

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

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I. INTRODUCTION

This year’s article tracks recent and significant developments in the law of life and accident insurance; disability insurance; ERISA; and health insurance, including continued litigation and trends concerning the Patient Protection and Affordable Care Act. Courts continue to struggle with the impact and operation of alcohol and medical treatment exclusions in the context of accident insurance. Life insurers also continue to test the boundaries of when and how they can rescind policies for lack of insurable interest and retain premiums thereunder. This year’s ERISA jurisprudence is marked by continuing ripples from the Supreme Court’s expansion of the availability of equitable remedies under ERISA, as well as perennial issues involving discovery, conflict of interest, and the fiduciary exception to the attorney-client privilege. Certain trends in the context of disability insurance continue to hold sway: insurers cannot require purely objective evidence for conditions that are defined solely by subjective complaints, but can require objective evidence that such conditions impair a claimant’s ability to work. Contrary to some high profile cases in prior years, however, courts this year upheld an insurer’s use of surveillance as a legitimate part of evaluating a disability claim.

II. ACCIDENTAL DEATH

Whether a death constitutes an “accident” has long been at the crux of decisions evaluating whether coverage exists under accidental death policies. Over the years, however, many insurers have defined (or better defined) the term “accident” in such policies, and often have added specific exclusions aimed at clarifying the type of deaths that are not covered under their policies. As a result, the primary issues analyzed in accidental death cases have evolved as well—shifting from being heavily focused on the meaning of accident toward more litigation with respect to the meaning and applicability of exclusions in accidental death policies. As this year’s cases concentrated on deaths involving alcohol, drugs, and medical treatment, the trends in those areas are described.

A. Alcohol-Related Death

Whether or not the policy contains an alcohol or intoxication exclusion continues to significantly impact the likelihood that an alcohol-related death will be covered under an accidental death policy. As a sampling of this year’s accidental death cases demonstrate, and perhaps common sense dictates, courts are much more likely to uphold an insurer’s decision to deny accidental death benefits because the insured was intoxicated if the subject policy contains an alcohol exclusion. When no such exclusion is present, the outcome is less predictable—even in ERISA-governed cases where the arbitrary and capricious standard of review applies.

1. No Alcohol Exclusion

An insured-driver’s high blood alcohol content (BAC), along with application of the arbitrary and capricious standard of review, was not enough for the federal district court to uphold the insurer’s denial of coverage where no alcohol exclusion was present in *Buzzanga v. Life Insurance Co. of North America*.¹ The insured-driver died in a single-vehicle accident with a BAC of 0.232% after his truck veered off the side of the road and struck a tree.² In denying the plaintiff-beneficiary’s claim on grounds that the insured’s death was not a covered accident, the insurer claimed the insured would have known the risks inherent in operating his vehicle while under the influence of alcohol.³ Appealing the insurer’s decision, the plaintiff argued that since the insured was a functional alcoholic, he would not have understood the effects of an elevated alcohol level.⁴ After the court remanded the matter with directions to reconsider the

1. 2013 WL 64656 (E.D. Mo. Jan. 4, 2013).

2. *Id.* at *2.

3. *Id.* at *3.

4. *Id.*

plaintiff's claim under the *Wickman*⁵ standard, the insurer again denied the claim; the case returned to the district court and the parties pursued summary judgment.⁶ The court concluded the insurer abused its discretion because it improperly applied the *Wickman* test when it failed to consider the insured's "subjective expectations of the risk inherent in his conduct."⁷ Rejecting the insurer's position that it was impossible to determine the insured's subjective beliefs, the court found the record was replete with evidence that the insured subjectively expected to survive his drive and meet up with his wife.⁸ Accordingly, under the *Wickman* test, the insured's death was deemed accidental.⁹

The Fourth Circuit also found the plaintiff-beneficiary was entitled to benefits under an ERISA-governed accidental death plan that did not define "accident" or contain an alcohol exclusion in *Johnson v. American United Life Insurance Co.*¹⁰ There, the insured died after crashing his vehicle into a highway sign while legally intoxicated.¹¹ Reviewing the case de novo, the court explained that the fact that "[d]riving-drunk collisions are not expressly and categorically excluded from" accidental death and dismemberment (AD&D) coverage means "at the very least that there are some circumstances in which AD&D benefits would be paid for injuries to drunk drivers."¹² It further explained that language in the subject policy providing that a seat belt benefit would not be paid if the insured was operating an automobile while legally intoxicated would be rendered meaningless unless drunk driving collisions were deemed "accidents" in the first instance.¹³ Ultimately, the court concluded that "a reasonable plan participant in circumstances similar to those before us would easily have

5. *Wickman v. Nw. Nat'l Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990). Under the *Wickman* test, for an insured's death to be an "accident," he or she must have subjectively expected to survive the circumstances and that expectation must have been objectively reasonable "from the perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences." *Id.* at 1088. If there is insufficient evidence of the insured's expectations, however, a purely objective analysis is undertaken and death is not considered an "accident" if "a reasonable person, with background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct." *Id.*

6. *Buzzanga*, 2013 WL 64656, at *5-6.

7. *Id.* at *9.

8. *Id.* at *11-12.

9. *Id.* at *12. Failure to consider the insured's reasonable expectations under the *Wickman* standard was also found to be an abuse of discretion in *Bryner v. E.I. DuPont De Nemours & Co.*, 914 F. Supp. 2d 755, 764 (E.D. Va. 2012), where the insured died from colchicine toxicity resulting from a prescribed treatment for gout.

10. 716 F.3d 813 (4th Cir. 2013).

11. *Id.* at 817.

12. *Id.* at 821.

13. *Id.* at 821-22.

understood that this accident was covered,”¹⁴ and thus found the plaintiff was entitled to benefits.

The Fourth Circuit’s finding that the absence of an alcohol exclusion must mean that some drunk driving collisions are covered under the policy provides a not-so-subtle reminder to insurers that alcohol exclusions should be included in their accidental death policies if they want to avoid covering drunk driving deaths. Not all courts this survey period, however, required an exclusion to find the insured’s death was not covered under such circumstances. In *Clark v. Life Insurance Co. of North America*,¹⁵ an insured’s death after crashing the motorcycle he was operating with a BAC of 0.176% and marijuana in his system was not an accident under the ERISA-governed policy.¹⁶ The court found the insured should have known it was highly likely he would be killed under such conditions.¹⁷

2. Alcohol Exclusion Present in Policy

There were a number of cases this year where courts upheld the insurer’s determination that an alcohol exclusion barred accidental death coverage for the insured’s death resulting from driving while intoxicated. *Johnson v. Prudential Insurance Co. of America*¹⁸ is one example of a fairly typical drunk driving case where coverage was denied because the policy specifically excluded losses sustained in “an accident that occurs while operating a motor vehicle involving the illegal use of alcohol.”¹⁹ There, the court rejected the plaintiff’s theory that to be “illegal use” under the exclusion the consumption itself must be illegal—an interpretation which would only exclude coverage for losses due to underage consumption of alcohol.²⁰ An intoxication exclusion also barred coverage in *Randall v. Life Insurance Co. of North America*,²¹ where the intoxicated insured fell to his death off of an overpass after exiting the vehicle he had just crashed into a concrete barrier.²² The district court found it was reasonable for the insurer to deter-

14. *Id.* at 822–23.

15. 950 F. Supp. 2d 1348 (N.D. Ga. 2013).

16. *Id.* at 1356–57.

17. *Id.* at 1349–50, 1354. *See also* *Whinery v. Life Insurance Co. of North America*, 2012 WL 8652619 (C.D. Cal. Nov. 7, 2012) (district court upheld denial of accidental death benefits even under a heightened level of skepticism giving the insurer’s decision only minimal deference and where the policy did not have an alcohol exclusion because a reasonable person would know that death was substantially certain to follow from speeding around in circles on city streets at 89 to 95 miles per hour, without a seat belt on, and with a BAC of .22% and cannabinoids in his system).

18. 2012 WL 5378313 (S.D. Ohio Oct. 31, 2012).

19. *Id.* at *1.

20. *Id.* at *5–6.

21. 2013 WL 1286006 (E.D. Okla. Mar. 27, 2013).

22. *Id.* at *1–2.

mine that the insured's death resulted, at least in part, from his operating a vehicle while under the influence of alcohol and thus his death fell within the ERISA-governed policy's intoxication exclusion.²³

In other decisions this survey period, courts found alcohol exclusions barred accidental death coverage, even though the insured was not driving drunk. In *Cultrona v. Nationwide Life Insurance Co.*,²⁴ an insured found dead on the bathroom floor was deemed to have died from positional asphyxia and acute ethanol intoxication (with a .22% BAC).²⁵ The subject alcohol exclusion exempted from coverage injuries sustained while the insured was "deemed and presumed, under the law of the locale in which the *Injury* is sustained, to be under the influence of alcohol or intoxicating liquors."²⁶ After concluding it was reasonable for the insurer to determine that the "law of the locale" was the law of the state where the accident occurred²⁷ and that the coroner's finding of ethanol intoxication created a rebuttable presumption that the insured was intoxicated,²⁸ the court found the denial of accidental death benefits was not arbitrary and capricious.²⁹ Similarly, in *Rau v. Hartford Life & Accident Insurance Co.*,³⁰ the court granted summary judgment to the insurer on a claim for denial of benefits where the insured died from falling out of the passenger side window of a moving vehicle with a .3% BAC after intentionally hanging out the window.³¹ The court concluded the insurer did not abuse its discretion in finding exclusion applied regardless of whether the injury was caused by the intoxication where the subject exclusion barred "[i]njury sustained while intoxicated."³²

B. Interplay Between Medical Treatment and Prescription Drug Exclusions

The interaction between exclusions addressing prescription drugs and those involving medical treatment was examined in a number of decisions this survey period. Beneficiaries attempted to argue—to no avail—that these provisions created inconsistencies when referenced together. In *Brown v. Stone-*

23. *Id.* at *6–7.

24. 936 F. Supp. 2d 832 (N.D. Ohio 2013).

25. *Id.* at 840.

26. *Id.* at 839–40.

27. *Id.* at 844–45.

28. *Id.* at 847–48.

29. *Id.* at 848.

30. 2013 WL 1985305 (D. Conn. May 13, 2013).

31. *Id.* at *2, *4–6.

32. *Id.* at *1, *4–6. *But see* *Ciberay v. L-3 Comm'ns Corp. Master Life and Accidental Death and Dismemberment Ins. Plans*, 2013 WL 2481539 (S.D. Ca. June 10, 2013) (finding abuse of discretion to deny claim for accidental death benefits based on intoxication exclusion where insured, who was hospitalized due to pelvic fractures sustained from falling down the stairs while intoxicated, did not die until nine days after his fall and there was evidence that the insured likely died from a pulmonary embolism; intoxication was too remote from death to reasonably conclude it proximately caused the death).

bridge Life Insurance Co.,³³ the Illinois Appellate Court affirmed the trial court's entry of summary judgment for the insurer defendants, both of which found that the insured's death from Fentanyl intoxication was excluded under the medical treatment exclusions contained in their respective accidental death policies since the insured undisputedly used Fentanyl patches to treat her back pain.³⁴ The plaintiffs argued that the subject policies' drug exclusions, which excluded death occurring while the insured was taking or using drugs unless the drugs were taken or used as prescribed by a doctor, provided an exception to the medical treatment exclusion, creating an inference that coverage existed if the insured took the drug as his physician prescribed.³⁵ Rejecting this argument, the court explained that the only reasonable way to interpret these drug exclusions is to find that they exclude coverage if an insured's injury resulted from taking illegal drugs or from taking controlled drugs other than as prescribed by a physician.³⁶ Thus, they are not inconsistent with the medical treatment exclusions, which involve death due to ingesting prescribed drugs as part of medical treatment for a sickness or disease.³⁷ Since the insured's death resulted from medical treatment, the court said it was properly deemed excluded by each carrier.³⁸

A similar issue was raised in *Cady v. Hartford Life & Accidental Insurance Co.*³⁹ The insured died from an overdose of various prescription and non-prescription drugs, including Xanax, Cymbalta, and Zyprexa, which had been prescribed to treat his depression and anxiety.⁴⁰ Methadone, which had not been prescribed by a doctor, was also in the insured's system at the time of his death.⁴¹ The insurer denied coverage both because medical treatment did not fall within "injury" as defined in the accidental death policy and because coverage was barred by the policy's drug exclusion, concluding the drugs that caused the insured's overdose were either taken as part of his medical treatment or not taken in accordance with a prescription.⁴² The plaintiff claimed that the insurer's interpretation of the policy language was unreasonable because as applied it "exclude[s] coverage any time a person is found to have had prescription and non-prescription drugs in their system, even if they died due to a totally unre-

33. 990 N.E.2d 895 (Ill. App. Ct. 2013). The insurer-defendants in this case were represented by the authors' firm, Chittenden, Murday & Novotny LLC.

34. *Id.* at 897.

35. *Id.* at 898-900.

36. *Id.* at 900.

37. *Id.*

38. *Id.*

39. 930 F. Supp. 2d 1216 (D. Idaho 2013).

40. *Id.* at 1220.

41. *Id.*

42. *Id.* at 1221-22.

lated accident.”⁴³ The court found the argument inapposite, explaining: “[T]here is no evidence in this case of any accident independent from drug use pursuant to medical treatment or without a prescription which caused Mr. Marsh’s death.”⁴⁴ The court thus concluded that substantial evidence supported the finding that no covered loss occurred since the insured’s overdose was either the result of medical treatment or was excluded under the drug exclusion because it was caused by his Methadone use.⁴⁵

C. Other Drug, Sickness, or Medical Treatment Exclusion Cases

Several other decisions involved drug, sickness, or medical treatment exclusions this survey period with interesting results. In *Hutchinson v. Liberty Life Insurance Co.*,⁴⁶ the South Carolina Supreme Court determined the insured’s death in a single vehicle collision while under the influence of methamphetamine was not excluded by policy language barring coverage for “injury as a result of the insured being under the influence of any narcotic unless administered on the advice of a physician and taken in the dosage prescribed.”⁴⁷ Although the insurer successfully argued to the appellate court that methamphetamine is commonly understood to be a “narcotic” in light of its widespread illegal use, the Supreme Court deemed the term ambiguous and construed “narcotic” in the beneficiary’s favor to mean a “defined type of controlled substance rather than a generic term for illegally used substances.”⁴⁸ Under this definition, methamphetamine was found not to be a narcotic and the death was not excluded.⁴⁹

In contrast, it was not an abuse of discretion for the insurer to deny coverage for an insured’s death after falling out of a hospital bed a couple of weeks post-brain surgery, the court in *Vining v. Progressive Casualty Insurance Co.*⁵⁰ found, where the accidental death policy issued by Metropolitan Life Insurance Company excluded any loss caused or contributed to by “[p]hysical or mental illness or infirmity, or the diagnosis or treatment of such illness of [sic] infirmity.”⁵¹ Although the insured died from a subdural hematoma caused by his fall, the court found the fall would not have

43. *Id.* at 1227.

44. *Id.* at 1230 n.10.

45. *Id.* at 1230–33. See also *Kallaus v. Nationwide Death Benefit Plan*, 2012 WL 5411082 (S.D. Ohio Nov. 6, 2012) (ERISA plan administrator’s reliance on both a sickness/disease exclusion and a prescription drug exclusion to deny coverage under an accidental death policy was not internally inconsistent as the plaintiffs claimed, since there was nothing to support the plaintiffs’ argument that multiple exclusions cannot be relied on where multiple factors contributed to the insured’s death).

46. 743 S.E.2d 827 (S.C. 2013).

47. *Id.* at 828.

48. *Id.* at 829.

49. *Id.* at 829–30.

50. 2013 WL 3975220, at *2 (D. Colo. Aug. 1, 2013).

51. *Id.*

been fatal if he had not been taking anticoagulants and did not have friable brain tissue as a result of his brain cancer.⁵² Accordingly, the insurer's denial of benefits was found to be supported by substantial evidence and not arbitrary and capricious.⁵³

III. DISABILITY

Co-morbidity and the underlying causes of a claimant's inability to work continue to present challenges for disability insurers, as do cases involving risk of relapse. But courts this year also recognized the validity of surveillance as a part of the claim evaluation process and further acknowledged that, even for conditions diagnosed purely by subjective complaints, insurers can still require objective evidence of functional impairment when evaluating a claim.

A. *Factual versus Legal Disability*

When a claimant loses his professional license but might also be disabled, courts must evaluate the disability independent of the loss of licensure. In *Jacobs v. Northwestern Mutual Life Insurance Co.*,⁵⁴ the claimant, a plastic surgeon who suffered from bipolar disorder and drug addiction, sought disability benefits when his medical license was suspended "because his continued practice 'constituted an imminent danger to the health of the people of' " New York.⁵⁵ The insurer denied his claim arguing he was prevented from working because his license was suspended (legal disability), not because of his bipolar disorder and drug addiction (factual disability).⁵⁶ In fact, the claimant had worked right up until the day his license was suspended, notwithstanding his conditions.⁵⁷ The claimant argued that by the time his license was suspended he was already disabled due to his mental illness, the existence of which was not disputed).⁵⁸ Ultimately, the court found the claimant was disabled prior to his license's suspension,⁵⁹ citing his long-documented history of bipolar disorder, which his physicians concluded "rendered him unable to perform 'the principal duties of his occupation.'"⁶⁰

52. *Id.* at *4.

53. *Id.* at *4-5. See also *Garza v. Sun Life Assurance Co. of Canada*, 2013 WL 1816989 (S.D. Tex. Apr. 29, 2013) (not an abuse of discretion to determine that insured's death from allergic reaction to a wasp sting was excluded as a disease under policy provision excluding "bodily or mental infirmity or disease of any kind," since insured had known hymenoptera allergy).

54. 103 A.D.3d 78 (N.Y. App. Div. 2012).

55. *Id.* at 80.

56. *Id.* at 85.

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.* at 87 (internal citation omitted).

B. Mental Illness Limitation

When policies limit coverage for disabilities caused by mental illness, the cause of the mental illness and whether it exists in conjunction with another ailment resulting in a disability must be evaluated. The issue in *White v. Prudential Insurance Co. of America*⁶¹ was whether a twenty-four month mental illness limitation applied where the claimant had a mental illness but was also involved in a serious car accident and suffered a head injury.⁶² The insurer terminated benefits having determined the claimant's limitations were the result of "mental and nervous condition(s) of depression and anxiety,"⁶³ and the policy's mental illness benefits had been exhausted.⁶⁴ The court, however, found the injury did not fall within the twenty-four month mental illness limitation because if his disability stemmed from mental illness, such mental illness was caused by a traumatic brain injury sustained in the car accident.⁶⁵

The comorbidity of the claimant's dementia and bipolar conditions were at issue in *Reid v. Metropolitan Life Insurance Co.*⁶⁶ The policy provided that its twenty-four month mental health limitation did not apply to certain "exclusionary diagnoses," such as schizophrenia, dementia, or organic brain disease.⁶⁷ Although the claimant had dementia, the insurer terminated benefits on the grounds that her disability was caused solely by a bipolar disorder and not dementia.⁶⁸ That argument was untenable,⁶⁹ according to the court, because the claimant provided documentation establishing that "her disability resulted from dementia"⁷⁰ and that she was disabled due to both a bipolar disorder and dementia.⁷¹ Accordingly, the court ordered that her benefits be reinstated.⁷²

C. Risk of Relapse

A serious risk of relapse can be the basis for concluding a claimant remains disabled. In *Colby v. Union Security Insurance Co. & Management Co. for Merrimack Anesthesia Associates Long Term Disability Plan*,⁷³ an anesthesiologist addicted to Fentanyl received long-term disability (LTD) benefits

61. 908 F. Supp. 2d 618 (E.D. Penn. 2012).

62. *Id.* at 621.

63. *Id.* at 624.

64. *Id.* at 622.

65. *Id.* at 639.

66. 2013 WL 1932659, at *1 (N.D. Ga. Mar. 29, 2013).

67. *Id.* at *23.

68. *Id.* at *29.

69. *Id.* at *32.

70. *Id.* at *29.

71. *Id.* at *32.

72. *Id.* at *42.

73. 705 F.3d 58 (1st Cir. 2013).

until she was released from an inpatient treatment center.⁷⁴ Thereafter, the plan denied additional LTD benefits, even though her physician feared a relapse, concluding “a risk for relapse is not the same as a current disability.”⁷⁵ The plan language, however, did not categorically exclude risk of relapse as a basis for disability⁷⁶ and thus the First Circuit found “no basis for importing an unwritten textual exclusion for risk of relapse.”⁷⁷ Accordingly, the court said it was unreasonable for the plan to refuse to consider whether the claimant’s risk of relapse could rise to the level of a disability—something the court characterized as “a commonsense proposition” given the circumstances of her substance dependency.⁷⁸ Furthermore, allowing the termination of benefits to stand would create a “perverse incentive” for her to return to work, putting put both the claimant and her patients at risk.⁷⁹ The court thus upheld judgment in favor of the claimant.⁸⁰

D. Surveillance

Courts this review period confirmed once again that video surveillance is a valid and acceptable practice by insurers if properly used. In *Duncan v. CIGNA Life Insurance Co. of New York*,⁸¹ the claimant argued surveillance of him performing his “pastoral duties as a Jehovah’s Witness” improperly targeted his exercise of religion and claimed the termination of his benefits because of those activities violated his religious freedom.⁸² In affirming the benefits termination, the Second Circuit held that the claimant failed to allege CIGNA was a “state actor” and, at any rate, CIGNA’s focus was “on [his] ability to walk for prolonged periods, carry items, and drive longer distances,” not on his religious activities.⁸³

In *Minutello v. Hartford Life and Accident Insurance Co.*,⁸⁴ the district court found that surveillance of the claimant was warranted and, while not dispositive of whether she was disabled, could be considered with other available evidence because “‘video surveillance remains a proper method of investigating disability insurance claims.’”⁸⁵ Moreover, although Hartford had to give serious consideration to the claimant’s treating physician’s statements, “it was not required to credit ‘visible fiction’” where surveillance

74. *Id.* at 60.

75. *Id.*

76. *Id.* at 65.

77. *Id.* at 66.

78. *Id.*

79. *Id.*

80. *Id.* at 68.

81. 507 F. App’x 61 (2d Cir. 2013).

82. *Id.* at 64.

83. *Id.*

84. 2013 WL 4053144, at *1 (W.D. Pa. Aug. 12, 2013).

85. *Id.* at *14 (internal citation omitted).

video showed her lifting and carrying a large desk with another person, thereby giving Hartford reasonable grounds to find that the “extreme limitations” imposed by her physician were unsupported.⁸⁶

E. *Bad Faith*

The Seventh Circuit examined whether an honest mistake in an insurer’s claim analysis constituted bad faith under Wisconsin law. In *Blue v. Hartford Life & Accident Insurance Co.*,⁸⁷ the insurer denied benefits using the “any occupation” standard contained in the claimant’s initial policy rather than that in the amended policy issued several years later.⁸⁸ The insurer argued its application of the incorrect standard was an innocent mistake, not bad faith.⁸⁹ Applying Wisconsin’s bad faith test,⁹⁰ the Seventh Circuit agreed, finding that even if no reasonable basis existed for denying the claimant’s claim, the insurer’s use of the incorrect standard was an honest mistake.⁹¹

F. *Own Occupation*

In interpreting and applying the “own occupation” standard this survey period, courts reached differing conclusions regarding when and to what extent a claimant’s actual job duties should be considered in making a disability determination. In *Carlson v. Standard Insurance Co.*,⁹² the claimant argued he was disabled from doing the specific duties of his job as a “Plant Operation Manager.”⁹³ The policy contained language declaring that, for purposes of determining the claimant’s “Occupation,” the insurer was entitled to consider how his job was performed in the national economy.⁹⁴ Citing the U.S. Department of Labor’s Dictionary of Occupational Titles (“DOT”), the insurer determined that the claimant’s occupation fell within the description of a “Production Superintendent,” a light duty occupation.⁹⁵ Since the claimant could perform the duties of such an occupation, his disability claim was denied.⁹⁶ The court agreed with the insurer,

86. *Id.* at *15.

87. 698 F.3d 587 (7th Cir. 2012).

88. *Id.* at 590.

89. *Id.* at 591.

90. Wisconsin’s bad faith standard requires the plaintiff to show: (1) the absence of a reasonable basis for denying benefits of the policy, and (2) the defendant’s knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. *Id.* at 595 (citing *Anderson v. Cont’l Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978)).

91. *Id.* at 597.

92. 920 F. Supp. 2d 1028 (W.D. Mo. 2013).

93. *Id.* at 1030–31.

94. *Id.* at 1030.

95. *Id.* at 1033.

96. *Id.*

finding it applied the correct “own occupation” standard regardless of whether the claimant could perform the specific duties of his actual job.⁹⁷

In contrast, the court in *Kavanay v. Liberty Life Assurance Co. of Boston*⁹⁸ held that the insurer abused its discretion by refusing to consider the claimant’s actual job duties.⁹⁹ The claimant was a claims adjuster whose duties included going into the field to inspect claim sites.¹⁰⁰ His benefits were terminated after the insurer’s vocational consultant found that two types of claims examiner existed in the national economy—“inside” and “outside”—and classified the claimant as an “inside” claims examiner.¹⁰¹ The court found that the specific duties of the claimant’s actual job were relevant to the occupational analysis and thus the insurer abused its discretion in focusing exclusively on the DOT’s definition of an inside claims examiner.¹⁰²

G. Subjective versus Objective Evidence

Courts continue to find that although insurers can reasonably demand objective evidence that a claimant’s subjective complaints prevent her from working, they cannot demand objective evidence to support the existence of a condition diagnosed based on a claimant’s subjective complaints, such as fibromyalgia or tinnitus, if there is no test that could objectively establish the condition is present. For example, in *Geiger v. Pfizer, Inc.*,¹⁰³ the court held it was unreasonable for the insurer to deny a claim based on the lack of objective evidence of fibromyalgia because the condition could not be established by objective testing.¹⁰⁴ Similarly, the court in *Miles v. Principal Life Insurance Co.*¹⁰⁵ found the insurer could not demand that the claimant obtain objective evidence of tinnitus because there was no way to objectively test for that condition and, thus, it would be impossible to satisfy such a demand.¹⁰⁶ According to the court, the insurer also could not ignore a claimant’s subjective evidence just because there was no objective evidence to accompany it.¹⁰⁷ The *Miles* court further faulted the insurer for refusing to consider the claimant’s subjective complaints, finding it had to either assign some weight to those complaints or explain its rationale for disregarding them.¹⁰⁸

97. *Id.*

98. 914 F. Supp. 2d 832 (S.D. Miss. 2012).

99. *Id.* at 835.

100. *Id.* at 833, 835.

101. *Id.* at 834–35.

102. *Id.* at 835.

103. 918 F. Supp. 2d 697 (S.D. Ohio 2013).

104. *Id.* at 705.

105. 720 F.3d 472 (2d Cir. 2013).

106. *Id.* at 488.

107. *Id.* at 486.

108. *Id.* at 487.

In contrast, the insurer's termination of benefits was upheld in *Howard v. Hartford Life & Accident Insurance Co.*¹⁰⁹ because the claimant could not produce objective evidence of either the fibromyalgia infirmities about which she complained or of her inability to work due to those alleged infirmities.¹¹⁰ The court found most significant the lack of objective evidence showing an inability to work, prompting it to comment that "[e]ven for subjective conditions like fibromyalgia, it is reasonable to expect medical evidence of an inability to work."¹¹¹ Similarly, simply having evidence to support a fibromyalgia diagnosis was not enough to satisfy the plan's definition of "totally disabled" in *Wilkins v. Proctor & Gamble Disability Benefit Plan*.¹¹² The claimant's inability to prove that her condition prevented her from returning to work, not just that she had a particular condition or disease, provided reasonable grounds for the plan's finding that she was no longer disabled.¹¹³

Courts also considered which party has the burden of obtaining objective evidence related to an alleged disability. In *Bloom v. Hartford Life & Accident Insurance Co.*,¹¹⁴ the claimant argued that Hartford could not rely on a lack of objective evidence when it failed to obtain such evidence itself.¹¹⁵ Rejecting that argument, the court found that the burden to prove disability rested with the claimant and, as such, the insurer was not required to obtain objective evidence related to the claimant's alleged disability.¹¹⁶ Just because an insurer is not required to obtain that evidence, however, does not mean it cannot request it. The court in *Ianniello v. Hartford Life & Accident Insurance Co.*¹¹⁷ concluded the insurer's request for "tender point" testing for fibromyalgia was reasonable because the test is a common "objective" measure helpful for diagnosing fibromyalgia.¹¹⁸

IV. ERISA

The availability of equitable relief under ERISA¹¹⁹ and how such relief can be shaped and calculated continues to be a main focus in ERISA law this survey period. Of course, the scope of discovery, the nature of an ERISA plan insurer's conflict of interest, and the application of the fiduciary ex-

109. 929 F. Supp. 2d 1264 (M.D. Fla. 2013).

110. *Id.* at 1296.

111. *Id.* at 1294-95 (internal quotations and citations omitted).

112. 2013 WL 3989584 (S.D. Ohio Aug. 2, 2013).

113. *Id.* at *9.

114. 917 F. Supp. 2d 1269 (S.D. Fla. 2013).

115. *Id.* at 1283.

116. *Id.*

117. 508 F. App'x 17 (2d Cir. 2013).

118. *Id.* at 20.

119. Employee Retirement Income Security Act of 1974, 29 U.S.C. ch. 18.

ception to claims of attorney client privilege remain sharply contested issues in ERISA litigation as well.

A. *Equitable Relief Under Section 502(a)(3)*

The Supreme Court's decision in *CIGNA Corp. v. Amara*¹²⁰ continues to have major repercussions for ERISA fiduciaries in the years since it was decided. During this survey period, various federal appellate courts characterized *Amara* as having significantly expanded the types of relief available under section 502(a)(3) of ERISA.¹²¹ As a result, the courts vacated or reversed dispositive rulings against participants who sought monetary relief for alleged fiduciary breaches by plan administrators.

That was the outcome in *Kenseth v. Dean Health Plan, Inc.*,¹²² where the plan administrator invited participants to call with questions about their health care coverage,¹²³ but did not advise that its answers to such questions could not be relied upon as definitive coverage determinations.¹²⁴ Prior to surgery, the plan advised a participant that it covered the costs of her surgery but, after the surgery, denied all benefits.¹²⁵ Asserting a claim under section 502(a)(3), the participant argued the plan administrator breached its fiduciary duties and asked the court to order the plan to pay her providers for the surgery and all related care.¹²⁶ Citing the Supreme Court's determination in *Amara* that "[e]quity courts possessed the power to provide relief in the form of monetary 'compensation' for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment,"¹²⁷ the Seventh Circuit found the district court erred in concluding that make-whole money damages were not available under section 502(a)(3) and it vacated the district court's judgment for the plan.¹²⁸

120. 131 S. Ct. 1866 (2011).

121. 29 U.S.C. §§ 1001–1461. See *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 876 (7th Cir. 2013) ("So the relief available for a breach of fiduciary duty under Section 1132(a)(3) is broader than we have previously held."); *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448, 450 (5th Cir. 2013) ("The Supreme Court recently stated an expansion of the kind of relief available under § 502(a)(3) when the plaintiff is suing a plan fiduciary and the relief sought makes the plaintiff whole for losses caused by the defendant's breach of a fiduciary duty."). Notably, the court in *Rogue v. Roofer's Union Welfare Trust Fund*, 2013 WL 2242455 (N.D. Ill. May 21, 2013), found that *Amara* did not affect the line of decisions declaring that participants could not assert actions under section 502(a)(3) if section 502(a)(1)(B) provided an adequate remedy, unless the actions were "truly distinct." *Id.* at *7.

122. 722 F.3d 869 (7th Cir. 2013).

123. *Id.* at 871.

124. *Id.* at 872–73.

125. *Id.* at 872.

126. *Id.* at 875.

127. *Id.* at 878.

128. *Id.* at 891–92.

Similarly, the plan administrator in *Geralds v. Entergy Services, Inc.*¹²⁹ erroneously advised a participant orally and in writing that he would continue to receive medical benefits if he accepted early retirement.¹³⁰ When the plan sought to terminate those benefits, the participant sued under section 502(a)(3) and requested make-whole damages.¹³¹ The Fifth Circuit reversed the district court's dismissal of the participant's action, finding that *Amaral's* discussion of the remedies available under section 502(a)(3) meant the participant had stated a viable claim for relief.¹³²

B. Claims and Computations for Reimbursement

In contrast with the cases discussed above, courts this review period struggled with whether actions to recover benefit overpayments qualified as "appropriate equitable relief" under section 502(a)(3) and how those amounts are to be calculated. For example, in *US Airways, Inc. v. McCutchen*,¹³³ the Supreme Court addressed a circuit split over whether the common fund doctrine limited a plan's right to reimbursement. The Court held that a claimant may not assert equitable defenses such as the common fund doctrine if they contradict a plan's plain terms, but a plan's ambiguity or silence as to those defenses will not bar them.¹³⁴ In *McCutchen*, an administrator paid a claimant's medical bills; when the claimant received settlement monies from a third party, the plan requested reimbursement.¹³⁵ After the claimant paid the attorneys that secured the settlement their fees, however, the amount the administrator sought was more than the claimant actually received. Accordingly, he argued that the common fund doctrine, inter alia,¹³⁶ limited the plan's right to reimbursement. Because the plan did not expressly prohibit the payment of attorney fees, the Court concluded the claimant could assert a common fund doctrine defense.¹³⁷

The challenge of calculating the overpayment amount was explored in *Wolfensberger v. Aetna Life Insurance Co.*,¹³⁸ where fees and costs incurred to obtain a third-party settlement were rolled into the total settlement amount, but not apportioned. There, the plan treated the entire settle-

129. 709 F.3d 448 (5th Cir. 2013).

130. *Id.* at 449.

131. *Id.* at 450.

132. *Id.* at 451–52.

133. 133 S. Ct. 1537 (2013).

134. *Id.* at 1551.

135. *Id.* at 1543.

136. The participant also asserted an unjust enrichment defense, which the Court rejected as contrary to the plan's terms. *Id.* at 1548.

137. *Id.* at 1550. *But see* Quest Diagnostics v. Bomani, 2013 WL 3148651 (D. Conn. June 19, 2013) (plan language was not ambiguous and, therefore, left "no room for equitable defenses to operate"); Cavanagh v. Northern New England Benefit Trust, 2013 WL 2285203 (D.N.H. May 23, 2013) (same).

138. 2013 WL 942073 (N.D. Ill. Mar. 11, 2013).

ment amount as “other income benefits” and used that amount to calculate the overpayment.¹³⁹ Arguing the settlement was comprised of expenses beyond workers’ compensation benefits, such as medical expenses and attorney fees, the participant claimed those amounts should not be considered “other income benefits.”¹⁴⁰ The court disagreed, finding it was reasonable to calculate the overpayment based on the total settlement amount since the participant failed to adequately prove that a portion of the settlement was attributable to medical expenses and attorney fees.¹⁴¹ In *O’Brien-Shure v. U.S. Laboratories, Inc. Health & Welfare Benefit Plan*,¹⁴² the court rejected the claimant’s argument that the plan’s action sought *legal* relief as opposed to *equitable* relief since she did not still have the benefits that were overpaid. It held that a plan’s overpayment claim can be equitable in nature “even if the benefits it paid the insured are not specifically traceable to the insured’s current assets due to commingling or dissipation.”¹⁴³ The Second Circuit in *Thurber v. Aetna Life Insurance Co.*¹⁴⁴ similarly found that whether a claimant actually possessed the overpaid benefits was not relevant to the “equitable relief” analysis, so long as the claimant was on notice when the benefits were received that they belonged to the plan. Under that construct, the plan’s claim was equitable because it sought to enforce an equitable lien created by agreement and the claimant was holding the overpayment in a constructive trust.¹⁴⁵

C. Standard of Review—Discretionary Clauses and Plan Documents

A plan looking to reserve discretionary authority to a plan administrator must state its intent clearly; it cannot do so relying on subtle inferences drawn from unrevealing language. In *Gross v. Sun Life Assurance Co. of Canada*,¹⁴⁶ the First Circuit held that “satisfactory to us” language, without more, did not meet the “requisite minimum clarity” required to shift from de novo to deferential review.¹⁴⁷ Similarly, in *White v. Prudential In-*

139. *Id.* at *6.

140. *Id.* at *7.

141. *Id.* at *9–10; *see also* Sanders v. Hartford, 2013 WL 3944601 (D. Md. July 30, 2013) (concluding it was reasonable for plan to use Social Security Administration’s online benefit calculator to calculate amount of Social Security disability (SSD) benefits to offset).

142. 2013 WL 3321569 (N.D. Ill. July 1, 2013).

143. *Id.* at *3 (quoting Gutta v. Standard Select Trust Ins. Plans, 530 F.3d 614, 621 (7th Cir. 2008)); *see also* Anderson v. Reliance Standard Life Ins. Co., 2013 WL 1190782 (D. Md. Mar. 21, 2013) (SSD benefits, even if no longer in the claimant’s possession, are recoverable by the fiduciary under an equitable theory).

144. 712 F.3d 654 (2d Cir. 2013).

145. *Id.* at 664.

146. 2013 WL 4305006 (1st Cir. Aug. 16, 2013).

147. *Id.* at *11; *see also* Frey v. Herr Foods Inc. Emp. Welfare Plan, 2012 WL 6209896 (E.D. Pa. Dec. 13, 2012) (discretionary language in the summary plan description (SPD) was not part of the plan and, therefore, its contents were not legally enforceable).

insurance Co. of America,¹⁴⁸ the court applied the de novo standard of review because the language “[y]ou are disabled when Prudential determines” was insufficient to constitute a clear grant of discretionary authority.¹⁴⁹ In *Hammill v. Prudential Insurance Co. of America*,¹⁵⁰ the court found that the plan language did not grant Prudential discretion, but the summary plan description did. Citing the Supreme Court’s decision in *Amaro*,¹⁵¹ however, the court rejected the argument that the unincorporated SPD conferred discretionary authority on the plan administrator.¹⁵² In *Sullivan v. Prudential Insurance Co. of America*,¹⁵³ the de novo standard of review governed because the SPD—the only document reserving discretion to the administrator—clearly stated it did not constitute the terms of the plan.¹⁵⁴ In contrast, the grant of discretion at issue in *Frazier v. Life Insurance Co. of North America*¹⁵⁵ was set forth in the policy.¹⁵⁶ As a result, the court was forced to address the rather prosaic issue raised by the claimant as to whether the insurance policy was a plan document, rather than merely a summary document insufficient to confer discretion under *Amaro*.¹⁵⁷ The Sixth Circuit held that the policy was a plan document and rejected the claimant’s assertions, remarking: “[n]othing in [*Amaro*] supports the argument that an insurance policy . . . cannot be a plan document.”¹⁵⁸ The court thus applied an arbitrary and capricious standard of review.¹⁵⁹

D. Standard of Review—Conflict of Interest

Five years after the Supreme Court’s decision in *Metropolitan Life Ins. Co. v. Glenn*,¹⁶⁰ disputes continue to arise over whether deferential review should be altered because of the “conflict of interest” that arises when a plan administrator is responsible for both evaluating claims and paying benefits. The plan terms in *Rice v. ADP TotalSource, Inc.*¹⁶¹ required the court to

148. 908 F. Supp. 2d 618 (E.D. Pa. 2012).

149. *Id.* at 626–27.

150. 2013 WL 27548 (E.D.N.Y. Jan. 2, 2013).

151. 131 S. Ct. 1866 (2011) (“summary documents,” such as an SPD, “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).”)

152. *Id.* at *4.

153. 2013 WL 1281861 (E.D. Cal. Mar. 25, 2013).

154. *Id.* at *1; *see also* *Belheimer v. Fed. Express Corp. Long Term Disability Plan*, 2012 WL 5945042 (D.S.C. Nov. 28, 2012) (Aetna’s decision was reviewed de novo because the LTD Plan did not contemplate or authorize the delegation of authority from Federal Express to Aetna).

155. 725 F.3d 560 (6th Cir. 2013).

156. *Id.* at 566.

157. *Id.* at 566–67.

158. *Id.* at 566.

159. *Id.* at 567.

160. 128 S. Ct. 2343.

161. 936 F. Supp. 2d 951 (N.D. Ill. 2013).

apply the deferential standard of review.¹⁶² The court rejected the assertion that “a more stringent standard” of review was in order, however, after finding the denial of benefits was not tainted by the insurer’s conflict of interest.¹⁶³ It also explained that “speculative conclusions” regarding the motives of the insurer’s employees were insufficient to conclude a conflict of interest infected the insurer’s decision.¹⁶⁴ The claimant in *Rall v. Aetna Life Insurance Co.*¹⁶⁵ argued a conflict of interest affected Aetna’s benefit decision, but alleged no facts to support that claim, such as improper motives by Aetna’s employees, third-party consultants, or doctors, or claims Aetna had a history of unreasonably denying meritorious claims.¹⁶⁶ The only fact supporting a conflict was Aetna’s dual role of both evaluating and paying claims; beyond this there was no evidence of bias by Aetna.¹⁶⁷ Further evidence showed Aetna took active steps to promote accuracy by giving the plaintiff numerous opportunities to supplement the medical evidence.¹⁶⁸ Consequently, the court afforded Aetna’s conflict of interest “minimal weight” as a factor in the abuse of discretion analysis.¹⁶⁹

E. Discovery

The challenge of determining what showing a plaintiff must make to be entitled to conduct conflict-related discovery continues. Some courts do not require any preliminary showing by the plaintiff if a structural conflict of interest exists for the plan administrator making benefits decisions,¹⁷⁰ or if a plan has a history of biased claims administration.¹⁷¹ Other courts require a “threshold showing” that a conflict improperly influenced a denial of benefits¹⁷² or a “colorable challenge” of bias before limited discovery is permitted.¹⁷³ One court concluded those limitations disappear, however, when a party seeks equitable relief.¹⁷⁴ In *Malbrough v. Kanawha Insurance Co.*,¹⁷⁵ the claimant registered online for group life insurance in

162. *Id.* at 960.

163. *Id.* at 962–63.

164. *Id.* at 964.

165. 2013 WL 1768685 (D. Colo. Apr. 24, 2013).

166. *Id.* at *9.

167. *Id.*

168. *Id.*

169. *Id.* at *9.

170. *Villanueva v. Life Ins. Co. of N. Am.*, 2013 WL 398878, at *3 (E.D. Cal. Jan. 31, 2013).

171. *Tretola v. First Unum Life Ins. Co.*, 2013 WL 2896804, at *3 (S.D.N.Y. June 13, 2013).

172. *Semedo v. Boston Bldg. Serv. Emps. Trust Fund Long Term Disability Plan*, 2013 WL 3805130, at *3 (D. Mass. July 19, 2013).

173. *Angel Jet Servs., LLC v. Cleveland Clinic Emp. Health Plan Total Care*, 2012 WL 5269993, at *4 (N.D. Ohio Oct. 23, 2012).

174. *Malbrough v. Kanawha Ins. Co.*, 2013 WL 1818032, at *7 (W.D. La. Apr. 29, 2013).

175. *Id.*

an amount greater than what the plan's terms permitted.¹⁷⁶ After the claimant died and the plan paid only the amount allowed under the plan,¹⁷⁷ the beneficiaries sued seeking equitable relief under ERISA section 502(a)(3).¹⁷⁸ Because the beneficiaries' claims did not depend on the plan terms (since the website was not a plan document)¹⁷⁹ or on the administrative record (where the claim was analyzed under the plan's terms),¹⁸⁰ the court found it would be inappropriate to limit discovery to an administrative record that had little bearing on the parties' dispute.¹⁸¹

F. *Fiduciary Exception*

The fiduciary exception to attorney-client privilege requires that privileged communications between a plan and its counsel be disclosed to plan participants and beneficiaries.¹⁸² The exception falls away, however, once the parties' interests become "sufficiently adverse."¹⁸³ Two decisions from the past year illustrate how this exception has been applied. In *Whinery v. Life Insurance Co. of North America*,¹⁸⁴ the court held the exception did not apply to correspondence between a fiduciary and its counsel that occurred during a remand, since litigation had already commenced and was still technically pending.¹⁸⁵ In *Carr v. Anheuser-Busch Cos.*,¹⁸⁶ the fiduciary denied the claimant's requests for benefits, the claimant appealed, and the fiduciary denied the appeal.¹⁸⁷ The Eighth Circuit affirmed an order compelling the production of an otherwise privileged e-mail written between the appeal and final claim decision, but affirmed the district court's refusal to compel production of two e-mails sent after the final denial, reasoning that the claimant and fiduciary's interests did not become sufficiently adverse until the final denial.¹⁸⁸

Last survey period, the Ninth Circuit decided *Stephan v. Unum Life Insurance Co. of America*,¹⁸⁹ which disagreed with the Third Circuit's decision in *Wachtel v. Health Net, Inc.*¹⁹⁰ where the Third Circuit declined to

176. *Id.* at *1.

177. *Id.* at *2.

178. *Id.* at *4.

179. *Id.* at *3, *7.

180. *Id.* at *7.

181. *Id.* at *7.

182. *Krase v. Life Ins. Co. of N. Am.*, 2013 WL 3805134, at *3-4 (N.D. Ill. July 18, 2013).

183. *Whinery v. Life Ins. Co. of N. Am.*, 2012 WL 8652619, at *2 (C.D. Cal. Nov. 7, 2012).

184. 2012 WL 8652619 (C.D. Cal. Nov. 7, 2012).

185. *Id.* at *2.

186. 495 F. App'x 757 (8th Cir. 2012).

187. *Id.* at 760-61.

188. *Id.* at 768.

189. 697 F.3d 917 (9th Cir. 2012).

190. 482 F.3d 225 (3d Cir. 2007).

apply the fiduciary exception to insurers acting as ERISA plan fiduciaries.¹⁹¹ This survey period, the Northern District of Illinois in *Krase v. Life Insurance Co. of North America*¹⁹² opted to follow *Stephan*.¹⁹³ In so holding, it reasoned that insurers, like all other ERISA fiduciaries, are subject to ERISA's disclosure obligations and must act in the beneficiaries' interests.¹⁹⁴ Because there was no basis for distinguishing insurers from other ERISA fiduciaries, the court held that the fiduciary exception applied to insurers as well.¹⁹⁵

G. Parties and Fiduciaries

This year found courts arriving at different conclusions concerning what assignment language is required to give a medical provider standing to sue, and it found another court expanding slightly an exception that allows plan administrators to be named as defendants in benefit denial cases. In *MHA, LLC v. Aetna Health, Inc.*,¹⁹⁶ a hospital sued a plan to recover benefits the plan allegedly underpaid.¹⁹⁷ The court held that the hospital's assignment was deficient and that the hospital lacked standing to seek benefits from the plan directly.¹⁹⁸ Although the plan's beneficiaries signed contracts stating "I authorize payment directly to [hospital] for hospital medical insurance,"¹⁹⁹ the court found that a valid assignment must be irrevocable and include a clearer expression of intent on behalf of the assignor to transfer his or her rights.²⁰⁰ The court in *Productive MD, LLC v. Aetna Health, Inc.*,²⁰¹ however, concluded similar assignment language was effective.²⁰² It found that beneficiary statements declaring "I authorize payment of medical benefits to [provider] for services rendered"²⁰³ qualified as an assignment and gave the provider a right to receive plan benefits.²⁰⁴

The claimant in *Ayotte v. Prudential Insurance Co. of America*²⁰⁵ was permitted to maintain an action against a plan administrator as opposed to the plan itself in an action to reinstate long-term disability benefits.²⁰⁶ Although governing Seventh Circuit precedent provided that a plaintiff may

191. *Stephan*, 697 F.3d at 931 n.6; *Wachtel*, 482 F.3d at 234.

192. 2013 WL 3805134 (N.D. Ill. July 18, 2013).

193. *Id.* at *3.

194. *Id.*

195. *Id.*

196. 2013 WL 705612 (D.N.J. Feb. 25, 2013).

197. *Id.* at *1.

198. *Id.* at *7–8.

199. *Id.* at *4.

200. *Id.* at *7.

201. 2013 WL 4587859 (M.D. Tenn. Aug. 28, 2013).

202. *Id.* at *8.

203. *Id.* at *1.

204. *Id.* at *8.

205. 900 F. Supp. 2d 814, 815 (N.D. Ill. 2012).

206. *Id.* at 819.

assert a claim for benefits “only against the plan as an entity,”²⁰⁷ the court noted that an exception permits suits against entities that are “closely intertwined”²⁰⁸ with the plan and where the party controls eligibility for benefits and makes benefit payments.²⁰⁹ The long-term disability insurer was indeed “closely intertwined” with the plan, according to the court, because the plan documents referred interchangeably to the insurer and the plan, and the insurer both paid benefits and had sole discretion to interpret the plan and determine benefit eligibility.²¹⁰

H. Attorney Fees

Multifactor tests can help determine whether an attorney fee claimant achieved some degree of success on the merits, but courts continue to refine their application and analysis of those factors.²¹¹ In *Raybourne v. CIGNA Life Insurance Co. of New York*,²¹² the Seventh Circuit noted, after factoring in the results of its own multiple-factor test, that “a showing of bad faith” is no longer vital to a fee award. It then affirmed a fee award in its entirety, even though the participant had “lost a few skirmishes along the way.”²¹³ In *Barboza v. California Association of Professional Firefighters*,²¹⁴ the district court refused to award attorney fees to either party because both were equal in their success on the merits.

I. Preemption—State Law Claims

While ERISA has “extraordinary preemptive power,”²¹⁵ courts this survey period reiterated that it does not preempt state laws that have only tenu-

207. *Id.* at 820.

208. *Id.* at 819.

209. *Id.* at 817, 819.

210. *Id.* at 819; *see also* *Montvale Surgical Ctr. v. Horizon BCBS of N.J.*, 2012 WL 6089814, at *2 (D.N.J. Dec. 6, 2012) (permitting § 502(a)(1) claim against a third party administrator of a self-funded plan if the administrator is a fiduciary of the plan, which in turn requires the administrator to exercise more discretion and control than a mere claims processor).

211. *See* *Scarangella v. Group Health, Inc.*, 731 F.3d 146, 154–55 (2d Cir. 2013) (Second Circuit remanded for a determination of attorney fees because dismissal of cross-claim was not merely a procedural victory); *see also* *Binaley v. AT&T Umbrella Benefit Plan No. 1*, 2013 WL 5402236, at *4–6 (N.D. Cal. Sept. 26, 2013) (plan participant did not achieve sufficient success on the merits because district court made no finding in approving the parties’ stipulation for voluntary dismissal).

212. 700 F.3d 1076 (7th Cir. 2012).

213. *Id.* at 1091.

214. 2013 WL 4012645, at *4 (E.D. Cal. Aug. 6, 2013).

215. *See* *Dreczka v. Hartford Life & Accident Ins. Co.*, 2013 WL 1148899, at *2–3 (E.D. Wis. Mar. 19, 2013) (where plan participant and spouse sought recovery of long-term disability benefits, claims for “unreasonable surveillance and trespassing,” and “offense to a reasonable person, invasion of privacy, intentional infliction of emotional distress, and loss of companionship” were preempted) (case handled by authors’ firm); *see also* *Ford v. CIGNA Corp.*, 2012 WL 5931887, at *2–3 (D. Mont. Nov. 27, 2012) (ERISA preempted plan participant’s claims under Montana’s Unfair Trade Practices Act, MONT. CODE ANN. § 33–18–242 (1987)); *S.M. v. Oxford Health Plans (N.Y.), Inc.*, 2013 WL 1189467, at *5 (S.D.N.Y. Mar. 22, 2013) (ERISA preempted state law claims for fraud, unjust enrichment, and deceptive trade practices arising out of plan’s denial of participant’s claim for benefits).

ous, remote, or peripheral connections to it.²¹⁶ In *McNeal v. Frontier AG, Inc.*,²¹⁷ the plaintiff accepted a job offer that included representations about the disability benefits available to him as an employee.²¹⁸ When the benefits under the employer's plan did not match those promised, the plaintiff sued for breach of the employment agreement.²¹⁹ The employer argued the action concerned plan benefits and, therefore, was preempted by ERISA.²²⁰ Rejecting that argument, the court observed that the plaintiff did not seek plan benefits, but rather damages from the employer for the difference between the plan's benefits and those promised in the employment agreement.²²¹ Thus, the plaintiff's action did not "regulate plan benefits, create requirements for ERISA plans, or provide rules for calculating benefits to be paid" and ERISA did not preempt it.²²²

Two recent decisions address the application of ERISA's preemption provision to divorce. In *Andochick v. Byrd*,²²³ the decedent's ex-husband waived his rights to the decedent's 401(k) under a settlement agreement finalizing their divorce.²²⁴ When the decedent died before changing the beneficiary designation, the plan determined the benefits had to be paid to the ex-husband.²²⁵ The decedent's estate then sued the ex-husband (not the plan) to enforce his waiver, but he argued ERISA preempted the estate's action.²²⁶ Since the estate's action assumed the plan would pay benefits according to the plan documents (i.e., to the ex-husband), the court found the estate's action neither interfered with plan administration nor exposed the plan to double liability.²²⁷ Therefore, it was not preempted by ERISA.²²⁸

In *Metropolitan Life Insurance Co. v. McCray*,²²⁹ both a former spouse and surviving spouse sought life insurance benefits owed under the partic-

216. *Fustok v. UnitedHealth Group, Inc.*, 2013 WL 2189874, at *6 (S.D. Tex. May 20, 2013) (plan administrator's counterclaim for fraud was not preempted because there was "too tenuous a connection to warrant ERISA preemption"); see also *Alexandra H. v. Oxford Health Ins., Inc.*, 2013 WL 4002883, at *6 (S.D. Fla. Aug. 6, 2013) (ERISA did not preempt a New York statute permitting external appeal of benefits decision because it was "not materially different" from the statute the Supreme Court concluded was not preempted in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)).

217. 2013 WL 74350 (D. Kan. Jan. 7, 2013).

218. *Id.* at *1.

219. *Id.*

220. *Id.* at *3.

221. *Id.* at *3-4.

222. *Id.* at *3.

223. 709 F.3d 296 (4th Cir. 2013).

224. *Id.* at 297.

225. *Id.* at 298.

226. *Id.*

227. *Id.* at 299.

228. *Id.*

229. 2013 WL 398791, at *5-6 (E.D. Mo. Feb. 1, 2013).

ipant's plan following his death.²³⁰ Although the former spouse argued the divorce decree required the plan to pay the benefits to her, the court found that giving effect to the divorce decree would run counter to the plan's terms and interfere with plan administration by undermining ERISA's plan documents rule.²³¹ As a result, it held that ERISA preempted the benefits provision in the divorce decree.²³²

J. Full and Fair Review

In two cases this past year, the Fifth Circuit considered whether plan administrator actions substantially complied with ERISA's claim review regulations, thus giving participants a "full and fair review" of their claims. In *Shedrick v. Marriott International, Inc.*,²³³ the Fifth Circuit held the plan administrator substantially complied with the full and fair review requirement because it engaged in a meaningful dialogue with the claimant, explaining more than once why additional benefits were being denied and offering the participant multiple opportunities to supplement the administrative record during the four-month review process.²³⁴ Also, the plan administrator's consultation with an orthopedic surgeon to evaluate pain management substantially complied with the requirement to consult "a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment."²³⁵ In *Rossi v. Precision Drilling Oilfield Services Corp. Employee Benefits Plan*,²³⁶ however, the Fifth Circuit held that the plan administrator failed to substantially comply with the full and fair review requirement because its decision to uphold the denial of benefits during administrative review was based on an entirely different ground than the initial denial of benefits.²³⁷

V. HEALTH INSURANCE

Perhaps even more than last year, this survey period has been dominated by the Patient Protection and Affordable Care Act. Litigation challenging the individual mandate and the application of certain requirements under the Act continue to fill the courts. The development of private insurance exchanges has been another interesting and significant trend arising from

230. *Id.* at *1.

231. *Id.* at *4.

232. *Id.*

233. 500 F. App'x 331, 338-40 (5th Cir. 2012).

234. *Id.* at 339.

235. *Id.* at 339-40.

236. 704 F.3d 362 (5th Cir. 2013); see also *Lukas v. United Behavioral Health*, 504 F. App'x 628, 629 (9th Cir. 2013) (reviewing physician's conclusory statement that medical necessity requirements were not met did not satisfy ERISA's meaningful dialogue requirement).

237. *Rossi*, 704 F.3d at 368.

the Act's implementation. State mandated benefits also continue to play a role in health insurance litigation this year.

A. Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act²³⁸ (Act) was a significant part of this year's health insurance jurisprudence. There were a large number of constitutional and statutory challenges to the Act's "individual mandate,"²³⁹ requiring individuals to purchase minimal health insurance coverage, and to the "employer mandate,"²⁴⁰ requiring large employers to offer coverage to their employees and their dependents. In addition, guidelines adopted by the Health Resources and Services Administration²⁴¹ clarified the Act's requirement that employers provide coverage for "women's preventive care,"²⁴² which gave rise to several lawsuits and related rulings.

1. Individual and Employer Mandates

A nonprofit national civic league and two of its members filed suit challenging the constitutionality of the individual mandate in *U.S. Citizens Association v. Sebelius*.²⁴³ The Sixth Circuit affirmed summary judgment in the government's favor, finding the Supreme Court had already concluded in *National Federation of Independent Business v. Sebelius*²⁴⁴ that Congress did not exceed its authority when it enacted the individual mandate and affirmed the dismissal of the plaintiffs' remaining claims.²⁴⁵ The court further found the individual mandate did not infringe upon the plaintiffs' right of intimate association with their physicians.²⁴⁶ Specifically, the court concluded that corporate entities (such as the civic league) did not have a protected right of "intimate association"²⁴⁷ and nothing in the Act precluded the individual plaintiffs from establishing relationships with the medical professionals of their choice.²⁴⁸ The court also said the Act imposed no significant burden on the plaintiffs' freedom of expression under the First Amendment, as plaintiffs were "free to voice their disap-

238. 42 U.S.C. § 18001 et seq.

239. 26 U.S.C. § 5000A(a)–(b).

240. 26 U.S.C. § 4980H(a)–(b).

241. See 78 Fed. Reg. 39870 (July 2, 2013) (updated from original rules at 77 Fed. Reg. 8725 (Feb. 15, 2012); see also <http://www.fda.gov/forconsumers/byaudience/forwomen/ucm118465.htm>.FreePublications/UCM282014.pdf (last updated Aug. 2012).

242. 42 U.S.C. § 300gg–13(a).

243. 705 F.3d 588 (6th Cir. 2013).

244. 132 S.Ct. 2566 (2012).

245. 705 F.3d at 603; see also *Sissel v. U.S. Dep't of Health & Human Services*, 2013 WL 3244826 (D.D.C. June 28, 2013) (dismissing plaintiff's action after finding the merits of plaintiff's Commerce Clause challenge to the Act's individual mandate had already been decided by the Supreme Court).

246. *Id.* at 599.

247. *Id.*

248. *Id.*

proval of [the Act] or health insurance in general.”²⁴⁹ The Act’s financial penalty was not so coercive that it burdened the plaintiffs’ fundamental right to liberty since they “remain[ed] free to choose their medical providers and the medical treatments they [would] or [would] not accept.”²⁵⁰ Finally, the court concluded that the Act did not violate the plaintiffs’ right to privacy because it did not compel them to disclose any personal medical information.²⁵¹ To the contrary, the plaintiffs could avoid any privacy concerns altogether by making the shared responsibility payment in lieu of purchasing health insurance.²⁵²

A religious university and certain individuals argued that the individual and employer mandates exceeded Congress’s powers and violated various constitutional and statutory rights in *Liberty University, Inc. v. Lew*.²⁵³ Like the Sixth Circuit’s decision in *U.S. Citizens Association*, the Fourth Circuit found the Supreme Court “squarely rejected Plaintiffs’ contention that the individual mandate exaction is not a constitutional tax.”²⁵⁴ According to the court, the taxing power analysis in the Supreme Court’s decision “inevitably leads to the conclusion that the employer mandate exaction, too, is a constitutional tax.”²⁵⁵ Furthermore, because health insurance comprises a substantial part of employees’ compensation and substantially impacts employment mobility, the court concluded the employer mandate substantially affects interstate commerce and constitutes a valid exercise of Congress’s Commerce Clause powers.²⁵⁶ The Fourth Circuit rejected the plaintiffs’ claim that the Act violated the Free Exercise Clause of the First Amendment and the Religious Freedom Restoration Act (RFRA),²⁵⁷ concluding the Act was a neutral law that did not infringe upon or restrict any practices based on religious motivation.²⁵⁸ Moreover, the court concluded that the plaintiffs presented “no plausible claim” that the Act substantially burdened their free exercise of religion or forced them to facilitate or support medical services to which they had a religiously-based objection, such as abortion, as the Act provided the plaintiffs the option to purchase a plan that did not cover those abortion services.²⁵⁹

249. *Id.* at 600.

250. *Id.* at 601.

251. *Id.*

252. *Id.*

253. 733 F.3d 72 (4th Cir. 2013), *cert. denied*, 82 U.S.L.W. 3119 (U.S. Dec. 2, 2013) (No. 13-306).

254. *Id.* at 97 (citing *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2594–2600 (2012)).

255. *Id.* at 95.

256. *Id.* at 94–95.

257. *Id.* at 99–100 (citing 42 U.S.C. § 2000bb-1).

258. *Id.*

259. *Id.* (citing 42 U.S.C. § 18054(a)(6) and 42 U.S.C. § 18023(b)(1)(A)(i)).

2. Objections to Providing Women's Preventative Care

There was a surge of litigation over the Act's requirement that employers provide coverage for certain women's preventive care, including FDA-approved contraceptives known as emergency contraceptives. By and large, the plaintiffs were individuals and organizations opposing the mandate as contrary to their religious beliefs. The Act exempted certain churches and religious entities that qualified as "religious employers,"²⁶⁰ but it did not exempt other religious organizations such as universities, hospitals, and charities. In response to strong opposition from those organizations, the government crafted a safe harbor that suspended enforcement of the women's preventative coverage mandate for certain "eligible organizations" that opposed the mandated coverage, were non-profit entities that held themselves out as religious organizations, and certified they met the foregoing requirements.²⁶¹

Between the time the safe harbor was proposed and the date it became effective, many courts dismissed lawsuits filed by "eligible organizations" finding that the parties either lacked standing or the dispute was not ripe.²⁶² *Wheaton College v. Sebelius*²⁶³ was an expedited appeal involving two cases filed by religious colleges that did not qualify as exempted "religious employers."²⁶⁴ The district court held that the colleges lacked standing and that their actions were not ripe for review.²⁶⁵ On appeal, the D.C. Circuit held that the colleges had suffered an actual injury for purposes of standing, but concluded that the case was not ripe for review because the government announced its intention to change to the Act's coverage requirement to accommodate the religious objections of non-profit organizations such as the colleges and, therefore, the government would not enforce the policy against them.²⁶⁶ Several district courts han-

260. A "religious employer" is an entity that meets the following criteria: (1) the inculcation of religious values is the purpose of the organization; (2) the organization primarily employs persons who share the religious tenets of the organization; (3) the organization serves primarily persons who share the religious tenets of the organization; and (4) the organization is a nonprofit organization described in section 6033(a)(1) and (a)(3)(A)(i) or (iii) of the Internal Revenue Code." 45 C.F.R. § 147.130(a)(1)(iv)(B).

261. 78 Fed. Reg. 39871 (July 2, 2013); 45 C.F.R. § 147.131(b) (2013).

262. See, e.g., *Belmont Abbey Coll. v. Sebelius*, 878 F. Supp. 2d 25 (D.D.C. 2012), *reconsideration denied*, 2012 WL 3861255 (D.D.C. Sept. 5, 2012), *appeal held in abeyance*, 703 F.3d 551 (D.C. Cir. 2012); *Nebraska ex rel. Bruning v. U.S. Dep't of Health & Human Servs.*, 877 F. Supp. 2d 777 (D. Neb. 2012); *Univ. of Notre Dame v. Sebelius*, 2012 WL 6756332 (N.D. Ind. Dec. 31, 2012); *Zubik v. Sebelius*, 911 F. Supp. 2d 314 (W.D. Pa. 2012).

263. 703 F.3d 551 (D.D.C. 2012).

264. *Id.* at 552.

265. *Id.*

266. *Id.* (citing 77 Fed. Reg. 8725-01, 8727-28 (Feb. 15, 2012)).

dling similar actions followed the reasoning in *Wheaton College* and dismissed the actions before them for lack of ripeness when it appeared the safe harbor rule would apply to the plaintiffs in those cases.²⁶⁷

The Tenth Circuit found in *Hobby Lobby Stores, Inc. v. Sebelius*²⁶⁸ that some of the Act's contraceptive coverage requirements may violate employers' constitutional and statutory rights to religious freedom.²⁶⁹ The plaintiffs were privately held, secular, for-profit corporations whose individual owners asserted that their constitutional and statutory rights to religious freedom were violated by the mandate's requirement to provide coverage for four specific types of contraception.²⁷⁰ The court concluded the corporate plaintiffs were "persons" exercising religion for purposes of the RFRA and, as a matter of constitutional law, may have First Amendment Free Exercise rights.²⁷¹ As a result, the court reversed the denial of a preliminary injunction and remanded the case for further proceedings.²⁷² In so holding, it rejected the government's argument that the public health and gender equality interests it cited were compelling government interests that justified the mandate's reported infringement on the plaintiffs' First Amendment rights.²⁷³ The fact that the government created an exemption to the mandate for "religious employers" and "eligible organizations" meant the interests were not sufficiently compelling to infringe on the rights of those employers or the "tens of millions of people" who obtained coverage from such employers.²⁷⁴ If the interests were not compelling enough to override the rights of "religious employers" and "eligible organizations," the court reasoned, they could not be considered compelling enough to justify infringement of the plaintiffs' rights.²⁷⁵ The fact that the plaintiffs did not prevent the employees from using their own money to purchase coverage under the plan for the four contraceptives at issue was significant to the court.²⁷⁶ Such a cost-shifting burden was necessary in the

267. See, e.g., *Catholic Diocese of Biloxi, Inc. v. Sebelius*, 2012 WL 6831407 (S.D. Miss. Dec. 20, 2012); *Roman Catholic Archbishop of Washington v. Sebelius*, 920 F. Supp. 2d 8 (D.D.C. 2013), *appeal held in abeyance*, 2013 WL 3357814 (D.C. Cir. June 21, 2013); *Colorado Christian Univ. v. Sebelius*, 2013 WL 93188 (D. Colo. Jan. 7, 2013); *Catholic Diocese of Peoria v. Sebelius*, 2013 WL 74240 (C.D. Ill. Jan. 4, 2013); *Persico v. Sebelius*, 919 F. Supp. 2d 622 (W.D. Pa. 2013); *Eternal Word Television Network, Inc. v. Sebelius*, 935 F. Supp. 2d 1196 (N.D. Ala. 2013).

268. 723 F.3d 1114 (10th Cir. 2013), *cert. granted*, 82 U.S.L.W. 3139 (U.S. Nov. 26, 2013) (No. 13-354).

269. *Id.* at 1121.

270. *Id.* at 1122.

271. *Id.* at 1126.

272. *Id.* at 1120.

273. *Id.* at 1143.

274. *Id.*

275. *Id.* at 1143-44.

276. *Id.*

court's view to protect the plaintiffs' religious freedoms, and it noted again the exemption for certain religious employers, whose employees had to bear the costs of coverage if they desired it.²⁷⁷ According to the court, "[t]hat is part of accommodating religion—and is RFRA's basic purpose."²⁷⁸

The Third Circuit disagreed with the analysis the Tenth Circuit applied, holding in *Conestoga Wood Specialties Corp. v. Secretary of U.S. Department of Health & Human Services*²⁷⁹ that a secular, for-profit corporation had no free exercise rights under the First Amendment and was not a "person" under the RFRA.²⁸⁰ The plaintiffs, Conestoga Wood Specialties Corp. and five of its shareholders, asserted that the contraceptive coverage requirement violated their religious beliefs and sought a preliminary injunction to enjoin its enforcement.²⁸¹ After an evidentiary hearing, the district court issued a detailed opinion articulating the reasons for denying injunctive relief and denied the plaintiffs' subsequent motion for a stay pending appeal of that decision.²⁸² The Third Circuit denied the plaintiffs' request for a stay pending appeal after finding "a secular, for-profit corporation," such as Conestoga, had "no free exercise rights under the First Amendment . . . and [was] not a 'person' under the RFRA."²⁸³ Although acknowledging it was "a close call," the Third Circuit concluded the contraception mandate did not violate the individual plaintiffs' rights under the Free Exercise Clause because it was not targeted at conduct motivated by religious belief, was neutral in promoting public health and gender equality, and did not impose a "substantial burden" on the plaintiffs.²⁸⁴ Furthermore, because the mandate "appli[ed] equally to organizations of every faith and [did] not favor one denomination over another, and [did] not create excessive government entanglement with religion"²⁸⁵ the court concluded the plaintiffs were unlikely to prevail on their claim that the Act vi-

277. *Id.* at 1144-45.

278. *Id.* at 1145. *See also* *Tyndale House Publishers, Inc. v. Sebelius*, 2013 WL 2395168 (D.C. Cir. May 3, 2013) (court granted injunctive relief to a for-profit Christian publishing company owned for the most part by a nonprofit entity based on constitutional challenges to the Act's contraceptive coverage mandate); *but see* *Grote Indus., LLC v. Sebelius*, 914 F. Supp. 2d 943 (S.D. Ind. 2012) *reconsideration denied*, 2013 WL 53736 (S.D. Ind. Jan. 3, 2013) (court denied motion for injunctive relief by a secular, for-profit corporation after finding there was a substantial likelihood that the preventive services coverage mandate was a neutral law of general applicability that did not offend the First Amendment's Free Exercise Clause).

279. 2013 WL 1277419 (3d Cir. Feb. 8, 2013).

280. *Id.* at *2.

281. *Id.* at *1.

282. *Id.*

283. *Id.* (citing *Conestoga Wood Specialties Corp. v. Sebelius*, 917 F. Supp. 2d 394 (E.D. Pa. 2013)).

284. *Id.* at *2.

285. *Id.*

olated the Establishment Clause of the First Amendment.²⁸⁶ The plaintiff's Free Speech claim also had little likelihood of success, according to the court, because the Act did not interfere with the plaintiffs' "expression of their opinions" or what they "may or may not say" regarding contraceptives, but rather merely affected what they must do.²⁸⁷

In a subsequent appeal, the Third Circuit also affirmed the district court's denial of injunctive relief after finding Free Exercise rights are "purely personal," "uniquely human," and unavailable to corporations,²⁸⁸ explaining that "[w]e do not see how a for-profit artificial being, invisible, intangible, and existing only in contemplation of law, that was created to make money could exercise such an inherently human right."²⁸⁹ It also found its determination that a for-profit corporation was unable to assert a claim under the Free Exercise Clause "necessitates the conclusion that a for-profit, secular corporation cannot engage in the exercise of religion . . . [and therefore] cannot assert a RFRA claim."²⁹⁰ However, this time around, since it already concluded a for-profit corporation could not assert a RFRA claim, it found it "need not decide whether such a corporation is a 'person' under the RFRA."²⁹¹

On November 26, 2013, the United States Supreme Court granted petitions for writs of certiorari in the *Hobby Lobby* and *Conestoga Wood* cases.²⁹²

3. Private Health Insurance Exchanges

One notable outgrowth of the Affordable Care Act is the advent of private health insurance exchanges. The Affordable Care Act's requirements for large employers are prompting the development of private health insurance exchanges, which, if widely used, stand to reshape the health insurance landscape in the United States beyond that dictated by the terms of the Act.

Under the Act, an employer with fifty or more full time employees is considered a "large employer."²⁹³ If a large employer has at least one full-time employee who receives or is certified to receive a premium tax subsidy to purchase insurance on an individual exchange, and the employer either fails to offer qualified coverage to its full-time employees and their dependents²⁹⁴ or it offers coverage that does not meet the Act's affor-

286. *Id.*

287. *Id.*

288. *Conestoga Wood Specialties Corp. v. Sebelius*, 724 F.3d 377, 384 (3d Cir. 2013), *cert. granted*, 82 U.S.L.W. 3139 (U.S. Nov. 26, 2013) (No. 13-356).

289. *Id.* at 385 (internal quotations omitted).

290. *Id.* at 388.

291. *Id.*

292. *See supra* notes 268 and 279.

293. 26 U.S.C. § 4980H(c)(2).

294. 26 U.S.C. § 4980H(a).

dability or minimum value standards,²⁹⁵ the employer will be assessed a tax penalty.²⁹⁶ Private exchanges are designed to allow an employer to offer coverage without exposing itself to unpredictable increases in the costs of health insurance.

Private exchanges operate as follows: (1) a private exchange is established offering a slate of health care plans from several carriers at varying levels of coverage and prices, all of which satisfy the Affordable Care Act's essential benefit requirements; (2) an employer chooses a private exchange through which it will offer health care coverage to employees; (3) the employer determines how much it will pay (usually a lump sum) toward health care coverage per employee; (4) each employee visits the exchange's on-line marketplace and selects the carrier and plan that best suits the employee; and (5) the employee is responsible for making up the difference between the costs of the plan selected and the employer's contribution.²⁹⁷ Because the plans listed on the exchange are group contracts under which the employer is the plan sponsor, the employer's contributions remain tax deductible.²⁹⁸ At the same time, paying a set amount per employee means employers no longer have to deal with unforeseen increases in the costs of providing health care coverage.²⁹⁹ Some question whether the shift is good for employees, wondering whether they will ultimately end up paying more for their coverage. In that respect, they liken the approach to the shift thirty years ago from employer-funded pension plans to 401(k) plans.³⁰⁰ Exchange proponents, however, predict costs will remain manageable because "carriers must compete for each and every participant alongside competitors, so they have every incentive to respond to market needs and demands with greater value, affordable pricing and increased efficiencies."³⁰¹

One observer predicts "a bifurcation between private exchanges and public exchanges," where regulatory requirements on the public exchanges

295. 26 U.S.C. § 4980H(b). In general, employer-provided coverage will satisfy the Act's "affordability" requirement as long as the employee's required contribution under the plan does not exceed 9.5 percent of his or her household income. 26 U.S.C.A. § 36b(c)(2)(C)(i). Coverage satisfies the Act's "minimum value" standard if the plan pays 60 percent or more of the total allowed costs for benefits under the plan. 26 U.S.C.A. § 36b(c)(2)(C)(ii).

296. While the employer mandate was scheduled to go into effect on January 1, 2014, the Obama administration announced in July 2013 that it was postponing enforcement of the tax until 2015. Mike Dornig & Alex Wayne, *Health-Law Employer Mandate Delayed By U.S. Until 2015*, BLOOMBERG (July 3, 2013, 6:51 AM).

297. Timothy W. Martin & Christopher Weaver, *Walgreen to Shift Health Plan for 160,000 Workers*, WALL ST. J. (Sept. 18, 2013, 11:29 AM), <http://online.wsj.com/news/articles/SB10001424127887323527004579081563998551366>; *Our Unique Exchange*, AON HEWITT, <http://aonhewittcorporateexchange.com/our-unique-exchange/> (last visited Nov. 5, 2013).

298. *Our Unique Exchange*, *supra* note 297.

299. *Id.*

300. Martin & Weaver, *supra* note 297.

301. *Our Unique Exchange*, *supra* note 297.

will result in fewer coverage options and smaller provider networks, while the freedom to experiment on the largely unregulated private exchanges will result in greater coverage and network options and, ultimately, more personalized health care options for employees.³⁰² Time will tell whether private exchanges become commonplace. But the benefits the private exchanges offer employers may be irresistible, and the fact that several large employers have already moved to the exchanges for employee or retiree coverage³⁰³ suggests the changes the Act prompted in thinking about the individual coverage marketplace are likely to spread to the large employer market as well.

B. Mandated Benefits

Courts this review period were called upon to address whether insurance companies violated state mandated-benefit laws by denying benefits or charging copayments in connection with certain benefits. In *Larson v. United Healthcare Insurance Co.*,³⁰⁴ participants in employer-based health plans brought a putative class action against six insurance companies alleging they violated a Wisconsin statute³⁰⁵ by requiring co-payments for chiropractic services.³⁰⁶ In affirming the dismissal of the plaintiffs' complaint, the Seventh Circuit rejected the argument that chiropractic copayments were prohibited by "negative implication" under Wisconsin's statutory scheme.³⁰⁷ The court found the statutory language clear: it required "equal treatment of chiropractic services; it [did] not mandate a particular amount or level of coverage;" and, more importantly, "it [did] not expressly prohibit chiropractic copayments."³⁰⁸

In *New Hampshire Independent Pharmacy Association v. New Hampshire Insurance Department*,³⁰⁹ a trade association filed suit against the New Hampshire Department of Insurance (NHID) concerning its interpreta-

302. Paul Howard, *Obamacare Is Killing Traditional Employer-Sponsored Health Insurance*, FORBES (Sept. 23, 2013, 12:01 AM), <http://www.forbes.com/sites/theapothecary/2013/09/23/obamacare-killing-traditional-employer-insurance/> (last visited Nov. 5, 2013).

303. Walgreen Co., Sears Holding Corp, and Darden Restaurants have moved or are moving their employees to a private exchange, while IBM and Time Warner Inc. plan to move thousands of retirees from company-administrated plans to private exchanges. See Martin & Weaver, *supra* note 297; Howard, *supra* note 302.

304. 723 F.3d 905 (7th Cir. 2013).

305. Section 632.87(3)(a) provides that no insurance "policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed chiropractor . . . if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath." WIS. STAT. ANN. § 632.87(3)(a).

306. *Id.*

307. 723 F.3d at 918.

308. *Id.*

309. 58 A.3d 680 (N.H. 2012).

tion of statutes³¹⁰ protecting an insured's right to purchase a ninety-day supply of covered prescription drugs at one time. Insurers and health benefit plans interpreted the statutes in a way that allowed them to limit coverage for ninety-day orders to purchases made from mail-order pharmacies, which was consistent with NHID's interpretation.³¹¹ The trade association argued the statutes required the plans and insurers to cover purchases made from retail pharmacies as well.³¹² In affirming summary judgment for the NHID, the New Hampshire Supreme Court found the statutes were unambiguous and "although the statutes *require* health insurers and health benefit plans to provide 90-day prescription coverage, they merely *permit*—but do not require—insurers and benefit plans to allow such prescriptions to be filled at local retail pharmacies rather than through mail order pharmacies."³¹³

VI. LIFE INSURANCE

The tension between a life insurance policy's incontestability provision and an insurer's efforts to challenge illegal contracts continued to play out in the courts this year, as did the related question of whether an insurer can retain premiums when seeking to challenge the validity of a fraudulently procured policy. In the meantime, perennial issues involving misrepresentation and beneficiary designations round out developments this year on the life insurance front.

A. *Misrepresentation—Conduct of Agent*

Two federal appeals courts considered what follows when an agent erroneously completes an insured's life insurance application such that it con-

310. N.H. REV. STAT. ANN. §415:6-aa (2007) provides:

An insurer issuing or renewing accident and health insurance policies shall allow its insureds to purchase an up-to-90 day supply of covered prescription drugs on the covered person's health plan formulary at one time. . . . Nothing in this section shall be construed to limit the health plan's ability to establish co-payments, coinsurance deductibles, or other member cost shares. A pharmacy dispensing a 90-day supply of covered prescription drugs under this section shall comply with any specified terms, conditions, and price which the plan may require for pharmacies that fill 90-day prescriptions.

With parallel language, N.H. REV. STAT. ANN. § 420-J:7-b, VIII (2007) provides:

Every health benefit plan that provides prescription drug benefits shall allow its covered persons to purchase an up-to-90 day supply of covered prescription drugs on the covered person's health benefit plan formulary at one time. . . . Nothing in this paragraph shall be construed to limit the health benefit plan's ability to establish co-payments, coinsurance deductibles, or other member cost shares. A pharmacy dispensing a 90-day supply of covered prescription drugs under this paragraph shall comply with any specified terms, conditions, and price which the health benefit plan may require for pharmacies that fill 90-day prescriptions.

311. 58 A.3d at 683.

312. *Id.*

313. *Id.* at 683.

tains material misrepresentations of the insured's health. In *Corbeil v. Pruco Life Insurance Co.*,³¹⁴ a life insurance policy beneficiary asserted tort and breach of contract actions against the agent who completed the policy application and the insurer that rescinded the policy due to material misrepresentations in the application.³¹⁵ According to the beneficiary, the agent caused her damages by breaching his common law duties of care in completing the insurance application, reviewing it with the insured, and failing to advise the insured of his duty to inform the insurer of changes to his health prior to policy issuance.³¹⁶ As a result, the application did not reflect several medical events and conditions that occurred or were discovered after it was completed.³¹⁷ Rejecting the beneficiary's claims, the Second Circuit found that, under Vermont law, it was the insured's failure to notify the insurer of his changed medical condition that caused the insurer to rescind coverage, not the agent's alleged negligence.³¹⁸ It further held that even if an oral contract required the agent to use reasonable care to secure the life policy, there was no evidence any alleged breach damaged the beneficiary.³¹⁹ After all, the insurer did not rescind because of the agent's breach; it rescinded because of the insured's material misrepresentations.³²⁰

The Eighth Circuit reversed the district court's grant of summary judgment due to fact questions in *Ser Yang v. Western-Southern Life Assurance Co.*³²¹ There, the insured was a Hmong immigrant who could not read and spoke almost no English.³²² The agent who interviewed the insured and completed her application spoke fluent Hmong.³²³ Both on the application and during a recorded application interview, the insured denied medical treatment or testing in the past ten years, but in truth, the insured had been diagnosed with Hepatitis B approximately five years earlier.³²⁴ In reversing summary judgment for the insurer, the Eighth Circuit found the insured's recorded interview statements could not be considered because the policy only permitted the insurer to rely on statements in the application to contest the policy, and neither the recorded interview nor a transcript of the interview were attached to the application.³²⁵ Also,

314. 512 F. App'x 36 (2d Cir. 2013).

315. *Id.* at 38.

316. *Id.* at 38-39.

317. *Id.* at 38.

318. *Id.*

319. *Id.* at 39.

320. *Id.* at 39-40.

321. 713 F.3d 429 (8th Cir. 2013).

322. *Id.* at 431.

323. *Id.* at 431-32.

324. *Id.* at 432.

325. *Id.* at 435.

the court rejected the argument that even if the agent erroneously transcribed the insured's responses the insured ratified such errors by signing the application. The court held that an insured who relies in good faith on an agent's completion of an application has no duty to review the application for errors before signing.³²⁶ Due to a fact dispute regarding whether the insured relied in good faith on the agent's completion of the applications, however, summary judgment was deemed improper.³²⁷

B. *Incontestability Clauses*

There is a long-standing division among courts regarding whether an incontestability clause bars an insurer from arguing that a contract is void ab initio for lack of an insurable interest after the contestability period has passed. The majority view is that incontestability clauses have no effect where a policy is void ab initio for lack of an insurable interest; under the minority view, however, the expiration of a contestability period bars insurers from contesting the validity of insurance policies, even where there is no insurable interest.³²⁸ Two cases this review period followed the minority view.

In *Pruco Life Insurance Co. v. US Bank*,³²⁹ the district court held that Florida's two-year incontestability statute barred an insurer from contesting the validity of two \$5 million life insurance policies seven years after issuance due to lack of an insurable interest.³³⁰ After finding Florida law clearly barred an insurer's attempt to contest a policy for fraud once the two-year period expired, the court rejected the insurer's "thinly veiled attempt" to circumvent the policy's incontestability provision by classifying the fraud as a lack of an insurable interest.³³¹ It stated: "In a STOLI context, a lack of insurable interest may not be divided from the fraud that created it."³³²

A New York court found that the incontestability clauses in two policies blocked the insurers' fraud and insurable interest defenses in *Ganelina v. Public Administrator, New York County*.³³³ The insurers moved to dismiss actions to enforce the policies and asked the court to declare the policies void ab initio because they were obtained in furtherance of a criminal enterprise; specifically, the two primary beneficiaries conspired to persuade the insured to obtain the policies and name them as the primary beneficiaries, and then murder her for the insurance proceeds.³³⁴ The in-

326. *Id.* at 433-34 (citing *Pomerenke v. Farmers Life Ins. Co.*, 36 N.W. 2d 703, 706 (Minn. 1949)).

327. *Id.* at 435.

328. *Pruco Life Ins. Co. v. US Bank*, 2013 WL 4496506, at *4 (S.D. Fla. Aug. 20, 2013).

329. *Id.*

330. *Id.* at *3.

331. *Id.* at *4-5.

332. *Id.* at *5.

333. 963 N.Y.S.2d 545 (Sup. Ct. 2013).

334. *Id.* at 547.

surers also claimed that the insured made false representations on her application as to her salary and her relationship with the primary beneficiaries, who she falsely claimed were her brother and sister.³³⁵ The court found that, under New York law, the contestability period's expiration prevented the insurers from contesting the policies' validity, irrespective of the alleged misrepresentations or the lack of insurable interest.³³⁶

Does a policy become incontestable two years from issuance or reinstatement even if the insured does not live that long? According to the court in *Cardenas v. United of Omaha Life Insurance Co.*,³³⁷ if the insured died within two years after reinstatement, the policy never became incontestable and the insurer was not required to bring an action contesting the policy's validity within that two-year period.³³⁸ Under Texas law, life insurance policies must state they become incontestable two years from the date of issuance and “*during the lifetime of the insured.*”³³⁹ Arguing this statute applied only to policy issuances and not reinstatements, the beneficiary claimed Texas's Administrative Code imposed a strict two-year contestability period for reinstated policies without a “lifetime of the insured” requirement.³⁴⁰ The court rejected the beneficiary's argument, concluding a policy only becomes incontestable if an insured survived the two-year contestability period.³⁴¹

C. *Stranger Originated Life Insurance (STOLI)*

In the past few years, courts have reached different conclusions when it comes to whether insurers may retain the premiums paid on rescinded STOLI contracts, or whether they must be returned to the insured. In two decisions this survey period, courts found for insurers on this issue. The First Circuit allowed the insurer to keep the premiums in *PHL Variable Insurance Co. v. P. Bowie 2008 Irrevocable Trust*.³⁴² In so holding, the court found that Rhode Island's “tender back” requirement for rescission actions did not flatly prohibit the district court from using the policy premiums to offset the insurer's costs of underwriting, administration, and servicing of the policy, and its investigation into the misrepresentation in the application.³⁴³ It also concluded that refusing to reward the trust with a return of premium was warranted under Rhode Island law in light of the trust's “unclean hands” and evidence showing that the trust

335. *Id.* at 548.

336. *Id.*

337. 731 F.3d 496 (5th Cir. 2013).

338. *Id.* at 504.

339. *Id.* at 499 (quoting TEX. INS. CODE ANN. § 1101.006 (2009)) (emphasis added).

340. *Id.* at 499–500 (citing 28 TEX. ADMIN. CODE § 3.104(a) (2013)).

341. *Id.* at 504.

342. 718 F.3d 1 (1st Cir. 2013).

343. *Id.* at 10.

did not pay the premiums from its own funds.³⁴⁴ A Minnesota district court also permitted the insurer to retain premiums in *PHL Variable Insurance Co. v. 2008 Christa Joseph Irrevocable Trust*.³⁴⁵ There, after finding the subject policy should be rescinded due to fraudulent misrepresentations, including gross misrepresentations of the insured's financial status,³⁴⁶ the court held the insurer could keep the premiums paid under the procured-by-fraud exception to the general rule that rescission requires unearned premiums to be returned.³⁴⁷

D. Beneficiary Designations

While a policyholder's failure to follow all technical requirements for changing a beneficiary is not necessarily fatal to effecting the change, the insured nevertheless must clearly express his intent to change beneficiaries and manifest that intent as far as is reasonably possible. In *Minnesota Life Insurance Co. v. Kagan*,³⁴⁸ the Seventh Circuit held the insured did not satisfy Illinois' "substantial compliance" doctrine for changing his policy's beneficiary when he signed and completed a change of beneficiary form more than fifteen months before he died but never sent the insurer the form.³⁴⁹ In *Wray v. American United Life Insurance Co.*,³⁵⁰ the Sixth Circuit reviewed a challenge to a beneficiary change form which the insurer argued did not strictly comply with its requirements.³⁵¹ The court ultimately found that the insured fully satisfied the policy's requirements for making a change of beneficiary when he wrote "Attached" in the space provided on the pre-printed form for listing the primary beneficiary, signed and dated the form, and included an unsigned and undated page with three names and associated percentages.³⁵² In so holding, the court rejected the insurer's argument that all pages had to be signed and dated, since there was no such requirement in the policy.³⁵³

E. Condition Precedent

Arguments that life insurance policies never became effective because insureds failed to satisfy conditions precedent proved to be powerful defenses to enforcement of those contracts this review period. In *Dallas v.*

344. *Id.*

345. 2013 WL 4829291 (D. Minn. Sept. 10, 2013).

346. *Id.* at *12.

347. *Id.* (citing *PHL Variable Ins. Co. v. Lucille E. Morello 2007 Irrevocable Trust ex rel. BNC Nat. Bank*, 645 F.3d 965, 969 (8th Cir. 2011)).

348. 724 F.3d 843 (7th Cir. 2013).

349. *Id.* at 853.

350. 503 F. App'x 377 (6th Cir. 2012).

351. *Id.* at 382-83.

352. *Id.* at 383.

353. *Id.* at 382-83.

American General Life & Accident Insurance Co.,³⁵⁴ the insured's failure to pay his initial premium before his death meant his life insurance contract never went into effect. While the insured intended to pay premiums using the insurer's automated payment method, the agent used incorrect information to set up the account and the errors were not corrected before the insured's death.³⁵⁵ The court found that under both Missouri law and the policy's terms, receipt by the insurer of the initial premium was a condition precedent to the policy's formation.³⁵⁶ Since the insurer did not receive the first premium payment before the insured's death, no benefits were due under the policy.³⁵⁷

The life insurance application at issue in *Smith v. Pruco Life Insurance Co. of New Jersey*³⁵⁸ expressly stated the policy would only become effective if the health of the insured was as stated in the application at policy issuance.³⁵⁹ After completing the application but before the policy was issued, the insured was diagnosed with Stage IV colon cancer.³⁶⁰ The insured never advised the insurer of his cancer diagnosis and did not amend or supplement his answers to his application to reflect that diagnosis.³⁶¹ Since the insured's health status changed from that stated in the application upon his death, the insured did not satisfy the policy's condition precedent and the insurer was not required to pay any benefits prior to issuance.³⁶²

VII. CONCLUSION

While this article cannot include an exhaustive summary of every decision relevant to life, accident, health, ERISA and disability law, the authors hope they have provided a good summary of the most significant trends. Certainly, in the year to come, we can expect more litigation arising out of the Affordable Care Act, particularly given the current technical struggles that have slowed down the smooth implementation of the Act's provisions. We anticipate that ERISA law will continue to develop in response to the *Amara* decision, along with continued restrictions on the ability of insurers to argue for application of a deferential standard of review on their claims decisions. In the context of life insurance, challenges to STOLI and related cases involving the retention of premium will continue to dominate.

354. 709 F.3d 734 (8th Cir. 2013).

355. *Id.* at 735–36.

356. *Id.* at 737.

357. *Id.* at 740.

358. 710 F.3d 476 (2d Cir. 2013).

359. *Id.* at 478–79.

360. *Id.* at 478.

361. *Id.* at 479.

362. *Id.* at 482–83.