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

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I. INTRODUCTION

This year's article could easily be devoted entirely to the Supreme Court's decision in *CIGNA Corp. v. Amara*, which will have ramifications for ERISA practitioners for years to come, or to the constellation of cases challenging the Affordable Care Act. As always, however, this year also brings a host of interesting decisions, from cases continuing to grapple with conflict-of-interest issues in the ERISA context, to courts weighing in on an insurer's right to retain the premium when STOLI policies are procured by fraud. While an exhaustive survey of all cases in this area is beyond the scope of this article, your authors have endeavored to bring the most interesting and relevant decisions to your attention.

II. ACCIDENT INSURANCE

A. *Foreseeability*

From whose perspective is an event foreseeable? In *Sellers v. Zurich American Insurance Co.*,[1] the insured underwent surgery to repair a knee injury.

1. 627 F.3d 627 (7th Cir. 2010).

The surgery included insertion of a temporary wire. The wire broke; fourteen months later, the insured had surgery to remove it, which the surgeon noted was "in many degrees, [] expected."[2] The insured died nine days later from "acute pulmonary embolism with infarct, due to immobilization following the wire removal."[3] Zurich denied the claim, given the expected nature of the injury.[4] The Seventh Circuit held that Zurich failed to consider whether the accident was reasonably foreseeable from the insured's perspective, not that of the physician.[5] Ultimately, however, the court upheld Zurich's decision because the policy contained a provision limiting coverage to deaths that occur within 365 days of the accident.[6] In support of its ruling, the court held that because the wire break was a complication and risk associated with the original surgery and injury, which occurred more than 365 days before the death, there was no coverage.[7]

B. *Intoxication*

How do courts determine whether an insured is intoxicated? In *River v. Edward D. Jones Co.*,[8] the insured died in a single-vehicle motorcycle crash with a blood alcohol content (BAC) of 0.128 percent.[9] The policy's intoxication exclusion barred payment where "the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident."[10] The policy defined intoxication as a blood alcohol level that "met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred."[11] While plaintiff argued that there was no evidence of intoxication, and eyewitness accounts refuted the toxicology report,[12] the Eighth Circuit disagreed, holding that "[t]he toxicology report constituted evidence that a 'reasonable mind might accept as adequate to support a conclusion,' . . . and therefore satisfies the substantial evidence standard."[13]

In *Redeaux v. Southern National Life Insurance Co.*,[14] the Fifth Circuit found in favor of the insurer on the same issue without an intoxication

2. *Id.* at 630–31.
3. *Id.* at 630.
4. *Id.*
5. *Id.* at 632.
6. *Id.* at 630.
7. *Id.* at 634.
8. 646 F.3d 1029 (8th Cir. 2011).
9. *Id.* at 1031.
10. *Id.* at 1032.
11. *Id.*
12. *Id.* at 1033.
13. *Id.* at 1034 (quoting Ratliff v. Jefferson Pilot Fin. Ins. Co., 489 F.3d 343, 346 (8th Cir. 2007)).
14. 424 F. App'x 271 (5th Cir. 2011).

exclusion. The insured died in a single-vehicle crash with a BAC of 0.21 percent.[15] The policy excluded "loss which in any way results from . . . injury or death occurring as a result of the commission of a crime or the attempt to commit a crime."[16] The beneficiary challenged the application of this exclusion absent criminal charges; the court disagreed, finding that "[t]he failure of the state criminal justice system to prosecute an individual . . . by no means constitutes an affirmative finding that the individual is absolved of any crime."[17] The court also rejected the argument that a BAC was insufficient to prove intoxication because, under Louisiana law, proof of intoxication is not required, only a BAC over 0.1 percent.[18]

C. *Loss of Use versus Physical Loss*

The unusual question of whether a body part must be physically separated from the body to recover benefits under an accidental death and dismemberment policy was addressed by the Ninth Circuit in *Fier v. Unum Life Insurance Co. of America*,[19] where a gunshot wound left the insured a quadriplegic.[20] The policy defined "loss" as, "for hands or feet, . . . dismemberment by severance at or above the wrist or ankle joint."[21] Unum denied the insured's claim because the insured's hands and feet were not physically severed from his body.[22] The insured argued that his hands and feet were functionally lost due to the "severance" of his spinal cord.[23] The Ninth Circuit concluded that "dismemberment by severance" means "actual, physical separation" from the body,[24] agreeing with the Second Circuit's holding in *Cunninghame v. Equitable Life Assurance Society of the United States*.[25]

15. *Id*. at 272.
16. *Id*.
17. *Id*. at 273 (alteration in original) (quoting James v. La. Laborers Health & Welfare Fund, 29 F.3d 1029, 1034 (5th Cir. 1994)).
18. *Id*. at 273–74. *See also* Likens v. Hartford Life & Accident Ins. Co., 794 F. Supp. 2d 720 (S.D. Tex. 2011) (upholding application of policy exclusion given BAC of 0.328 percent and rejecting argument that exclusion required adjudication that BAC finding violated state law); Tran v. United of Omaha Life Ins. Co., 780 F. Supp. 2d 965 (D. Neb. 2011) (holding coroner's report finding BAC slightly above legal limit "presumptively correct"; insurer did not abuse discretion in relying on toxicology report to deny claim).
19. 629 F.3d 1095 (9th Cir. 2011).
20. *Id*. at 1096.
21. *Id*. at 1099.
22. *Id*. at 1097.
23. *Id*. at 1099.
24. *Id*.
25. 652 F.2d 306 (2d Cir. 1981).

D. *Self-Inflicted Injury*

Autoerotic activity leading to death was excluded as an intentionally self-inflicted injury in *Martin v. Hartford Life & Accident Insurance Co*.[26] The insured electrocuted himself while engaging in autoerotic activity involving attaching an electrical device to his genitalia.[27] The policy precluded benefits for any loss caused or contributed to by intentionally self-inflicted injury.[28] The beneficiary argued that the insured had not intended to injure himself, noting that he was an electrician who had engaged in similar activity in the past.[29] Upholding Hartford's denial of the claim, the court focused on whether the insured intended to injure himself when he applied household current to his body. Since the human body can be injured with as little as two-tenths of an ampere of current, and it is "common knowledge" that household electrical circuits typically allow up to 15 amperes of current to pass before circuit breakers cut off the flow, the court held that it was not arbitrary and capricious for Hartford to conclude that the insured had attempted to injure himself, such that the exclusion would apply.[30]

III. DISABILITY INSURANCE

A. *Any Occupation and Own Occupation*

Courts continue to address interpretations and applications of the terms "regular," "own," and "any occupation," ruling against parties who ignore essential evidence and fundamental principles of contract interpretation. In *Mead v. ReliaStar Life Insurance Co*.,[31] an ERISA plan provided "total disability" benefits if, for the first twenty-four months, the participant was "unable to do the essential duties of [her] own occupation, due to sickness or accidental injury."[32] The court noted that in the Second Circuit, although the term "'regular occupation' . . . means 'a position of the same general character as the insured's previous job, requiring similar skills and training, and involving comparable duties,' that definition requires consideration of what sort of position is 'of the same general character.'"[33] The ERISA plan administrator determined that the participant "could perform the essential duties of her occupation with reasonable accommodation."[34]

26. 784 F. Supp. 2d 169 (W.D.N.Y. 2011).
27. *Id*. at 170–74.
28. *Id*. at 171.
29. *Id*. at 174.
30. *Id*. at 181.
31. 755 F. Supp. 2d 515 (D. Vt. 2010).
32. *Id*. at 519.
33. *Id*. at 531 (internal quotation marks omitted).
34. *Id*. at 534.

The court found that the plan administrator's denial of long-term disability benefits was arbitrary and capricious because it failed to first determine the physical demands of the essential duties of the participant's job.[35]

Similarly, the court in *Givens v. Prudential Insurance Co. of America*[36] held that the ERISA plan administrator abused its discretion when it relied on a "foundationally flawed" vocational expert's report in making a disability determination under the plan's definition of "any occupation."[37] Furthermore, the plan administrator failed to explain why it switched its position regarding a vocational report that it previously rejected. But the court granted summary judgment in favor of the insurer in *Hake v. Massachusetts Mutual Life Insurance Co.*,[38] rejecting the insured's argument that his "own occupation was the precise practice he enjoyed with his employer, not another position no matter how similar, somewhere on this continent."[39] Applying "[t]he plain and ordinary meaning" of the contract's terms, the court noted that the applicable policy rider used the term "'Regular Occupation' and not 'job.'"[40]

B. *Bad Faith*

Material misrepresentations on disability insurance applications and unreasonable interpretations of disability insurance contract terms or controlling law can result in determinations that a party acted in bad faith. The insured's material misrepresentation in *Massachusetts Mutual Life Insurance Co. v. Zaucha*[41] provides a clear example. Although the insured stated annual income of $80,000 on his disability insurance application, he reported far less to the IRS. Granting summary judgment to the insurer, the court refused to impute to the insurer any alleged knowledge of the insured's true income by the agent, finding that the insured acted in bad faith. Specifically, the court held that "[t]he only reasonable inference from the record is that, when he chose to disclose an amount that he knew did not

35. *Id.* at 533.
36. 778 F. Supp. 2d 1011 (W.D. Mo. 2011).
37. *Id.* at 1026; *cf.* Seleine v. Fluor Corp. Long-Term Disability Plan, 409 F. App'x 99, 100 (9th Cir. 2010) (rejecting plaintiff's contention that she was "entitled to 'any occupation' benefits merely because she was awarded 'own occupation' benefits under the [ERISA] Plan in a prior action" and noting that her "entitlement to 'any occupation' benefits was not considered or decided in the prior action"); Kostal v. Life Ins. Co. of N. Am., No. 09-CV-31, 2011 WL 2731228, at *2 (E.D. Wis. July 12, 2011) (noting that it was premature for the court "to address disability eligibility under the [regular occupation standard] when [the insurer] has not had the opportunity to determine whether [the insured] was eligible under that standard").
38. No. 2:09-CV-01563-KJD-GWF, 2011 WL 3444176, at *4 (D. Nev. Aug. 8, 2011).
39. *Id.*
40. *Id.*
41. No. 10 C 1978, 2011 WL 3584766, at *5 (N.D. Ill. Aug. 15, 2011).

accurately reflect his income, Zaucha acted with the bad faith intent of inflating [the insurer's] insurance coverage."[42]

But in *Barbour v. Unum Life Insurance Co. of America*,[43] the court reminded insurers and plan administrators of the importance of conducting investigations carefully. The court noted that "[t]he key to a bad faith claim is whether or not the insurer's denial of coverage was reasonable."[44] Denying summary judgment to Unum on a bad-faith claim, the court identified a number of facts that could support a jury's finding of unreasonable conduct, including reliance on a surveillance video of the wrong person,[45] ignoring surveillance video consistent with reports from the insured's physician, and reliance on "less than 12 minutes of surveillance video taken on a single day to support the conclusion that Plaintiff 'has full time sedentary capacity.' "[46] Finally, the court found Unum's failure to seek an independent medical examination of the insured could also lead a jury to conclude that Unum failed to properly investigate the insured's claim.[47]

C. *Racketeer Influenced and Corrupt Organizations Act*

Allegations against disability insurers based on the Racketeer Influenced and Corrupt Organizations Act (RICO)[48] failed in two cases in 2011. In *Shields v. UnumProvident Corp.*,[49] the district court found that the McCarran-Ferguson Act[50] preempted RICO claims. Plaintiffs, beneficiaries of a self-insured ERISA plan, alleged that the insurer operated a racketeering enterprise, enabling it to conspire to "institutionalize[] bad faith claims handling" and to use "bogus trusts to avoid governmental oversight and regulation and enable improper changes in coverage and policy terms."[51] The Sixth Circuit agreed with the insurer that the beneficiaries failed "to adequately plead the existence of an 'association of fact' RICO

42. *Id.*
43. No. 09cv2724-WQH-WVG, 2011 WL 3586144 (S.D. Cal. Aug. 15, 2011).
44. *Id.* at *8 (quoting Guebara v. Allstate Ins. Co., 237 F.3d 987, 992 (9th Cir. 2001)).
45. *Id.* at *9.
46. *Id.* at *10.
47. *Id.*; *cf.* Polich v. Prudential Fin., Inc., 646 F.3d 1116, 1118 (8th Cir. 2011) (finding insurer's requests for an independent medical examination in connection with insured's second appeal of denial of benefits reasonable under Iowa law); *but see* Northwestern Mut. Life Ins. Co. v. Koch, 424 F. App'x 621, 624 (9th Cir. 2011) (noting that the insured "produced no evidence that [the insurer's] decision to rescind [the insured's] policies was based on an unreasonable interpretation of the policies or controlling law"); Pyun v. Paul Revere Life Ins. Co., 768 F. Supp. 2d 1157 (N.D. Ala. 2011) (rejecting bad-faith claim, given legitimate reasons for claim denial).
48. 18 U.S.C. § 1962(c).
49. 415 F. App'x 686 (6th Cir. 2011).
50. 15 U.S.C. § 1011.
51. *Shields*, 415 F. App'x at 690.

enterprise" and, therefore, declined to address the preemption issue.[52] Similarly, the court in *Davis v. Unum Group*[53] granted an insurer and administrator's motion for summary judgment on the ERISA plan participants' RICO claim. The court held that the participants did not establish the existence of a RICO "enterprise" nor a "'nexus' between defendants' operation, acquisition, or control of a RICO enterprise and defendants' [alleged] racketeering activities."[54]

D. *Subjective versus Objective Evidence*

Conditions involving subjective complaints of pain that are difficult to test objectively continue to plague the courts. In *Van Valen v. Employee Welfare Benefits Committee Northrup Grumman Corp.*,[55] the court upheld a denial of continued benefits for a claimed disability caused by Chronic Fatigue Syndrome (CFS) because the insured failed to provide "objective proof of impairment," as opposed to "objective proof of Chronic Fatigue Syndrome."[56] Upholding the insurer's decision, the court followed the Seventh and First Circuits, observing the distinction between subjectively experienced pain and the limitations caused by pain that can be objectively measured. Moreover, the court observed that it was common practice for insurers to require objective evidence in CFS claims, and it noted that the Social Security Administration even requires a CFS claimant to provide information determinative of the severity of his or her impairment.[57] Nevertheless, the court noted that requiring the insured to provide objective proof of a condition that cannot be objectively measured is "tantamount to saying that it will not provide coverage for such a disease," and it cautioned insurers to explicitly state their policies in the plan documents.[58]

E. *Mental Illness Limitation*

In the past year, courts have yielded varying opinions on the interpretation of mental illness limitation provisions in disability policies. As is often the case, the plan in *Ringwald v. Prudential Insurance Co. of America*[59] limited the

52. *Id.* at 691.
53. No. 03-940, 2011 WL 2438632 (E.D. Pa. June 17, 2011).
54. *Id.* at *4, *7 (quoting *In re* Ins. Brokerage Antitrust Litig., 618 F.3d 300, 370–72 (3d Cir. 2010)).
55. 741 F. Supp. 2d 756 (W.D. Va. 2010).
56. *Id.* at 763.
57. *Id.* at 763–64.
58. *Id.* at 763; *see also* Eppley v. Provident Life & Accident Ins. Co., 789 F. Supp. 2d 546, 573 (E.D. Pa. 2011) (holding that insured's subjective reports of foot pain simply did not establish that he was incapable of performing the "networking, sales consulting, and marketing" functions of his job).
59. 754 F. Supp. 2d 1047 (E.D. Mo. 2010).

pay period for disability benefits "due in whole or part to mental illness" to twenty-four months during the insured's lifetime.[60] After deciding that the provision was tied to the benefits section of the plan and, therefore, required the insured to prove his disability,[61] the court next acknowledged and rejected the insured's contention that his depression and bipolar disorder had a "physical, rather than a purely mental, etiology" because the plan clearly defined mental illness to expressly include depression and bipolar illness "regardless of cause."[62] Granting summary judgment for the insurer, the court held that the mental illness limitation provision was not ambiguous, particularly because the insured admitted that his inability to work was caused by depression and bipolar illness.[63]

F. *Sickness versus Injury*

A belated examination of the sickness versus injury issue by the insurer did not pass muster with the court in *August v. Provident Life & Accident Insurance Co*.[64] The policy offered a lifetime benefit for total disability due to an "accident" beginning before the insured's sixty-fifth birthday, while the "sickness" provision paid only up to the insured's sixty-fifth birthday.[65] The insured suffered a spinal injury from a skiing accident and filed a claim for "total disability" benefits, citing the injury as the basis for his claim.[66] After paying the claim for ten years, Provident told the insured that it would need to evaluate whether his loss was the result of "accident" or "sickness" because it had failed to do so when he submitted his claim. Shortly thereafter, having determined that the insured's claim was due to "sickness," Provident formally terminated the insured's benefits. The insured argued that Provident was equitably estopped from asserting a "sickness" defense.[67] Finding that California law recognized an insurer's obligation to "assist the insured to recover bargained-for policy benefits," the court agreed that Provident had a duty to disclose information regarding an insured's coverage.[68] The court also found that the insured "suffered evidentiary disadvantage" from the loss of material witnesses and medical records

60. *Id*. at 1050.
61. *Id*. at 1056–57.
62. *Id*. at 1057–58.
63. *Id*. at 1058–59; *but see* Morgan v. Prudential Ins. Co. of Am., 755 F. Supp. 2d 639, 649–50 (E.D. Pa. 2010) (finding administrator's selective "segregati[on] [of] symptoms from the disease," in a case involving both fibromyalgia and depression, suggested that it was deliberately looking for a reason to deny benefits).
64. 772 F. Supp. 2d 1197 (C.D. Cal. 2011).
65. *Id*. at 1200.
66. *Id*. at 1200–01.
67. *Id*. at 1204–05.
68. *Id*. at 1206.

that would have been relevant to determining whether a preexisting condition would have affected his claim.[69]

IV. ERISA

A. *Attorney Fees*

While courts continue to grapple with the decision of whether to award fees and how to calculate the appropriate amount,[70] a number of cases in the past year also explored the more novel concepts of who can be liable for a fee award, the ability of out-of-state practitioners to prove reasonableness of fees by affidavit, and the survival of a fee demand when a plan pays a claim post-suit. For example, in *1 Lincoln Financial Co. v. Metropolitan Life Insurance Co.*,[71] an assignee of ERISA insurance benefits sued MetLife to recover plan benefits. The district court ruled in favor of MetLife and awarded fees. On appeal, the assignee argued that "ERISA only permits fee awards when a lawsuit is brought by a 'participant, beneficiary, or fiduciary' of a benefits plan" and thus didn't apply to assignees.[72] The Fifth Circuit rejected this argument, finding that an assignee stood "in the shoes of the original beneficiary and plan participant."[73] Accordingly, the court ruled that ERISA permitted an award of fees.

In *Anderson v. Hartford Life & Accident Insurance*,[74] the court considered an issue important to national practitioners: whether affidavits from out-of-state counsel were sufficient to establish that an in-state attorney's claimed hourly rates were reasonable in her community. The court ruled that the affidavits were insufficient.[75] The court noted that the applicant for a fee award bears the burden of proving the "market rate" for purposes of a fee award; i.e., "the rate that lawyers of similar ability and experience in the community normally charge their paying clients for the kind of work in question."[76]

Finally, in *Pakovich v. Verizon LTD Plan*,[77] the Seventh Circuit considered the "challenging question" of whether a court retains jurisdiction to

69. *Id.* at 1209; *see also* Laun v. AXA Equitable Life Ins. Co., 716 S.E.2d 760 (Ga. Ct. App. 2011) (holding that hand surgeon receiving total disability benefits due to osteoarthritis, a "sickness" under the subject policy, was not entitled to have his benefits reclassified as "accident total disability" benefits after sustaining a wrist injury, an "injury" under the policy).

70. *See, e.g.*, Shore v. Int'l Painters & Allied Trades Indus. Pension Plan, 418 F. App'x 597, 600 (9th Cir. 2011) (holding that the district court has discretion in a fee award but cannot simply depart from the lodestar amount, absent specific and articulable reasons).

71. 428 F. App'x 394 (5th Cir. 2011).

72. *Id.* at 395–96.

73. *Id.* at 396.

74. 772 F. Supp. 2d 1025 (S.D. Ind. 2011).

75. *Id.* at 1027.

76. *Id.* at 1028.

77. 653 F.3d 488 (7th Cir. 2011).

consider a fee demand in an ERISA suit when the underlying claim is rendered moot as a result of the plan paying benefits in full shortly after the suit was filed.[78] The Seventh Circuit noted that courts must retain such equitable jurisdiction because to hold otherwise may provide "opportunistic plans" with an incentive to delay claims decisions until a participant files suit.[79] The court also speculated that plaintiffs would forgo filing suit unless "their expected recovery of benefits exceeded their legal fees."[80] The Seventh Circuit concluded that these scenarios would contradict the ERISA policy of providing participants with appropriate remedies and access to federal courts.[81]

B. *Conflict of Interest*

The impact of structural conflicts of interest on ERISA claims has continued to be a topic of interest among the courts in the wake of the Supreme Court's *Glenn*[82] decision in 2008. In *Blankenship v. Metropolitan Life Insurance Co*.,[83] the Eleventh Circuit found that "[t]he presence of a structural conflict of interest—an unremarkable fact in today's marketplace—constitutes no license, in itself, for a court to enforce its own preferred de novo ruling about a benefits decision."[84] Similarly, the Second Circuit, in *Schnur v. CTC Communications Corp. Group Disability Plan*,[85] also downplayed the significance of a structural conflict if the administrators take "active steps to reduce potential bias . . . by walling off claims administrators from those interested in firm finances and, as such, the asserted conflict prove[s] less important (perhaps to the vanishing point)."[86] However, the Ninth Circuit, in *Hicklin v. Hartford Life & Accident Insurance Co*.,[87] held that its review under the abuse-of-discretion standard must be "tempered with skepticism" when a structural conflict is present. Similarly, in weighing the plan's structural conflict as a factor, the Ninth Circuit, in *Salomaa v. Honda Long Term Disability Plan*,[88] held that the plan's failure to address a Social Security Administration award of disability benefits was of "sufficient significance" that it constituted an abuse of discretion.[89] The

78. *Id*. at 492–93.
79. *Id*. at 493.
80. *Id*.
81. *Id*.
82. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008).
83. 644 F.3d 1350 (11th Cir. 2011).
84. *Id*. at 1355–56.
85. 413 F. App'x 377 (2d Cir. 2011).
86. *Id*. at 380 (alteration in original) (internal quotation marks omitted) (citing *Glenn*, 554 U.S. at 117).
87. 407 F. App'x 108, 109 (9th Cir. 2010).
88. 642 F.3d 666 (9th Cir. 2011).
89. *Id*. at 679.

Ninth Circuit acknowledged that the *Glenn* standard for metaphorically weighing a conflict is difficult and noted that "unlike weighing potassium bromide and potassium ferricyanide in a traditional darkroom, our 'weighing' is done without a scale, without the little brass weights, and without a substance to weigh that has any weighable mass."[90]

C. *Exhaustion of Administrative Remedies*

The courts have continued to explore the exhaustion of administrative remedies requirement as a prerequisite to seeking judicial relief under ERISA plans. In *DuPerry v. Life Insurance Co. of North America*,[91] the Fourth Circuit found that plaintiff need not have exhausted her administrative remedies under the plan because she made a "clear and positive" showing that such exhaustion would be futile.[92] This decision stands out because plaintiff was granted long-term disability benefits under the "any occupation" standard of the policy without applying for benefits or affording the plan an opportunity to review or make a coverage determination under this standard.[93] Plaintiff filed suit in federal court after she applied for, was denied, and exhausted her administrative remedies for long-term disability benefits under the "regular occupation" standard of the plan. The standard for disability changed to "any occupation" during the pendency of the case.[94] After finding that the administrator abused its discretion by denying plaintiff's claim, the district court awarded plaintiff long-term disability benefits under both standards.[95] The Fourth Circuit affirmed, explaining that plaintiff could "hardly be blamed" for not applying for benefits. Given the prior denial, "there [was] no indication that the change in standard would affect the result" and, therefore, "a remand to the plan administrator would serve no purpose."[96]

90. *Id*. at 675; *but see* Finley v. Hartford Life & Accident Ins. Co., 400 F. App'x 198, 201 (9th Cir. 2010) (finding that the district court improperly accorded "significant weight" to the structural conflict of interest factor and should have reviewed the termination decision with only a "moderate degree of skepticism," given the claimant's lack of credibility and her doctor's unsupported assertion that she could not work); Morris v. Am. Elec. Power Long-Term Disability Plan, 399 F. App'x 978, 982–83 (6th Cir. 2010) (holding that no conflict of interest existed as to the third-party administrator where the administrator's advertising materials on its website emphasized cost savings and a positive impact on the employer's "bottom line"; there was no evidence that the independent claims administrator was functionally equivalent to the entity paying the claims).

91. 632 F.3d 860 (4th Cir. 2011).

92. *Id*. at 875–76.

93. *Id*. at 876 (noting that "while [the administrator] has not yet passed on the question of whether [plaintiff] could satisfy the any-occupation standard, in this case there is no indication that the change in standard would affect the result").

94. *Id*.

95. *Id*. at 875.

96. *Id*. at 876.

Courts have also continued to enforce the deadlines and procedural requirements for administrative appeals. In *Edwards v. Briggs & Stratton Retirement Plan*,[97] the Seventh Circuit affirmed summary judgment in favor of the defendant plan after finding that plaintiff failed to timely file an administrative appeal. In so doing, the Seventh Circuit rejected plaintiff's argument that his late appeal was excused by the doctrine of substantial compliance and found that this position was contrary to ERISA's interest in having " 'finality of decisions' regarding claims for benefits that militates against reopening a plan's administrative claim process willy-nilly."[98]

D. *Functional Capacity Evaluations*

In *Green v. Union Security Insurance Co.*,[99] the Eighth Circuit found that the plan administrator's decision to deny a claim for long-term disability benefits was reasonable and, therefore, the administrator did not abuse its discretion, where there was substantial evidence showing that the claimant's fibromyalgia did not render him disabled.[100] The court cited one of its prior decisions,[101] holding that a functional capacity evaluation (FCE) "alone constitutes more than a scintilla of evidence" when the FCE concludes that a benefits claimant does not meet an ERISA plan's definition of "disability."[102] Noting its previous endorsement of the use of FCEs in evaluating the effect of fibromyalgia on ERISA benefits claimants,[103] the court also found that it was reasonable for the claims administrator to rely on the two-day video surveillance of the claimant's activities because the surveillance video provided objective evidence that tended to contradict the claimant's claim that he was totally disabled and was consistent with the FCE.[104] The cumulative nature of this and other evidence, therefore, constituted "more than a scintilla of evidence" indicating that the claimant was not "disabled" under the policy's definition.[105]

97. 639 F.3d 355 (7th Cir. 2011).

98. *Id.* at 362; *see also* Barboza v. Cal. Ass'n of Prof'l Firefighters, 651 F.3d 1073, 1079–80 (9th Cir. 2011) (holding that plaintiff will be deemed to have exhausted its administrative remedies where the plan fails to timely render a benefits decision); Wallace v. Bashas' Inc. Grp. Disability Plan, 428 F. App'x 681 (9th Cir. 2011) (dismissing participant's appeal for his failure to adhere to procedural rules (for citing excerpts of the record), which prevented a meaningful review of his appeal).

99. 646 F.3d 1042 (8th Cir. 2011).

100. *Id.* at 1050–53.

101. Jackson v. Metro. Life Ins. Co., 303 F.3d 884, 887–88 (8th Cir. 2002).

102. *Green*, 646 F.3d at 1051.

103. *Id.*; *see, e.g.*, Pralutsky v. Metro. Life Ins. Co., 435 F.3d 833, 841 (8th Cir. 2006); Farfalla v. Mut. of Omaha Ins. Co., 324 F.3d 971, 974 (8th Cir. 2003).

104. *Green*, 646 F.3d at 1052.

105. *Id.* at 1053.

E. *Limitations Periods*

Because ERISA does not specify a limitations period for private enforcement actions, and given the uncertainty regarding the "most analogous state statute of limitations" standard, many ERISA-governed plans include limitations periods in the plan documents. In *Young v. United Parcel Services, Inc. Employees' Short Term Disability Plan*,[106] the court held that a six-month limitations period contained in the plan's summary plan description (SPD) was reasonable and enforceable, noting that the plan provision was prominently and appropriately displayed under the heading, "If Your Claim Is Denied."[107] The court further stated that the failure of the administrator to specify when the "final" determination was made (thus commencing the limitations period) did not render the plan's limitation provision ambiguous because the plan was sufficiently clear that such "determination" did not refer to intermediate steps in the appeal process. Accordingly, the court held that the limitation provision was unambiguous and an enforceable part of the plan.[108] But the court reached a contrary result in *Novick v. Metropolitan Life Insurance Co.*,[109] despite very similar facts. In *Novick*, the claimant argued that the plan violated ERISA's requirements by not expressly stating the limitations period in its termination letter.[110] The court agreed, stating: "[The insurer's] initial benefits termination letter violated the ERISA regulations by failing to include the applicable time limit for bringing a civil action pursuant to § 1132(a) after an adverse benefits decision on appeal."[111] The court then held that because of this violation, New York's six-year statute of limitations governed, and the claim for benefits was timely.[112]

F. *Mental Illness Limitation*

In *Wrenn v. Principal Life Insurance Co.*,[113] the court found that the insurer abused its discretion by denying health benefits for the treatment of anorexia nervosa on the basis that the focus of the treatment was for mental health rather than the claimant's physical condition. The court concluded that the evidence was insufficient to show that mental health treatment was the primary focus, where it was clear that severe malnutrition (a physical condition) was the reason for admission, and that the claimant's discharge

106. 416 F. App'x 734 (10th Cir. 2011).
107. *Id.* at 738–39.
108. *Id.*
109. 764 F. Supp. 2d 653 (S.D.N.Y. 2011).
110. *Id.* at 660.
111. *Id.*
112. *Id.*
113. 636 F.3d 921 (8th Cir. 2011).

depended on an objective measure of her physical health (body weight and vital signs), not upon progress made in the treatment of her mental health.[114]

G. *Parties and Fiduciaries*

Who can be an ERISA defendant? Who can be an ERISA fiduciary? In *Cyr v. Reliance Standard Life Insurance Co.*,[115] the Ninth Circuit, sitting en banc, rejected the notion that only the ERISA plan itself, or the designated plan administrator, can be the proper defendant to an ERISA benefit claim. Noting that ERISA did not explicitly limit which parties could be proper defendants, the Ninth Circuit further highlighted that in many instances, like the case before it, a plan administrator "has no authority to resolve benefit claims or any responsibility to pay them,"[116] which instead falls to the insurer, making it "a logical defendant for an action by Cyr to recover benefits due to her . . . and to enforce her rights under [ERISA]."[117] As part of its holding, the Ninth Circuit explicitly overruled any contrary language or decisions.[118]

In *DeLuca v. Blue Cross Blue Shield of Michigan*,[119] an entity's status as a "fiduciary" was front and center. The beneficiary of a self-insured health benefit plan claimed that the plan administrator had breached its fiduciary duties under ERISA by negotiating changes in hospital reimbursement rates. The Sixth Circuit noted that ERISA defines "fiduciary" not in terms of formal trusteeship, but in functional terms of control and authority over the plan.[120] The court recognized that the administrator, in addition to negotiating rates, also acted as the claims-processing agent for the plan, which would be a fiduciary role.[121] But the court further noted that an examination of the conduct at issue was necessary to determine whether such actions gave rise to fiduciary concerns or were merely a business decision that had an effect on the ERISA plan.[122] The court concluded that negotiating changes in reimbursement rates were business dealings not directly associated with the benefit plan at issue.[123] Accordingly, the court found that the administrator was not acting in fiduciary capacity when it

114. *Id.* at 925–27.
115. 642 F.3d 1202 (9th Cir. 2011).
116. *Id.* at 1206–07.
117. *Id.*
118. *Id.*
119. 628 F.3d 743 (6th Cir. 2010).
120. *Id.* at 747 (citing Mertens v. Hewitt Assocs., 508 U.S. 248, 262 (1993)).
121. *Id.*
122. *Id.* (citing Hunter v. Caliber Sys., Inc., 220 F.3d 702, 718 (6th Cir. 2000)).
123. *Id.*

negotiated changes in hospital reimbursement rates and, thus, was not liable for breach of fiduciary duty in that regard.[124]

H. *Plan Documents Rule*

Several decisions in the past year affirm the precedence of ERISA plan terms over other documents, particularly in the context of life insurance benefits. In *Jackman Financial Corp. v. Humana Insurance Co.*,[125] the Seventh Circuit considered the effect of a facility-of-payment clause in the context of an ERISA-governed group life insurance policy. In that case, Humana paid life insurance proceeds to the insured's children pursuant to a facility-of-payment clause, instead of paying the funeral financing company (Jackman) that received an assignment of the benefits from the administrator of the insured's estate. Jackman argued that Humana abused its discretion because it knew that Jackman was assigned the benefits. The Seventh Circuit said otherwise: "We disagree with plaintiff's reasoning because it fails to come to grips with the facility-of-payment clause in the policy."[126] The court held that the clause conferred "broad discretion" on Humana, further noting, "Future potential beneficiaries, as well as assignees of such potential beneficiaries, should take heed as to the broad selection authority granted to the insurer through these clauses . . . ."[127]

While the *Jackman* decision focused on the freedom of an administrator to rely on the plan in making its decision, two cases examined the "plan documents rule" set forth in the Supreme Court's 2009 decision *Kennedy v. Plan Administrator for DuPont Savings & Investment Plan*.[128] The rule mandates compliance with plan documents. In *Matschiner v. Hartford Life & Accident Insurance Co.*,[129] the Eighth Circuit considered whether the plan documents on file at the time of the participant's death controlled over a divorce decree relinquishing a named beneficiary's interest in the proceeds. The Eighth Circuit recognized that the "savings and investment plan at issue in *Kennedy* was an 'employee pension benefit plan,'" but held that the Court's reasoning applied to welfare benefit plans as well.[130] Moreover, the Eighth Circuit found that "the cautionary footnote 13 [in the *Kennedy*

124. *Id.*
125. 641 F.3d 860 (7th Cir. 2011).
126. *Id.* at 865.
127. *Id.* at 867.
128. 555 U.S. 285 (2009) (holding that ERISA mandates that a plan administrator act "in accordance with the documents and instruments" of the plan and foreclose any federal common law inquiry into whether a properly designated beneficiary's divorce decree waived his or her entitlement to plan benefits).
129. 622 F.3d 885 (8th Cir. 2010).
130. *Id.* at 887.

decision][131] . . . did not intend to exempt from the plan documents rule all welfare benefit plans that do not contain an express waiver-of-benefits provision."[132] Accordingly, the court held that even though the plan did not contain a "formal procedure" for the waiver of a beneficiary's interest, the plan documents, not the divorce decree, controlled.[133] Similarly, in *Boyd v. Metropolitan Life Insurance Co.*,[134] the Fourth Circuit found that a life insurer did not breach its fiduciary duty under ERISA by distributing plan death benefits to a participant's estranged husband, the designated beneficiary, notwithstanding his waiver of any claim to benefits in a separation agreement. The court, looking to both *Kennedy* and *Matschiner*, noted, "If MetLife had ignored the beneficiary designation form on file and given dispositive weight to the separation agreement, it would have contravened the text of 29 U.S.C. § 1104(a)(1)(D), the terms of the plan, and the core principles animating *Kennedy*."[135]

I. *Post*-Glenn *Discovery*

In *Crosby v. Louisiana Health Service & Indemnity Co.*,[136] plaintiff sought discovery concerning the compilation of the administrative record, the proceedings at the administrative level, and the administrator's past coverage determinations in situations involving similar conditions.[137] The Fifth Circuit rejected the plan administrator's argument that discovery should be limited to the administrative record, explaining that plaintiff's discovery requests were distinct from the question of whether there was coverage. The court concluded that the district court abused its discretion in so limiting discovery and prejudiced plaintiff's ability to demonstrate that the administrator failed to comply with ERISA's procedural requirements, the administrative record failed to contain all relevant information made available to the administrator, and the administrator afforded coverage in similar situations.[138]

131. 555 U.S. at 304 n.13 ("We do not address a situation in which the plan documents provide no means for a beneficiary to renounce an interest in benefits.").

132. *Matschiner*, 622 F.3d at 888.

133. *Id.*

134. 636 F.3d 138 (4th Cir. 2011).

135. *Id.* at 145.

136. 647 F.3d 258 (5th Cir. 2011).

137. *Id.* at 262.

138. *Id.* at 263–64; *see also* Micha v. Sun Life Assurance Co. of Can., 789 F. Supp. 2d 1248 (S.D. Cal. 2011) (allowing limited discovery); Harvey v. Standard Ins. Co., 787 F. Supp. 2d 1287 (N.D. Ala. 2011) (allowing limited discovery into conflict); *but see* McCandless v. Standard Ins. Co., 765 F. Supp. 2d 943 (E.D. Mich. 2011) (limiting discovery to the administrative record); Parent v. Principal Life Ins. Co., 763 F. Supp. 2d 257 (D. Mass. 2011) (same).

J. *Preemption—State Law Claims*

Which claims "relate to" ERISA plans and which arise from separate, independent obligations for purposes of preemption under ERISA? In *Montefiore Medical Center v. Teamsters Local 272*,[139] the Second Circuit found breach of contract claims for reimbursement of services involved "right to payment" under an ERISA plan and, therefore, raised colorable claims for plan benefits and were completely preempted by ERISA.[140] The court explained that plaintiff's claims did not involve disputes over the "amount of payment," which would implicate independent obligations outside of the plan, i.e., provider fee schedules and other fee payment contracts between the provider and the plan and/or PPO.[141] In rejecting plaintiff's argument that its telephone calls to verify coverage gave rise to an independent legal duty between itself and the plan,[142] the Second Circuit stated: "Whatever legal significance these phone conversations may have had, . . . they did not create a sufficiently independent duty under *Davila*—indeed, as [plaintiff] concedes, this pre-approval process was expressly required by the terms of the Plan itself and is therefore inextricably intertwined with the interpretation of Plan coverage and benefits."[143]

In *Hansen v. Harper Excavating, Inc.*,[144] the Tenth Circuit found that plaintiff's state law claims were not completely preempted by ERISA because he lacked standing.[145] Plaintiff first filed suit against his former employer under ERISA in federal court[146] and recovered a substantial award for his employer's failure to properly enroll him in its ERISA plan.[147] Plaintiff filed a second action against his former employer in state court, asserting state-law claims based on his employer's failure to timely submit his enrollment application to the plan's insurer. After removal, the district court denied plaintiff's motion to remand and dismissed plaintiff's claims based on res judicata.[148] The Tenth Circuit reversed on the grounds that plaintiff was never "covered" under the plan and, therefore, he did not have standing to sue under ERISA.[149] In so doing, the Tenth Circuit rejected

139. 642 F.3d 321 (2d Cir. 2011); *see also* Bicknell v. Lockheed Martin Grp. Benefits Plan, 410 F. App'x 570 (3d Cir. 2011) (holding that participant's claim of breach of the common law duty of good faith and fair dealing was preempted by ERISA).
140. *Montefiore Med. Ctr.*, 642 F.3d at 331.
141. *Id.*
142. *Id.* at 332.
143. *Id.*
144. 641 F.3d 1216 (10th Cir. 2011).
145. *Id.* at 1225.
146. *See* Hansen v. Harper Excavating, Inc., No. 2:05cv940-DAK, 2007 WL 1378561 (D. Utah May 8, 2007).
147. *Hansen*, 641 F.3d at 1219.
148. *Id.*
149. *Id.* at 1220.

plaintiff's argument that "but for" his employer's wrongful behavior, he would have been a plan participant.

K. *Remand versus Remedy*

The Third Circuit addressed the issue of whether remand is an appropriate remedy in *Miller v. American Airlines, Inc.*[150] Recognizing that remand is the appropriate remedy when "benefits are improperly denied at the outset," the court distinguished that situation from one involving improper termination of ongoing benefits.[151] While remand in the first case allows an administrator to consider whether the claimant is disabled,[152] in the latter context "a finding that a decision was arbitrary and capricious means that the administrator terminated the claimant's benefits unlawfully."[153] The Third Circuit thus followed the Sixth, Seventh, and Ninth Circuits in ruling that "benefits should be reinstated to restore the status quo" when a plan abuses its discretion in terminating benefits.[154]

L. *Remedies*

In May 2011, the U.S. Supreme Court issued its ruling in *CIGNA Corp. v. Amara*,[155] a pension case with implications for ERISA practitioners in the life, health, and disability arena. The Court first considered whether the district court had authority to reform the terms of CIGNA's "new" pension plan as a remedy for CIGNA misleading its employees about the plan's features.[156] After holding that § 502(a)(1)(B) does not authorize the relief that the district court entered, the Court turned to whether such relief was proper as appropriate equitable relief under § 502(a)(3).[157] It found that the relief fashioned by the district court—reformation of the terms of the plan, holding CIGNA to what it promised (which resembles estoppel), and entering injunctions requiring payment of money owed under the plan as reformed (considered a surcharge remedy)—fell within the scope of § 502(a)(3).[158] The Court next considered the appropriate legal standard for determining whether members of the relevant employee class

150. 632 F.3d 837 (3d Cir. 2011).
151. *Id.* at 856.
152. *Id.* at 856–57.
153. *Id.* at 857.
154. *Id.*; *see also* Weitzenkamp v. Unum Life Ins. Co. of Am., 661 F.3d 323 (7th Cir. 2011) (noting that the proper remedy for insurer's arbitrary and capricious termination of insured's disability benefits was reinstatement of benefits, not remand to the insurer for further proceedings).
155. 131 S. Ct. 1866 (2011).
156. *Id.* at 1874–78.
157. *Id.* at 1878.
158. *Id.* at 1879–80.

were injured. After noting that the relevant portions of ERISA did not set forth any particular standard for determining harm, the Court turned to the law of equity. It found that when a court imposes a remedy equivalent to estoppel under § 502(a)(3), "a showing of detrimental reliance must be made."[159] The Court then concluded, however, that this showing is not always necessary for other equitable remedies and explained: "We believe that, to obtain relief by surcharge for violations of §§ 102(a) and 104(b), a plan participant or beneficiary must show that the violation injured him or her. But to do so, he or she need only show harm and causation."[160] It continued: "Although it is not always necessary to meet the more rigorous standard implicit in the words 'detrimental reliance,' actual harm must be shown."[161] Because the district court had not determined if an appropriate remedy could be imposed under § 502(a)(3), the Court ultimately vacated the judgment below and remanded the case for further proceedings.

M. *Self-Reported Symptoms Limitation*

The *Weitzenkamp* decision, noted above, also explained the limits of a plan's self-reported symptoms limitation. After paying long-term disability benefits to a claimant diagnosed with "fibromyalgia, chronic pain, anxiety, and depression" for twenty-four months, the insurer terminated these benefits, finding that the participant received the maximum benefits allowed under the plan's self-reported symptoms limitation, which restricted benefits payable for "[d]isabilities, due to sickness or injury, which are primarily based on self-reported symptoms," to twenty-four months.[162] The Seventh Circuit explained that the only viable interpretation of this limitation is that it "applies to disabling illnesses or injuries that are diagnosed primarily based on self-reported symptoms rather than to all illnesses or injuries for which the disabling symptoms are self-reported."[163] It then concluded that because the insured's fibromyalgia was diagnosed using the eighteen-point trigger test related to the condition, it was not primarily based on self-reported symptoms, and the self-reported symptoms limitation did not apply.[164]

N. *Social Security Overpayments*

The *Weitzenkamp* decision further addressed whether the Social Security Act[165] precludes the recovery of overpayments resulting from an insured's

159. *Id.* at 1881.
160. *Id.*
161. *Id.* at 1881–82.
162. Weitzenkamp v. Unum Life Ins. Co. of Am., 661 F.3d 323, 330 (7th Cir. 2011).
163. *Id.*
164. *Id.* at 331.
165. 42 U.S.C. § 407(a).

receipt of Social Security benefits. The insured argued that § 207(a) of the Social Security Act, which provides that Social Security benefits shall not "be subject to execution, levy, attachment, garnishment, or other legal process," precluded such recoupment.[166] While the Seventh Circuit acknowledged that the insurer could not impose a lien directly on the participant's Social Security benefits, it found that the Act did not bar the insurer's recovery of overpayments because the insurer sought an equitable lien on the "specific funds" that it paid to the participant, not on the Social Security benefits themselves.[167]

O. *Standard of Review*

In *Schwalm v. Guardian Life Insurance Co. of America*,[168] the Sixth Circuit explained the "arbitrary and capricious" standard of review as follows: "Although the evidence may be sufficient to support a finding of disability, if there is a reasonable explanation for the administrator's decision denying benefits in light of the plan's provisions, then the decision is neither arbitrary nor capricious."[169] The court, however, may not "rubber stamp" the claim administrator's decision and must "review the quantity and quality of the medical evidence on each side."[170] The Sixth Circuit also acknowledged the inherent conflict of interest where the insurer was both the payer of long-term disability benefits and the administrator vested with discretion to determine eligibility for benefits, but concluded that, based on the record as a whole, the decision to terminate benefits was supported by substantial evidence.[171]

P. *Standard of Review—Prohibition of Discretionary Clauses*

In *McClenahan v. Metropolitan Life Insurance Co.*,[172] the Tenth Circuit held that a Colorado statute,[173] which requires de novo review of a disability benefits claim that has been denied in whole or in part, did not apply retroactively.[174] Given that ruling, the court noted that it did not have

166. *Weitzenkamp*, 661 F.3d at 331–32.

167. *Id.* In so holding, the Seventh Circuit cited the Sixth Circuit's holding in *Hall v. Liberty Life Assurance Co. of Boston*, 595 F.3d 270 (6th Cir. 2010), and the First Circuit's holding in *Cusson v. Liberty Life Assurance Co. of Boston*, 592 F.3d 215 (1st Cir. 2010).

168. 626 F.3d 299 (6th Cir. 2010).

169. *Id.* at 308.

170. *Id.*

171. *Id.* at 311; *see also* O'Hara v. Nat'l Union Fire Ins. Co. of Pittsburgh, 642 F.3d 110 (2d Cir. 2011) (remanding when district court improperly applied deferential standard of review).

172. 416 F. App'x 693 (10th Cir. 2011).

173. Colo. Rev. Stat. § 10-3-1116(3) (effective Aug. 6, 2008).

174. *McClenahan*, 416 F. App'x at 696.

"occasion to pass on the question whether, if applicable, the Colorado statute might or might not be preempted by ERISA."[175]

Q. *Summary Plan Description*

In *CIGNA Corp. v. Amara*,[176] discussed above, the U.S. Supreme Court also addressed whether language contained in a summary plan description can be considered a term of an ERISA plan. The district court reformed CIGNA's "new" pension plan pursuant to § 502(a)(1)(B) of ERISA after finding that CIGNA misled its employees and provided them with incomplete and inaccurate descriptions of the new plan's features. In reviewing the appropriateness of this reformation, the Court considered whether § 502(a)(1)(B) of ERISA grants a court the power to change the terms of a plan. Rejecting the argument that the district court enforced the new plan's terms as written because the plan "includes the disclosures that constituted the summary plan descriptions," the Court stated, "[W]e cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a)(1)(B)) as the terms of the plan itself."[177] It explained that the objective of a summary plan description is to be a clear, simple communication, and it expressed that making the language of a summary plan description legally binding could lead to plan administrators sacrificing "simplicity and comprehensibility in order to describe plan terms in the language of lawyers."[178] Ultimately, the Court concluded "that the summary documents, important as they are, provide communication with beneficiaries about the plan," but "their statements do not themselves constitute the terms of the plan for purposes of § 502(a)(1)(B)."[179]

In *Huss v. IBM Medical & Dental Plan*,[180] the plan administrator determined that an employee who wanted to re-enroll her adult, dependent son in the plan when she retired could not do so because she failed to submit a written application at least sixty days before her son's twenty-third birthday (approximately two and one-half years earlier).[181] The plan administrator based her decision on the language of the 2006 Summary Plan Description (SPD), instead of the 2003 SPD in effect at the relevant time, and required

175. *Id.*; *see also* Flowers v. Life Ins. Co. of N. Am., 781 F. Supp. 2d 1127 (D. Colo. 2011) (finding that ERISA preempted a provision in same statute providing that a first-party claimant whose claim for payment of benefits has been unreasonably delayed or denied may bring an action in a district court to recover reasonable attorney fees and costs).

176. 131 S. Ct. 1866 (2011).

177. *Id.* at 1877.

178. *Id.* at 1877–78.

179. *Id.* at 1878.

180. 418 F. App'x 498 (7th Cir. 2011).

181. *Id.* at 501–02.

a request only by phone, as opposed to a written request, of a coverage extension.[182] The Seventh Circuit held that it was unreasonable for the administrator to deny enrollment in the plan because of the participant's failure to fulfill a condition that did not exist on the critical date.[183] However, the court also found that the 2003 SPD language was ambiguous regarding eligibility for coverage and continuation of benefits. Giving deference to the plan administrator's interpretation, it was not "downright unreasonable" for the administrator to have concluded that the employee had to take action within sixty days of the disabled adult dependent's twenty-third birthday to assure continued eligibility for enrollment beyond age twenty-three.[184] But a genuine issue of fact remained regarding whether the employee had taken sufficient action under the terms of the 2003 SPD to re-enroll her son, so the Seventh Circuit remanded the case to the plan administrator to examine the evidence available at the administrative level.[185]

V. HEALTH INSURANCE

A. *The Patient Protection and Affordable Care Act*

In March 2010, Congress passed the Patient Protection and Affordable Care Act,[186] which included comprehensive changes to the health care insurance industry designed to improve access to the national health care market, reduce health care costs, and increase coverage for those who lack protection. The constitutionality of the Act has been challenged from the moment it was signed into law, with mixed results. The Supreme Court will weigh in during the 2012 election year.[187] In the meantime, we address the current lower-court decisions on this issue.

In *Virginia ex rel. Cuccinelli v. Sebelius*,[188] the district court found that Virginia had standing to challenge the Act by virtue of the purported conflict between the Act and the state's own statute, the Virginia Health Care Freedom Act,[189] which provided that "[n]o resident of [Virginia] . . . shall be required to obtain or maintain a policy of individual insurance coverage" and declared the "minimal essential coverage" provision of the Act an

182. *Id.*
183. *Id.* at 504–05.
184. *Id.* at 506–07.
185. *Id.* at 508.
186. Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).
187. A writ of certiorari was granted in *Florida v. U.S. Department of Health & Human Services*, 132 S. Ct. 604 (2011).
188. 702 F. Supp. 2d 598 (E.D. Va. 2010), *rev'd*, Virginia *ex rel.* Cuccinelli v. Sebelius, 656 F.3d 253 (4th Cir. 2011).
189. Va. Code Ann. § 38.2-3430.1:1.

unconstitutional overreach of congressional authority.[190] On appeal, the Fourth Circuit found that Virginia lacked standing and could not challenge the Act's individual mandate provision because the mandate imposed no obligations on Virginia.[191]

In contrast, the court in *Mead v. Holder*[192] found that individual taxpayers had standing to challenge the constitutionality of the "individual mandate" where they claimed that they had been (and would be) injured by the Act, due to annual shared responsibility payments (i.e., penalties) when they did not obtain the required coverage and needed to rearrange their current finances to pay anticipated penalties.[193] The court then dismissed their complaint on the merits because plaintiffs could not demonstrate that "no set of circumstances exists under which the Act would be valid."[194] The court also found that the "individual mandate" was an appropriate means "rationally related to the achievement of Congress's larger goal of reforming the national health insurance system."[195] In *Liberty University, Inc. v. Geithner*,[196] the court found standing to challenge the "mandatory coverage" provision of the Act because plaintiffs claimed they would have to undertake a significant and costly reorganization of their financial affairs in order to comply with the Act when it takes effect or risk paying the penalty for noncompliance.[197] The court also found that the Anti-Injunction Act (AIA)[198] did not apply to bar the court from reaching a decision on the merits, and it dismissed plaintiffs' claim because Congress acted in accordance

190. Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768, 790 (E.D. Va. 2010), *vacated*, *Virginia*, 656 F.3d 253.

191. *Virginia*, 656 F.3d at 265; *see also* Baldwin v. Sebelius, 654 F.3d 877 (9th Cir. 2011) (finding no standing where citizen plaintiff failed to show an "injury in fact" and raised only a generally available grievance about government; no standing for plaintiff employer because the "individual mandate" does not apply to employers); Purpura v. Sebelius, No. 10-04814, 2011 WL 1547768 (D.N.J. Apr. 21, 2011) (finding no standing where plaintiffs failed to allege sufficient facts demonstrating the effect that the Act had on them or the effect it would have on them in the future); Peterson v. United States, 774 F. Supp. 2d 418 (D.N.H. 2011) (finding no standing where plaintiff, a Medicare recipient, failed to plausibly allege an injury "fairly traceable" to the mandate because Medicare coverage automatically satisfies the Act's health insurance mandate); N.J. Physicians, Inc. v. Obama, 757 F. Supp. 2d 502 (D.N.J. 2010) (finding no standing where the patient's claims were conjectural and speculative, the physician did not suffer an injury in fact, and the nonprofit corporation's only member (the physician) also lacked standing).

192. 766 F. Supp. 2d 16 (D.D.C. 2011).

193. *Id.* at 26.

194. *Id.* at 28.

195. *Id.* at 35.

196. 753 F. Supp. 2d 611 (W.D. Va. 2010), *vacated*, Liberty Univ., Inc. v. Geithner, No. 10-2347, 2011 WL 3962915 (4th Cir. Sept. 8, 2011).

197. *Id.* at 625–26.

198. 26 U.S.C. § 7421 (providing that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person").

with its constitutionally delegated powers when it passed the Act.[199] On appeal, the Fourth Circuit vacated the district court's decision, finding that the suit constituted a pre-enforcement action seeking to restrain the assessment of a tax, which stripped the court of its jurisdiction under the AIA.[200]

In *Thomas More Law Center v. Obama*,[201] the district court found that plaintiffs had standing to challenge the Act because their spending decisions, as a result of the mandated insurance, are injuries fairly traceable to the Act for the purpose of conferring standing.[202] The court upheld the constitutionality of the Act, finding that Congress had the power under the Commerce Clause to require individuals to purchase insurance.[203] The Sixth Circuit upheld the constitutionality of the Act, concurring that Congress had a rational basis for concluding that the practice of self-insuring the cost of health care substantially affects interstate commerce.[204] In contrast, the district court in *Florida ex rel. Bondi v. U.S. Department of Health & Human Services*[205] ruled that the "individual mandate" provision of the Act was unconstitutional because the provision exceeded Congress's authority and further held that the remainder of the Act was void because the individual mandate was so "essential" to the Act that it was not severable.[206] On appeal, the Eleventh Circuit upheld the ruling that the individual mandate was unconstitutional, but it also ruled that it was severable so that no other parts of the Act were struck down.[207]

B. *An Insurer's Duty to Disclose*

In *Levine v. Blue Shield of California*,[208] plaintiffs claimed that their insurer had a duty to disclose information concerning how to structure their health insurance coverage to lower premiums. Plaintiffs alleged Blue Shield failed to disclose that "the same benefits and coverages [were] available . . . for lesser premiums by designating a different party as the primary insured or adding minor dependents to a family plan" and sought a refund of the overpaid premium.[209] The court noted that the authority most on point, *California Service Station & Automobile Repair Ass'n v. American Home*

199. *Geithner*, 753 F. Supp. 2d at 630.
200. *Geithner*, 2011 WL 3962915, at *1; *cf.* Goudy-Bachman v. U.S. Dep't of Health & Human Servs., 764 F. Supp. 2d 684 (M.D. Pa. 2011).
201. 720 F. Supp. 2d 882 (E.D. Mich. 2010).
202. *Id.* at 889.
203. *Id.* at 895.
204. Thomas More Law Ctr. v. Obama, 651 F.3d 529 (6th Cir. 2011).
205. 780 F. Supp. 2d 1256 (N.D. Fla. 2011), *aff'd in part*, *rev'd in part*, 648 F.3d 1235 (11th Cir. 2011), *cert. granted*, 132 S. Ct. 604 (2011).
206. *Id.* at 1305.
207. *Florida*, 648 F.3d 1235, *cert. granted*, 132 S. Ct. 604.
208. 189 Cal. App. 4th 1117 (2010).
209. *Id.* at 1123.

Assurance Co.,[210] was to the contrary.[211] Relying on *California Service*, the court rejected the notion that an insurer owed a purchaser of insurance any "special duty" in "negotiating the price of an insurance contract" because the amount of money that an insurer is willing to accept in exchange for coverage does not relate to coverage or to the processing of claims.[212]

In *Clark v. Prudential Insurance Co. of America*,[213] however, the court allowed a similar claim to stand. Plaintiffs sued their health insurer, claiming that it deceived them by concealing facts about its conduct that would inevitably lead to the collapse of their health insurance plans. According to plaintiffs, Prudential sold individual health policies that provided coverage for high or unexpected medical expenses. Prudential then created a shared risk pool to cover any higher-than-expected claims. In 1981, Prudential "closed the block" and stopped selling these policies. Plaintiffs alleged that Prudential knew this would create a "death spiral" of repeated cycles of higher premiums and a continually shrinking pool of healthy policyholders until premiums became so high that all policyholders would be forced to drop their policies. Plaintiffs argued that Prudential's conduct materially altered the premiums charged and their ability to secure coverage for later-developed medical conditions. The court denied Prudential's motion to dismiss because these material changes threatened the "peace of mind and security from loss" that "foster the unique purposes of an insurance contract," and thereby give rise to the special obligations under California law.[214]

C. *Health Insurance Portability and Accountability Act*

In a matter of first impression, the court in *Bonney v. Stephens Memorial Hospital*[215] held that HIPAA[216] did not create a private right of action in the patient's favor when a hospital security guard disclosed to a police officer that he overheard a patient telling his treating physicians that he (the patient) had been assaulted.[217] After speaking with the patient and security guard, the officer obtained a warrant to search the patient's home for evidence relating to the assault. While searching the patient's residence, the officer discovered evidence of marijuana cultivation, which resulted in a drug-trafficking conviction for the patient. The patient sued the hospital and security guard, alleging violations of state and federal law for disclos-

210. 62 Cal. App. 4th 1166 (1998).
211. *Levine*, 189 Cal. App. 4th at 1128.
212. *Id.* at 1129, 1131.
213. No. 08-6197 (DRD), 2011 WL 940729 (D.N.J. Mar. 15, 2011).
214. *Id.* at *7.
215. 17 A.3d 123 (Me. 2011).
216. 42 U.S.C. §§ 1320d to 1320d-9.
217. *Bonney*, 17 A.3d at 127.

ing confidential health care information. The court granted the hospital's motion to dismiss because HIPAA does not provide a private right of action.[218] In support of its finding, the court noted that HIPAA is silent with respect to private enforcement and that it could not discern any basis on which to conclude that Congress viewed a private right of action as implicit in a comprehensive law that fails to make such a cause of action explicit.[219]

VI. LIFE INSURANCE

A. *Cancellation*

The court in *Yosco v. Aviva Life & Annuity Co*.[220] explained that "[t]his case illustrates the importance of precision in setting a cancellation date for a life insurance policy."[221] On June 18, 2009, the insured faxed a written statement to Aviva, cancelling his life insurance policy "effective immediately."[222] Because he had already paid the June 2009 premium, Aviva treated the insured's coverage as continuing for the remainder of the month, making his cancellation effective July 1, 2009.[223] The insured died on July 1, and Aviva, unaware of this, sent him a letter on July 2, the relevant portion of which stated: "As requested, this policy has been cancelled effective July 1, 2009."[224] The policy did not have a cancellation provision. In light of that, the court found (and the parties agreed) that mutual consent was required to cancel the policy.[225] The court concluded that the request to cancel the policy "effective immediately" was an "offer" that terminated with the insured's death on July 1. Because Aviva did not attempt to "accept" the offer until July 2, after it ceased to be valid, the court concluded that there was no meeting of the minds as to the requested cancellation and, therefore, the policy remained in force at the time of death.[226] Alternatively, the court concluded that Aviva's July 2 "acceptance" did not mirror the June 18 "offer" to cancel the policy immediately.[227] Consequently, there was no meeting of the minds as to the terms for the cancellation, and the policy remained in force.[228]

218. *Id.* at 128.
219. *Id.* at 127.
220. 753 F. Supp. 2d 607 (E.D. Va. 2010).
221. *Id.* at 608.
222. *Id.*
223. *Id.* at 608–09.
224. *Id.* at 609.
225. *Id.* at 610.
226. *Id.*
227. *Id.*
228. *Id.* at 611.

B. *Retained Asset Accounts*

The court in *Keife v. Metropolitan Life Insurance Co*.[229] rejected the insurer's assertion that the creation of a "retained asset" account in the name of the life insurance beneficiary, and the crediting of that account in the amount of the death benefit, satisfied the insurer's obligation under the policy to "immediately" pay the death benefits to the beneficiary.[230] After the insured's death, the insurer established in plaintiff's name a "retained assets" account, which the insurer referred to as a total control account (TCA).[231] Plaintiff closed the account three months later by writing himself a check from the account for the full account balance. Thereafter, plaintiff filed a putative class action lawsuit, alleging that the insurer breached the policy by depositing the death benefits into the TCA instead of paying those benefits to him "immediately," as required under the policy.[232] In denying the insurer's motion to dismiss, the court found that "crediting a TCA does not constitute immediate payment of the death benefits and, as such, [plaintiff] has sufficiently alleged that [the insurer] breached the . . . policy."[233] The court also rejected the insurer's assertion that plaintiff, having received from the TCA the full amount of the policy's death benefits, could not allege facts to show that he was damaged by the breach. The court found that plaintiff sufficiently alleged damages based on the difference between the higher rate of interest that plaintiff could have received from financial markets for the three months between the TCA's opening and his withdrawal of those funds and the rate of interest he actually received under the TCA.[234]

C. *STOLI—Incontestability*

In *PHL Variable Insurance Co. v. Price Dawe 2006 Insurance Trust*,[235] the Delaware Supreme Court confirmed that Delaware law permits insurer challenges to the validity of life insurance policies based on the lack of an

229. 797 F. Supp. 2d 1072 (D. Nev. 2011).
230. *Id*. at 1077.
231. *Id*. at 1074.
232. *Id*. at 1074, 1077.
233. *Id*. at 1077; *see also* Lucey v. Prudential Ins. Co. of Am., 783 F. Supp. 2d 207 (D. Mass. 2011) (rejecting insurer's argument on motion to dismiss that plaintiff failed to state a cognizable claim because there was no material distinction between payment of death benefits to retained assets account and lump-sum payment directly to the beneficiary).
234. *Keife*, 797 F. Supp. 2d at 1077–78.
235. 28 A.3d 1059 (Del. 2011). The court's decision in *Lincoln National Life Insurance Co. v. Joseph Schlanger 2006 Insurance Trust*, 28 A.3d 436 (Del. 2011), was issued the same day as its decision in *Price Dawe*. One of the questions presented in *Price Dawe* was nearly identical to the question presented in *Joseph Schlanger*. The court's analysis and holding on that issue were identical in both cases. In light of that, we cite to the holding in *Price Dawe* only, as citing to the *Joseph Schlanger* decision would be redundant.

insurable interest after the two-year contestability period expires.[236] The court observed that Delaware's incontestability statute did not directly prohibit insurer challenges to the validity of life insurance contracts after the contestability period.[237] The court found that Delaware public policy prohibited the use of insurance as a "wagering contract" on the life of an insured.[238] Because a contract that violates public policy is invalid as a matter of law, the court reasoned that "wagering contracts" were void ab initio because they violated Delaware public policy.[239] Thus, if a stranger originated life insurance (STOLI) contract containing a contestability provision is void ab initio because it is a wagering contract, then the contract's contestability clause is also void and "does not bar an insurer from asserting a claim on the basis of a lack of insurable interest."[240]

D. *STOLI—Pleadings Issues*

The court in *Ohio National Life Assurance Corp. v. Davis*[241] found that the insurer pled facts sufficient to show that the life insurance policy at issue was part of a STOLI scheme. As part of its analysis, the court considered whether the circumstances alleged suggested that the contract was an illegal "wagering contract."[242] The insurer's allegations showed (1) the insured did not need a life insurance policy; (2) the insured was induced to fill out the application by defendants' offer of a $40,000 payment; (3) defendants created all of the documents, designated the beneficiaries and owners, and asserted control over the insured; and (4) the insured did not believe that he applied for insurance; rather, he believed he was "enrolling" in a program under which defendants would pay him in order to receive life insurance benefits for themselves.[243] Those allegations, according to the court, established for purposes of stating a claim that the case was not one involving an insured's exercise of his right to take out insurance on his life and designate a beneficiary of his choosing.[244] Consequently, the court concluded that the circumstances alleged suggested

236. *Price Dawe*, 28 A.3d at 1064–65; *see also* Sun Life Assurance Co. of Can. v. Berck, 770 F. Supp. 2d 728 (D. Del. 2011). The court in *Ohio National Life Assurance Corp. v. Davis*, No. 10 C 2386, 2011 WL 2680500, at *7 (N.D. Ill. July 6, 2011), reached a similar conclusion, citing a long line of decisions in Illinois holding that "the two-year limit that the incontestability provision normally imposes on insurers does not apply to wagering contracts."
237. *Price Dawe*, 28 A.3d at 1066.
238. *Id.* at 1067–68.
239. *Id.*
240. *Id.* at 1068.
241. No. 10 C 2386, 2011 WL 2680500 (N.D. Ill. July 6, 2011).
242. *Id.* at *4.
243. *Id.* at *5.
244. *Id.*

that the contract was closer to a STOLI scheme than to a valid contract for life insurance.[245]

In contrast, the court in *Sun Life Assurance Co. of Canada v. Berck*[246] sidestepped the issue of whether an insurer seeking rescission of a STOLI contract must allege that there was a bilateral agreement or plan to sell the policy to a party that lacked an insurable interest in an insured's life. After issuing a $4 million life insurance policy on the life of a seventy-seven-year-old insured, Sun Life concluded that the trust that owned the policy lacked an insurable interest in the insured's life, and it sought a judgment declaring the policy void ab initio. Defendants moved to dismiss, arguing that Sun Life failed to allege the existence of "a bilateral plan, scheme, or agreement with a stranger third party," which, according to defendants, was "required to establish a violation of [Delaware's] insurable interest requirement."[247] The court denied the trust's motion to dismiss, concluding that even if the insurer was required to allege the existence of an agreement, Sun Life's detailed allegations describing defendants' STOLI scheme were sufficient to establish that there was a "third party with whom defendants had an agreement to sell the [policy] at the time of its procurement," and, therefore, Sun Life stated a claim for relief.[248]

E. *STOLI—Refund of Premium*

Four courts in the past year considered whether an insurer was permitted to retain the premiums paid on STOLI contracts that were declared void ab initio. Two held that insurers could retain the premiums, while the other two held that insurers could not. In *TTSI Irrevocable Trust v. ReliaStar Life Insurance Co.*,[249] an attorney and insurance broker convinced his eighty-five-year-old client to permit the plaintiff trust to take out an insurance policy on her life. When ReliaStar discovered that the trust had no insurable interest in the insured, it cancelled the policy as void ab initio and

245. *Id.*; *see also Price Dawe*, 28 A.3d at 1076 (holding that "the insured's subjective intent for procuring a life insurance policy is not the relevant inquiry" for determining whether the policy lacked an insurable interest at the time of procurement; rather, "[t]he relevant inquiry is who procured the policy and whether or not that person" had an insurable interest in the insured).

246. 770 F. Supp. 2d 728 (D. Del. 2011).

247. *Id.* at 734.

248. *Id.* at 735–36; *see also* Ohio Nat'l Life Assurance Corp. v. Davis, No. 10 C 2386, 2011 WL 2680500 (N.D. Ill. Jul. 6, 2011) (appearing to accept the argument that in order to state a claim to declare a life insurance policy void ab initio, a bilateral agreement to carry out a STOLI scheme must be alleged, and finding that the insurer's "extensive[]" allegations "describ[ing] the numerous moving pieces that Defendants coordinated to implement the scheme" were sufficient to establish "that Defendants had a scheme in place before the [policy] was issued to get around the prohibition against wagering contracts").

249. 60 So. 3d 1148 (Fla. Dist. Ct. App. 2011).

informed the broker that no funds would be remitted in connection with the policy's termination.[250] The trust argued that ReliaStar had rescinded the policy and that a return of premiums was necessary after rescission in order to return the parties to the *status quo ante*. The court rejected the trust's argument, concluding that the STOLI contract was void ab initio because it was a "wagering contract" that violated public policy.[251] The court observed that "contracts that are void as contrary to public policy will not be enforced by the courts and the parties will be left as the court found them," rather than returned to the *status quo ante*.[252] The court refused to depart from that general rule, considering that the trust was the party that "engaged in deceptive and misleading conduct," and it affirmed the judgment permitting ReliaStar to keep the premiums paid on the policy.[253]

The court in *PHL Variable Insurance Co. v. Lucille E. Morello 2007 Irrevocable Trust*[254] also allowed an insurer to retain the premiums paid on a STOLI contract. Through a series of loans and assignments, the policy's $542,062 premium was paid by a third party, New Stream Insurance, LLC.[255] The insurer and the defendant trust entered into a settlement agreement whereby the trust stipulated to its fraud in connection with the application for the policy.[256] After settlement, the parties filed a motion to rescind the policy ab initio and permit ReliaStar to retain the premiums. In the face of New Stream's opposition, the Eighth Circuit observed that there was a "well-recognized exception" whereby "the insurer is relieved from any duty to return the premium when it was induced to enter into the contract by the actual fraud of the insured."[257] In light of the trust's stipulation to fraud at the policy's inception, the court held that Minnesota's exception applied, and that the insurer was "relieve[d] . . . of any duty it otherwise may have owed to return premiums already paid."[258]

The court in *Principal Life Insurance Co. v. Lawrence Rucker 2007 Insurance Trust*,[259] however, came to a different conclusion. After finding that the policy at issue was void on public policy grounds for lack of an insurable interest at the policy's inception,[260] the only remaining issue was whether

250. *Id.* at 1149.
251. *Id.* at 1150.
252. *Id.*
253. *Id.*
254. 645 F.3d 965 (8th Cir. 2011).
255. *Id.* at 968.
256. *Id.* at 968–69.
257. *Id.* at 969–70.
258. *Id.* at 970.
259. 774 F. Supp. 2d 674 (D. Del. 2011).
260. *Id.* at 677 (citing Principal Life Ins. Co. v. Lawrence Rucker 2007 Ins. Trust, 735 F. Supp. 2d 130, 140 (D. Del. 2010)).

Principal was required to return the premiums paid for the policy.[261] Principal argued that the trust was "estopped from seeking a return of premiums paid . . . based on the court's finding that the Policy was procured by [the trust] as part of a fraudulent scheme to evade the law."[262] The court rejected Principal's estoppel argument because there was no finding that the trust had acted fraudulently, and because the retention of contract premiums was inconsistent with Principal's rescission action.[263] While the court denied Principal's request to keep the premiums, it found that Principal could seek damages for the expenses it incurred in issuing the policy, including the costs of underwriting, administration, service, policy investigations, and the payment of commissions.[264]

261. *Id.* at 679.

262. *Id.*

263. *Id.* at 682–83. Notably, the court did not examine whether the insurer could have retained the premiums based on the reasoning in *TTSI Irrevocable Trust*; i.e., that parties to contracts that are void as contrary to public policy will be left as the court finds them and not enforced. TTSI Irrevocable Trust v. ReliaStar Life Ins. Co., 60 So. 3d 1148, 1150 (Fla. Dist. Ct. App. 2011).

264. *Id.* at 682–83; *see also* PHL Variable Ins. Co. v. Robert Gelb Irrevocable Trust, No. 10 C 957, 2010 WL 4363377 (N.D. Ill. Oct. 27, 2010) (striking insurer's request to retain premiums).