RECENT DEVELOPMENTS IN HEALTH, LIFE, AND DISABILITY INSURANCE

William A. Chittenden III, Elizabeth G. Doolin, Joseph J. Hasman, and Julie F. Wall

William A. Chittenden III, Elizabeth G. Doolin, and Joseph J. Hasman are partners and Julie F. Wall is an associate at Chittenden, Murday & Novotny LLC in Chicago.

I. INTRODUCTION

This year, your authors have endeavored to bring you the cases of greatest interest: life and accident cases addressing pertinent questions of coverage, ERISA cases demonstrating continued struggles with the standard of review and the scope of discovery in the wake of *Metropolitan Life Insurance Co. v. Glenn*,[1] and disability cases confronting difficult issues arising out of disability claims, particularly those involving mental illness and addiction.

II. ACCIDENT INSURANCE

A. *Accident versus Sickness*

This year saw mixed decisions on whether a loss results from an accident when sickness is involved. In *Flores v. Monumental Life Insurance Co.*,[2] the insured injured her arm in a fall. After surgery she was released to a rehabilitation facility, where she died within a few hours of arrival. An autopsy showed the cause of death was Verapamil toxicity; the insured had taken this blood pressure medication for several years prior to her death. The court found the accidental death claim fell outside the coverage of the policy, which required that "Injury must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness."[3] The court concluded there was no accident that caused the insured's death "independent of all other causes," as required by the policy.[4]

1. 128 S. Ct. 2343 (2008).
2. No. CIV-08-1067-F, 2009 WL 1138050 (W.D. Okla. Apr. 27, 2009).
3. *Id.* at *2.
4. *Id.* at *6.

The court in *McAuley v. Federal Insurance Co.*[5] reached a similar conclusion. The insured in *McAuley* died in his sleep after he returned home from an international business trip. Plaintiffs argued the insured died as a result of acute bilateral pulmonary thromboemboli, which resulted from his airplane flight earlier that day.[6] Federal countered that although the insured's death may have been sudden and unexpected, it was not the consequence of an accident, as required by the language of the policies at issue.[7] The court agreed, holding the policy required an accident (and not an otherwise uneventful flight) be the cause of any unexpected death.[8] The court also found that even if they had been otherwise covered, the claims would have been excluded from coverage by the policies' disease, illness, or bodily malfunctions exclusions.[9]

The court was more willing to find in favor of coverage when the accident was more closely tied to the "sickness" in *Sellers v. Zurich American Insurance Co.*[10] The insured tore a tendon in his knee during training exercises at the cable company for which he worked. His knee surgery included the insertion of a metal wire, which eventually broke in several places, requiring another surgery to remove the wire. The insured later suffered an acute pulmonary embolism and fatal heart attack. Relying on the Seventh Circuit's decision in *Senkier v. Hartford Life & Accident Insurance Co.*,[11] the insurer argued that a death from surgical complications is due to illness and not an accident. The court disagreed, holding the insurer misinterpreted the policy language and the *Senkier* decision, and that "the death does not necessarily have to be a direct result of [or solely caused by] the injury."[12]

B. *Felony/Intoxication*

This year's lone felony/intoxication case raises an interesting question: when is driving under the influence a felony? In *Kay-Woods v. Minnesota Life Insurance Co.*,[13] the insured died in a single-vehicle accident while driving with a revoked license and under the influence of alcohol and cocaine. The policy provided that benefits would not be paid if the death resulted from or was caused directly by commission of a felony. Although the spouse argued the cause of the revoked license was a previous reckless driving

5. No. 4:05CV1826, 2009 WL 913510, at *1 (E.D. Mo. Mar. 31, 2009).
6. *Id.* at *5.
7. *Id.* at *10.
8. *Id.* at *19.
9. *Id.* at *23.
10. 615 F. Supp. 2d 816 (E.D. Wis. 2009).
11. 948 F.2d 1050 (7th Cir. 1991).
12. *Sellers*, 615 F. Supp. 2d at 820.
13. 622 F. Supp. 2d 704 (S.D. Ill. 2009).

conviction, the evidence showed this same reckless driving conviction extended an earlier DUI license revocation. Under the Illinois Vehicle Code, driving under the influence of alcohol on a revoked license that resulted from a previous DUI violation was a Class 4 felony; therefore, the district court ruled that the felony exclusion applied.[14]

C. *Foreseeability*

The court in *Munger v. Transguard Insurance Co. of America, Inc.*[15] distinguished between a foreseeable *event* and a foreseeable *injury* in upholding a denial of an accident claim. The plaintiff, a tractor and trailer operator, sustained injury to his back while performing the duties of his employment, which he had done "hundreds of times" over the years.[16] In affirming Transguard's claim denial, the court found that regardless of whether the *injury* was unforeseeable, unexpected, and unintended, in order to satisfy the definition of accident in the policy, the injury must have been caused by an *event* that was unforeseeable, unexpected, and unintended.[17] The court found plaintiff's voluntary action while performing his work was the foreseen consequence of an undertaking that resulted in his foreseeable injury, such that his injury was not covered under the policy.[18]

D. *Self-Inflicted Injury*

In the context of an ERISA claim in which the insurer's structural conflict of interest was a factor in the court's analysis, the court concluded the record was insufficient to determine if the insured's drinking antifreeze was accidental in *Catledge v. Aetna Life Insurance Co.*[19] The policy excluded loss "caused or contributed to by: an intentional self-inflicted injury" or "use of . . . intoxicants."[20] According to the death certificate, corroborated by police reports, the insured died after he "drank antifreeze," which the coroner called an "accident."[21] The court criticized Aetna for failing to construe what the decedent's intent was when he drank antifreeze and concluded Aetna should have sought "to clarify the ambiguous record *prior to making a decision* on the intertwined questions of whether [the insured] died" of accidental causes.[22]

14. *Id.* at 709.
15. No. 284574, 2009 WL 1717393, at *1 (Mich. Ct. App. June 18, 2009).
16. *Id.* at *1.
17. *Id.*
18. *Id.*
19. 594 F. Supp. 2d 610 (D.S.C. 2009).
20. *Id.* at 613.
21. *Id.*
22. *Id.*

III. DISABILITY INSURANCE

A. *Addiction*

The court found the risk of relapse following plaintiff's treatment for an opioid addiction constituted a disability under the terms of her employee benefit plan in *Colby v. Assurant Employee Benefits*.[23] Plaintiff was an anesthesiologist; after her addiction was discovered, she relinquished her medical license and checked herself into a treatment facility. Upon being discharged from the treatment facility, plaintiff's physicians recommended she not return to work for six months to allow her to continue to work on her recovery and avoid the risk of relapse. Concluding "the potential for relapse is not the same as current disability," the insurer terminated plaintiff's benefits following her release from in-patient treatment.[24] Noting the plan's terms made no distinction between mental and physical disabilities, the court found if the risk of relapse due to a physical sickness constituted a disability under the plan, the risk of relapse due to a mental illness also must constitute a disability.[25]

B. *Mental Illness*

Courts continue to struggle when policy limitations for mental illness conflict with claims of physical disability. When a mental illness is clear-cut, courts find in favor of the limitation; they are less willing to do so when a more physical condition can be responsible, in part, for the claimed disability. Thus, in *Doe v. Hartford Life and Accident Insurance Co.*,[26] the court upheld Hartford's decision that plaintiff's bipolar disorder fell within his ERISA plan's twenty-four-month mental illness limitation. The plan defined mental illness as "any psychological, behavioral, or emotional disorder, or ailment of the mind," but did not refer to a standardized medical reference guide or list of examples.[27] As a result, the court found there was no clear guidance on whether bipolar disorder fit within the plan's definition of "mental illness," and concluded the benefits limitation "is subject to reasonable alternative interpretations."[28] Plaintiff then argued, "under the doctrine of contra proferentum if a plan term is ambiguous, the ambiguity should be resolved in favor of the insured."[29] The court rejected plaintiff's argument and found Hartford's conclusion was reasonable "when consid-

23. 603 F. Supp. 2d 223 (D. Mass. 2009).
24. *Id.* at 234.
25. *Id.* at 244.
26. No. 05-2512 (JLL), 2008 WL 5400984 (D.N.J. Dec. 23, 2008).
27. *Id.* at *4.
28. *Id.* at *10.
29. *Id.* at *4.

ered in light of the limitation language which limits benefits when a claimant is disabled for 'mental illness that results from any cause.' "[30]

The court reached a different conclusion in *Gunn v. Reliance Standard Life Insurance Co*.[31] The insured in *Gunn*, who suffered from multiple sclerosis (MS) and severe depression, received disability benefits from Reliance. At the conclusion of the policy's twenty-four-month "own occupation" period, Reliance advised him it would review his case to determine whether he was disabled from performing the duties of "any occupation." When a medical review concluded ninety-nine percent of the insured's disability stemmed from his psychiatric condition and only one percent from his MS, Reliance terminated his benefits under the policy's twenty-four-month mental disorder limitation. Finding that Reliance abused its discretion in terminating the benefits, the court determined that because the summary plan description (SPD) and the policy language conflicted, the language in the SPD favoring the insured applied, and concluded that the policy's twenty-four-month mental disorder limit would not apply unless the insured's inability to work was *solely* attributable to depression.[32]

Similarly, in *Michaels v. The Equitable Life Assurance Society of the United States Employees, Managers & Agents Long Term Disability Plan*,[33] the Third Circuit found the plan administrator's interpretation of an ERISA long-term disability plan to be unreasonable where it precluded plaintiff from receiving benefits after twenty-four months based on any mental condition, even though the participant had a totally disabling physical condition.[34] The plan specifically permitted benefits to continue beyond twenty-four months for disabilities arising from something other than a mental condition and gave the administrator discretion to continue *or* terminate benefits if the participant suffered from both mental and physical conditions, so long as the combined effect rendered the participant totally disabled. The court rejected the administrator's view that the plan's limitation on benefits applies if a mental condition exists, notwithstanding the presence of a totally disabling physical condition, finding this interpretation would lead to the absurd result of rendering the participant's physical condition completely irrelevant, as the presence of any mental condition would negate the effect of total physical disability.[35]

30. *Id*. at *11.
31. 592 F. Supp. 2d 1251 (C.D. Cal. 2008).
32. *Id*. at 1261.
33. 305 F. App'x 896 (3d Cir. 2009).
34. *Id*. at 903–04.
35. *Id*.

In the context of *de novo* review in an ERISA benefits case, the court in *Jewell v. Life Insurance Co. of North America*[36] found that whether an illness fell under the plan's twenty-four-month mental illness limitation depended on whether the condition was organic or nonorganic. Under the plan, an organic brain disorder resulted from physical changes in the brain structure, such as from lesions or changes resulting from physical injury to the brain. A nonorganic or psychiatric brain disorder was a mental illness that was not caused by physical changes to the brain. In the case at issue, while the objective medical tests did not confirm an organic cause, the subjective evidence presented by the insured's doctors supported such a diagnosis. The court interpreted the phrase "caused or contributed to by" to mean: "if an employee suffers from an organic brain dysfunction as well as a non-organic psychiatric illness, the employee's non-organic psychiatric illness has not 'contributed to' the employee's disability if the organic brain dysfunction would be independently disabling even without the presence of the psychiatric illness."[37] The court found that the preponderance of the medical evidence established that organic brain dysfunction caused or contributed to the insured's disability and, therefore, the mental illness limitation did not apply.[38]

C. *Objective Evidence*

The court rejected the notion that lack of "objective evidence" was a sound basis to deny an ERISA disability benefits claim in *Lee v. BellSouth Telecommunications, Inc*.[39] BellSouth argued plaintiff failed to submit objective medical evidence of her chronic pain syndrome. While the court agreed the plan required plaintiff to provide objective medical evidence of her condition, it disagreed that she had not done so. Noting there is "no laboratory dipstick test to diagnose chronic pain syndrome,"[40] the court found plaintiff had done more than enough because she had "presented repeated evidence of medical tests and examinations completed by pain care specialists supporting a diagnosis of chronic pain syndrome" and "it was unclear what additional 'objective' evidence of her condition" could have been provided.[41] The court also criticized BellSouth's reliance on peer reviewers, who completely ignored the clear reports of plaintiff's physicians identifying her syndrome and pain, and rejected BellSouth's

36. No. 04-cv-00122-ZLW-BNB, 2009 WL 792227 (D. Colo. Mar. 20, 2009).
37. *Id*. at *11.
38. *Id*. at *14.
39. 318 F. App'x 829 (11th Cir. 2009).
40. *Id*. at 837.
41. *Id*. at 838–39.

conclusion that plaintiff could perform "sedentary" work when her physicians reported that she could not "move, speak, or breathe freely."[42]

D. *Own Occupation*

In *Doe v. Provident Life & Accident Insurance Co.*,[43] the insured, a physician allegedly suffering from post-traumatic stress disorder ("PTSD") resulting from his emergency room work, sought total and residual disability benefits. Citing his PTSD, the insured reduced his full-time emergency room work hours, supplementing them with work as an internist. Applying Virginia law to the insured's breach of contract claim, the court granted Provident Life's motion for summary judgment regarding the claim for total disability. The court noted the insured's "earliest possible onset of his alleged total disability" occurred when he worked primarily as an internist, and that his occupation was that of a "physician," not merely an "emergency room physician," under the policy's terms.[44] Concluding the policy's contemplated duties under the definition of residual disability were more specific than for total disability, however, the court denied Provident Life's motion for summary judgment regarding the residual disability claim.[45]

IV. ERISA

A. *Administrative Record*

In considering the administrative record in ERISA benefits cases, courts this year addressed both what must be included in the administrative record and the admissibility of its contents. In *Nally v. Life Insurance Co. of North America*,[46] plaintiff argued her deceased husband's employee benefit plan impermissibly relied on evidence such as police and expert reports that would not be admissible under the Federal Rules of Evidence or the Supreme Court's decision in *Daubert v. Merrell Dow Pharmaceuticals*.[47] The Third Circuit held that when the plan gives the plan administrator discretion to construe and interpret the plan, evidence in the administrative record is admissible "for the purpose of determining whether the administrator's review was arbitrary and capricious."[48] The court further noted that plaintiff failed to point to any legal support for her assertion that a plan

42. *Id.*
43. 601 F. Supp. 2d 290 (D.D.C. 2009).
44. *Id.* at 293.
45. *Id.* at 297.
46. 299 F. App'x 125 (3d Cir. 2008).
47. 509 U.S. 579 (1993).
48. *Nally*, 299 F. App'x at 129–30.

administrator deciding a claim for benefits could only consider evidence that would be admissible in a district court proceeding.[49]

In addressing the contents of the administrative record that must be disclosed to a claimant, the court in *Mondry v. American Family Mutual Insurance Co*.[50] concluded that a claim administrator's internal documents and guidelines could be subject to mandatory production in ERISA cases if the claims administrator expressly cites to such documents and equates them to plan language when ruling on a claim for benefits. The letters denying plaintiff's claim for benefits cited documents other than the SPD as the basis for the plan's denial of her claim, and the reasoning behind the denials turned on language that did not appear in the SPD. The claims administrator initially refused to produce the documents requested by plaintiff, even when the plan administrator intervened on her behalf, but eventually relented. The documents showed that denial of plaintiff's claim was improper and the claims administrator reversed it. The court further found that the plan administrator, even though it did not have direct control over the documents, could be liable for failing to produce them because it could have included in its contract with the claims administrator the right to obtain copies of any documents that it might be required to produce under ERISA.[51] The Seventh Circuit also confirmed the documents at issue fell within the scope of 29 U.S.C. § 1024(b)(4) and held that a plan fiduciary that fails to make the disclosures required by ERISA breaches its fiduciary duties to a participant like plaintiff.[52]

B. *Extra Record Evidence*—De Novo *Review*

A number of cases this year addressed the scope of evidence that can be considered under the *de novo* standard of review. These cases range from the more traditional "only if needed" rule to the "treat these cases like any other insurance dispute" approach taken by Judge Easterbrook in *Krolnik v. Prudential Insurance Co. of America*.[53] In *Krolnik*, the Seventh Circuit rejected the argument that discovery in ERISA benefits cases governed by the *de novo* standard of review should be limited. The court specifically held that a *de novo* review requires the court to make an independent *decision*, rather than an independent *review*.[54] To fulfill this fact-finding func-

49. *Id*.
50. 557 F.3d 781 (7th Cir. 2009).
51. *Id*. at 802.
52. *Id*. at 808.
53. 570 F.3d 841 (7th Cir. 2009).
54. *Id*. at 843.

tion, the court found discovery could be essential.[55] The Seventh Circuit directed that the court must weigh *all* of the medical evidence and, if the paper record contains a material dispute, conduct a trial.[56] Because the district court failed to weigh this evidence, did not mention any of the evidence favoring plaintiff in its decision, and did not explain why summary judgment was appropriate, the Seventh Circuit vacated the decision in favor of Prudential.[57]

In a less "all or nothing" approach, the court in *Beaty v. Prudential Insurance Co. of America*[58] found the district court abused its discretion by excluding evidence of plaintiff's alleged disability without considering whether the proffered evidence was necessary to make an adequate decision concerning plaintiff's eligibility for plan benefits.[59] The Ninth Circuit clarified that "[a]lthough a district court generally may consider only evidence contained in the administrative record, an exception exists when the court reviews a plan administrator's decision *de novo*."[60] In that instance, a district court has discretion to consider the evidence when necessary for an adequate review of plaintiff's claim.[61] In light of the district court's error, the Ninth Circuit reversed the judgment in favor of Prudential and remanded the case for further proceedings consistent with its opinion.[62] Following the Ninth Circuit's directive, the court in *Blackwood v. Sun Life Assurance Co. of Canada*[63] allowed plaintiff to augment the administrative record with additional medical records from the onset of her medical condition. The court stated it would exercise its discretion to supplement the administrative record only under unusual circumstances and when "necessary to conduct adequate *de novo* review of the benefit decision."[64]

C. *Fees*

This year's crop of ERISA attorney fees cases address the perennial issues: Who is entitled to fees? What fees can be recovered? How are fees measured? In evaluating who is entitled to fees, the court in *Colby v. Assurant Employee Benefits*[65] held that an ERISA plaintiff who obtained a remand of her claim was a prevailing party under ERISA. After the court awarded at-

55. *Id.*
56. *Id.* at 844.
57. *Id.* at 844–45.
58. 313 F. App'x 46 (9th Cir. 2009).
59. *Id.* at 47–48.
60. *Id.*
61. *Id.* at 48.
62. *Id.* at 49.
63. No. CVF08-1822 AWI DLB, 2009 WL 636571 (E.D. Cal. Mar. 11, 2009).
64. *Id.* at *4.
65. 635 F. Supp. 2d 88 (D. Mass. July 22, 2009).

torney fees and costs to the plan participant, *sua sponte*, the plan objected, arguing the plan participant was not a "prevailing party" because the court ordered a remand for further consideration of her claim. While acknowledging that the First Circuit incorporated a prevailing party requirement for a fee award, the court noted "prevailing party" is a "legal term of art."[66] In the First Circuit, a party prevails if they "succeed on any significant issue in litigation which achieves some of the benefit the parties sought in bringing suit."[67] Rather than adopt a bright-line rule that a court-ordered remand to the plan administrator always or never makes an ERISA plaintiff a prevailing party, the court held that an ERISA plaintiff who secures a court-ordered remand *may* be a prevailing party.[68] In this matter, plaintiff was a "prevailing party" because she achieved some of the relief she sought in bringing her lawsuit.[69]

The court in *Spectrum Health v. Valley Truck Parts*[70] also addressed the issue of who is entitled to a fee award, finding a medical provider that received an assignment of a beneficiary's claim for benefits was also entitled to attorney fees and costs under ERISA. In rejecting the defendant's argument that a medical provider could not seek attorney fees or costs because it was not an ERISA beneficiary or participant, the court noted that a "health care provider may assert an ERISA claim as a 'beneficiary' of an employee benefit plan if it has received a valid assignment of benefits."[71] The court further held that, as an assignee, a health care provider also has standing to seek both attorney fees and statutory penalties authorized by ERISA.[72]

Courts have been less willing to award fees incurred during administrative proceedings *prior* to ERISA litigation. For example, the *Colby* court rejected such a claim, finding that even though the plan participant was a "prevailing party" and entitled to recover reasonable attorney fees and costs, such recovery does not include fees and costs incurred during pre-litigation administrative proceedings.[73] Awarding pre-litigation fees and costs could undermine ERISA's purpose and might encourage plans to pay questionable claims in order to avoid liability for attorney fees.[74] Likewise,

66. *Id*. at 92.
67. *Id*.
68. *Id*. at 95.
69. *Id*.
70. No. 1:07-CV-1091, 2008 WL 5273627 (W.D. Mich. Dec. 17, 2008).
71. *Id*. at *1.
72. *Id*. at *2.
73. Colby v. Assurant Employee Benefits, 635 F. Supp. 2d 88, 98 (D. Mass. July 22, 2009).
74. *Id*. at 99.

in *Finks v. Life Insurance Co. of North America*,[75] the court rejected the prevailing plaintiff's claim to recover the fees she incurred during pre-litigation proceedings. Following the interpretation of the ERISA fee provision by the seven circuits that have addressed this issue, the court denied plaintiff's claim for legal fees incurred during the administrative proceedings.[76] It held ERISA's statutory fee provision language—"[i]n any *action* under this title"—does not include the term *proceeding* and, therefore, cannot include an award of pre-litigation attorney fees.[77]

Finally, one ERISA fee case this year upheld the amount of a fee award, despite a substantial reduction in the underlying benefit award after appeal. In *Delcastillo v. Odyssey Resource Management, Inc.*,[78] the court originally awarded plaintiffs $109,317.50 in attorney fees and costs after a two-day bench trial where it awarded plaintiffs $301,866.11 for ERISA and COBRA violations. After two appeals and two remands, the court concluded plaintiffs were entitled to recover just $3,759.30 in medical expenses and $2,528.32 in prejudgment interest.[79] Defendants argued the "fee award should be reduced in an amount comparable to the limited success achieved by plaintiffs on appeal."[80] Rejecting that argument, the court pointedly observed that "the defendants were alter ego corporations that were used to perpetuate the denial of [the plaintiff's] recourse and remedies" and stated that throughout this litigation defendants failed to raise a substantive factual defense to the wrongful denial and breach of fiduciary duty claims.[81] The court further found that defendants' conduct "was egregious, bordering on bad faith."[82] While the court acknowledged plaintiffs did not prevail on all of their claims, it concluded the claims were "not without merit."[83] Moreover, according to the court, "[a] comparison of the monetary value of the plaintiffs' recovery to the whole scope of the litigation is not appropriate where, as here, the defendants needlessly expanded the scope of the litigation by raising spurious defenses and unnecessarily prolonging the litigation."[84]

D. *Full and Fair Review/Adequacy and Sufficiency*

Courts continue to reject plaintiffs' demands for substantive remedies when they find procedural violations of ERISA in connection with con-

75. No. 08-1272 (ESH)(AK), 2009 WL 2230899, at*1 (D.D.C. July 24, 2009).
76. *Id.* at *8.
77. *Id.* at *7–8.
78. No. 8:01C342, 2009 WL 324167 (D. Neb. Feb. 9, 2009).
79. *Id.* at *2.
80. *Id.*
81. *Id.* at *3–4.
82. *Id.* at *4.
83. *Id.* at *4–5.
84. *Id.* at *5.

tested claims decisions. For example, in *Gagliano v. Reliance Standard Life Insurance Co.*,[85] after Reliance terminated the insured's long-term disability benefits, with a termination letter including the requisite notice of appeal rights, the insured filed an appeal, but then filed a civil action before the administrative review process was completed. Reliance completed its review and issued a second termination of benefits letter. This second letter did not advise the insured that she was entitled to an administrative appeal and, for the first time, cited the preexisting conditions limitation as the basis for denial of the disability benefits. The district court held that the second letter did not comply with ERISA's appeals-notice requirements and, as a remedy, reinstated the benefits on the grounds of waiver and estoppel.[86] The court of appeals affirmed the judgment of the district court with regard to the notice requirements of ERISA but held that a substantive remedy was inappropriate for a procedural ERISA violation; the correct remedy was a remand to the plan administrator for a "full and fair review" of the denial of benefits.[87]

In *Love v. National City Corporation Welfare Benefits Plan*,[88] the Seventh Circuit remanded a benefits decision back to the plan after it terminated plaintiff's disability benefits without providing a sufficient explanation for its reasoning. The court found neither the initial termination letter nor the subsequent letter denying plaintiff's appeal sufficiently explained the reasons for the denial. While both letters asserted that all relevant evidence had been considered, they did not address any reliable, contrary evidence presented by plaintiff.[89] In ruling the plan administrator acted arbitrarily and capriciously, the Seventh Circuit specifically noted that it was not ruling that plaintiff was totally disabled, only that the plan administrator failed to comply with ERISA by not providing a more thorough explanation for its determination.[90] Accordingly, the Seventh Circuit remanded this matter back to the plan so that it could conduct a more thorough inquiry into whether plaintiff met the definition of "disability" and properly document the reasons for its decision.[91]

The court rejected the insured's claim that she did not receive a "full and fair review" in *Midgett v. Washington Group International Long Term Disability Plan*.[92] The insurer denied short-term disability benefits after two

85. 547 F.3d 230 (4th Cir. 2008).
86. *Id.* at 239.
87. *Id.* at 240.
88. 574 F.3d 392 (7th Cir. 2009).
89. *Id.* at 397.
90. *Id.* at 398.
91. *Id.*
92. 561 F.3d 887 (8th Cir. 2009).

peer reviews, concluding the insured's medical records did not support a functional impairment that would prevent her from performing her sedentary duties as an assistant contract manager. The Eighth Circuit denied the insured's assertion that she should have been entitled to the opportunity to review and rebut the peer reviews prior to the decision on the administrative appeal.[93] The court also held that peer reviews did not need to be performed by examining physicians, the administrator was not required to provide detailed credentials for the peer reviewers, and the notification of the benefit determination did not require the plan administrator to discuss specific evidence submitted by the insured.[94] The court further rejected the insured's argument that the administrator's decision was arbitrary and capricious because it credited the conclusion of the peer reviewers, supported by reliable evidence, although in conflict with her treating physicians' conclusions.[95] The court upheld the dismissal of the insured's claim for long-term disability benefits because she did not exhaust the administrative remedies prior to filing her claim with the court.[96]

E. *Jury Trial*

The court in *Walker v. Life Insurance Co. of North America*,[97] followed established precedent that does not allow jury trials in ERISA benefits cases. The court granted the insurer's motion to strike the jury demand, noting that the Seventh Circuit has consistently held an ERISA claim for benefits is an equitable claim, under which a plaintiff has no right to a jury trial.[98] The court rejected the insured's argument that the Supreme Court's "classification of 'money damages' as 'legal relief' " in *Great-West Life & Annuity Insurance Co. v. Knudson*[99] compelled it to find the insured was entitled to a jury trial.[100] The court further noted that the insured sought only equitable relief, and "even under the *Great-West* framework" was not entitled to a jury trial.[101]

F. *Limitations Period*

Courts continue to recognize the validity of ERISA plan terms that provide a limitations period for legal actions. In two cases, the courts enforced such

93. *Id.* at 895.
94. *Id.* at 896.
95. *Id.* at 898.
96. *Id.* at 899.
97. No. 08 C 6768, 2009 WL 561834 (N.D. Ill. Mar. 2, 2009).
98. *Id.* at *1.
99. 534 U.S. 204 (2002).
100. *Walker*, 2009 WL 561834, at *2.
101. *Id.*

provisions that measured the limitations period from the date of required proof of loss, contrary to the Fourth Circuit's holding a few years ago in *White v. Sun Life Assurance Co. of Connecticut*.[102] As in *White*, the limitations period in *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*[103] prohibited a claimant from bringing legal action more than "three years after the time written Proof of Loss is required to be furnished."[104] Expressly rejecting the *White* decision, the Second Circuit upheld the enforceability of this limitations period even though it began before the plan participant could actually file suit because she had not yet exhausted her administrative remedies.[105] Noting that the reasonableness of the application of any limitations period was within the scope of a court's review, the court reasoned that the plan participant had ample time within which to bring suit because two years and five months of the limitations period remained after she exhausted her administrative remedies.[106] Similarly, the court in *Rice v. Jefferson Pilot Financial Insurance Co*.[107] upheld enforcement of a plan provision that stated, "No legal action may be brought more than three years after written proof of claim is required to be given."[108] Like the court in *Burke*, the *Rice* court found the application of the provision in that case was reasonable, taking particular note of the plan's provision that a claim would be considered denied ninety days after application, which would prevent any running of the limitations period before the insured could bring legal action.[109] Other decisions this year also upheld application of the plan limitations period to bar claims.[110]

G. *Post*-Glenn *Discovery*

The clear trend in light of the Supreme Court's ruling in *Metropolitan Life Insurance Co. v. Glenn*[111] is to allow *some* discovery into whether a plan in-

102. 488 F.3d 240 (4th Cir. 2007).
103. 572 F.3d 76 (2d Cir. 2009).
104. *Id*. at 79.
105. *Id*. at 81.
106. *Id*.
107. 578 F.3d 450 (6th Cir. 2009).
108. *Id*. at 453.
109. *Id*. at 456.
110. *See* Grasselino v. First Unum Life Ins. Co., No. 08-CV-635 (DMC), 2008 WL 5416403 (D.N.J. Dec. 22, 2008) (upholding limitations period running from claim denial letter that provided "clear repudiation" of plaintiff's claim); Klimowicz v. Unum Life Ins. Co. of Am., 296 F. App'x 248 (3d Cir. 2008) (rejecting argument that insured's appeal was a new claim not governed by plan's limitation period); Salisbury v. Hartford Life Accident Ins. Co., No. 08-3316, 2009 WL 3112411, at *1 (10th Cir. Sept. 30, 2009) (Tenth Circuit found limitations period was clear and unambiguous, and enforceable even if claim could accrue before end of administrative review).
111. 128 S.Ct. 2343 (2008).

surer's structural conflict of interest biased the claims decision at issue. The extent of discovery allowed, however, varies from jurisdiction to jurisdiction. The First Circuit in *Denmark v. Liberty Life Assurance Co. of Boston*[112] offered guidance regarding how district courts should approach discovery in ERISA cases in light of the Supreme Court's holding in *Glenn*. While finding that the "majority opinion in *Glenn* fairly can be read as contemplating some discovery on the issue of whether a structural conflict has morphed into an actual conflict," the court explained that "any such discovery must be allowed sparingly and, if allowed at all, must be narrowly tailored so as to leave the substantive record essentially undisturbed."[113] The First Circuit explained:

> In future cases, plan administrators, aware of *Glenn* can be expected as a matter of course to document the procedures used to prevent or mitigate the effect of structural conflicts. That information will be included in the administrative record and, thus, will be available to a reviewing court. Conflict-oriented discovery will be needed only to the extent that there are gaps in the administrative record. If, say, the plan administrator has failed to detail its procedures, discovery may be appropriate, in the district court's discretion. Otherwise, discovery normally will be limited to the clarification of ambiguities or to ensuring that the documented procedures have been followed in a particular instance.[114]

Then, noting that the case before it falls within a "special niche" of cases in which the denial of benefits and the commencement of the suit both predated *Glenn*, the court suggested that during these "temporally awkward circumstances" the district court may want to afford the parties "a limited opportunity to flesh out the record."[115]

The Sixth Circuit in *Johnson v. Connecticut General Life Insurance Co*.[116] rejected the idea that the *Glenn* decision means that "discovery will automatically be available any time the defendant is both the administrator and the payor under an ERISA plan," explaining that the limitation on discovery in cases where discretionary authority has been conferred results from the determination that matters outside of the administrative record ordinarily are not relevant to the court's review of a benefit decision under ERISA.[117] It then found that "[d]istrict courts are well-equipped to evaluate and determine whether and to what extent limited discovery is appropriate in furtherance of a colorable procedural challenge."[118]

112. 566 F.3d 1 (1st Cir. 2009).
113. *Id*. at 10.
114. *Id*. (footnote omitted).
115. *Id*.
116. 324 F. App'x 457, 467 (6th Cir. 2009).
117. *Id*. at 467.
118. *Id*. at 466–67.

Taking a less-than-limited approach, in *Hughes v. CUNA Mutual Group*,[119] the court compelled defendant to respond to discovery concerning the nature and extent of its conflict of interest, finding such discovery permissible as long as the expense did not outweigh its expected benefits.[120] Although the court recognized one way to balance the competing discovery considerations would be to allow conflict-related discovery after the parties submitted cross-motions for summary judgment, and only if the extent and effect of the inherent conflict of interest would matter to the court's decision, the court ultimately rejected that approach because defendant failed to show that its case was so strong and had already provided certain "self-serving" interrogatory responses describing steps it took to alleviate any inherent conflicts.[121] The court concluded that plaintiff was entitled to view defendant's selective discovery responses with skepticism and to test its skepticism by pursuing additional discovery.[122]

The court in *McQueen v. Life Insurance Co. of North America*[123] set greater limits on the scope of permissible discovery into bias.[124] Although the court found that discoverable information may include statistics about claim outcomes submitted to reviewers, "active steps" the administrator took to "reduce potential bias and to promote accuracy" (including "walling off claim administrators from those interested in firm finances"), and internal policies encouraging denials with employee rewards or pressure, it concluded that both discovery requests involving performance reviews and personnel files of reviewer employees are "unduly burdensome and their intrusiveness outweighs any likely benefit."[125] Similarly, the court in *Santos v. Quebecor World Long Term Disability Plan*,[126] while allowing limited discovery, cautioned that "such discovery must be narrowly tailored and cannot be a fishing expedition."[127]

119. 257 F.R.D. 176 (S.D. Ind. 2009).
120. *Id*. at 179.
121. *Id*.
122. *Id*. at 180; *see also* Fowler v. Aetna Life Ins. Co., 615 F. Supp. 2d 1130 (N.D. Cal. 2009) (court allowed the insured to conduct limited discovery regarding any bias Aetna may have had in making its claim decision and which documents Aetna chose to include in the administrative record).
123. 595 F. Supp. 2d 752 (E.D. Ky. 2009).
124. *Id*. at 754–55.
125. *Id*. at 756 (citation omitted).
126. 254 F.R.D. 643 (E.D. Cal. 2009).
127. *Id*. at 648; *see also* Elder v. Life Ins. Co. of N. Am., No. 4:07CV1387 CDP, 2009 WL 367701 (E.D. Mo. Feb. 11, 2009) (allowing limited conflict/bias discovery after the participant was found dead of accidental death due to autoerotic asphyxiation with traces of amphetamine and methamphetamine in his blood); Pemberton v. Reliance Standard Life Ins. Co., No. 08-86-SBJ, 2009 WL 89696, at *3 (E.D. Ky. Jan. 13, 2009) (the court noted that the scope of the discovery allowed "must be limited to the conflict of interest and any allegations of bias"); Wilcox v. Metro. Life Ins. Co., No. CV 04-0926 PHX-DGC, 2009

H. *Post*-Glenn *Standard of Review*

1. Evaluating Conflict

The gravity of a conflict of interest has been found to be a significant factor for courts in deciding whether the claim decision was proper. In *Marrs v. Motorola, Inc.*,[128] a participant sought recovery of long-term disability benefits under an ERISA plan. The Seventh Circuit held that the plan administrator's denial of disability benefits based on the employer's plan amendment was not an abuse of discretion, affirming the trial court's decision.[129] In so holding, the court found that defendant's decision would be reversed only if it were arbitrary and capricious.[130] After analyzing the *Glenn* decision, the Seventh Circuit considered under what circumstances a potential conflict of interest by a plan administrator is serious enough to be given weight in its review of a denial of benefits. Finding that the "*likelihood* that the conflict influenced the decision is . . . the decisive consideration," the court explained that it is "not the existence of a conflict of interest—which is a given in almost all ERISA cases—but the *gravity* of the conflict, as inferred from the circumstances, that is critical."[131] Ultimately, it concluded that "[t]here are no indications in this case" "that the plan administrator labored under a conflict of interest serious enough to influence his decision consciously or unconsciously—a decision that was otherwise entirely reasonable—decisively."[132]

The Seventh Circuit also addressed the impact of a conflict of interest on the standard of review in an ERISA case in *Raybourne v. Cigna Life Insurance Co*.[133] There, it vacated the district court's decision to grant summary judgment to defendant plan administrator who terminated plaintiff's long-term disability benefits under an ERISA plan and remanded the case to the district court because it was unclear whether it sufficiently applied the balancing analysis required by *Glenn*. The court noted that the Supreme Court in *Glenn* clarified that a structural conflict is only "one factor among many that are relevant in the abuse-of-discretion analysis," but it will "act

WL 57053, at *2–3 (D. Ariz. Jan. 8, 2009) (the court recognized potential relevant factors such as defendant's "evidence of malice, self-dealing, or a practice of denying benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record" but rejected the participant's claim for generalized discovery and, instead, limited discovery "(a) to those subjects most likely to reveal the effect of the conflict, (b) to a limited number of written discovery requests and depositions, and (c) to a relatively short period of time").

128. 577 F.3d 783 (7th Cir. 2009).
129. *Id*. at 786.
130. *Id*.
131. *Id*. at 789.
132. *Id*.
133. 576 F.3d 444 (7th Cir. 2009).

as a tiebreaker when the other factors are closely balanced."[134] The Seventh Circuit remanded the case to "ensure that the [district] court conducts in the first instance the balancing analysis that *Glenn* requires."[135]

The Fourth Circuit declined to alter the standard of review applicable when reviewing an ERISA plan's discretionary determination denying disability benefits in *Champion v. Black & Decker (U.S.) Inc.*,[136] despite the presence of a structural conflict of interest, without "evidence raising a concern that would increase the weight of the conflict."[137] There, the court noted that the plan "manifested an approach demonstrating an unbiased interest that favored [plaintiff]" when it overruled the initial denial of short-term disability benefits by the third-party administrator and voluntarily granted the participant a second appeal after she retained counsel—thereby "reducing the conflict factor 'to the vanishing point.'"[138]

In *Nolan v. Herald College*,[139] the district court allowed plaintiff to submit evidence outside the administrative record that bore on MetLife's structural conflict of interest at the summary judgment stage. On review, the Ninth Circuit found that the district court erred by considering and weighing that evidence without reference to the traditional rules of summary judgment (e.g., the requirement that evidence be viewed in the light most favorable to the nonmoving party).[140] Noting that the evidence permitted inferences of bias that could have materially affected the abuse of discretion standard of review, especially at summary judgment, the court found plaintiff was entitled to have that evidence examined by the district court at a bench trial, where a full and detailed inquiry into the bias issue, including the opportunity for additional evidence or testimony, would allow the court as the trier of fact to effectively determine bias with finality.[141]

2. Evaluating Standard of Review

Despite a clear directive from the *Glenn* Court that a plan insurer's structural conflict of interest does not change the applicable deferential standard of review, courts across the country continue to struggle with the standard of review post-*Glenn*. In *Degrado v. Jefferson Pilot Financial Insurance Co.*,[142] for example, the district court "dial[ed] back" the deference normally given

134. *Id.* at 449.
135. *Id.* at 450.
136. 550 F.3d 353 (4th Cir. 2008).
137. *Id.* at 362 (citation omitted).
138. *Id.* (citation omitted).
139. 551 F.3d 1148 (9th Cir. 2009).
140. *Id.* at 1154.
141. *Id.* at 1155.
142. No. 02-cv-01533-WYD-BNB, 2009 WL 279019, at*1 (D. Colo. Feb. 5, 2009).

to a plan administrator since the plan administrator was operating under a conflict of interest.[143] Applying a sliding scale approach, the court recognized that while there was evidence in the record to support a finding that plaintiff did not work enough for his disability to be treated as a "new" claim, a review of the administrative record, along with the lengthy history of the case, led to the conclusion that it was arbitrary and capricious to treat plaintiff's claim as "recurrent."[144]

In *Hession v. Prudential Insurance Co. of America*,[145] the Third Circuit reversed summary judgment for Prudential, which was both the insurer and plan administrator in an ERISA action for long-term disability benefits, remanding the action with instructions to award benefits to the insured. After finding that the district court "applied an improperly deferential standard of review," failed "to account for the structural conflict inherent in Prudential's decision, and did not recognize that procedural conflicts also were present," the court determined that "at least moderately, not just slightly, heightened arbitrary and capricious review was warranted based on [Prudential's] structural conflict."[146] The court also identified procedural irregularities "warranting heightened scrutiny," such as Prudential's termination of benefits one month after awarding them without further medical evidence and its retention of a reviewing physician *after* terminating benefits, *inter alia*.[147]

Contrary to these decisions, the Seventh Circuit in *Leger v. Tribune Co. Long Term Disability Benefit Plan*[148] determined that the *Glenn* decision did not create a new, heightened standard of review for claims involving a conflict of interest. Rather, explaining that the decision is "best read as an extension of the Court's previous decision in *Firestone*"[149] in that it illustrates "how the general principle established in *Firestone* should be applied to the more specific case in which responsibility for both claim determinations and pay-outs is vested in the same entity," the Seventh Circuit concluded that "[i]n such a situation, a court is required to take such an obvious conflict of interest into consideration—along with all of the other relevant factors—in determining whether the entity's determination was arbitrary and capricious.[150] The court also explained that "[i]t would be an even more

143. *Id.* at *16.
144. *Id.* at *32.
145. 307 F. App'x 650 (3d Cir. 2008).
146. *Id.* at 654.
147. *Id.* at 655.
148. 557 F.3d 823 (7th Cir. 2009).
149. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).
150. *Leger*, 557 F.3d at 831.

serious misreading of *Glenn* to suggest that it establishes a 'heightened arbitrary and capricious standard' for cases in which the administrator and the payor are two separate entities."[151]

In *Carden v. Aetna Life Insurance Co.*,[152] the Fourth Circuit rejected plaintiff's argument that the plan language regarding offset of "other income," if ambiguous, must be interpreted in his favor and against Aetna, due to Aetna's conflict of interest. The court noted that the Supreme Court's decision in *Glenn* foreclosed application of the "*contra proferentum*" rule, and that it must consider the conflict of interest "as only 'one factor among many'" in deciding the reasonableness of Aetna's decision.[153] The court concluded Aetna's interpretation of the offset language in the plan "was a reasonable one, if not the best one, and was consistent with the purposes stated in the plan."[154]

Also recognizing *Glenn*'s directive that judges should weigh a structural conflict of interest as they would any other pertinent factor when reviewing a denial of benefits, the First Circuit in *Denmark v. Liberty Life Assurance Co. of Boston*[155] analyzed the impact the Supreme Court's decision would have on the standard of review it articulated in its earlier cases. Noting "*Glenn*'s baseline principle" that judicial review of a benefit-denial decision is for abuse of discretion where the plan contains a sufficient delegation of discretionary authority to trigger deferential review, the court identified two ways in which its prior approach to the standard of review requires refinement.[156] First, post-*Glenn*, the "market forces rationale no longer allows a reviewing court to disregard a structural conflict without further analysis"; rather, *Glenn* requires "that structural conflicts be accorded weight—albeit not necessarily dispositive weight—in the standard of review equation," making courts "duty-bound to inquire into what steps a plan administrator has taken to insulate the decision making process against the potentially pernicious effects of structural conflicts."[157] Second, *Glenn* "makes explicit what was implicit in our earlier decisions; in cases in which a conflict has in fact infected a benefit-denial decision, such a circumstance may justify a conclusion that the denial was itself arbitrary and capricious (and, thus, an abuse of discretion)."[158]

151. *Id.*; *see also* McCauley v. First UNUM Life Ins. Co., 551 F.3d 126 (2d Cir. 2008) (rejecting "sliding scale" of deference as a result of conflict).
152. 559 F.3d 256 (4th Cir. 2009).
153. *Id.* at 260.
154. *Id.* at 262.
155. 566 F.3d 1 (1st Cir. 2009).
156. *Id.* at 9.
157. *Id.*
158. *Id.*

I. *Social Security*

This year, the Tenth Circuit in *Brown v. Hartford Life Insurance Co.*[159] followed the Sixth Circuit to hold that a court reviewing an insurer's disability determination should consider the "inconsistency created by" an insurer instructing its insured to apply for social security benefits and "reaping the benefits of" a successful determination of such application and then "summarily rejecting the evidentiary value of that determination."[160] The court found that defendant's failure to specifically explain why the Social Security Administration and the Oklahoma Workers' Compensation Court's disability determinations were not relevant must be considered when evaluating whether defendant acted arbitrarily or capriciously in denying plaintiff's claim for benefits.[161] Ultimately, because the district court erred in applying the *de novo* standard of review, the court reversed the district court's judgment for defendant and remanded the case. In remanding the matter, the court instructed the district court to "re-examine all the evidence in light of the applicable standard of review," asking it to weigh defendant's inherent conflict of interest and its "summary rejection" of the agencies' findings that the insured was disabled—noting that the court should take into account the "differing standards applied by the governmental agencies" and any financial benefit defendant derived from the agencies' determinations.[162]

J. *Standard of Review—Party with Discretion*

The Sixth Circuit addressed the need for the entity actually exercising the discretionary authority provided in an ERISA plan to be the entity to which the authority is granted in *Shelby County Health Care Corp. v. Majestic Star Casino, LLC.*[163] Although the plan documents clearly gave defendant discretionary authority to interpret the plan and make the final benefit decision, the Sixth Circuit upheld the district court's finding that the arbitrary and capricious standard of review did not apply because the third-party administrator for the plan, not defendant, made the decision to deny coverage, communicated that decision to plaintiff's counsel, and then simply "informed" defendant of the decision.[164] In so finding, the court noted that the plan explicitly stated that the third-party administrator is not a plan fiduciary and does not exercise any of the discretionary authority and

159. 301 F. App'x 772 (10th Cir. 2008).
160. *Id.* at 776.
161. *Id.*
162. *Id.* at 777.
163. Nos. 08-6078, 08-6419, 2009 WL 2997985 (6th Cir. Sept. 22, 2009).
164. *Id.* at *5–7.

responsibility granted the plan administrator.[165] The court concluded the defendant was "almost totally uninvolved in the decision to deny benefits" because the third-party administrator investigated the claim on its own, sent letters related to the claim on its letterhead, and advised defendant that the claim was not covered.[166]

K. *State Prohibitions on Discretionary Clauses*

In response to the Michigan Office of Financial and Insurance Services promulgating rules prohibiting insurers from issuing, delivering, or advertising insurance contracts or policies that contain "discretionary clauses," three insurance associations filed an action in federal district court seeking a declaration that these rules were preempted by ERISA. In *American Council of Life Insurers v. Ross*,[167] the Sixth Circuit affirmed the district court's conclusion that the rules are not preempted by ERISA, finding that they "fall within the ambit of ERISA's savings clause insofar as they are state laws regulating insurance."[168] Applying the test used in *Kentucky Ass'n of Health Plans v. Miller*[169] for determining whether a state law regulates insurance under ERISA's savings clause, the court considered whether the rules (1) are specifically directed towards entities engaged in insurance and (2) substantially affect the risk-pooling arrangement between the insurer and the insureds.[170] Rejecting plaintiffs' contention that the first prong of the *Miller* test is not met because the effect of the rules is primarily felt by the fiduciary administering the plan and not the insurer, the court found that the rules are in fact directed towards entities engaged in the business of insurance regardless of the fact that they may impact others, and concluded that "there can be no serious dispute" that the first prong of the *Miller* test is met because the rules "regulate *insurers* with respect to their *insurance practices*."[171]

The Sixth Circuit also rejected plaintiffs' position that the rules do not substantially affect the risk-pooling arrangement between insurers and insureds because they have an impact only *after* the risk has been transferred, explaining that the *Miller* test does not contain a timing element for when the "substantial [e]ffect" on the risk-pooling arrangement must occur.[172] It then concluded that the rules substantially affect the risk-pooling ar-

165. *Id*. at *5.
166. *Id*. at *5–6.
167. 558 F.3d 600 (6th Cir. 2009).
168. *Id*. at 602.
169. 538 U.S. 329 (2003).
170. *Ross*, 558 F.3d at 605.
171. *Id*.
172. *Id*. at 606.

rangement because they alter the scope of the permissible bargains between insurers and insureds by prohibiting them from entering into contracts that include discretionary clauses and by prohibiting enforcement of such clauses.[173] After finding that the rules fall within the scope of ERISA's savings clause, the Sixth Circuit also determined that they do not conflict with ERISA's civil enforcement provisions because they do not "create, duplicate, supplant, or supplement any of the causes of action that may be alleged under ERISA"; rather, the rules "at most may affect the standard of judicial review if, and when, such a claim is brought before a court."[174] The court also held that the rules do not conflict with ERISA's policy, which favors a uniform set of rules, noting that the *de novo* standard of review is already the default standard in ERISA cases, making it "difficult to imagine how a state law requiring that level of review would conflict with the statute."[175] Ultimately, the Sixth Circuit affirmed the district court's entry of summary judgment in favor of the defendants.

The Ninth Circuit in *Standard Insurance Co. v. Morrison*[176] similarly considered whether a state could refuse to allow discretionary clauses in insurance policies issued in its state, but in the context of the Montana insurance commissioner's "practice" of prohibiting these provisions rather than a specific state law forbidding discretionary clauses. Montana's insurance commissioner, the defendant in the *Morrison* case, adopted the "practice" of disapproving any insurance contract containing a discretionary clause.[177] After its proposed disability insurance forms, which contained discretionary clauses, were rejected, Standard sued the commissioner in district court arguing that ERISA preempted his "practice." Like the *Ross* court, the *Morrison* court applied the Supreme Court's test in *Miller* to determine whether the commissioner's practice of denying approval of insurance forms with discretionary clauses is preempted by ERISA. It also concluded that the practice of disapproving discretionary clauses is saved from ERISA preemption because it is specifically directed towards insurers and substantially affects the risk-pooling arrangement between insurers and the insureds, relying in part on the Sixth Circuit's decision in *Ross*.[178] In finding that the risk-pooling arrangement is substantially affected, the Ninth Circuit suggested that removing the benefit of a deferential standard of review from insurance policies will likely lead to a greater number of claims being paid and stated "[m]ore losses will thus be covered, increas-

173. *Id*. at 607–08.
174. *Id*.
175. *Id*. at 608.
176. No. 08-35246, 2009 WL 3429501 (9th Cir. 2009).
177. *Id*. at *1.
178. *Id*. at *3, 6.

ing the benefit of risk pooling for the consumers."[179] Similar to *Ross*, the court also rejected plaintiff's arguments that the insurance commissioner's practice conflicts with both ERISA's exclusive remedial scheme and its purpose.[180] Ultimately, the Ninth Circuit affirmed the decision to grant summary judgment in the commissioner's favor.

Unlike the courts in *Ross* and *Morrison*, however, the federal district court in *Lucero v. Hartford Life & Accident Insurance Co*.[181] recently concluded that ERISA preempts Utah's insurance rule, which prohibits discretionary authority clauses for non-ERISA insurance plans and provides certain limitations on discretionary authority clauses contained in ERISA insurance plans. After determining that the first prong of the Supreme Court's *Miller* test was met because the Utah rule is directed specifically towards entities engaged in insurance, the court found that the rule does not fall within ERISA's savings clause because it does not substantially affect the risk-pooling arrangement between insurers and the insured.[182] In so finding, the court differentiated this rule from state insurance mandates that require insurers to assume risk for particular adverse events, explaining this rule "applies only to the administrative function of interpreting the insurance plan's terms and judicial review of the use of that administrative function" and thus is "unrelated to either the risk of adverse events occurring or their potential magnitude."[183] The court thus found that this rule could not be applied to the ERISA plan at issue, and the discretionary clause contained therein remained effective.

V. HEALTH INSURANCE

A. *Exclusions*

This year, while the Sixth Circuit held that an illegal act exclusion could not be applied because of a lack of causation between the illegal act and the injuries for which benefits were sought, an Indiana district court found that an administrator's decision to deny health benefits based on a plan exclusion was "not unreasonable" even though it did not require the injury for which benefits are sought to be caused by the insured's intoxicated state. In *Shelby County Health Care Corp. v. Majestic Star Casino, LLC*,[184] plaintiff, acting pursuant to an assignment from its patient, challenged the ERISA

179. *Id*. at *2.
180. *Id*. at *7.
181. No. 2:08-CV-302 TS, 2009 WL 2170048 (D. Utah July 17, 2009).
182. *Id*. at *5.
183. *Id*. at *6.
184. Nos. 08-6078, 08-6419, 2009 WL 2997985 (6th Cir. Sept. 22, 2009).

plan administrator's decision to deny the patient health insurance benefits. Plaintiff claimed that defendant improperly denied benefits for medical charges incurred by this patient, a plan insured, after he sustained injuries in a single-car accident while driving without a driver's license or proof of insurance.[185] Defendant denied benefits under the plan's "illegal-act provision," which excluded benefits for "any loss caused by, incurred for, or resulting from . . . [c]harges for or in connection with an injury or illness arising out of . . . the commission or attempted commission of an illegal or criminal act."[186] After rejecting the defendant's attempt to assert a different basis for denial of benefits than that asserted by the claims administrator, the Sixth Circuit agreed with the district court that the term "illegal act" was ambiguous since it was undefined in the policy.[187] It then found that a reasonable interpretation of "illegal act" might not include driving without insurance or driving without a license.[188] Ultimately, since the record provided "no support for the assertion that driving without a license or driving without insurance 'caused' [the] accident and resulting injuries," the Sixth Circuit upheld the finding that plaintiff erred in denying the claim for benefits.[189]

In *Kehoe v. 1st Source Bank Healthcare Benefits Plan*,[190] the court affirmed an ERISA plan administrator's denial of health coverage where claimant had a blood alcohol level of 0.128, as tested at the treating hospital, and the plan excluded "[c]harges resulting from an illness or injury incurred while under the influence of alcohol or illegal drugs as evidenced by a blood alcohol level equal to or in excess of the legal amount allowed in the state where the injury occurs or any other drug or alcohol screening test."[191] The court rejected claimant's contention that *de novo* review applied because the administrator's decision "was so unusual that [it] went beyond simply interpreting the Plan and, instead, modified the Plan's terms and conditions."[192] The court held that the administrator's interpretation of the exclusion did not modify the plan's language, which did not require illegal consumption of alcohol to trigger the exclusion but rather that an injury incurred while "under the influence," an objective standard based on state law.[193] The court further held that the administrator's claim decision was

185. *Id.* at *1–2.
186. *Id.* at *1–3.
187. *Id.* at *8–9.
188. *Id.* at *9.
189. *Id.* at *10–11.
190. No. 3:08-CV-62 CAN, 2008 WL 5273561 (N.D. Ind. Dec. 16, 2008).
191. *Id.* at *1.
192. *Id.* at *2.
193. *Id.* at *2–3.

not arbitrary and capricious because it was not unreasonable to incorporate the Indiana motor vehicle intoxication statute, defining 0.08 as the minimum BAC for legal intoxication.[194]

B. *Mandated Coverage*

The difference between being required to *offer* coverage and being mandated to *provide* certain coverage was recently addressed in *Yeager v. Blue Cross of California*.[195] There, an insured sued Blue Cross to recover for an alleged violation of the statutory duty to offer coverage for treatment of infertility in a group health plan. The court found that the statute in question, which provided that "[e]very health care service plan contract . . . shall offer coverage for the treatment of infertility . . . under those terms and conditions as may be agreed upon between the group subscriber and the plan,"[196] obligated Blue Cross to *offer* coverage for infertility treatment, but that it did not *mandate* it.[197] Because Blue Cross offered the coverage, which plaintiff's employer declined, the court ruled that it complied with the statute.[198] In reaching this conclusion, the court noted that the statute was not ambiguous and that the legislature had provided for coverage mandates elsewhere in the code and knew how to clearly word such provisions.[199]

C. *Terms*

In the health insurance context, courts continue to carefully apply the terms of the subject health insurance policy—in one case deciding in favor of the insurer and in favor of coverage in the other. In *Crossland v. Anthem Health Plans, Inc.*,[200] plaintiffs sued to obtain benefits for the treatment of their adult daughter at a residential treatment center for mental health care. Plaintiffs' insurance certificate did not define "Residential Treatment Center," but the underlying contract defined "Residential Treatment *Facility*" as a "treatment center for children and adolescents."[201] Treating "Residential Treatment Center" and "Residential Treatment Facility" as synonymous, plaintiffs' daughter was not treated at a "Residential Treatment Center" because the facility treated adults and denied plaintiffs'

194. *Id.* at *3 (citing Ind. Code § 9-30-5-1).
195. 175 Cal. App. 4th 1098 (Cal. Ct. App. 2009).
196. Cal. Health & Safety Code § 1374.55 (West 2009).
197. *Yeager*, 175 Cal. App. 4th at 1102.
198. *Id.*
199. *Id.* at 1103.
200. No. (X02) UWY-CV-06-5007647S, 2009 WL 1055237 (Conn. Super. Ct. Mar. 24, 2009).
201. *Id.* at *1 (emphasis added).

claim.[202] On review, the court held that it was required to give effect to "each word contained in an insurance policy" and, therefore, declined to find that the phrases "Residential Treatment Center" and "Residential Treatment Facility" were interchangeable.[203] Rather, construing the words in the phrase "Residential Treatment Center" according to their dictionary meanings, the court concluded the treatment was covered.[204]

In *White v. St. Luke's Episcopal Health System*,[205] the Fifth Circuit affirmed the district court's grant of summary judgment in favor of defendant, which had denied plaintiff coverage for her son's "neurofeedback" therapy. This denial was based on the subject policy's "nonmedical services" exclusion, contained in the summary plan description, that excluded 'nonmedical counseling or ancillary services, including . . . neurofeedback.'"[206] Rejecting plaintiff's argument that this exclusion related only to "nonmedical" neurofeedback and thus did not apply here, where her son's neurofeedback was "medical" in nature, the court ruled that "the exclusion applies to *all* neurofeedback, which is always considered to be a nonmedical service under the Plan, irrespective of the purpose for which it is prescribed."[207] Plaintiff further argued that the SPD "should be interpreted in her favor because more particularized standards apply where, as here, the administrator bases its denial of benefits on the [SPD] rather than the Plan itself."[208] The court disagreed and held that the SPD was not ambiguous, finding that just because the denial was based on it "does not allow [plaintiff] to create ambiguities where they do not exist."[209]

VI. LIFE INSURANCE

Among the life insurance cases reviewed this year are cases addressing the proper beneficiary under a policy, bad faith claims associated with interpleaders, misrepresentations in applications for life coverage, and viatical investments.

A. *Beneficiary*

In *Henninger v. Standard Insurance Co.*,[210] the insured's mother alleged that she, rather than the insured's ex-wife, was entitled to the proceeds of the

202. *Id.*
203. *Id.* at *3–4.
204. *Id.* at *4–5.
205. 317 F. App'x 390 (5th Cir. 2009).
206. *Id.* at 392.
207. *Id.* at 393–94.
208. *Id.*
209. *Id.* at 395.
210. 332 F. App'x 557 (11th Cir. 2009).

life insurance policy on her deceased son. On his beneficiary designation form, which provided "unless you specify otherwise, benefits are divided equally between the beneficiaries you name," the insured wrote the following underneath the beneficiary designation instructions:

> Denise Henninger—wife—100%
>
> Norma Henninger—mother—100%

The Eleventh Circuit found the insured's beneficiary designation ambiguous because it could be construed as creating either contingent beneficiaries or co-beneficiaries.[211] Obligated to attempt to resolve this ambiguity prior to submitting the issue to a jury, the court allowed testimony from the benefits coordinator showing the insured intended to designate his wife and mother as contingent beneficiaries. The court then found that despite the insured's purported subsequent intent to change the beneficiary designation to remove his ex-wife as beneficiary, his failure to take any affirmative act toward actually changing the beneficiary designation in that manner—such as contacting defendant—prevented it from considering the change to be made.[212] Some affirmative act on the part of the insured to change the beneficiary is required; his mere intention will not suffice to change the beneficiary.[213]

B. *Interpleader*

In *DeLuca v. Starmount Life Insurance Co., Inc.*,[214] after the insured's death and prior to distribution of the benefits of a life insurance policy, defendant insurer learned of a forgery allegation that "called into question who were proper beneficiaries of the policy," causing it to refuse to pay the named beneficiaries, file an interpleader, and deposit the proceeds with the court—all within a few weeks of learning of the insured's death.[215] Although they acknowledged the beneficiary dispute, plaintiffs filed an action for vexatious refusal to pay against defendant, claiming that at the time it refused to pay benefits it was acting vexatiously—regardless of its later actions and deposit of insurance proceeds with the court.[216] The court acknowledged that "whether an insurer's attitude was vexatious and recalcitrant is to be made by viewing the facts as they appeared at the time [of] refusal" but granted defendant's summary judgment upon finding "that at

211. *Id.* at 558.
212. *Id.* at 560.
213. *Id.*
214. No. 4:08CV1372SNLJ, 2009 WL 259743 (E.D. Mo. Feb. 3, 2009).
215. *Id.* at *4.
216. *Id.*

the time of refusal defendant was aware of the familial dispute and was making a good faith effort to determine the proper beneficiaries before payment was made."[217] In making this determination, the court relied on the maxim that, "[w]here there exists a question of law or fact, the insurer may insist on a determination without being penalized."[218]

C. *Misrepresentation*

In *Northwestern Mutual Life Insurance Co. v. Gil*,[219] after its insured died, Northwestern filed a rescission action on his $15 million life insurance upon learning of several material misrepresentations on his application, including an undisclosed medical history, drug use, and psychiatric treatment. Northwestern's writing agent smoked marijuana with the insured, interacted with him socially, and was aware that he sought marital counseling.[220] In granting summary judgment for Northwestern, the court held that the misrepresentations were attributable to the insured because, even if he had no knowledge of any misstatements when he signed the applications, he ratified the false statements when he accepted the completed and executed policies.[221] The court also declined to adopt a standard contrary to Connecticut law and hold that the insured's misrepresentations were not material because they were unrelated to the cause of his death, which was homicide.[222] Finally, the court held that even though Northwestern's agent knew of the insured's marijuana use and marital counseling (neither of which were bases for summary judgment), he did not know about the cocaine use or unidentified psychiatric and other medical treatment and thus Northwestern could not be charged with knowledge that the insured's answers were false.[223]

In *Thorpe v. Banner Life Insurance Co.*,[224] the beneficiary of a life insurance policy challenged Banner's denial of benefits and attempt to rescind the policy because of material misrepresentations in the application. Banner's investigation of the insured's death revealed that the insured filled prescriptions for a variety of medications that were not disclosed in his application. Banner moved for summary judgment, arguing that the beneficiary's breach of contract claim fails because it was entitled to rescind the policy and argued, in the alternative, that the policy was never valid. Ruling in Banner's favor, the court rejected the beneficiary's claim that Banner

217. *Id.*
218. *Id.*
219. No. 3:07-cv-00303 (VLB), 2009 WL 276086 (D. Conn. Feb. 5, 2009).
220. *Id.* at *2.
221. *Id.* at *4.
222. *Id.*
223. *Id.*
224. 632 F. Supp. 2d 8 (D.D.C. 2009).

waived its right to conduct an investigation following the insured's death because it conducted only a cursory investigation at the time the policy was applied for, finding it did not have "actual knowledge" of the insured's prescription medicine use at the time of application.[225] The court found, however, that it could not conclude as a matter of law that Banner was entitled to rescind the policy because it could not determine the materiality of the insured's statements at that stage; the court thus denied Banner's motion for summary judgment.[226]

D. *Viatical Investment*

In *Wuliger v. Manufacturers Life Insurance Co.*,[227] the Sixth Circuit reversed the district court, holding, *inter alia*, that under Ohio law life insurance policies fraudulently obtained for the benefit of a viatical investment company were voidable at the insurer's option as a "failure by the insured to disclose conditions affecting the risk, of which he is aware," not void *ab initio*.[228] Because the receiver of the viatical company conceded the company committed fraud in its procurement of insurance policies, the court held the equitable defense of unclean hands barred the receiver's rescission claim.[229] The receiver could not sustain its unjust enrichment claim because the claim was premised upon express insurance policies and the at-issue premiums were paid pursuant to those contracts.

VII. CONCLUSION

This year's case highlights revisited some trends, as well as the perennial issues in this area of the law. More disability decisions explored the link between mental and physical illness, with the line between the two blurring substantially. The meaning of "accident" continues to stymie courts and litigants. In the ERISA context, while courts seem nearly universally disposed to allow *some* discovery into whether a plan's fiduciary's structural conflict of interest biased the decision at issue, there is less consensus on how this inquiry ultimately works within the framework of the arbitrary and capricious standard of review. We anticipate this area of ERISA litigation will continue to be very active in 2010. While a complete summary of all decisions in the area of life, health, disability, and ERISA litigation is beyond the scope of this article, the authors hope this summary of the high points (and low points) of recent developments is helpful.

225. *Id.* at 12.
226. *Id.* at 13–18.
227. 567 F.3d 787 (6th Cir. 2009).
228. *Id.* at 796 (citation omitted).
229. *Id.* at 797.