No. 22-

IN THE

Supreme Court of the United States

JAY C. RICHMOND,

Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, in this denial of benefits case under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.*, the court of appeals applied the wrong standard of judicial review under *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989) in view of *Conkright v. Frommert*, 559 U.S. 506 (2010), and deepened an established circuit split, when the court:

   a. extended the plan's grant of interpretive authority beyond plan terms that are "clear and accurate" to even *ambiguous* terms that are not ERISA-compliant, and concluded—by virtue of the presumed grant—that the plan administrator's interpretation of an ambiguous exclusionary provision was entitled to *Firestone* deference; and

   b. did not invoke the doctrine of *contra proferentem* to resolve the ambiguous exclusionary provision.

2. Does ERISA's "full and fair review" mandate apply to *each* ground asserted in a plan administrator's final denial, such that a plan administrator abuses its discretion in barring benefit recovery based on a procedurally defective ground?

RELATED PROCEEDINGS

- *Richmond v. Life Ins. Co. of N. Am.*, No. 19-cv-2026-LRR, U.S. District Court for the Northern District of Iowa, Eastern Division. Judgment entered Dec. 7, 2021.
- *Richmond v. Life Ins. Co. of N. Am.*, No. 21-3929, U.S. Court of Appeals for the Eighth Circuit. Judgment entered Oct. 18, 2022.

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Petitioner Jay Richmond respectfully petitions for a writ of certiorari to review the judgment below of the United States Court of Appeals for the Eighth Circuit.

INTRODUCTION

Under *Firestone Tire & Rubber Co. v. Bruch*, an ERISA plan benefits determination challenged under § 1132(a)(1)(B) is to be reviewed *de novo*, unless the benefit plan expressly grants discretionary authority to a plan administrator to construe "the terms of the plan." 489 U.S. 101, 115 (1989). *Firestone* itself involved no such grant. Yet, some circuit courts have misplaced reliance on *Firestone* dicta to authorize constructive grants of interpretive discretion to construe *ambiguous* plan terms. The Eighth Circuit did exactly that in the case below when it applied "*Firestone* deference" to Respondent's interpretation of a contested Plan term—in which the court found natural ambiguity. Although the Plan grants to Respondent the discretion to interpret "the terms of the Plan," App. 17a, the grant does not nullify ERISA's mandate for eminent clarity and accuracy of a plan administrator's obligations. *See* 29 U.S.C. § 1022; 29 CFR 2520.102-3(*l*).

Conkright v. Frommert, meanwhile, clarified the obvious: a trust law principle may be incorporated into ERISA only insofar as ERISA permits. 559 U.S. 506, 516 (2010) (instructing courts to consider what if anything in the ERISA statute, its structure, or its purposes requires departing from trust law principles). This case presents to the Court directly the open issue of whether the principle that "a trustee may be given power to construe *disputed or doubtful* terms," *Firestone*, at 111 (emphasis added), is properly incorporated into ERISA law as it reads, or whether ERISA's imperative for understandability necessitates that the

emphasized language be read out of the trust law principle as a prerequisite for its incorporation into ERISA. To wit: Should merely retaining interpretive discretion provide a plan administrator with lawful cover (or not) to opt out of ERISA disclosure requirements and grant itself the power to draft ambiguous plan terms that are not ERISA-compliant (i.e., not readily discernible to an average plan participant)?

In the Fifth Circuit, ambiguities are read against the plan administrator, irrespective of its vested interpretive authority. *See Koehler v. Aetna H'lth Inc.*, 683 F.3d 182, 188 (5th Cir. 2012). However, most circuits reject the *contra proferentem* rule as inherently incompatible with *Firestone* deference. The Court has twice called for the Solicitor General's views on granting cert petitions presenting the circuit split on *contra proferentem*'s role in the abuse of discretion context.

The decision below also presents another issue of exceptional importance requiring resolution by the Court: The court's unprecedented conflating of the vastly different administrative processes underlying each of the two grounds for denial—as a single, compliant (i.e., "full and fair") review. If the decision holds, a benefit denial may be upheld on a ground for which a claims review process is less than "full and fair," as long as a claim review process for an unrelated ground may have been, even where the unrelated ground is irrelevant to the court's ruling to affirm the denial.

Finally, the rulings below do not give proper effect either to administrative regulations for disclosure or for claims review procedure. Asserting the dispositive applicability of these regulations is vitally important given that "the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue." *Firestone*, 489 U.S. at 115.

OPINIONS BELOW

The opinion of the court of appeals (App. 1a-12a) is reported at 51 F.4th 802 (8th Cir. 2022). The order of the district court (App. 13a-42a) is not reported.

JURISDICTION

The court of appeals entered its judgment on October 18, 2022 (App. 12a), and denied a petition for panel or en banc rehearing on November 22, 2022 (App. 43a). The jurisdiction of the Court is invoked under 28 U.S.C. § 1254(1). The court of appeals had jurisdiction under 28 U.S.C. § 1291.

STATUTORY PROVISIONS INVOLVED

Relevant provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, are reproduced at App. 61a-83a.

STATEMENT OF THE CASE

1. Title I of the Employee Retirement Income Security Act of 1974 ("ERISA" or "Act"), 29 U.S.C. § 1001 *et seq*. is administered and enforced by the Secretary of Labor ("ERISA regulatory authority" or "ERISA regulator"). The ERISA regulator has authority to interpret the Act and promote the interests of the Act, which include promoting uniformity of employee benefit law, protecting participants and beneficiaries, enforcing fiduciary standards, and ensuring the financial stability of plan assets. *Secretary of Labor v. Fitzsimmons*, 805 F.2d 682 (7th Cir. 1986) (en banc). Under ERISA's reporting and disclosure provisions, the administrator of an employee benefit plan—like

the one at issue in this case—must provide plan participants with a summary plan description (SPD) that "shall be sufficiently accurate and comprehensive to reasonably apprise [them] of their rights and obligations under the plan." 29 U.S.C. § 1022(a).

The SPD must disclose, in relevant part, "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b). The ERISA regulator's reporting and disclosure regulations provide that the SPD must "clearly identify[ ] circumstances which may result in ... denial ... of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide...." 29 CFR 2520.102-3(*l*). These guarantees are vital: "'It is grossly 'unfair to ... disqualify [an employee] from benefits if ... [the] conditions [which lead to the disqualification] were stated in a misleading or incomprehensible manner'" in plan documents. *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 980 (5th Cir. 1991) (alterations are the court's), *abrog'd on other grounds by CIGNA Corp. v. Amara*, 563 U.S. 421 (2011) (quoting H.R.Rep. No. 93-533 (1974), U.S. Code Cong. & Admin. News 4639, 4646).

Further, ERISA's provisions for claims review procedure obligate the plan administrator to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1). The plan must also "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review." 29 U.S.C. § 1133(2). The "full and fair" review mandate imposes a substantive

requirement for an internal administrative appeals process that is meant to ensure that an adverse benefits decision is the product of a principled and deliberative reasoning process. *See* 29 CFR 2560.503-1(h).

2. The facts of the case are not in dispute. Richmond is the sole beneficiary of his late wife's employer-sponsored employee benefit plan ("Plan") governed by ERISA. A longtime pain management nurse, Mrs. Richmond bought the Plan's accidental death coverage through her hospital employer. App. 2a. Tragedy befell the Richmond family when one of their six minor children discovered Mrs. Richmond unresponsive in her bedroom in their rural Iowa home one evening after work. The unprescribed pain medications that Mrs. Richmond injected intravenously proved fatal. App. 3a.

Richmond's subsequent claim for the Plan's $500,000 death benefit was denied by Respondent on two separate grounds: 1) Mrs. Richmond's death was not a "Covered Accident"—finding that her subjective expectations could not be known but that objectively, the outcome was foreseeable ("ineligibility ground"), and 2) the supposed applicability of an exclusionary provision that expressly excludes from coverage accidental deaths caused by or resulting from "voluntary ingestion of any narcotic, drug, poison, gas or fumes" ("exclusionary ground"). App. 4a. Richmond pursued Respondent's internal appeals process, contesting the substantiation of the assertions with respect to the Plan's definition of "covered accident," and the relevance of "ingestion," as commonly understood, to the act of self-injection. CA App. 82-84.

3. Upon internal review, the same two grounds were cited for upholding the claim denial. Regarding

the ineligibility ground, the review decision articulated the "analytical framework"—corresponding to circuit precedent—used to determine that the fatal outcome was objectively "foreseeable" in the absence of evidence establishing a "subjective lack of an expectation of death." Regarding the exclusionary ground, Respondent's review decision asserted that "ingestion" is the process of "absorbing" a substance, which somehow relates to intravenous introduction into the body. CA App. at 89-90.

Richmond, through counsel, again appealed the review decision internally—this time presenting fact and expert witness testimony applied to the subjective and objective elements of the ineligibility ground. With respect to the exclusionary ground, Richmond presented evidence relevant to a five-factor test articulated in circuit precedent (i.e., "*Finley* factors") for assessing the reasonableness of Respondent's interpretation of "ingestion." CA App. at 92-133.

4. Richmond's internal appeal produced two legally distinct responses by Respondent as set forth in its final denial decision. For the ineligibility ground, Respondent engaged a forensic witness and devoted almost the entirety of its eight-page final decision to a detailed rationale for its determination—at best, approaching at least a "full and fair" review. In stark contrast, nothing in the administrative record indicates that Respondent consulted a legal professional or anyone else in response to Richmond's evidence and factor-by-factor analysis refuting the exclusionary ground. Respondent's cursory one-paragraph justification for its exclusionary ground is reproduced here in its entirety:

> The evidence supports that Ms. Richmond s's [sic] death was caused by her ingestion of morphine, hydromorphone, meperidine, and fentanyl. These drugs were not prescribed by a physician. In addition, the death was contributed to by sertraline, and diphenhydramine. You assert that term [sic] ingestion is specific to oral intake, and you assert that the drugs were taken by injection. We can reasonably interpret terms in an ERISA plan and have done so. We consider the injection of a drug to be ingestion. Because Ms. Richmond's death was caused by the ingestion of drugs not prescribed by a doctor, payment of benefits is excluded by the policy.

CA App. at 156. The "rationale" simply recites the Plan's grant of discretionary interpretive power to Respondent, which in relevant part provides that Respondent "shall have the authority, in its discretion, to interpret the terms of the Plan." *Id.* at 48. The rationale did not account for, much less refute, Richmond's evidence in opposition to the exclusionary ground for benefit denial.

5. Richmond sued Respondent in district court under ERISA's remedial provision to challenge the adverse benefit determination, and moved for a judgment on the administrative record. The district court denied Richmond's motion, applying *Firestone* deference and upholding both grounds for claim denial. App. 27a. Inexplicably, Respondent's misapplication of the legal definition of "accident" was upheld as lawful by the district court despite authoritative circuit precedent imposing an award of attorney fees

against Respondent expressly to deter it from committing this precise misapplication of the legal definition of "accident" in the future. *McClelland v. Life Ins. Co. of N. Am.*, 679 F.3d 755, 762 (8th Cir. 2012) (stating that the imposition of attorney fees against Respondent "would benefit others" hurt by Respondent's violation of ERISA common law's "accident" definition).

Turning to the exclusionary ground for claim denial, the district court applied the five-factor *Finley* test for reasonableness articulated in circuit precedent. In particular, the district court concluded that each of the *Finley* factors weighed in Respondent's favor in support of its interpretation of "ingestion," and that Respondent had met its burden of proving the applicability of the exclusionary provision. App. 36a. Nowhere did the district court opinion address Richmond's contention that he had not been provided with a "full and fair" administrative review with respect to the exclusionary ground for the claim denial.

6. The Eighth Circuit affirmed the district court's holding that Respondent had construed "ingestion" reasonably, and had lawfully barred recovery under the exclusionary provision. App. 11a. In so doing, the Eighth Circuit applied a deferential standard of review of the benefit denial decision without expressly invoking *Firestone*. App. 5a. The Eighth Circuit found it unnecessary to reach the ineligibility ground (i.e., "covered accident").

To determine whether Respondent's interpretation of "ingestion" was reasonable, the Eighth Circuit employed a *de novo* review of the five-factor *Finley* test, to assess 1) whether Respondent's interpretation is consistent with the Plan's goals, 2) whether Respond-

ent's interpretation renders any Plan language meaningless or internally inconsistent, 3) whether Respondent's interpretation conflicts with ERISA's substantive or procedural requirements, 4) whether Respondent interpreted "ingestion" consistently, and 5) whether Respondent's interpretation is contrary to the clear language of the Plan. App. 5a, 7a. The Eighth Circuit found that the second, third, and fifth factors weighed in Respondent's favor, and that the first and fourth factors weighed in neither party's favor. The Eighth Circuit concluded that, at 3-0-2 (as opposed to 5-0 as found by the district court), the determination for reasonableness tilted "slightly" in Respondent's favor. App. 7a-11a.

In assessing whether Respondent's interpretation is contrary to the clear language of the Plan (i.e., fifth *Finley* factor), the Eighth Circuit found that the term "ingestion" is reasonably susceptible to more than one meaning—rendering the term inherently ambiguous. Nevertheless, without reference to a recognized canon of construction, the Eighth Circuit determined that the textual interpretation of "ingestion" would render part of the exclusion provision meaningless. App. 10a-11a. The Eighth Circuit decision did not discuss the use of any other mode of construction urged by Richmond as relevant to ascertaining the meaning of "ingestion." That is, extrinsic evidence demonstrating the lack of use of the term "ingestion" in the administrative record by anyone to describe the circumstances of Mrs. Richmond's death; the customary usage within the relevant industry which considers "ingestion" and "injection" as separate and distinct actions in drug-related incidents; and Respondent's other accidental

death and dismemberment (AD&D) plans that expressly exclude coverage for deaths resulting from voluntary "self-administration" of drugs. *See infra* n. 5.

In assessing whether Respondent's interpretation of "ingestion" conflicts with ERISA's substantive or procedural requirements (i.e., third *Finley* factor), the Eighth Circuit reasoned that "the average plan participant would read the voluntary ingestion exclusion to cover any death caused by willingly *using* unprescribed narcotics." App. 9a (emphasis added). The Eighth Circuit did not explain how the identified ambiguity in the plan language could conceivably comply with ERISA's disclosure requirements.

Further, the Eighth Circuit concluded that Richmond's claim for benefits had received a "full and fair" administrative review in view of Respondent's "due consideration of Respondent's evidence and arguments; gratuitous two-stage appeal process; well-reasoned, eight-page, single-spaced final denial letter citing nearly all of the evidence of record." App. 12a. The Eighth Circuit did not acknowledge that all but one paragraph of the final denial letter pertained to the ineligibility ground, which did not factor into the court's decision.

7. Richmond filed a timely request for panel or en banc rehearing. The petition emphasized that had the case arisen in the Fifth Circuit, Richmond would have prevailed through application of the doctrine of *contra proferentem* to resolve the ambiguous plan language—a result of giving proper effect to ERISA's disclosure requirements. The petition also asserted that the failure to apprehend the difference between the administrative claims review processes underlying the ineligibility and exclusionary grounds renders the

guarantee for a "full and fair" review an illusory one, since the latter ground was legally defective. On November 22, 2022, the Eighth Circuit denied without explanation the request for panel or en banc rehearing. App. 43a.

REASONS FOR GRANTING THE PETITION

I. The Issue of the Extent of Deference Owed to Interpretations of Non-Compliant ERISA Plan Language Merits the Court's Review.

In a line of decisions involving ERISA plans, the Court has reiterated that determining the proper standards of review is predicated on a proper consideration of 1) the terms of the plan, 2) principles of trust law, and 3) the purposes of ERISA. The Eighth Circuit's application of *Firestone* deference to Respondent's interpretation of a term which the court identified as ambiguous is fundamentally at odds with those decisions. If the Eighth Circuit had instead considered "whether, or to what extent, the language of the [ERISA] statute, its structure, or its purposes require departing from [the] common-law trust requirements" on which a grant of primary interpretive authority is based, *Conkright*, 559 U.S. at 516, the Eighth Circuit would have deduced that trust law does not resolve the issue of what deference is owed to Respondent's interpretation of the ambiguous term. As instructed in *Conkright*, the court should have looked instead to the guiding principles underlying ERISA to determine the proper standard of review. *See id*. The holding below also conflicts with federal common law that invokes the doctrine of *contra*

proferentem to resolve contested plan language that violates ERISA's disclosure requirements.[1]

Review should be granted to resolve the circuit conflict, to ensure that the Eighth Circuit decision does not undermine the *Firestone*/*Conkright* regime, and to vindicate ERISA's fundamental goal of ensuring uniform and consistent interpretations of ERISA plans.

A. The Eighth Circuit Decision Cannot Be Reconciled with the Court's ERISA Authority.

1. ERISA's remedial provision does not set out the legal standard of review for actions seeking an award of benefits due under the terms of an ERISA-regulated plan. *Firestone*, 489 U.S. at 109. To fill the gap, federal courts adopted the arbitrary and capricious standard developed under a provision of the Labor Management Relations Act (LMRA). *Id*. In *Firestone*, the Court rejected the importation of the LMRA standard of review into ERISA as unwarranted. The Court was concerned that the LMRA standard afforded plan participants less protection than they received under pre-ERISA cases which applied a *de novo* standard in interpreting plans—a result that Congress could not have intended in light of ERISA's stated purpose of

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[1] *Firestone* expressly recognized that the trust law *de novo* standard of review is consistent with the contract principles courts used to interpret terms of employee benefit plans before the enactment of ERISA. *See Firestone*, 489 U.S. at 112. Because pre-ERISA, courts applied the *contra proferentem* rule to benefit plans, *Firestone* intended no wholesale rejection of prevailing principles of plan interpretation when the Court looked to trust law on the subject of the appropriate standard of judicial review.

promoting the interests of employees and their beneficiaries in employee benefit plans. *Id.* at 114.

Instead, the Court—guided by principles of trust law—held that an adverse benefit determination challenged under § 1132(a)(1)(B) 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." *Id.*, at 115. The Court, in *Varity Corp. v.* Howe, concluded that the wholesale importation of trust law principles into ERISA is also not warranted because "ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection." 516 U.S. 489, 497 (1996). The Court in *Conkright* further clarified that trust law principles are incorporated into ERISA only insofar as ERISA permits: "In some instances, trust law will offer only a starting point, after which courts must go on to ask whether, or to what extent, the language of the [ERISA] statute, its structure, or its purposes require departing from common-law trust requirements." *Conkright*, 559 U.S. at 516.

2. Under ERISA's reporting and disclosure provisions, the administrator of an employee benefit plan—like the one at issue in this case—must provide plan participants with a summary plan description (SPD) that "shall be sufficiently *accurate* and comprehensive to reasonably apprise [them] of their rights and obligations under the plan." 29 U.S.C. § 1022(a) (emphasis supplied). The SPD must disclose, among other things, "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b). The ERISA regulator's reporting and

disclosure regulations provide that the SPD must "*clearly* identify[ ] circumstances which may result in ... denial ... of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide ...." 29 CFR 2520.102-3(*l*) (emphasis supplied).

The Court has observed that Congress' purpose in enacting the ERISA disclosure standards is to "ensur[e] that the individual plan participant knows exactly where he stands." *Firestone*, 489 U.S. at 118. The Court has noted ERISA's "elaborate scheme ... for enabling beneficiaries to learn their rights and obligations at any time, a scheme that is built around reliance on the face of written plan documents." *Curtiss-Wright Corp. v. Schoonejongen*, 512 U.S. 73, 83-84 (1995). By definition, ambiguous terms are something less than clear, something less than accurate, and render illusory the guarantees mandated by ERISA disclosure requirements.

3. The instant Plan provides that "[t]he Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, [and] to decide questions of eligibility for coverage or benefits under the Plan...." App. 17a. Nothing in the provision expressly confers or even implies a grant of authority that empowers Respondent to construe *ambiguous* terms, *unsettled* terms, *doubtful* terms, or any other qualified "terms of the Plan" that would violate ERISA's disclosure requirements by virtue of their inclusion in the Plan.[2] Under the only reasonable reading of the Plan's

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[2] *Cf. Winters v. Costco Wholesale Corp.*, 49 F.3d 550, 552 (9th Cir. 1995) (noting that the plan granted the plan administrator the absolute discretion and authority to construe "disputed or seemingly inconsistent" plan provisions).

grant of interpretive authority, Respondent is simply empowered to interpret and apply unambiguous, ERISA-compliant Plan terms to the facts of Richmond's claim. Thus, it would have been proper to apply *Firestone* deference to Respondent's exercise of its primary interpretive authority to construe any ERISA-compliant Plan terms—of which "ingestion" was not one.

The Court should grant review to eliminate the irreconcilable conflict between the Eighth Circuit decision and the *Firestone*/*Conkright* regime. In the absence of such review, the decision below threatens to negate Congress' purpose in imposing ERISA disclosure requirements. That is, the Eighth Circuit decision renders ERISA disclosure standards worse than ineffectual because they create perverse incentives for plan administrators to *not* meet their plan drafting obligations for accuracy and clarity by claiming an "ambiguity" in the plan's provisions, and then invoking their discretionary powers to "construe" the provisions in their favor under the guise of a "full and fair review."

B. The Eighth Circuit Decision Deepens an Established Circuit Split.

1. Following *Firestone*, most courts of appeals, including the Eighth Circuit, have held or opined that the *contra proferentem* doctrine is an inapplicable rule of construction in abuse of discretion ERISA actions.[3]

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[3] At the same time, nearly all of the courts of appeals, including the Eighth Circuit, *see Delk v. Durham Life Ins. Co.*, 959 F.3d 104, 105-06 (8th Cir. 1992), have held or opined that the *contra proferentem* doctrine is federal common law that is applicable in

See e.g., Spizman v. BCBSM, Inc., 855 F.3d 924, 927-28 (8th Cir. 2017) (holding that in construing ambiguities in an ERISA plan, the court does not apply "the contra insurer" doctrine in an abuse of discretion review); *Clemons v. Norton H'thcare Inc.*, 890 F.3d 254, 266 (6th Cir. 2018) ("[C]*ontra proferentum* is inherently incompatible with *Firestone* deference."); *Blankenship v. Liberty Life Assur. Co. of Boston*, 486 F.3d 620, 625 (9th Cir. 2007) (The *contra proferentem* rule "applies in interpreting ambiguous terms in an ERISA-covered plan except where the plan: (1) grants the administrator discretion to construe its terms ...."); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1100 (10th Cir. 1999) ("[W]hen a plan administrator has discretion to interpret the plan and the standard of review is arbitrary and capricious, the doctrine of contra proferentem is inapplicable.").

In direct contrast, ambiguities in plans in actions before the Fifth Circuit are deemed to violate ERISA disclosure requirements and the doctrine of *contra proferentem* is applied to plan term interpretations even when the plan administrator is vested with discretion to interpret the plan. *E.g., Koehler*, 683 F.3d at 188. The single point of contention in *Koehler* was the ERISA plan administrator's interpretation of "pre-authorization" with respect to plan coverage of out-of-

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cases where a challenged benefit determination is not entitled to *Firestone* deference. *Miller v Monumental Life Ins. Co.*, 502 F.3d 1245, 1253-54 (10th Cir. 2007) (collecting cases to establish that "most circuits employ *contra proferentem* to construe ambiguous language in contracts governed by ERISA where review is de novo [and thus] employing the doctrine comports with the principle underlying ERISA preemption, uniformity").

network healthcare services rendered on an *ad hoc* basis. After applying *Firestone* discretion, the court found the plan summary description to be ambiguous regarding the pre-authorization provision. The court relied on circuit authority in *Rhorer v. Raytheon Eng'rs & Constrs., Inc.*, 181 F.3d 634 (5th Cir. 1999) and *Hansen* in holding that ambiguities in a plan summary are resolved in favor of the claimant even when discretion to interpret the plan has been expressly conferred on the plan administrator—in accordance with ERISA disclosure requirements' demand for accuracy. *Koehler*, 683 F.3d at 188. *Hansen* illuminated the Fifth Circuit's rationale for judicial enforcement of ERISA's mandate for a clear delineation of the scope of a plan administrator's obligations: "Accuracy is not a lot to ask. And it is especially not a lot to ask in return for the protection afforded by ERISA's preemption of state law causes of action—causes of action which threaten considerably greater liability than that allowed by ERISA." 940 F.2d at 982.

2. The well-developed circuit split has been observed by commentators and courts alike. *See ERISA Fiduciary Law* 177 (Serota & Brodie eds., 2d ed. 2006) (noting that "[c]ontroversy has arisen from application of the doctrine of *contra proferentem*;" and contrasting approaches of different circuits); Traynor, Mark, "Kunin v. Benefit Trust Life Insurance Co.: Protecting Employees under ERISA by Constructing Ambiguous Plan Terms against the Insurer" (1993), *Minnesota Law Review*, 1890 (observing that *contra proferentem* has received "mixed reviews in the context of ERISA contracts" and that the circuit split "undermines the uniformity of treatment of ERISA issues"); Wright, Patrick D., "Contra Proferentem's Applicability to ERISA Insurance Claims" (2020), *ERISA & Disability*

Benefits Newsletter, Vol. 12, Issue 4 ("Courts ... have been consistently inconsistent in applying the ... common law doctrine of *contra proferentem* to ERISA plans."). The deep division among the courts has been acknowledged by the U.S. Solicitor General. *See e.g.*, *AT&T Pen. Ben. Plan v. Call*, 552 U.S. 805 (2007), *cert. den'd*, Brief for the United States as Amicus Curiae (acknowledging that "the courts of appeals have expressed different views on whether the *contra proferentem* principle applies when reviewing an administrator's interpretation of an ERISA plan for an abuse of discretion") (visited at www.justice.gov/osg/brief/att-pension-benefit-plan-v-call-amicus-invitation-petition); *AK Steel Corp. Ret. Accum. Pen. Plan v. West*, 553 U.S. 1092 (2008), *cert. den'd*, Brief for the United States as Amicus Curiae (repeating the acknowledgement made in *AT&T*) (visited at www.justice.gov/osg/brief/ak-steel-corp-retirement-accumulation-pension-plan-v-west-amicus-invitation-petition).

As explained *infra*, Richmond's case presents a better vehicle than either *AK Steel* or *AT&T* for definitively resolving the issue—a view that would undoubtedly be shared by the Solicitor General, whose view the Court is urged to seek.

Review by the Court is imperative to resolve the deep division among the courts in this fundamental issue of ERISA plan construction.

C. The Case Presents an Ideal Vehicle to Address a Recurring Issue of National Importance.

1. As observed in *Firestone*, "the validity of a claim to benefits under an ERISA plan is likely to turn on

the interpretation of terms in the plan at issue." *Firestone*, 489 U.S. at 115. Richmond's case warrants resolution by the Court of a vitally important recurring question implicating the Court's long-standing adherence to ERISA plan terms, above all else, as the ultimate source of rights and obligations under millions of ERISA plans, which provide financial security for over 150 million American workers and their beneficiaries. *See* U.S. Government Accountability Office, GAO-21-376, May 2021 (visited at https://www.gao.gov/products/gao-21-376).

The single point of contention in this case is Respondent's interpretation of the plan term "ingestion." The lower court's conclusion that Respondent did not abuse its discretion in construing "ingestion" to include "injection" was outcome determinative. The Eighth Circuit's five-factor *Finley* analysis—designed to assess the reasonableness of a plan administrator's interpretation—includes determining whether such interpretation conflicts with ERISA's substantive or procedural requirements. [4]

2. The Eighth Circuit erred in finding that Respondent's interpretation of an ambiguous provision did not conflict with ERISA. Significantly, even if the court had correctly determined that the ambiguous

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[4] *See Finley v. Special Agts. Mut. Ben. Assoc., Inc.*, 957 F.2d 617 (8th Cir. 1992). Other circuits employ similar tests for determining reasonableness in ERISA plan interpretation reviews. *See e.g.*, *Champion v. Black & Decker (U.S.) Inc.*, 550 F.3d 353, 359 (4th Cir. 2008) (applying the eight "*Booth* factors" identified in *Booth v. Wal-Mart Stores, Inc. Assocs. H'lth & W'fare. Plan*, 201 F.3d 335 (4th Cir. 2000), in particular, "whether the decision was consistent with the procedural and substantive requirements of ERISA").

provision violates ERISA disclosure requirements—and properly credited that factor to Richmond—the court would have presumably found the interpretation to be a reasonable one under its multi-factor test, since two factors would have weighed in Respondent's favor, one in Richmond's favor, and two factors in neither party's favor (2-1-2). Thus, under the multi-factor test for reasonableness of a plan term interpretation in the Eighth Circuit, as well as other circuits, application of *Firestone* deference allows plan administrators to interpret plan terms in a way that violates ERISA's disclosure requirements and nevertheless sustained upon judicial review as being reasonable.

In light of its expertise and experience, a plan administrator should be expected to set forth any limitations on its liability clearly enough for the average plan participant to understand them; failing to do so, the plan administrator should not be allowed to take advantage of the very ambiguities that it was obligated to have prevented with greater diligence. *Miller*, 502 F.3d at 1254. Employing hindsight while ignoring relevant forensic evidence,[5] the Eighth Circuit concluded—without adherence to prevailing principles of construction[6]—that the court, acting as a proxy for

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[5] Richmond's demonstration below that the physiological assumptions made by the court were erroneous relative to Respondent's interpretation, was not addressed by the Eighth Circuit.

[6] Richmond's demonstration below that the customs and usages in the relevant industry are for plans to disclose—with the requisite precision—the drug-related accidents excluded from coverage, was not addressed by the Eighth Circuit. *See Anderson v. Liberty Mut. Ins.*, 2018 WL 3521176 U.S. Dist. Ct., (D. Maine

"the average plan participant," reads the voluntary ingestion exclusion to cover any death caused by willingly "using" unprescribed narcotics. App. 10a. To be sure, ERISA law does not preclude Respondent from excluding coverage for any *drug-related* death—so long as Respondent discloses that limitation with the specificity that ERISA explicitly requires.[7]

But having failed to do that below, the Eighth Circuit neglected to demand from Respondent a fair reading of the Plan. Significantly, Congress did not intend, as happened here, to permit Respondent to simply rely on a federal court to retroactively fix Respondent's own problematic plan language. Trust law principles are similarly unavailing in this regard.

II. The "Full and Fair Review" Issue also Merits the Court's Review.

"ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the

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July 20, 2018), at *1 (The relevant exclusionary provision excluded from coverage a loss caused by controlled substances voluntarily "taken, ingested or injected, unless as prescribed or administered by a physician."); *Jean Baptiste v. Securian Fin. Grp.*, 2021 U.S. Dist. LEXIS 164424 (S.D. Fla. Aug. 31, 2021), at *3 (The relevant exclusionary provision excluded from coverage a loss caused by "the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes, or other substances taken, absorbed, inhaled, ingested or injected.").

[7] The administrative record includes evidence that Respondent manages other ERISA-regulated AD&D plans that expressly exclude deaths resulting from voluntary "self-administration" of drugs. *See* App. 34a.

administrator 'discharge [its] duties' in respect to discretionary claims processing 'solely in the interests of the participants and beneficiaries' of the plan, § 1104(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators 'provide a 'full and fair review' of claim denials,' *Firestone*, 489 U.S., at 113, 109 S.Ct. 948 (quoting § 1133(2)); and it supplements marketplace and regulatory controls with judicial review of individual claim denials, *see* § 1132(a)(1)(B)." *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008) (alterations in original); *see also* 29 CFR § 2560.503-1(h)(2)(iv).

The decision below neglects to differentiate between the two separate grounds (i.e., ineligibility and exclusionary) used to bar recovery, for the purpose of assessing the legal adequacy of Respondent's claims review procedure. That is, the Eighth Circuit erroneously credited Respondent's claims processing related to the ineligibility ground (almost seven pages of the eight-page final decision letter[8]) to Respondent's claims processing for the exclusionary ground, which amounted to a single paragraph of the eight-page final

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[8] According to circuit authority, the text of Respondent's final decision letter is the single point of reference in the administrative record that serves as the basis for judicial review. *See* App. 40a. This common law conspicuously aligns with the ERISA regulator's claims review procedure principle that each successive stage of an internal appeal process be conducted independently and impartially (e.g., a different reviewer at each stage and who is not a subordinate of a previous reviewer), as opposed to a culmination of a series of deferential reviews. *See generally*, 63 Fed.Reg. at 48396 (3rd col.) and 48407(3rd col.); *see also*, ERISA Claims Procedure Regs., DOL Final Rule, 65 Fed.Reg. 70246, 70252-53 (Nov. 21, 2000) (codified at 29 CFR Part 2560).

decision letter. As noted *supra*, the Eighth Circuit affirmed the district court's decision with respect to the exclusionary ground alone, without reaching the issue of the ineligibility ground.

The totality of Respondent's response to Richmond's four single-spaced pages of his administrative appeal letter, setting forth a factor-by-factor analysis of Respondent's faulty interpretation of "ingestion," is reproduced here without alteration or omission:

> The evidence supports that Ms. Richmond s's [sic] death was caused by her ingestion of morphine, hydromorphone, meperidine, and fentanyl. These drugs were not prescribed by a physician. In addition, the death was contributed to by sertraline, and diphenhydramine. You assert that term [sic] ingestion is specific to oral intake, and you assert that the drugs were taken by injection. We can reasonably interpret terms in an ERISA plan and have done so. We consider the injection of a drug to be ingestion. Because Ms. Richmond's death was caused by the ingestion of drugs not prescribed by a doctor, payment of benefits is excluded by the policy.

CA App. 156. Substantively, Respondent's "review" amounts to "we get to decide, and we have decided." If Respondent's review can reasonably be considered ERISA-compliant, then ERISA's "full and fair review" requirement would have also been satisfied by a final denial letter simply consisting of a mere two paragraphs, with the rationale "we get to decide, and we have decided," regarding both of its interpretations of

disputed Plan terms "covered accident" and "ingestion." Obviously this approach would impede ERISA's employee-protection objective.

Accordingly, to promote uniformity of ERISA law, review by the Court is necessary to resolve that the statutory/regulatory mandate for a "full and fair review" in the Circuit applies to *each* ground for denial when a plan administrator asserts independent grounds for the denial. Absent the Court's review, ERISA mandates for a "full and fair review" are rendered worse than ineffectual because the mandates create perverse incentives for plan administrators to intentionally evade their obligations for scrutability by inviting "more terse and conclusory decisions from plan administrators, leaving room for them—or, worse yet, federal judges—to brainstorm and invent various proposed 'rational bases' when their decisions are challenged in ensuing litigation." *University Hosp. of Cleve. v. Emerson Elec.*, 202 F.3d 839 n.7 (6th Cir. 1999). This insidious practice is inimical to the spirit of ERISA and cannot survive the Court's review.

CONCLUSION

The petition for a writ of certiorari should be granted or, at a minimum, the Court should call for the views of the Solicitor General.

Respectfully Submitted,

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February 17, 2023

APPENDIX

APPENDIX:

Opinion of the United States Court of Appeals for the Eighth Circuit, *Richmond v. Life Ins. Co. of N. Am.*, 51 F.4th 802 (8th Cir. 2022) 1a

Order of the United States District Court for the Northern District of Iowa, *Richmond v. Life Ins. Co. of N. Am.*, No-19-CV-2026-LRR (Dec. 7, 2021) 13a

Order of the United States Court of Appeals for the Eighth Circuit Denying Rehearing, *Richmond v. Life Ins. Co. of N. Am.*, No-21-3929 (Nov. 22, 2022) 43a

Statutory Provisions Involved 44a

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*:

§ 102, 29 U.S.C. § 1022 ..... 44a

§ 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) 44a

§ 503, 29 U.S.C. § 1133 ..... 45a

Federal Regulations Involved 45a

Title 29 of the Code of Federal Regulations, 29 CFR Part 2500 *et seq.*:

29 CFR 2520.102-2(b) 45a

29 CFR 2520.102-3 ..... 46a

29 CFR 2560.503-1(h) 47a

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 21-3929

Jay C. Richmond

Plaintiff - Appellant

v.

Life Insurance Company of North America

Defendant - Appellee

Appeal from United States District Court
for the Northern District of Iowa - Eastern

Submitted: September 22, 2022
Filed: October 18, 2022

Before GRUENDER, SHEPHERD, and ERICKSON, Circuit Judges.

SHEPHERD, Circuit Judge.

Jay Richmond sought accidental death benefits under an employee benefit plan governed by the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq., after his wife, Marie

Richmond, died from injecting herself with a cocktail of unprescribed narcotics. The district court[1] upheld the Life Insurance Company of North America's (LINA) decision to deny benefits based on a policy exclusion for the "voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician." Richmond appeals, contending that the district court erred because LINA's decision was unreasonable and not supported by substantial evidence. Having jurisdiction under 28 U.S.C. § 1291, we affirm.

I.

At the time of her death, Marie was working as a registered nurse, a position that she had held for almost two decades. Throughout her tenure, Marie was a qualified participant in her employer's voluntary accident insurance plan (the Plan), managed by LINA. She maintained accidental death benefits in the amount of $500,000. Richmond is the sole beneficiary.

A few hours after work one day, at Marie's home, family members found her slumped over the side of her bed, unresponsive. After attempts to revive her failed, emergency responders pronounced her dead. Shortly thereafter, investigators discovered a vacutainer blood collection kit, a 20 mL syringe containing 1 mL of red liquid, a used quick-release tourniquet, and an opened 30 mL bottle of hydrochloride. The autopsy report identified serial needle punctures in multiple locations on Marie's limbs. The medical examiner

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[1] The Honorable Linda R. Reade, United States District Judge for the Northern District of Iowa.

opined that Marie died of mixed drug toxicity involving morphine, hydromorphone, meperidine, and fentanyl. Marie had no prescriptions for any of these drugs. Although the dosage of each of the medications was within the reported therapeutic range, and none alone would have been sufficient to kill her, the combination of these drugs was lethal.

Following Marie's death, Richmond sought accidental death benefits from LINA. Under the Plan, such benefits are paid only for deaths resulting from a "Covered Accident," which it defines as:

> A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:
>
> 1. occurs while the Covered Person is insured under this Policy;
>
> 2. is not contributed to by disease, sickness, mental or bodily infirmity;
>
> 3. is not otherwise excluded under the terms of this Policy.

R. Doc. 18-6, at 36. The Plan then lists certain exclusions. Especially relevant here, the Plan provides the following:

> In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from

> any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:
>
> ...
>
> 10. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

R. Doc. 18-6, at 40.

After receiving evidence from Richmond, LINA denied his claim on two separate grounds. First, LINA determined that the voluntary ingestion exclusion barred recovery of benefits. Second, LINA determined that Marie's death was not a Covered Accident because death was a reasonably foreseeable result of self-injecting a mixture of controlled substances. Richmond appealed LINA's decision internally. After reconsideration, LINA upheld its initial denial on the same grounds. Richmond then appealed LINA's decision internally for a second time, presenting new evidence. After reconsidering Richmond's claims in light of the new evidence, LINA upheld its initial denial of benefits on the same grounds. In its eight-page, single-spaced final denial letter, LINA explained that (1) it can reasonably interpret terms in the Plan and did so in interpreting "ingestion" to include absorption via intravenous injection; and (2) even in light of the new evidence, Marie's death was not a Covered Accident.

Richmond then filed this action, arguing that LINA's decision was unreasonable and not supported by substantial evidence. Shortly thereafter, Richmond

filed a motion for judgment on the administrative record. The district court granted judgment in favor of LINA. Specifically, it held that LINA had reasonably interpreted the voluntary ingestion exclusion to include absorption of a substance through intravenous injection, and even if the exclusion did not apply, Marie's death was not an accident within the meaning of the Plan and under this Court's precedent. Richmond appeals.

II.

Under ERISA, a covered participant or beneficiary may bring a lawsuit to recover benefits under an employee welfare benefit plan. 29 U.S.C. § 1132(a)(1). "We review the district court's adjudication of this claim de novo, applying the same standard of review to the plan administrator's decision as the district court." McClelland v. Life Ins. Co. of N. Am., 679 F.3d 755, 759 (8th Cir. 2012). Where, as here, an ERISA plan grants the plan administrator discretionary authority to interpret plan provisions and determine claimant eligibility, we review the administrator's decision for an abuse of discretion. McIntyre v. Reliance Standard Life Ins. Co., 972 F.3d 955, 958-59 (8th Cir. 2020). "Because a conflict of interest exists due to the fact that LINA is both the decision-maker and the insurer, we give that conflict some weight in the abuse-of-discretion calculation." McClelland, 679 F.3d at 759.

To determine whether LINA abused its discretion, we apply a two-step analysis. First, we must evaluate whether LINA's interpretation of the Plan language is reasonable. King v. Hartford Life & Accident Ins. Co., 414 F.3d 994, 999 (8th Cir. 2005) (en banc). Second,

we analyze LINA's application of that interpretation to the facts to ensure that it is supported by substantial evidence. Id. At bottom, LINA's decision stands if "a reasonable person *could* have reached a similar decision, given the evidence before him, not that a reasonable person *would* have reached that decision." Phillips-Foster v. UNUM Life Ins. Co. of Am., 302 F.3d 785, 794 (8th Cir. 2002) (citation omitted). "Any reasonable decision will stand," even if we would have found differently in the first instance. Manning v. Am. Republic Ins. Co., 604 F.3d 1030, 1038 (8th Cir. 2010).

III.

We begin by reviewing LINA's analysis of the voluntary ingestion exclusion since it is dispositive of this appeal. "Because it is an exception to coverage, [LINA] has the burden of proving that the exclusion applies." Nichols v. Unicare Life & Health Ins. Co., 739 F.3d 1176, 1184 (8th Cir. 2014).

A.

First, we evaluate LINA's interpretation of the exclusion. The Plan excludes coverage for any accident resulting from the "voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage." It is undisputed that the drugs found in Marie's system were not prescribed or taken under the direction of a physician. Indeed, the single point of contention here is LINA's interpretation of "ingestion." LINA argues that the term includes self-injections, while Richmond counters that the term is limited to oral intake for the purposes of digestion. To determine whether LINA's

interpretation is reasonable, we employ the five-factor Finley v. Special Agents Mutual Benefit Ass'n, Inc. test and ask:

> whether [LINA's] interpretation is consistent with the goals of the Plan, whether [its] interpretation renders any language in the Plan meaningless or internally inconsistent, whether [its] interpretation conflicts with the substantive or procedural requirements of the ERISA statute, whether [it has] interpreted the words at issue consistently, and whether [its] interpretation is contrary to the clear language of the Plan.

957 F.2d 617, 621 (8th Cir. 1992). Importantly, while these factors inform our analysis, "[t]he dispositive principle remains . . . that where plan fiduciaries have offered a 'reasonable interpretation' of disputed provisions, courts may not replace [it] with an interpretation of their own-and therefore cannot disturb as an 'abuse of discretion' the challenged benefits determination." King, 414 F.3d at 999 (alterations in original) (citation omitted).

The first Finley factor asks whether LINA's interpretation is consistent with the Plan's goals. Id. Richmond argues that it is not, quoting a recent district court opinion stating that "[t]he primary goal of the Plan, and specifically accidental death coverage, is to provide benefits in the case of the insured's accidental death." Boyer v. Schneider Elec. Holdings, Inc., 350 F.Supp.3d 854, 862 (W.D. Mo. 2018), rev'd, 993 F.3d 578 (8th Cir.), cert. denied, 142 S.Ct. 566 (2021). Yet we recently reversed this decision, specifically stating that a plan administrator "need not pursue that goal

to the exclusion of all others." Boyer, 993 F.3d at 583. LINA emphasizes this language and argues that the primary goal of the Plan is instead to pay only meritorious claims, thereby preserving the actuarial soundness of the Plan. We have indeed suggested that this is an important goal of ERISA plans generally. See Farfalla v. Mut. of Omaha Ins. Co., 324 F.3d 971, 975 (8th Cir. 2003) ("[T]he purpose of the Plan is to benefit all covered employees, a purpose that is not furthered by paying an uncovered claim."). But there is an inherent circularity in both parties' arguments here. Richmond presumes Marie's death is covered under the Plan for purposes of arguing that the primary goal of the Plan is to pay covered claims. LINA, on the other hand, presumes Marie's death is not covered under the Plan for purposes of arguing that the primary goal of the Plan is to only pay covered claims. Thus, this first factor does not weigh in either party's favor.

The second Finley factor requires us to determine whether LINA's interpretation renders any Plan language meaningless or internally inconsistent. King, 414 F.3d at 999. Richmond argues that it does, suggesting that LINA's interpretation would mean that "drug-related deaths are by their very nature nonaccidental," rendering the voluntary ingestion exclusion superfluous. This argument lacks merit, as the exclusion specifically excepts all accidents resulting from ingesting prescribed drugs under the direction of a physician. It also implicitly excepts any accidents resulting from taking drugs involuntarily. Additionally, as LINA convincingly argues, if we were to interpret "ingestion" in Richmond's way, i.e., to mean only for the purpose of digestion, it would render the part of

the exclusion about gas or fumes nonsensical. Thus, the second factor weighs in LINA's favor.

The third Finley factor asks whether LINA's interpretation conflicts with ERISA's substantive or procedural requirements. Id. Substantively, Congress enacted ERISA "to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place." Conkright v. Frommert, 559 U.S. 506, 516 (2010). Further, "ERISA does not prohibit exclusions in plan benefits where the exclusion has a legitimate business purpose." Davidson v. Wal-Mart Assocs. Health & Welfare Plan, 305 F.Supp.2d 1059, 1087 (S.D. Iowa 2004). Procedurally, ERISA requires administrators to write plan documents in a way that the "average plan participant" can understand. 29 U.S.C. § 1022(a). Richmond argues that interpreting "ingestion" to mean self-injection misleads plan participants and stretches the definition beyond all applicable meaning. But as LINA persuasively counters, the average plan participant would read the voluntary ingestion exclusion to cover any death caused by willingly using unprescribed narcotics. Since LINA's interpretation and ERISA do not conflict, this factor supports LINA.

The fourth Finley factor requires us to ask whether LINA has interpreted "ingestion" consistently. King, 414 F.3d at 999. There is no evidence of LINA's past interpretations of "ingestion." In cases involving this fourth factor, we have never decided definitively how to weigh the absence of past interpretations. See, e.g., Cash v. Wal-Mart Grp. Health Plan, 107 F.3d 637, 644 n.7 (8th Cir. 1997) (finding that factor four supported

plan administrator's interpretation when neither party presented argument on the fourth factor); Donaldson v. Nat'l Union Fire Ins. Co., 863 F.3d 1036 1041 (8th Cir. 2017) (finding that factor four supported plan administrator's interpretation when there was no indication that it had "taken inconsistent positions in the past."); see also West v. Aetna Life Ins. Co., 171 F.Supp.2d 856, 896 (N.D. Iowa 2001) (giving factor four no weight when there was no evidence of the plan administrator's past interpretations of "accident"). Without deciding, we give Richmond the benefit of the doubt and assume that this fourth factor does not weigh in either party's favor.

Finally, the fifth Finley factor asks whether LINA's interpretation is contrary to the Plan's clear language. Where, as here, a plan document does not define a term, "[r]ecourse to the ordinary, dictionary definition of words is not only reasonable, but may be necessary." Finley, 957 F.2d at 621 (citation omitted). We also look to the context in which the word is used. Kutten v. Sun Life Assurance Co. of Canada, 759 F.3d 942, 945-46 (8th Cir. 2014). Richmond cites one dictionary definition of "ingest" which is: "to take in for ... digestion." Richmond argues that, under this definition, since Marie did not introduce the drugs into her digestive tract, LINA's interpretation is contrary to the clear language of the voluntary ingestion exclusion. LINA counters by citing another dictionary definition of "ingestion" as "the process of taking food, drink, or another substance into the body by swallowing or absorbing it." According to LINA, "ingestion" then, means the "process of absorbing a substance"-including drugs taken intravenously. Neither of these

interpretations are unreasonable. However, the context controls here. Indeed, as discussed in our analysis of factor two, part of the exclusion refers to the ingestion of "gas or fumes," both of which are typically inhaled through the nose or mouth to the lungs, not the digestive system. Consequently, LINA's interpretation is more in line with the Plan's clear language, as Richmond's would render part of the exclusion meaningless. Thus, the fifth factor weighs in LINA's favor.

After weighing all five, the Finley factors tilt slightly in LINA's favor. Crucially, the dispositive question on abuse of discretion review is merely whether LINA "offered a 'reasonable interpretation of [ingestion.]'" King, 414 F.3d at 999 (citation omitted). Since the Finley analysis suggests that it has, LINA's interpretation stands.

B.

Having decided that LINA's interpretation of "ingestion" was reasonable, we now turn to whether LINA's application of its interpretation to the facts is supported by substantial evidence. Id. Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Id. Here, Marie undisputedly died because she willingly injected herself with a combination of unprescribed narcotics. Therefore, there is sufficient evidence to support LINA's application of the voluntary ingestion exclusion to Marie's death. Ultimately, since "a reasonable person *could* have reached a similar decision" as LINA given the evidence before it, Phillips-Foster, 302 F.3d at 794, LINA's decision must stand, even if we might have found differently in the first instance, Manning, 604 F.3d at 1038.

IV.

Because we agree with the district court's conclusion that LINA's denial of benefits was justified in light of the voluntary ingestion exclusion, we need not address LINA's assertion that Marie's death was not accidental, River v. Edward D. Jones Co., 646 F.3d 1029, 1034 (8th Cir. 2011), and we do not reach that issue today. Finally, Richmond argues that LINA did not provide him with a "full and fair review" of his claim as required by 29 U.S.C. § 1133. However, LINA's due consideration of Richmond's evidence and arguments; gratuitous two-stage appeal process; well-reasoned, eight-page, single-spaced final denial letter citing nearly all the evidence of record; and our analysis demonstrate otherwise.

For the foregoing reasons, we affirm the judgment of the district court.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
EASTERN DIVISION

JAY C. RICHMOND,

Plaintiff, No. 19-CV-2026-LRR

vs. ORDER

LIFE INSURANCE COMPANY OF NORTH AMERICA,

Defendant.

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I. INTRODUCTION

The matter before the court is Plaintiff Jay C. Richmond's "Motion for Judgment on the Administrative Record" ("Motion") (docket no. 21).

II. RELEVANT PROCEDURAL HISTORY

On April 30, 2019, Richmond filed the Complaint (docket no. 1), alleging that Defendant Life Insurance Company of North America's ("LINA") "denial of [Richmond's] claim for benefits was made contrary to substantial evidence, applicable law, and the express terms of the [life insurance policy]." Complaint ¶ 24. Richmond seeks "judicial relief under 29 U.S.C. § 1132(a)(1)(B) to recover benefits to which [Richmond] is entitled under the [life insurance policy]." Id. ¶ 25. On July 26, 2019, LINA filed an Answer to the Complaint and Affirmative Defenses (docket no. 10).

On October 16, 2019, Richmond filed the Motion. On January 2, 2020, LINA filed the "Opposition Motion for Judicial Review Based on the Administrative Record" ("LINA's Brief") (docket no. 24). On January 16, 2020, Richmond filed the Reply (docket no. 27). LINA requests oral argument. See LINA's Brief at 29. The court finds that oral argument is unnecessary. Accordingly, LINA's request is denied. The matter is fully submitted and ready for decision.

III. SUBJECT MATTER JURISDICTION

The court has jurisdiction over the instant action because it arises under ERISA, 29 U.S.C. § 1132(a)(1)(B). See 28 U.S.C. § 1331 ("The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.").

IV. RELEVANT BACKGROUND

A. The Parties

Richmond was married to Marie A. Richmond ("Marie"). Complaint ¶ 7. Marie was an employee of UnityPoint Health and a qualified participant in her employer's Voluntary Accident Insurance Plan ("the Policy"). *Id.* Richmond is the sole beneficiary to the Policy. *Id.* ¶ 8. Richmond is a resident of Buchanan County, Iowa. *Id.* ¶ 3.

LINA is a Pennsylvania corporation which does business in the State of Iowa. *Id.* ¶ 4. LINA is the administrator and fiduciary of the Policy and is subject to the laws, provisions and regulations of ERISA. *Id.* ¶ 9.

B. The Policy

Under the Policy, accidental death and dismemberment benefits will be paid "for any one of the Covered Losses listed in the Schedule of Benefits, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the Schedule of Benefits." Administrative Record ("AR") (docket no. 18-6) at 47. A "Covered Loss" is defined as:

> A loss that is all of the following:
>
> 1. the result, directly or independently of all other causes, of a Covered Accident;
> 2. one of the Covered Losses specified in the Schedule of Covered Losses;
> 3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.

Id. at 36. The Policy defines a "Covered Accident" as:

> A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:
>
> 1. occurs while the Covered Person is insured under this Policy;
> 2. is not contributed to by disease, sickness, mental or bodily infirmity;
> 3. is not otherwise excluded under the terms of this Policy.

Id. A "Covered Injury" is defined as "[a]ny bodily harm that results directly and independently of all other causes from a Covered Accident." Id.

The Policy also contains exclusions which preclude the payment of benefits to a beneficiary:

> In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section:
>
> . . .
>
> 10. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage[.] . . .

Id. at 40.

The Plan Administrator appointed LINA as the "named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims." *Id.* at 53. LINA has the "authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage of benefits under the Plan, and to make any related findings of fact." *Id.*

C. Factual Background

On February 12, 2018, at approximately 2:00 p.m., Marie ended her shift at St. Luke's Hospital in Cedar Rapids, Iowa, where she worked as a pain management nurse in the post-operative recovery room. After returning home, Marie eventually retired to her bedroom. At approximately 7:00 p.m., Marie was discovered not breathing by a family member. Attempts to resuscitate Marie were unsuccessful and she was pronounced dead at 8:16 p.m.

According to the Buchanan County Sheriff's Office Incident Report, in Marie's bedroom, Deputy Sheriff Matt Cook found a Vacutainer Blood Collection Kit which was opened and placed on a 20 mL syringe, with the syringe containing 1 mL of red liquid appearing to be blood, a tourniquet and a 30 mL bottle of Hydrochloride, with the bottle's seal broken. See AR (docket no. 18-5) at 18. At Richmond's request, Deputy Sheriff Cook returned to the Richmond's residence to retrieve a "kit" belonging to Marie which contained multiple syringes, needles, tourniquets and gauze. *See id.* at 19.

An autopsy was performed on Marie. The medical examiner determined that Marie's cause of death was

mixed drug toxicity, involving morphine, hydromorphone, meperidine and fentanyl. See AR (docket no. 18-4) at 36. Further, the medical examiner determined that the manner of Marie's death was an accident. See id. The medical examiner opined that:

> Toxicological analysis of postmortem blood demonstrated the presence of multiple medications capable of depressing respiratory drive including morphine, hydromorphone, meperidine, and Fentanyl. Although the doses are within the reported "therapeutic range," collectively they can be lethal. The decedent had no known prescription for morphine, hydromorphone, meperidine, or Fentanyl.

Id. at 40.

On April 6, 2018, the Iowa Department of Public Health issued a Certificate of Death. See generally AR (docket no. 18-6) at 16. The immediate cause of death is listed as mixed drug toxicity, involving morphine, hydromorphone, meperidine and fentanyl. See id. The manner of death is listed as an accident. Id. The description of the injury states "Self-administered Drugs." *Id.*

D. Procedural Background

On April 24, 2018, Richmond filed a claim for benefits under the Policy. See AR (docket no. 18-1) at 2. On June 14, 2018, LINA denied Richmond's claim. See generally AR (docket no. 18-4) at 29-33. LINA explained its decision to deny Richmond's claim as follows:

> Documentation received and reviewed supports that Marie Richmond died on 2/12/2018 from mixed drug toxicity. These drugs included mor-

phine, hydromorphone, meperidine, and fentanyl. An ItelliScript prescription records search did not reveal that she [had] a valid prescription for any of the drugs listed. Additionally, the medical examiner's report noted that there are no known prescriptions for these drugs.

Morphine, hydromorphone, meperidine, and fentanyl are classified as Schedule II drugs by the Drug Enforcement Agency. This means that these drugs have a high potential for abuse and severely restricted medical use. All of these drugs require a valid prescription from a physician in order to be obtained legally.

[The] Policy . . . as previously quoted states that "benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from . . . voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with prescribed dosage." Marie Richmond's death was the direct result of her voluntary administration of morphine, hydromorphone, meperidine, and fentanyl. Given that she did not have a valid prescription for any of the drugs listed, [and] she was not taking these drugs under the direction of [a] physician or as prescribed[,] . . . her death is specifically excluded under the terms of the policy.

[The] Policy . . . also defines a Covered Accident as a "sudden, unforeseeable, external event." In

> order to determine whether an event was foreseeable, [LINA] considers whether the insured's intentional conduct was objectively reasonable, or reasonable based on the judgement of a similar individual. Because we cannot determine Marie Richmond's objective expectations prior to her incident, we must consider whether a reasonable person with a background and characteristics similar to Ms. Richmond would have viewed serious injury or death as highly likely outcomes. Marie Richmond was 43 years old and employed by Unity Point for 17 years as a registered nurse. As a registered nurse, Ms. Richmond would have been increasingly aware of the effects of the individual drugs that she administered as well as their combined effects on the human body. LINA has determined that a reasonable person of similar age, background, and age-based experience would have understood that serious injury or death was a foreseeable outcome of her voluntary self-administering morphine, hydromorphone, meperidine, and fentanyl. Based on the above reasoning, we have determined that Ms. Richmond's death was a foreseeable outcome of her voluntary actions. As a result, it does not meet the definition of a Covered Accident as defined by the policy.
>
> For all of the above stated reasons, no Accidental Death insurance benefits are payable under [the] policy.

Id. at 31-32.

On July 20, 2018, Richmond filed an appeal of LINA's decision to deny his claim. *See generally id.* at 24-26. On August 31, 2018, LINA upheld its initial decision and denied Richmond's appeal. *See generally id.* at 10-16. In considering Richmond's appeal, LINA noted that:

> In your [appeal] letter you advised that Mrs. Richmond's death was not caused by or resulted from the delivery mode of "ingestion" of the substances that were found in her system. . . .
>
> You also stated that while the decision concluded that Mrs. Richmond's death was foreseeable because a reasonable person with similar background and experience to her would have viewed serious injury or death as highly likely to occur as a result of her actions, you believe the facts tend toward the opposite conclusion. You pointed out that the Medical Examiner's report concluded that the levels of each medication in Mrs. Richmond's postmortem blood were found in therapeutic levels therefore because she was a nurse she was even less likely to have understood that serious injury or death were likely to result.

Id. at 13. LINA explained its reasons for denying Richmond's appeal as follows:

> While you have opined that Mrs. Richmond did not "ingest" the drugs found in her postmortem system, the term "ingestion" does not only require a substance to be taken through the mouth. Ingestion is the process of absorbing a substance. LINA would interpret the term "ingestion" to include drugs taken intravenously.

The information in the claim file supports that Mrs. Richmond injected some or all of the medications found in her postmortem system herself. She had multiple syringes and tourniquets found on her possession as well as used bottles of the drugs found in her system and multiple needle marks were found on her body on autopsy that were not part of the life-saving medical interventions after she was found to be unresponsive. Dr. Thompson did state that all of the drugs were found within the reported therapeutic range, he did state ". . . collectively they can be lethal." Dr. Thompson did not report any evidence of asphyxiation that caused her death, only concluding that her death was due to mixed drug toxicity and specifically named these drugs as morphine, hydromorphone, meperidine, and fentanyl. There is no information that she was taking any of these drugs as the medical treatment on the advice and supervision of a Physician. . . .

The evidence supports that Mrs. Richmond had voluntarily ingested morphine, hydromorphone, meperidine, and fentanyl, some of them most likely intravenously. Her ingestion of these drugs directly caused here death. The information in the claim file reports that she did not have a valid prescription from a Physician for morphine, hydromorphone, meperidine, and fentanyl. As the evidence supports that Mrs. Richmond's death was directly caused by or resulted from her ingestion of drugs for which she did not have a prescription, payment of benefits is excluded by the policy.

Id. at 14. LINA also explained that:

> We are unable to determine Mrs. Richmond's subjective expectations. Because she is deceased, we cannot know what her expectations were. Nor are we able to speculate what Mrs. Richmond's expectations were. The evidence supports that she ingested multiple drugs for which she had no prescription, therefore she was not taking them under the direction of a physician and taking them illicitly. Regardless of the reason, she purposefully embraced the nature and potential ramifications of ingesting these medications without the supervision of a physician. Mrs. Richmond was a 43 year[] old woman who had worked as a registered nurse for 17 years. While you have stated that the fact the drugs were found to be individually in reported therapeutic levels, taking them collectively they were lethal. All of these drugs are classified as Schedule II substances by the United States Drug Enforcement Administration. Schedule II substances have a high potential for abuse and are also considered dangerous. As a registered nurse she would have been aware of the classification and danger of the use of these drugs outside of the direction and supervision of a Physician. Given all of these factors, a reasonable person, with background and characteristics similar to Mrs. Richmond would have viewed the resulting death as a probable consequence highly likely to occur, and therefore her death was foreseeable and was not caused by a Covered Accident

> as defined by the policy, and no benefits are payable.

Id. at 15.

On October 30, 2018, Richmond filed a second appeal in response to LINA's denial of the first appeal. *See generally* AR (docket no. 18-3) at 29-44. On January 31, 2019, LINA upheld its decision to deny Richmond's claim and denied his second appeal. *See generally* AR (docket no. 18-1) at 14-22. In considering Richmond's second appeal, LINA noted that, in the second appeal, Richmond argues that LINA's "interpretation of the term ingestion is improper and thus unreasonable and that evaluation of the facts to determine the plan as it regards a Covered Accident is not supported by substantial evidence." *Id.* at 17. LINA considered Richmond's arguments and additional supporting evidence and determined that:

> It is still LINA's position that we are unable to determine if Ms. Richmond subjectively lacked an expectation of death or injury. Ms. Richmond cannot describe her expectations of the outcome of the event. The statements provided do not contain details of the event. Dr. Yun's letter does not address Ms. Richmond's specific knowledge of the drugs that were taken, but addresses the general knowledge of nurses. Dr. Fox speculates that Ms. Richmond would not have the sophisticated technical understanding required to appreciate the risk of lethality associated with the specific drug- drug interactions of the incident narcotic and non-narcotic drugs in combination.

> Therefore[,] LINA asks whether a reasonable person, with background and characteristics similar to Ms. Richmond, would have viewed the resulting injury or death as a probable consequence highly likely to occur as a result from the insured's conduct. Given the common meanings of the words, we interpret highly likely to occur to entail a level of inevitability that is of a significant or large degree.
>
> Ms. Richmond was a nurse with over 18 years [of] experience. As Dr. Yun states, a nurse with this level of training and experience would have experience providing pain management for patients including administering therapeutic doses of medication including morphine, hydromorphone, meperidine, and fentanyl. Such a person would be familiar with the respiratory depression and accentuation they can cause, and would also understand that the doses would need to be determined by a licensed physician because of the potential interactions and cumulative effects. Such a person would also be trained in the need for monitoring patients who have been administered these medications.
>
> It is LINA's position that a registered nurse with over 18 years of experience would recognize that morphine, hydromorphone, meperidine, and fentanyl, are classified as Schedule II substances by the United States Drug Enforcement Administration because they are considered dangerous. As such the dosage of these drugs along with sertraline and diphenhydramine should be determined by a physician and

> should be administered with supervision. Given all of these factors, a reasonable person, with background and characteristics similar to Ms. Richmond would have viewed the resulting death as a probable consequence likely to occur. Therefore[,] her death was foreseeable and was not caused by a Covered Accident as defined by the policy, and no benefits are payable.

Id. at 19. Further, LINA determined that:

> The evidence supports that Ms. Richmond's death was caused by her ingestion of morphine, hydromorphone, meperidine, and fentanyl. These drugs were not prescribed by a physician. . . . You assert that [the] term ingestion is specific to oral intake, and you assert that the drugs were taken by injection. We can reasonably interpret terms in an ERISA plan and have done so. We consider the injection of a drug to be ingestion. Because Ms. Richmond's death was caused by the ingestion of drugs not prescribed by a doctor, payment of benefits is excluded by the policy.

Id. at 21.

V. ANALYSIS

A. Standard of Review

Pursuant to ERISA, a party may bring a lawsuit to recover benefits under an employee welfare benefit plan. *See* 29 U.S.C. § 1132(a)(1). In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the United States Supreme Court, recognizing that the ERISA statute does not provide a standard of review, held

that, in actions challenging the determination of eligibility for benefits, where the benefit plan confers discretionary authority to the plan administrator to determine eligibility for benefits, the plan administrator's decision is given deference and is reviewed under an abuse of discretion standard. *Id.* at 115-16. The abuse of discretion standard of review is extremely deferential and reflects the "general hesitancy to interfere with the administration of a benefits plan." *Norris v. Citibank, N.A. Disability Plan* (501), 308 F.3d 880, 883 (8th Cir. 2002) (quoting *Layes v. Mead Corp.*, 132 F.3d 1246, 1250 (8th Cir. 1998)). "Under an abuse of discretion standard of review, a plan administrator's decision will stand if reasonable; 'i.e., supported by substantial evidence.'" *Id.* (quoting *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1179 (8th Cir. 2001)).

The court must affirm the plan administrator's decision "if a reasonable person could have reached a similar decision, given the evidence before him [or her], not that a reasonable person would have reached that decision." *Prezioso v. Prudential Ins. Co. of Am.*, 748 F.3d 797, 805 (8th Cir. 2014) (quoting *Ferrari v. Teachers Ins. & Annuity Ass'n*, 278 F.3d 801, 807 (8th Cir. 2002)). "Any reasonable decision will stand, even if the court would interpret the language differently as an original matter." *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030, 1038 (8th Cir. 20210). A decision is reasonable if it is supported by substantial evidence. *See Wilcox v. Liberty Life Assurance Co. of Boston*, 552 F.3d 693, 700 (8th Cir. 2009). Substantial evidence is "more than a scintilla, but less than a preponderance." *Id.* (quoting *Clapp v. Citibank, N.A. Disability Plan* (501), 262 F.3d 820, 828 (8th Cir. 2001)); *see also Ortlieb v. United HealthCare Choice Plans*,

387 F.3d 778, 781 (8th Cir. 2004) ("Substantial evidence . . . means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion") (quotation omitted). Additionally, when the plan administrator is both the decision maker and the insurer, a conflict of interest exists which the court must take "into account and give it some weight in the abuse-of-discretion calculation." *Carrow v. Standard Ins. Co.*, 664 F.3d 1254, 1259 (8th Cir. 2012).

B. Voluntary Ingestion Exclusion

1. Parties' arguments

Richmond argues that "LINA's interpretation of 'ingestion' is unreasonable and the 'voluntary ingestion exclusion' is inapplicable to the circumstances of Marie's death." Richmond's "Brief in Support of Plaintiff's Motion for Judgment on the Administrative Record" ("Richmond's Brief") (docket no. 21-1) at 24. Richmond maintains that "[e]xamination of the *Finley* factors weighs against the reasonableness of LINA's expansive interpretation of 'ingestion' to cover injection." Id. at 25. Richmond asserts that, "even under the most deferential standard of review, LINA's application of the 'voluntary ingestion exclusion' to Marie's death was arbitrary and capricious." Id. at 30.

LINA notes that Richmond does not dispute that LINA "was granted discretionary authority" and had "the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact." LINA's Brief at 11 (quotation omitted). LINA asserts that, "[a]pplying its discretionary authority, LINA reasonably interpreted 'ingestion' as 'the process of absorbing a substance' that included the injection of a drug." *Id.* LINA maintains that "each of the *Finley* factors supports the conclusion that

LINA's interpretation of the term 'ingestion' is reasonable and must be upheld under the abuse of discretion standard." *Id.* at 12.

2. Applicable law

In determining whether a plan administrator's interpretation of a policy term is reasonable, courts consider the following factors:

> [1] whether their interpretation is consistent with the goals of the Plan,
>
> [2] whether their interpretation renders any language of the Plan meaningless or internally inconsistent, [3] whether their interpretation conflicts with the substantive or procedural requirements of the ERISA statute, [4] whether they have interpreted the words at issue consistently, and [5] whether their interpretation is contrary to the clear language of the Plan.

Donaldson v. National Fire Ins. Co. of Pittsburgh, PA, 863 F.3d 1036, 1039 (8th Cir. 2017) (alterations in original) (quoting *King v. Hartford Life & Accident Ins. Co.*, 414 F.3d 994, 999 (8th Cir. 2005), in turn quoting *Finley v. Special Agents Mut. Benefit Assoc., Inc.*, 957 F.2d 617, 621 (8th Cir. 1992)). While the foregoing factors inform the court's analysis, the "dispositive principle remains . . . that where plan fiduciaries have offered a reasonable interpretation of disputed provisions, courts may not replace [it] with an interpretation of their own—and therefore cannot disturb as an abuse of discretion the challenged benefits determination." *Donaldson*, 863 F.3d at 1039 (alteration in original) (quoting *King*, 414 F.3d at 999).

If the plan administrator's interpretation of the term is reasonable, a court must next determine "whether the plan administrator reasonably applied

its interpretation of the term to the facts of the claim" and whether the plan administrator's decision is "adequately supported by the evidence on record." *Hanna v. United of Omaha Life Ins. Co.*, 553 F.Supp.2d 1064, 1068 (S.D. Iowa 2008). In sum, the decision of a plan administrator "must be supported by both a reasonable interpretation of the plan and substantial evidence in the materials considered by the administrator." *King*, 414 F.3d at 1000.

3. Application

First, the court considers whether LINA's interpretation of "ingestion" is consistent with the goals of the Plan. Richmond asserts that "LINA's interpretation of the Plan term 'ingestion' is inconsistent with the goal of providing accidental death benefits for legitimate claims[.]" Richmond's Brief at 25-26. The court is unpersuaded by Richmond's assertion. Here, the Plan's goal is to provide benefits for a Covered Accident, which the Policy defines as a "sudden, unforeseeable, external event" that, among other conditions, is "not otherwise excluded under the terms of [the] Policy." AR (docket no. 18-6) at 36. Further, under ERISA, a plan fiduciary must administer the plan prudently and in accordance with the Plan documents, "for the exclusive purpose of providing benefits to ... beneficiaries" and "defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1)(A)(i)-(ii). LINA argues that its "interpretation of 'ingestion' as 'the process of absorbing a substance' is consistent with the Plan goal to pay meritorious claims for 'sudden, unforeseeable, external events' that are not subject to an exclusion." LINA's Brief at 13. The Policy exclusion at issue here excludes the payment of benefits or a death resulting from the voluntary ingestion of unprescribed narcotics and is consistent with the

Plan goal of not paying benefits to someone who engages in taking unprescribed narcotics resulting in death. *See Farfalla v. Mutual of Omaha Ins. Co.*, 324 F.3d 971, 975 (8th Cir. 2003) ("[T]he purpose of the Plan is to benefit all covered employees, a purpose that is not furthered by paying an uncovered claim"); *see also Venditti v. Unum Life Ins. Co. of Am.*, No. 18-CV-25-LRR, 2018 WL 6571204, at *6 (N.D. Iowa Dec. 13, 2018) ("Courts recognize that a goal of all insurance policies is to pay only meritorious claims so as to preserve plan assets for deserving plan members."). Based on the foregoing, the court finds that LINA's interpretation of "ingestion" is reasonable and is consistent with the goals of the Plan. Accordingly, the first Finley factor weighs in favor of LINA.

Second, the court considers whether LINA's interpretation of "ingestion" renders any language of the Plan meaningless or internally inconsistent. Richmond argues that "LINA's decision that Marie's death is not a Covered Accident renders the 'voluntary ingestion exclusion' inoperative and the Plan internally inconsistent." Richmond's Brief at 26. Specifically, Richmond argues that, "if—as LINA has asserted—drug-related deaths are by their very nature nonaccidental, defining an express exclusion to eliminate from coverage what otherwise would fall outside the meaning of 'accident' would be superfluous." *Id.* The court is unpersuaded by Richmond's argument. The Policy exclusion at issue here states that benefits will not be paid for a Covered Loss or Covered Injury which results from the "voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage." AR (docket no. 18-6) at 40. Neither LINA nor the Policy language suggest

"drug-related deaths are by their very nature nonaccidental." Richmond's Brief at 26. LINA's determination that Marie's death fell within the exclusion is based on the facts relating to her death and LINA's reasonable interpretation of the term "ingestion. Based on the foregoing, the court finds that LINA's interpretation of "ingestion" does not render any language of the Plan meaningless or internally inconsistent. Accordingly, the second Finley factor weighs in favor of LINA.

Third, the court considers whether LINA's interpretation of "ingestion" conflicts with the substantive or procedural requirements of the ERISA statute. Richmond contends that "LINA's interpretation of ingestion to include the near-boundless, process of absorbing a substance, conflicts with the substantive and/or procedural requirements of ERISA by misleading plan participants . . . and by stretching the definition beyond applicable meaning[.]" Richmond's Brief at 27 (quotations omitted). The court is unpersuaded by Richmond's contention.

Substantively, ERISA was enacted "to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place." *Conkright v. Frommert*, 559 U.S. 506, 516 (2010); see also *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (providing that "ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits" and "plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans"); *Hanna*, 553 F.Supp.2d at 1070 ("ERISA does not require an employer to offer accidental death benefits; therefore, the level of benefits to be provided is within

the control of the private party creating the Plan"). Further, "ERISA does not prohibit exclusions in plan benefits where the exclusion has a legitimate business purpose." *Davidson v. Wal-Mart Associates Health & Welfare Plan*, 305 F.Supp.2d 1059, 1087 (S.D. Iowa 2004). Procedurally, "ERISA represents a "'careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.'" *Conkright*, 559 U.S. at 517 (quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004)). Additionally, the "summary plan description ... shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a).

Here, LINA's interpretation of "ingestion" to include unprescribed narcotics taken by injection under the relevant Policy exclusion language—"voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage"—is more than reasonable. Indeed, by the plain language of the Policy exclusion, an average and reasonable Plan participant would understand that the Policy does not provide benefits for an individual who dies from voluntarily taking unprescribed narcotics, whether orally, by injection, by inhalation or by other means. Based on the foregoing, the court finds that LINA's interpretation of "ingestion" does not conflict with the substantive or procedural requirements of the ERISA statute. Accordingly, the third Finley factor weighs in favor of LINA.

Fourth, the court considers whether LINA has interpreted "ingestion" consistently. Citing a single unpublished case, *Buzzanga v. Life Ins. Co. of North Am.*, No. 4:09-CV-1353(CEJ), 2013 WL 64656 (E.D. Mo. Jan. 4, 2013), Richmond argues that like in the *Buzzanga* policy, LINA should have used the words "self-administration" instead of "ingestion" in the Policy. Richmond's Brief at 28. Apparently, Richmond believes that by not using "self-administration" in the instant Policy, that somehow makes LINA's interpretation of "ingestion" inconsistent. The court his wholly unpersuaded by this argument. Not only does Richmond's argument fail to properly apply the fourth Finley factor, Richmond makes no argument and offers no evidence to suggest that LINA has ever inconsistently interpreted "ingestion." Richmond's citation to *Buzzanga* is misplaced, as *Buzzanga* has no relevance to the consideration of the fourth *Finley* factor. Richmond's belief that LINA should have used "self-administration" in the Policy instead of "ingestion" has nothing whatsoever to do with whether LINA has consistently interpreted "ingestion." Accordingly, as there is no evidence that LINA has inconsistently interpreted the term "ingestion," the court finds that the fourth *Finley* factor weighs in favor of LINA.

Fifth, the court considers whether LINA's interpretation of "ingestion" is contrary to the clear language of the Policy. Relying on the Merriam Webster Dictionary, Richmond asserts that "ingest" is defined as "to take in for . . . digestion." Richmond's Brief at 28. Richmond argues that "LINA's interpretation of 'ingestion' to include 'taken intravenously' does not satisfy the dictionary definition with respect to introduction into the digestive tract" and is contrary to the

language of the Policy. Id. at 29. The court is unpersuaded by Richmond's argument, as he fails to fully appreciate the full dictionary definitions associated with the relevant terms for interpreting the word "ingestion."

The precise dictionary definition of "ingestion" is "the act or process of taking in something for or as if for digestion."[1] Interestingly, one of the dictionary examples for using the word "ingestion" in a sentence, involves reading books, clearly not something involved with physiological digestion. "After two years of almost manic ingestion of book after book—Montaigne, Milton, Seneca, Dante—he began to write Moby-Dick."[2] Further, one of the definitions for the verb "digest" is to absorb.[3] "Absorb" is defined as "to take in and make part of an existent whole."[4] The online Oxford English Dictionary defines "ingestion" as "the process of taking food, drink, or another substance into the body by swallowing or absorbing it."[5] LINA's interpretation of "ingestion" as "the process of absorbing a substance," which LINA interpreted to include "drugs taken intravenously" is consistent with the term's dictionary definitions and is not contrary to the clear Policy language. *See* AR (docket no. 18-4) at 14. Based on the foregoing, the court finds that LINA's interpretation of "ingestion" is not contrary to the

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[1] Merriam-Webster.com, https://www.merriam-webster.com/dictionary/ingestion (last visited December 2, 2021).
[2] *Id.*
[3] Merriam-Webster.com, https://www.merriam-webster/dictionary/digest (last visited December 2, 2021).
[4] Merriam-Webster.com, https://www.merriam-webster/dictionary/absorb (last visited December 2, 2021).
[5] Oxford English Diction Online, https://www.lexico.com/en/definition/ingestion (last visited December 6, 2021).

clear language of the Policy. Accordingly, the fifth Finley factor weighs in favor of LINA.

Having considered all five Finley factors, the court finds that all five factors weigh in favor of LINA. Thus, the court finds that LINA's interpretation of "ingestion" is reasonable and not an abuse of discretion. Next, the court must determine: (1) whether LINA reasonably applied its interpretation of "ingestion" to the facts of the claim; and (2) whether LINA's decision is supported by substantial evidence on the record. There is no question that LINA reasonably applied its interpretation of "ingestion" to the facts of Richmond's claim and that LINA's decision was supported by substantial evidence on the record. It is undisputed that Marie died as a result of voluntary ingestion of unprescribed narcotic drugs—morphine, hydromorphone, meperidine, and fentanyl. *See* AR (docket no. 18-4) at 36, 40, AR (docket no. 18-5) at 18-19. Having taken LINA's inherent conflict of interest into account while considering this case, the court finds that LINA properly determined that the "voluntary ingestion" exclusion applied in this case and properly denied benefits to Richmond. Accordingly, Richmond's Motion is denied, and the Complaint is dismissed.

C. "Covered Accident"

In his brief, Richmond also argues that LINA's determination that Marie's death was not a "Covered Accident" is not supported by substantial evidence and LINA's application of the *Wickman* standard for making such a determination was flawed. *See generally* Richmond's Brief at 9-23. At the outset, the court notes that, because the court has determined that LINA properly determined that the "voluntary ingestion" exclusion applies in this case, and properly denied benefits to Richmond, it is unnecessary for the

court to conduct the *Wickman* accident analysis. *See McClelland v. Life Ins. Co. of North Am.*, 679 F.3d 755, 761-62 (8th Cir. 2012) (discussing that the *Wickman* analysis is unnecessary in a case where a policy exclusion is applicable); *River v. Edward D. Jones Co.*, 646 F.3d 1029, 1031 (8th Cir. 2011) (same); *Venditti*, 2018 WL 6571204, at *5 ("The court must conduct an accident analysis if there is no applicable policy exclusion"). While unnecessary, the court will nevertheless address the accident analysis under *Wickman*.

In *West v. Aetna Life Ins. Co.*, 171 F.Supp.2d 856 (N.D. Iowa 2001), the district court set forth the *Wickman* standard in detail:

> The court in *Wickman* then laid out an analytical process for determining whether the insured's death or injury was an "accident" based on (1) determination of the insured's actual expectations, and (2) determination of whether the insured's actual expectations were reasonable from an objective viewpoint, as follows:
>
> If the fact-finder determines that the insured did not expect an injury similar in type or kind to that suffered, the fact-finder must then examine whether the suppositions which underlay that expectation were reasonable. This analysis will prevent unrealistic expectations from undermining the purpose of accidental insurance. If the fact-finder determines that the suppositions were unreasonable, then the injuries shall be deemed not accidental. The determination of what suppositions are unreasonable should be made from the perspective of the insured, allowing the insured a great

> deal of latitude and taking into account the insured's personal characteristics and experiences.
>
> Finally, if the fact-finder, in attempting to ascertain the insured's actual expectation, finds the evidence is insufficient to accurately determine the insured's subjective expectation, the fact-finder should then engage in an objective analysis of the insured's expectations. In this analysis, one must ask whether a reasonable person, with background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct. An objective analysis, when the background and characteristics of the insured are taken into account, serves as a good proxy for actual expectation. Requiring an analysis from the perspective of the reasonable person in the shoes of the insured fulfills the axiom that accidents should be judged from the perspective of the insured.

Id. at 883-84 (quoting *Wickman v. Northwestern National Ins. Co.*, 908 F.2d 1077, 1088 (1st Cir. 1990)).

In addressing this issue, the court will focus its *Wickman* accident analysis on LINA's decision upholding Richmond's second appeal. *See generally* AR (docket no. 18-1) at 14-22; *see also Whitley v. Standard Ins. Co.*, 815 F.3d 1134, 1140-41 (8th Cir. 2016) ("Because exhaustion of an ERISA plan's appeal procedures serves many important purposes, 'the reviewing court reviews the claim administrator's final decision to deny a claim, rather than the initial denial that was reconsidered during the internal appeal'") (quoting

Galman v. Prudential Ins. Co. of Am., 254 F.3d 768, 770-71 (8th Cir. 2001))). The court also considers that the Policy defines a "Covered Accident" as a "sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss." AR (docket no. 18-6) at 36. Further, in making its determination to deny benefits to Richmond, LINA evaluated the evidence in the claim file, which included law enforcement incident reports, Medical Examiner reports, letters from Richmond, Richmond's family members, friends and coworkers, and various expert reports. *See* AR (docket no. 18-1) at 15-16.

Turning to the *Wickman* analysis, the court will first consider LINA's determination that it could not determine whether Marie "subjectively lacked an expectation of death or injury." Id. at 19. In its decision, LINA addressed Richmond's argument from his second appeal that LINA's prior decision "neglects the requisite analysis of Ms. Richmond's state of mind." Id. at 18. LINA pointed out that Richmond's argument relied on "statements from people who knew Ms. Richmond describing her mood and future plans," which Richmond asserted demonstrates that Marie did not "intend[] to kill herself or wanted to die." Id. It is clear that LINA considered the statements provided by Richmond. Specifically, LINA stated in its decision that:

> The statements that you provide contain descriptions of the perceptions of people that knew Ms. Richmond of her general demeanor, her education, work and family history, and their experiences with Ms. Richmond close to the date of her death. However, the statements do not include information regarding her use of

> morphine, hydromorphone, meperidine, and fentanyl on 02/12/2018.

Id. Further, LINA explained that it could not determine Marie's subjective expectations because there is no evidence of Marie's subjective expectations, and, due to her death there is no longer any way of knowing her subjective expectations. *See id.* at 19. Additionally, LINA explained that the expert reports from Richmond provided general information, but lacked specific information relating to Marie's use of morphine, hydromorphone, meperidine, and fentanyl on February 12, 2018. *See id.* Based on the foregoing, and, having taken LINA's inherent conflict of interest into account while considering this case, the court finds that LINA's determination that it could not determine Marie's subjective expectations is both reasonable and supported by substantial evidence on the record.

Second, the court will consider LINA's determination that "a reasonable person with background and characteristics similar to Ms. Richmond would have viewed the resulting death as a probable consequence highly likely to occur." *Id.* at 19. In making this determination, LINA explained that: (1) Marie was a nurse with over 18 years of experience; (2) Richmond's expert, Dr. Yun, opined that, as an experienced pain management nurse, Marie would have had experience providing pain management and administering therapeutic doses of medications such as morphine, hydromorphone, meperidine, and fentanyl; (3) Marie would have known that determining the doses of morphine, hydromorphone, meperidine, and fentanyl should have been in consultation with a licensed physician due to Marie's knowledge that these drugs can cause

respiratory depression and accentuation; and (4) Marie would have had training in monitoring patients who had been administered morphine, hydromorphone, meperidine, and fentanyl. *See id.* LINA concluded that, "[g]iven all of these factors, a reasonable person, with background and characteristics similar to Ms. Richmond would have viewed the resulting death as a probable consequence likely to occur." *Id.* Contrary to Richmond's assertions, LINA's explanation does not demonstrate that "[o]nce LINA learned of the mere presence of controlled substances in Marie's system, all objective analysis ceased and LINA categorically determined her death was not accidental." Richmond's Brief at 17. It is clear from the record that LINA's determination is well-reasoned and properly based on Marie's knowledge and experience as a registered nurse, which included experience working with pain medications and licensed physicians.

Further, LINA addressed *Wickman's* "highly likely to occur" standard, stating that "we interpret highly likely to occur to entail a level of inevitability that is of a significant or large degree." AR (docket no. 18-1) at 19. In its determination, LINA noted that the Marie's autopsy found that the cause of death was "mixed drug toxicity" from morphine, hydromorphone, meperidine, and fentanyl, which collectively "can be lethal." *See id.* at 17. Also, LINA noted that its toxicology expert, Dr. Jerrold Leikin, M.D., opined that "[c]ertainly at the doses listed, fatality can occur due to respiratory depression and accentuation of the effects of morphine, hydromorphone, meperidine, and fentanyl when taken together. Since the effects of these four drugs are very similar, as well as their toxic profile, it does appear that this combination is potentially fatal

at the doses/concentrations that are listed above." *Id.* at 20. Having taken LINA's inherent conflict of interest into account while considering this case, the court finds that LINA's determination that Marie's death was not a "Covered Accident" based on her experience and knowledge as a nurse, and based on the objective medical evidence, is both reasonable and supported by substantial evidence on the record. While Richmond disagrees with LINA's determination and would not have reached the same conclusion, the court finds that it must affirm LINA's decision because a reasonable person could have reached a similar decision, given the evidence before him or her. *See Prezioso*, 748 F.3d at 805 (providing that a court must affirm the plan administrator's decision "if a reasonable person could have reached a similar decision, given the evidence before him [or her], not that a reasonable person would have reached that decision"). Accordingly, Richmond's Motion is denied, and the Complaint is dismissed.

VI. CONCLUSION

In light of the foregoing, it is hereby ORDRED:

(1) Plaintiff Jay C. Richmond's Motion for Judgment on the Administrative Record (docket no. 21) is DENIED;

(2) The Complaint (docket no. 1) is DISMISSED WITH PREJUDICE;

(3) The Clerk of Court is DIRECTED to enter judgment in favor of Defendant Life Insurance Company of North America and against Plaintiff Jay C. Richmond; and

(4) The Clerk of Court is DIRECTED to CLOSE THIS CASE.

IT IS SO ORDERED.

DATED this 7th day of December, 2021.

s/ LINDA R. READE, JUDGE.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No: 21-3929

Jay C. Richmond

Appellant

v.

Life Insurance Company of North America

Appellee

Appeal from U.S. District Court for the Northern District of Iowa - Eastern (6:19-cv-02026-LRR)

ORDER

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

November 22, 2022

Order Entered at the Direction of the Court:
Clerk, U.S. Court of Appeals, Eighth Circuit.

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s/ Michael E. Gans

STATUTORY PROVISIONS INVOLVED

1. Section 102 of ERISA, 29 U.S.C. § 102, provides:

> **§ 1022. Summary plan description**
> **(a)** A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.
>
> * * *
>
> **(b)** The summary plan description shall contain the following information:
>
> * * *
>
> circumstances which may result in disqualification, ineligibility, or denial or loss of benefits;
>
> * * *

2. Section 502(a)(2) of ERISA, 29 U.S.C. § 1132(a)(2), provides:

> **§ 1132. Civil enforcement**
> **(a) Persons empowered to bring a civil action**
> A civil action may be brought—
>
> (1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, ... ;

3. Section 503 of ERISA, 29 U.S.C. § 1133, provides:

§ 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

FEDERAL REGULATIONS INVOLVED

1. Title 29 of the Code of Federal Regulations, Section 2520.102, provides:

§ 2520.102-2. Style and format of summary plan description.

* * *

(b) General format. The format of the summary plan description must not have the effect to misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or

otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits....

* * *

2. Title 29 of the Code of Federal Regulations, Section 2520.103, provides:

§ 2520.102-3. Contents of summary plan description.

* * *

The following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans ... :

* * *

(*l*) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section....

* * *

3. Title 29 of the Code of Federal Regulations, Section 2520.503, provides:

§ 2560.503-1. Claims procedure.

* * *

(h) Appeal of adverse benefit determinations -

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. [T]he claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures –

* * *

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim,...

* * *