

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

*William A. Chittenden III, Elizabeth G. Doolin, Julie F. Wall,
and Joseph R. Jeffery*

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I. INTRODUCTION

This year's article covers key recent developments in life, health, and disability insurance law, including Supreme Court decisions on the constitutionality of the Affordable Care Act's contraception coverage provisions and on the enforceability of legal actions limitations period provisions in Employee Retirement Income Security Act (ERISA) plan documents; an alarming (but potentially short-lived) expansion of restitution as a form of "equitable relief" under ERISA; the latest battles in the stranger originated life insurance (STOLI) wars; and perennial issues arising out of disability and accident insurance cases.

II. ACCIDENTAL DEATH

The most noteworthy accidental death cases over this year's survey period involve intoxication exclusions, including how those exclusions apply in situations that do not involve drunk driving; prescription drug exclusions; and whether coverage exists when a seizure causes an accident that results in death. The survey period also saw a relative newcomer: whether a death due to air travel was covered under a provision allowing benefit for accidental exposure to the elements.

A. Intoxication

Broadly speaking, courts continue to enforce intoxication exclusions. For example, in *Shaw v. Prudential Insurance Co. of America*,¹ an insured with a blood alcohol content (BAC) of 0.126% died in a single-vehicle crash.² Prudential applied the ERISA-governed policy's intoxication exclusion

1. 566 F. App'x 536 (8th Cir. 2014).

2. *Id.* at 537.

to deny the claim.³ The exclusion stated that “a loss is not covered if it results from . . . an accident that occurs while operating a motor vehicle involving the illegal use of alcohol.”⁴ While the beneficiary argued the terms “results from” and “illegal use of alcohol” were ambiguous, the Eighth Circuit disagreed, upholding the district court’s grant of summary judgment to Prudential.⁵

Alcohol exclusions may bar coverage even where the intoxicated insured was not operating a motor vehicle, although some uncertainty remains when the exclusion relies on a particular state’s definition of intoxication. For example, in *Nichols v. Unicare Life & Health Insurance Co.*,⁶ an insured was found dead in her bedroom and the resulting autopsy determined that she died from “mixed drug intoxication.”⁷ The plan administrator denied the resulting claim because the plan excluded coverage if the insured died from being “legally intoxicated as determined by the laws of the jurisdiction where the accident occurred.”⁸ Arkansas, the relevant jurisdiction, had an intoxication statute that applied only in the context of drunk driving and public intoxication.⁹ The Eighth Circuit found the state’s lack of a catchall intoxication statute would lead a reasonable insured to believe the exclusion only covered deaths related to drunk driving and public intoxication, and not other instances such as intoxication due to prescribed medication.¹⁰ Accordingly, the Eighth Circuit affirmed the Eastern District of Arkansas’s grant of summary judgment to the beneficiary.¹¹

In contrast, questions of fact precluded summary judgment in *Stoulig v. Union Security Insurance Co.*,¹² where the policy at issue excluded coverage for losses resulting directly or indirectly from the insured’s intoxication.¹³ After a night of drinking, the insured was found lying on his hotel room floor, sandwiched between the bed and wall, with marks on the back of his head consistent with hitting the edge of the night stand.¹⁴ The autopsy concluded he had a BAC of 0.22% and was “found in a position so as to compromise” his airway¹⁵ with the immediate cause of death listed as “positional asphyxia.”¹⁶ The death certificate similarly reflected that

3. *Id.* at 537, 541.

4. *Id.*

5. *Id.*

6. 739 F.3d 1176 (8th Cir. 2014).

7. *Id.* at 1179.

8. *Id.* at 1180, 1184.

9. *Id.* at 1184.

10. *Id.*

11. *Id.*

12. 2013 WL 5588728 (E.D. La. Oct. 10, 2013).

13. *Id.* at *1.

14. *Id.* at *1–2.

15. *Id.* at *2.

16. *Id.*

the insured had passed out in a position that prevented blood flow back into his heart and compromised his airway.¹⁷ Claiming the alcohol exclusion applied regardless of whether the insured was operating a motor vehicle,¹⁸ the insurer denied the beneficiary's claim and moved for summary judgment. The beneficiary's medical expert admitted the insured died of positional asphyxia because of his intoxication, but claimed additional information was needed to determine whether a postmortem increase in his BAC occurred, or if there was "something else" that caused his unconsciousness and death.¹⁹ In light of this expert's testimony that information was missing that "could have been useful," the Eastern District of Louisiana found there was a genuine issue of material fact and denied summary judgment.²⁰

The Sixth Circuit reached a different conclusion in *Cultrona v. Nationwide Life Insurance Co.*²¹ There, the beneficiary found the insured dead after he had spent the previous night drinking.²² An autopsy later determined the insured had a BAC of 0.22%, his cause of death was "positional asphyxia," and his manner of death was "acute ethanol intoxication."²³ Nationwide denied the beneficiary's claim, asserting the ERISA-governed plan excluded benefits if the insured suffered an injury while "under the influence of alcohol or intoxicating liquors."²⁴ A district court granted Nationwide summary judgment and the Sixth Circuit affirmed. The Sixth Circuit reasoned that the autopsy listed the manner of death as "acute ethanol intoxication," the insured had an elevated BAC, and the beneficiary failed to present any contrary evidence.²⁵ The court concluded the autopsy alone was sufficient, and Nationwide did not abuse its discretion in denying the claim.²⁶

B. Prescription Drugs/Medical Treatment

Beneficiaries and insurers continue to grapple over whether an accidental death policy affords coverage when an insured dies as a result of taking prescribed medication and the policy contains medical treatment or drug exclusions. Beneficiaries saw varying degrees of success in the survey

17. *Id.*

18. *Id.* at *2, 6 (The insurer asserted that "[t]he exclusion, by its plain terms, states that it applies if the loss occurs while the insured is intoxicated, and that it is not limited to operating a motor vehicle.").

19. *Id.* at *3.

20. *Id.* at *6-7.

21. 748 F.3d 698 (6th Cir. 2014).

22. *Id.* at 702.

23. *Id.*

24. *Id.*

25. *Id.* at 706.

26. *Id.*

period, with the relevant standard of review appearing to be a primary distinguishing characteristic.

For example, in *Rustad-Link v. Metropolitan Life Insurance Co.*,²⁷ the court concluded that the denial of benefits was reasonable based on a medical treatment exclusion.²⁸ A doctor placed an intravenous line in the insured's artery instead of her vein, the medication flowed incorrectly, and the resulting injuries necessitated amputation of her leg.²⁹ MetLife denied the claim based on the policy's exclusion "for any loss caused or contributed to" by "physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity."³⁰ The policy also contained an exclusion for any loss caused or contributed to by "the voluntary intake or use by any means of: any drug, medication or sedative, unless it is taken or used as prescribed by a Physician."³¹ On cross-motions for summary judgment, the U.S. District Court for the District of Montana agreed with the insured that the exclusions were ambiguous when read together.³² As the court was applying a deferential standard of review, however, it found that MetLife's denial was not an abuse of discretion.³³ The court explained that MetLife could reasonably find that a medical treatment caused or contributed to the loss of the insured's leg.³⁴ As for any conflict between the two exclusions, the court cited *Brown v. Stonebridge Life Insurance Co.*³⁵ and explained that, having denied coverage based on the medical treatment exclusion, "it was reasonable for MetLife to conclude that the Plan's medication intake exclusion, including its prescribed medication exception, was simply inapplicable."³⁶

*Bolin v. Hartford Life & Accident Insurance Co.*³⁷ provides more insight into the potentially broad scope of a medical treatment exclusion where a death results from prescription drug use. In *Bolin*, the insured died

27. 2014 WL 3956761 (D. Mont. Aug. 13, 2014).

28. *Id.* at *9–10.

29. *Id.* at *3. Unlike the other cases discussed in this section, the insured in *Rustad-Link* lost her leg but did not die. *Id.* The policy at issue covered both accidental death and dismemberment, however, so the court's analysis likely would not have changed had the insured died.

30. *Id.* at *7.

31. *Id.* at *9.

32. *Id.*

33. *Id.*

34. *Id.* at *2, *9–10.

35. *Id.* at 11 (citing *Brown v. Stonebridge Life Ins. Co.*, 990 N.E.2d 895 (Ill. App. Ct. 2013)). The insurer-defendants in *Brown* were represented by the authors' firm, Chittenden, Murday & Novotny LLC.

36. 2014 WL 3956761, at *11. *But see* *O'Daniel v. Hartford Life Ins. Co.*, 2014 WL 3970081 (D.S.D. Aug. 13, 2014) (finding ambiguity with medical treatment exclusion, which contained standard "unless taken as presented by physician" language, and ruling in favor of the beneficiary).

37. 2014 WL 2945748 (D. Minn. June 30, 2014).

from “mixed drug toxicity,” elevated levels of a prescribed pain medication, and a BAC of 0.318%.³⁸ His accidental death policy excluded losses “resulting from . . . medical or surgical treatment of a sickness or disease.”³⁹ Hartford denied the beneficiaries’ claim, contending the insured’s death resulted from medical treatment because his use of prescription medication substantially contributed to his death.⁴⁰ The beneficiaries argued the insured would not have died if he had not consumed alcohol and, accordingly, his death was not caused by medical treatment.⁴¹ Reasoning that the medical treatment exclusion required only a causal connection between the treatment and the insured’s death and did not require medical treatment to be the *only* cause of death,⁴² the Minnesota federal district court found the insured’s death from a combination of alcohol and prescription medication was excluded, and granted Hartford summary judgment.⁴³

C. *Sickness or Accident: Seizure*

Courts continue to wrestle with whether a beneficiary is entitled to accidental death benefits when an insured dies from injuries resulting from a seizure. As in previous years, a consensus has failed to develop. In *Ferguson v. United of Omaha Life Insurance Co.*,⁴⁴ an insured with a history of epileptic seizures drowned after being warned by his doctor not to swim alone because he had previously almost drowned from a seizure.⁴⁵ The ERISA-governed policy defined “accident” as “a sudden, unexpected, unforeseeable and unintended event, independent of Sickness and all other causes.”⁴⁶ The administrator denied coverage for the insured’s death because it was caused by a sickness, i.e., epilepsy.⁴⁷ Whether a seizure caused the insured to drown was disputed.⁴⁸ An autopsy was not performed, but the responding emergency personnel assumed the insured had a seizure because of his medical history.⁴⁹ The court reasoned that the relevant

38. *Id.* at *1.

39. *Id.*

40. *Id.* at *3.

41. *Id.*

42. *Id.* at *3–4.

43. *Id.* at *4. The policy also excluded “injuries sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription . . . unless the drug is taken as prescribed or administered by a licensed physician.” *Id.* at *2 n.2. The court did not analyze the drug exclusion, although doing so may not have helped the insured because he arguably did not take his medication “as prescribed” when he drank alcohol while taking the drug. *Id.*

44. 3 F. Supp. 3d 474 (D. Md. 2014).

45. *Id.* at 477–78.

46. *Id.* at 478.

47. *Id.* at 479, 486.

48. *Id.* at 479.

49. *Id.* at 482.

question was not whether a sickness caused an accident that led to death, but instead whether a sickness was a cause of death.⁵⁰ In effect, the court found it must determine whether the insured's seizure *alone* would have caused his death.⁵¹ Finding no facts suggesting the insured would have died from the seizure alone (had he not been swimming in a pool), the Maryland district court held the seizure did not cause the insured's death and granted the beneficiary's summary judgment motion.⁵²

A federal court in Arizona reached a different conclusion in *Creno v. Metropolitan Life Insurance Co.*,⁵³ in which an insured under an ERISA plan had a history of seizures, which allegedly would cause him to "roam around the house in a daze destroying parts of the residence."⁵⁴ Ultimately, the insured was found dead, face down in a pond in his yard. His home was considered "chaotic" because responders found a broken mirror and lamp, along with droplets of blood.⁵⁵ The death certificate listed drowning as the immediate cause of death and seizure disorder as another significant condition contributing to death.⁵⁶ Since the plan excluded "loss caused or contributed to by . . . physical or mental illness or infirmity," MetLife denied the beneficiary's claim on grounds that the insured's seizure contributed to his death.⁵⁷ The beneficiary claimed MetLife abused its discretion in failing to analyze whether an illness caused the death itself, rather than whether an illness caused an accident that caused the death.⁵⁸ The court disagreed, holding the plan language could reasonably be interpreted to preclude coverage where an illness directly causes a fatal accidental injury.⁵⁹ MetLife thus did not abuse its discretion in denying benefits.⁶⁰

D. *Exposure*

In *Yasko v. Reliance Standard Life Insurance Co.*,⁶¹ an insured underwent surgery for a lung tumor. Five months later, the insured suffered a massive, fatal pulmonary embolism shortly after landing on a flight from

50. *Id.* at 483, 487.

51. *Id.*

52. *Id.* at 488 (explaining the insured "died of an accidental drowning. Whether the cause of the drowning was a seizure, a slip and fall into a pool, being swept off a boat, or any other cause, is simply not material.").

53. 2014 WL 4053410 (D. Ariz. Aug. 15, 2014).

54. *Id.* at *1.

55. *Id.*

56. *Id.*

57. *Id.* at *2–3.

58. *Id.* at *6.

59. *Id.* at *8, *10.

60. *Id.* at *11. It also bears noting that *Ferguson* and *Creno* cannot be reconciled by examining the standard of review, as both analyzed the administrator's decision under an abuse of discretion standard. See *Ferguson v. United of Omaha Life Ins. Co.*, 3 F. Supp. 3d 474, 480 (D. Md. 2014); *Creno*, 2014 WL 4053410, at *5.

61. 2014 WL 2940536 (N.D. Ill. June 30, 2014) [*Yasko III*].

Houston to Mexico.⁶² The ERISA-governed accident policy excluded coverage for loss “to which sickness [or] disease . . . is a contributing factor.”⁶³ It included coverage, however, for loss due to exposure if “such loss result[ed] directly and independently of all other causes from accidental exposure to the elements. . . .”⁶⁴ The beneficiary asserted the insured’s death was due to “air travel causing pulmonary embolism.”⁶⁵ The administrator denied the claim because a disease caused the insured’s death and, accordingly, it was not accidental.⁶⁶ Reviewing the administrator’s decision de novo, the Northern District of Illinois found that both the administrator’s own expert and Seventh Circuit precedent refuted a finding that death from an embolism is death from a disease.⁶⁷ Turning to the exposure provision, the court held that if the policy covered accidental exposure to the elements, then

it follows that exposure to high altitudes while flying should be covered, as well, either as an example of “accidental exposure to the elements” or at least as an analogous scenario. . . . Death from a pulmonary embolism after flying at a high altitude is at least analogous to, for example, death from hypothermia after exposure to extremely cold temperatures or death from heat stroke after exposure to extremely hot temperatures.⁶⁸

As a result, the court denied the administrator’s summary judgment motion.⁶⁹

While a decision that death from pulmonary embolism after air travel is a covered loss under an exposure provision appears to be somewhat unique,⁷⁰ earlier in 2014 another district court in the Northern District of Illinois considered whether the same insured’s death entitled the same beneficiary to benefits under a different plan.⁷¹ In *Yasko I*, the beneficiary claimed the insured’s “extended demobilization” on the airplane caused the pulmonary embolism such that his death was an accident.⁷² The court there granted summary judgment for the insurer. Two key differences existed between *Yasko I* and *Yasko II*, which seemingly led to disparate results. The *Yasko I*

62. *Id.* at *2–3.

63. *Id.* at *1.

64. *Id.*

65. *Id.* at *3.

66. *Id.*

67. *Id.* at *5.

68. *Id.*

69. *Id.* at *7 (also determining that the definition of “accident” is ambiguous and must be construed against the administrator).

70. Compare *McAuley v. Fed. Ins. Co.*, 2009 WL 913510, at *19 (E.D. Mo. Mar. 31, 2009) (determining it was reasonable for administrator to interpret exposure coverage as not including air travel).

71. *Yasko v. Standard Ins. Co.*, 2014 WL 2155227, at *10–11 (N.D. Ill. May 19, 2014) [*Yasko I*].

72. *Id.* at *3.

court reviewed the administrator's decision under an abuse of discretion standard (not de novo) and the subject plan did not include exposure coverage.⁷³ The varying dispositions of *Yasko I* and *Yasko II* not only highlight the importance of the standard of review, but suggest that exposure coverage could be ripe for litigation in coming years.

III. DISABILITY

This year courts continued to tackle the meaning and interpretations of the terms “own occupation” and “any occupation” in disability policies, along with whether insurers can require objective proof of disability. Interesting decisions also were issued regarding mental illness and how its relation to employment can impact coverage, and how a loss of professional license can affect a disability claim.

A. “Any Occupation”

The Sixth Circuit examined whether an “any occupation” definition in a long-term disability (LTD) policy can include hypothetical jobs in *Kenward v. Means Industries, Inc.*⁷⁴ The claimant, a machine operator, injured his lungs and became ultra-sensitive to fumes.⁷⁵ His treating physician thus mandated he work in an absolute clean-air environment.⁷⁶ After attempts to provide a clean-air environment for the claimant were unsuccessful, he stopped working and sought disability benefits, which the plan administrator denied.⁷⁷ The claimant argued that there were no jobs in the national economy he could perform that complied with the strict conditions required by his doctor.⁷⁸ On appeal, the plan administrator reasoned that the plan’s “any occupation” standard included jobs that exist only in theory.⁷⁹ The Sixth Circuit rejected this argument because no absolutely clean-air jobs existed and hypothetical jobs do not meet the “any occupation” standard.⁸⁰

In contrast, the Sixth and Eighth Circuits held this year that a limited ability to work supported insurers’ decisions to deny LTD benefits. In *McClain v. Eaton Corp. Disability Plan*,⁸¹ the claimant received short-term disability (STD) benefits due to a back injury,⁸² but was denied

73. *Id.* at *5; *Yasko II*, 2014 WL 2940536, at *7.

74. 555 F. App’x 555, 558 (6th Cir. 2014).

75. *Id.* at 556.

76. *Id.*

77. *Id.* at 556–57.

78. *Id.* at 557–58.

79. *Id.* at 558.

80. *Id.*

81. 740 F.3d 1059 (6th Cir. 2014).

82. *Id.* at 1061.

LTD benefits because her physician indicated she could work part time in a sedentary position with frequent rest.⁸³ The claimant argued that the plan administrator failed to take into account her part-time limitation.⁸⁴ The administrator responded, and the Sixth Circuit ultimately agreed, that regardless of whether the claimant was limited to part-time work, she still did not meet the plan's definition of disability under an "any occupation" standard.⁸⁵ Even if the administrator found the claimant was limited to part-time work, the Sixth Circuit held that "[i]t is reasonable to conclude that an ability to do some work means one is not unable to do 'any work.'"⁸⁶

Similarly, in *Gerhardt v. Liberty Life Assurance Co. of Boston*,⁸⁷ the Eighth Circuit held it was reasonable for Liberty Life to rely on the results of a transferable skills analysis (TSA) that identified at least one occupation of which the claimant was capable and reasonably fit to perform.⁸⁸ The claimant was diagnosed with osteoarthritis, fibromyalgia, depression, arthritis, and osteoporosis.⁸⁹ She received LTD benefits until a vocational consultant, applying a TSA, identified seven jobs she could perform.⁹⁰ Although the claimant argued that she could not perform any of the jobs identified in the TSA,⁹¹ the court disagreed, finding she was not disabled under the "any occupation" standard because she could perform at least one of the jobs identified.⁹²

B. "Own Occupation"

In interpreting and applying the "own occupation" standard, courts evaluate a claimant's ability to perform the specific requirements of his or her occupation. In *Doe v. Unum Life Insurance Co. of America*,⁹³ a Massachusetts federal court held that a plan administrator's decision to terminate the claimant's LTD benefits was arbitrary and capricious because it "did not meaningfully reconcile [the claimant's] medical condition with his stressful daily professional activities."⁹⁴ The claimant, a partner in a

83. *Id.* at 1062.

84. *Id.* at 1065.

85. *Id.* at 1066.

86. *Id.* at 1067.

87. 736 F.3d 777 (8th Cir. 2013).

88. *Id.* at 782.

89. *Id.* at 779.

90. *Id.* at 781.

91. *Id.* Six of the jobs required a registered nurse's license or bachelor's degree, but the claimant's license had expired and she did not have a degree. *Id.* The claimant disputed the suitability of the seventh position because it was in the emergency services field, not health care. *Id.*

92. *Id.* at 782.

93. 35 F. Supp. 3d 182 (D. Mass. 2014).

94. *Id.* at 193.

global accounting firm who suffered from fecal incontinence and chronic fatigue,⁹⁵ sued after the plan administrator terminated his LTD benefits.⁹⁶ On review, the court criticized both the administrator's reviewing physicians, claiming they chose to either "cursorily reference" well-documented evidence of fatigue and fecal incontinence or "ignore it altogether."⁹⁷ The court also criticized the plan administrator's "flimsy recommendation" that the claimant have a restroom near his office.⁹⁸ The court noted "it is essential that any rational decision to terminate disability benefits under an own-occupation plan consider whether the claimant can actually perform the specific job requirements of a position."⁹⁹

Whether insurers' "own occupation" analyses properly considered the definitions of "occupation" or "job" under the relevant plan language—which are often defined as the position the insured held when disability was claimed—was also explored this year. In *Anderson v. Sun Life Assurance Co. of Canada*,¹⁰⁰ the claimant worked as a registered nurse for approximately fifteen years. She then became a patient satisfaction representative (PSR) after she suffered a work-related injury.¹⁰¹ The plan defined "own occupation" as the work the employee performed "immediately prior to the first date Total or Partial Disability began."¹⁰² After a year as a PSR, the claimant stopped working and submitted a claim for LTD benefits. The insurer denied the claim because her injury did not affect her work as a PSR.¹⁰³ The claimant argued her "own occupation" "should be the material duties of her long held position" as a registered nurse and not her recent position as a PSR.¹⁰⁴ The court disagreed and granted summary judgment for the insurer, finding it was bound by the policy's definition of "occupation."¹⁰⁵

Similarly, in *Johnson v. Ohio National Assurance Co.*,¹⁰⁶ the plaintiff was employed as an obstetrician/gynecologist (OB/GYN) for twenty-four years before working as a part-time urgent care physician for one year.¹⁰⁷ He developed psoriatic arthritis, a condition that prevented him from being a surgeon and an OB/GYN but did not stop him from work-

95. *Id.* at 186.

96. *Id.* at 188.

97. *Id.* at 192.

98. *Id.* at 193.

99. *Id.* (citations and punctuation omitted).

100. 2013 WL 6076547 (D. Ariz. Nov. 19, 2013).

101. *Id.* at *1.

102. *Id.* at *8 (emphasis omitted).

103. *Id.* at *2.

104. *Id.* at *9.

105. *Id.*

106. 2014 WL 201691 (Ohio Ct. App. Jan. 17, 2014).

107. *Id.* at *1.

ing as an urgent care physician.¹⁰⁸ The policies insuring the plaintiff provided disability benefits if he could not perform the substantial and material tasks of his “own job” or “regular occupation.”¹⁰⁹ The Ohio appellate court held that, although the plaintiff was a board certified OB/GYN and still considered himself an OB/GYN, his regular occupation at the time of disability was that of an urgent-care physician—a job he could still perform.¹¹⁰ The court thus affirmed the trial court’s grant of summary judgment for the insurer because the plaintiff was not totally disabled under the terms of his policies.¹¹¹

C. *Risk of Relapse*

A future disability must be more than “possible” for a claimant to be considered disabled by it. Thus, the Western District of Pennsylvania found a plan administrator did not abuse its discretion in *Pini v. First Unum Life Insurance Co.*¹¹² when it concluded a potential future heart attack did not render a participant disabled under the terms of her ERISA-governed LTD plan.¹¹³ The claimant had a cardiac event due to stress caused largely by a specific supervisor and received STD benefits.¹¹⁴ She then sought LTD benefits, claiming she was disabled because she was at risk for future heart problems. Specifically, she claimed that “her cardiac condition, when coupled with the ‘inherently stressful’ nature of her occupation, render[s] her unable to return to work as a product analyst in the national economy.”¹¹⁵ The plan administrator denied her claim for LTD benefits, reasoning that her stress would not be an issue at another employer and under a different supervisor.¹¹⁶ Although the court noted other courts have recognized that “a risk of ‘future injury’ induced by stress can sometimes create a ‘present disability,’”¹¹⁷ the *Pini* court ultimately found it was reasonable for the plan administrator to conclude the claimant was not disabled. The claimant’s risk of relapse was only possible, not probable.¹¹⁸

D. *Subjective versus Objective Evidence*

Several courts during the review period considered whether objective proof of disability is a requirement for eligibility of benefits. The courts

108. *Id.*

109. *Id.* at *3.

110. *Id.*

111. *Id.* at *4.

112. 981 F. Supp. 2d 386 (W.D. Pa. 2013).

113. *Id.* at 415.

114. *Id.* at 393.

115. *Id.* at 408.

116. *Id.* at 400.

117. *Id.* at 409.

118. *Id.* at 411.

in *James v. Liberty Life Assurance Co. of Boston*¹¹⁹ and *Cosey v. Prudential Insurance Co. of America*¹²⁰ held that the plans at issue had no such requirement.¹²¹ In *James*, the policy defined “proof” of disability as evidence that includes, but is not limited to, “objective medical evidence.”¹²² The claimant’s pain and depression related to shoulder injuries stemming from a car accident, and her self-reports were corroborated by her treating physicians’ physical examinations and assessments.¹²³ The insurer denied her claim, however, because she lacked objective evidence of a disabling condition.¹²⁴ After analyzing the claimant’s subjective and objective evidence, the court granted her retroactive LTD benefits,¹²⁵ finding it is “unreasonable to reject a claimant’s self-reported evidence where the plan administrator has no basis for believing it is unreliable, and where the ERISA plan does not limit proof to ‘objective’ evidence.”¹²⁶

Similarly, in *Cosey*, the STD and LTD plans at issue did not require the claimant to submit objective proof of disability¹²⁷ to substantiate her fatigue, sleep disorder, fibromyalgia, dysautonomia, myoclonus, and dizziness. After the insurer provided three weeks of benefits, it denied further benefits because the claimant’s self-reported symptoms were out of proportion with the medical evidence and not disabling.¹²⁸ The district court agreed, granting the insurer summary judgment under the abuse of discretion standard.¹²⁹ On review, the Fourth Circuit found that the *de novo* standard applied¹³⁰ and vacated the summary judgment award. The Fourth Circuit remanded to the district court with instructions to conduct a *de novo* review¹³¹ because the policies did not require objective evidence of the claimant’s alleged disability.¹³²

In contrast, in *Hopp v. Aetna Life Insurance Co.*,¹³³ the court held the plan at issue required objective evidence of disability, explaining the “administrator’s decision to deny benefits for failure to produce such evidence is reasonable, even though such evidence might be impossible to

119. 984 F. Supp. 2d 730 (W.D. Mich. 2013).

120. 735 F.3d 161 (4th Cir. 2013).

121. See *James*, 984 F. Supp. 2d at 739; *Cosey*, 735 F.3d at 171.

122. *James*, 984 F. Supp. 2d at 739.

123. *Id.* at 740.

124. *Id.* at 739.

125. *Id.* at 740.

126. *Id.* at 739.

127. *Cosey v. Prudential Ins. Co. of Am.*, 735 F.3d 161, 171 (4th Cir. 2013).

128. *Id.* at 163.

129. *Id.* at 165.

130. *Id.* at 168.

131. *Id.* at 172.

132. *Id.* at 165.

133. 3 F. Supp. 3d 1335 (M.D. Fla. 2014).

obtain for that condition.”¹³⁴ The plaintiff sought STD benefits claiming she was prevented from working for several reasons, including her emotional state, stress related to her husband’s illness, her mother’s death, her high-volume workload, and her difficulty sleeping.¹³⁵ The plan administrator denied her claim because the clinical information she submitted lacked objective measures.¹³⁶ On review, the court stated that the plan administrator “must take into account Plaintiff’s subjective reports of fatigue” but should also “consider the extent to which objective medical evidence supports or contradicts Plaintiff’s subjective reports.”¹³⁷ Ultimately, under deferential review, the court held the plan administrator’s decision to deny the plaintiff’s request for STD benefits was reasonable¹³⁸ because it considered all of the evidence and found it was insufficient to establish her disability.¹³⁹

E. *Mental Health*

Whether a claimant’s alleged mental illness relates to her employment can impact whether she is deemed disabled under her disability policy. *Fite v. Bayer Corp.*¹⁴⁰ addressed whether the claimant’s major depressive and generalized anxiety disorders fell within the policy’s STD coverage, which excluded “disabilities resulting from employment-related mental or emotional disabilities.”¹⁴¹ Bayer initially denied her claim because there was no objective evidence supporting her disability.¹⁴² On appeal, however, she was evaluated by an independent psychiatrist, who determined her conditions were disabling,¹⁴³ but her mental and emotional diagnoses were related to her employment because she “referred to her job many times when discussing her anxiety and depression, and most of her panic attacks were work related.”¹⁴⁴ Bayer ultimately found the claimant was not entitled to disability benefits because her mental disabilities resulted from her employment.¹⁴⁵ The district court held that Bayer did not abuse its discretion by this determination. On review, the Tenth Circuit found that the claimant disposed of her challenge to the claim denial by stipulating that her disability was work-related before the district

134. *Id.* at 1354.

135. *Id.* at 1347–48.

136. *Id.* at 1348.

137. *Id.* at 1349.

138. *Id.* at 1355.

139. *Id.*

140. 554 F. App’x 712 (10th Cir. 2014).

141. *Id.* at 716.

142. *Id.* at 715.

143. *Id.*

144. *Id.* at 715–16.

145. *Id.* at 716.

court.¹⁴⁶ The court explained that her stipulation defeated her arguments that she was prejudiced by Bayer’s “ultimate reliance” on the independent psychiatrist’s opinion and his failure to “recite any objective evidence” to support his opinion.¹⁴⁷

The Sixth Circuit in *Hayden v. Martin Marietta Materials, Inc. Flexible Benefits Program*¹⁴⁸ concluded that whether the claimant’s mental disability was work-related was irrelevant, and that reviewing physicians cannot apply heightened extracontractual standards in defining mental illness.¹⁴⁹ At issue was whether the claimant was “unable to perform the material and substantial duties of her own occupation” during the elimination period and any occupation twenty-four months thereafter due to depression and anxiety.¹⁵⁰ A reviewing physician agreed the claimant suffered from depression and anxiety, but determined “[t]here was no evidence of cognitive impairment, severe psychiatric symptoms, suicidal ideation, homicidal ideation, hallucinations or cognitive impairment that would have precluded [her] from engaging in a full time job during the Elimination period.”¹⁵¹ The Sixth Circuit overturned the district court’s decision to uphold the claim denial, finding the reviewing physician applied “a significantly heightened standard for a disabling mental illness that contravenes” the plan definition.¹⁵² It also held the reviewing physician’s determination that the claimant’s disability was caused by job stressors and would subside if she worked elsewhere was unsupported by the record and irrelevant under the plan.¹⁵³ In so holding, the Sixth Circuit commented that, even under the applicable deferential standard, “where a reviewing physician’s opinion applies standards that conflict with the terms of the plan, that opinion is not evidence supporting a conclusion that the claimant is not disabled within the meaning of the plan.”¹⁵⁴ Ultimately, the court declined to remand the matter back to the plan administrator because the claimant “clearly established she is mentally disabled under the plan.” Instead, the court remanded her claim to the district court to enter an order awarding “benefits consistent with the terms of the Plan.”¹⁵⁵

146. *Id.* at 718.

147. *Id.* at 718–19.

148. 763 F.3d 598 (6th Cir. 2014).

149. *Id.* at 607.

150. *Id.*

151. *Id.* at 604.

152. *Id.* at 607.

153. *Id.* at 608.

154. *Id.* at 607.

155. *Id.* at 609.

F. *Racketeer Influenced and Corrupt Organizations Act*

Courts remain reluctant to allow racketeering claims to stand where insurers working with outside vendors deny disability claims.¹⁵⁶ In *Friedland v. Unum Group*,¹⁵⁷ a federal district court considered whether Unum's actions in discontinuing the claimant's benefits amounted to a violation of the Federal Racketeer Influenced and Corrupt Organizations Act (RICO),¹⁵⁸ particularly § 1962(c) and (d).¹⁵⁹ The claimant was injured in 1994 and Unum determined she was totally disabled, even after she reported having part-time jobs on two occasions over the next two decades.¹⁶⁰ Unum later discontinued her benefits because it determined her condition had improved enough to work full time.¹⁶¹ The claimant then sued and alleged Unum's decision was not based on "new medical evidence, but instead from an illegal policy and scheme to reduce expensive payouts."¹⁶² The claimant argued that the "defendants acted through their employees and outside vendors to implement the 'RICO Plan' as a means of improperly processing benefit claims."¹⁶³ Considering Unum's motion to dismiss, the court held the "appropriate inquiry is not whether the participants of the alleged RICO 'enterprise' can be properly regarded as defendants' agents[]" but instead "whether defendants participated in the conduct of a distinct RICO 'enterprise,' or merely conducted their own business affairs."¹⁶⁴ The district court ultimately dismissed the RICO claim because the claimant did not allege the defendants were doing more than conducting their own affairs.¹⁶⁵

G. *Legal versus Factual Disability: Loss of Professional License*

The Eighth Circuit examined whether the timing of a claimant's disability in relation to his loss of licensure impacted his right to benefits in *Cich v. National Life Insurance Co.*¹⁶⁶ There, the plaintiff sued for disability benefits after becoming disabled one year after the State of Minnesota sus-

156. This issue arose previously in *Shields v. UnumProvident Corp.*, 415 F. App'x 686, 691 (6th Cir. 2011), where the Sixth Circuit held that a plaintiff failed "to adequately plead the existence of an 'association in fact' RICO enterprise[]" where the plaintiff alleged that the insurance company's "various subsidiaries, affiliates, wholly owned companies, customers, policy holders, claimants, independent contractors, and governmental and nongovernmental regulators[]" were "an enterprise distinct from itself for RICO purposes."

157. 2014 WL 2796879, at *1 (D. Del. June 19, 2014).

158. 18 U.S.C. § 1961.

159. *Friedland*, 2014 WL 2796879, at *1.

160. *Id.*

161. *Id.*

162. *Id.* at *2.

163. *Id.* at *5.

164. *Id.* at *4.

165. *Id.* at *5.

166. 748 F.3d 807 (8th Cir. 2014).

pended his professional chiropractic license.¹⁶⁷ At issue was whether the plaintiff had to be actively engaged as a chiropractor at the time his disability accrued to be eligible for policy benefits at any time thereafter.¹⁶⁸ The Eighth Circuit upheld the district court's decision that benefits were not payable because, due to the loss of his professional license, the claimant was not performing the duties of his regular occupation when he became disabled.¹⁶⁹

Similarly, in *Young v. Paul Revere Life Insurance Co.*,¹⁷⁰ after the claimant's medical license was suspended due to a history of drug and alcohol abuse,¹⁷¹ he received disability benefits until a reviewing physician "found that 'but for lack of licensure, insured would be able to practice his profession at this time.'"¹⁷² The claimant then sued, arguing his lack of license met the policy's definition for "total disability"—defined as being "unable to perform the important duties of [his] Occupation."¹⁷³ The insurer responded that the claimant's limitation stemmed from a legal disability (his lack of medical license) and not a factual disability caused by his addiction.¹⁷⁴ Agreeing with the insurer, the federal district court held that because the claimant was able to work *but for* his lack of license, disability benefits were precluded.¹⁷⁵

IV. ERISA

ERISA practitioners saw many familiar issues this year, including cases addressing questions related to standard of review, the sufficiency of vocational and employability analyses, and the scope and impact of conflict of interest. The most significant ERISA rulings were the U.S. Supreme Court's ruling in *Heimeshoff v. Hartford Life & Accident Insurance Co.*¹⁷⁶ and the Sixth Circuit's decision in *Rochow v. Life Insurance Co. of North America*.¹⁷⁷ The *Heimeshoff* decision generally pleased the industry, with the Supreme Court upholding a contractual limitations period that began to run when proof of loss was due and ran during the internal review process. The Sixth Circuit shook the industry with its decision in *Rochow*, however, by finding that disgorgement is an appropriate remedy

167. *Id.* at 808–09.

168. *Id.* at 809.

169. *Id.* at 810.

170. 2014 WL 1323391 (W.D. La. Mar. 31, 2014).

171. *Id.* at *2.

172. *Id.* at *3.

173. *Id.* at *4 n.6.

174. *Id.* at *5.

175. *Id.* at *6.

176. 134 S. Ct. 604 (2013).

177. 737 F.3d 415 (6th Cir. 2013), *reh'g en banc granted and opinion vacated* (Feb. 19, 2014).

under ERISA § 502(a)(B). The impact of the *Rochow* ruling was lessened when the insurer's motion for rehearing en banc was granted. But the future of disgorgement claims remains far from certain at this point.

A. *Standard of Review*

In *Prezioso v. Prudential Insurance Co. of America*,¹⁷⁸ the Eighth Circuit held that plan language providing Prudential “may request . . . proof . . . satisfactory to Prudential” was sufficient “discretion-granting language” to trigger the arbitrary and capricious standard of review.¹⁷⁹ In so holding, it noted that the summary plan description (SPD) supported its finding of discretion, as it clearly gave Prudential “sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits.” The SPD also provided that Prudential's decisions as claims administrator “shall not be overturned unless arbitrary and capricious.”¹⁸⁰ The Eighth Circuit justified its reliance on the SPD because the plan's language was ambiguous with respect to discretion, as opposed to altogether silent.¹⁸¹ In contrast, the court in *Herbert v. Prudential Insurance Co. of America*,¹⁸² found the same “satisfactory to Prudential” language insufficient to confer discretion to Prudential because the statements did not provide notice of the broad-ranging authority Prudential wished to assert.¹⁸³ It also refused to consider the SPD's language since the SPD's terms did not constitute the plan's terms.¹⁸⁴

Significantly, the number of states in which discretionary review is available is waning. Several states have adopted statutes or regulations prohibiting discretionary clauses from being included in insurance policies.¹⁸⁵ As a result, more and more decisions are being reviewed de novo, even where the plans contain sufficient discretion-granting language. A Washington statute, for example, voids any plan language granting discretion to a plan administrator.¹⁸⁶ Michigan adopted similar statutory language, stating that “[o]n or after [July 1, 2007], a discretionary clause issued or delivered to any person in this state in a policy, contract, rider, indorsement, certificate, or similar contract document is void and of

178. 748 F.3d 797 (8th Cir. 2014).

179. *Id.* at 803–04.

180. *Id.* at 803.

181. *Id.* at 804.

182. 2014 WL 4186553 (E.D. Pa. Aug. 22, 2014).

183. *Id.* at *1.

184. *Id.* at *2 (quoting *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011)).

185. See *Criss v. Union Sec. Ins. Co.*, 26 F. Supp. 3d 1161, 1164 (N.D. Ala. 2014) (“[A]n increasing number of states have adopted a statute or insurance industry rule that precludes the inclusion of the so-called ‘discretionary clause’ in a disability insurance policy.”).

186. See WASH. REV. CODE § 284-96-012 (2014).

no effect.”¹⁸⁷ Notably, one Michigan court allowed discretionary language to stand despite Michigan’s clear prohibition. Because the claimant was unable to offer any proof that a certificate or any other policy document was actually delivered to him or any other person in Michigan, the court in *Tikkanen v. Liberty Life Assurance Co. of Boston*¹⁸⁸ concluded there was no basis to void the policy’s discretionary language.¹⁸⁹ In *Rapolla v. Waste Management Employee Benefits Plan*,¹⁹⁰ the administrator argued California’s prohibition of discretionary clauses in “insurance policies” applied only to the insurance policy and not the plan.¹⁹¹ Rejecting that argument, the federal district court found that the insurance policy, which funded the benefits at issue, and the plan were part of a “single integrated contract” and the policy became part of the plan when the policy became effective.¹⁹²

B. Conflict of Interest Discovery

The scope of permissible conflict of interest discovery continued to be a point of contention during this survey period. In *Smith v. Life Insurance Co. of North America*,¹⁹³ for example, the court granted the claimant’s motion to compel production of performance evaluations for employees who were involved in administering her claim, reasoning the information might reveal whether the employees had a review-based incentive for denying claims.¹⁹⁴ The court also ordered the administrator to produce its entire claims procedure manual (not just the index or table of contents), noting the manual’s language might reveal a bias toward denying claims.¹⁹⁵ The administrator also had to produce three years’ worth of liability acceptance rates in Alabama for ERISA and non-ERISA claims because the court believed such information could show a lack of safeguards to protect against conflict.¹⁹⁶ In *Atkins v. UPMC Healthcare Benefits Trust*,¹⁹⁷ however, the court denied requests for the defendant’s employees’ personnel files and pay records because the information sought was beyond the narrow scope of permissible discovery.¹⁹⁸ As these decisions reflect, the scope of permissible conflict of interest discovery is still in flux.

187. MICH. ADMIN. CODE R. 500.2202(c) (2014).

188. 31 F. Supp. 3d 913 (E.D. Mich. 2014).

189. *See id.* at 922.

190. 2014 WL 2918863 (N.D. Cal. June 25, 2014).

191. *Id.* at *4.

192. *Id.* at *5.

193. 33 F. Supp. 3d 1324 (N.D. Ala. 2014).

194. *Id.* at 1328–29.

195. *Id.* at 1329.

196. *Id.* at 1329–30.

197. 2014 WL 1572439 (W.D. Pa. Apr. 17, 2014).

198. *Id.* at *2.

C. Administrative Record

Courts in this survey period affirmed that review under the arbitrary and capricious standard is limited to the evidence before the administrator when it made its decision, except in limited circumstances when extra-record evidence supports a procedural challenge to a benefits decision.¹⁹⁹ In *Hawkins v. Community Legal Aid Services, Inc.*,²⁰⁰ the court declined to consider documents related to the Social Security Administration (SSA) because they were not part of the administrative record and not submitted for the limited purpose of supporting a procedural challenge to a benefits decision.²⁰¹ On de novo review, where courts generally have discretion to look beyond the administrative record, another court explained it would do so only where the circumstances “clearly establish” that additional evidence is necessary for an adequate review.²⁰² A conflict of interest is one circumstance that may warrant the introduction of additional evidence.²⁰³ For instance, if “the fairness of the ERISA appeal process cannot be established using only the record before the administrator,” additional evidence may be appropriate.²⁰⁴

As the application of the de novo standard of review becomes more common, practitioners should determine early on whether extra-record discovery will be permitted and confirm that an independent evidentiary foundation will not be required for documents in the administrative record. Generally, courts do not require parties to lay the foundation for documents contained in the administrative record. In *Jones v. Allen*,²⁰⁵ the court noted that unless there is a procedural challenge “[u]nder either ‘arbitrary and capricious’ review or de novo review, ‘a court’s review of a plan administrator’s decision . . . is confined to the evidence in the administrative record.’”²⁰⁶ A recent decision from the Northern District of Illinois squarely addressed evidentiary challenges to an administrative record. In *Schlattman v. United of Omaha Life*

199. See, e.g., *Kludka v. Qwest Disability Plan*, 581 F. App’x 633 (9th Cir. 2014); *Hawkins v. Cmty. Legal Aid Servs., Inc.*, 2014 WL 3749412, at *10 (N.D. Ohio July 30, 2014).

200. 2014 WL 3749412.

201. *Id.* at *10.

202. See *Gonda v. Permanente Med. Grp. Inc.*, 300 F.R.D. 609, 613 (N.D. Cal. 2014).

203. See *Tretola v. First Unum Life Ins. Co.*, 2014 WL 2815586, at *2 (S.D.N.Y. June 23, 2014).

204. *Id.* (quoting *DeFelice v. Am. Int’l Life Assurance Co.*, 112 F.3d 61, 66 (2d Cir. 1997)).

205. 2013 WL 5728344 (S.D. Ohio Oct. 22, 2013).

206. *Id.* at *9 (quoting *Daft v. Advest, Inc.*, 658 F.3d 583, 594–95 (6th Cir. 2011)); see also *James v. Liberty Life Assurance Co. of Boston*, 984 F. Supp. 2d 730, 736 (W.D. Mich. 2013) (“[A court should not hear or consider evidence not presented to the plan administrator in connection with a claim.”).

Insurance Co.,²⁰⁷ both the plaintiff and the defendant objected to the admission of documents that were submitted during the administrative appeal and part of the administrative record. The plaintiff objected to the admissibility of a consulting physician's report and the defendant asserted a hearsay objection to a letter from the plaintiff's former business associate. The court overruled both objections, holding that because it was required to "weigh" the entire administrative record as part of its de novo review, the documents in the administrative record were not subject to the Federal Rules of Evidence's foundation and hearsay rules.²⁰⁸

D. *Full and Fair Review—Vocational and Employability Analyses*

Courts considering whether an administrator conducted a full and fair review of an ERISA claim frequently consider the appropriateness of a plan administrator's reliance on a vocational analysis. In *Williams v. Target Corp.*,²⁰⁹ the court questioned how the wage data for the plan administrator's employability analysis report (EAR) was computed and what data were used, remanding the case to the district court with instructions to remand the issue to the plan administrator for further development of the record.²¹⁰ In another Sixth Circuit decision, *Gillespie v. Liberty Life Assurance Co. of Boston*,²¹¹ the court affirmed judgment for the plan participant, after criticizing the plan's vocational analysis for failing to

discuss the physical requirements of the proposed occupations[,] . . . provide a description of the occupation beyond its name, or explain how the individual conducting the analysis concluded that [the plan participant] could perform the proposed occupation.²¹²

As the decisions in *Williams* and *Gillespie* indicate, plan administrators must carefully consider whether data underlying their vocational analyses are fully and accurately supported or risk remand or written criticism of their analyses.

207. No. 12 C 7847, slip op. at 2 (N.D. Ill. July 31, 2014). Attorneys from the authors' firm, Chittenden, Murday & Novotny LLC, represented the insurer in this litigation.

208. *Id.* (citing *Black v. Long Term Disability Ins.*, 582 F.3d 738, 746 n.3 (7th Cir. 2009)).

209. 579 F. App'x 390 (6th Cir. 2014).

210. *Id.* at 391. *But see* *DeBoard v. Liberty Life Assurance Co. of Bos.* 2014 WL 4064249, at *1 (E.D. Mich. Aug. 18, 2014) (in affirming decision of plan administrator, court did not question the basis for the wage data used in the occupational analysis).

211. 567 F. App'x 350 (6th Cir. 2014).

212. *Id.* at 354–55. *But see* *Waldoch v. Medtronic, Inc.*, 757 F.3d 822, 833 (8th Cir. 2014) ("We see no flaw in Medtronic relying on the EAR to conclude that Waldoch could obtain a position similar to his at Medtronic in a lower-stress, sedentary environment.").

E. *Enforcement of Contractual Limitations Periods*

In a ruling favoring plan sponsors and administrators, the U.S. Supreme Court in *Heimeshoff v. Hartford Life & Accident Insurance Co.*²¹³ recently clarified that an ERISA plan's contractual limitations period should be enforced, although it left the door open to waiver and estoppel claims if administrative review is completed after the contractual limitations period expires. In *Heimeshoff*, the Supreme Court affirmed dismissal of the plan participant's ERISA § 502(a)(1)(B) claim as time-barred under the plan's three-year contractual limitations period, which began to run when the proof of loss was due.²¹⁴ The plan participant filed suit less than three years after she exhausted the internal review process, but more than three years after her proof of loss was due.²¹⁵ The court found it must give effect to the plan's limitations provision unless it is "unreasonably short" or a "controlling statute" prevents such provision from taking effect.²¹⁶ Neither party argued the three-year contractual limitations period was facially unreasonable, as regulations governing internal review under ERISA are such that "mainstream claims" are resolved in about a year.²¹⁷ The Court then considered the participant's argument that ERISA is a "controlling statute" to the contrary because the limitations provision will undermine ERISA's remedial scheme. The Court essentially rejected this argument because comprehensive regulations address such concerns and they are otherwise unfounded.²¹⁸ Discarding arguments that the limitations period should be tolled during internal review and that ERISA regulations require such tolling,²¹⁹ the Court found that ERISA regulations²²⁰ only require a plan to toll a limitations provision when it offers "voluntary internal appeals beyond what is permitted by regulation."²²¹ It then suggested that the time remaining for filing suit after internal review is complete may dictate whether a contractual limitations period is enforceable, observing: "even in the rare cases where internal review prevents participants from bringing § 502(a)(1)(B) actions within the contractual period, courts are well equipped to apply traditional doctrines that may nevertheless allow participants to proceed."²²²

213. 134 S. Ct. 604 (2013).

214. *Id.* at 609–10.

215. *Id.* at 609.

216. *Id.* at 612.

217. *Id.* Here, the participant was still left with one year to file suit after completing the internal review process. *Id.*

218. *Id.* at 613–15.

219. *Id.* at 616.

220. 29 C.F.R. § 2560.503-1(c)(3)(ii) (2014).

221. *Heimeshoff*, 134 S. Ct. at 616.

222. *Id.* at 615; *see also* Russell v. Catholic Healthcare Partners Emp. Long Term Disability Plan, 577 F. App'x 390 (6th Cir. 2014) (holding *Heimeshoff* was controlling and enforcing

Enforcement of contractual limitations periods also depends on notice that alerts plan participants to time limits for seeking judicial review. In *Moyer v. Metropolitan Life Insurance Co.*,²²³ the district court dismissed the plan participant's action as time-barred. Because the insurer did not include the time limits for judicial review in the benefits termination letter, however, the Sixth Circuit reversed the dismissal and remanded the case to the district court.²²⁴ The fact that ERISA benefits are paid monthly does not give rise to new limitations periods every month. In *Riley v. Metropolitan Life Insurance Co.*,²²⁵ a plan beneficiary claimed the plan underpaid his monthly benefits. Joining the Second, Third, and Ninth Circuits, the First Circuit rejected the argument that a monthly underpayment of benefits under "the ERISA plan must be treated as a continuing violation or as an installment contract, with a new accrual date starting a new limitations period for each payment."²²⁶

F. Equitable Relief Under Section 502(a)(3)

Currently, the Sixth Circuit is testing the limits of the equitable relief available under § 502(a)(3) of ERISA. In *Rochow v. Life Insurance Co. of North America (LINA)*,²²⁷ the Sixth Circuit took what the dissent argued was "an unprecedented and extraordinary step to expand the scope of ERISA coverage" by granting a plan participant approximately \$3.8 million for disgorgement of profits under § 502(a)(3).²²⁸ The plan participant brought claims for recovery of benefits and for breach of fiduciary duty under §§ 502(a)(3) and 404(a), respectively.²²⁹ The district court entered judgment for the plan participant, concluding LINA acted arbitrarily and capriciously in denying benefits, and ultimately awarding both unpaid benefits and equitable disgorgement.²³⁰ In affirming the district court's disgorgement award, the Sixth Circuit held that § 502(a)(1)(B) "cannot provide the equitable redress of preventing LINA's unjust enrichment. . . ." ²³¹ The Sixth Circuit also rejected the argument that disgorgement would result in double compensation or constitute punishment, holding

three-year contractual limitations period where more than six months to sue remained); *Nelson v. Standard Ins. Co.*, 2014 WL 4244048, at *5 (S.D. Cal. Aug. 26, 2014). Even if one hundred days in which to sue is a reasonable period, "the Court would be required to consider extrinsic evidence to evaluate Plaintiff's claim that equitable estoppel prevents assertion of the contractual limitations provision." *Nelson*, 2014 WL 4244048, at *6.

223. 762 F.3d 503 (6th Cir. 2014).

224. *Id.* at 507.

225. 744 F.3d 241 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 94 (2014).

226. *Id.* at 246.

227. 737 F.3d 415 (6th Cir. 2013), *reh'g en banc granted, opinion vacated* (Feb. 19, 2014).

228. 29 U.S.C. § 1132(a)(3) (2014).

229. *Rochow*, 737 F.3d at 418.

230. *Id.*

231. *Id.* at 425.

“disgorgement is an appropriate equitable remedy under § 502(a)(3) and can provide a separate remedy on top of a benefit recovery.”²³² Two months after the ruling, however, the Sixth Circuit granted LINA’s motion for rehearing en banc and vacated the opinion. It then heard oral argument in June 2014 but the en banc decision has not yet been issued. Since the *Rochow* decision, other decisions addressing similar disgorgement claims have rejected those claims.²³³

G. Social Security Administration Awards

This survey period courts reinforced the notion that a plan administrator’s failure to address an SSA award when denying or upholding the denial of benefits may tip the scales toward a finding that the decision was arbitrary and capricious.²³⁴ Notably, the failure to consider an award is not grounds for reversal by itself.²³⁵ In *Oates v. Walgreen Co.*,²³⁶ the administrator did not consider the SSA’s benefit award or notice of award letter but did consider the SSA’s independent medical examination (IME). On appeal, the Eleventh Circuit determined it was sufficient for the administrator to consider only the SSA’s IME because that was the only substantive evidence the SSA process generated.²³⁷ The court specifically noted that SSA awards, which claimants typically provide plan administrators, lack information about a claimant’s condition and the SSA process for reaching its decision.²³⁸ Accordingly, the court was satisfied that the plan administrator’s review did not “ignore the evidence generated by the SSA process.”²³⁹

The Eleventh Circuit in *Melech v. Life Insurance Co. of North America*,²⁴⁰ however, chided the plan administrator not only for ignoring SSA records, but for failing to obtain the SSA records on its own initiative.²⁴¹

232. *Id.* at 426.

233. See *Sexton v. Standard Ins. Co.*, 2014 WL 1745420, at *2 (N.D. Ill. Apr. 30, 2014) (“Sexton’s attempt to characterize the disgorgement of profits in this case as an equitable remedy separate and distinct from the remedy available under § 502(a)(1)(B) is unavailing.”); *Halley v. Aetna Life Ins. Co.*, 2014 WL 4463239, at *4 (N.D. Ill. Sept. 10, 2014) (“The possibility that the *Rochow* decision may be reinstated does not alter the Supreme Court and Seventh Circuit’s current view of duplicative § 502(a)(3) claims or this Court’s mandate to follow its own Circuit’s precedent.”); *Hannon v. Unum Life Ins. Co. of Am.*, 2014 WL 4352156, at *2 (S.D. Ind. Sept. 2, 2014) (dismissing claim for disgorgement under § 502(a)(3) where claim was “based entirely on the Defendants’ wrongful termination/denial of benefits”).

234. *Beach v. Hartford Life & Accident Ins. Co.*, 2014 WL 3724846, at *8 (M.D. La. July 28, 2014).

235. *Salz v. Standard Ins. Co.*, 554 F. App’x 600, 602 (9th Cir. 2014).

236. 573 F. App’x 897 (11th Cir. 2014).

237. *Id.* at 911.

238. *Id.*

239. *Id.* (quoting *Melech v. Life Ins. Co. of N. Am.*, 739 F.3d 663, 675 (11th Cir. 2014)).

240. *Melech*, 739 F.3d at 663.

241. *Id.* at 666.

Although the plaintiff informed the administrator of the award, she never produced any SSA records during the administrative review process.²⁴² Nevertheless, the court found the plan administrator had an “obligation to consider the evidence presented to the SSA,” even though it did not have such documents.²⁴³ This ruling was based on the court’s view that “self-interested efforts” fueled the plan administrator’s failure to consider the SSA records,²⁴⁴ and the “fundamental requirement that an administrator’s decision to deny benefits must be based on a complete administrative record that is the product of a fair claim-evaluation process.”²⁴⁵ Ultimately, the court remanded the matter to the plan administrator so it could evaluate the merits of the plaintiff’s claim using evidence not previously considered, i.e., the SSA records.²⁴⁶

Given the dictates of *Metropolitan Life Insurance Co. v. Glenn*,²⁴⁷ it is conceivable that more and more administrators will address a claimant’s SSA award by categorically explaining why the award is not controlling or binding without really giving it any appreciable weight. This approach passed muster in *Beach v. Hartford Life & Accident Insurance Co.*, where Hartford, as the claim administrator, specifically addressed the plaintiff’s SSA award and explained that such award, although considered, was not controlling or binding.²⁴⁸ Courts recognize that the SSA uses a more demanding definition of disability than most plans and, consequently, may be skeptical when a plan fails to discuss an SSA award when denying benefits. Plans would be wise to address any SSA award when denying benefits because if they do not, a reviewing court almost certainly will.²⁴⁹

H. Attorney Fees

Courts have flexibility in determining whether parties meet the threshold requirement of having achieved “some degree of success on the merits” before awarding attorney fees. In *Gross v. Sun Life Assurance Co. of Canada*,²⁵⁰ the First Circuit held that where the district court, on remand,

242. *Id.*

243. *Id.*

244. *Id.* at 674.

245. *Id.* at 676.

246. *Id.*

247. 554 U.S. 105 (2008).

248. 2014 WL 3724846, at *8 (M.D. La. July 28, 2014).

249. *See, e.g.,* *Branca v. Liberty Life Assurance Co. of Bos.*, 2014 WL 1340604, at *13 (E.D. Pa. Apr. 3, 2014) (the SSA award letter did not state the SSA’s reasons for finding the plaintiff was disabled, but the court said the fact that the SSA deemed the plaintiff disabled under a far more stringent standard must be considered in determining whether it was arbitrary and capricious for the plan administrator to deny benefits).

250. 763 F.3d 73 (1st Cir. 2014); *see also* *Hannon v. Unum Life Ins. Co. of Am.*, 2014 WL 4653058 (S.D. Ind. Aug. 6, 2014) (a remand without an award of benefits “does not mean that [the plan participant] did not achieve some degree of success on the merits”).

ordered the plan administrator to render a new decision, including reconsideration of videotape evidence not fairly examined in the initial administrative process, the plan participant received more than just another opportunity for “full and fair review”²⁵¹ and was entitled to fees. A remand relating to a remedy different from the one the plan participant sought did not preclude an attorney fees award in *Berkoben v. Aetna Life Insurance Co.*²⁵² There, the plan participant sought reinstatement of LTD benefits that were terminated due to the plan’s twenty-four-month mental illness limitation.²⁵³ The district court, however, inquired about the participant’s “any occupation” status apart from the twenty-four-month mental illness limitation, remanding the case to the plan administrator to address that issue.²⁵⁴ Acknowledging it was awarding fees for securing a remand on a different issue than that presented by the participant, the court found it had discretion to do so as the Third Circuit had “yet to weigh in on” the issue.²⁵⁵ Finally, courts in the Second Circuit applying multifactor tests to determine fee awards must be thorough. In remanding a fee award, the Second Circuit in *Donachie v. Liberty Life Assurance Co. of Boston*²⁵⁶ explained that courts choosing to analyze multifactor tests “cannot selectively consider some factors while ignoring others.”²⁵⁷ Because the district court in *Donachie* selectively applied the multifactor test, the Second Circuit vacated its denial of the plaintiff’s request for fees and remanded to the district court, instructing that it award reasonable attorney fees.²⁵⁸

V. HEALTH INSURANCE

The Patient Protection and Affordable Care Act (ACA) remained in the forefront of health insurance litigation this year, with significant constitutional and statutory challenges to the ACA’s birth control mandate (also known as the contraceptive-coverage requirement)²⁵⁹ and health law subsidies.²⁶⁰

251. *Gross*, 763 F.3d at 78.

252. 2014 WL 3565959 (W.D. Pa. July 18, 2014).

253. *Id.* at *1.

254. *Id.* at *4.

255. *Id.*

256. 745 F.3d 41 (2d Cir. 2014).

257. *Id.* at 46–47.

258. *Id.* at 47.

259. See 42 U.S.C. § 300gg-13(a)(4) (2014).

260. See 26 U.S.C. § 36B(b)(2)(A) (2014).

A. Affordable Care Act

1. Birth Control Mandate

The Supreme Court issued a landmark decision in *Burwell v. Hobby Lobby Stores, Inc.*,²⁶¹ holding the ACA's birth control mandate violated certain employers' constitutional and statutory protections of religious freedom.²⁶² The Court consolidated two conflicting cases involving closely held, for-profit corporations: the Tenth Circuit's decision in *Hobby Lobby Stores, Inc. v. Sebelius [Hobby Lobby I]*²⁶³ and the Third Circuit's ruling in *Conestoga Wood Specialties Corp. v. Secretary of Health & Human Services*.²⁶⁴ In *Hobby Lobby I*, the Tenth Circuit found that privately held, for-profit secular corporations were "persons" under the Religious Freedom Restoration Act (RFRA);²⁶⁵ the plaintiffs established a likelihood of success on their claim that their rights under RFRA were substantially burdened by the ACA's birth control mandate and caused them irreparable harm;²⁶⁶ and, as a matter of constitutional law, free exercise rights may extend to some for-profit organizations.²⁶⁷ Conversely, in *Conestoga Wood* the Third Circuit held that a secular, for-profit corporation had no free exercise rights under the First Amendment, was not a "person" under the RFRA, and had no standing to challenge the ACA's birth control mandate.²⁶⁸

The Supreme Court's five-justice majority opinion²⁶⁹ in *Hobby Lobby* closely tracked the Tenth Circuit's reasoning in *Hobby Lobby I*, holding: (1) for-profit, closely held corporations are "persons" under RFRA; (2) with respect to four specific contraceptives, the ACA's birth control mandate placed a substantial burden on such corporations' religious beliefs under RFRA; and (3) although giving employees free access to these four contraceptives was a matter of compelling interest to the federal government, the ACA's mandate did not satisfy RFRA's least-restrictive-means requirement.²⁷⁰ The Court explained that nothing in RFRA suggested Congress intended to depart from the common definition of "person," which "includes[s] corporations, . . . as well as individuals."²⁷¹ Moreover, the Court found no reason why "person" would include

261. 134 S. Ct. 2751 (2014).

262. *Id.* at 2751.

263. 723 F.3d 1114 (10th Cir. 2013).

264. 2013 WL 1277419 (3d Cir. Feb. 8, 2013).

265. 723 F.3d at 1126 (citing 42 U.S.C. § 2000bb-1(a)).

266. *Id.* at 1120.

267. *Id.* at 1126.

268. *Conestoga*, 2013 WL 1277419, at *2.

269. The five justices joining the majority opinion were Justices Alito, Roberts, Scalia, Kennedy, and Thomas.

270. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2751 (2014).

271. *Id.* at 2768.

nonprofit religious corporations (which all parties agreed could bring RFRA claims), but exclude for-profit corporations.²⁷² The Court then determined that the ACA's financial penalties for noncompliance were severe enough to constitute a substantial burden on the plaintiffs' exercise of religion,²⁷³ noting penalties could be \$1.3 million per day or about \$475 million per year for Hobby Lobby, about \$90,000 per day or \$33 million per year for Conestoga, and \$40,000 per day or about \$15 million per year for Mardel.²⁷⁴ Turning to whether the federal government had a compelling interest, the Court assumed that "guaranteeing cost-free access to the four challenged contraceptive methods is compelling within the meaning of RFRA"²⁷⁵ but concluded that the government failed to meet its burden because the ACA's mandate was not the least restrictive means available; the ACA provided a less restrictive option by allowing an "accommodation" for religious, nonprofit entities, which could be applied to for-profit corporations such as plaintiffs.²⁷⁶ The Court limited its holding to the particular facts presented, stating its decision "concerns only the contraceptive mandate and should not be understood to hold that all insurance-coverage mandates, e.g., for vaccinations or blood transfusions, must necessarily fall if they conflict with an employer's religious beliefs."²⁷⁷

In the wake of the *Hobby Lobby* decision, courts have addressed additional religious objections to the ACA's birth control mandate, but none have succeeded. In *Michigan Catholic Conference v. Burwell*,²⁷⁸ the Sixth Circuit consolidated and reviewed two cases involving religious employers that had been denied preliminary injunctions in the district court related to their allegations that the contraceptive-coverage requirement violated RFRA, the First Amendment's Free Exercise, Free Speech, and Establishment Clauses, and the Administrative Procedure Act. The plaintiffs were religious employers that were relieved from the contraceptive-coverage requirement either because they were eligible for the total exemption or were religiously affiliated nonprofit corporations that qualified for an accommodation to the mandate.²⁷⁹ The district courts denied the plaintiffs injunctive relief, finding they failed to show a likelihood of success on the merits of their claims²⁸⁰ and concluded the mandate did

272. *Id.* at 2773–75.

273. *Id.* at 2779–80.

274. *Id.* at 2775–76.

275. *Id.* at 2780.

276. *Id.* at 2786.

277. *Id.* at 2758.

278. 755 F.3d 372 (6th Cir. 2014).

279. *Id.* at 379.

280. *Id.* at 381.

not impose a substantial burden on their religious beliefs because they were excused from the contraceptive-coverage requirement.²⁸¹

In affirming, the Sixth Circuit rejected the plaintiffs' argument that the exemption or accommodation forced them "to play an integral role in the delivery of objectionable products and services to their employees"²⁸² because the plaintiffs failed to "identify any particular action that they must take to obtain the exemption that burdens their exercise of religion."²⁸³ The Sixth Circuit also rejected the plaintiffs' contentions that the self-certification process substantially burdened their religious beliefs²⁸⁴ and that their compliance with such process "triggered" coverage, as only the ACA dictated coverage.²⁸⁵ The plaintiffs' argument that the accommodation to the mandate violated the First Amendment was rejected by the court because the plaintiffs were not deprived of their freedom to speak out about their beliefs,²⁸⁶ as was the argument that the contraceptive-coverage requirement violated the Free Exercise Clause.²⁸⁷ Explaining the exemption and accommodation provisions "[did] not prefer a denomination or excessively entangle government in religious practice," the court found that they therefore did not violate the Establishment Clause.²⁸⁸ Finally, the Sixth Circuit rejected the plaintiffs' claim that the contraceptive-coverage requirement violated the Administrative Procedure Act because it covered "abortifacients" (under the FDA-approved emergency contraceptives) in violation of the Weldon Amendment.²⁸⁹ The plaintiffs failed to show that the federal government classified these drugs as "abortifacients" or that they were considered "abortions" under the Weldon Amendment.²⁹⁰

Other nonprofit, religious employers challenging the ACA's birth-control mandate were equally unsuccessful. In *University of Notre Dame v. Sebelius*,²⁹¹ the Seventh Circuit affirmed the denial of the plaintiff's request for injunctive relief after concluding the plaintiff, which was given an accommodation to providing contraceptive coverage, failed to show it

281. *Id.* at 382.

282. *Id.* at 384 (internal citations omitted).

283. *Id.* at 385.

284. *Id.* at 386.

285. *Id.* at 387.

286. *Id.* at 391–92.

287. *Id.* at 393–94.

288. *Id.* at 395.

289. The Weldon Amendment is a rider to an appropriations bill that denies funding to federal agencies or programs "if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." Consolidated Appropriations Act of 2012, Pub. L. No. 112–74, div. F, tit. V, § 507(d)(1), 125 Stat. 786, 1111 (2011).

290. *Burwell*, 755 F.3d at 397.

291. 743 F.3d 547 (7th Cir. 2014).

would suffer irreparable harm.²⁹² The plaintiff claimed that abiding by the certification process “triggered” or enabled coverage since it was the “*cause* of the provision of contraceptive services to its employees, in violation of its religious beliefs.”²⁹³ Explaining that certification merely provides notice that the plaintiff is excused from its obligation to provide contraception under the ACA and tells the insurer and/or third-party administrator that it will have to take up “the slack under compulsion of federal law,” the court found that the certification acts as “a warning, not a trigger” and “enables nothing” because “[t]he sole ‘enabler’ is the federal statute that Notre Dame has been allowed to opt out of.”²⁹⁴ The court also rejected the plaintiff’s argument that the ACA violates the First Amendment’s Establishment Clause because it favors certain types of religious organizations over others by giving some (churches) an automatic exemption while requiring others (such as Notre Dame) to complete a certification form to obtain an accommodation because “[t]he establishment clause does not require the government to equalize the burdens (or the benefits) that laws of general applicability impose on religious institutions.”²⁹⁵ The court further rejected the plaintiff’s contention that the ACA’s contraception requirements violated the First Amendment’s Free Speech Clause because the plaintiff was not prohibited “from expressing its opposition to the use of contraceptives.”²⁹⁶ Other courts considering these issues have reached similar conclusions.²⁹⁷

2. Premium Tax Credits

Another high-stakes battle this year involved the contradictory rulings in the federal appeals courts over the allowance of health law subsidies under the ACA, designed to offset the cost of insurance to make it affordable. The ACA created a marketplace, known as American Health Benefit Exchanges or Exchanges, for individuals to purchase qualifying healthcare plans.²⁹⁸ Section 1311 of the ACA delegates the primary responsibility

292. *Id.* at 554.

293. *Id.* at 553.

294. *Id.* at 557.

295. *Id.* at 560.

296. *Id.*

297. See *Eternal World Television Network, Inc. v. Burwell*, 2014 WL 2739347 (S.D. Ala. June 17, 2014) (district court held the ACA’s certification requirement for an accommodation to the contraceptive mandate did not violate RFRA or the Free Exercise, Free Speech, or Establishment Clauses under the First Amendment); *Little Sisters of the Poor Home for the Aged v. Sebelius*, 2013 WL 6839900 (D. Colo. Dec. 27, 2013) (district court denied injunction because the plaintiff failed to show certification requirement for accommodation substantially burdened its religious beliefs); *Roman Catholic Archbishop of Wash. v. Sebelius*, 2013 WL 6729515 (D.D.C. Dec. 20, 2013) (district court held the ACA’s contraceptive mandate did not violate RFRA; the Free Exercise, Free Speech, or Establishment Clauses of the First Amendment; or the Administrative Procedure Act).

298. 42 U.S.C. § 18031(b)(1), (d)(1) (2014).

for establishing Exchanges to individual states,²⁹⁹ but if states opt out of creating their own Exchanges, § 1321 requires the federal government through the Secretary of Health and Human Services (HHS) to “establish and operate such an Exchange within the State.”³⁰⁰ The dispute focuses on an IRS regulation (IRS Rule),³⁰¹ interpreting § 36B of the Internal Revenue Code enacted as part of the ACA, which provides tax credits for health insurance purchased on Exchanges “*established by the State* under section 1311.”³⁰²

On its face, § 36B authorizes tax credits for insurance purchased only on an Exchange established by a state or the District of Columbia.³⁰³ The IRS Rule authorizes the IRS, however, to give tax credits for insurance purchased on state or federally established Exchanges. The ramifications of the IRS Rule are significant because thirty-six states opted out of creating their own Exchanges; thus, the IRS Rule provides substantially greater tax credits than if such credits were limited to state-established Exchanges. This rule also has a significant impact on employer penalties under the ACA’s employer mandate because they hinge on applicability of tax credits.³⁰⁴

In *Halbig v. Burwell*,³⁰⁵ the D.C. Circuit found “a federal Exchange is not an ‘Exchange established by the State,’ and Section 36B does not authorize the IRS to provide tax credits for insurance purchased on federal Exchanges.”³⁰⁶ In so finding, the court concluded the ACA was unambiguous and, “at least in light of Sections 1311 and 1321, the meaning of Section 36B appears plain: a federal Exchange is not an ‘Exchange established by the State.’”³⁰⁷ And it held the statutory text of § 36B “in the absence of any contrary indications . . . is conclusive evidence of Congress’s intent.”³⁰⁸

299. 42 U.S.C. § 18031(d)(1) (providing “[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange . . . for the State”).

300. 42 U.S.C. § 18041(c)(1).

301. 26 C.F.R. § 1.36B-2(a)(1); 45 C.F.R. § 155.20 (IRS defined Exchange as “an Exchange serving the individual market for qualified individuals . . . regardless of whether the exchange is established and operated by a State . . . or by HHS”); *see also* 26 C.F.R. § 1.36B-1(k) (incorporating definition in 45 C.F.R. § 155.20 by reference).

302. 26 U.S.C. § 36B(e)(2)(A)(i)(emphasis added).

303. 42 U.S.C. § 18024(d).

304. The ACA penalizes any large employer that fails to offer its full-time employees suitable coverage if one or more of those employees “enroll[s] . . . in a qualified health plan with respect to which an applicable tax credit . . . is allowed or paid with respect to the employee.” 26 U.S.C. § 4980H(a)(2); *see also* 26 U.S.C. § 4980H(b) (linking another employer penalty to employees’ receipt of tax credits).

305. 758 F.3d 390 (D.C. Cir. 2014), *reh’g en banc granted, judgment vacated* (Sept. 4, 2014).

306. *Id.* at 399.

307. *Id.*

308. *Id.*

Only two hours after *Halbig* was decided, the Fourth Circuit issued a contrary ruling in *King v. Burwell*.³⁰⁹ Presented with the same arguments, this court found the ACA to be ambiguous.³¹⁰ While it acknowledged the “common sense appeal” of the plaintiffs’ literal reading of the ACA, it found the government’s position was slightly more compelling.³¹¹ The court explained the government’s “primary counterargument points to [the ACA’s] §§ 1311 and 1321, which, when read in tandem with 26 U.S.C. § 36B, provide an equally plausible understanding of the statute, and one that comports with the IRS’s interpretation that credits are available nationwide.”³¹² The court was persuaded by the government’s position that “[g]iven that Congress defined ‘Exchange’ as an Exchange established by the state, it makes sense to read § 1321(c)’s directive that HHS establish ‘such Exchange’ to mean that the federal government acts on behalf of the state when it establishes its own Exchange.”³¹³

With a split among the federal appellate courts, the race began. On July 31, 2014, the *King* plaintiffs filed a petition for certiorari with the Supreme Court asking it to decide “whether the Internal Revenue Service may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through Exchanges established by the federal government under section 1321 of the [ACA].” On August 1, 2014, the government filed a motion for rehearing en banc in *Halbig*, which the D.C. Circuit granted the next month, vacating the prior judgment.³¹⁴ On November 7, 2014, the Supreme Court granted certiorari in the *King* case,³¹⁵ and five days later, the *Halbig* court held oral argument in abeyance, pending a ruling in *King*.³¹⁶ Further discussions of these issues are anticipated in the next survey period.

B. Preemption

In addition to confirming that the ACA’s individual mandate does not violate substantive due process, following the Sixth Circuit’s decision in *United States Citizens Association v. Sebelius*,³¹⁷ the Ninth Circuit also held that the ACA preempted a state’s constitutional amendment excusing ACA penalties for those who abstain from purchasing health insurance in *Coons v. Lew*.³¹⁸ The court found the ACA preempted the Arizona Health

309. 759 F.3d 358 (4th Cir. 2014).

310. *Id.* at 368–69.

311. *Id.*

312. *Id.*

313. *Id.* at 369.

314. *Halbig v. Burwell*, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014).

315. *King v. Burwell*, 135 S. Ct. 475 (Nov. 7, 2014).

316. *Halbig*, No. 14-5018, slip op. (D.C. Cir. Nov. 12, 2014).

317. 705 F.3d 588 (6th Cir. 2013).

318. 762 F.3d 891 (9th Cir. 2014).

Care Freedom Act,³¹⁹ which amended Arizona's Constitution to provide that "[a] law or rule shall not compel . . . any person . . . to participate in any health care system" and purported to excuse people from payment of any fines or penalties.³²⁰ In holding that the ACA preempted these provisions, the court noted, "the ACA presents a classic case of preemption by implication,"³²¹ finding Arizona's Constitutional amendment obstructed the purposes and objectives of the ACA.³²²

VI. LIFE INSURANCE

Life insurance litigation this year featured ongoing battles over the legitimacy of stranger originated life insurance policies, with attendant issues of insurable interest, rescission after the contestability period, and return of premiums. Choice-of-law analysis is important in this context given the inconsistent conclusions within and among both state and federal courts. We also include some interesting misrepresentation decisions in which insurers were permitted to rescind policies based on misstatements about height/body mass or financial condition, and cases where important medical records were not produced during the underwriting process.

A. *Stranger Originated Life Insurance (STOLI)*

Familiar questions dominate the STOLI landscape this year. Does insurable interest matter? Can insurers rescind a STOLI policy after the expiration of the contestable period? Can insurers retain premiums on rescinded STOLI policies? In several decisions during this survey period, choice-of-law decisions played a part in answering these questions. For example, a Delaware federal district court determined Florida law applied to the issue of whether an insurer could challenge the validity of a STOLI policy after the expiration of the contestable period in *PHL Variable Insurance Co. v. Hudson Valley, EPL, LLC*.³²³ In an interesting twist, although the defendant urged application of Florida law, the court applied that law to rule for the insurer.³²⁴ It concluded that, even though the insured died outside the contestability period, the insurer's complaint adequately stated allegations that, if proven, would render the policy void from its inception for lack of an insurable interest.³²⁵ In reaching this decision, the court criticized the analysis in *Pruco Life Insurance Co. v. U.S. Bank*,³²⁶ a

319. ARIZ. CONST. art. XXVII, § 2.

320. *Cooms*, 762 F.3d at 901–02.

321. *Id.* at 902.

322. *Id.*

323. 2014 WL 4635454 (D. Del. Sept. 16, 2014).

324. *Id.* at *3.

325. *Id.* at *5.

326. 2013 WL 4496506 (S.D. Fla. Aug. 20, 2013).

federal court decision out of the Southern District of Florida, which held an incontestability clause applied equally to policies that were void ab initio.³²⁷ The *Hudson Valley* court specifically noted³²⁸ that the *U.S. Bank* case failed to analyze or even mention the decision in *TTSI Irrevocable Trust v. ReliaStar Life Insurance Co.*,³²⁹ which interpreted the Florida statute regarding incontestability clauses to apply only to a policy that was “in force.”³³⁰ The *Hudson Valley* court went on to hold that “the presence of an insurable interest is a fundamental prerequisite to the existence of an insurance policy under Florida law, and public policy renders a policy procured without a valid insurable interest void *ab initio*, *i.e.*, from inception.”³³¹

For similar reasons, in *PHL Variable Insurance Co. v. Bank of Utah*,³³² the court allowed an insurer to contest the validity of a \$5 million policy issued to an elderly insured after the two-year contestability period expired, finding the policy was void ab initio because an insurable interest did not exist when the policy was issued. Citing Minnesota common law, the court explained a life insurance policy “‘issued to one who has no interest in the continuation of the life of the person insured, is both a gambling contract, and a contract which creates a motive for desiring the termination of such life, and is therefore against public policy and void.’”³³³ Although the insured initially procured the policy and his wife was the beneficiary of the trust that owned the policy, the court held the subsequent assignment of the policy to the persons financing the premiums was not in good faith, but instead a “‘mere cover for taking out insurance in the beginning in favor of one without [an] insurable interest.’”³³⁴ Also, noting that neither the Minnesota Supreme Court nor the Eighth Circuit had addressed whether the expiration of the contestability period barred the insurer’s action, the court found Minnesota’s incontestability statute applies to a policy only after it has been “in force.”³³⁵ Because a policy that is void ab initio never comes into force, its incontestability provision has no effect.³³⁶ The court also rejected the defendant’s argument that waiver and estoppel principles barred the insurer from challenging the policy’s validity. The *Bank of Utah* court held that “waiver and estoppel cannot give legal effect to a policy lacking

327. *Hudson Valley*, 2014 WL 4635454, at *5.

328. *See id.* at *5 n.5.

329. 2010 WL 8721575 (Fla. Cir. Ct. Feb. 9, 2010).

330. *See id.* at *9 (interpreting FLA. STAT. ANN. § 627.455 (West 2010)).

331. *Hudson Valley*, 2014 WL 4635454, at *5.

332. 2013 WL 6190345 (D. Minn. Nov. 27, 2013).

333. *Id.* at *8 (citing *Christenson v. Madson*, 149 N.W. 288, 289 (Minn. 1914)).

334. *Id.* (citations omitted).

335. *Id.* at *9 (citing MINN. STAT. ANN. § 61A.03, subd. 1(c)).

336. *Id.*

an insurable interest in the insured's life" even though the insurer approved the premium financing program and transfers of the policy.³³⁷

Federal district courts in Minnesota and Utah reached opposite results during the survey period on whether an insurer can retain premiums paid on a STOLI policy. In *PHL Variable Insurance Co. v. Bank of Utah*,³³⁸ the court looked to general principles of Minnesota law requiring a return of premiums paid on a policy unless the policy is "against law or public morals"³³⁹ and found that where a contract violates public policy, a court must act as though it never existed and take no further action with respect to the contract.³⁴⁰ In response to the defendant's argument that, in other jurisdictions, a party may seek to recover premiums paid through an unjust enrichment claim, the court determined that the insurer might need to return the premiums if the defendant could show it failed to diligently investigate facts suggesting an insurable interest was lacking.³⁴¹ Accordingly, the court denied the insurer's request to retain all premiums paid on the policy pending resolution of the defendant's counterclaim for unjust enrichment.³⁴²

PHL succeeded, however, in challenging a STOLI policy and recovering premiums in a rescission action brought in Utah federal district court. In *PHL Variable Insurance Co. v. Sheldon Hathaway Family Insurance Trust*,³⁴³ the court found it equitable to allow the insurer to retain premium payments to cover its damages related to issuing the policy, paying brokers, and incurring attorney fees and costs.³⁴⁴ Because rescission is an equitable doctrine, the court had discretion to depart from the general rule that the goal of rescission is to restore the status quo that existed prior to the parties' agreement.³⁴⁵ It ultimately held that a rule requiring the insurer to repay premiums on a fraudulently procured life insurance policy "would be an invitation to commit fraud."³⁴⁶

337. *Id.*

338. *Id.*

339. *Id.* at *14 (citing *Taylor v. Grand Lodge, A.O.U.W. of Minn.*, 105 N.W. 408, 413 (Minn. 1905)).

340. *Id.* (citing *Seitz v. Michel*, 181 N.W. 102, 108 (Minn. 1921)).

341. *Id.* at *15 (citing *Pruco Life Ins. Co. v. Brasner*, 2012 WL 4364613, at *4 (S.D. Fla. Sept. 21, 2012)).

342. *Id.* at *17.

343. 2013 WL 6230351 (D. Utah Dec. 2, 2013).

344. *Id.* at *9.

345. *Id.* (citing *Dugan v. Jones*, 724 P.2d 955, 957 (Utah 1986)).

346. *Id.* (citing *PHL Variable Ins. Co. v. Lucille E. Morello 2007 Irrevocable Trust*, 2010 WL 2539755, at *4 (D. Minn. Mar. 3, 2010)). In another interesting decision from the federal district court in Delaware, the court granted the insurer's motion to deposit the proceeds of a \$7 million life insurance policy into the court's registry pursuant to Fed. R. Civ. P. 67 until the court determined whether the policy was void or voidable due to the lack of an insurable interest and/or misrepresentations in the application. See *Penn Mutual Life Ins. Co. v. Norma Espinosa 2007-1 Ins. Trust*, 2014 WL 4811879 (D. Del. Sept. 29, 2014).

The *Hathaway* court also found that misrepresentations in the application entitled the insurer to rescind the policy, despite the defendants' arguments that under Utah law a contract induced by fraud is not void but voidable and that an insurance policy is not void for lack of an insurable interest.³⁴⁷ The court rejected these arguments because the potential insured made misrepresentations about his net worth, assets, intention to assign rights under the policy, and methods used to fund the policy, which were material and relied upon by the insurer to determine how much insurance the applicant required.³⁴⁸ Therefore, rescission of the policy was proper under Utah's statutes defining misrepresentations that invalidate a policy.³⁴⁹ The court also rejected the argument that the broker's and producer's knowledge of the misrepresentations was imputed to the insurer, finding that, at most, they were brokers, not the insurer's agents.³⁵⁰ It also rejected the claim that the insurer waived its right to rescind the policy by not commencing an action upon receiving the Utah Department of Insurance's letter raising suspicions about insurance policies the producer handled.³⁵¹ To the contrary, the court found the insurer acted reasonably in determining whether the application contained misrepresentations before filing suit.³⁵²

Finally, STOLI issues relating to annuities also were considered during this survey period. In *Western Reserve Life Assurance Co. of Ohio v. ADM Associates, LLC*,³⁵³ the First Circuit tackled whether annuities that provide a death benefit require an insurable interest and whether a provision purporting to make an annuity incontestable from the date of issuance precluded an action based on a lack of insurable interest. After a lengthy analysis, it concluded Rhode Island law was unclear as to both of these issues and certified these questions to the Rhode Island Supreme Court.³⁵⁴

B. *Misrepresentations*

Some of the more interesting misrepresentation decisions this year included cases involving missing health records, a misstatement of body mass, and the duty to read the application to ensure that questions are answered accurately. A California court permitted rescission of a life insur-

347. *Hathaway*, 2013 WL 6230351, at *9.

348. *Id.* at *5.

349. *Id.* at *4-5 (citing UTAH CODE ANN. §§ 31A-36-102(18), 31A-21-105(2)).

350. *Id.* at *6-7.

351. *Id.* at *8.

352. *Id.*; see also *Vasquez v. ReliaStar Life Ins. Co.*, 2014 WL 1267171, at *4 (Tex. App. Mar. 27, 2014) (in which a Texas Appellate Court found financial misrepresentations related to assets, income, and previous bankruptcy petitions were material and affected the amount of life insurance coverage provided, and, therefore, the risk assumed by the insurer).

353. 737 F.3d 135 (1st Cir. 2013).

354. *Id.* at 143-44.

ance policy despite the argument that the insurer should not have been able to rely on medical records received after it filed the rescission action. In *PWPG, LLC v. Primerica Life Insurance Co.*,³⁵⁵ the insured answered “no” to application questions related to whether he had ever used or been treated for the use of illegal drugs.³⁵⁶ When the insured sought benefits under the policy’s “Terminal Illness Accelerated Benefit” rider after learning he was terminally ill from lung cancer, the insurer conducted a routine investigation of his medical history. The insurer discovered his cocaine and alcohol abuse from behavioral health records that were not produced during the underwriting process.³⁵⁷ Notably, the court did not preclude the insurer from relying on evidence of the insured’s illegal drug use to support its rescission because it was uncovered “post-litigation.”³⁵⁸

In *Mulrooney v. Life Insurance Co. of the Southwest*,³⁵⁹ an insurer was allowed to rescind a life insurance policy based only upon a misstatement of the insured’s height, even though the insured misrepresented other aspects of her health history and medical treatment. The application reflected the potential insured was 5’8” tall and weighed 275 pounds, when in reality she was inches shorter. Evidence also showed that, less than four months before the application was signed, the insured weighed 322 pounds when she was taken to the hospital for the nonfatal stroke that prompted her to apply for benefits under the policy’s Accelerated Benefits rider.³⁶⁰ The court explained that health risks can be approximated by body mass index, and if the insured’s true height had been used, the resultant increase in her body mass index (and increased risk of future health problems and premature death) would have been substantial.³⁶¹ Even though the insured attributed the misstatement about her height to the insurance agent completing the application, the court held insured responsible for the misstatement because she signed the application and had a duty to confirm the representations in the application were correct.³⁶²

VII. CONCLUSION

Given the explosion of litigation in this area of law in the past quarter century, this survey cannot cover every case touching on the legal issues that

355. 2014 WL 3661110 (Cal. Ct. App. July 24, 2014).

356. *Id.* at *1–2.

357. *Id.* at *2.

358. *Id.* at *7.

359. 2014 WL 4407854 (Del. Super. Ct. Sept. 3, 2014).

360. *Id.* at *6.

361. *Id.* at *9.

362. *Id.*

arise every day in this context. Your authors hope, however, that this survey has provided a helpful guide to some of the most important and interesting cases from this past year.

The next year for health, life, and disability insurance practitioners is expected to offer further developments in the areas covered in this year's article. Most significantly, the industry awaits the Sixth Circuit's en banc decision in *Rochow v. Life Insurance Co. of America* and additional activity on the premium tax credit front, given the Supreme Court's decision to grant certiorari in *King v. Burwell*.