inherently implicate clear and substantial interests of the National Government, which cannot be served consistently with respect for state interests." (brackets and internal quotation marks omitted)).

In contrast, *Boyle v. United Technologies Corp.*, 487 U.S. 500, 512 (1988), held that federal common law, not state law, applied in a diversity case against a federal contractor for an alleged design defect when the contractor's design conformed to government specifications. The estate of a Marine pilot sought to hold a government contractor liable for defective design of a military helicopter's escape hatch that caused the pilot's death. *See id.* at 503. Although no federal statute precluded government contractors from being held liable for design defects, *see id.* at 504, the Court adopted a federal rule that displaced liability under state law in certain limited circumstances: "when (1) the United States approved reasonably precise specifications; (2) the equipment conformed to those specifications; and (3) the supplier warned the United States about the dangers in the use of the equipment that were known to the supplier but not to the United States." *Id.* at 512. The Court observed that "imposition of liability on Government contractors will

directly affect the terms of Government contracts: either the contractor will decline to manufacture the design specified by the Government, or it will raise its price. Either way, the interests of the United States will be directly affected." *Id.* at 507. To impose design-defect liability under state law would be "precisely contrary to the duty imposed by the Government contract (the duty to manufacture and deliver helicopters with the sort of escape-hatch mechanism shown by the specifications)." *Id.* at 509.

The issue before us, therefore, is whether any federal policy or interest demands the creation of a uniform federal rule either requiring or prohibiting enforcement of discretion-granting provisions in ERISA plans. If not, we should leave to state law whether to permit or allow such provisions. In particular, is there a federal interest in requiring that decisions by administrators be subject to de novo judicial review—that is, depriving administrators of discretionary power? Or is there a federal interest in always allowing plans to grant discretion to administrators? In our view, decisions of the Supreme Court have pretty much answered those two questions. On the one hand, the Court has set forth with considerable sympathy how granting discretion to administrators advances certain ERISA objectives. *See Conkright*, 559 U.S. at 517–21. It would be hard to read the discussion in *Conkright* and conclude that an ERISA plan's grant of deference is inconsistent with federal policies and objectives. On the other hand, the Court has established de novo judicial review as the default standard for reviewing administrator decisions. *See Firestone Tire*, 489 U.S. at 110–15. That holding would seem inconsistent with a determination that ERISA policy forbids discretionary bans like Colorado's. Thus, we can assume that permitting grants of discretion and forbidding such grants are both consistent with

ERISA. Accordingly, there would be no need for a uniform federal-common-law rule favoring one approach over the other. Adopting a state-law rule of decision is appropriate.

The next question is which state's law to use. The general rule is that federal choice-of-law principles are used in resolving federal causes of action.[5] *See, e.g., Berger v. AXA Network LLC*, 459 F.3d 804, 809–10 & n.7 (7th Cir. 2006) (citing cases); *Gluck v. Unisys Corp.*, 960 F.2d 1168, 1179 & n.8 (3d Cir. 1992); 17A James Wm. Moore et al., Moore's Federal Practice § 120.31[1][b][ii], at 120–73 (3d ed. 2011) ("[I]n federal question cases, federal courts look to federal choice of law principles."). Thus, in *Kamen*, after determining that no uniform federal rule was required and that the courts should apply state law regarding the demand-futility exception for derivative actions under the ICA, the Court did not look to state choice-of-law doctrine before declaring that federal courts must apply the "demand futility exception as it is defined by the law of the State of incorporation." 500 U.S. at 109 (emphasis added). Similarly, after deciding that state contract law should be incorporated to resolve a dispute over a lease for a federal post office, this court in Turley, again without canvassing state choice-of-law doctrine, held that Oklahoma law should govern because that was where the property was

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[5] Ellis cites our decision in *Loveridge v. Dreagoux*, 678 F.2d 870, 877 (10th Cir. 1982), for the proposition that when selecting the applicable state law we must "follow the conflict of laws rules of the forum state where jurisdiction is based on a federal question." Aplee. Br. at 18. But *Loveridge* is readily distinguishable. Although the jurisdiction of the federal court was based on a federal-law claim (under the Securities Exchange Act of 1934), the choice-of-law issue arose with respect to a pendent state-law claim—a breach- of-contract claim under Utah law. *See id.* at 872.

located. 878 F.3d at 957. (This is not to say that federal law cannot incorporate state choice-of-law doctrine in resolving a federal claim. In *Richards v. United States*, 369 U.S. 1 (1962), the Supreme Court interpreted the Federal Tort Claims Act to apply not only the substantive law of the State where the negligence occurred but also that State's choice-of-law doctrine, *see id.* at 10–11; *see also In re Gaston & Snow*, 243 F.3d 599, 604–07 (2d Cir. 2001) (applying forum State choice-of-law rule for contract dispute in bankruptcy court).

In particular, in ERISA cases the federal circuits have applied federal choice-of- law principles to determine whether to give effect to a policy's choice-of-law provision. Other circuits have identified three possible approaches, two of which have been adopted.

The Ninth Circuit has said that the choice-of-law provision in an ERISA plan should be followed if "not unreasonable or fundamentally unfair." *Wang Labs v. Kagan*, 990 F.2d 1126, 1128–29 (9th Cir. 1993). The dispute before the court concerned an employee whose ERISA plan required him to reimburse medical expenses paid by the plan for injuries he received in a vehicle accident after he obtained a tort recovery for the accident. *See id.* at 1127. The employee argued that the plan's reimbursement claim was barred by the applicable statute of limitations. *See id.* The plan contained a choice-of- law provision selecting Massachusetts law. *See id.* at 1128. The employer and the plan administrator were headquartered there, and most employees affected by the plan lived there; but the employee resided in California at all relevant times and the accident occurred in California. *See id.* at 1127–28.

The court relied on the Supreme Court's decision in *Carnival Cruise Lines v. Shute*, 499 U.S. 585 (1991). *See*

Wang, 990 F.2d at 1128–29. Carnival held that forum- selection clauses, even in contracts of adhesion (such as a cruise ticket), should be enforced if not unreasonable or fundamentally unfair. *See* 499 U.S. at 592–95. *Wang* reasoned that choice-of-law clauses would be less burdensome to plan beneficiaries than forum-selection clauses because beneficiaries could still litigate ERISA disputes in their home state. *See* 990 F.2d at 1129. It ruled that the choice-of-law clause in the ERISA contract was not unreasonable or fundamentally unfair since the employer was headquartered in Massachusetts, most covered employees resided in the state, and "[n]o sensible person would hesitate to join a health plan because claims would be subject to the limitations period of the employer's headquarters state." *Id.* The Eighth and Eleventh Circuits have followed Wang's unreasonable-or-fundamentally-unfair test for choice-of-law provisions in ERISA contracts. *See Brake v. Hutchinson Tech. Inc.*, 774 F.3d 1193, 1197 (8th Cir. 2014) (declining to apply law of South Dakota (plaintiff's home state and the forum state) disallowing discretion clause in health-insurance policies); *Buce v. Allianz Life Ins. Co.*, 247 F.3d 1133, 1149 (11th Cir. 2001) (adhering to plan's choice of Georgia law (plaintiff's home state and forum state)).

The Sixth Circuit has adopted a different approach, applying the test set out in Section 187 of the Restatement (Second) of Conflict of Laws for when a contractual choice-of-law provision should be enforced.[6] See

[6] Ellis contends that § 188 of the Restatement should control this case, and that under § 188's multi-factor test Colorado law should apply. But § 188 is titled (and unsurprisingly concerns): "Law Governing in Absence of Effective Choice by the Parties." Restatement (Second) of Conflict of Laws § 188 (1971) (emphasis added). Here, the Policy contains a clear choice-of-law provision, and Ellis makes no argument

DaimlerChrysler v. Durden, 448 F.3d 918, 922 (6th Cir. 2006) ("In the absence of any established body of federal choice of law rules, we begin with the Restatement (Second) of Conflicts of Law." (internal quotation marks omitted)). Section 187 provides, in relevant part:

> (1) The law of the state chosen by the parties to govern their contractual rights and duties will be applied if the particular issue is one which the parties could have resolved by an explicit provision in their agreement directed to that issue.
>
> (2) The law of the state chosen by the parties to govern their contractual rights and duties will be applied, even if the particular issue is one which the parties could not have resolved by an explicit provision in their agreement directed to that issue, unless either
>
>> (a) the chosen state has no substantial relationship to the parties or the transaction and there is no other reasonable basis for the parties' choice, or
>>
>> (b) application of the law of the chosen state would be contrary to a fundamental policy of a state which has a materially greater interest than the chosen state in the determination of the particular issue

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why this is not an "effective choice" within the meaning of the Restatement.

> and which, under the rule of § 188, would be the state of the applicable law in the absence of an effective choice of law by the parties.

Restatement (Second) of Conflicts of Laws, § 187 (1971). Durden involved two women who each claimed to be the "surviving spouse" of an employee covered under his employer's ERISA-governed pension plan, which had a choice-of-law provision selecting Michigan law. 448 F.3d at 921. After the employee passed away, his surviving spouse was entitled to benefits from the pension plan, including life-insurance proceeds. *Id.* The court ultimately decided that Ohio law governed because it had the most significant relationship to both marriages. *See id.* at 923–27.

When faced with resolving whether an ERISA plan's choice-of-law provision governed in determining if the employee's misconduct forfeited his benefits, the Fifth Circuit identified three possible approaches. *See Jimenez v. Sun Life Assur. Co.*, 486 F. App'x 398, 407–08 (5th Cir. 2012). It noted the *Wang* and *Durden* tests, and said that in international-disputes cases it had presumptively enforced a contractual choice-of-law provision unless the party hoping to avoid enforcement clearly showed "that the clause [was] unreasonable under the circumstances." *Id.* at 408 (internal quotation marks omitted). But it declined to choose a standard because it held that the employee challenging the administrator's denial of benefits failed to satisfy his burden of overcoming the contractual choice-of-law provision under all three approaches. *See id.*

In our view, the above three circuit approaches, all of which sound primarily in reasonableness, are inadequate because they overlook the uniformity and efficiency objectives central to ERISA. Over several decades the Supreme Court has repeatedly recognized and emphasized that ERISA policy is best effectuated if a plan administrator is subject to only one legal regime.

The choice-of-law issue obviously is most likely to arise for interstate employers. And it is precisely in plans for interstate employers that the need for a single legal regime is most pressing. As stated in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983), "By establishing benefit plan regulation as exclusively a federal concern, Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees." (citation and internal quotation marks omitted).

The Court noted that the imposition of patchwork regulation by a variety of states could be particularly burdensome to "[a]n employer with employees in many States [who] might find that the most efficient way to provide benefits to those employees is through a single employee benefit plan." *Id.* at 105 n.25. The consequences would be harmful to employers and employees:

> The employer might choose to offer a number of plans, each tailored to the laws of particular States; the inefficiency of such a system presumably would be paid for by lowering benefit levels. Alternatively, assuming that the state laws were not in conflict, the employer could comply with the laws of all States in a uniform plan. To offset the additional expenses, the employer

> presumably would reduce wages or eliminate those benefits not required by any State. Another means by which the employer could retain its uniform nationwide plan would be by eliminating classes of benefits that are subject to state requirements with which the employer is unwilling to comply.

Id.

Likewise, in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987), the Court observed that "[a] patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." To avoid such outcomes, ERISA preemption "ensures that the administrative practices of a benefit plan will be governed only by a single set of regulations." *Id.*

More recently the Court has reiterated that "[o]ne of the principal goals of ERISA is to enable employers to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff*, 532 U.S. at 148 (internal quotation marks omitted). "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Id.* "Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of minimizing the administrative and financial burden[s] on plan administrators—burdens ultimately borne by the beneficiaries." *Id.* at 149–50 (brackets and internal quotation marks omitted). Such "tailoring of plans and employer conduct to the peculiarities of the law

of each jurisdiction is exactly the burden ERISA seeks to eliminate." *Id.* at 151 (internal quotation marks omitted); see H.R. Rep. No. 93-533, 1973 WL 12549, at 4650 (1973) ("Finally, it is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.").

And the Court in *Conkright,* 559 U.S. at 517, reiterated that "ERISA induces employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." (brackets and internal quotation marks omitted). Of particular importance, the Court noted a potential problem with patchwork state regulation that could be fatal to interstate plans: "[A] group of prominent actuaries tells us that it is impossible even to determine whether an ERISA plan is solvent (a duty imposed on actuaries by federal law, *see* 29 U.S.C. §§ 1023(a)(4), (d)) if the plan is interpreted to mean different things in different places." *Id.* at 517–18.

These concerns explain not only the preemption of most state law regarding ERISA plans but also the need for uniform interpretation and enforcement of plan provisions in those areas where state law is not preempted. The Supreme Court's decision in *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan*, 555 U.S. 285, 300 (2009), is instructive. In *Kennedy* an employee who participated in his company's ERISA plan signed a form designating his then-spouse to receive benefits under the plan upon his death. *Id.* at 288–89. When

the couple divorced several years later, the divorce decree stated that it divested the woman of all rights she may have had in any of the employee's benefit plans. *See id.* at 289. But the employee did not execute any documents removing her as a beneficiary of the pension plan. *See id.* After first holding that the divorce-decree divestment provision was not void under ERISA's anti-alienation provision, *see id.* at 297, the Court considered whether the plan administrator had to honor the decree or could instead pay the former spouse benefits under the plan's terms.

The Court unanimously held that the "plan administrator did its statutory ERISA duty by paying the benefits to [the former spouse] in conformity with the plan documents." *Id.* at 299–300. ERISA not only "requires '[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument,'" *id.* at 300 (quoting 29 U.S.C. § 1102(a)(1)), but further obliges the plan administrators to act "'in accordance with the documents and instruments governing the plan insofar as [they] are consistent with [ERISA],'" *id.* (quoting 29 U.S.C. § 1104(a)(1)(D)). The Court also pointed out that ERISA allows a beneficiary to file suit "'to recover benefits due to him under the terms of his plan,'" further reinforcing the command to abide by plan terms. *Id.* (quoting 29 U.S.C. § 1132(a)(1)(B) (emphasis added)). A claim under ERISA "therefore stands or falls by the terms of the plan, § 1132(a)(1)(B), a straightforward rule of hewing to the directives of the plan documents that lets employers establish a uniform administrative scheme, with a set of standard procedures to guide processing of claims and disbursement of benefits." *Id.* (brackets and internal quotation marks omitted). Given the statutory goals of uniformity and predictability in the administration of

ERISA plans, "the cost of less certain rules would be too plain." *Id.* at 301.

Heimeshoff v. Hartford Life & Accident Insurance Co. adhered to the "plan- documents rule" of Kennedy, recognizing that the "focus on the written terms of the plan is the linchpin of a system that is not so complex that administrative costs, or litigation expenses, unduly discourage employers from offering ERISA plans in the first place." 571 U.S. 99, 108 (2013) (upholding plan provision that commenced three-year limitations period before ERISA cause of action accrues) (brackets and internal quotation marks omitted); see also *U.S. Airways, Inc. v. McCutchen*, 569 U.S. 88, 101 (2013) ("The plan, in short, is at the center of ERISA.").

Our choice-of-law doctrine in the ERISA context must therefore account for the centrality of the plan in ERISA matters and the aims of uniformity and reduced administrative costs that are essential to ERISA's purposes. *See Durden*, 448 F.3d at 928–29 (Merritt, J., dissenting) ("the overriding purpose and policy of uniformity behind the ERISA statute [and] behind the interpretation of ERISA benefits contracts" requires courts to enforce parties' choice of law in ERISA plans); William Baude, Beyond DOMA: Choice of State Law in Federal Statutes, 64 Stan. L. Rev. 1371, 1420 (2012) (criticizing Sixth Circuit's decision in Durden to follow Restatement instead of enforcing choice-of-law provision in plan documents: "In light of the plan-documents doctrine established by the Supreme Court, the better rule for ERISA cases is to follow a marital choice-of-law rule required by the plan documents.").

These considerations apply with full force to the present context. To recognize the Policy's grant of discretion

to the administrator for plan participants in some states but not in others would create significant complications. Legislatures enact statutes forbidding discretionary provisions for the purpose of awarding more benefits to participants in insurance plans. But there are costs in doing so. In *Conkright* the Supreme Court pointed out that granting deference to the administrator promotes efficiency, predictability, and uniformity. *See* 559 U.S. at 517. The increase in costs from denying discretion can lead employers to reduce benefits or even to cancel plans or refrain from offering them altogether. Indeed, it is precisely because discretion-denying statutes "substantially affect the risk pooling arrangement between the insurer and the insured," *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. at 342, that such statutes have been held to be laws regulating insurance that are exempted from ERISA preemption. See, e.g., *Orzechowski*, 856 F.3d at 694–95; *Fontaine*, 800 F.3d at 888–89; *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 844–45 (9th Cir. 2009) (under a discretion- denying statute, "insureds may no longer agree to a discretionary clause in exchange for a more affordable premium").

When the plan is a single-state plan, the pluses and minuses of denying discretion are relatively clear and manageable. Every employee is treated the same; each has a better opportunity to get benefits provided by the plan and each will bear his or her proportionate share of any employer costs that may affect what benefits are provided.

But for multistate plans, employees in different states may be treated differently if the meaning (or enforceability) of the provisions of the plan differ depending on the state where the employee lives or works. Those whose

benefits are governed by discretion- denying statutes will have a better chance of receiving benefits than those governed by the law of states without such statutes. We have already noted that the Supreme Court in *Shaw* expressed how such a state of affairs would run contrary to ERISA policy to "minimize[] the need for interstate employers to administer their plans differently in each State in which they have employees," and would adversely affect plan beneficiaries. 463 U.S. at 105. Moreover, the disparity in treatment of plan participants in different states may make it difficult, if not impossible, to determine the solvency of the ERISA plan. *See Conkright* at 517–18.

All this is not to say that discretion-denying statutes are good or bad. As stated above, ERISA itself is agnostic on the matter. But if the plan has a legitimate connection to the State whose law is chosen (since Pennsylvania is where Comcast is incorporated and has its principal place of business, there can be no question of the propriety of the Policy's selecting the law of Pennsylvania), ERISA's interest in efficiency and uniformity, as well as its recognition of the primacy of plan documents, compels the conclusion that the selected law should govern whether a discretion-granting provision is enforceable. A clear, uniform rule enforcing an ERISA plan's choice of law is required to ensure plan administrators enjoy the predictable obligations and reduced administrative costs central to ERISA—particularly as the choice of law affects the validity of discretionary clauses. We therefore decide that, as a matter of federal law, the choice of law in the Policy governs. Pennsylvania law applies to this dispute.[7]

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[7] In *Dang v. Unum Life Insurance Co. of America*, this court considered a claim for benefits under an ERISA plan without a choice-of-law provision. *See* 175 F.3d 1186, 1190 (10th Cir. 1999). To determine

Ellis's arguments to the contrary are unpersuasive. He first contends that choice- of-law provisions incorporate only substantive law, and "[b]ecause Colorado law dictating the standard of review applicable to ERISA benefits decision[s] is procedural, it applies here despite [the] Policy's choice-of-law provision." Aplee. Br. at 18. But the very case Ellis cites for this proposition explains that in cases arising under federal law, federal rules govern procedural issues, meaning Colorado law would still be inapplicable. *See FDIC v. Petersen*, 770 F.2d 141, 142–143 (10th Cir. 1985) (in action brought by United States, limitations period from relevant federal statute applied because Illinois choice-of-law provision in guarantee

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which state's law regarding the notice-prejudice rule to incorporate as the rule of decision, Dang applied the forum state's choice-of-law rule. *See id.* Its rationale for doing so, however, appears incorrect on its face. The court explained that "[a] federal court adjudicating state law claims must apply the forum state's choice of law principles," citing *Klaxon Co. v Stentor Electric Manufacturing. Co.*, 313 U.S. 487, 496 (1941). *Id.* But Dang's claim was brought under ERISA, *see id.* at 1188, and, as discussed at some length above, the Supreme Court has made clear that claims brought under ERISA's civil-enforcement provision are federal claims. *See Metropolitan Life*, 481 U.S. at 67; *Pilot Life*, 481 U.S. at 56. Moreover, a few days before Dang was filed, the Supreme Court explained that even if a state-law rule of decision (there, a notice-prejudice rule, as in *Dang*) is incorporated into federal law to resolve an ERISA benefits claim, there is still no state-law claim. *See Unum*, 526 U.S. at 377 (1999). All that is involved is that "[t]he notice-prejudice rule supplied the relevant rule of decision for this § [1132](a) suit." *Id.*

Dang, however, may have intended to declare merely that a federal court should follow a forum state's choice-of-law rule when the applicable ERISA plan has no choice-of-law provision. But we need not decide whether *Dang's* analysis or conclusions are correct in that context under current law because the Policy in this case contains a choice-of-law provision.

contract presumably did not apply to such procedural issues). In any event, Ellis failed to make this argument to the district court. Since he does not argue for plain error on appeal, we consider the argument waived. *See Richison v. Ernest Grp., Inc.*, 634 F.3d 1123, 1130–31 (10th Cir. 2011).

Ellis next mounts several arguments that applying Pennsylvania law would be unfair, but these would be unpersuasive even if we were not bound by the plan-documents rule. He argues that choice-of-law determinations should consider unfair surprise to litigants and that he had no contacts with Pennsylvania. But the Policy's choice of Pennsylvania law was clear on its face, preventing any such surprise. Ellis also claims that unfairness is demonstrated by the fact that the district court ruled in his favor under de novo review but ruled in Liberty's favor when it reviewed for abuse of discretion. This difference in result is a well-recognized possibility, which is the justification for state laws like Colorado's that require de novo review. We have already observed, however, that the Supreme Court has endorsed choices by ERISA plans to provide abuse-of-discretion review, noting the potential benefits for both employees and employers. *See Conkright*, 559 U.S. at 517. We see no unfairness.

B. Review Of Liberty's Decision

The district court initially ruled that it should review for abuse of discretion (it had originally decided that the Colorado discretion-denying statute did not apply because it postdated the Policy) and upheld the decision by Liberty. But on a motion for reconsideration by Ellis, it changed its mind regarding applicability of the Colorado statute, exercised de novo review, and ruled in favor of Ellis. Its first decision was correct. We agree that under an

abuse-of-discretion standard, Liberty's denial of benefits must be affirmed.

We uphold a plan administrator's decision under the abuse-of-discretion standard "so long as it is predicated on a reasoned basis." *Adamson v. Unum Life Ins. Co. of Am.*, 455 F.3d 1209, 1212 (10th Cir. 2006). We ask only that the decision "reside[] somewhere on a continuum of reasonableness—even if on the low end." *Id.* at 1212 (internal quotation marks omitted). "Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician," *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003), but a benefits decision can be reasonable even when the insurer receives evidence contrary to the evidence it relies on, *see Holcomb v. Unum Life Ins. Co. of Am.*, 578 F.3d 1187, 1193–94 (10th Cir. 2009). "[C]ourts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Black & Decker*, 538 U.S. at 834.

Ellis contends that under the Supreme Court's decision in *Metropolitan Life Insurance Co. v. Glenn*, 554 U.S. 105 (2008), we must use a less deferential standard when, as here, the administrator operates under a conflict of interest by both paying out benefits and adjudicating claims. But Glenn explicitly rejected this proposition, saying that "[t]rust law continues to apply a deferential standard of review to the discretionary decisionmaking of a conflicted trustee." *Id.* at 115. It instead instructed that "the reviewing judge . . . take account of the conflict when determining whether the trustee,

substantively or procedurally, has abused his discretion." *Id.*; *see id.* at 115–17. "[C]onflicts are but one factor among many that a reviewing judge must take into account." *Id.* at 116. Indeed, we have relied on Glenn to explain that the effect of a conflict is case-specific and "'prove[s] less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy,'" including by utilizing independent physicians. *Holcomb*, 578 F.3d at 1193 (quoting *Glenn*, 554 U.S. at 117 (2008)).

Under the Policy a claimant cannot receive long-term disability benefits without proof of disability arising from an injury or sickness that renders the claimant unable to perform the duties of any occupation. We hold that Liberty did not abuse its discretion in deciding that Ellis had not established such a disability in light of the evidence presented to it.

Ellis obtained support for his claim of neurological impairment from several sources. First, in June 2012 he consulted with Dr. Zacharias, a neurologist, who noted Ellis's complaints of "poor concentration, dizziness, slowing of physical and mental skills," and recommended cognitive and physical therapy. Aplt. App., Vol. I at 268–69. He also wrote, though, that he "did not do detailed neuropsychological testing," and that Ellis was "alert and attentive," had no "evidence of a primary neuromuscular disease," and had an "[u]nremarkable brain MRI." *Id.* at 269. In August 2012, Dr. Zacharias wrote in a follow-up report: "I am still not sure what accounts for Michael's condition.

My best assessment would be something happened with hypoxic injury with either his syncopal episode or his pulmonary embolism." *Id.* at 265. He noted Ellis was progressing with therapy, "but still struggles significantly."

Id. at 265. Completing a restrictions form sent by Liberty in May 2013, Dr. Zacharias provided a diagnosis for Ellis of "hypoxic/ischemic encephalopathy" and in response to a question asking for a description of his "physical, mental and/or cognitive restrictions," he directed Liberty "to see neuropsych testing that supports his impairment." *Id.* at 239.

Also in May 2013, Ellis's primary-care physician, Dr. Hadley, reported in response to a Liberty restrictions form that Ellis suffered from "cognitive impairment from hypoxic encephalopathy." *Id.* at 192 (internal quotation marks omitted).

In April 2013 one of Liberty's consulting neuropsychologists, Dr. Crouch, opined that Ellis "would likely be precluded from performing the usual duties of his job, regardless of accommodations provided." *Id.* at 187. He also commented that Ellis's test results from Dr. Helffenstein's evaluation appeared "valid/reliable." *Id.* at 187. In September 2013, Dr. Crouch reaffirmed that the available records "provide reasonable support for significant impairment," although he suggested that Ellis be reevaluated. *Id.* at 189.

Ellis has relied most heavily on the conclusions of Dr. Helffenstein, a neuropsychologist, who first tested Ellis in August and September 2012. According to his report, "The testing identified significant cognitive deficits suggesting bilateral frontal and bilateral temporal involvement. The pattern is consistent with cerebral hypoxia.

There is absolutely no way Michael could do his job at this time from a cognitive standpoint." Aplee. Supp. App., Vol. II at 578 (internal quotation marks omitted). He also opined "within reasonable neuropsychological probability

that the cognitive deficits noted on testing related directly and solely to the medical event that occurred on February 1, 2012. It seems reasonable that an episode of cerebral hypoxia did occur during this event." Aplt. App., Vol. I at 262. Dr. Helffenstein reevaluated Ellis in May 2014. He reported that Ellis "demonstrated . . . notable improvement on testing from my first evaluation with him to my re-evaluation," *id.* at 144, but maintained that he was "totally and permanently disabled from competitive employment," *id.* at 145.

Finally, Ellis obtained a SPECT scan in May 2014, and the neurologist interpreting the scan concluded: "The nature, location, and pattern of these abnormalities is most consistent with the scientific literature pertaining to a diffuse, toxic/hypoxic encephalopathic process and the patient's clinical history which was received after the blind review." *Id.* at 220.

But Liberty had sound reasons not to adopt the above views. Dr. Hadley, Ellis's primary care physician, does not specialize in neurology or neuropsychology, and was likely just deferring to the views of specialists. And Dr. Crouch, a consulting neuropsychologist for Liberty, consistently expressed the view that a 24-second heart stoppage could not cause neurological injury, and he came to have doubts whether Ellis suffered cognitive impairments. In September 2013 he had suggested a reevaluation and after receiving Dr. Gant's evaluation of Ellis in October, Dr. Crouch opined that the results "are insufficient to support the presence of valid/reliable impairment" and that "results from multiple measures of response bias were suboptimal, indicating that observed abnormal test results were 'related to the patient's desire to obtain disability benefits.'" *Id.* at 194 (internal quotation marks omitted).

As for Dr. Zacharias, he admitted that he did not conduct detailed neuropsychological testing, and the brain MRI was "[u]nremarkable." *Id.* at 269. The restrictions form he completed for Liberty included no new data and simply directed Liberty to see prior testing. Further, the persuasiveness of his conclusions in support of Ellis is diminished by his adoption of the theory that Ellis's claimed deficits may have been caused by cerebral hypoxia stemming from his 24-second heart stoppage, as this was deemed medically implausible by essentially every other physician to review the case.

The SPECT scan is obviously objective data, but the relevance could reasonably be questioned by Liberty. Dr. Belliveau expressed doubts:

> Scientific studies about the utility of SPECT procedures during evaluation of dementia or brain injury due to trauma may not necessarily be applicable to evaluation of brain injury due to hypoxic-ischemic events, and . . . the cognitive and psychological assessment methods used during neuropsychological examination represent a more direct process of determining the examinee's functional status.

Id. at 110. Although Ellis submitted to Liberty a number of medical-journal articles and court documents discussing the utility of SPECT scans, these focused almost exclusively on evaluating traumatic brain injury—without any mention of their utility in assessing hypoxic injury. And Ellis has not alleged that his disability was caused by physical trauma to the brain.

There remains Dr. Helffenstein. Liberty could reasonably have questioned his objectivity. He was hired by Ellis's attorney to evaluate Ellis; and his initial report in November 2012 appears to have been a bit overenthusiastic. Although he had been advised that the duration of Ellis's cardiac standstill had been only 24 seconds, the report stated that Ellis's "cognitive deficits noted on testing relate directly and solely to the medical event that occurred on February 1, 2012. It seems reasonable that an episode of cerebral hypoxia did occur during this event." *Id.* at 262 (emphasis added). By August 2013 he had walked back this theory, stating that he would "totally concur" with the assessment that "it is highly unlikely that the reported 24-second period of asystole on February 1, 2012 would be the cause of [Ellis's] cognitive complaints." *Id.* at 228 (internal quotation marks omitted). He proposed instead that Ellis's "cognitive dysfunction most likely relates to a more extended period of cerebral hypoxia," but failed to identify how or when such an event might have occurred. *Id.* His final report in July 2014 then broadened his original hypothesis, suggesting that Ellis "experience[d] some type of neurological event (likely a hypoxic episode or episodes) during the early part of February of 2012 related to his various medical conditions." *Id.* at 144. But he added: "I am not sure that any physician or neuropsychologist could point to a specific time or event that resulted in Mr. Ellis'[s] injury but, at this point, I am absolutely convinced that such an injury did occur." *Id.*

Most importantly, two neuropsychologists challenged Dr. Helffenstein's methods and the validity of his results. Dr. Belliveau, Liberty's consulting neuropsychologist, questioned the results of Dr. Helffenstein's testing because of significant evidence of symptom overreporting and other evidence of invalidity. He noted that tests differ

in their ability to detect insufficient effort and that Ellis had passed the less sensitive tests but failed those that are more sensitive to insufficient effort. In light of the "multiple findings of invalid neuropsychological test data," Dr. Belliveau concluded that the "available medical record documentation" in Ellis's file "represents insufficient support for the conclusion that the claimant has permanent cognitive impairment due to hypoxic- ischemic encephalopathy." *Id.* at 124.

Similarly, Dr. Gant, the independent neuropsychologist Liberty retained from an outside vendor, criticized Dr. Helffenstein for using outdated and inadequate tests. He conducted his own testing and evaluation but decided that many of the test scores were invalid. He reported: "It is unlikely that [Ellis] provided valid effort during this examination. Clear evidence of symptom exaggeration and suboptimal effort was identified." *Id.* at 202. In particular, he observed:

> Ellis reported an unusual and elevated degree of neurological complaints which are likely to be vague and illogical . . . [Other tests] indicated that the degree of neurological impairment reported by . . . Ellis was highly atypical and illogical. Such a presentation includes symptoms that are illogical or inconsistent with symptoms of a bona fide neurologic disorder or they occur very rarely in neurologically impaired patients.

Id. at 203–04. He concluded that "within reasonable medical probability [Ellis] has not suffered cognitive impairment related to the asystole event which lasted 24 seconds on February 1, 2012," and that "elements of secondary gain and/or impairment related to somatic

exaggeration is responsible for [Ellis's] presentation." *Id.* at 196.

On this record we cannot say that Liberty's denial of benefits was an abuse of discretion. Ellis criticizes several aspects of Liberty's decision-making. Although some of the criticism has weight, a decision is not arbitrary and capricious just because some may be persuaded otherwise. Ellis first asserts that Liberty improperly relied on the conclusions of its hired reviewers despite flaws in their testing methods and reports. He argues that Liberty failed to credit Dr. Helffenstein's claim that fatigue during testing could alone account for Ellis's "sub optimal performance on symptom validity measures" during Dr. Gant's testing. *Id.* at 135. But Dr. Helffenstein does not explain how fatigue could cause the apparently intentionally dishonest reporting observed by Dr. Gant. And even though Ellis was provided breaks during his 2012 evaluation with Dr. Helffenstein, Dr. Belliveau expressed doubts as to the validity of the scores obtained during that evaluation as well —contrary to the suggestion that fatigue fully accounted for the symptom exaggeration and other measures of invalidity that Dr. Gant observed.

Ellis also claims that Dr. Gant did not review Dr. Helffenstein's raw data, and that Dr. Crouch, who did, opined that Dr. Helffenstein's test findings were valid and reliable. But Dr. Gant was still able to criticize the testing on the ground that the tests were out of date and that "inadequate testing was done to evaluate patient effort and test validity"; and he suggested that the raw data be obtained. *Id.* at 202. In any event, Dr. Belliveau did review that data and, like Dr. Gant, criticized Dr. Helffenstein's results and methods, not only stating that Dr. Helffenstein used outdated tests but also that his data indicated symptom

overreporting. And Dr. Crouch agreed with Dr. Gant's conclusion that Ellis had not been candid in Dr. Gant's testing.

Ellis criticizes Liberty's instructions for conducting a July 2013 vocational report. The vocational case manager who submitted the report was asked "to base [the] report on a presumed sedentary work capacity, and not to include any cognitive and/or mental restrictions and limitations" in her assessment. Aplee. Supp. App., Vol. II at 455. Ellis argues that these instructions are "clear[] evidence that Liberty never intended to provide Ellis with a full and fair review of his claim, but instead, conducted a result-oriented investigation solely intended to terminate his benefits." Aplee. Br. at 49. The argument is not totally off-the-wall, but it is a stretch. The record shows that the vocational report was for "an exploratory TSA [transferable skills analysis]," Aplee. Supp. App., Vol. I at 28, which would be necessary because in two months Mr. Ellis's eligibility for disability would require inability to perform the "material and substantial duties of any occupation" rather than "of his own occupation," Aplt. App. at 296 (emphasis added). That would not be a nefarious purpose for conducting the limited evaluation, particularly since Liberty was at the same time pursuing the medical basis of the alleged cognitive deficits and would thus later be able to assess Ellis's ability to perform the alternate occupations identified in the vocational report in light of any mental limitations.

Ellis complains that Liberty instructed that Dr. Crouch, who had expressed some support for Ellis's claim, should not be assigned to review the file on internal appeal. But the reason given for the instruction was that "he previously handled the file." Aplee. Supp. App., Vol. I at

55. On its face, it seems reasonable, and apparently legally mandated, to have an appeal handled by persons other than those who handled the initial decision. *See* 29 C.F.R. § 2560.503–1(h)(3)(v).

Finally, Ellis claims that Liberty ignored other evidence demonstrating he was cognitively disabled, namely (1) Liberty's surveillance of him, (2) his Social Security Disability Insurance (SSDI) award, and (3) a letter from his speech therapist and other clinical notes from various providers. But the record rebuts this assertion.

To begin with, Drs. Belliveau, Crouch, and Gant all reviewed the surveillance reports as part of their consideration of Ellis's claim. In particular, Dr. Crouch remarked that there were "[n]o cognitive [symptoms] documented" in the first surveillance report, Aplt. App., Vol. I at 182, and "[n]o abnormalities noted in limited visual contact" in the second report, *id.* at 191, diminishing their relevance to Ellis's claim of cognitive impairments.

Liberty also acknowledged the SSDI award. Its letter denying benefits stated that it was "aware [of] and fully considered" the December 2013 ruling of the Social Security Administration (SSA) granting the award. It explained, though, that its decision was "based upon updated medical records and testing, and different medical and vocational reviews that would not have been considered by the SSA in December 2013," and that the SSA requirements are not the same as those in the Policy. *Id.* at 105. Ellis's SSDI application was submitted before Dr. Gant's evaluation and report and Dr. Belliveau's review, and there is no indication that the SSA considered the later reports.

Similarly, the record indicates that all the clinical notes were reviewed by Liberty experts. The experts did

not disregard them; it is just that they found that the record considered as a whole was inadequate to support Ellis's claim. Dr. Belliveau explicitly stated his conclusion was based on "[t]he available medical record documentation, including the scope, severity, and persistence of the claimant's reported symptoms; *observations of his treatment providers*; [and] multiple findings of invalid neuropsychological test data." *Id.* at 124 (emphasis added). Dr. Gant similarly arrived at his opinion "[a]fter reviewing the medical records, the report completed by Dr. Helffenstein, and completing [his] own evaluation." *Id.* at 210. Again, the existence of evidence supporting Ellis's claim does not render a denial of benefits unreasonable. *See Holcomb*, 578 F.3d at 1193–94 (upholding benefits denial even though insurer "had received a large volume of reports, letters, imaging studies, and exams that were not entirely consistent").

In sum, Liberty relied on two expert neuropsychologists, Drs. Gant and Belliveau, who both concluded that there was insufficient evidence from Ellis's medical records and test data to support his claim of cognitive deficits. Because the record shows Liberty and the experts it retained considered all the pertinent evidence submitted by Ellis and that Liberty reasonably gave less weight to much of Ellis's evidence, we cannot say that Liberty abused its discretion in denying Ellis's claim for benefits.

III. CONCLUSION

We **REVERSE** the district court's judgment in Ellis's favor and **REMAND** for entry of judgment in Liberty's favor.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLORADO
LEWIS T. BABCOCK, JUDGE

Civil Action No. 15-cv-00090-LTB

MICHAEL D. ELLIS,
Plaintiff,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON, a New Hampshire corporation,
Defendant.

MEMORANDUM OPINION AND ORDER

Babcock, J.

This ERISA case is before me on Plaintiff Michael D. Ellis's Motion for Reconsideration/Amendment of Judgment under Fed. R. Civ. P. 59 and/or for Relief From Order Pursuant to Rule 60 [Doc #68]. In its response to Mr. Ellis's motion, Defendant Liberty Life Assurance Company of Boston ("Liberty") moved to strike an exhibit attached to Mr. Ellis's motion [Doc #70]. After consideration of the parties' briefs, the record, and the case file, and for the reasons set forth below, I grant Mr. Ellis's motion;

deny Liberty's motion to strike; vacate the judgment entered in this case in favor of Liberty; and enter judgment in favor of Mr. Ellis.

I. Background

By Memorandum Opinion and Order dated September 18, 2018 [Doc # 66] (the "Order"), I entered judgment in favor of Liberty on Mr. Ellis's claim that Liberty wrongfully terminated his long term disability benefits under Liberty's Group Disability Income Policy GF3-830-502315-01 (the "Policy"). In analyzing Mr. Ellis's claim, I applied an arbitrary and capricious standard of review after determining that the Policy provision giving Liberty discretionary authority to construe the terms of the Policy and determine benefits eligibility was not void pursuant to C.R.S. § 10-3-1116(2) which prohibits such discretionary provisions. By his motion, Mr. Ellis, represented by new counsel, again argues that § 10-3-1116(2) is applicable in this case and that his benefits claim is therefore subject to de novo review. Mr. Ellis further argues that de novo review dictates that judgment be entered in his favor on his claim for continuing long term disability benefits under the Policy.

III. Analysis

A. Standard of Review

My conclusion that § 10-3-1116(2) was not retroactively applicable to the Policy was predicated on the fact that the Policy was issued in 2005, prior to the enactment of §10-3-1116(2) in 2008. In reaching this conclusion, I considered Mr. Ellis's argument that the 2005 issuance date was not determinative because relevant events, including renewals and amendments to the Policy and the assertion and processing of his disability claim, occurred after 2008.

In again arguing that 2005 is not the determinative date in analyzing the applicability of §10-3-1116(2), Mr. Ellis focuses on amendments to the Policy which he made cursory reference to in his original briefing and a Summary Plan Description ("SPD") for Comcast's Disability Plan that was not part of the administrative record. With respect to amendments, Mr. Ellis cites footers on several pages of the Policy to demonstrate that portions of the Policy were amended subsequent to the 2005 issuance date, most notably in 2011. *See* Doc # 52, pp. 16, 17, 18, 21, 22, 31 & 32. The cited pages do not include the General Provisions section of the Policy which contains the discretionary authority provision that Liberty relies on for application of an arbitrary and capricious standard of review. In fact, this section of the Policy does not reference any effective date, either 2005 or any subsequent year. *See* Doc # 52, pp. 41-5. Liberty, however, bears the burden of establishing that the arbitrary and capricious standard of review is applicable in this case. *LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment and Dependent Life Ins. Plan*, 605 F.3d 789,796 (10th Cir. 2010).

Liberty has failed to provide any evidence to rebut Mr. Ellis's argument that the Policy has been amended several times. Liberty has also failed to cite any legal authority to rebut Mr. Ellis's argument that these amendments take this case out of the purview of *Johnson v. Life Ins. Co. of North Amer.*, 2017 WL 1154027 at *11-*13 (D. Colo. Mar. 28, 2017) and *Mustain-Wood v. Nw. Mut. Life Ins. Co.*, 938 F. Supp. 2d 1081, 1084-85 (D. Colo. 2013), which informed my analysis of the retroactivity of § 10-3-1116(2) in the Order. Since both Johnson and Mustain-Wood dealt solely with policy renewals, I no longer find them persuasive authority for my analysis of this issue.

In addition, the SPD submitted by Mr. Ellis with his motion provides as follows:

> This [Plan] is effective January 1, 2011 and is established by [Comcast] to provide both short-term disability and long-term disability benefits to its eligible employees. It is the successor plan to the previously maintained Short-Term Disability Plan and Long-Term Disability Plan.

See Ex. 1 to Motion, p.2. Liberty argues that I should not even consider the SPD because it was not part of the administrative record before the Court. As Mr. Ellis points out, however, Liberty was responsible for compiling the administrative record to be reviewed by the Court (see Doc #70, p.2) and owed a fiduciary duty to him to ensure that he received any benefits to which he was entitled. *See Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807-08 (10th Cir. 2004). Asking the Court not to consider information known to it that is relevant to Mr. Ellis's claim for long term disability runs counter to the duty that Liberty owes Mr. Ellis. I therefore reject Liberty's request that I strike the SPD from consideration.

Liberty also argues that it should not be bound by the SPD since it was prepared and issued by Comcast. Clearly though, the SPD and the Policy are related. *See* Exhibit 1 to Motion, p. 2 ("... benefits which are insured are provided through a contract of insurance..."). Furthermore, Mr. Ellis's claim for long term disability benefits arises out of his participation in Comcast's Disability Plan which, per the SPD, went into effect in 2011, or well after the enactment of § 10-3-1116(2)'s prohibition on discretionary provisions like that contained in the Policy.

Again, Liberty bears the burden of establishing that

the arbitrary and capricious standard of review is applicable in this case. *LaAsmar, supra*. In light of the numerous amendments to the Policy that have now been highlighted by Mr. Ellis and the SPD submitted to the Court with his motion, I conclude that Liberty is unable to meet its burden of establishing that it is entitled to a more deferential standard of review because the Policy issuance date of 2005 precludes application of § 10-3-1116(2). I must therefore reconsider Mr. Ellis's claim for continuing long term disability benefits de novo.

In this case, de novo review means that I give no deference to Liberty's decision to terminate payment of long term disability benefits to Mr. Ellis but rather take a fresh look at all of the evidence and determine whether a preponderance of the evidence supports Liberty's decision. *See Smith v. Reliance Standard Life Ins. Co.*, 322 F. Supp. 2d 1168, 1176 (D. Colo. 2004); *Reynolds v. UNUM Life Ins. Co. of Amer.*, 1998 WL 654475 at *3 (D. Colo. June 15, 1998).

B. Merits Of Mr. Ellis's Claim For Continuing Long Term Disability Benefits

The background relating to Mr. Ellis's claim for long term disability benefits that was set forth in the Order is incorporated herein by reference. *See* Doc # 66, pp. 1-12. I further note that neither Mr. Ellis nor Liberty has presented any new evidence regarding Mr. Ellis's claim of ongoing disability or made any additional arguments regarding Liberty's decision to terminate his long term disability benefits. Applying the de novo standard of review to the evidence and arguments presented in the parties' original briefing, I conclude that Liberty's decision to terminate Mr. Ellis's long term disability benefits under the Policy's "Any Occupation" provision is not

supported by a preponderance of the evidence and therefore enter judgment in favor of Mr. Ellis for the reasons set forth below As set forth in the Order, Mr. Ellis's treatment providers were all in agreement that he suffered from some degree of cognitive impairment after experiencing significant health issues in January and February of 2012. *See* e.g. Order, pp. 3-4. Drs. Hadley and Zacharias expressly advised Liberty that this impairment rendered Mr. Ellis unable to work. *Id.* Dr. Helffenstein reached the same conclusion after his initial neuropsychological examination of Mr. Ellis, and Dr. Crouch, Liberty's own consulting neuropsychologist, twice reached this same conclusion though he questioned whether the 24 seconds of heart stoppage that Mr. Ellis experienced on February 1, 2012 could be the sole cause of his impairment. *Id.* at pp. 6-7. Results from clandestine surveillance conducted of Mr. Ellis on behalf of Liberty over several days were consistent with these assessments in that they showed minimal activity where Mr. Ellis was once driven by someone else and walked slowly using a cane. Doc # 34-12, pp. 4-6 & Doc # 35-5, pp. 14-18.

Although a Transferrable Skills Analysis/Vocational Review of Mr. Ellis that was performed on behalf of Liberty determined that Mr. Ellis could work in occupations including software engineer and computer systems engineer, this analysis notably did not include any of the cognitive limitations that are noted throughout Mr. Ellis's file and which were unchallenged at the time vocational analysis was completed. *Id.* at p. 8. Prior to Liberty's termination of Mr. Ellis's long term disability benefits then, the only evidence that it had to support this decision was Dr. Gant's report from his neuropsychological testing of Mr. Ellis at Liberty's request During his testing of Mr. Ellis, Dr. Gant observed that Mr. Ellis had issues with his

balance, was slow to complete the testing, and had difficulty expressing himself. Doc # 34-10, p. 5 - 6. However, the results of Dr. Gant's testing were "invalid," and Dr. Gant concluded that he was "not certain" that Mr. Ellis suffered from cognitive impairment though he too opined that any such impairment was not caused by the 24-second period of asystole that Mr. Ellis suffered on February 1, 2012. *Id.* at p. 11. Notably, Dr. Gant also stated "however, if additional information is provided for review, including Dr. Helffenstein's raw data, I would be happy to either confirm or amend my current opinions." Doc # 34-9, p. 23. No further information was provided to Dr. Gant even though Dr. Helffenstein's raw data had previously been provided to Dr. Crouch, and Dr. Gant neither confirmed nor amended his findings. Liberty terminated Mr. Ellis's long term disability benefits based on Dr. Gant's neuropsychological testing despite all the other evidence supporting his claim. Doc # 34-9, p. 15.

In appealing Liberty's decision to terminate benefits, Mr. Ellis provided even more compelling additional evidence to support his claim for long term disability benefits including a report from a neuropsychological re-evaluation of Mr. Ellis performed by Dr. Helffenstein, a letter from a speech-language therapist who treated Mr. Ellis "over several sessions," findings of disability by the Social Security Administration, and abnormal results from a SPECT brain imaging study. *See* Order, p. 2, 4, 10-11. Liberty denied Mr. Ellis's appeal. In support of this decision, Liberty relied on the report of Dr. Timothy Belliveau, Ph.D., who reviewed Mr. Ellis's file but did not personally see Mr. Ellis. Although Dr. Belliveau concluded that the records he reviewed did not support a finding that Mr. Ellis suffered from any cognitive impairment, the findings that led to this conclusion are often difficult to follow and

unpersuasive in any event.

Most significantly, Dr. Belliveau was critical of Dr. Helffenstein's opinions of Mr. Ellis's disability based on the testing Dr. Helffenstein utilized to assess the validity of Mr. Ellis's cognitive limitations. However, Mr. Ellis passed the bulk of the validity tests administered by Dr. Helffenstein, and there is ample evidence to show that Mr. Ellis consistently demonstrated the same cognitive limitations to his treatment providers. Dr. Belliveau emphasizes that Mr. Ellis did not pass what he characterizes as the most sensitive symptom validity tests - the Word Memory Test ("WMT") and the Nonverbal Medical Symptom Validity Test ("NVMSVT") administered by Dr. Gant. However, Dr. Crouch did not specify that either of these tests should be administered in responding to Liberty's request for an outline of suggested tests and questions for a neuropsychological examination of Mr. Ellis (Doc # 34-11, pp. 11 -12), and Mr. Ellis had no notice that these specific tests would be determinative. *See* Doc # 34-9, p. 17. Liberty also relied on Dr. Belliveau for its rejection of the SPECT imaging results even though Dr. Belliveau stated that he would defer to analysis by a consulting neurologist or radiologist on this issue.

There is no evidence that Liberty ever requested such a consultation.

Ultimately, Liberty's conclusion that Mr. Ellis was capable of performing the alternative occupations identified in his vocational analysis was predicated on its conclusion that Mr. Ellis did not suffer from any cognitive impairment. This conclusion, however, is not supported by a preponderance of the evidence. Rather, in reaching this conclusion, Liberty attached greater weight to the relatively scant evidence that supported a denial of ongoing

long term disability benefits for Mr. Ellis than to the voluminous evidence that supported a contrary conclusion. Moreover, the probative value of the evidence relied on by Liberty is significantly undermined by Liberty's failure to address acknowledged shortcomings in this evidence through additional review and consultation.

III. Conclusion

Because I conclude that de novo review of this case dictates a different result than the arbitrary and capricious standard of review previously employed, justice requires that the judgment entered in favor of Liberty be vacated and a new judgment entered accordingly. IT IS THEREFORE ORDERED as follows:

1. Plaintiff Michael D. Ellis's Motion for Reconsideration/Amendment of Judgment under Fed. R. Civ. P. 59 and/or for Relief From Order Pursuant to Rule 60 [Doc 68] is GRANTED;

2. Defendant Liberty Life Assurance Company of Boston's Motion to Strike Pursuant to Fed. R. Civ. P. 12(f) [Doc # 70] is DENIED;

3. The Court's Memorandum Opinion and Order dated September 18, 2018 [Doc #66] and the corresponding Final Judgment entered September 19, 2018 [Doc # 67] are hereby VACATED;

4. Judgment shall enter in favor of Mr. Ellis for long term disability benefits in the amount of $8,572.29 per month beginning December 4, 2013 and continuing unless and until Mr. Ellis's medical condition changes or until he reaches the age of 65 on September 12, 2023;

5. The monthly benefit payable to Mr. Ellis by Liberty shall be reduced by the amount of any Social Security Disability Income paid to him for the same time period;

6. Mr. Ellis shall be awarded his costs and may also file a motion for interest and attorney fees within thirty (30) days of the date of this Order.

Dated: January 15, 2019.

BY THE COURT:

s/Lewis T. Babcock
Lewis T. Babcock, Judge

APPENDIX D

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLORADO
LEWIS T. BABCOCK, JUDGE

Civil Action No. 15-cv-00090-LTB

MICHAEL D. ELLIS,
Plaintiff,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON, a New Hampshire corporation,
Defendant.

MEMORANDUM OPINION AND ORDER

Babcock, J.

This ERISA case is before me for determination of the merits following briefing by the parties. *See* Doc #s 57, 61 & 62. After consideration of the parties' briefs, the record, and the case file, and for the reasons stated below, I enter judgment in favor of Defendant Liberty Life Assurance Company of Boston ("Liberty").

I. Background

Plaintiff Michael D. Ellis is a former Senior Systems Architect for Comcast Corporation ("Comcast"). As

Senior Systems Architect, Mr. Ellis's responsibilities included (1) analyzing product requirements working with Senior Management, Product Management, Product Design, Finance, Product Development, Integration/Test, and Operations; (2) allocating system requirements into individual requirements for new and existing components and interfaces; (3) analyzing feature complexity and time estimates, negotiating with management to determine feature set to be delivered; (4) creating detailed architectural documents; (5) managing requirements database; (6) creating detailed interface documents; and (7) performing bandwidth modeling. Doc # 35-12, p.1.

In January of 2012, Mr. Ellis, now 59 years of age, became ill with pneumonia and developed severe chest pain caused by a pulmonary embolism. Doc # 35-22, p. 10. While receiving emergency medical treatment for his chest pain on February 1, 2012, Mr. Ellis went into cardiac arrest and his heart stopped beating for a period of 24 seconds. *Id.* Several weeks later, Mr. Ellis reported diminished concentration, dizziness, and feeling weak and wobbly. Doc # 35-21, p. 24-5. Mr. Ellis's last day of work for Comcast was February 29, 2012, and he was awarded SSDI benefits from the Social Security Administration ("SSA") beginning in August of 2012 based on his claim of disability due to brain injury, cognitive deficits, possible cerebral hypoxia, leg weakness, balance problems, depression, tremors, and numbness. Doc # 33-12, pp. 9 & 11-15.

As a Comcast employee, Mr. Ellis was eligible to participate in Liberty's Group Disability Income Policy GF3-830-502315-01 (the "Policy"). Mr. Ellis was a Class 4 employee for purposes of coverages under the Policy. Mr. Ellis's claim for short term disability benefits, payable by Comcast pursuant to its Short Term Disability Plan, was

first approved as of March 1, 2012. Liberty, as the administrator of Comcast's Short Term Disability Plan ultimately extended Mr. Ellis's short term disability benefits to the maximum period of September 5, 2012.

A. Mr. Ellis's Medical Records

Mr. Ellis received physical and speech-language therapy. Notes from Mr. Ellis's physical therapy sessions dated in 2012 reflect that Mr. Ellis was experiencing weakness, fatigue, and loss of balance/coordination. *See* e.g. Doc # 34- 14, p. 9. Notes from Mr. Ellis's speech therapy sessions in 2012 and 2013 reflect that Mr. Ellis was experiencing mild to moderate cognitive deficits in areas including attention, memory, and complex reasoning. *See* e.g. Doc #34-15, p. 22.

Dennis A. Helffenstein, Ph.D., performed a neuropsychological examination of Mr. Ellis in August and September of 2012. Doc # 35-6, pp. 7-22. In a report dated November 10, 2012, Dr. Helffenstein detailed cognitive deficits he observed in Mr. Ellis and opined that these deficits "relate directly and solely to the medical event that occurred on February 1, 2012" and that it "seems reasonable that an episode of cerebral hypoxia did occur during this event." *Id.* at p. 19. Dr. Helffenstein concluded that due to a combination of his "physical, fatigue, visual, cognitive, and emotional coping problems," Mr. Ellis was totally disabled from competitive employment at that time. *Id.* at p. 21.

Daniel C. Hadley, M.D., Mr. Ellis's primary care physician who had been treating him since February of 2012, completed a restrictions form for Liberty on May 23, 2013 and stated that Mr. Ellis was unable to participate indefinitely in any work situation requiring a minimal amount of concentration for more than 10 - 20 minutes due to "cognitive impairment from hypoxic encephalopothy." Doc # 34-

16, p. 21. Alan Zacharias, a neurologist who began treating Mr. Ellis in May of 2012, also completed a restrictions form for Liberty on May 25, 2013 and stated that Mr. Ellis was unable to work as shown by neuropsychological testing and his notes. Doc # 34-16, p. 11.

On August 12, 2013, Dr. Hadley answered Liberty's request for specific activities restrictions/limitations and recommended that in an 8-hour workday Mr. Ellis could sit for 1-1½ hours at a time for a cumulative total of over 5½ hours; stand and walk for a cumulative total of 2½ hours; push, pull, lift, and carry up to 20 pounds for short distances for a cumulative total of 2½ hours; and was restricted in climbing, squatting, bending, and kneeling due to dizziness. Doc # 34-12, pp. 11-13. Dr. Hadley also noted that Mr. Ellis "continues to have cognitive impairment resulting in ongoing disability related to concentration/memory." *Id.* at p. 13.

On May 16, 2014, Mr. Ellis was seen for a high-resolution brain SPECT imaging study. S. Gregory Hipskind, M.D. Ph.D., reported that the results of the study were abnormal and that the abnormalities "were most consistent with the scientific literature pertaining to a diffuse, toxic/hypoxic encephalopathic process and the patient's clinical history." Doc # 34-7, pp. 22-4.

B. Liberty's Policy

The Policy provides that "Liberty shall possess the authority, in its sole discretion, to construe the terms of this policy and to determine benefit eligibility hereunder. Liberty's decisions regarding construction of the terms of the policy and benefit eligibility shall be conclusive and binding." Doc # 52, p. 42.

In pertinent part, the Policy defines "Disability" or "Disabled" for purposes of long term disability as follows:

i. if the Covered Person is eligible for the 12 Month Own Occupation Benefit, "Disabled" or "Disability" means that during the Elimination Period and the next 12 months of Disability the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of his Own Occupation; and

ii. thereafter, the Covered Person is unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.

Id. at p. 9. Under the Policy,

> **"Own Occupation"** means the Covered Person's occupation that he was performing when his Disability or Partial Disability began. If the Covered Person is unable to earn 80% of his predisability earnings he will be considered unable to perform his Own Occupation. For purposes of determining Disability under the policy, Liberty will consider the Covered Person's occupation as it is normally performed in the national economy.
>
> **"Any Occupation,"** with respect to Class 4, means any gainful occupation that the Covered Person is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity. Gainful occupation means an occupation in which the earnings are:

> -equal to or greater than 80% of the Employee's pre-disability income;
>
> -less than 80 % of the Employee's average pre-disability income, but higher than the average earnings for the geographic area in which the Employee resides; or
>
> -equal to or greater than the gross benefit.

Id. at pp. 7 & 12.

The Policy provides that payment of long term disability benefits will cease on the earliest of

> 1. the date the Covered Person fails to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;...
>
> 8. The date the Covered Person s no longer Disabled according to this Policy;...

Id. at pp. 34-5. The Policy also contains a Mental Illness, Substance Abuse and/or Non-Verifiable Symptoms Limitation (the "Mental Illness provision") which provides that the benefit for disability due to any of these conditions will not exceed a period of 24 months. *Id.* at p. 26.

C. Liberty's Handling of Mr. Ellis's Claim for Long Term Disability Benefits

By letter dated January 21, 2013, Liberty advised Mr. Ellis that he would be receiving long term disability benefits under a reservation of rights while it conducted a medical review to determine his eligibility. Doc # 35-4, p. 22. Liberty had Dr. John A. Crouch, a neuropsychologist affiliated with Liberty's Clinical Services Department,

and Dr. Gilbert Wager, a doctor of internal medicine, pulmonary medicine and critical care medicine, review Mr. Ellis's medical records. Dr. Wager stated that an assessment of Mr. Ellis's reported neuropsychological impairments was outside the scope of his expertise but opined that from a physical perspective Mr. Ellis appeared able to perform sedentary work on a full time, sustained basis. Dec # 35-5, p. 9. After reviewing Dr. Helffenstein's raw data, Dr. Crouch set forth the following findings in a report dated April 4, 2013:

> . . . various statistically and clinically significant impairments are revealed across multiple neurocognitive domains including learning/memory, attention/concentration, and processing speed.
>
> A variety of significant restrictions and limitations would likely result from this claimant's impairment including difficulty with concentration, persistence, pace, and adaptation. Given the reportedly cognitively demanding nature of [Mr. Ellis's] job, he would likely be precluded from performing the usual duties of the job, regardless of accommodations provided . . . the likelihood that his 2/1/12 reported 24-second period of asystole is the sole cause of his functional difficulties is highly unlikely. Although findings from measures of emotional/psychological functioning suggest a possible psychiatric contribution, other possible contributors remain unclear. Given this lack of diagnostic clarity, [Mr. Ellis's] prognosis for possible future RTW

remains unclear.

Doc # 35-4, p.4.

By letter dated April 11, 2013, Liberty notified Mr. Ellis that "[a]lthough the etiology of your cognitive deficits is unclear at this time, we have determined you are disabled from cognitive deficits and are eligible to receive LTD benefits." Doc # 35-3, p. 22. By this letter, Liberty also advised Mr. Ellis that both of its medical reviewers indicated that it was highly unlikely that 24-second period of asystole was the cause of his impairments and that its reviewing neuropsychologist identified a possible psychiatric component to his cognitive deficits. *Id.* at pp. 21 - 22. Based on the latter, Liberty further notified Mr. Ellis and that his claim for long term disability benefits was subject to the Mental Illness provision of the Policy. *Id.* at p. 22. Liberty identified Mr. Ellis's date of disability as March 1, 2012 and determined that he was entitled to receive benefits (after the elimination period) as of September 6, 2012. *Id.*

In response to this letter, Mr. Ellis provided Liberty with a letter from Dr. Helffenstein in which he expressed his agreement with Liberty's reviewing doctors' opinions that it was highly unlikely that the 24-second period of asystole Mr. Ellis experienced on February 1, 2012 was the cause of his cognitive impairments. Doc # 34-12, pp. 1-2. Dr. Helffenstein stated that Mr. Ellis's cognitive dysfunction "most likely relates to a more extended period of cerebral hypoxia." *Id.* at p. 1. Dr. Helffenstein further stated that he had no indication "that depression or any other psychiatric issue was contributing to [Mr. Ellis's] cognitive dysfunction identified by [his] testing" and that Liberty would be making a grievous error if it limited Mr. Ellis's disability benefits under the Policy's Mental Illness provision "as absolutely no part of his cognitive

dysfunction relates to a mental illness." *Id.* at pp. 1-2.

Following a request for clarification by Mr. Ellis, Liberty, by letter dated August 26, 2013, explained that Mr. Ellis was approved for long term disability benefits but because "the etiology of Mr. Ellis's cognitive impairments remains unclear and a psychiatric condition has been noted as a contributing condition," the Policy's Mental Illness provision had been applied and was running concurrently as Liberty continued to evaluate Mr. Ellis's claim. Doc # 34-11, pp. 23-24. Liberty further advised that it was evaluating whether Mr. Ellis could perform any alternative occupations since the Policy definition of "Disability" changed after twelve months of benefits. *Id.* at p. 24.

A Transferrable Skills Analysis/Vocational Review ("TSA/VR") dated July 24, 2013 was performed on behalf of Liberty. The Vocational Case Manager indicated that she based her report on a presumed full time sedentary work capacity and that she did not include any cognitive and/or mental restrictions and limitations. Doc #34-13, pp. 10-11. The Vocational Case Manager identified software engineer, project director/manager, computer systems engineer, and computer information & systems manager as occupations that Mr. Ellis could perform. *Id.* at p. 13.

In September of 2013, Liberty again referred the case to Dr. Crouch and asked him to provide an updated assessment of Mr. Ellis's ability to perform alternate occupations. Doc # 34-11, p. 11. Dr. Crouch responded, in part, that he found it "unlikely that the claimant could perform the job duties of alternate occupations comparable to his prior job." *Id.*

Dr. Bob L. Gant performed neuropsychological testing of Mr. Ellis on behalf of Liberty in October of 2013 and reported his results as "invalid." Doc # 34-10, p. 8. Dr.

Gant opined as follows:

> ...it is my determination that within reasonable medical probability the patient has not suffered cognitive impairment related to the asystole event which lasted 24 seconds on February 1, 2012. In fact, I am not certain that the patient suffers from cognitive impairment. It is likely that elements of secondary gain and/or impairment related to somatic exaggeration is responsible for [Mr. Ellis's] presentation. During this examination, Mr. Ellis displayed evidence of symptom exaggeration and poor effort within the context of a disability examination.

Id. at p. 11. Dr. Gant reviewed Dr. Helffenstein's November 10, 2012 report and concluded that "inadequate testing was done [by Dr. Helffenstein] to evaluate patient effort and test validity." *Id.* at p. 3. Dr. Gant further opined about Dr. Helffenstein's testing:

> ... the performance validity tests utilized by Dr. Helffenstein ... are considered inadequate by current standards ... for assessing a patient referred within the context of a disability assessment with unequivocal evidence of secondary gain. Several of the tests discussed by Dr. Helffenstein are no longer published and Dr. Helffenstein did not appear to utilize the most current version of the available tests for assessing secondary gain issues and poor effort.

Id. Dr. Gant indicated that he would be happy to confirm or amend his opinions if provided with additional

information, including Dr. Helffenstein's raw data. Doc # 34-9, p. 23.

By letter dated December 10, 2013, Liberty advised Mr. Ellis that long term disability benefits would no longer be paid to him after December 3, 2013. Doc # 34- 9, pp. 11-16. By way of explanation, Liberty stated that Mr. Ellis's failure to put forth valid and reliable effort at the neuropsychological testing performed by Dr. Gant left Liberty "unable to accurately assess his cognitive complaints to determine if he remains impaired from working in any capacity." *Id.* at p. 15. Liberty also noted Mr. Ellis's subjective complaints of fatigue and dizziness but stated that there was no indication from any treatment provider that these symptoms were causing impairment to Mr. Ellis or that these symptoms required continued restrictions and limitations that would prevent Mr. Ellis from performing the duties of Any Occupation. *Id.*

Mr. Ellis appealed Liberty's termination of his long term disability benefits. Doc #s 34-5, pp. 13-16 & 34-7 pp. 1-12. In connection with his appeal, Mr. Ellis provided Liberty with the report from his neuropsychological reevaluation performed by Dr. Helffenstein in March of 2014. Doc # 33-6, p. 21 - Doc # 33-7, p.10. Therein, Dr. Helffenstein noted that Mr. Ellis had shown improvement in some areas of testing but had reached maximum medical improvement such that all remaining cognitive deficits were to be considered permanent. Doc # 33-7, pp. 9-10. Dr. Helffenstein ultimately concluded that Mr. Ellis was totally and permanently disabled from competitive employment and further opined as follows:

> ... Mr. Ellis experienced a 24-second period of asystole (i.e., cardiac standstill). It is obvious that such a brief period of cardiac

> standstill would not be expected to result in any significant cerebral hypoxia. However, Mr. Ellis did experience some type of neurological event during this timeframe.
>
> Based on my re-evaluation with Mr. Ellis, I am even more convinced that he did experience some type of neurological event (likely a hypoxic episode or episodes) during the early part of February of 2012 related to his various medical conditions. I am not sure that any physician or neuropsychologist could point to a specific time or event that resulted in Mr. Ellis's neurological injury but, at this point, I am absolutely convinced that such an injury did occur.

Doc # 33-6, pp. 21-22 & Doc # 33-7, p. 9.

Mr. Ellis also provided Liberty with a letter from his speech-language therapist who indicated that his "observations and evaluations of Mr. Ellis over many sessions demonstrate that he has cognitive deficits, most notably in the areas of attention, memory, organization, speed of cognitive processing, problem- solving/reasoning, word-finding and cognitive overload." Doc # 33-12, p. 8. Mr. Ellis's therapist further indicated that his observations were consistent with the areas of impairment identified by Dr. Helffenstein. *Id.*

Liberty referred Mr. Ellis's claim to Dr. Timothy Belliveau, Ph.D., for review. Dr. Belliveau summarized Mr. Ellis's medical records and provided a detailed analysis of the three neuropsychological evaluations. Doc # 33-3, p. 3 - 33-4, p. 1. Dr. Bellivaeu concluded that the records provided insufficient support "for the presence of cognitive or psychologically-based impairment that would necessitate

occupational restrictions or limitations" and "for the presence of cognitive impairment attributed to hypoxic-ischemic encephalopathy." Doc # 33-3, pp. 5-6.

By letter dated September 19, 2014, Liberty advised Mr. Ellis that his medical condition "is not of a nature and severity that would preclude him from performing the material and substantial duties of the alternative occupations identified as being within his functional capacity and vocational skills" and that Liberty was therefore maintaining its decision to deny continued long term disability benefits to him beginning December 4, 2013. Doc # 33-2, p. 20 - 33-3 p.1.

II. Standard of Review

While Liberty captioned its brief as a Combined Response Brief and Motion for Summary Judgment in an ERISA Case [*see* Doc # 61], it concedes that Fed. R. Civ. P. 56 standards are not applicable in ERISA cases. Instead, I act as an appellate court and evaluate the reasonableness of Liberty's decision based on the evidence contained in the administrative record. *Panther v. Synthes*, 380 F. Supp. 2d 1198, 1207 n. 9 (D. Kan. 2005). "'[A] denial of benefits' covered by ERISA 'is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" *LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan*, 605 F.3d 789, 796 (10th Cir. 2010) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). Where the plan gives the administrator such discretionary authority "[courts] employ a deferential standard of review, asking only whether the denial of benefits was arbitrary and capricious." *Id.* (quoting *Weber v.*

GE Group Life Assur. Co., 541 F.3d 1002, 1010 (10th Cir. 2008)).

The Policy expressly gives Liberty discretion to construe its terms and to determine benefit eligibility. Mr. Ellis argues that I should nonetheless employ a de novo standard of review because the applicable provision of the Policy is void pursuant to C.R.S. § 10-3-1116(2) which states as follows:

> 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.

For § 10-3-1116(2) to be applicable, I must first determine if this case is subject to Colorado law. Liberty argues that this case is governed by Pennsylvania law because the Policy so expressly provides and the Policy was issued to Comcast there. In response, Mr. Ellis argues that the Policy was in fact issued to him as a Comcast employee in Colorado and that Liberty has failed to cite any authority to support the argument that it can exempt itself from Colorado's statutory insurance regulations by electing to be governed by the laws of another state. I agree with Mr. Ellis.

Contracting parties may choose the law to govern their relations "unless there is no reasonable basis for their choice or unless applying the law of the state so chosen would be contrary to the fundamental policy of a state whose law would otherwise govern." *Hansen v. GAB Bus. Servs., Inc.*, 876 P.2d 112, 113 (Colo. App. 1994) (citing Restatement (Second) of Conflict of Laws § 187 (1971)).

Colorado has an express public policy of regulating insurance to promote the public welfare. *See* C.R.S. § 10-1-101. § 10-3-1116(2) was enacted in furtherance of this policy. Because there is no comparable statutory provision under Pennsylvania law, applying Pennsylvania law here would be contrary to a fundamental policy of the State of Colorado. Having failed to cite any authority to show otherwise, Liberty's argument based on the Policy's choice-of-law provision must fail. *See LaAsmar*, 605 F.3d at 796 (party arguing for more deferential arbitrary and capricious standard of review bears the burden of establishing that it should be applied). I further conclude that the Policy was issued in Colorado for purposes of § 10-3-1116(2). *See Shafer v. Metro. Life Ins. Co.*, 80 F. Supp. 3d 1244, 1250-51 (D. Colo. 2015) (policy issued to corporate employer out-of-state but then issued to claimant in Colorado was issued in Colorado for purposes of §10-3-1116(3)).

Liberty also argues that § 10-3-1116(2) is not applicable in this case because it is preempted by ERISA. This issue has not been addressed by the Tenth Circuit but another judge of this Court considered this question in *McClenahan v. Metro. Life Ins. Co.*, 621 F. Supp. 2d 1135 (D. Colo. 2009), and concluded that § 10-3- 1116(2) is not preempted by ERISA. I agree with and adopt the preemption analysis in McClenahan. I further note that the only authority cited by Liberty in support of its preemption argument is distinguishable because there the court considered whether § 10-3-1116(3), not §10-3-1116(2), was preempted by ERISA. *See Shafer*, 80 F. Supp. 3d at 1251-57. *See also* C.R.S. § 10-3-1116(6) (providing that provisions of § 10-3-1116 are severable).

Finally, Liberty argues that § 10-3-1116(2) does not apply in this case because the statute is not retroactive. *See*

McClenahan v. Metro. Life Ins. Co., 416 Fed. Appx. 693, 696 (10th Cir. 2011). This argument is predicated on the fact that the Policy was issued in 2005, prior to the enactment of §10-3-1116(2) in 2008. In response, Mr. Ellis argues that because relevant events, including renewals and amendments to the Policy and his disability claim, occurred after the 2008 enactment of § 10-3-1116(2), application of this statute would not be retroactive. I agree with Liberty that application of § 10-3-1116(2) in this case would be retroactive and therefore improper.

Two other judges of this Court have considered the question of whether § 10- 3-1116(2) can be applied to policies renewed after its effective date and both concluded that it could not though by different reasoning. *See Johnson v. Life Ins. Co. of North Amer.*, 2017 WL 1154027 at *11-*13 (D. Colo. Mar. 28, 2017); *Mustain-Wood v. Nw. Mut. Life Ins. Co.*, 938 F. Supp. 2d 1081,1085 (D. Colo. 2013). I am persuaded by the reasoning in *Johnson* that the Colorado Legislature's failure to expressly state that § 10-3-1116(2) would apply to insurance policies renewed after its effective date despite having done so with respect to other statutes was an intentional omission that precluded the prospective application of § 10-3-1116(2) based on policy renewals. Mr. Ellis's remaining argument that application of § 10- 3-1116(2) in this case would not be retroactive because all of the events giving rise to his disability claim occurred well after the statute's effective date is also unavailing. Because § 10-3-1116(2) prohibits the inclusion of certain discretionary authority provisions in insurance policies, the applicable date for retroactivity analysis must necessarily relate directly to the policy at issue. *Compare Kisselman v. Amer. Family Mut. Ins. Co.*, 292 P.3d 964, 975-6 (Colo. App. 2011)(provisions of §§ 10-3-1115 & 1116 that prohibit acts of unreasonable

delay or denial of payment of benefits can be violated by insurer's post-effective date conduct regardless of when claim for benefits was made).

Consistent with the terms of the Policy then, I apply the arbitrary and capricious standard of review. Under this standard, my "review is limited to determining whether the interpretation of the plan was reasonable and made in good faith." *Kellogg v. Metro. Life Ins. Co.*, 549 F.3d 818, 826 (10th Cir. 2008) (internal quotations omitted). A benefits decision will be upheld unless it is not grounded on any reasonable basis. *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999) (citation omitted). The decision need not be the only logical one nor even the best one so long as it falls somewhere on a continuum of reasonableness - even if on the low end. *Id.* Indicia of arbitrary and capricious decisions include lack of substantial evidence, mistake of law, bad faith, and conflict of interest by the fiduciary. *Caldwell v. Life Ins. Co. of N. Amer.*, 287 F.3d 1276, 1282 (10th Cir. 2002). Substantial evidence is such evidence that a reasonable mind might accept as adequate to support the decision. *Rekstad v. U.S. Bancorp*, 451 F.3d 1114, 1119- 20 (10th Cir. 2006).

An inherent conflict of interest arises when the entity that determines eligibility for benefits is the same entity that pays the benefits. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 111-15 (2008). When such a conflict of interest exists as it does here, the benefits decision is still subject to the arbitrary and capricious standard of review but the conflict is weighed as a factor in determining whether there is an abuse of discretion. *Id.* at 115-16.

III. Analysis

The question presented by this appeal is whether Liberty's decision to deny Mr. Ellis long term disability

benefits under the Policy's "Any Occupation" provision was reasonable. Under the arbitrary and capricious standard of review applicable to this case, I conclude that it was and therefore enter judgment in favor or Liberty for the reasons set forth below. Preliminarily, Mr. Ellis argues that Liberty's handling of his claim for long term disability benefits became arbitrary and capricious beginning in April of 2013 when it took the position that Mr. Ellis's claim was subject to the Policy's Mental Illness provision and questioned the causal connection between the 24-second period of cardiac arrest and Mr. Ellis's cognitive deficits. Mr. Ellis acknowledges, however, that Liberty continued to pay benefits for several months after April of 2013. Moreover, Liberty's ultimate decision to terminate Mr. Ellis's long term disability benefits was not based on either the Policy' Mental Illness provision or a lack of causation but rather because Mr. Ellis did not meet the Policy's definition of disability under the Policy's "Any Occupation" provision after December 3, 2013. Doc # 34-9, p. 15. I therefore attach little significance to Liberty's reference to these considerations in its correspondence in April of 2013 or in subsequent correspondence.

As for Liberty's decision to terminate his long term disability benefits, Mr. Ellis makes several arguments to undermine the neuropsychological evaluation performed at Liberty's request by Dr. Gant. First, Mr. Ellis argues that Liberty's reliance on Dr. Gant's evaluation was not reasonable because Dr. Gant failed to comply with Dr. Crouch's specifications for what should be included in a neuropsychological re-evaluation of Mr. Ellis. Doc # 34-11, p. 11-12. Specifically, Mr. Ellis asserts that Dr. Gant failed to discuss Mr. Ellis's background, work accomplishments, earnings, activities, and physical issues and failed to obtain information from a collateral source regarding Mr. Ellis's functioning prior and subsequent to his alleged

impairment. Dr. Crouch, however, reviewed Dr. Gant's report and did not note these purported deficiencies. Dr. Belliveau, who reviewed Dr. Gant's report in connection with Mr. Ellis's appeal, likewise did not identify comparable deficiencies in Dr. Gant's report.

Next, Mr. Ellis argues that Liberty's reliance on Dr. Gant's report was arbitrary and capricious because Dr. Gant did not review Dr. Helffenstein's raw data. That Dr. Gant's evaluation was meant to be independent undermines this argument. Since Dr. Gant expressed a willingness to review this data, it may have nonetheless been preferable for Liberty to provide it to him but its failure to do so was not unreasonable particularly since Dr. Helffenstein's raw data was provided to Drs. Crouch and Belliveau who, unlike Dr. Gant, did not have the benefit of their own firsthand observations or conduct their own testing of Mr. Ellis.

Mr. Ellis also argues that Dr. Gant's report fails to reconcile his own observations of Mr. Ellis with his conclusion that there was insufficient evidence that Mr. Ellis suffered from a cognitive impairment. Dr. Gant's ultimately concluded that Mr. Ellis "displayed evidence of symptom exaggeration and poor effort" during his evaluation. Doc # 39-9, p. 22. While Mr. Ellis clearly disagrees with this conclusion, it is obvious that Dr. Gant attached greater significance to the results of symptom validity tests administered to Mr. Ellis than to his observations, and no further explanation was warranted.

Mr. Ellis faults Dr. Gant, and more generally Liberty, for ignoring "voluminous" evidence from his treating physicians and therapists. However, Drs. Gant, Crouch, Wager, and Belliveau all discuss Mr. Ellis's medical records at some length. This consideration of his medical records contradicts Mr. Ellis's attempt to characterize

Liberty's treatment of the evidence in this case as "cherry-picking." Under ERISA, Liberty was not required to accord special weight to the opinions of Mr. Ellis's treatment providers nor did it bear the burden of explaining why it credited other reliable evidence that arguably conflicted with these opinions. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003). In many cases, however, the records simply reflect Mr. Ellis's subjective reporting of his condition. *See e.g.* Doc # 35-13, p. 1038. For all of these reasons, I find no reversible error in Liberty's treatment of the records from Mr. Ellis's treating physicians and therapists.

Mr. Ellis also argues that Liberty's review of its decision to terminate Mr. Ellis's long term disability benefits was arbitrary and capricious based on claims notes that show little activity on Mr. Ellis's claim other than referring it to Dr. Belliveau for review. In light of the detailed letter Liberty sent regarding its review of Mr. Ellis's claim and the thorough report prepared by Dr. Belliveau, there is no basis for me to conclude that Liberty failed to give due consideration to Mr. Ellis's appeal. The fact that Dr. Belliveau is affiliated with Liberty does not alter this conclusion. By the same token, it is noted that Dr. Helffenstein, on whose opinions Mr. Ellis repeatedly relies, was retained by his counsel.

Turning to the substance of Liberty's September 19, 2014 letter denying continued long term disability benefits, Mr. Ellis first asserts that Liberty mis- characterized Dr. Gant's otherwise flawed report. *See* Opening Brief, p. 77. The distinctions Mr. Ellis attempts to make between Liberty's characterization of Dr. Gant's report and the report itself, however, are inconsequential; the fact remains that Dr. Gant disputed the results of Dr. Helffenstein's first neuropsychological evaluation of Mr. Ellis and

questioned whether Mr. Ellis suffered from any cognitive impairment.

Next, Mr. Ellis challenges Liberty's purported failure to account for Mr. Ellis's abnormal SPECT study as evidenced in its letter denying Mr. Ellis's appeal. Liberty accurately summarized the conclusions of this study, including its statement that "[h]owever, [Dr. Hipskind] noted that correlation with [Mr. Ellis's] entire medical history is advised." Mr. Ellis argues that the advised correlation was provided by Dr. Helffenstein and his brief in this appeal. However, as also referenced in Liberty's September 2014 letter, Dr. Belliveau opined that the scientific studies supportive of SPECT studies related to evaluating dementia or brain injury to trauma and may not be applicable to evaluating brain injury due to hypoxic-ischemic events and that neuropsychological evaluations were a more direct way to assess functional status. Doc # 33-4, p. 7. Although Mr. Ellis takes issue with this opinion, his unsupported argument fails to demonstrate that it is categorically unreasonable. While Dr. Belliveau went on to say that he would defer to a consulting neurologist or radiologist's analysis if there was a need for further review of the SPECT study, Liberty's failure to seek further review of the study, while arguably preferable, was not arbitrary and capricious in light of the neuropsychological evaluations available to it.

Mr. Ellis argues that another portion of Dr. Belliveau's report cited by Liberty is confusing and/or irrelevant. *See* Opening Brief, p. 80. This argument has merit yet the quoted language has little significance in the context of Liberty's ultimate decision on Mr. Ellis's claim for continued long term disability benefits.

Indeed, Mr. Ellis identifies other conclusions in Dr. Belliveau's report concerning validity test results as "the

opinion that is at the crux of the case:" *See* Opening Brief, p. 81. Liberty accurately summarized this conclusion as follows:

> The reviewer notes that Mr. Ellis passed the tests for validity in the 2014 exam with relatively lower sensitivity; but, he had previously failed the tests with relative higher sensitivity during the 2012 and 2013 exams; and his passing on the performance of the most sensitive cognitive performance validity test in 2012, is actually a failure by current test interpretation standards.

Doc # 33-2, p. 25. *See also* Doc # 33-3, pp. 17-19.

Mr. Ellis argues Dr. Belliveau's did not adequately explain his conclusion regarding Mr. Ellis's performance on the most sensitive validity test administered in 2012, i.e., the Word Memory Test ("WMT"), but this argument does not warrant a finding that Liberty acted unreasonably in relying on this expert conclusion which was supported by some explanation though not to the degree propounded by Mr. Elis. Additionally, Dr. Gant similarly concluded that Dr. Helffenstein did not appear to utilize the most current version of tests to assess issues of secondary gain and poor effort. Doc # 34-10, p. 3. Mr. Ellis continues to focus on the WMT throughout the remainder of his argument about Dr. Bellivau's validity testing conclusions when in fact Mr. Ellis had invalid results on other tests in 2013 and showed signs of symptom over-reporting/exaggeration in 2012 and 2013. Doc # 33-3, pp. 13, 15-16.

Mr. Ellis also argues that Liberty's denial letter demonstrates that it acted unreasonably because of its reliance on the TSA/VR to demonstrate Mr. Ellis's work capabilities when this analysis did not consider any cognitive impairments or restrictions. This approach, however,

is entirely consistent with Liberty's position that Mr. Ellis did have a demonstrable cognitive impairment that affected his ability to perform full time sedentary work.

Lastly, Mr. Ellis argues that Liberty acted unreasonably in failing to consider the SSA's determination that he was disabled and entitled to benefits. The relevant evidence in the record does not allow for my review of the context of or basis for the SSA's determination of disability. *See* Doc # 33-12, pp. 9 & 11-15 & Doc # 34-8, pp. 13-18. There is therefore no basis for me to conclude that Liberty's contrary determination was arbitrary and capricious or to reject Liberty's assertion that its decision to terminate Mr. Ellis's may well have been based on information not available to the SSA at the time of its decision.

While reasonable minds might differ on the question of Mr. Ellis's entitlement to continued long term disability benefits under the Policy, I conclude that the decision by Liberty to terminate those benefits it is not subject to reversal under the arbitrary and capricious standard of review applicable here even after taking Liberty's conflict of interest is taken into account. *See Nance v. Sun Life Assur. Co. of Canada*, 294 F.3d 1263, 1269 (10th Cir. 2002) (arbitrary and capricious standard is "a difficult one for a claimant to overcome"). It is not surprising that in a 90 page brief Mr. Ellis was able to identify some issues with Liberty's handling of his claim for continued long term disability benefits. However, based on the record before me, these issues, viewed both separately and cumulatively, do not render Liberty's ultimate decision to deny Mr. Ellis continuing long term disability benefits under the Policy's "Any Occupation" provision unreasonable.

IV. Conclusion

For the reasons set forth above, IT IS HEREBY ORDERED that judgment is entered in favor of Liberty, and this case is DISMISSED WITH PREJUDICE.

Dated: September 18 , 2018.

BY THE COURT:

s/Lewis T. Babcock

Lewis T. Babcock,
Judge