RECENT DEVELOPMENTS IN HEALTH INSURANCE, LIFE INSURANCE, AND DISABILITY INSURANCE CASE LAW

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I. INTRODUCTION

This has been an interesting year, particularly for cases arising in the ERISA context. Following the Supreme Court's decision in *Metropolitan Life Insurance Co. v. Glenn*,[1] courts have been forced to deal with new arguments arising out of various interpretations of that decision. While *Glenn* may have resolved the question of how a structural conflict of interest impacts the standard of review in ERISA benefits claim cases, parties are now litigating whether the Supreme Court's decision allows plaintiffs to conduct discovery into a conflicted fiduciary's supposed "bias." In the meantime, this year marked an increase in reported accidental death cases involving the consumption of alcohol, with the usual varying results. We also noticed an increase in cases dealing with exhaustion of administrative remedies, attorney fees, ERISA preemption, notice, and preexisting condition issues in the health and disability contexts.

II. ACCIDENTAL DEATH BENEFITS

A. *Definition of Autopsy*

In *Mega Life & Health Insurance Co. v. Pieniozek*,[2] the accidental death and dismemberment rider to the policy provided for an accidental death benefit "if death was 'directly caused by an accidental bodily injury, independent of all other causes, which is supported by an autopsy . . . .'"[3] Neither the policy nor the accidental death and disability rider defined "autopsy." The coroner performed a post-mortem examination stating the insured died of closed-head trauma due to a car accident,[4] but he did not request or perform an autopsy. Rejecting the insurer's claim denial, the Eleventh Circuit, applying Alabama law, looked to common definitions of autopsy "to determine the customary and normal meaning" of the word "that a reasonably prudent person applying for insurance would understand."[5] It noted that while some definitions included dissection and inspection of the body's internal structure, others only required a "post-mortem examination," as was performed on the insured.[6] The court therefore affirmed summary judgment in the beneficiary's favor holding that "MEGA's argument that there was no 'autopsy' performed does not preclude [the beneficiary's] recovery under the AD&D rider."[7]

1. 128 S. Ct. 2343 (2008).
2. 516 F.3d 985 (11th Cir. 2008).
3. *Id.* at 987.
4. *Id.* at 991.
5. *Id.*
6. *Id.* at 992.
7. *Id.* at 993.

B. *Intoxication*

In *Arnold v. Hartford Life Insurance Co.*,[8] Hartford denied a beneficiary's claim for accidental death benefits, concluding that the insured's death was not due to an "injury" as defined in the policy.[9] The insured died at the scene of a motorcycle crash; the immediate cause of death was a closed-head injury with cervical spine fracture; at the time of the crash, the insured was legally intoxicated. Hartford denied the claim because the insured's death was reasonably foreseeable and the assumption of a known risk by the insured did not constitute an "accident" under the terms of the policy.[10] Plaintiff argued the policy included an alcohol/intoxication exclusion with regard to seat belt coverage, but not with regard to AD&D coverage, and contended the specific exclusion for intoxicants under the seat belt coverage would not be necessary if the term "accident" was understood not to include a situation where the insured was legally intoxicated.[11] The court disagreed, noting that for the alcohol/intoxication exclusion under the seat belt coverage to apply, a person would simply have to be under the influence of alcohol, not necessarily intoxicated. The court held that the insured's death was reasonably foreseeable because his alcohol consumption placed him well above the legal limit at the time of the crash that ultimately led to his death. In the absence of any other reasonable explanation for the crash, the court found that it was reasonable for Hartford to determine the insured's death was not an "accident" as that term was used in the policy.[12]

The insurer denied the claim for accidental death benefits in *Grose v. Sun Life Assurance Co. of Canada*[13] because the insured was intoxicated when he crashed his motorcycle, and his injuries were reasonably foreseeable. The beneficiaries argued there was no evidence of intoxication at the time of the crash and that the death was a result of an accident. The court first concluded the insured was intoxicated; the insured's blood-alcohol content was twice the legal limit when his body *was found*—which was *five hours* after his death and *twelve hours* after his crash.[14] The court next rejected the beneficiaries' novel argument that, even if the insured was intoxicated, his death was still accidental because there was no evidence his intoxication was voluntary. The court noted that the beneficiaries failed to provide any evidence "in support of these fantastical, though not impossible, sce-

8. 542 F. Supp. 2d 471 (W.D. Va. 2008).
9. *Id.* at 474. The policy defined "injury," in relevant part, as "bodily injury resulting directly and independently of all other causes from an accident which occurs while the Covered Person is covered under this policy." *Id.*
10. *Id.* at 475.
11. *Id.* at 479.
12. *Id.* at 481.
13. 568 F. Supp. 2d 652 (W.D. Va. 2008).
14. *Id.* at 655.

narios," and "it would be unreasonable to conclude anything other than voluntary intoxication."[15]

The court found a plan administrator's interpretation of the alcohol exclusion in an ERISA accidental death insurance plan "legally correct" and granted the defendant's motion for summary judgment in *Pando v. Prudential Insurance Co. of America*.[16] The exclusion provided that "[a] loss is not covered if it results from . . . [w]hile operating a motor vehicle, the person's illegal use of: (1) alcohol."[17] The plan defined neither "use" nor "illegal use."[18] Plaintiff contended that the decedent's actual consumption of alcohol was legal in that he was of legal age and there was no evidence that he consumed alcohol while driving.[19] Prudential argued that by driving while intoxicated under state law, the decedent illegally "used" alcohol.[20] The court found the exclusionary provision ambiguous, analyzed legal authority within and outside the Fifth Circuit, and stated that "the law is clear that an administrator's reasonable interpretation of an ambiguous provision is entitled to deference."[21] The court held that Prudential's interpretation was reasonable and consistent with a fair reading of the plan.[22] The court further held that Prudential's factual determination that the decedent's use of alcohol was illegal at the time of his death and that intoxication significantly contributed to his death was supported by sufficient evidence, namely autopsy and police reports attesting to the decedent's blood-alcohol concentration and driving behavior, respectively.[23]

In *Sarac v. Minnesota Life Insurance Co.*,[24] the plaintiff's husband was a forensic scientist employed by the Illinois State Police who died in an automobile accident after losing control of his vehicle and driving into the rear of a truck.[25] The decedent's blood-alcohol level at the time of the accident was 0.203, more than twice the 0.08 level for legal intoxication.[26] The insurer contended that the policy only covered losses resulting from unforeseen circumstances and, as a forensic scientist, the decedent knew the risks and dangers of drunk driving.[27] The court surveyed Illinois law and concluded that accidental death and dismemberment policies in Illinois

15. *Id.* at 655–56.
16. 524 F. Supp. 2d 848, 853–56 (W.D. Tex. 2007).
17. *Id.* at 853.
18. *Id.*
19. *Id.* at 854.
20. *Id.* at 854–55.
21. *Id.* at 855–56.
22. *Id.* at 856.
23. *Id.* at 856–57.
24. 529 F. Supp. 2d 924 (N.D. Ill. 2007).
25. *Id.* at 926.
26. *Id.*
27. *Id.*

covered such losses unless (1) an insured subjectively expected death or serious bodily injury to occur as a result of his conduct and (2) a reasonable person would expect death or serious bodily harm to be the natural and probable consequence of driving drunk.[28] Because defendant could not show that the insured expected to die or to be seriously injured as a result of his decision to drive while intoxicated, the court decided his death was an "accident" under Illinois law and entered judgment in favor of plaintiff.[29]

The insured in *Smith v. Liberty Life Insurance Co.*,[30] a lifelong drug addict with seven arrests for driving under the influence, was killed when the truck he was driving struck two trees. Toxicology reports established that he had potentially lethal doses of drugs in his system along with ethanol. The policy excluded from coverage any death resulting directly or indirectly from injury occurring while under the influence of alcohol or drugs.[31] The Fifth Circuit concurred with the lower court's determination that, under Louisiana law, the policy exclusion could be interpreted less favorably to insureds than a similar Louisiana statute mandating that an "insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of narcotics unless administered on the advice of a physician."[32] Interpreting Louisiana law, the court found Liberty proved the insured was "under the influence" of drugs sufficient to "lose normal control" of his faculties and proof of a complete loss of control was not necessary.[33] The court held Liberty was only required to prove intoxication was a contributing cause, which it did when it presented uncontroverted testimony that the insured's level of intoxication "impaired his faculties and contributed to his death."[34]

C. *Sickness or Injury*

In *Feit v. Great West Life and Annuity Insurance Co.*,[35] the insured was found dead in his car after a crash, with no signs of physical trauma. An autopsy report concluded the decedent died due to myocardial infarction. At trial, the jury found circumstantial evidence supported a finding that the decedent suffered some type of bodily injury that activated a preexisting medical condition, causing his death. The district court set aside the jury verdict because the beneficiary failed to present sufficient evidence that

28. *Id.* at 930.
29. *Id.* at 931.
30. 535 F.3d 308 (5th Cir. 2008).
31. *Id.*
32. *Id.* at 315.
33. *Id.* at 316.
34. *Id.* at 317.
35. 271 F. App'x 246 (3d Cir. 2008).

the insured suffered any bodily injury,[36] and the Third Circuit affirmed. The court found that while there was sufficient circumstantial evidence that the decedent suffered a bodily injury, there was no evidence that a bodily injury triggered his underlying heart condition.[37] Further, the court defined circumstantial evidence as "a preponderance of the probabilities according to common experience."[38] The circumstantial evidence offered by the beneficiary was insufficient because it focused on the possibilities rather than probabilities.[39]

III. DISABILITY INSURANCE

A. *Age versus Indemnity Period*

A disability insurer's decision to terminate monthly disability payments on the policy date closest to the insured's sixty-fifth birthday was at issue in *Spence v. Berkshire Life Insurance Co*.[40] Plaintiff, who had chosen an indemnity period of sixty months under the policy and became disabled at age sixty-three, believed he was entitled to disability payments beyond his sixty-fifth birthday, for the entire indemnity period. Plaintiff alleged breach of contract and a violation of Massachusetts' consumer protection statute.[41] The court granted the insurer's motion for summary judgment on both counts, holding that plaintiff's interpretation of the policy was unreasonable because the policy contained a cut-off for age sixty-five independent of the sixty-month indemnity period.[42] The court further found plaintiff's breach of contract claim premature and that a noncommercial claim based on the theory of anticipatory repudiation was impermissible. In addition, the court held that under the consumer protection act claim, the plaintiff failed to show any actionable damage resulting from the insurer's conduct as any dispute alleged was a good-faith dispute not involving "unfair or deceptive acts or practices."[43]

B. *Any Occupation*

The Tenth Circuit upheld the termination of plaintiff's long-term disability benefits under an ERISA plan in *Niedens v. Continental Casualty Co*.[44] Plaintiff, whose reported disability was caused by Crohn's Disease and

36. *Id*. at 251.
37. *Id*. at 252.
38. *Id*.
39. *Id*.
40. 561 F. Supp. 2d 126 (D. Mass. 2008).
41. *Id*. at 127–28 (citing Mass. Gen. Laws. ch. 93A, § 2).
42. *Id*. at 129.
43. *Id*. at 130–31 (quoting Mass. Gen. Laws. ch. 93A, § 2).
44. 258 F. App'x 216 (10th Cir. 2007).

associated diarrhea requiring his immediate access to a bathroom, argued that the district court erroneously allowed the defendant to supplement the administrative record with an affidavit from an appeal team leader and that the termination of his benefits was arbitrary and capricious and not supported by substantial evidence. Under the ERISA plan, plaintiff had to establish his inability to engage in any "gainful occupation."[45] The defendant relied in part on a labor market survey conducted by a third party that concluded that plaintiff could perform a sedentary occupation.[46] Plaintiff argued that the survey was never actually completed and presented several affidavits in support of his argument. Affirming summary judgment in favor of the defendant, the court pointed out various deficiencies in the affidavits that the plaintiff submitted and further noted documentation supporting the labor market survey. The court also found the denial letters substantially complied with ERISA's requirements and agreed that the medical records showed plaintiff could work in a sedentary occupation as long as he had "ready access to a bathroom."[47] Finally, because the court found that the defendant's decision was not arbitrary and capricious, it did not decide whether the district court erred in allowing the defendant to supplement the administrative record with an affidavit or whether the affidavit was "competent evidence."[48]

In *White v. Continental Casualty Co.*,[49] the court held that a disability income policy's definition of total disability was clear and unambiguous and an insured physician was not totally disabled within the meaning of the policy. Under the policy, the insured was considered totally disabled if he was "unable to perform the substantial and material duties of [his] occupation due to an Injury or Sickness" *and* unable to "[perform] the duties of any gainful occupation for which [he is] reasonably fitted by education, training, or experience."[50] The insured sought disability benefits under the policy, stating that he was unable to pursue his occupation as an orthopedic surgeon due to a hip condition.[51] On appeal, the insured argued the policy's "any occupation" provision was ambiguous and that he satisfied the "own occupation" provision as a matter of law.[52] Relying on the plain language of the policy and case law involving similar language, the court held that the definition was "reasonably susceptible to only one meaning" and, thus,

45. *Id.* at 217–18.
46. *Id.* at 218.
47. *Id.* at 219–20.
48. *Id.* at 218.
49. 878 N.E.2d 1019 (N.Y. 2007).
50. *Id.* at 1020.
51. *Id.* at 1020–21.
52. *Id.*

clear and unambiguous.[53] The court further noted that while the insured stopped performing surgeries, he rendered second medical opinions on spinal surgery, performed independent medical examinations, and served as an expert medical witness, supporting the lower court's determination that he was performing the duties of a gainful occupation to which he was reasonably fitted.[54]

C. *Bad Faith*

An insured truck driver brought an action against a disability insurer, its policyholder, and the policyholder's employee for misrepresenting that group occupational accident insurance (OAI) was "just like" workers' compensation insurance in *Delka v. Continental Casualty Co*.[55] Plaintiff enrolled under the company's group OAI policy. After a work-related accident, the insurer paid all disability and medical benefits afforded thereunder.[56] Plaintiff claimed he would need medical care for the rest of his life; however, the benefits were limited to five years.[57] Plaintiff brought suit for deceit, bad faith, violation of South Dakota's Unfair Trade Practices Act, violation of Pennsylvania's Unfair Insurance Practices Act, negligent misrepresentation, breach of fiduciary duty, conversion, fraud, concealment, and negligence.[58] The appellate court affirmed summary judgment in favor of the insurer on all counts. Among its findings, the court rejected plaintiff's argument that the insurer was vicariously liable for his employer's actions because "[i]n procuring such [group] insurance, obtaining applications, taking payroll deductions, and paying premiums, the employer acts as agent for the employees and for themselves . . . thus rendering their employees a service and promoting industrial goodwill."[59] The court also held the insurer had no contractual duty to plaintiff that would support his negligence or bad faith claims,[60] and found no pre-enrollment duty of an insurer to potential employees or enrollees.[61] Further, plaintiff failed to establish the existence of a duty independent of the contract that would give rise to a bad faith claim against the insurer, presented no evidence of "deceitful intent" on the part of the insurer, and alleged no direct communications between plaintiff and the insurer that would support an unfair trade practices claim under a state statute.[62]

53. *Id*. (citations omitted).
54. *Id*. at 1021–22.
55. 748 N.W.2d 140 (S.D. 2008).
56. *Id*. at 143.
57. *Id*.
58. *Id*.
59. *Id*. at 145.
60. *Id*. at 146.
61. *Id*.
62. *Id*. at 149.

D. *Dictionary of Occupational Titles*

An animal feed products sales representative applied for long-term disability benefits through the plan offered by his employer in *Jones v. Mountaire Corp. Long Term Disability Plan*,[63] claiming that he was unable to perform his sedentary job because he had emphysema and could no longer work around dust and chemicals. After the plan insurer denied his initial claim for benefits, plaintiff appealed, submitting additional medical records from his physician and a job description identifying his duties as lifting up to fifty-pound bags of feed, visiting farms, handling large animals, and participating in quarterly inventories, which required standing, stooping, lifting, and moving inventory for hours in a dusty and dirty environment. After reviewing and comparing the supplemental job description with the Dictionary of Occupational Titles (DOT), the insurer's rehabilitation specialist determined plaintiff's "regular occupation" was "Sales Representative, Animal-Feed Products," which was classified as a "light" occupation.[64] The insurer's medical director and claim manager determined plaintiff did not meet the plan's definition of disabled as his medical history did not prevent him from doing a light-duty job. Plaintiff again appealed the denial and requested the insurer look at his actual job duties to make sure it chose the DOT job that accurately portrayed his work requirements. After conducting an independent review of plaintiff's claim and the DOT job, the insurer issued a final denial of benefits to plaintiff.[65] The district court awarded benefits to plaintiff and, based on its own research, criticized the insurer for relying on the DOT because it was last updated in 1977, was superseded by the Occupational Information Network (O*Net), and did not give a detailed description of work environments.[66] Following the appeal, the Eighth Circuit held that the district court erred by failing to give the parties an opportunity to brief the issues on the merits of the differences between the two databases (DOT and O*Net), and the reasons the insurer used the DOT and not the O*Net.[67]

E. *Functionality versus Disability*

Plaintiff in *Green v. Sun Life Assurance Co. of Canada*[68] appealed the district court's decision that his claim for long-term disability benefits was properly denied. The policy in question defined "disability" as the inability of the insured to "perform the Material and Substantial Duties of his Own

63. 542 F.3d 234 (8th Cir. 2008).
64. *Id.* at 236–37.
65. *Id.* at 238.
66. *Id.*
67. *Id.* at 239.
68. 259 F. App'x 42 (9th Cir. 2007).

Occupation."[69] In interpreting this provision, the district court applied a "functionality test," where the insured would be disabled only if he were to "leave work because of a specific condition" that must "last throughout the elimination period."[70] Applying a *de novo* standard of review to the district court's interpretation of the policy in question, the Ninth Circuit held that the "functionality test" was "not supported by the plain language of the policy,"[71] which merely required that the insured show "that he was 'totally disabled' for the duration of the elimination period."[72] The court noted that, if a combination of disabling factors, such as the plaintiff's vertigo and orthopedic problems, rendered the plaintiff unable to perform the material duties of his occupation during the period in question, he would be "totally disabled" under the terms of the policy. The Ninth Circuit reversed the district court's decision and remanded for further proceedings.

F. *Mental Illness*

An ERISA plan participant sought long-term disability benefits based on bipolar disorder in *Fitts v. Unum Insurance Co. of America*,[73] arguing that her bipolar disorder was not a "mental illness" subject to the plan's two-year benefit limitation. The district court granted partial summary judgment for the participant, holding that bipolar disorder is not a mental illness, the participant had bipolar disorder, and she was disabled because of it. The plan defined "mental illness" as "mental, nervous or emotional diseases or disorders of any type."[74] The district court noted that physicians for both parties acknowledged "that bipolar disorder is characterized by a combination of physical, psychological, and social factors, and they generally agree as to what those factors are."[75] On appeal, the D.C. Circuit noted that the federal courts of appeals do not agree as to "whether a court may rely on a cause-based interpretation of illness to find ambiguity in an ERISA-covered plan." It declined to choose among the courts' approaches finding there was a genuine dispute over the possible causes of bipolar disorder and noting the evidence Unum submitted casting doubt on the plan participant's illness.[76] The court vacated the district court's decision and remanded the case for further proceedings.

69. *Id.* at 44.
70. *Id.*
71. *Id.*
72. *Id.*
73. 520 F.3d 499 (D.C. Cir. 2008).
74. *Id.* at 500.
75. *Id.* at 501.
76. *Id.* at 501–02.

G. *Notice*

An occupational disability insurer terminated the insured's claim for benefits in *Bakal v. Paul Revere Life Insurance Co*.[77] based on its determination that the insured's hearing loss did not preclude him from working as an electronic trader.[78] The insured sued for breach of contract. The insurer moved for summary judgment, contending the insured failed to submit timely notice of his claim, failed to submit timely proof of loss, and was not "under the regular and personal care of a Physician" on the onset date of his disability.[79] The insured admitted he did not timely submit notice of his claim but maintained the insurer waived its right to rely on this defense because it paid benefits without any mention of this defense.[80] Notwithstanding the insured's admission or the insurer's express reservation of its right to assert the notice prerequisite as a defense to coverage, the court found there was an issue of material fact as to whether the insured provided notice "as soon as reasonably possible" after the start of his disability and denied the insurer's motion on this issue.[81] With respect to proof of loss, the court found the insured provided timely proof but noted the issue was moot because it determined the "physician's care provision" precluded the insured from recovering "total disability" benefits for any period prior to February 18, 2005.[82] The court further found that the undisputed evidence demonstrated the insured was under the regular care of a physician after February 18, 2005, and was, therefore, entitled to receive "total disability" benefits for any period thereafter.[83]

H. *Objective versus Subjective Evidence*

In *Salomaa v. Honda Long Term Disability Plan*,[84] plaintiff brought suit alleging his claim for long-term disability benefits for chronic fatigue syndrome (CFS) was improperly denied. In affirming the denial of benefits, the court drew a distinction between "establishing a medical condition" and "establishing the effects of that condition."[85] The court explained that the plan did not require the plaintiff to provide objective evidence of CFS, a condition that does not "lend (itself) to objective clinical findings";[86] however, "the physical limitations imposed by the symptoms" of illnesses such as

77. No. 06 C 1936, 2008 WL 4210793 (N.D. Ill. Sept. 10, 2008).
78. *Id*. at *3.
79. *Id*. at *4.
80. *Id*.
81. *Id*. at *6–7.
82. *Id*. at *9.
83. *Id*. at *11.
84. 542 F. Supp. 2d 1068 (C.D. Cal. 2008).
85. *Id*. at 1077.
86. *Id*.

CFS "do lend themselves to objective analysis."[87] The administrator was within its rights to "require objective evidence that employees are totally disabled by the medical condition which afflicts them, regardless [of] the condition at issue."[88] The court held the plan administrator did not abuse its discretion as the "lack of objective evidence regarding Plaintiff's ability to perform the material duties of his regular occupation" provided a reasonable basis for denial.[89]

I. *Potential Future Disability*

The Fourth Circuit found that a plan administrator did not abuse its discretion in *Stanford v. Continental Casualty Co.*[90] when it concluded that a potential "drug relapse" did not render a participant disabled under the terms of his ERISA long-term disability plan. Plaintiff, a nurse anesthetist, became addicted to Fentanyl, a drug he regularly administered. During his second relapse, Continental approved long-term disability benefits for the duration of his rehabilitation treatment and subsequently terminated them after plaintiff was rehabilitated.[91] On administrative appeal, plaintiff argued that he remained at risk for relapse if exposed to Fentanyl. Continental denied the appeal because the terms of the policy did not cover "potential risks."[92] The court noted plaintiff no longer suffered from physical or mental impairments that would technically prohibit him from performing the duties of his occupation.[93] While the court recognized the risk of relapse in cases involving physical conditions, it found that the instant case was distinguishable because an addict's risk of relapse always involves a conscious decision.[94] Finally, the court observed the disagreement among the circuits regarding this issue in that reasonable minds could differ as to whether the risk of drug relapse qualifies as a disability.[95]

J. *Predisability Status*

Plaintiff in *Jackson v. Prudential Insurance Co. of America*,[96] after being terminated from his job, claimed he suffered from a heart condition that interfered with his ability to perform the physical and cognitive aspects of his sedentary occupation.[97] Prior to the onset of plaintiff's alleged disability,

87. *Id.*
88. *Id.*
89. *Id.* at 1081.
90. 514 F.3d 354 (4th Cir. 2008).
91. *Id.* at 356.
92. *Id.*
93. *Id.* at 358.
94. *Id.*
95. *Id.* at 359.
96. 530 F.3d 696 (8th Cir. 2008).
97. *Id.* at 699.

he had severe obstructive sleep apnea that adversely affected his "ejection fraction" (i.e., the amount of blood plaintiff's heart pumped out with every heartbeat), resulting in severe fatigue.[98] Plaintiff's sleep apnea had been addressed by the time his alleged disability began and tests showed improvement in plaintiff's health across the board.[99] Finding no objective medical evidence of physical or mental impairment that would prevent plaintiff from performing the duties of his own occupation, Prudential denied his claim.[100] The court held that Prudential reasonably concluded plaintiff was capable of performing the duties of his occupation *before* his health improved in response to treatment; therefore, he was capable of performing those duties *after* his health improved.[101] This conclusion, coupled with the fact that plaintiff's medical records lacked any objective evidence of cognitive impairment, led the court to uphold Prudential's denial of benefits.[102]

K. *Preexisting Condition*

Plaintiff sued when his insurer denied his claim for an accidental total disability lump-sum benefit in *Ray v. Federal Insurance Co./CHUBB*,[103] after it determined his "disability was caused in total, or at least in part, by a preexisting degenerative medical condition and not solely" from his accidental fall down a staircase.[104] The insurance contract excluded coverage for loss caused or resulting from the "insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, or bodily malfunctions."[105] Under Pennsylvania law, if a policy contains a clause precluding recovery for injury or death caused by a preexisting condition, the beneficiary bears the burden of establishing no other cause contributed to the complained-of condition.[106] The court ruled in favor of the insurer, holding that plaintiff failed to prove his current condition came about solely as a result of the alleged accident and that no other cause, including any preexisting condition, "contributed in any way to his current condition."[107]

L. *Vocational Support*

Plaintiff was originally awarded long-term disability benefits because of her difficulties with severe anxiety and depression in *Tate v. Long Term*

98. *Id*. at 698–99.
99. *Id*. at 699.
100. *Id*. at 700.
101. *Id*. at 701–02.
102. *Id*.
103. 256 F. App'x 566 (3d Cir. 2007).
104. *Id*. at 567.
105. *Id*. at 568.
106. *Id*.
107. *Id*. at 568–69.

Disability Plan for Salaried Employees of Champion International Corp.[108] The plan administrator terminated plaintiff's benefits based on reports of two independent reviewing physicians who found that her problems did not render her unable to perform in any occupation for which she was qualified. In contrast, plaintiff's treating physician found she was not capable of performing any job because she suffered from moderately severe bipolar disorder and was depressed, hypomanic, inefficient in completing tasks, unable to handle activities of daily living, and prone to pronounced concentration problems, emotional volatility, and episodic rages.[109] The Seventh Circuit affirmed judgment for plaintiff, finding the plan failed to provide any vocational support for its conclusion that plaintiff could perform an occupation for which she was qualified.[110] After noting that one of the reviewing physician's records did not review plaintiff's employment information and the other did not apply any employment information to her analysis, the Seventh Circuit concluded that the plan administrator's "bare conclusion" that plaintiff could do another job was unreasonable and thus arbitrary and capricious.[111] While expressing "no opinion as to whether ERISA plan administrators as a rule must hire vocational experts or perform a transferable skills analysis," the court found that "it is the Plan's burden to make sure that its determination—that [plaintiff] could perform a job for which she was qualified despite her medical condition—is reached in a manner that substantially complies with ERISA."[112]

M. *Social Security Benefits*

In *Bennett v. Kemper National Services, Inc*.,[113] the Sixth Circuit held an ERISA plan administrator's failure to discuss the Social Security Administrator's determination that the insured was disabled weighed in favor of finding an abuse of discretion.[114] After the claimant began receiving disability benefits, her insurer helped her obtain Social Security disability benefits and then offset its payments to her by the amount awarded. When the twenty-four-month period for "own-occupation" disability benefits drew to a close, the insurer issued a decision terminating claimant's benefits without explaining why it reached a conclusion contrary to that of the Social Security Administration.[115] The Sixth Circuit found that a plan

108. Nos. 07-1022, 07-1116, 2008 WL 4276593, at *1 (7th Cir. Sept. 19, 2008). This case is also discussed in Part IV.S, *infra*.
109. *Id*. at *2, *3, *6.
110. *Id*. at *4.
111. *Id*. at *6.
112. *Id*. at *5.
113. 514 F.3d 547 (6th Cir. 2008).
114. *Id*. at 554.
115. *Id*. at 550.

administrator's decision could not be considered arbitrary and capricious solely because the Social Security Administration rendered a different decision. It held, however, that a contrary finding would be an abuse of discretion if the plan administrator (1) assisted the claimant in obtaining disability benefits from the Social Security Administration, (2) reaped financial benefits from the decision, and (3) failed to explain why it reached a disability conclusion at odds with the Social Security Administration's findings.[116] Accordingly, the court vacated judgment in favor of the plan administrator and remanded the claim back to the administrator for a "full and fair review."[117]

In *Speciale v. Blue Cross and Blue Shield Ass'n*, the Seventh Circuit, reversing the trial court, found a plan administrator's denial of benefits was reasonable and the plan administrator was not required to consider a disability ruling and award of benefits by the Social Security Administration.[118] The participant's treating physician and physiatrist opined that the participant could work with some restrictions and that she could work in sedentary or light-duty jobs. Vocational evidence demonstrated that other comparable employment opportunities existed even if the participant could not continue her current position.[119] Therefore, the court upheld the plan administrator's decision under the arbitrary and capricious standard.

IV. ERISA

A. *Attorney Fees*

The Ninth Circuit reversed the district court's decision denying the plan participant's motion for attorney fees in *Flom v. Holly Corp*.[120] The ERISA plan participant sought attorney fees when MetLife reinstated his disability benefits after remand. The court held that he was a "prevailing party" because, when he obtained the reinstatement of his disability benefits after being allowed to submit additional information in support of his disability claim, he achieved "a judicially sanctioned and material change in the legal relationship between the parties," which "need not be a judgment on the merits."[121] The court noted that it was irrelevant whether the plan participant "raised the argument in district court that ultimately led to the reinstatement of benefits or whether the court raised it *sua sponte*" because a fee award "or-

116. *Id*. at 554.
117. *Id*.
118. 538 F.3d 615, 623 (7th Cir. 2008).
119. *Id*.
120. 276 F. App'x 615 (9th Cir. 2008).
121. *Id*. at 616.

dinarily protects ERISA plaintiffs, not their lawyers, and the performance" of his attorney was "not relevant to his status as a prevailing plaintiff."[122]

The Sixth Circuit vacated and remanded an award of attorney fees against a plan administrator by the district court in *Gaeth v. Hartford Life Insurance Co.*,[123] where the award would not confer a common benefit on plan participants and the district court did not consider the relative merits of the parties' positions. The Sixth Circuit also found that the lower court failed to consider whether the case implicated or resolved any significant ERISA legal questions; in fact, the dispute was whether an insurer's decision to terminate benefits was arbitrary and capricious, "a legal standard that has been analyzed repeatedly by th[e] court."[124] The court went on to find that the district court's failure to analyze the relative merits of the parties' positions neglected the record's "minimal objective medical evidence of [the claimant's] continued disability."[125] The Sixth Circuit found that the district court "might well have decided that this factor weighs against a fee award" had it considered the parties' positions.[126]

In a case of first impression for that court, the Third Circuit in *Hahnemann University Hospital v. All Shore, Inc.*[127] held that attorney fees incurred during administrative proceedings, before the filing an ERISA action, are not recoverable as attorney fees awarded to a prevailing party.[128] Because ERISA allows recovery of attorney fees for "any action," rather than "any action or proceeding," the court determined the congressional intent was to allow for recovery of attorney fees accumulated after the commencement of formal ERISA proceedings. The court noted a previous Supreme Court decision holding that, in interpreting a statutory provision authorizing attorney fees, reference to an "action" rather than "action or proceeding" was not enough to establish congressional intent.[129] However, the Third Circuit distinguished that holding because the attorney fees at issue in that case were authorized "only when the administrative proceedings occurred after litigation and were necessary to enforce a final judgment that had been already obtained."[130] Because plaintiff's fees were incurred

122. *Id.* at 617.
123. 538 F.3d 524 (6th Cir. 2008).
124. *Id.* at 533–34.
125. *Id.* at 534.
126. *Id.*
127. 514 F.3d 300 (3d Cir. 2008).
128. *Id.* at 313.
129. *Id.* (citing Pennsylvania v. Delaware Valley Citzens' Council for Clean Air, 478 U.S. 546, 559 (1986)).
130. *Id.* at 314.

prior to the formal ERISA proceedings, the court found the district court's award of those attorney fees inappropriate.[131]

B. *Church Plan*

The insurer in *Schalit v. Cigna Life Insurance Co. of New York*[132] moved to dismiss plaintiff's complaint for disability benefits under a plan maintained by her employer, Union of American Hebrew Congregations, because the plan qualified as a "church plan" exempt from ERISA. Under the statute, an organization is associated with a church if it "shares common religious bonds and convictions with that church or convention or association of churches."[133] The court identified the following three factors necessary for resolving the issue: "(1) whether the religious institution plays an official role in the governance of the organization, (2) whether the organization receives assistance from the religious institution, and (3) whether a denominational requirement exists for any employee or patient/customer of the organization."[134] The court, *sua sponte*, converted the motion to dismiss into a motion for summary judgment and invited Cigna to submit information allowing the court to use the statutory, regulatory, and case-law criteria to determine whether the plaintiff's employer was part of a "convention or association of churches."[135]

C. *Conflict of Interest—Post-*Glenn *Decisions*

The Ninth Circuit, in *Daic v. Hawaii Pacific Health Group Plan for Employees of Hawaii Pacific Health*,[136] analyzed whether MetLife, the insurer who administered the ERISA plan but was not a specifically named fiduciary, was nonetheless a plan fiduciary and whether, in light of *Metropolitan Life Insurance Co. v. Glenn*,[137] the district court erred by inadequately considering MetLife's structural conflict of interest. The Ninth Circuit rejected the argument that MetLife was not a fiduciary, finding that the discretionary language in the plan sufficiently identified MetLife as a fiduciary for purposes of ERISA.[138] The Ninth Circuit also found that the district court adequately considered the conflict of interest, noting that while "the district court did not have the benefit of [*Glenn*], it made a careful analysis of the relevant factors, including MetLife's structural conflict of interest."[139] The

131. *Id.*
132. 539 F. Supp. 2d 715 (S.D.N.Y. 2008).
133. *Id.* at 717 (citing 29 U.S.C. § 1002(33)(c)(iv)).
134. *Id.* (citation omitted).
135. *Id.*
136. No. 06-17324, 2008 WL 3862074 (9th Cir. Aug. 13, 2008).
137. *Id.* at *1 (citing Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008)).
138. *Id.*
139. *Id.*

court explained: "Because the record does not contain evidence of malice, self-dealing, or other circumstances suggesting a higher likelihood that the structural conflict affected the benefits decision, the district court did not err in holding that the importance of MetLife's conflict was low."[140]

The Eleventh Circuit reconsidered its decision in favor of an ERISA plan participant in *Doyle v. Liberty Life Assurance Co. of Boston*,[141] following the Supreme Court's ruling in *Glenn*. In its earlier decision, the Eleventh Circuit found the insurer/administrator was acting under a conflict of interest, a heightened arbitrary and capricious standard of review applied, and the administrator failed to show its denial was not influenced by a conflict of interest.[142] On rehearing, after concluding the district court did not err in its determination that the insurer's decision was reasonable, the Eleventh Circuit asked whether "the district court should have placed greater weight on the existence of a conflict of interest than it did."[143] The court first noted that "*Glenn* implicitly overrules and conflicts with our precedent requiring courts to review under the heightened standard a conflicted administrator's benefits decision."[144] Moreover, after *Glenn*, the administrator does not bear "the burden of proving that its discretion was not influenced by a conflict."[145] The court held that *Glenn* requires a court to consider a conflict of interest whenever it is present, regardless of whether the administrator was influenced.[146] Nevertheless, the court stated that "there is no evidence in the record suggesting 'a higher likelihood that [the conflict] affected [the insurer's] benefits decision.' "[147] Accordingly, the court held that the conflict should have been accorded little weight, and "[b]ecause the evidence is close, we cannot say, even accounting for the conflict, that [the insurer] abused its discretion."[148]

D. *Conflict of Interest—Self-Funded Plan*

The Ninth Circuit provided significant guidance for the district court to consider regarding a conflict of interest involving self-funded plans in *Burke v. Pitney Bowes Inc. Long-Term Disability Plan*.[149] While the district court ruled in favor of the plan, it reached its decision prior to the Ninth

140. *Id*.
141. 542 F.3d 1352 (11th Cir. 2008).
142. Doyle v. Liberty Life Assurance Co. of Boston, 511 F.3d 1336 (11th Cir. 2008), *opinion withdrawn and superseded on reh'g by Doyle*, 542 F.3d at 1352.
143. *Doyle*, 542 F.3d at 1358.
144. *Id*. at 1359.
145. *Id*. at 1360.
146. *Id*. at 1363.
147. *Id*. (quoting Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 2351 (2008)).
148. *Id*.
149. 544 F.3d 1016 (9th Cir. 2008).

Circuit's *en banc* decision in *Abatie v. Alta Health & Life Insurance Co*.[150] and the Supreme Court's decision in *Glenn*. The Ninth Circuit therefore remanded the matter for the district court to consider the potential conflict of interest in light of *Glenn* and *Abatie*.[151] In doing so, the court rejected the proposition that a structural conflict of interest cannot exist where a plan is self-funded, with benefits paid out of a trust. The court held that "even when benefits are paid out of a trust, instead of directly by an employer, the employer has a financial incentive to deny claims because every dollar not paid in benefits is a dollar that will not need to be contributed to fund the Trust."[152] The court also noted that, even though employees contribute to the trust, the structural conflict of interest is only mitigated, not eliminated. The court explained: "although there is not a dollar-for-dollar correlation, it still remains true that the more that the Trust pays out in benefits, the more [the plan] must contribute to maintain the Trust's solvency."[153]

E. *Conflict of Interest—Trust*

Participants in a long-term disability plan argued the plan benefits committee, which had been delegated powers by the plan sponsor and administrator, operated under a conflict of interest in *White v. Coca-Cola Co*.[154] The committee had discretionary authority to determine eligibility for benefits, and it retained the final authority to determine all issues arising under the plan. The benefits themselves were paid by a third-party administrator, which was reimbursed by a trust, funded by Coca-Cola, through periodic, nonreversionary payments. The participants contended that "the committee operated under a conflict of interest because the third-party administrator pays benefits to participants and is later reimbursed by the trust." Accordingly, in light of *Glenn*, the participants sought to have the conflict taken into account. The court rejected the idea that the company was acting under a conflict of interest because the company did not incur an "immediate expense as a result of paying benefits."[155] Citing circuit precedent, the court stated: "The delegation of a ministerial task to the third-party administrator does not create a conflict because benefits are paid by the trust and Coca-Cola incurs no immediate expense as a result of paying benefits."[156]

150. *Id*. (citing Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955 (9th Cir. 2006)).
151. *Id*. at 1025.
152. *Id*. at 1026.
153. *Id*. at 1026–27.
154. 542 F.3d 848 (11th Cir. 2008). This case is also discussed in Part IV.P, *infra*.
155. *Id*. at 858 (quoting Gilley v. Monsanto Co., Inc., 490 F.3d 848, 856 (11th Cir. 2007)).
156. *Id*. at 857 (quoting *Gilley*, 490 F.3d at 856).

F. *Discovery—Post-*Glenn *Decisions*

Plaintiff filed a "Motion to Conduct Discovery" with respect to the insurer's conflict of interest due to its dual role as insurer and claims administrator in *Achorn v. Prudential Insurance Co. of America*.[157] Plaintiff requested "the opportunity to discover 'whether Prudential maintains procedures which reduce the potential bias such as segregating claims administration from financial administrators and managers' and 'whether Prudential has a system in place for penalizing inaccurate decision making without regard to which party the inaccuracy benefits.' "[158] The court rejected the notion that *Glenn* was "a case about discovery," noting that the *Glenn* Court "did not state that reviewing courts should or should not permit discovery to explore the particular dimensions of an administrator's conflict." In addition, the court followed First Circuit case law requiring "at least some very good reason to overcome the strong presumption that the record on review is limited to the record before the administrator," allowing the plaintiff to conduct certain limited discovery.[159] Granting the Motion to Conduct Discovery in part, the court ordered Prudential to disclose the rate and compensation Prudential paid to third-party firms it used, "[t]he total number of claims" Prudential administered under the plan at issue for a certain time period, the amount of those claims Prudential referred to third-party firms, the amount of the claims the third-party firms reviewed and recommended denial, and of the claims the third-party firms recommended denial, the number of claims Prudential denied.[160]

Plaintiff in *Christie v. MBNA Group Long Term Disability Plan*[161] requested leave to serve interrogatories concerning the conflicted claims administrator's policies and procedures regarding "penalizing or rewarding accurate versus inaccurate claims decisions" and internal procedures for separating claims handlers and employees interested in the company's finances.[162] The court held that *Glenn* was inapplicable because it "was not a case about discovery and the Supreme Court did not state to what extent reviewing courts should or should not permit discovery to explore the particular dimensions of an administrator's conflict."[163] Accordingly, it held that the law of the First Circuit still applied regarding discovery in ERISA benefits cases, and denied plaintiff's request because the interrogatories were

157. Civ. No. 1:08-cv-125-JAW, 2008 WL 4427159 (D. Me. Sept. 25, 2008).
158. *Id.* at *3.
159. *Id.* at *2 (citing Liston v. Unum Corp. Officer Severance Plan, 330 F.3d 19, 23 (1st Cir. 2003)).
160. *Id.* at *6–7.
161. Civ. No. 1:08-cv-44-JAW, 2008 WL 4427192 (D. Me. Sept. 25, 2008).
162. *Id.* at *1.
163. *Id.* at *2.

limited to "exploring the contours of the structural conflict of interest that exists" for the insurer/claims administrator. Instantly, the plaintiff already knew the fact that the claims decision "was made under the cloud of a structural conflict of interest."[164]

Plaintiff in *Dubois v. Unum Life Insurance Co. of America*[165] objected to a scheduling order set by the court because she believed, in light of *Glenn*, that she was entitled to discovery "to determine the extent to which the defendant's role as both administrator and funder of claims may have led to an improper denial of her claim."[166] Unum responded: "the plaintiff reads far more into *Glenn* than is there, and that under still-controlling standards set forth in *Liston v. Unum Corp. Officer Severance Plan*,[167] the plaintiff fails to make an adequate showing to justify discovery." The court sided with Unum noting: "In this case, the plaintiff presents no case-specific circumstances demonstrating a possibility of bias in the denial of her claim."[168] Indeed, the court highlighted that the claim at issue was decided pursuant to the claims-handling procedures put in place as a result of Unum's 2004 agreement with the Department of Labor.[169] Accordingly, the court overruled plaintiff's objection, holding: "*Glenn* does not alter the legal landscape sufficiently to overrule the *Liston* standards of ERISA discovery, and . . . the plaintiff does not meet the *Liston* standards."[170]

The court in *Florczyk v. Metropolitan Life Insurance Co.*,[171] after reviewing letter-briefs regarding *Glenn*, stated that *Glenn* did not affect its ruling in favor of the defendant. The court further noted that "because of the conflict [of interest], the Court [previously] permitted limited discovery that uncovered nothing probative. Further discovery is not warranted, and to permit the 'fishing expedition' proposed by Plaintiff would entirely frustrate ERISA's efforts to avoid complex review proceedings."[172] The court granted summary judgment in favor of the defendant.

Plaintiff in *Hogan-Cross v. Metropolitan Life Insurance Co.*,[173] an ERISA benefits case, moved to compel discovery regarding the compensation arrangements between the plan administrator and its outside consultants. After the court granted plaintiff's motion, the insurer moved for reconsid-

164. *Id.* at *3.
165. Civ. No. 08-163-P-S, 2008 WL 2783283 (D. Me. July 14, 2008).
166. *Id.* at *1.
167. *Id.* at *2 (citing Liston v. Unum Corp. Officer Severance Plan, 330 F.3d 19, 23 (1st Cir. 2003)).
168. *Id.*
169. *Id.*
170. *Id.* at *3.
171. No. 5:06-CV-0309 (GHL), 2008 WL 3876096 (N.D.N.Y. July 11, 2008).
172. *Id.* at *3.
173. 568 F. Supp. 2d 410 (S.D.N.Y. 2008).

eration on the grounds that the plaintiff was not entitled to any information beyond the administrative record where there was no evidence of an actual conflict of interest in the administrative record. Rejecting the insurer's argument, the court explained that plaintiff is entitled to discovery, even in administrative review cases, if the request is relevant and "appears reasonably calculated to lead to the discovery of admissible evidence."[174] Referring to the Supreme Court's decision in *Glenn* and finding that MetLife had a structural conflict of interest, the court noted, "the existence of such a conflict is a factor to be weighed by the court when reviewing the denial of benefits."[175] The court went on to hold that "[i]nformation bearing on the manner in which a conflicted plan administrator compensates outside consultants could be highly pertinent. Maintenance of compensation arrangements that create economic incentives for consultants to recommend denial or termination of benefits would have a material bearing on the likelihood that the administrator's conflict affects its benefit determinations."[176]

The court rejected plaintiff's argument that *Glenn* amended the arbitrary and capricious standard of review the court used in reviewing the claims administrator's decision in *Marszalek v. Marszalek & Marszalek Plan*.[177] In addition, the court held that *Glenn* did not mandate discovery into the claims administrator's conflict of interest. Characterizing the plaintiff's interpretation of the *Glenn* decision as "misguided, at best," the court noted, "discovery in ERISA cases may be appropriate only in 'exceptional' circumstances where the claimant is able to 'identify a specific conflict of interest or instance of misconduct' and 'make a *prima facie* showing that there is good cause to believe limited discovery will reveal a procedural defect.'"[178] The court also rejected plaintiff's speculation that the insurer "somehow concealed the existence of lawsuits filed against it," preventing the plaintiff from "discovering its history of biased claim administration," noting the administrative record showed the claims administrator "construed the terms of the Plan in a manner consistent with the overall purpose of the Plan."[179]

In *Myers v. Prudential Insurance Co. of America*,[180] the court denied Prudential's motion for a protective order, which it filed in response to written discovery plaintiff initiated in an ERISA disability case. The court opined

174. *Id.* at 414.
175. *Id.*
176. *Id.* at 415.
177. No. 06 C 3558, 2008 WL 4006765 (N.D. Ill. Aug. 26, 2008).
178. *Id.* at *2 (quoting Semien v. Life Ins. Co. of N. Am., 436 F.3d 805 (7th Cir. 2006)).
179. *Id.*
180. No. 1:08-cv-22, 2008 WL 4569969 (E.D. Tenn. Sept. 22, 2008).

that *Glenn* contained "persuasive dicta" regarding "discovery issues."[181] Specifically, the court stated, "[t]he undersigned reads this language from *Glenn* as a warning against establishing special evidentiary procedures to apply to interest/bias issues that arise in ERISA-denial-of[-]benefits cases. Instead, the Supreme Court exhorts the courts to examine and review each case on an individual basis, which would include fashioning an appropriate discovery plan based on the tools already available to parties in any other civil action."[182]

The court in *Samuel v. Citibank, N.A., Long Term Disability Plan*[183] reconsidered its denial of the plaintiff's "motion 'to permit limited, but thorough, discovery of any incentives and methods MetLife may have concerning predisposition to deny long term disability claims through the use of unfair biased practices and tactics, especially their practice of misrepresenting non-independent physician consultation reviews as 'independent.' "[184] The court relied upon the Eighth Circuit's decision in *Wakkinen v. Unum Life Insurance Co. of America*,[185] in which the court "adhered to the principle that" it would examine only the administrative record when reviewing the benefits determination. Accordingly, the *Samuel* court denied the plaintiff's motion to reconsider.

The district court allowed discovery in an ERISA disability case in *Sanders v. Unum Life Insurance Co. of America*,[186] based not on *Glenn*, but on Eighth Circuit case law. In ruling on plaintiff's motion to compel discovery responses, the *Sanders* court rejected the plaintiff's assertion that *Glenn* determined "the rules of discovery ordinarily applicable in civil cases should apply." Instead, the court found, "the Supreme Court intended to say that cases in which the same entity evaluates claims for benefits and pays claims should be governed by the rules that govern other ERISA claims. Sanders's argument would single those cases out to be treated in a manner differently from other ERISA cases." The court followed Eighth Circuit case law that predated the *Glenn* decision, which allowed "limited discovery" to assist the court in determining the standard of review to apply to the plan administrator's decision. Because the Eight Circuit had applied the *de novo* standard of review when the insurer and plan administrator were the same entity and when they "provided incentives and bonuses to [the] claims reviews board on 'claims savings,' " the court permitted discovery

181. *Id.* at *8.
182. *Id.*
183. No. CIV. 07-4051, 2008 WL 4138174 (D.S.D. Sept. 3, 2008).
184. *Id.* at *1.
185. *Id.* (citing Wakkinen v. Unum Life Ins. Co. of Am., 531 F.3d 575, 581 (8th Cir. 2008)).
186. No. 4:08CV00421 JLH, 2008 WL 4493043 (E.D. Ark. Oct. 2, 2008).

on the limited issue of whether claims review employees "had a financial incentive to deny [the plaintiff's] claim."[187]

G. *Exhaustion of Administrative Remedies*

The Ninth Circuit held that an ERISA plan participant exhausted her administrative remedies in *Hallstead v. Liberty Life Assurance Co. of Boston*,[188] although the participant failed to completely follow the appeals process.[189] In its letter terminating plaintiff's disability benefits, Liberty advised her she must request a review within 180 days and state the reasons why she felt her claim should not have been denied; plaintiff thereafter provided written notification of her intent to appeal.[190] In a second letter, Liberty confirmed receipt of the request for appeal and asked plaintiff to submit any medical and/or vocational information supporting her position. Plaintiff refused to provide further information because she had previously provided all of her medical records to Liberty, and its consulting physician had requested and received recent medical records from her treating physician.[191] Reversing the district court's dismissal of plaintiff's case, the Ninth Circuit held that Liberty's second letter was contradictory to the appeal process set forth in its first letter.[192] The court found although plaintiff never provided the statement required, she relied on the permissive language in Liberty's second letter in choosing not to provide any further information, and therefore plaintiff exhausted her administrative remedies.[193]

The Ninth Circuit, in *Vaught v. Scottsdale Healthcare Corp. Health Plan*,[194] considered whether ERISA claimants are subject to an issue-exhaustion requirement before filing suit. Plaintiff, who had been denied reimbursement of medical expenses under his employee benefit plan, brought suit alleging the plan's handling of his claim violated ERISA and the terms of the plan. Declining to address the merits of plaintiff's complaint, the district court granted the plan's motion for summary judgment, holding that, because plaintiff relied on a new theory that he had not raised in his requests for internal review, he had failed to exhaust his administrative remedies. On appeal, the Ninth Circuit relied heavily on the Supreme Court's decision in *Sims v. Apfel*,[195] which addressed issue exhaustion in the Social

187. *Id.* at *4 (quoting Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997)).
188. 269 F. App'x 708 (9th Cir. 2008).
189. *Id.* at 710.
190. *Id.* at 709.
191. *Id.* 709–10.
192. *Id.* at 710.
193. *Id.*
194. No. 06-15507, 2008 WL 4380616 (9th Cir. Sept. 29, 2008).
195. *Id.* at *9 (citing Sims v. Apfel, 530 U.S. 103, 107 (2000)).

Security context. The court examined the similarities between ERISA and the Social Security Act and specifically noted that "ERISA's internal review procedures share the nonadversarial characteristics of the Social Security Act procedures[;]" and "[s]imilar to the Social Security requirements, the [plan] provided for an informal appeal process" that "does not require issue exhaustion."[196] The court stated that "*Sims* leads to the conclusion that issue exhaustion is not applicable in the ERISA context." The court ruled that plaintiff "was not precluded from raising his new theory to the district court"[197] and reversed the district court's grant of summary judgment to the plan.

H. *Fiduciary*

The court granted the defendants' motion for summary judgment in *Mahoney v. J.F. Weiser & Co., Inc.*,[198] holding that a health benefits plan sponsored by a union local retirees' association was governed by ERISA, that an insurance broker was not a plan fiduciary with regard to alleged excessive premiums and high commissions, and that the association's former directors did not violate any fiduciary duties to the participants. The court disagreed with the defendants' contention that the decision to purchase and renew a policy was a settlor function not subject to ERISA's fiduciary duty requirement. The court found the decision "more analogous to the selection of a service provider or the determination of how to invest a plan's assets, which are subject to ERISA's fiduciary oversight."[199] While the benefits plan administrator and insurance brokerage firm that helped issue the plan "may or may not have been a fiduciary with regard to the processing of claims," the complaint did not allege that the administrator abused its discretion in denying claims that should have been approved. Rather, the complaint focused on purportedly excessive premiums.[200] The court concluded that "[t]he alleged receipt of excessive premiums and payment of high commissions does not transform an insurance company into an ERISA fiduciary."[201]

I. *IME*

The court in *Pitts v. Prudential Insurance Co. of America*[202] found Prudential's failure to conduct an IME, when it challenged the credibility of the insured's treating physician, arbitrary and capricious. Plaintiff's primary

196. *Id.* at *10–11.
197. *Id.*
198. 564 F. Supp. 2d 248 (S.D.N.Y. 2008).
199. *Id.* at 256.
200. *See id.* at 251, 257.
201. *Id.* at 257.
202. 534 F. Supp. 2d 779 (S.D. Ohio 2008).

care physician listed depression, mood swings, and insomnia as obstacles preventing plaintiff's return to work.[203] Prudential's reviewing psychiatrist concluded that plaintiff could have returned to work part time several months earlier; that he could return immediately, beginning with "a brief part-time work hardening period"; and that plaintiff had "the functional capacity to return to his prior occupation."[204] Plaintiff argued that because the plan covered subjective disorders and expressly allowed for self-reported symptoms of disability, it was arbitrary and capricious for Prudential to deny coverage based on a supposed lack of objective medical evidence.[205] Prudential responded that plaintiff's benefits were terminated because he presented no evidence to show the disabling severity of his condition, not for lack of objective evidence.[206] Nevertheless, the court found that nothing in the record supported Prudential's challenge to plaintiff's psychotherapist's credibility and stated "the possibility of returning to work on a limited trial period, in light of 'overwhelming evidence to the contrary,' is an insufficient basis upon which to terminate benefits."[207] The court also found Prudential's failure to conduct an independent medical examination as additional evidence that the termination was arbitrary and capricious, noting, "Prudential cannot have it both ways by arguing that it would be impossible for an IME to produce objective evidence of the severity of [plaintiff's] self-reported symptoms, but also cite the lack of 'data' validating [plaintiff's] claims as a justification for termination of benefits."[208]

J. *Interest*

In *Weber v. GE Group Life Assurance Co.*,[209] a life insurer appealed from a summary judgment order obligating it to pay prejudgment interest at the Oklahoma statutory rate of fifteen percent per annum. The insurer argued this rate was punitive and therefore disallowed under ERISA. The court noted that while "courts commonly look to state statutory prejudgment interest provisions as guidelines for a reasonable rate," a statutory rate is not free from scrutiny.[210] The court acknowledged it had previously held that "an excessive prejudgment interest rate [which] would overcompensate an ERISA plaintiff, thereby transform[s] the award of prejudgement [sic]

203. *Id.* at 784.
204. *Id.*
205. *Id.* at 786.
206. *Id.*
207. *Id.* at 788 (citation omitted).
208. *Id.*
209. 541 F.3d 1002 (10th Cir. 2008).
210. *Id.* at 1016 (*citing* Allison v. Bank One-Denver, 289 F.3d 1223, 1244 (10th Cir. 2002)).

interest from a compensatory damage award to a punitive one."[211] Nevertheless, the Tenth Circuit rejected the notion that the fifteen percent rate was punitive in this case. The court held: "[b]ecause (1) the [statutory] prejudgment interest rate is of broad applicability—and is not necessarily punitive—and (2) nothing in the record suggests that the award of 15% here is punitive, we conclude that the district court did not abuse its discretion in awarding the prejudgment interest in this case."[212]

K. *Limitations Period*

The Seventh Circuit found that a three-year legal action provision contained in plaintiff's ERISA plan barred his lawsuit challenging the termination of his long-term disability benefits in *Abena v. Metropolitan Life Insurance Co*.[213] Plaintiff argued that the plan's three-year limitations period, measured from the time proof of disability was to be filed, was unreasonable under the circumstances presented: his claim was initially approved and he received benefits for two years prior to his benefits being terminated.[214] While agreeing "that the manner in which the Plan sets the limitations period is better suited to the initial claim decision than it is to claims that are initially granted and subsequently terminated," and acknowledging that it could imagine circumstances where the application of the plan's legal action provision would not be reasonable, the Seventh Circuit found that the legal action provision was reasonable as applied to plaintiff's situation because plaintiff still had seven months following the conclusion of the internal appeals process to file his suit and there was no reason he could not have filed suit during that time.[215]

An ERISA plan participant faced dismissal of her benefits claim as untimely in *Pettaway v. Teachers Insurance and Annuity Ass'n of America*.[216] The court held the statute of limitations began to run when the claimant was informed that her benefits had been terminated.[217] Because there is no express statute of limitations period in the ERISA statute, the court applied the three-year statute of limitations for a breach of contract claim under District of Columbia law. The court found good cause to equitably toll the statute of limitations because the claimant first had to exhaust the internal administrative remedies provided by the plan.[218] The court concluded that

211. *Id*. (quoting *Allison*, 289 F.3d at 1243).
212. *Id*. at 1017.
213. 544 F.3d 880 (7th Cir. 2008).
214. *Id*. at 883.
215. *Id*. at 884.
216. 547 F. Supp. 2d 1 (D.D.C. 2008).
217. *Id*. at 3.
218. *Id*. at 4.

the period of time during which the claimant diligently pursued her administrative appeal would be subtracted from the full limitations period. Accordingly, the court denied the plan's motion to dismiss.

L. *Participant's Cooperation*

An ERISA plan participant who sought permanent disability benefits in *Gertjejansen v. Kemper Insurance Cos., Inc.*[219] appealed the district court's grant of summary judgment in favor of Kemper. Although the Summary Plan Description (SPD) unambiguously gave "the Plan administrator discretionary authority to determine eligibility for benefits and to construe the terms of the plan," the Ninth Circuit reviewed Kemper's claim decision *de novo* because Kemper failed to show it properly provided the plan participant with the SPD, as ERISA regulations required.[220] Nevertheless, the court affirmed summary judgment in favor of Kemper because the plaintiff did not cooperate with Kemper's "request for a scheduled appointment for case management," as unambiguously required by the SPD.[221] The court concluded that whether plaintiff was in fact disabled was irrelevant because her failure to cooperate prevented Kemper from making a disability determination.

M. *Plan*

The court in *Mandala v. California Law Enforcement Ass'n*[222] examined whether a group disability insurance program offered by the California Law Enforcement Association (CLEA) was an ERISA-governed plan. CLEA removed plaintiff's breach of contract action from state court and plaintiff moved to remand, asserting the plan was not governed by ERISA.[223] The parties agreed CLEA was not an employer and instead focused their dispute on whether it was "any employees' beneficiaries association organized for the purpose in whole or in part, of establishing [an employee benefit] plan."[224] To define "employees' beneficiary association,"[225] the court looked to the four criteria used by the Department of Labor: (1) membership conditioned on employment status; (2) a formal organization, with officers, bylaws, or other indications of formality; (3) generally no dealings with employers; and (4) organization for the purpose of establishing a welfare or pension plan.[226] While the parties did not dispute CLEA satisfied criteria

219. 274 F. App'x 569 (9th Cir. 2008).
220. *Id.* at 570–71.
221. *Id.* at 571.
222. 561 F. Supp. 2d 1130 (C.D. Cal. 2008).
223. *Id.* at 1132.
224. *Id.*
225. *Id.*
226. *Id.* at 1133–34.

(2) and (3), the court held criterion (1) required the association's members to have some commonality of interest with respect to their employment relationships more than mere employment or union membership and unrelated to the provision of benefits.[227] Membership in the CLEA plan was open to members of various law enforcement associations, but "a law enforcement officer whose association does not participate in CLEA may still become a CLEA member and subscribe to the plan as an 'Eligible Individual Participant'" (EIP).[228] The court found no commonality of interest unrelated to the provision of benefits and concluded criterion (1) was not satisfied as an EIP's "only relationship to CLEA stems from the benefit plan itself."[229] The court rejected CLEA's argument that a sufficient commonality of interest existed because all peace officers share special characteristics because those characteristics concerned only the members of CLEA and not the relationship between CLEA and its members.[230]

N. *Plan Interpretation*

The beneficiary of a group life insurance policy in *Blackshear v. Reliance Standard Life Insurance Co*.[231] appealed from a judgment in favor of the insurer/administrator of an ERISA plan who applied the "clerical errors" provision of the policy to deny coverage. At the time of the insured's death, the plan afforded coverage to the insured without a waiting period. To correct this "error," the insurer amended the plan (after receiving the claim at issue) to include a service waiting period and, relying on the amended terms, denied the beneficiary's claim. On appeal, the beneficiary argued the insurer/administrator abused its discretion by not following the clear and unambiguous language of the original plan. The Fourth Circuit held an administrator's discretion never includes the authority to "read out unambiguous provisions" contained in an ERISA plan and to do so constitutes an abuse of discretion.[232] The appellate court also determined that an administrator could not equitably reform an ERISA plan to correct what it unilaterally perceived to be a mistake or error contained in the plan's written terms.[233] Rather, the court found that reformation, like other forms of equitable relief, must be requested by the party seeking to reform the contract and granted by a court.[234]

227. *Id*. at 1134 (quoting Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Pub. Instruction, 804 F.2d 1059, 1063 (8th Cir. 1986)).
228. *Id*. at 1135.
229. *Id*.
230. *Id*. at 1135–36.
231. 509 F.3d 634 (4th Cir. 2007).
232. *Id*. at 639.
233. *Id*. at 642.
234. *Id*.

O. *Preemption*

The Fifth Circuit held that an insurance commissioner's directive was saved from preemption in *Benefit Recovery, Inc. v. Donelon*[235] because it "regulated insurance" within the meaning of the ERISA savings clause.[236] Benefit challenged a Louisiana state insurance directive that precluded insurers from enforcing their subrogation rights until the insured was fully compensated for injury.[237] Benefit argued that the directive was not saved from preemption because it was a "State law" under § 1144(c), which includes rules, regulations, and anything else having the effect of law, but was not a "law of any State" under § 1144(b).[238] The court refused to distinguish "State laws" from "laws of any State" and instead focused its analysis on whether the directive, if classified as a state law, would be saved from preemption because it regulates insurance.[239] The court determined that the directive was specifically intended to regulate entities engaged in insurance because it required insurance companies to include certain terms in their contracts and affected "risk pooling" because it altered the permissible bargains between insurers and insureds.

The Fourth Circuit held that a third-party administrator's state law claims against an employer plan sponsor were not subject to ERISA preemption in *Great-West Life & Annuity Insurance Co. v. Information Systems & Networks Corp*.[240] The employer contracted with Great-West to perform certain nondiscretionary administrative services under the direction of the plan administrator. Under the contract, Great-West fronted the payment of claims made by employees and the employer was to reimburse Great-West for those payments.[241] When the employer refused to reimburse Great-West for those benefit claims it had paid on the plan's behalf, Great-West filed suit for breach of contract and unjust enrichment. The employer moved to dismiss on ERISA preemption grounds. The court reasoned Great-West's state law claims did not involve ERISA because (1) Great-West did not mandate employee benefit structures or their administration, (2) Great-West did not bind the plan to particular choices or preclude uniform administrative practice, and (3) Great-West did not provide an alternate enforcement mechanism for the employees to obtain ERISA plan benefits.[242]

235. 521 F.3d 326 (5th Cir. 2008).
236. *Id*. at 330.
237. *Id*. at 327.
238. *Id*. at 329.
239. *Id*. at 330.
240. 523 F.3d 266 (4th Cir. 2008).
241. *Id*. at 268.
242. *Id*. at 272.

When plaintiff submitted his claim for disability benefits under an ERISA plan in *Sgro v. Danone Waters of North America, Inc.*,[243] the claim administrator, MetLife, required him to submit his medical records but refused to pay the photocopying costs for the records. Plaintiff sued MetLife and his employer under state and federal law, seeking disability benefits, the photocopying costs, an injunction ordering the defendants to pay such photocopying costs in the future, and statutory penalties for the defendants' failure to provide him with certain claim documents.[244] The parties settled the plaintiff's claim for unpaid benefits and the plaintiff appealed the dismissal of his remaining claims. Plaintiff argued that the disability benefits plan at issue fell within the "safe harbor" set forth in 29 C.F.R. § 2510.3-1(j) and was not governed by ERISA, but he did not allege, as an element of the "safe harbor," that the employer made no contributions to the plan. The Ninth Circuit affirmed the dismissal of plaintiff's state law claims but instructed the district court on remand to allow plaintiff the opportunity to amend his complaint.[245] The court also affirmed the dismissal of the plaintiff's claim under a California insurance regulation requiring the defendants to reimburse him for the photocopying costs,[246] holding that the regulation was not saved from ERISA preemption because it did not "substantially affect the risk pooling arrangement between the insurer and the insured."[247] In addition, the court affirmed the dismissal of plaintiff's claim that the defendants violated an ERISA regulation on "claims procedures" by "requir[ing] payment of a fee or costs as a condition to making a claim"[248] because the photocopying costs were not a "condition" required of every application. Further, the court upheld the dismissal of plaintiff's claim that the defendants did not provide him with all relevant claim documents in violation of ERISA regulations[249] because plaintiff did not specifically allege that claim against the plan administrator.[250] Finally, the court held that plaintiff was not "entitled to a class certification hearing or to an injunction" requiring the defendants to pay photocopying expenses for the class because he had not alleged facts removing the plan from ERISA's safe harbor and ERISA does not require the defendants to pay photocopying costs.[251]

243. 532 F.3d 940 (9th Cir. 2008).
244. *Id.* at 942.
245. *Id.* at 942–43.
246. *Id.* at 943 (citing Cal. Code Regs. tit. 10, § 2695.11(g)).
247. *Id.*
248. *Id.* at 944 (citing 29 C.F.R. § 2560.503-1(b)(3)).
249. *Id.* (citing 29 C.F.R. § 2560.503-1(h)(2)(iii)).
250. *Id.* at 944–45.
251. *Id.* at 945–46.

P. *Offsets*

Participants in a long-term disability plan brought a putative class action against their employer, the plan administrator under ERISA, in *White v. Coca-Cola Co.*,[252] challenging its decision to offset Social Security disability benefits against long-term disability benefits that resulted in a benefit award that was less than the stated default monthly benefit under the plan. The district court found that the interpretation of the offset provision was "*de novo* wrong" but reasonable and entitled to deference. The district court also found the employer's interpretation of the recoupment provision "*de novo* right" and granted summary judgment for the company. While the Eleventh Circuit noted a clause in the plan's offset provision setting a benefit floor conflicted with other plan provisions and created an ambiguity arguably to be construed in the participants' favor,[253] it found the plan had discretion and its approach "reasonably interpreted the clause to make it consistent with the summary plan description, the past practices of Coca-Cola, and the other provisions of the plan." The court concluded: "[t]he plain language of the plan permits the withholding of future benefits to recover any overpayment arising from a retroactive payment of benefits from outside sources."[254]

Q. *Scope of Review*

In *Farr v. Hartford Life and Accident Insurance Co.*,[255] Hartford terminated plaintiff's benefits after an independent medical examiner, a physician who reviewed plaintiff's records, and plaintiff's own provider all concluded plaintiff was capable of performing the duties of a sedentary occupation.[256] Plaintiff argued that the independent medical examiner's revision of his original report regarding plaintiff's functional abilities was improper and, as a result, the administrative record lacked the substantial evidence required to support defendant's termination of plaintiff's disability benefits under her employee benefit plan.[257] The court rejected plaintiff's argument, finding no facts to suggest the independent medical examiner was coerced to change his report, that he believed the change was unnecessary or inappropriate, or that the corrected version of the report represented anything but his full and complete opinion concerning plaintiff's medical condition and its effect on plaintiff's ability to work.[258] Accordingly, the court refused to reverse Hartford's benefit determination on those grounds.

252. 542 F.3d 848 (11th Cir. 2008). This case is also discussed in Part IV.E, *supra*.
253. *Id.* at 855.
254. *Id.* at 858.
255. 564 F. Supp. 2d 1255 (D. Kan. 2008).
256. *Id.* at 1263–65.
257. *Id.* at 1265.
258. *Id.*

The Tenth Circuit limited the *de novo* review of an ERISA disability benefits claim to the administrative record in *Jewell v. Life Insurance Co. of North America*.[259] The court acknowledged that the denial of benefits should be reviewed *de novo*, but went on to note that such review is limited to the administrative record before the plan administrator. The court found that supplemental evidence should be admitted only in exceptional circumstances if it is "necessary to the district court's de novo review," the party can "demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision was made," and it is neither "cumulative or repetitive" nor "simply better evidence than the claimant mustered for the claim review."[260] In applying these factors, the court concluded the district court erroneously allowed plaintiff to admit extra record exhibits into evidence, and this evidence had "a substantial effect on the district court's disposition of the case."[261] The Tenth Circuit remanded the case for *de novo* review based only on the administrative record before the plan administrator when it made its claims decision.

The Eighth Circuit acknowledged in *Wakkinen v. Unum Life Insurance Co. of America*[262] that after the Supreme Court's decision in *Glenn*, a court's review under the arbitrary and capricious standard is limited to a review of the administrative record. Plaintiff sued Unum, the insurer and plan administrator of the ERISA plan, challenging the denial of his claim for long-term disability benefits. In affirming the district court's decision in favor of Unum, the Eighth Circuit noted that under *Glenn*, while a conflict existed due to UNUM's role as both the decider and payor of claims, that conflict had no effect on the standard of review. Weighing the conflict in accordance with *Glenn*, the appellate court found there was not a "sufficiently close balance for the conflict of interest to act as a tiebreaker" in Unum's determination to deny plaintiff's claim.[263] In so doing, the appellate court explained, "[w]e examine only the evidence that was before the administrator when the decision was made, and . . . we are to determine whether a reasonable person could have—not would have—reached a similar decision."[264]

R. *Standard of Review*

An insured sued a group disability insurer in *Gutta v. Standard Select Trust Insurance Plans*[265] after the insured's long-term disability benefits were

259. 508 F.3d 1303 (10th Cir. 2007).
260. *Id*. at 1309.
261. *Id*. at 1317.
262. 531 F.3d 575 (8th Cir. 2008).
263. *Id*. at 582–83.
264. *Id*. at 583.
265. 530 F.3d 614 (7th Cir. 2008).

terminated. The insurer counterclaimed for reimbursement of the amount it paid to the insured based upon the "Income From Other Sources" provision of its policy. In an attempt to overturn the administrator's decision, the insured argued that the plan did not grant the insurer discretionary authority and, even if it had discretionary authority, its decision was unreasonable and, therefore, arbitrary and capricious. The insured also argued that the insurer was not entitled to reimbursement because the money the insured received was not from a group insurance plan and had been commingled with other funds. The Seventh Circuit upheld the district court's ruling in favor of the insurer, finding that the plan language unambiguously communicated the message that the payment of benefits was subject to the insurer's discretion.[266] In reviewing the plan administrator's decision deferentially, the court found that the decision easily satisfied the "arbitrary and capricious" standard of review because it was based upon substantial evidence and was consistent with the medical evidence in the record.[267] The court also allowed the insurer to bring its counterclaim under ERISA's equitable relief provision.[268] On rehearing following the Supreme Court's decision in *Glenn*, the Seventh Circuit affirmed its prior ruling.

The ERISA plan at issue in *Wintermute v. The Guardian*[269] granted Guardian, the claims fiduciary, discretion to determine eligibility for benefits and to construe the terms of the plan. It did not, however, grant such authority to ClaimSource, an external service provider of claims management that terminated the insured's benefits. Neither the policy at issue nor the plan summary granted ClaimSource discretionary authority or authorized Guardian to delegate its authority to ClaimSource. The court declined to adopt the arbitrary and capricious standard of review of the decision made by an "unauthorized body that [did] not have fiduciary discretion to determine benefits."[270] Nevertheless, under the *de novo* standard of review, the court determined the decision to terminate benefits was correct.[271] The court specifically noted that its purpose was not to play the role of "substitute plan administrator" and, therefore, it was not permitted to receive or consider evidence that was not presented to the decision maker at the time of its decision.[272]

The court in *Woods v. Prudential Insurance Co. of America*[273] analyzed whether the language of an ERISA plan was sufficient to confer discretion

266. *Id.* at 619.
267. *Id.* at 620.
268. *Id.* at 621.
269. 524 F. Supp. 2d 954 (S.D. Ohio 2007).
270. *Id.* at 959–60 (citation omitted).
271. *Id.* (citation omitted).
272. *Id.*
273. 528 F.3d 320 (4th Cir. 2008).

on a plan administrator. Prudential "contend[ed] that such authority should be implied because the Plan specifies that claimant is eligible for benefits 'when Prudential determines' that eligibility exists and that disabilities are 'determined by Prudential.' "[274] The court held that although the plan's language vested authority, "it does not create any discretionary authority."[275] The court concluded that "a plan which simply conveys authority to an administrator creates the expectation only that such authority will be exercised, not that the administrator will enjoy wide discretion in wielding its authority as well as freedom from searching judicial scrutiny."[276]

S. *Remand*

After upholding the district court's determination that an ERISA plan administrator arbitrarily and capriciously terminated plaintiff's long-term disability benefits because it failed to determine whether plaintiff was able to work in an occupation for which she was qualified in spite of her impairments, in *Tate v. Long Term Disability Plan for Salaried Employees of Champion International Corp.*,[277] the Seventh Circuit found that the district court did not abuse its discretion in remanding the matter to the plan administrator. The court explained that remand was proper because its finding that the plan administrator's termination of benefits was arbitrary and capricious was based on the plan administrator's failure to provide adequate reasons for its conclusion.[278] The court rejected plaintiff's argument that reinstatement of benefits was appropriate because her claim involved the denial of benefits to which she had initially been deemed eligible, finding that while the plan administrator determined that plaintiff was eligible for benefits under the ERISA plan's "own occupation" provision, there was no showing that it ever found her eligible for benefits under the plan's "any occupation" standard.[279] Thus, while the Seventh Circuit agreed that reinstatement would be the proper remedy if plaintiff could prove that she had been entitled to continued benefits at the time of the plan administrator's decision to terminate benefits, it explained that the case before it was more akin to an initial denial of benefits than a termination of benefits, which made remand the appropriate remedy.[280] The court further denied plaintiff's request for attorney fees under ERISA,

274. *Id.* at 322.
275. *Id.*
276. *Id.* at 323.
277. Nos. 07-1022, 07-1116, 2008 WL 4276593 (7th Cir. Sept. 19, 2008). This case is also discussed in Part III.L, *supra*.
278. *Id.* at *7.
279. *Id.*
280. *Id.* at *7–8.

finding that plaintiff was not a "prevailing party" as required to receive an attorney fee award under ERISA because she was only awarded a remand and there was no finding that the plan administrator's termination was not substantially justified.[281]

V. HEALTH INSURANCE

A. *Domestic Partner Benefits*

A union constituency group, various public employees, and their same-sex domestic partners brought an action against the Governor of Michigan and the City of Kalamazoo in *National Pride at Work, Inc. v. Governor of Michigan*,[282] seeking a declaratory judgment that the marriage amendment to the state constitution did not preclude public employers from extending health-insurance benefits to same-sex domestic partners. The marriage amendment provided: "To secure and preserve the benefits of marriage for our society and for future generations of children, the union of one man and one woman in marriage shall be the only agreement recognized as a marriage or similar union for any purpose."[283] The trial court held that providing health insurance benefits to domestic partners did not violate the marriage amendment because public employers were not recognizing domestic partnerships as unions similar to marriage. The Supreme Court of Michigan, affirming an appellate court reversal, held that the pertinent question was not whether these unions gave rise to all of the same legal effects as marriage, but rather whether the unions were being recognized as unions similar to marriage "for any purpose." The court found that when two people entered a domestic partnership, a legal consequence arose from that union in the form of health insurance benefits. Therefore, the court concluded that the marriage amendment prohibited public employers from providing such benefits.

B. *Condition Precedent—Health "As Stated"*

The insured in *Hussey v. Fidelity & Guaranty Life Insurance Co*.[284] completed her application for insurance in October 2005. As part of the application, the insured answered "no" to whether she had ever been treated or diagnosed with hepatitis, gastritis, colitis, or any disease or disorder of the liver, stomach, pancreas, or intestines. Shortly after completing the application, the insured tested positive for hepatitis C and

281. *Id*. at *8.
282. 748 N.W.2d 524 (Mich. 2008).
283. *Id*. at 532.
284. 560 F. Supp. 2d 493 (S.D. Miss. 2008).

was killed in a single-car accident. Citing the policy application language, the insurer denied the claim for benefits, claiming that no insurance was in effect because there was no delivery and acceptance of policy while the insured's health was "as stated" in the application. The court held the conditional insuring agreement created by acceptance of the application did not operate to create coverage until the conditions set forth in the application were met (i.e., delivery and acceptance of the policy and health "as stated" in the application when those events of delivery and acceptance occurred).[285] In granting summary judgment for the insurer, the court found the policy never went into effect because the policy was not delivered and accepted when the insured was in the same health "as stated" in the application.

C. *HIPAA*

The John Alden Life Insurance Company (JALIC) in *Ex parte John Alden Life Insurance Co*.[286] sought a writ of mandamus from the Supreme Court of Alabama ordering the trial court to vacate an order compelling JALIC to produce information deemed "protected health information" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[287] and protected from disclosure under federal regulations.[288] Plaintiff in the underlying lawsuit alleged JALIC's agent sold him a group health insurance product and represented that any future premium increases would be uniform to all policyholders in the group.[289] Plaintiff claimed the premium increases were not uniformly instituted and sued JALIC for, *inter alia*, breach of contract and various torts.[290] Ruling on a discovery dispute, the trial court directed JALIC to produce a list of names and addresses of all Alabama policyholders to whom JALIC issued the same or a similar type of policy but set specific limits on how the information could be used and the circumstances under which the individuals listed could be contacted. The Alabama Supreme Court noted HIPAA permits discovery of protected information in judicial proceedings so long as the order directing its production is a "qualified protective order."[291] The court determined the trial court's order satisfied HIPAA's standards for what constitutes a qualified protective order and denied JALIC's petition.[292]

285. *Id*. at 499.
286. No. 1070414, 2008 WL 2469371 (Ala. June 20, 2008).
287. 42 U.S.C. § 1320(d)(4).
288. 45 C.F.R. §§ 160, 164.
289. *Ex parte John Alden Life Ins. Co*., 2008 WL 2469371, at *1.
290. *Id*.
291. *Id*. at *5–6.
292. *Id*. at *9–10.

D. *Notice*

The Ninth Circuit in *Raby v. American International Specialty Lines Insurance Co*.[293] held that although a notice of claim to an insurance agent was necessary, it was not sufficient to satisfy a health insurance policy's notice requirements. Plaintiffs notified Health Insurance Services, a broker/agent of American International, of their intent to file a complaint related to a claim denial. Health Insurance Services forwarded the claim to American International within the period allowed by the policy. However, the policy language expressly required plaintiff to deliver notice in writing to a designated individual at American International.[294] The court held that while the policy required notice to Health Insurance Services, plaintiff could not satisfy the policy's "claims made" term without notice to American International as well.[295] The court further found that there was no evidence American International acted in a manner to invite any understanding that notice to Health Insurance Services without notice to itself would suffice. The court concluded the agent acted as an agent of plaintiffs, and not as the agent of American International, when it accepted and delivered the notice.[296]

E. *Out-of-Network Treatment*

The Ninth Circuit held an ERISA-governed health plan abused its discretion when it denied benefits for out-of-plan services received in connection with an eating disorder in *Jacobs v. Kaiser Foundation Health Plan, Inc*.[297] After plaintiff sought treatment for her child's bulimia, the plan told her a plan-sponsored treatment service would become available in five to six months.[298] In the interim, the plan recommended that the child attend a "drop-in" group, meet with a clinical social worker, and make an appointment with her primary care physician. When the plan's "drop-in" group proved inadequate and the plan canceled the physician appointment, plaintiff found treatment outside of the plan.[299] The court concluded the plan abused its discretion when it denied benefits for out-of-plan services because it did not have any appropriate care available.[300] The court awarded attorney fees and costs, finding that the plan (1) never legitimately treated plaintiff's child despite the urgency of her situation,

293. 268 F. App'x 566 (9th Cir. 2008).
294. *Id*. at 567.
295. *Id*.
296. *Id*.
297. 265 F. App'x 652 (9th Cir. 2008).
298. *Id*. at 654.
299. *Id*.
300. *Id*.

(2) knew that it lacked any eating disorder programs, and (3) allowed the child's condition to decline to the point where her life was in jeopardy.[301]

F. *Preexisting Condition*

The court in *Pratt v. American Heritage Life Insurance Co.*[302] found that the insured's Hodgkin's lymphoma was not a preexisting condition.[303] Under the policy at issue, the term "pre-existing condition" was defined as "a condition not revealed in the application for which symptoms existed within the 12-month period before the effective date of coverage or for which medical advice or treatment was recommended by or received from a medical doctor within the 12-month period before the effective date of coverage."[304] The policy also stated that a preexisting condition can exist even though a diagnosis had not yet been made.[305] The key question before the court was whether the insured's Hodgkin's lymphoma was a condition "for which" symptoms existed or was a condition "for which" medical advice or treatment was recommended or received.[306] After considering other courts' interpretation of similar "for which" language, the court found that in order to be considered "pre-existing" under this policy, the ultimate condition must have been suspected with a reasonable degree of likelihood.[307] Here, the insurer denied coverage using an after-the-fact analysis of only nonspecific symptoms and neither the insured nor his doctors had a particular concern that he may have been suffering from any form of cancer on the policy's effective date.[308] Therefore, the court held that it would not make sense to say the insured's doctor offered medical advice or treatment for her cancer prior to the policy's effective date.[309]

The widow of the deceased insured in *LoCoco v. Medical Savings Insurance Co.*[310] sued Medical Savings on her own behalf and on behalf of her husband's estate, alleging Medical Savings denied coverage for her husband's lung cancer and canceled the health insurance policy at issue in bad faith. The Sixth Circuit upheld summary judgment in favor of Medical Savings, finding the deceased insured's lung cancer a noncovered preexisting condition. The policy defined the term as an illness "for which medical advice, care, or treatment" was recommended or received in the

301. *Id.* at 655.
302. No. 07-4026-SAC, 2008 WL 4169306 (D. Kan. Sept. 10, 2008).
303. *Id.* at *11.
304. *Id.* at *5.
305. *Id.*
306. *Id.*
307. *Id.* at *6.
308. *Id.*
309. *Id.* at *11.
310. 530 F.3d 442 (6th Cir. 2008).

12 months immediately preceding the effective date of the policy[311] and precluded coverage for the first year for "loss due to pre-existing condition or natural progression of a pre-existing condition," unless such condition was disclosed in the policy application.[312] While the insured had not received a definitive diagnosis of lung cancer prior to the effective date of the policy, he failed to disclose that he had sought and received treatment for a respiratory ailment prior to the effective date of the policy and that his physician suspected lung cancer and recommended additional tests.[313] The court further held that Medical Savings properly canceled the policy, noting that the plaintiffs never paid premiums at any time, and that "Medical Savings had no legal duty to notify them prior to cancellation for non-payment."[314]

G. *Secondary Coverage—No-Fault Insurance*

A motor vehicle insurer sued a health insurer to determine which company should pay for the medical treatment of a common insured injured in an automobile accident in *Metropolitan Property & Casualty Insurance Co. v. Blue Cross Blue Shield of Massachusetts, Inc*.[315] Under the "personal injury protection" definition of Massachusetts' no-fault insurance statute,[316] the first $2,000 in medical costs were to be paid under the automobile insurance policy, but the companies disagreed as to whether the health insurer could defer coverage of medical costs above $2,000 where the insured purchased optional medical payment benefits as part of his automobile policy. In denying coverage, the health insurer cited a clause in its subscriber certificate providing "[u]nless otherwise required by law, coverage under this contract will be secondary when another plan [defined to include 'automobile insurance, including medical payments coverage'] provides you with coverage for health care services."[317] The Massachusetts Supreme Court, which transferred the case from the appellate court on its own initiative, affirmed summary judgment for the health insurer, finding the automobile insurer failed to identify any statutory language in the Massachusetts no-fault insurance statute or any other statute that prohibited such deferral. Accordingly, the supreme court held the health insurer's practice of denying coverage because of the existence of optional medical payment benefits was permissible.

311. *Id*. at 446.
312. *Id*.
313. *Id*. at 444–45.
314. *Id*. at 449.
315. 885 N.E.2d 825 (Mass. 2008).
316. *Id*. at 827 (citing Mass. Gen. Laws ch. 90, § 34A).
317. *Id*.

H. *Workers' Compensation Exclusion*

Plaintiff in *Vanegas v. Board of Trustees of Health and Welfare Fund for the International Union of Operating Engineers*[318] alleged his claim for medical benefits was improperly denied under the "work related injury exclusion" of the plan at issue, which excluded benefits for any "injuries or diseases to the extent that the covered person is required to be covered by a workers' compensation law."[319] The plan administrator, CareFirst, argued the medical procedures at issue, which took place during the years 2004–2006, were directly related to a factory injury suffered by plaintiff in California in 1986, and, as such, fell under the auspices of the California workers' compensation law, and were excluded from coverage under the plan. The court found CareFirst's determination that the 2004–2006 medical procedures were related to the 1986 factory injury reasonable.[320] However, the court went on to note under California workers' compensation law, coverage is available where an original injury causes a "new and further injury" to arise within five years.[321] The court held that, while the injuries necessitating the 2004–2006 procedures were caused by the 1986 injury, the five-year statute of limitations had expired. Because no workers' compensation coverage was "required" under any law, the plan exclusion was inapplicable, and the court granted summary judgment to plaintiff.

VI. LIFE INSURANCE

A. *Bad Faith Delay*

An investor-beneficiary in a viatical insurance settlement sued the insurer after receiving the life insurance policy proceeds in *Mohnkern v. Professional Insurance Co.*,[322] alleging a delay in payment in violation of state law and seeking statutory attorney fees.[323] The delay of payment, however, had been necessitated by a separate court proceeding in which the court ordered the proceeds paid into its receiver's escrow account. The Sixth Circuit framed the issue as follows: "does the Florida statute automatically award attorneys' fees upon a successful outcome by the beneficiary/insured? Or does the statute require the insurer to have wrongfully caused the insured/beneficiary to resort to litigation before attorneys' fees can be awarded?"[324] The court acknowledged the technical language of the statute

318. 554 F. Supp. 2d 592 (D. Md. 2008).
319. *Id.* at 594.
320. *Id.*
321. *Id.* (citing CAL. LAB. CODE § 5410 (West).
322. 542 F.3d 157 (6th Cir. 2008).
323. *Id.* at 161 (citing FLA. STAT. ANN. § 627.428 (2005)).
324. *Id.*

supported the beneficiary's position because she "was compelled to sue to enforce her rights under the policy,"[325] but also noted the purpose of the statute was "to discourage the contesting of valid claims."[326] The court explained the insurer neither contested nor denied her claim and "never wrongfully caused [the beneficiary] to resort to litigation, rather [the insurer] was forced to abide by the district court's order."[327] Accordingly, the Sixth Circuit affirmed the district court's ruling.

B. *Condition Precedent—Health "As Stated"*

The insured in *Liu v. Fidelity & Guaranty Life Insurance Co.*,[328] who died from liver failure and lung cancer approximately three months after applying for his life insurance policy, stated on the application that he had not been treated for or diagnosed with cancer, a cyst, or a tumor in the previous ten years. In support of its claim denial, Fidelity argued it had not entered into an insurance contract because the insured did not satisfy its condition precedent: the "Health as Stated Clause." Applying Texas law and affirming summary judgment for the beneficiary, the Fifth Circuit held that although the insured's health was not as stated when he completed the application, his answers on the application were representations, not warranties that could make the coverage void or voidable. Further, the appellate court affirmed the district court's holding that Fidelity was required to "plead the elements of a misrepresentation in order to avoid coverage," but had not done so.[329] Because the appellate court affirmed this holding, it declined to address the district court's alternative holding that Fidelity owed the beneficiary the life insurance proceeds because the "General Provisions" portion of the policy indicated all "statements" on the application were representations.[330]

C. *Divorce*

The Ninth Circuit reversed the district court's award of life insurance proceeds to the insured's estate for intestate division among the insured's second wife and two children, in *Life Insurance Co. of North America v. Ortiz*,[331] finding that a divorce judgment did not extinguish the insured's first wife's expectancy interest in her ex-husband's life insurance proceeds,[332] for which she remained the beneficiary. In a biting dissent, Chief Judge Kozinski

325. *Id.* at 162.
326. *Id.*
327. *Id.*
328. 282 F. App'x 304 (5th Cir. 2008).
329. *Id.* at 309.
330. *Id.*
331. 535 F.3d 990 (9th Cir. 2008).
332. *Id.* at 993.

stated that the majority reached "a senseless, unjust and cruel result by awarding half a million dollars to the former wife of a peace officer felled in the line of duty, leaving the officer's widow and children out in the cold."[333] Judge Kozinski found that the law, facts, equities, common sense, and district court's findings all supported the just result of awarding the proceeds of policies "meant to protect the officer's loved ones to the people he actually loved," as opposed to a woman "who wasn't his dependent and whom, by all accounts, he despised."[334] In closing, Judge Kozinski excoriated the majority's "herculean efforts to swim against the current of California caselaw" with the end result of perpetrating an injustice in response to which he fully expects the insured to "yell[ ] from his grave."[335]

D. *Duty to Read Policy*

The Alabama Supreme Court rejected the fraud and negligence claims of an insured who admittedly did not read his policy, reversed a jury verdict in favor of the insured, and entered judgment in favor of the insurer in *AmerUS Life Insurance Co. v. Smith*.[336] On appeal, the court held that a plaintiff who is capable of reading documents, but who does not read them or investigate facts that should provoke inquiry, has not reasonably relied upon a defendant's oral representations that contradict the written terms in the documents.[337] While a relationship existed between the insured, as minister, and the agent as a member of the minister's church, the court found that relationship did not rise to the kind of special/confidential relationship that would relieve the insured of his duty to read the policy.[338] (The court noted the exception might have applied to the relationship had the insured been the member and the agent, the minister.[339]) The court concluded the language of the policies should have provoked inquiry or a simple investigation into the facts. The insured "blindly trust[ed]" the agent and "close[d] [his] eyes where ordinary diligence require[d] [him] to see."[340]

E. *Felony Exclusion*

In *Steele v. Life Insurance Co. of North America*,[341] plaintiff's husband, an ERISA plan participant, died in an automobile accident while he was driving under the influence of alcohol. The plan insurer denied plaintiff's claim

333. *Id.* (Kozinski, C.J., dissenting).
334. *Id.* at 995–96.
335. *Id.* at 999.
336. No. 1061535, 2008 WL 4277861 (Ala. Sept. 19, 2008).
337. *Id.* at *7 (citation omitted).
338. *Id.* at *9.
339. *Id.*
340. *Id.* (citation omitted).
341. 507 F.3d 593 (7th Cir. 2007).

based on a plan exclusion for loss resulting from the commission of a felony. The Seventh Circuit, evaluating the case as a coverage dispute under state law, held, "[i]f the insured's conduct is punishable as a felony, the insured's commission of that conduct is enough to come within the language of the policy's felony exclusion regardless of whether a felony *conviction* is actually sought or obtained."[342] The appellate court found that the plaintiff's claim fell within the policy's felony exclusion since the deceased's death resulted from his third DUI and, therefore, was punishable as a felony under Illinois law.

F. *Insurable Interest*

The court examined the nature of an insurable interest based on an economic relationship in *North American Co. for Life and Health Insurance v. Lewis*.[343] The insured purchased a $750,000 policy and named Charles Lewis as the beneficiary in connection with a contract for Lewis to purchase the insured's interest in certain real estate. The property at issue was held in trust with the insured to own the property if still alive on December 21, 2009. Lewis was to pay the insured in yearly installments, with the final payment to be made once the insured obtained the title and conveyed the property to Lewis. The policy was intended by the parties to protect Lewis in the event the insured died, and Lewis lost the right to acquire the property as a result. The policy was to terminate once Lewis had the deed to the property. The insured died in 2006 and at the time of death, Lewis had paid a total of $300,000 in installment payments. The insured's heirs made a claim for the remaining $450,000 in policy proceeds, arguing that Lewis had no further insurable interest. The court found Lewis had an uninsurable interest in the full $750,000. The court acknowledged that "in order to be entitled to proceeds from an insurance policy, the purchaser of the policy must have an insurable interest in the property or life insured" in keeping with "the public policy that one should not be permitted to wager on or have a direct interest in the loss of life or property of another."[344] The court explained that, to have an insurable interest in another, there must be a reasonable basis to expect an advantage from the continued life of the insured such as a pecuniary gain, blood interest, or affinity towards the insured. The court held that the beneficiary "had a substantial economic interest in having [the insured's] life continue"[345] because Lewis's interest in ultimately acquiring the property and profiting from its future development was significantly greater than $750,000.

342. *Id*. at 597.
343. 535 F. Supp. 2d 755 (S.D. Miss. 2008).
344. *Id*. at 759.
345. *Id*. at 762.

G. *Misrepresentation*

The insurer in *American General Life Insurance Co. v. Schoenthal Family, LLC*[346] sought rescission of the policy at issue and pursued an action in interpleader to settle the disbursement of the refunded premiums,[347] after it denied a claim for $7 million in benefits on the grounds that the application contained material misrepresentations about the insured's net worth and yearly income. First, the court determined American had not waived its right to seek rescission under Georgia law, which requires "a party seeking rescission to 'restore, or offer to restore, the consideration received *as a condition precedent to bringing the action*,'" because interpleader action constituted an offer to restore the premium amounts.[348] Next, the court recognized that, under Georgia statutory law, "an insurer can rescind an insurance contract if an insured made a misrepresentation 'material to either the risk or hazard assumed by the insurer,'"[349] and the material misrepresentation is one that would influence a prudent insurer, an objective standard, rather than inquire into what a particular insurer would have done had it known the truth.[350] The court concluded that no prudent insurer would have issued the policy based on the financial material misrepresentations on the application and granted summary judgment in American's favor.[351]

The plan administrator denied plaintiff's claim in *Johnson v. Connecticut General Life Insurance Co.*[352] on the grounds that the decedent had failed to disclose on her policy application that she had asthma and hypertension.[353] The court held the decedent's failure to disclose asthma and hypertension were not willful and material, and therefore were insufficient to permit the insurer to properly deny benefits under Ohio law.[354] The court found that the decedent's failure to disclose her hypertension was neither false nor willful, as she was aware of a history of "labile, or erratic" blood pressure, but unaware of any history of high blood pressure, at the time she completed the policy application.[355]

The insured in *PHL Variable Insurance Co. v. Fulbright McNeill, Inc.*[356] relied upon the statements of a physician and a paramedic that he was in good health when he completed both parts of the policy application. A few

346. 248 F.R.D. 298 (N.D. Ga. 2008).
347. *Id.* at 303.
348. *Id.* at 309 (quoting Nexus Servs., Inc. v. Manning Tronics, Inc., 410 S.E.2d 810, 811 (Ga. Ct. App. 1991)).
349. *Id.* (quoting Ga. Code Ann. § 33-24-7(b)(2)).
350. *Id.*
351. *Id.* at 310.
352. 541 F. Supp. 2d 935 (N.D. Ohio 2008).
353. *Id.* at 937.
354. *Id.* at 940.
355. *Id.*
356. 519 F.3d 825 (8th Cir. 2008).

weeks after completing the second part of the application, however, the insured took a coronary test, which his physician told him showed that he had a ninety percent chance of having a heart attack and a "high risk of cardiovascular disease."[357] When PHL issued the policy, its agent incorrectly informed the insured "that he need not read the [policy] acceptance form because the form merely confirmed delivery of the policy."[358] However, the acceptance form had an "express affirmation" that the insured's health condition representations remained unchanged since he completed the second part of the application.[359] The insured signed the acceptance form but did not disclose the results of his coronary test. The insured died of a heart attack approximately six months later. The Eighth Circuit affirmed summary judgment for PHL, concluding the insured had a duty to inform it "of the substantial change in his health condition assessment that occurred after he completed the application."[360] The court also held that the insured's failure to inform PHL of the coronary test results was a material misrepresentation in the application at the time the policy was issued. The court based its decision on the common-law doctrine, recognized by the Arkansas Supreme Court, "that, as a matter of utmost good faith and fair dealing, if an applicant for insurance discovers facts that make portions of his application no longer true while the company deliberates, he must make full disclosure of the newly discovered facts."[361]

H. *Mistake in Payment*

The court addressed the proper distribution of life insurance benefits mistakenly paid to a former beneficiary in *Standard Insurance Co. v. Burch*.[362] After the insured's death, the insurer promptly but mistakenly distributed group life insurance proceeds to the decedent's legally separated husband (Burch), in addition to their two children, based on an old beneficiary designation form. The insurer placed the proceeds in a draft account for which it delivered Burch and the children checkbooks. After one of the children informed the insurer that the current designation form did not include Burch, the insurer left messages and sent a letter advising Burch the proceeds paid to him were "paid in error" because he was not a named beneficiary and requesting immediate repayment.[363] Thereafter, the insurer brought a declaratory judgment action, naming Burch and the children as

357. *Id.* at 827.
358. *Id.*
359. *Id.*
360. *Id.* at 828.
361. *Id.* at 829.
362. 540 F. Supp. 2d 98 (D.D.C. 2008).
363. *Id.* at 103.

defendants, and sought a temporary restraining order (TRO) and preliminary injunction to prevent Burch from dissipating the proceeds.[364] Burch appeared with counsel at a TRO hearing, where the court enjoined him from spending or transferring any relevant funds.[365] After *each* of the aforementioned communications, legal processes, or court actions, Burch wrote or cashed checks from the account or transferred proceeds among several banks.[366] The court "easily concluded" that the subsequent designation form was valid, that the children were the sole intended beneficiaries of the decedent, and that Burch was "unjustly enriched by his receipt and squandering of [monies] from [the insurer] and that he should be ordered to repay all of it, since he did not begin his spending spree until after [a Senior Life Benefits Analyst's] phone call . . . alerting him that there was an issue with the distribution."[367]

I. *Premiums*

Plaintiff, in *Pate v. Conseco Life Insurance Co.*,[368] purchased a life insurance policy and agreed to pay a planned monthly premium for it. Several years later, the insurer notified the plaintiff that if he did not pay an increased premium, the policy would lapse.[369] The Mississippi Supreme Court reversed the trial court's granting of summary judgment to the insurer, holding that the unambiguous terms of the life insurance policy did not allow the insurer to require the plaintiff to pay an increased premium. The court further held that because the policy did not unambiguously or clearly provide for "an increase in the monthly planned premium," plaintiff's cause of action did not arise until the insurer notified him of the increased premium, and therefore the plaintiff timely filed his breach of contract action within the three-year statute of limitations period.[370]

VII. CONCLUSION

As has been true for the last several years, ERISA cases continue to dominate this survey, particularly as courts struggle with how to interpret the *Glenn* decision. After less than a year, courts are already reaching conflicting results about how to handle discovery requests in post-*Glenn* ERISA benefits cases. Other cases reflect some of the issues that came to a head in

364. *Id.*
365. *Id.* at 103–04.
366. *See id.* at 102–04.
367. *See id.* at 106.
368. 971 So. 2d 593 (Miss. 2008).
369. *Id.* at 594.
370. *Id.* at 595–96.

this election year. The Michigan Supreme Court's ruling on the availability of domestic partner benefits for public employees may be echoed soon in other states that have passed similar definitions of marriage. The issue of when a drunk-driving death is an accident, and when it is not, continues to generate case law nationwide. While we have not been able to include every case arising out of the life, health, or disability insurance context in this article, we hope our summary gives the reader a good sense of the trends in these areas of the law.