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

William A. Chittenden III, Elizabeth G. Doolin, Julie F. Wall, and Joseph R. Jeffery are members of Chittenden, Murday & Novotny LLC in Chicago. *The authors wish to thank the following people for their invaluable assistance: Craig M. Bargher, Robert S. Hunger, Georgia L. Joyce, Kaitlyn E. Luther, Stuart F. Primack, Jennifer S. Stegmaier, and Victor F. Terrizzi.*

I. INTRODUCTION

If your body is found floating near your capsized sailboat and your blood alcohol content is over the legal limit, does an intoxication exclusion in your accident policy preclude payment? If you have a remedy under ERISA for unpaid plan benefits, can you also recover the value of the carrier's "profit" on your unpaid benefits as a form of equitable disgorgement? Does a contractual "preferred provider" have standing under ERISA to sue for alleged violations of ERISA's regulations? Can a disability insurer consider the Department of Labor's description of a job when the insured refuses to provide one? Are individuals who obtained coverage through a Federal Exchange entitled to tax credits under the ACA or are they exempted from the ACA's coverage mandate?

This year's article covers key recent developments in life, health, and disability insurance law, including the Supreme Court's decision on the applicability of the ACA's tax credits; issues of standing and standard of review in ERISA litigation, as well as the resolution of whether the equitable remedy of disgorgement is available to a typical ERISA litigant; the latest battles in the STOLI wars; and perennial issues arising out of disability and accident insurance cases.

II. ACCIDENTAL DEATH

There were several interesting decisions addressing accidental death insurance this survey period, including decisions considering whether a covered accident occurred in circumstances involving deaths resulting from pulmonary embolism, vehicle collisions with intoxication and excessive speed, a slip and fall triggering cardiac arrest, medications for chronic

pain, and a self-injected heroin overdose. Cases considering exclusions in accidental death policies were also decided this year, including decisions involving an intoxication exclusion in the context of a sailing accident, felony and criminal act exclusions where vehicular offenses were at issue, and a sickness exclusion's application to over-the-counter drugs.

A. *Covered Accident or Not a Covered Accident?*

"What is an accident? Everyone knows what an accident is until the word comes up in court. Then it becomes a mysterious phenomenon. . . ."[1] In *Bliss v. National Union Fire Insurance Co. of Pittsburgh, Pa.*, the district court concluded that an insured's death from a pulmonary thromboembolism was not an accident. The insured died within days of returning from a business trip to Kenya, which involved van travel over rough roads, crowded conditions, and a return flight totaling approximately sixteen hours.[2] The plaintiff sought benefits under an ERISA-governed accident insurance policy, which provided benefits if injury resulted in death within 365 days of the accident that caused the injury.[3] Injury was defined as "bodily injury *caused by* an accident."[4] In granting the insurer's motion to dismiss, the court found the policy required an accident apart from the injury itself[5] and agreed with the insurer that "Mr. Bliss's internal reaction to the usual, normal, and expected operation of the aircraft was not caused by an accident."[6]

The Ninth Circuit similarly determined in *Williams v. National Union Fire Insurance Co. of Pittsburgh, Pa.*[7] that the insured's sudden death from deep vein thrombosis (DVT), which triggered a pulmonary thromboembolism following twenty-eight hours of air travel over five days, was not an accident.[8] The insurer denied accidental death benefits, finding the insured's death did not result from an "injury," which the ERISA-governed policy defined as "bodily injury . . . sustained as a direct result

1. Bliss v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 2015 WL 5521821, at *1 (D. Md. Sept. 17, 2015) (quoting Brenneman v. St. Paul Fire & Marine Ins. Co., 192 A.2d 745, 747 (Pa. 1963)), *appeal docketed*, No. 15-2272 (4th Cir. Oct. 20, 2015).

2. *Id.* at *1.

3. *Id.* at *2.

4. *Id.* (emphasis by the court). Because the term "accident" was not defined, the court applied the common definition of "accident" used in Maryland and the Fourth Circuit, which includes "an unforeseen and unplanned event or circumstance." *Id.* at *4.

5. *Id.* at *5.

6. *Id.* at *1, *6. The court acknowledged that its decision was contrary to *Yasko v. Reliance Standard Life Insurance Co.*, 53 F. Supp. 3d 1059, 1064–69 (N.D. Ill. 2014), a case discussed in last year's article, where a pulmonary embolism from sitting on an airplane for an extended period was an accidental death under the policy because the insured had a reasonable expectation of survival and death was not substantially certain from his conduct.

7. 792 F.3d 1136, 1138 (9th Cir. 2015).

8. *Id.*

of an unintended, unanticipated accident that is external to the body."[9] Rather, the insurer concluded that the insured's death resulted from "an internal reaction of his body to an external period of inactivity."[10] The Ninth Circuit affirmed the district court's grant of summary judgment to the insurer, noting "the cause of death thus must be not only external, but also an 'accident'—i.e., an unintended and unanticipated occurrence."[11] There was nothing "unintended" or "unanticipated" about the insured's seating arrangement, nor did the plaintiffs claim the insured "unexpectedly was prevented from moving around, drinking fluids, or taking other measures to minimize the risk of DVT."[12]

In two cases involving single-vehicle crashes and excessive alcohol consumption, courts reached opposite conclusions based on different interpretations of foreseeability. In *Williams v. Life Insurance Co. of North America*,[13] the court found the insured's death was the foreseeable result of deliberately choosing to drive twice the posted speed limit after consuming significant amounts of alcohol.[14] The insured lost control of his motorcycle, collided head-on with a car, and died on impact.[15] His blood alcohol content (BAC) was over twice the legal limit in Washington.[16] Because the policy did not define "accident," the court considered Washington common law, which provides an "accident is never present when a deliberate act is performed, unless some additional, unexpected, independent, and unforeseen happening occurs which produces or brings about the result of injury or death."[17] Finding the term "accident" was not subjective and thus it was irrelevant whether the insured intended or expected the result, the court concluded the insured's death was the foreseeable result of his deliberate actions and granted the summary judgment for the insurer.[18]

In contrast, the court in *James v. Life Insurance Co. of North America*[19] considered foreseeability from a reasonable insured's viewpoint and found his death, after his vehicle hit a tree and caught fire, was an accident. The insured had a BAC of 0.19%, more than twice Virginia's legal limit.[20] Coverage under the group policy was triggered when "the

9. *Id.* at 1137–38.
10. *Id.* at 1139.
11. *Id.* at 1141.
12. *Id.*
13. 2015 WL 4604100 (W.D. Wash. July 30, 2015).
14. *Id.* at *6.
15. *Id.* at *2.
16. *Id.*
17. *Id.* at *6 (quoting Johnson v. Bus. Men's Assurance Co. of Am., 228 P.2d 760, 762 (Wash. 1951)).
18. *Id.*
19. 2015 WL 4126580, at *1 (S.D. Tex. July 8, 2015).
20. *Id.* at *5.

Covered Person suffer[ed] a Covered Loss resulting directly and independently of all other causes from a Covered Accident,"[21] with "Covered Accident" defined as a "sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or a Covered Loss."[22] Finding that "unforeseeable" must incorporate reasonableness, making the issue whether the insured could *reasonably* foresee that driving with an illegal BAC would lead to serious injury or death,[23] the court denied the insurer's summary judgment motion.[24] It held that "a reasonable person would not necessarily anticipate, much less find highly likely, serious injury or death from driving with a BAC percentage higher than the state's legal limit."[25] The court also found that, since the denial letter focused almost entirely on the insured's BAC and did not discuss how other factors informed its decision, the insurer improperly applied a per se rule to deny coverage.[26]

Courts this year also found that deaths involving sickness and disease or resulting medical treatment were not covered accidents. A federal district court granted summary judgment for the insurer in *Morrison v. Stonebridge Life Insurance Co.*,[27] where the insured died after falling and striking his head on the track of a sliding glass door when exiting the shower, triggering cardiac arrest and brain damage.[28] "Injury" was defined in the policy as "bodily injury caused by an accident . . . resulting: . . . 2. Directly and independently of all other causes, in a Loss covered by the policy."[29] The insured's doctor, who had previously treated him for coronary artery disease, found heart disease contributed to his death.[30] In concluding there was no coverage, the court applied the Tenth Circuit's "general rule," derived from Oklahoma case law, that if

> "death resulted because the accident aggravated the effects of the disease, or the disease aggravated the effects of the accident, with both the disease and the accident acting in concurring causes of death," there is no coverage under a policy that provides benefits for a death that occurs as a direct result of an injury caused by an accident, independent of all other causes.[31]

21. *Id.* at *1.
22. *Id.*
23. *Id.* at *7.
24. *Id.* at *5.
25. *Id.*
26. *Id.* at *6–7 (quoting Firman v. Life Ins. Co. of N. Am., 684 F.3d 533, 544 (5th Cir. 2012)).
27. 2015 WL 137261 (W.D. Okla. Jan. 9, 2015).
28. *Id.* at *3.
29. *Id.* at *2.
30. *Id.* at *6.
31. *Id.* (quoting Flores v. Monumental Life Ins. Co., 620 F.3d 1248, 1252 (10th Cir. 2010)).

The court in *Bruce-Thomas v. Hartford Life & Accident Insurance Co.*[32] determined that chronic pain constitutes a sickness or disease, and prescribing medications to alleviate such pain was deemed medical treatment.[33] The insured died due to the combined toxicity of an inadvertent overdose of oxycodone and alprazolam, which were prescribed to treat chronic pain, cervical radiculopathy, and anxiety.[34] Because loss resulting from sickness or disease or medical or surgical treatment of same was not considered to be resulting from injury, the court found the insurer's decision to deny coverage based on the policy's definition of "injury" was correct.[35]

B. *Intoxication Exclusion*

In *Horton v. Life Insurance Co. of North America*,[36] the insured was an experienced sailor who died while sailing. The U.S. Coast Guard found his sailboat floating upside down around 2:00 a.m. and located his body floating face down about five hours later, approximately a mile from the sailboat.[37] An autopsy showed the insured's BAC was 0.13%, which was above Maryland's legal limit.[38] The accident report stated the insured suffered "Death–By drowning," listed hypothermia as the "other likely cause of death" and provided that "Alcohol Use" was a "Contributing Factor."[39] LINA denied accidental death benefits based on the policy's intoxication exclusion, which barred benefits for death directly or indirectly caused by or resulting from operating "any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant." Per the policy, "under the influence of alcohol" in the exclusion meant "intoxicated" as defined by the state's law where the "Covered Accident" occurred.[40]

The district court reviewed the administrative record de novo, but concluded it could not determine whether the insured was intoxicated at the time of his death.[41] His BAC while sailing was disputed because the autopsy report did not reflect when his blood was tested.[42] The precise time the insured entered the water, when he died, and the time between his death and when he was found also had not been established.[43] Experts

32. 2015 WL 736350 (M.D. Fla. Feb. 20, 2015).
33. *Id.* at *3.
34. *Id.* at *1.
35. *Id.* at *3.
36. 2015 WL 1469196 (D. Md. Mar. 30, 2015).
37. *Id.* at *3–4.
38. *Id.* at *6.
39. *Id.* at *5.
40. *Id.* at *2.
41. *Id.* at *16–18.
42. *Id.* at *16.
43. *Id.* at *16–17.

further disputed whether the conditions and the water's frigid temperature offered a "plausible alternative cause of the occurrence."[44]

The court analyzed the intoxication exclusion, emphasizing "there must be some evidence of the role of alcohol in the loss, beyond the insured's intoxicated state, to establish the application of the exclusion."[45] LINA had to show that operating the sailboat while intoxicated "caused [the insured's] death, directly or indirectly, in whole or in part."[46] Since fact questions existed, the court denied both parties' summary judgment motions.

In *Wiles v. American Family Life Assurance Co. of Columbus*,[47] the Kansas Supreme Court relied on similar reasoning to find the insurer failed to prove the accident resulted from the insured's intoxication and the policy's intoxication exclusion applied.[48] After drinking vodka at a friend's house, the insured got behind the wheel, lost control, and overturned his truck, rendering himself a quadriplegic.[49] The insured acknowledged he had been drinking alcohol before the accident.[50] The trial court nevertheless found the intoxication exclusion did not apply, relying on the insured's claims that he ran off the road while reaching for his cell phone, which was sliding off the console, and that his post-incident neurological exam was normal.[51] Concluding it was not in a positon to reweigh the evidence before the trial judge, the Kansas Supreme Court affirmed.[52]

C. *Felony and Criminal Act Exclusions*

Two interesting decisions involving felony and criminal act exclusions were issued this survey period. In *Williams v. Life Insurance Co. of North America*,[53] the insurer concluded the policy's felony exclusion, which provided that no benefits would be paid for loss resulting from the insured's commission of a felony, barred coverage.[54] Although the insured was not charged with or convicted of vehicular assault, a Class B felony in Washington,[55] the court found the elements of vehicular assault were present since his BAC was almost double the legal limit and he caused substantial bodily harm (traumatic brain injury) to the driver of the car he hit.[56] The

44. *Id.* at *29.
45. *Id.*
46. *Id.* at *18, *29.
47. 350 P.3d 1071 (Kan. 2015).
48. *Id.* at 1071.
49. *Id.* at 1074.
50. *Id.* at 1081.
51. *Id.*
52. *Id.*
53. — F. Supp. 3d —, 2015 WL 4604100 (W.D. Wash. July 30, 2015).
54. *Id.* at *9.
55. *See* WASH. REV. CODE § 46.61.522(2).
56. 2015 WL 4604100, at *2, *11.

court also deemed the felony exclusion consistent with Washington's public policy of not insuring criminal acts and not void for public policy reasons, as the plaintiff argued.[57] The court thus concluded that the insurer reasonably denied benefits under the exclusion.[58]

A criminal act exclusion in an ERISA-governed accidental death policy, however, did not bar coverage for a fatal motorcycle collision. The insured in *Locklear v. Sun Life Assurance Co. of Canada*,[59] who was not speeding and had no drugs or alcohol in his system, died after colliding head on with a truck while attempting to pass a construction vehicle on his motorcycle in a no-passing zone.[60] On de novo review, the court found the insured's actions, which violated certain sections of Pennsylvania's Vehicle Code, were not "crimes" and thus the plan administrator erred in finding the policy's "criminal act" exclusion barred coverage.[61] For an offense to fall under the Pennsylvania Crimes Code (Title 18), it must carry the possibility of imprisonment or death,[62] and the Vehicle Code violations at issue were summary offenses, not punishable by imprisonment.[63] The court also rejected the claim that the insured's actions constituted reckless endangerment, finding the insurer did not raise that issue at the administrative level but, even if it had, it failed to present evidence of unsafe driving sufficient to show the mens rea for recklessness.[64]

D. *Sickness/Disease and Medical Treatment Exclusions*

Whether coverage was excluded for death resulting from acetaminophen toxicity was at issue in *Mazzarino v. Prudential Insurance Co. of America*.[65] The insured had been taking Lortab (which contains acetaminophen)[66] four times per day for about a year to treat neck and lower back pain due to cervical spondylosis and lumbosacral disk disease.[67] On March 1, 2011, she began taking over-the-counter Tylenol (which also contains acetaminophen) for flu-like symptoms.[68] Two days later, she became lethargic and disoriented and was admitted to the hospital, where she died on March 8, 2011, from what the death certificate termed "brain edema, due

57. *Id.* at *11–13.
58. *Id.* at *13.
59. 2015 WL 1964675 (M.D. Pa. May 1, 2015).
60. *Id.* at *1.
61. *Id.* at *3–5.
62. *Id.* at *3.
63. *Id.* at *4.
64. *Id.* at *5–8.
65. 2015 WL 1399048 (D.N.J. Mar. 26, 2015), *appeal docketed*, No. 15-1956 (3d Cir. Apr. 21, 2015).
66. The Lortab contained 10mg of hydrocodone and 500 mg acetaminophen (the active ingredient in Tylenol). *Id.* at *1.
67. *Id.*
68. *Id.*

to (or as a consequence) of liver failure, due to (or as a consequence) of Tylenol overdose."[69] In appealing the claim denial, the plaintiffs included a forensic toxicologist's report noting the acetaminophen concentration was for the generic Tylenol, not for the Lortab, and suggesting the policy exclusion for "any loss arising out of sickness or treatment of that sickness" did not apply.[70] The court noted "the plan here precluded coverage where the loss, i.e., the death, 'results directly or indirectly' from sickness or treatment of that sickness."[71] As the medical records indicated the overdose was caused by some combination of Lortab and Tylenol, the court upheld the insurer's determination that the exclusion applied.[72]

III. DISABILITY

Courts this survey period addressed disputes over how to identify and define a claimant's "own occupation" and considered what effect a claimant's physical impairments had on a mental disorder limitation. Rounding out this discussion are decisions examining how a claimant's loss of a professional license affected his disability claim, an administrator's obligation to seek out a claimant's known Social Security award, the appropriate balance between subjective complaints of impairment and the need to verify such complaints using objective evidence, and insureds' racketeering claims against the insurer's post-claim denial.

A. *Own Occupation*

Two courts this survey period examined benefits decisions that defined a claimant's material duties by reference to an occupation's physical demands, as opposed to its material duties. To be disabled under the plan in *McDonough v. Aetna Life Insurance Co.*,[73] the claimant had to be unable to perform the material duties of his own occupation due to disease or injury.[74] But the administrator never identified the material duties of the claimant's occupation as a senior analyst of a corporate information technology division.[75] It considered only whether the claimant's reported limitations prevented him from performing his occupation's sedentary phys-

69. *Id.* at *2.
70. *Id.* at *3–4.
71. *Id.* at *7.
72. *Id.* at *7–9.
73. McDonough v. Aetna Life Ins. Co., 783 F.3d 374 (1st Cir. 2015).
74. *Id.* at 376. Specifically, a participant's material duties were defined as those "normally required for the performance of [the participant's] own occupation," as long as they "cannot be reasonably [] omitted or modified." *Id.* at 376–77. The plan defined "own occupation" as the occupation "routinely perform[ed]" by the participant at the time the disability began as that occupation is "normally performed in the national economy," rather than how it is performed for that employer. *Id.* at 377.
75. *Id.* at 380.

ical demands[76] and terminated the claimant's benefits since they did not.[77] But claimant's alleged disability included anxiety and panic attacks.[78] Noting the cognitive demands of the claimant's high-pressure work environment, where he was constantly on call and responsible for managing systems and employees, the court held the administrator's failure to identify the extent that such duties were integral to the claimant's occupation and to analyze whether he was prevented from performing his material duties made the termination of benefits arbitrary and capricious.[79]

In contrast, the court in *Schussheim v. First Unum Life Insurance Co.*[80] held that under certain circumstances a plan administrator does not act arbitrarily and capriciously when it relies on an occupation's physical work intensity demands to define the occupation's material duties.[81] The claimant, a medical malpractice attorney seeking long-term disability benefits after foot surgery, declined repeated requests to identify her job duties.[82] The plan administrator then defined the material duties of her occupation using job descriptions former employers provided and the Dictionary of Occupational Titles' job duties and work intensity descriptor for "Attorney."[83] Notably, the claims manual allowed the administrator to use the occupation's physical work intensity descriptor to define an occupation's material duties if detailed descriptions of an occupation's duties were unavailable.[84] The claimant complained that the occupational description used to terminate her benefits was arbitrary and capricious, but the court rejected this argument and granted the insurer summary judgment, citing the claims manual and her lack of cooperation.[85]

The dispute in *Whitley v. Standard Insurance Co.*[86] was not over the description of the claimant's material duties, but whether the administrator correctly identified his occupation.[87] The court ultimately found it was arbitrary and capricious to conclude that the claimant's "own occupation" was a "family medicine physician" since the record confirmed he was an "emergency room physician."[88] Although the administrator relied on

76. *Id.* at 377–78, 380.
77. *Id.* at 377–78.
78. *Id.* at 377.
79. *Id.* at 381–82.
80. 80 F. Supp. 3d 360 (E.D.N.Y. 2015).
81. *Id.* at 379.
82. *Id.* at 377–78.
83. *Id.* at 378–79.
84. *Id.* at 377.
85. *Id.* at 380.
86. 90 F. Supp. 3d 839 (D. Minn. 2015), *appeal docketed*, No. 15-1524 (8th Cir. Mar. 11, 2015).
87. *Id.* at 853.
88. *Id.* at 856.

the claimant's board certification as a family practitioner, it ignored evidence, including a vocational assessment, employer's statement, employee's statement, and various correspondence, showing he was an ER doctor for many years before becoming disabled.[89] The court also noted "the conflict of interest factor comes into play, because, in choosing an Own Occupation of family practitioner, [the administrator] selected the occupation that involved less physical and emotional stress," thereby making it less likely the claimant would be deemed disabled.[90]

B. *Mental Health*

The disability plan in *Dutkewych v. Standard Insurance Co.*[91] limited benefits to twenty-four months for disabilities caused or contributed to by mental disorders.[92] It further provided no benefits would be paid after twenty-four months "unless on that date you continue to be Disabled as a result of a Physical Disease . . . for which payment of LTD Benefits is not limited."[93] The insured, who had several Lyme disease tests yielding different results, was diagnosed with depression, OCD, and anxiety.[94] Although the administrator approved his initial benefit claim due to his mental disorder,[95] the insured sought additional benefits after twenty-four months, claiming he was disabled due to Lyme disease.[96] The administrator found he was not disabled from Lyme disease, relying on medical experts who questioned whether the insured even had it.[97] The First Circuit, applying an abuse of discretion standard, upheld the administrator's benefit denial. The court said it did not need to determine whether the insured had Lyme disease or if Lyme disease contributed to his disability; if mental disorders contributed to his disability, the twenty-four-month limitation period applied.[98] Ample evidence confirmed the insured's mental illness contributed to his disability.[99]

Similarly, in *Glenn v. American United Life Insurance Co.*,[100] an insured who stopped working due to bipolar disorder received disability benefits

89. *Id.* at 855.
90. *Id.*
91. 781 F.3d 623 (1st Cir. 2015).
92. *Id.* at 626.
93. *Id.*
94. *Id.* at 627.
95. *Id.* at 628.
96. *Id.*
97. *Id.* at 632.
98. *Id.* at 634–35.
99. *Id.* at 633–34.
100. 604 F. App'x 893 (11th Cir. 2015).

for the twenty-four-month period allowed under his policy.[101] When that period ended, the insured claimed that back pain and related medications clouded his mind and prevented him from working.[102] After the administrator denied the claim, the insured sued and the trial court granted the administrator judgment as a matter of law.[103] Applying a de novo standard, the Eleventh Circuit affirmed.[104] It explained that the insured had to prove that his back pain and medication, not bipolar disorder, prevented him from performing his employment-related duties, but that he failed to do so.[105] The court cited previous statements attributing his cognitive impairments to bipolar disorder and not pain medication.[106]

Whether an insurer could condition disability payments on an insured submitting to a mental health examination not specifically permitted in the policy was the issue in *HSK v. Provident Life & Accident Insurance Co.*[107] After the insured claimed he was disabled by a number of mental disorders and submitted medical reports the insurer found to be conclusory,[108] the insurer asked him to submit to an independent psychiatric medical exam. When the insured refused, arguing the policy only allowed the insurer to request a physical exam, the insurer subsequently denied his claim.[109] Although the insurer could not deny benefits solely because the insured failed to submit to a psychiatric examination, the court denied summary judgment to the insured on his breach-of-contract claim.[110] The court said a jury might well credit the insurer's conclusion that the information provided did not sufficiently demonstrate the insured's right to benefits.[111]

C. *Professional License*

In *Hampton v. Reliance Standard Life Insurance Co.*,[112] the Eighth Circuit examined whether the reason for loss of a professional license affected a claimant's right to benefits.[113] The claimant lost his commercial driver's license per federal regulations after a diabetes diagnosis rendered him unable to work as a truck driver.[114] The disability plan provided that if the insured's occupation required a license, "the loss of such license for any

101. *Id.* at 894.
102. *Id.* at 897–98.
103. *Id.* at 897.
104. *Id.* at 898.
105. *Id.*
106. *Id.* at 899.
107. — F. Supp. 3d —, 2015 WL 5136269 (D. Md. Aug. 31, 2015).
108. *Id.* at *2.
109. *Id.*
110. *Id.* at *5–8.
111. *Id.* at *5.
112. 769 F.3d 597 (8th Cir. 2014).
113. *Id.* at 601.
114. *Id.* at 599.

reason does not in and of itself constitute 'Total Disability.' "[115] The district court ruled for the claimant, but the Eighth Circuit reversed.[116] The court found reasonable the insurer's interpretation that a claimant who loses a license is not foreclosed from receiving benefits under the plan; "it merely requires that the claimant show that the injury or sickness itself—independent of the loss of license—renders him unable to perform his occupation."[117] The insured may have lost his license because federal regulations preclude a person with insulin-dependent diabetes mellitus from operating a commercial vehicle,[118] but the insured's doctor identified no physical limitations on the insured's ability to do so as a direct result of his diabetes.[119]

D. *SSA Awards and Offsets*

The claim that a plan administrator must consider and account for Social Security Administration (SSA) benefits when it denies a long-term disability claim found further support this survey period.[120] The court in *Lundsten v. Creative Community Living Services, Inc.*[121] went a step further, holding that a plan administrator had an implied duty to actively seek out a contrary SSA determination when the claimant did not provide it.[122] As the plan required, the claimant applied for SSA benefits.[123] The plan's disability definition was less stringent than SSA's definition and, under the plan, if SSA benefits were awarded they would be offset against any long-term disability (LTD) benefits owed.[124] SSA found the claimant was totally disabled and awarded her benefits.[125] She then told the plan of the SSA award and gave it signed authorizations so it could obtain information about the award, but did not provide a copy of the award itself.[126] When the plan later denied her LTD claim, it did not offer a "plausible explanation" for reaching a different decision than SSA.[127]

115. *Id.*
116. *Id.* at 601.
117. *Id.*
118. *Id.* (citing 49 C.F.R. § 391.41(b)(3)).
119. *Id.* at 601–02.
120. *See, e.g.*, Puccio v. Standard Ins. Co., 80 F. Supp. 3d 1034 (N.D. Cal. 2015) (analyzing plan administrator's decision to deny benefits claim under the Ninth Circuit's *Montour* factors and determining insurer's failure to consider and account for the SSA's disability determination weighed heavily in finding that insurer abused its discretion).
121. — F. Supp. 3d —, 2015 WL 5010439 (E.D. Wis. Aug. 20, 2015), *appeal docketed*, No. 15-3058 (7th Cir. Sept. 21, 2015).
122. *Id.* at *11.
123. *Id.* at *7, *9.
124. *Id.* at *9.
125. *Id.* at *7. The claimant was diagnosed with fibromyalgia, degenerative disc disease, and arthritis. *Id.* at *3–4.
126. *Id.* at *7.
127. *Id.* at *10.

The court held the plan's failure to do so was not excused because the claimant did not provide a copy of the SSA award, finding the administrator had an affirmative duty to obtain that award.[128]

The court in *Hogan v. Unum Life Insurance Co. of America*[129] examined whether a disability insurer could offset benefits received from a franchise disability income plan.[130] The claimant, a psychiatrist, received disability coverage under her employer's group disability insurance policy (work policy) as well as under a policy purchased through the American Psychiatric Association (APA policy).[131] The claimant received disability benefits under both policies.[132] The work policy offset benefits owed thereunder by "Deductible Sources of Income," which did not include "franchise disability income plans."[133] After six years, the insurer for the work policy requested reimbursement for overpayments, claiming the insured's payments under the APA policy should offset the work policy's benefits.[134] Determining the APA policy was franchise insurance, the court found the benefits received under that policy could not be used to offset benefits under the work policy per its express terms.[135]

E. *Objective–Subjective Evidence*

Courts continue to look for the appropriate balance between a disability claimant's subjective complaints of impairment and the need to verify those complaints through objective evidence. The claimant in *Winfrey v. Hartford Life & Accident Insurance Co.*[136] complained of back pain when he was required to sit or stand for long periods of time.[137] The administrator denied his request for benefits because he did not provide objective evidence that his pain rendered him disabled.[138] The court agreed with the administrator, finding it did not abuse its discretion by relying on outside medical reviewers who concluded the claimant's subjective complaints were not supported by clinical, objective evidence of disability.[139]

In *Cox v. Allin Corp. Plan*,[140] the administrator agreed the claimant was disabled under the plan, but limited benefits to twenty-four months be-

128. *Id.* at *11.
129. 81 F. Supp. 3d 1016 (W.D. Wash. 2015).
130. *Id.* at 1018.
131. *Id.*
132. *Id.*
133. *Id.*
134. *Id.* at 1018–19.
135. *Id.* at 1024.
136. — F. Supp. 3d —, 2015 WL 5093280 (D. Kan. Aug. 28, 2015), *appeal docketed*, No. 15-3217 (10th Cir. Sept. 14, 2015).
137. *Id.* at *1.
138. *Id.* at *4, *9.
139. *Id.* at *3, *5, *10.
140. 70 F. Supp. 3d 1040 (N.D. Cal. 2014).

cause his disabling symptoms were "not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine."[141] Plan provisions that limit benefits for self-reported conditions may be used if it is not possible to objectively verify that a claimant suffers from a sickness or injury that leads to disability, but not to limit benefits simply because a claimant's disabling *symptoms* are subjective.[142] The claimant contended he suffered from vertigo, a subjective symptom of a variety of different conditions,[143] and had objective evidence that he had vertigo.[144] The district court found that because the insured's complaints of vertigo were objectively verified, the administrator improperly relied on the self-report limitation to limit benefits to twenty-four months.[145]

The Sixth Circuit considered the balance between subjective complaints and demands for objective evidence in *Hunt v. Metropolitan Life Insurance Co.*,[146] holding that, regardless of whether a disability or illness could be objectively confirmed, insureds must present objective evidence of their inability to work.[147] The claimant in *Hunt* reportedly suffered from fibromyalgia.[148] Because she did not provide objective findings showing she could not work, the administrator denied benefits.[149] Finding for the administrator, the court held that even though fibromyalgia could not be objectively confirmed, the claimant's failure to provide objective evidence of her functional limitations meant she failed to establish her right to benefits.[150]

F. *RICO*

Insureds recently had some success asserting RICO claims against disability insurers, suggesting some courts may have softened their distaste

141. *Id.* at 1048–49.

142. *See id.* at 1054–55 (citing cases and observing that although the Ninth Circuit has yet to address the contours of the self-reported limitation, other courts have uniformly made this distinction).

143. *See id.*

144. *Id.* at 1047–48.

145. *Id.* at 1055–56. The court granted the insured summary judgment despite applying ERISA's arbitrary and capricious standard. *Id.*; *see also* Doe v. Unum Life Ins. Co. of Am., — F. Supp. 3d —, 2015 WL 4139694, at *7–8 (S.D.N.Y. July 9, 2015).

146. 587 F. App'x 860 (6th Cir. 2014).

147. *Id.* at 862.

148. *Id.* at 861.

149. *Id.*

150. *Id.* at 862; *see also* Valentine v. Aetna Life Ins. Co., — F. Supp. 3d —, 2015 WL 5024569, at *11 (E.D.N.Y. Aug. 25, 2015) (although administrators "adjudicating claims involving such inherently subjective disorders . . . are not required to take such assertions of incapacity at face value, they may not dismiss them out of hand without adequate attention to the claimant's complaints").

toward civil RICO claims. In *Hepp v. Paul Revere Life Insurance Co.*,[151] an insured doctor obtained two disability policies from Unum subsidiaries Paul Revere and Provident.[152] The insured suffered an injury preventing him from performing some specialized surgeries.[153] Unum denied the insured's total disability claim, arguing he was eligible only for residual benefits since his injury prevented him from performing some surgeries, but not all.[154] Unum argued the insured's subsequent RICO claim must be dismissed since there was no evidence of racketeering activity.[155] The court disagreed, noting the insured claimed that Unum committed mail and wire fraud by asking for Current Procedural Terminology (CPT) codes "to determine duties" and "conveying the fraudulent results of the CPT code analysis as a basis to deny claims."[156] Unum also argued no distinct enterprise existed because Provident was its wholly owned subsidiary.[157] Again siding with the insured, the court reasoned that the distinctiveness of the two entities was a fact question and there was some evidence that Provident was not Unum's wholly owned subsidiary.[158]

IV. ERISA

ERISA decisions this review period addressed topics ranging from routine to notable. In the latter category, insurers breathed a sigh of relief when the Sixth Circuit vacated an equitable disgorgement award in *Rochow v. Life Insurance Co. of America*,[159] the Seventh Circuit found Illinois' prohibition on discretionary clauses fell within ERISA's savings clause, and decisions came down addressing novel issues related to a party's standing to sue under ERISA. As in years past, courts reached different conclusions concerning the enforcement of contractual limitations periods, and questions concerning the proper standard of review and the proper delegation of discretionary authority were addressed. These are just some of the more significant ERISA decisions from the survey period. Others concerning conflict discovery and Social Security awards are discussed below.

151. — F. Supp. 3d —, 2015 WL 4623733 (M.D. Fla. July 31, 2015).
152. *Id.* at *2.
153. *Id.*
154. *Id.*
155. *Id.* at *13.
156. *Id.* (further stating that "the sole use of CPT code analysis to classify medical specialists out of their occupation is a plausible RICO scheme").
157. *Id.* at *15–16.
158. *Id.* at *16; *see also* Rosen v. Provident Life & Accident Ins. Co., 2015 WL 260839 (N.D. Ala. Jan. 21, 2015) (insured doctor stated RICO claim against insurer by alleging it committed racketeering activity (mail and wire fraud) by improperly denying high volume of legitimate claims).
159. 780 F.3d 364, 366 (6th Cir. 2015), *cert. denied*, 84 U.S.L.W. 3087 (U.S. Nov. 9, 2015) (No. 15-163).

A. *Standing*

The Seventh Circuit distinguished between a party's standing to bring an ERISA claim and whether that claim arises under ERISA. The plaintiffs in *Pennsylvania Chiropractic Ass'n v. Blue Cross Blue Shield Ass'n*,[160] were two chiropractors and an association of chiropractors that were parties to a participating provider agreement with the defendant insurer. The insurer overpaid several claims, which it recouped by reducing future payments owed to the plaintiffs for other services.[161] The plaintiffs claimed the insurer's recoupment efforts violated the claims procedures under § 503 and sued to enforce their perceived rights under § 502(a)(1)(B).[162]

Although the parties characterized the dispute as raising an issue of the plaintiffs' "standing" to litigate under ERISA, the court found it was one of "statutory coverage," i.e., "whether [the plaintiffs'] claim comes within the zone of interests regulated by [ERISA]."[163] The Seventh Circuit rejected the plaintiffs' claims that they were ERISA "beneficiaries" and, therefore, fell within ERISA's "zone of interests" because their claims were not based on valid assignments of benefits or plan language designating them plan beneficiaries[164] but, rather, on the participating provider agreements with the insurer.[165] Because the plaintiffs were not ERISA "beneficiaries," their claims did not fall within ERISA's "zone of interests"[166] or entitle them to ERISA's protections.[167]

The claims administrator in *Connecticut General Life Insurance Co. v. True View Surgery Center One, LP*[168] had "statutory standing" and Article III standing to assert claims under § 502(a)(3) against a surgical center that "lured members to their out-of-network facilities by offering less expensive services and waiving" co-payments and other cost sharing obligations for those members.[169] The defendant's scheme affected 316 plans, a majority of which were governed by ERISA.[170] The plaintiff, Cigna, was

160. 802 F.3d 926 (7th Cir. 2015).

161. *Id.* at 928.

162. *Id.*; *Cf.* Conn. Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP, No. 3:14-cv-1859 (AVC), — F. Supp. 3d —, 2015 WL 5122269, at *1, *7 (D. Conn. Aug. 31, 2015) (suggesting that withholding future payments to recover overpayments would be an "adverse benefit determination subject to the claims procedure requirements of 29 U.S.C. § 1133").

163. *Pa. Chiropractic Ass'n*, 802 F.3d. at 928.

164. *Id.*

165. The Seventh Circuit joined four other circuits in recognizing this distinction. *Id.* at 929 (citing Rojas v. Cigna Health & Life Ins. Co., 793 F.3d 253 (2d Cir. 2015); Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc., 770 F.3d 1282, 1289 (9th Cir. 2014); Hobbs v. Blue Cross Blue Shield of Ala., 276 F.3d 1236, 1241 (11th Cir. 2001); and Ward v. Alt. Health Delivery Sys., Inc., 261 F.3d 624, 627 (6th Cir. 2001)).

166. *Id.* at 928.

167. *Id.* at 930.

168. *Conn. Gen. Life Ins.*, 2015 WL 5122269, at *1.

169. *Id.* at *2.

170. *Id.*

the claims administrator and a fiduciary for each of the ERISA plans.[171] Because Cigna alleged it had discretionary authority for the plans' review and appeal of claims, including recovery of improper payments made for the plans, the court found it alleged sufficient functional control and authority to be considered the plans' fiduciary and had "statutory standing" to assert the plans' § 502(a)(3) claims.[172] The administrator also had Article III standing, given its "concrete and particularized interest in paying only valid claims to ensure its members' financial interests [were] protected."[173] Further, the billing scheme affected Cigna personally because it "expended its own time and resources in investigating the surgical center's billing practices."[174]

B. *Enforcement of Limitations Periods*

Courts continued to wrestle with the contractual limitations periods that plans impose on actions to recover ERISA benefits. The decision in *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*[175] shows that a contractual limitations provision's enforceability depends on more than the length of the limitations period.[176] In *Spinedex*, the Ninth Circuit held a two-year contractual limitations period was unenforceable because it was set forth in the summary plan description (SPD) under the "General Legal Provisions" section and "Limitation of Actions" heading.[177] That placement, the court held, did not comply with the requirements of 29 C.F.R. § 2520.102-2(b), which states that a limitation provision must be "in close conjunction with the description or summary of benefits" or, alternatively, the page on which the limitations period was described must be noted adjacent to the benefit description.[178] As support for its holding, the court explained that if it found placement of the limitations period was proper, "we would, in effect, require a plan beneficiary to read every provision of an SPD in order to ensure that he or she did not

171. *Id.*

172. *Id.* at *4.

173. *Id.* at *4; *see also Spinedex Physical Therapy*, 770 F.3d 1282; N. Cypress Med. Ctr. Operating Co., Ltd., 781 F.3d 182, 191–92 (5th Cir. 2015) (health care providers may sue derivatively "standing in the shoes of their patients").

174. *Conn. Gen. Life Ins.*, 2015 WL 5122269, at *5.

175. *Spinedex*, 770 F.3d 1282.

176. Three-year time periods, for example, have been deemed reasonable, even if they begin while the plan participant is pursuing administrative remedies. *See, e.g.*, Hyatt v. Prudential Ins. Co. of Am., 2014 WL 5530130, at *2 (W.D.N.C. Oct. 31, 2014), *appeal docketed*, No. 14-2305 (4th Cir. Dec. 2, 2014).

177. *Spinedex*, 770 F.3d at 1294; *see also* Mirza v. Ins. Adm'r of Am., Inc., 800 F.3d 129, 130–31 (3d Cir. 2015).

178. *Id.* at 1294–95 (quoting 29 C.F.R. § 2520.102-2(b)). *But see* Jevelekides v. Lincoln Nat'l Corp., 2015 WL 3849312, at *4 (N.D.N.Y. June 22, 2015) (plan's limitations period that appeared in "Claim Procedures" section of the policy "clearly applie[d] to 'legal actions'"), *appeal dismissed*, No. 15-2315 (2d Cir. Aug. 20, 2015).

miss a limitation provision. Such a requirement is what the regulation is specifically designed to avoid."[179]

Regarding disability claims, plans often provide that the contractual limitations period for filing suit begins to run from the time proof of claim is given, which is typically required within ninety days of the start of disability or no later than one year after the start of disability.[180] Arguments that contractual limitations periods do not begin to run until that one-year period ends generally will succeed if it was not possible for the participant to provide proof of claim within the ninety-day period.[181] In a similar vein, equitable tolling of the time to sue will not spare untimely suits unless participants can show "extraordinary circumstances" to justify it.[182] Where a participant knew of the time limit to sue and how the plan calculated it, both of which were set forth in the plan, the court in *Santana-Diaz v. Metropolitan Life Insurance* concluded that equitable tolling was not justified.[183] Lastly, the Fourth Circuit joined the Tenth and Eleventh Circuits in holding that a disability insurer's failure to pay benefits was not a breach of an installment contract and the limitations period did not run separately as to each missed payment.[184]

C. *Standard of Review*

1. The Plan and Delegation of Discretion

On the surface, determining the appropriate standard of review sounds straightforward, but it continues to be a contentious issue in many ERISA cases. In *Wilkinson v. Sun Life & Health Insurance Co.*,[185] the court held that the delegation of discretionary authority in an attachment to the policy was sufficient to vest the administrator with discretionary authority.[186] Similarly, in *Oliver v. Aetna Life Insurance Co.*,[187] the plan document bestowed discretionary authority upon the "Administrator, Appeal Committee and the Committee, but not to any other entity."[188] The SPD and several other plan-related documents, including their amendments, granted discretionary authority to Aetna, the claims paying admin-

179. *Spinedex*, 770 F.3d at 1296.
180. *See, e.g.*, *Hyatt*, 2014 WL 5530130, at *1.
181. *See, e.g.*, Muchicka v. Hartford Life & Accident Ins. Co., 2015 WL 4162472, at *4 (W.D. Pa. July 9, 2015).
182. *See* Santana-Diaz v. Metro. Life Ins., 2015 WL 317194, at *3 (D.P.R. Jan. 23, 2015).
183. *Id.* at *3.
184. Curry v. Trustmark Ins. Co., 600 F. App'x 877, 881 (4th Cir. 2015) (citing Lang v. Aetna Life Ins. Co., 196 F.3d 1102, 1105 (10th Cir. 1999) and Dinnerstein v. Paul Revere Life Ins. Co., 173 F.3d 826, 828 (11th Cir. 1999)).
185. — F. Supp. 3d —, 2015 WL 5124323 (W.D.N.C. Sept. 1, 2015), *appeal docketed*, No. 15-2105 (4th Cir. Sept. 21, 2015).
186. *Id.* at *10.
187. 55 F. Supp. 3d 1370 (N.D. Ala. 2014).
188. *Id.* at 1380.

istrator.[189] The court rejected the claimant's argument that Aetna lacked discretionary authority because the delegation of authority must appear in the plan itself, not the SPD or other plan-related documents,[190] finding that all plan-related documents in the record are relevant when the parties disagree over the standard of review.[191] In contrast, in *Prichard v. Metropolitan Life Insurance Co.*,[192] the Ninth Circuit would not recognize the SPD's delegation of discretionary authority since it did not consider the SPD part of the policy.[193] The plan document contained an express integration clause that specifically included the policy and application, but not the SPD.[194] The court therefore reviewed the claim de novo.[195]

2. Delegation of Discretion to Non-Fiduciary

Plans that give discretionary authority to one decision-maker to make benefit decisions, only to allow a completely different entity to decide a claim, will not enjoy the advantages of discretionary review. Several courts this survey period reviewed benefit decisions de novo because the decisions were made by parties other than those to whom the plan delegated decision-making authority. In *Bilheimer v. Federal Express Corp. Long Term Disability Plan*,[196] the plan document vested the "appeal committee appointed by the plan" with discretionary authority, but when the plan administrator subsequently outsourced appeals decisions to Aetna, it did so without appointing Aetna as the "appeal committee."[197] Thus, Aetna did not have discretionary authority and the court reviewed the plan's benefit decision de novo.[198] The plan in *Rodas v. Standard Insurance Co.*[199] granted Sedgwick discretion to decide disability claims for the "own occupation" period and gave Standard discretion for the "any occupation" period.[200] The claim sought benefits for the own occupation period, but Standard rendered the benefits decision.[201] Concluding the plan had not granted Standard discretion to decide the claim, the court reviewed the decision de novo.[202]

189. *Id.* at 1379–80.
190. *Id.* at 1383.
191. *Id.* at 1384.
192. 783 F.3d 1166 (9th Cir. 2015).
193. *Id.* at 1171.
194. *Id.* at 1170.
195. *Id.*; *see also* Johnson v. United of Omaha Life Ins. Co., 775 F.3d 983, 988 (8th Cir. 2014) (under the policy and the integrated certificate of insurance, discretion was granted to United of Omaha to determine eligibility for benefits).
196. 605 F. App'x 172 (4th Cir. 2015).
197. *Id.* at 179.
198. *Id.* at 176.
199. 2015 WL 4477787 (C.D. Cal. July 10, 2015).
200. *Id.* at *2.
201. *Id.*
202. *Id.* at *3.

3. Violations Can Alter the Standard of Review

Even when a plan document properly grants discretionary authority to a claims-paying administrator, procedural violations can cause a court to review a decision de novo. In *Gordon v. Metropolitan Life Insurance Co.*,[203] for example, the plan document granted discretionary authority to MetLife, but the claimant argued for de novo review because MetLife violated ERISA's regulations by failing to timely decide his appeal.[204] The court accepted the premise that procedural violations can change the standard from deferential to de novo, but noted such violations must be "so flagrant" as to alter the substantive relationship between the employer and the employee, causing the beneficiary substantive harm.[205] Since the claimant could not identify any conduct by MetLife that altered its relationship with and substantially harmed the claimant, the court did not alter the standard of review.[206] In *Musser v. Harleysville Life Insurance Co.*,[207] the plan granted discretionary authority to the claim administrator, but the court modified the standard of review to de novo because a decision was never made on claimant's appeal,[208] reasoning that there was no analysis to which deference might be afforded without a final decision.[209] This is consistent with other courts that viewed the failure to render a claim decision as "deemed denied" and reviewed those claims de novo.[210]

4. Prohibition of Discretionary Clauses

The tide against discretionary review seems to be rising as nearly half of the states now have laws prohibiting discretionary clauses in insurance contracts.[211] Challenges to these laws have been nothing short of creative, but most challenges find themselves on the losing side of the battle. The parties in *Fontaine v. Metropolitan Life Insurance Co.*[212] agreed ERISA pre-

203. 103 F. Supp. 3d 1084 (N.D. Cal. 2015).

204. *Id.* at 1088–89.

205. *Id.* at 1089 (quoting Gatti v. Reliance Standard Life Ins. Co., 415 F.3d 978, 985 (9th Cir. 2005)).

206. *Id.* at 1089–90; *see also* Melech v. Life Ins. Co. of N. Am., 2015 WL 4744356, at *21 (S.D. Ala. Aug. 11, 2015) (claim administrator's seventeen-day delay in rendering a decision was not a serious procedural violation sufficient to trigger de novo review); Dimery v. Reliance Standard Life Ins. Co., 597 F. App'x 408, 409 (9th Cir. 2015) (claimant did not identify any substantive harm resulting from the administrator's untimely decision to warrant de novo review).

207. 2015 WL 4730091 (M.D. Pa. Aug. 10, 2015).

208. *Id.* at *7.

209. *Id.* at *7, *8.

210. *See* Wilson v. Walgreen Income Prot. Plan for Pharmacists & Registered Nurses, 2015 WL 4528962, at *11 (M.D. Fla. July 27, 2015) (cases discussed).

211. *See* Ravannack v. United Healthcare Ins. Co., 2015 WL 2354186, at *2 (E.D. La. May 15, 2015) (citing D. Andrew Portinga & Claire Madill, *Conflicts of Laws and State Law Bans Discretionary Clauses Under ERISA*, 55:12 For The Defense 46–47 (Dec. 2013).

212. 800 F.3d 883 (7th Cir. 2015).

empted Illinois' regulation banning discretionary clauses in insurance contracts, but disputed whether ERISA's savings clause "saved" it from preemption.[213] MetLife argued the regulation was not saved because it was "directed toward" plan sponsors, rather than entities engaged in insurance.[214] The court rejected that argument, explaining that "[r]egulations 'directed toward' certain entities will almost always disable other entities from doing . . . what the regulations forbid," as Illinois' regulation did.[215] MetLife also claimed the discretionary clause was not in an insurance policy but in an ERISA plan document and, thus, the regulation was not saved from preemption.[216] If MetLife's reasoning was adopted, the court observed, "states would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by inserting a contrary term in plan documents," which would "virtually read the savings clause out of ERISA."[217] The court in *Jahn-Derian v. Metropolitan Life Insurance Co.*[218] rejected similar arguments in addressing California's limitation on discretionary provisions,[219] concluding that allowing discretionary provisions in a plan document to survive, but not those in a plan's insurance policy, would "elevate form over substance."[220]

D. *Conflict of Interest Discovery*

Recent decisions involving the scope of discovery due to structural and procedural conflicts[221] were far from uniform, although the scope of discovery permitted was typically limited. The court in *Preitz v. American Airlines, Inc.*[222] rejected arguments that documents relating to the cost of the plan or the actuarial soundness of the plan or the plan sponsor

213. *Id.* at 886 (citing 29 U.S.C. § 1144(a) and (b)(2)(A)).
214. *Id.* at 887.
215. *Id.*
216. *Id.* at 887–88.
217. *Id.* at 888. The court had no difficulty concluding the second factor in a savings clause analysis—whether a regulation substantially affects risk pooling between the insurer and the insured—was satisfied. *Id.* at 886. "By prohibiting discretionary clauses in insurance policies, [Illinois' regulation] alters the scope of permissible bargains and dictates the conditions under which risk is assumed in the insurance market." *Id.*
218. 2015 WL 900717 (C.D. Cal. Mar. 3, 2015); *see also* Snyder v. Unum Life Ins. Co., 2014 WL 7734715 (C.D. Cal. Oct. 28, 2014).
219. *Id.* at *2–4; CAL. INS. CODE § 10110.6(a)–(c).
220. *Jahn-Derian*, 2015 WL 900717, at * 4 (quoting Novak v. Life Ins. Co. of Am., 956 F. Supp. 2d 900, 906 (N.D. Ill. 2013)).
221. *See* Alison R. v. Horizon Blue Cross Blue Shield of N.J., 2015 WL 3903290, at *2 (D.N.J. June 9, 2015) (structural conflicts involve "financial incentives inherent in a plan's design, such as where the same entity both funds and administers the benefits plan," and procedural conflicts concern "how the administrator treated a particular claimant and may arise from case-specific factors and irregularities") (internal quotations omitted).
222. 2015 WL 221065 (E.D. Pa. Jan. 15, 2015).

had no bearing on the existence of fiduciary bias.[223] Where proposed discovery concerning procedural conflicts went to the merits of a claim, courts were conservative about the discovery they would permit.[224]

Protecting the confidentiality of documents to be produced is a common concern for plan administrators, who must demonstrate the protective orders they seek are necessary. In *He v. CIGNA Life Insurance Co. of New York*,[225] the court granted the plan administrator's request for a protective order and directed a participant to maintain the confidentiality of the administrator's policies and procedures manual.[226] It did so even though the administrator had produced discrete portions of the manual in other cases without requiring confidentiality,[227] explaining:

> [W]e are still persuaded that a "clearly defined, specific and serious injury will occur" should plaintiff be given the green light to disseminate publicly a compilation of all these individual disclosures. We note further that [the] protective order sought imposes only the most minimal burden on plaintiff, as it requires only that the materials be used only for this litigation. No request is being made for "attorney's eyes only" treatment or other arrangements that would significantly restrict plaintiff's counsel's conduct of this litigation.[228]

These cases reinforce that there are no bright-line rules defining the scope of permissible discovery and the unique facts and needs of each case will be paramount in deciding discovery issues.

E. *Social Security Administration Awards*

Decisions from this survey period highlight that plan administrators must thoughtfully consider and address SSA awards and the rationales behind them as part of claim determinations. After granting the plan administrator's motion to strike the SSA decision from the record since it was not included in the original administrative record, the court in *Holt v. Life Insurance Co. of North America*[229] remanded the case for reconsideration of the claim.[230] In doing so, however, it noted that the administrator's failure

223. *Id.* at *3

224. *See Alison R.*, 2015 WL 3903290, at *3 ("Plaintiff is not entitled to discovery as it pertains to procedural irregularities because the requests appear to go to the merits of the claim."); *see also* Greene v. Hartford Life & Accident Ins. Co., 2015 WL 533257, at *3 (E.D. Pa. Feb. 6, 2015); Zavislak v. Google Inc. Welfare Benefit Plan, 2015 WL 909518, at *4 (N.D. Cal. Feb. 27, 2015).

225. 2015 WL 4114523 (S.D.N.Y. July 8, 2015).

226. *Id.* at *1, *5.

227. *Id.* at *5.

228. *Id.*

229. 2015 WL 1243529 (E.D. Tenn. Mar. 18, 2015).

230. *Id.* at *6. *But see* Hershberger v. Liberty Life Assurance of Boston, 2015 WL 1945022, at *11 (M.D. Pa. Apr. 29, 2015) (granting summary judgment for plan administrator, rather than remanding); Schussheim v. First Unum Life Ins. Co., 80 F. Supp. 3d 360, 386 (E.D.N.Y. 2015) (same).

to explain why it disagreed with the SSA award of which it was aware supported the plaintiff's claim that its determination was unreasonable.[231] Similarly, in *Cox v. Allin Corp. Plan*,[232] the court faulted the plan administrator for making "no effort to address the [SSA's] findings, let alone compare and contrast the applicable definitions or the medical evidence presented."[233]

The Eleventh Circuit in *Oliver v. Aetna Life Insurance Co.*[234] affirmed summary judgment for the plan administrator on de novo review, finding the plaintiff could "not simply rely on" the SSA's determination to establish a right to benefits.[235] The apt approach, the court explained, was to focus "on the evidence of the disability itself" in the administrative record, which included the SSA's record.[236] It also held the plan administrator was not judicially estopped from disagreeing with the SSA's disability finding.[237] This is contrary to another case where the court suggested a plan administrator's role in facilitating a participant's SSA award can limit its ability to disagree with the SSA.[238] In sum, the decisions this survey period illustrate that simply stating that a plan administrator considered, but disagreed with, the SSA's decision at best will be ineffective and, at worst, could lead to further litigation or an outright reversal of a benefits decision.

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

In a much anticipated en banc decision, the Sixth Circuit in *Rochow v. Life Insurance Co. of North America*[239] vacated the district court's multi-million dollar disgorgement award to a participant of a long-term disability plan under § 502(a)(3), which was in addition to an almost $1 million benefit award under § 502(a)(1)(B).[240] Describing the issue as whether the insured was "entitled to recover under both § 502(a)(1)(B) and § 502(a)(3) for LINA's arbitrary and capricious denial of long-term disability benefits," the majority found he was not, vacated the district court's disgorgement

231. *Holt*, 2015 WL 1243529, at *6.
232. 2015 WL 1737764 (N.D. Cal. Apr. 14, 2015).
233. *Id.* at *5; *see also* Liebel v. Aetna Life Ins. Co., 595 F. App'x 755, 763 (10th Cir. 2014).
234. 613 F. App'x 892 (11th Cir. 2015).
235. *Id.* at 899.
236. *Id.*
237. *Id.* at 903–04.
238. *Cf.* Schilling v. Epic Life Ins. Co., 2015 WL 856575, at *14 (W.D. Wis. Feb. 27, 2015) (granting the plan administrator's motion for summary judgment, the court noted in part that "there is no evidence that Epic facilitated Schilling's SSA application in such a way that Epic should be bound by the outcome or its dual role implicated").
239. 780 F.3d 364 (6th Cir. 2015) (en banc) (Gibbons, J., concurring) (White, J., concurring in part and dissenting in part) (Stranch, J., dissenting), *cert. denied*, 84 U.S.L.W. 3087 (U.S. Nov. 9, 2015) (No. 15-163).
240. *Id.* at 369.

award under § 502(a)(3), and remanded the case to the district court to consider whether and to what extent prejudgment interest was appropriate under § 502(a)(1)(B).[241]

Finding the insured was made whole by relief allowed under § 502(a)(1)(B) (i.e., benefits owed, attorney fees, and potential prejudgment interest), the Sixth Circuit rejected the insured's claim that he could not be made whole unless LINA disgorged to him the profits it earned from the use of his money.[242] The insured's theory and the disgorgement award, the court found, improperly focused on the "concern that LINA had wrongfully gained something, a consideration beyond the ken of ERISA make-whole remedies" rather than "the relief available to make Rochow whole."[243] The Sixth Circuit then identified the essential problem: "If an arbitrary and capricious denial of benefits implicated a breach of fiduciary duty entitling the claimant to disgorgement of the defendant's profits in addition to recovery of benefits, then equitable relief would be potentially available whenever a benefits denial is held to be arbitrary or capricious," and "[t]his would be plainly beyond and inconsistent with ERISA's purpose to make claimants whole."[244] *Rochow* has been relied on outside of the Sixth Circuit to defeat disgorgement claims where plan participants have an adequate remedy under § 502(a)(1)(B).[245] The U.S. Supreme Court has declined to take up this issue.

The Eleventh Circuit and the Supreme Court both weighed in during this survey period on an additional important issue related to § 502(a)(3): whether an equitable lien can be imposed on settlement funds through a reimbursement provision in an ERISA plan under § 502(a)(3) if those settlement funds have been spent or dissipated. In *Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile*,[246] the Eleventh Circuit considered whether a plan's attempt to obtain reimbursement of medical expenses it paid on the insured's behalf from a $500,000 settlement the insured received from a third-party tortfeasor was appropriate equitable relief under § 502(a)(3) if the funds had been dissipated.[247] Affirming the district court's entry of summary judgment for the plan on

241. *Id.* at 370, 376.
242. *Id.* at 375.
243. *Id.* at 371.
244. *Id.* at 372.
245. *See, e.g.*, Talbot v. Reliance Standard Life Ins. Co., 2015 WL 4134548, at *15–16 (D. Ariz. June 18, 2015) (finding *Rochow* "clearly precludes disgorgement under § 1132(a)(3)" and dismissing § 1132(a)(3) count "insofar as it is seeking disgorgement for . . . denying Plaintiff's benefits").
246. 593 F. App'x 903 (11th Cir. 2014), *cert. granted*, 135 S. Ct. 1700 (2015), *rev'd*, 136 S. Ct. 651 (2016).
247. *Id.* at 904–07.

this issue, the court held that the insured's argument that reimbursement was not appropriate equitable relief under § 502(a)(3) was foreclosed by its recent decision in *AirTran Airways, Inc. v. Elem*.[248] There, the court held that pursuant to § 502(a)(3)(B), "an equitable lien immediately attached to settlement funds where a plan provision's unambiguous terms gave the plan a first-priority claim to all payments by a third party" and the settlement funds were " 'specifically identifiable' and a plan participant's dissipation of the funds thus 'could not destroy the lien that attached *before*' the dissipation."[249] The plan could impose an equitable lien on the settlement proceeds, even if spent, because the SPD gave the plan a first-priority claim to settlement proceeds the insured received from a third-party settlement.[250]

With these rulings, the Eleventh Circuit joined the First, Third, Sixth, and Seventh Circuits in finding that equitable relief to allow recoupment under an ERISA plan is appropriate, even if the insured no longer possesses the funds upon which the lien attached.[251] The Ninth Circuit disagrees, holding that where the insured spent the monies the plan seeks to recover and as such there is no longer a specified fund in the insured's possession on which to assert an equitable lien, equitable relief is not allowed.[252]

Shortly before this article went to publication, the U.S. Supreme Court handed down its decision in *Montanile*,[253] reversing the Eleventh Circuit's decision and abrogating decisions by other circuits on the same issue. Briefly, the Court held that when an ERISA-plan participant wholly dissipates a third-party settlement on nontraceable items, the plan fiduciary may not bring suit under § 502(a)(3) to attach the participant's separate assets. The Court reasoned that "all types of equitable liens must be enforced against a specifically identified fund in the defendant's possession."[254] Thus, when an insured has dissipated all the assets of a settlement fund, the lien has been eliminated and the plan fiduciary can not attach the insured's general assets.[255] As there were fact issues regarding the extent of the dissipation by Montanile, the Court remanded the case

248. 767 F.3d 1192 (11th Cir. 2014).
249. *Montanile*, 593 F. App'x at 908 (quoting *Elem*, 767 F.3d at 1198).
250. *Id.*
251. Cusson v. Liberty Life Assurance Co. of Boston, 592 F.3d 215, 231 (1st Cir. 2010); Funk v. CIGNA Grp. Ins., 648 F.3d 182, 194–95 (3d Cir. 2011); Longaberger Co. v. Kolt, 586 F.3d 459, 472 (6th Cir. 2009); Gutta v. Standard Select Trust Ins. Plans, 530 F.3d 614, 621 (7th Cir. 2008).
252. Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083, 1094–97 (9th Cir. 2012); *see also* Tr. of Drury Indus., Inc. Health Care Plan & Trust v. Goding, 692 F.3d 888, 895 (8th Cir. 2012).
253. 2016 WL 228344, at *1 (U.S. Jan. 20, 2016) (No. 14-723).
254. *Id.* at *7 (emphasis in original) (citation omitted).
255. *Id.*

for further proceedings.[256] The Court's full decision and reasoning will be discussed at length in the next survey period.

G. *Summary Plan Description*

The *Montanile*[257] court also considered whether a single document, such as the SPD at issue in that case, can be both the written instrument that sets forth the ERISA plan's terms as mandated by § 1102(a)(1) and the SPD required by § 1022.[258] The situation presented was somewhat unique because the SPD was the only document that provided any information regarding eligibility for plan benefits, the extent of plan benefits, and claim-filing procedures.[259] The claimant relied on dicta from *CIGNA Corp. v. Amara*[260] in arguing that the SPD could not have a dual function and fulfill § 1102(a)(1) and § 1022, in part because the *Amara* court suggested an SPD's language may not be legally binding and stated that the syntax of § 1022 "requiring that participants and beneficiaries be advised of their rights and obligations 'under the plan,' suggests that the information *about* the plan provided in [the SPD] is not itself *part of* the plan."[261]

While stating that "dicta from the Supreme Court is not something to be lightly cast aside,"[262] the Eleventh Circuit noted that in *Amara* the SPD's terms conflicted with the terms in other plan documents, which was not the situation before it.[263] It explained that *Amara* did not address whether a SPD's terms can be enforced where that is the only document that details the circumstances under which payments associated with the ERISA plan are to be made, as required by § 1102(b).[264] Ultimately, the court found that since the SPD at issue did not conflict with any other plan documents setting out the parties' rights, its terms were enforceable under § 1132(a)(3).[265]

256. *Id.* at *9–10.
257. *Montanile*, 593 F. App'x 903.
258. *Id.* at 908–11. This issue was not included in the Supreme Court's recent reversal of *Montanile* on other grounds.
259. *Id.* at 905.
260. 563 U.S. 421 (2011).
261. *Montanile*, 593 F. App'x at 909 (quoting *Amara*, 563 U.S. at 436 (emphasis in original)).
262. *Id.* at 910 (quoting Peterson v. BMI Refractories, 124 F.3d 1386, 1392 n.4 (11th Cir. 1997)).
263. *Id.* at 910.
264. *Id.*
265. *Id.*

V. HEALTH INSURANCE

A. *ACA Tax Credits Are Available for Coverage Obtained Through Federal Exchanges*

The Supreme Court extended its three-year streak of reviewing challenges to the Patient Protection and Affordable Care Act (ACA or the Act) this survey period. In *King v. Burwell*,[266] a five-justice majority rejected arguments that ACA's language sharply limited the applicability of the tax credits that are one of the Act's key reforms.

Through ACA, Congress adopted a series of interlocking reforms designed to expand coverage in the individual health insurance market. The five reforms relevant to the Court's decision in *King* were: (1) a "coverage mandate" requiring individuals to obtain health insurance coverage with a prescribed set of benefits, (2) refundable tax credits to help individuals whose incomes were below a certain level purchase insurance and satisfy the coverage mandate, (3) a requirement that a health insurance exchange be established in each state, (4) a "guaranteed issue" mandate barring insurers from denying coverage based on an applicant's health status, and (5) a "community rating" mandate prohibiting insurers from charging an applicant a higher premium because of his health status.[267] ACA further provided that if, after accounting for the tax credits, an individual had to spend over 8 percent of his income to obtain the required health insurance, he was exempted from the coverage mandate.[268] State exchanges would be created in one of two ways: states could establish their own Exchanges or, if they declined to do so, the Secretary of Health and Human Services would establish and operate an Exchange in those states (Federal Exchanges).[269] In *King*, the Court considered whether ACA's tax credits were calculated the same way for individuals in State and Federal Exchanges.

The primary issue is that the statute describing the amount of the tax credit to which an individual is entitled refers to insurance obtained through "an Exchange *established by the State* under section 1113 of the Patient Protection and Affordable Care Act [hereafter 42 U.S.C. § 18031]."[270] But ACA is silent as to how tax credits should be calculated for individuals who obtained coverage through a Federal Exchange.[271]

266. 135 S. Ct. 2480 (2015).
267. *Id.* at 2486.
268. *Id.* at 2486–87.
269. *Id.* at 2487 (emphasis by the court).
270. *Id.* (citing 26 U.S.C. §§ 36B(b)–(c)).
271. *Id.* at 2495.

The petitioners, who were covered through a Federal Exchange, argued they were not entitled to tax credits under ACA and, because their costs of insurance would exceed 8 percent of their income without such credits, they were exempted from the coverage mandate.[272] An IRS rule, however, confirmed available tax credits were calculated the same way for individuals enrolled through State and Federal Exchanges.[273] The government argued the petitioners were required to purchase health insurance coverage since they were entitled to tax credits under this rule and with such credits their insurance would cost less than 8 percent of their income.[274] The petitioners challenged the IRS Rule and the Fourth Circuit upheld the district court's dismissal of that challenge, deferring to the IRS's interpretation of ACA in accordance with *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc*.[275]

Before the Supreme Court, the petitioners argued that under the "plain meaning" of the phrase "an Exchange established by the State [under 42 U.S.C. § 18031]," they were not entitled to any tax credits.[276] Although the majority acknowledged this argument was "strong," it ultimately rejected it, explaining "the context and structure of the Act compel us to depart from what would otherwise be the most natural reading of the pertinent statutory phrase."[277]

The Court began by finding ACA's reference to "an Exchange established by the State" was ambiguous.[278] If this phrase referred only to State Exchanges, as the petitioners asserted, a significant inconsistency would arise between the Act's operation and Congress's stated intentions.[279] ACA required both State and Federal Exchanges to make their health plans available to "qualified individuals," defined as individuals who "reside[] in the State that established the Exchange."[280] If the phrase "the State that established the Exchange [under 42 U.S.C. § 18031]" was given the limited meaning the petitioners advocated, "there would be *no* 'qualified individuals' on Federal Exchanges," clearly contrary to the Act's intent that "there will be qualified individuals on *every* Exchange."[281]

272. *Id.* at 2487.
273. *Id.*
274. *Id.* at 2488.
275. 467 U.S. 837 (1984) (cited in the procedural history recounted in *King*, 135 S. Ct. at 2487).
276. *King*, 135 S. Ct. at 2495.
277. *Id.*
278. *Id.* at 2489.
279. *Id.* at 2489–91.
280. *Id.* at 2490 (citing 42 U.S.C. §§ 18031(d)(2)(A) and 18032(f)(1)(A)).
281. *Id.* (emphasis in original).

That § 18031 directs states to establish State Exchanges[282] did not alter the Court's conclusion that a Federal Exchange could be an Exchange "established by the State [under 42 U.S.C. § 18031]." The authority to create Federal Exchanges arises under Section 18041, which directs the Secretary to establish and operate an "Exchange."[283] The Act defines "Exchange" to mean "an American Health Benefit Exchange established under section 18031."[284] In other words, "Section 18041 authorizes the Secretary to establish an Exchange under Section 18031, not (or not only) under Section 18041."[285] Moreover, the Court found that "[a]ll of the requirements that an Exchange must meet are in Section 18031, so it is sensible to regard all Exchanges as established under [Section 18031]."[286] The Court explained that "[t]he upshot of all this is that the phrase 'an Exchange established by the State under [42 U.S.C. § 18031]' is properly viewed as ambiguous," as it could refer to State Exchanges only or to State and Federal Exchanges.[287]

Because the tax credit provision was ambiguous, the Court looked to the "broader structure of the Act"[288] to ascertain its meaning. It began by considering the Nation's history of health reform efforts,[289] finding that prior state-level reforms were only successful at reducing the number of uninsured when they employed a coverage mandate together with tax credits and insurance market reforms, such as the guaranteed-issue and community-rating reforms.[290] Without a coverage mandate and accompanying tax credits, individuals would wait until they became ill to purchase insurance.[291] Insurers, which were barred from denying coverage based on health status, watched their risk pools grow more risky as they covered fewer healthy individuals and more ill ones.[292] As a result, premiums increased and even more individuals waited until they were sick to buy insurance.[293] The Court characterized this process as "an economic death spiral," which ultimately caused insurers to leave some state insur-

282. *Id.* (citing 42 U.S.C. § 18031(d)(2)(A)).
283. *Id.* at 2490–91.
284. *Id.* at 2490.
285. *Id.* at 2491.
286. *Id.*
287. *Id.*
288. *Id.* at 2492.
289. *Id.* at 2493–94.
290. *Id.* at 2485–86.
291. *Id.*
292. *Id.*
293. *Id.*

ance markets.[294] By adopting a version of the reforms that were successful at the state level, ACA sought to avoid those problems.[295]

Construing ACA as the petitioners advocated would mean State Exchange markets would enjoy the stability the Act's interlocking reforms provided, while Federal Exchange markets would be forced to survive without the tax credits that history showed were needed to ensure a functioning market.[296] Functioning Federal Exchanges were deemed significant to the Act's effectiveness, as thirty-four states had a Federal Exchange,[297] 87 percent of individuals who purchased insurance through those Exchanges used tax credits, and virtually all of them would be exempt from the coverage mandate without the tax credits.[298] The Court thus found that "[t]he combination of no tax credits and an ineffective coverage requirement could well push a State's individual insurance market into a death spiral."[299] Finding it was implausible to conclude Congress intended ACA to operate that way, the Court held that "the statutory scheme compels us to reject petitioners' interpretation because it would destabilize the individual insurance market in any State with a Federal Exchange, and likely create the very 'death spirals' that Congress designed the law to avoid."[300]

B. *ACA's Contraception Mandate*

The Supreme Court will extend its three-year run of reviewing challenges to ACA in 2016, having agreed to review four ACA-related decisions from this survey period.[301] The issue poised for consideration is whether regulations designed to accommodate religious objections to ACA's so-called "contraceptive coverage mandate" sufficiently address those objections or instead violate the Religious Freedom Restoration Act.

Under the "contraceptive coverage mandate," employers with fifty or more full-time employees must offer their employees a group health plan. Group health plans and health insurance issuers offering group health coverage to such plans must provide "minimum essential coverage" to plan participants and beneficiaries free of copayments, deductibles, or other costs; "minimum essential coverage" includes all FDA-approved

294. *Id.* at 2486.
295. *Id.*
296. *Id.* at 2493–94.
297. *Id.* at 2487.
298. *Id.* at 2493.
299. *Id.*
300. *Id.*
301. *See* U.S. S. Ct. Misc. Order Granting Certiorari, 577 U.S. — (Nov. 6, 2015) (consolidating Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, and 15-191), *available at* http://www.supremecourt.gov/orders/courtorders/110615zr_j4ek.pdf.

contraceptive methods and sterilization procedures for women.[302] An employer that does not comply with the mandate faces significant financial penalties.[303]

"Religious employers"[304] are exempt from the mandate so their group health plans do not have to provide coverage for contraceptive services to which the employers have religious objections.[305] ACA's regulations further give other "eligible organizations"[306] an accommodation that relieves them of their obligation to contract, arrange, pay, or make referrals for contraceptive services to which they have religious objections.[307] The accommodation also ensures, however, that contraceptive coverage is provided to covered employees at no additional cost to them.[308]

There are two ways an eligible organization can exercise its right to the accommodation. It can complete the Department of Labor's EBSA Form 700, which identifies the organization and certifies its eligibility for the accommodation, or it can state its religious objections to the mandate

302. 42 U.S.C. § 300gg-13; Grace Sch. v. Burwell, 801 F.3d 788, 791 (7th Cir. Sept. 4, 2015) (citing 42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130(a)(1)(iv)); Little Sisters of the Poor Home for the Aged v. Burwell, 794 F.3d 1151, 1159 (10th Cir. 2015), *cert. granted*, 84 U.S.L.W. 3056 (U.S. Nov. 6, 2015) (No. 15-105); E. Tex. Baptist Univ. v. Burwell, 793 F.3d 449, 452–53 (5th Cir. 2015), *cert. granted*, 84 U.S.L.W. 3050 (U.S. Nov. 6, 2015) (No. 15-35); Catholic Health Care Sys. v. Burwell, 796 F.3d 207, 210 (2d Cir. 2015).

303. *E. Tex. Baptist Univ.*, 793 F.3d at 449 ("An employer that does not comply with [ACA] faces draconian penalties: $2,000 per full-time employee per year for not offering a plan at all and $100 per affected individual per day for offering a plan that provides insufficient coverage, 26 U.S.C. § 4980D(a), (b)(1).").

304. "A religious employer is defined as an 'organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.'" *Grace Sch.*, 801 F.3d at 792 (citing 45 C.F.R. § 147.131(a), 26 U.S.C. § 6033(a)(3)(A)). That section of the Internal Revenue Code refers to "churches, their integrated auxiliaries, and conventions or associations of churches" and "the exclusively religious activities of any religious order." *Id.* (citing 26 U.S.C. § 6033(a)(3)(A)).

305. *Grace Sch.*, 801 F.3d at 792; *see also* Geneva Coll. v. Sec'y U.S. Dep't of Health & Human Serv., 778 F.3d 422, 428 (3d Cir. 2015), *cert. granted*, 84 U.S.L.W. 3096 (U.S. Nov. 6, 2015) (No. 15-191); Mich. Catholic Conference & Catholic Family Serv. v. Burwell, 2015 WL 4979692, at *2 (6th Cir. 2015). Religiously affiliated non-profit entities such as schools, hospitals, and charitable organizations generally do not fall within the definition of a "religious employer" and, therefore, are not entitled to the exemption. *See Grace Sch.*, 801 F.3d at 792; *E. Tex. Baptist Univ.*, 793 F.3d at 453.

306. An "eligible organization" is one that: (1) opposes providing coverage for one or more contraceptive services on religious grounds; (2) is organized and operates as either a non-profit entity that holds itself out as a religious organization or as a closely held for-profit entity that has adopted a resolution establishing that it objects to covering some or all of the contraceptive services on account of the owners' sincerely held religious beliefs; and (3) self-certifies to the foregoing in the manner prescribed by the Secretary. 45 C.F.R. § 147.131(b) (eff. Sept. 14, 2015).

307. *Geneva Coll.*, 778 F.3d at 429 (citing 78 Fed. Reg. 39874).

308. *Grace Sch.*, 801 F.3d at 792–93; *Little Sisters of the Poor*, 794 F.3d at 1159; *Geneva Coll.*, 778 F.3d at 429.

in a written notice to the Secretary.[309] A fully insured group health plan that completes Form 700 must give its insurer a copy,[310] while a self-insured plan completing the form must give a copy to its third-party administrator.[311] If an eligible organization notifies the Secretary of its objections, the Secretary must notify the plan's insurer or TPA (as applicable).[312]

Allowing eligible organizations to opt out of providing contraceptive coverage means the government must find another party to arrange, pay for, and administer those benefits. How the accommodation accomplishes that differs, depending on whether a plan is fully insured or self-insured. Under ACA, insurers and group health plans are jointly obligated to provide contraceptive coverage.[313] When an insurer is notified that an eligible organization exercised its right to the accommodation, the insurer becomes solely responsible for providing the mandated coverage.[314] It then must: (1) expressly exclude from the group health plan's insurance all coverage for the objected to contraceptive services, and (2) provide separate payments for those contraceptive services at no additional cost to participants and beneficiaries.[315] The insurer must also notify participants and beneficiaries that the organization does not administer or fund contraceptive benefits, but that it will provide separate payments for contraceptive services at no cost to them.[316]

309. 45 C.F.R. § 147.131(c) (eff. Sept. 14, 2015); 29 C.F.R. § 2590.715-2713A(b) (eff. Sept. 14, 2015).

310. 45 C.F.R. § 147.131(c)(1) (eff. Sept. 14, 2015).

311. 29 C.F.R. § 2590.715–2713A(b)(1) (eff. Sept. 14, 2015). Importantly, the accommodation is available to a self-insured plan only if it or its sponsoring eligible organization contracts with one or more TPAs. 29 C.F.R § 2590.715-2713A(b)(1)(i) (eff. Sept. 14, 2015).

312. 45 C.F.R. § 147.131(c)(1)(ii) (eff. Sept. 14, 2015); 29 C.F.R. § 2590.715–2713A(b)(1)(ii)(B) (eff. Sept. 14, 2015). It is important to note that "[a]s litigation on the ACA's contraception requirements has progressed in other cases and other circuits, new regulations have been issued in response to interim orders from the Supreme Court." *Grace Sch.*, 801 F.3d at 797 (discussing Little Sisters of the Poor Home for the Aged v. Sebelius, 134 S. Ct. 1022 (2014); Wheaton Coll. v. Burwell, 134 S. Ct. 2806 (2014); and Zubik v. Burwell, 135 S. Ct. 2924 (2015)); *see also Little Sisters of the Poor*, 794 F.3d at 1163–64 (citing same). The Court's interim orders relieved the appealing eligible organizations of the requirement that they submit the Form 700 to their insurers or TPAs to receive the benefit of the accommodation. *Grace Sch.*, 801 F.3d at 797–98. Instead, the orders allowed an organization to satisfy the accommodation's notice requirement by submitting written notice to the Secretary of Health and Human Services of the organization's religious objections to providing contraceptive coverage. *Id.* ACA's implementing regulations were amended to reflect that notice option. *Id.* at 798.

313. 42 U.S.C. § 300gg-13.

314. 45 C.F.R. § 147.131(c)(1)(i); 29 C.F.R. § 2590.715-2713A(c)(1)(i); *Little Sisters of the Poor*, 794 F.3d at 1165–66.

315. 45 C.F.R. § 147.131(c)(2) (eff. Sept. 14, 2015); 29 C.F.R § 2590.715–2713A(c)(2) (eff. Sept. 14, 2015).

316. 45 C.F.R. § 147.131(d) (eff. Sept. 14, 2015); 29 C.F.R § 2590.715–2713A(d) (eff. Sept. 14, 2015).

For self-insured plans, the process for providing contraceptive services is less direct. Once a TPA is notified that an eligible organization exercised its right to the accommodation, ACA's regulations require the plan's TPA to decide whether to continue its contractual relationship with the organization.[317] If the TPA opts to do so, the regulations designate it as "the plan administrator under section 3(16) of ERISA for any [mandated] contraceptive services" the eligible organization objects to providing.[318] The TPA then must ensure the group health plan delivers all mandated contraceptive services to the plan's participants or beneficiaries by (1) providing payments for the objected to contraceptive services, or (2) arranging for another entity to provide such payments.[319]

Several eligible organizations challenged the accommodation this survey period, arguing it imposed a substantial burden on their exercise of religion and violated the Religious Freedom Restoration Act (RFRA).[320] Under RFRA, the federal government may "not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability," unless the government "demonstrates that application of the burden to the person–(1) is in furtherance of a compelling government interest; and (2) is the least restrictive means of furthering that compelling governmental interest."[321]

The organizations argued the accommodation substantially burdened their exercise of religion by forcing them to participate in a system that delivered objectionable contraceptives to employees against their religious beliefs.[322] Specifically, the organizations objected to providing notice of their religious objections to their insurers, TPAs, or the Secretary, arguing that doing so would "trigger" or "facilitate" the provision of ob-

317. 29 C.F.R § 2590.715–2713A(b)(2) (eff. Sept. 14, 2015).

318. 29 C.F.R. § 2510.3-16(b). The regulations accomplish that designation by declaring the Form 700 or notice from the Secretary to the TPA, as applicable, "an instrument under which the plan is operated." 29 C.F.R. § 2510.3-16(b); *see also* 78 Fed. Reg. 39880 (July 2, 2013).

319. 29 C.F.R § 2590.715-2713A(b)(2) (eff. Sept. 14, 2015); *Little Sisters of the Poor*, 794 F.3d at 1166. To ensure TPAs are not required to absorb the costs of providing and arranging for contraceptive services for plan participants and beneficiaries, the regulations permit TPAs to seek reimbursement through adjustments to fees otherwise imposed by ACA. 29 C.F.R § 2590.715-2713A(b)(3) (eff. Sept. 14, 2015).

320. Several organizations also charged the accommodation violated their First Amendment rights and the Administrative Procedures Act. *See*, *e.g.*, *Mich. Catholic Conference*, 2015 WL 4979692, at *1; *Catholic Health Care Sys.*, 796 F.3d at 226. Because the protections afforded by RFRA are broader than those under the Establishment Clause, resolution of the RFRA claims also resolved the organizations' First Amendment claims. *See Mich. Catholic Conference*, 2015 WL 4979692, at *1; *Catholic Health Care Sys.*, 796 F.3d at 226. The decisions did not discuss the organizations' APA claims.

321. 42 U.S.C § 2000bb-1.

322. *See*, *e.g.*, *Grace Sch.*, 801 F.3d at 793–94; *Little Sisters of the Poor*, 794 F.3d at 1160; Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Serv., 801 F.3d 927, 938–39 (8th Cir. 2015).

jectionable contraceptive services by third parties and render them complicit in what they viewed as a grave moral wrong.[323]

Panels of the Second, Third, Fifth, Sixth, Seventh, and Tenth Circuits considered organizations' objections to the accommodation and held that requiring an eligible organization to notify others of its religious objections did not make the organization complicit in the delivery of those contraceptive services and did not substantially burden the organizations' exercise of religion.[324] For fully insured plans, the claim that the notifications were "triggers" that "caused" insurers to become obligated to provide contraceptive coverage was deemed "legally incorrect."[325] An insurer's obligation to provide contraceptive coverage existed independently of whether an eligible organization opted out of the mandate.[326] Thus, federal law, not an organization's notice of objection, imposed a duty to provide contraceptive coverage on insurers.[327] Even if the notification requirement could be characterized as "triggering" contraceptive coverage, that was not the proper focus of a substantial burden analysis under RFRA. The relevant inquiry was whether the act of notifying others substantially burdened the organizations' religious exercise.[328] Finally, even if the notification requirement burdened eligible organizations' religious exercise, several courts found the burden was de minimis under RFFA.[329]

For self-insured organizations, the "triggering" arguments were slightly different, but the results largely the same. Eligible organizations argued their notices did more than merely signal their religious objections to providing certain contraceptive coverage; they also designated the organizations' TPAs as plan administrators for providing contraceptive services.[330] The self-insured organizations thus claimed the notification requirement facilitated and made them complicit in the delivery of objectionable contraceptive services.[331] Courts rejected that argument,

323. *See, e.g.*, *Grace Sch.*, 801 F.3d at 802–03; *Little Sisters of the Poor*, 794 F.3d at 1178.

324. *Catholic Health Care Sys.*, 796 F.3d at 218–26; *Geneva Coll.*, 778 F.3d at 442; *E. Tex. Baptist Univ.*, 793 F.3d at 459; *Mich. Catholic Conference*, 2015 WL 4979692, at *10–12; Univ. of Notre Dame v. Burwell, 786 F.3d 606, 612–14 (7th Cir. 2015), *petition for cert. filed*, 84 U.S.L.W. 3356 (U.S. Dec. 18, 2015) (No. 15-812); Wheaton Coll. v. Burwell, 791 F.3d 792, 795–96 (7th Cir. 2015); *Grace Sch.*, 801 F.3d at 803–04; *Little Sisters of the Poor*, 794 F.3d at 1180–84, 1190–95.

325. *Grace Sch.*, 801 F.3d at 805; *Little Sisters of the Poor*, 794 F.3d at 1173–74 & 1180–85; *Geneva Coll.*, 778 F.3d at 437–38; *Mich. Catholic Conference*, 2015 WL 4979692, at *10; *E. Tex. Baptist Univ.*, 793 F.3d at 459.

326. *Mich. Catholic Conference*, 2015 WL 4979692, at *10.

327. 42 U.S.C. § 300gg-13; 45 C.F.R. § 174.131(c)(1)(i); *Univ. of Notre Dame*, 786 F.3d at 614; *Little Sisters of the Poor*, 794 F.3d at 1180–81; *Geneva Coll.*, 778 F.3d at 437.

328. *Geneva Coll.*, 778 F.3d at 439–40; *E. Tex. Baptist Univ.*, 793 F.3d at 459.

329. *Little Sisters of the Poor*, 794 F.3d at 1192; *Mich. Catholic Conference*, 2015 WL 4979692, at *9; *see also Wheaton Coll.*, 791 F.3d at 797.

330. *Grace Sch.*, 801 F.3d at 805.

331. *Geneva Coll.*, 778 F.3d at 438–39; *Univ. of Notre Dame*, 786 F.3d at 614–15.

pointing out that ACA's regulations deemed the designations to occur upon the TPA's agreement to continue its relationship with the plan.[332] Thus, federal law was responsible for designating their TPAs as plan administrators, not the organizations.[333]

What the organizations were really complaining about, some courts believed, was that the accommodation allowed the mandate to survive their objections by shifting responsibility to third parties.[334] But "[r]eligious objectors do not suffer substantial burdens under RFRA where the only harm to them is that they sincerely feel aggrieved by their inability to prevent what other people would do to fulfill regulatory objectives after they opt out."[335] "The rights conferred by . . . RFRA do not include a right to have the government or third parties behave in a manner that comports with an individual's religious beliefs."[336] After all, they noted, "[l]aw accommodates religion; it cannot wholly exempt religion from the reach of the law."[337]

The Eighth Circuit disagreed with its sister circuits' findings, upholding a preliminary injunction enjoining the government from enforcing the mandate against two eligible organizations.[338] Its holding turned on the deference it gave the organizations to determine what constituted a substantial burden on their exercise of religion:

> It is not our role to second-guess [the organizations'] honest assessment of a "difficult and important question of religion and moral philosophy, namely, the circumstances under which it is wrong for a person to perform an act that is innocent in itself but that has the effect of enabling or facilitating the commission of an immoral act by another."[339]

Because the plaintiffs sincerely believed the notification requirement would "result in conscience violating consequences," the burdens the

332. *Geneva Coll.*, 778 F.3d at 438–39; *Univ. of Notre Dame*, 786 F.3d at 614 (citing 29 C.F.R. § 2510.3-16(b)).

333. *Geneva Coll.*, 778 F.3d at 438; *Univ. of Notre Dame*, 786 F.3d at 614.

334. *Geneva Coll.*, 778 F.3d at 439 ("The appellees' real objection is to what happens after the form is provided—that is, to the actions of the insurance issuers and third-party administrators, required by law, once the appellees give notice of their objection."); *E. Tex. Baptist Univ.*, 793 F.3d at 459.

335. *Little Sisters of the Poor*, 794 F.3d at 1193; *see also E. Tex. Baptist Univ.*, 793 F.3d at 459, 461; *Geneva Coll.*, 778 F.3d at 438 n.13, 439.

336. *Catholic Health Care Sys.*, 796 F.3d at 226; *Geneva Coll.*, 778 F.3d at 439–40 ("The Supreme Court has consistently rejected the argument that an independent obligation on a third party can impose a substantial burden on the exercise of religion in violation of RFRA.").

337. *Little Sisters of the Poor*, 794 F.3d at 1172 (quoting United States v. Friday, 525 F.3d 938, 960 (10th Cir. 2008)).

338. *Sharpe Holdings*, 801 F.3d at 932; *see also* Wieland v. U.S. Dep't of Health & Human Servs., 793 F.3d 949 (8th Cir. 2015); Dordt Coll. v. Burwell, 801 F.3d 946 (8th Cir. 2015).

339. *Sharpe Holdings*, 801 F.3d at 941 (citing Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2778 (2014)).

mandate and accommodation scheme imposed were considered "substantial" under RFRA.[340] And because the government failed to show the accommodation was the least restrictive means for accomplishing a compelling government interest, the Eighth Circuit found the organizations were likely to succeed in their challenges to the mandate and accommodation.[341]

The key difference between the Eighth Circuit's analysis and the other circuits' was the deference afforded eligible organizations to decide if a burden was "substantial" under RFRA. The other circuits found the issue was a legal question reserved to the judiciary,[342] explaining Congress added the term "substantially" to RFRA to clarify that only some burdens would violate it and "[i]f plaintiffs could assert and establish that a burden [was] 'substantial' without any possibility of judicial scrutiny, the word 'substantial' would become wholly devoid of independent meaning."[343]

In November 2015, the Supreme Court granted petitions for certiorari related to four accommodation cases that arose during the survey period[344] and three earlier decisions. Chances are good that the current circuit split will be resolved by the end of the next survey period.

C. *Mental Health Parity*

An association of psychiatrists had standing to challenge the systemic policies and practices of an insurer that allegedly violated the Mental Health Parity and Addiction Equity Act of 2008.[345] The Second Circuit reversed the dismissal of the association's claim in *New York State Psychiatric Ass'n*,

340. *Id.*, 801 F.3d at 941.

341. *Id.* at 942–43.

342. *Little Sisters of the Poor*, 794 F.3d at 1176; *Grace Sch.*, 801 F.3d at 804; *Catholic Health Care Sys.*, 796 F.3d at 217; *E. Tex. Baptist Univ.*, 793 F.3d at 456; *Mich. Catholic Conference*, 2015 4979692, at *7; *Geneva Coll.*, 778 F.3d at 436, 442.

343. *Little Sisters of the Poor*, 794 F.3d at 1176; *see also Grace Sch.*, 801 F.3d at 804; *Catholic Health Care Sys.*, 796 F.3d at 217–18 ("If RFRA plaintiffs needed only to assert that their religious beliefs were substantially burdened, federal courts would be reduced to rubber stamps, and the government would have to defend innumerable actions under [a] demanding strict scrutiny analysis."); *E. Tex. Baptist Univ.*, 793 F.3d at 456; *Mich. Catholic Conference*, 2015 4979692, at *7; *Geneva Coll.*, 778 F.3d at 436, 442.

344. Little Sisters of the Poor Home for the Aged v. Burwell, 84 U.S.L.W. 3056 (U.S. Nov. 6, 2015) (No. 15-105); E. Tex. Baptist Univ. v. Burwell, 84 U.S.L.W. 3050 (U.S. Nov. 6, 2015) (No. 15-35); Geneva Coll. v. Burwell, 84 U.S.L.W. 3096 (U.S. Nov. 6, 2015) (No. 15-191); S. Nazarene Univ. v. Burwell, 84 U.S.L.W. 3061 (U.S. Nov. 6, 2015) (No. 15-119).

345. *See* N.Y. State Psychiatric Ass'n, Inc. v. UnitedHealth Grp., 798 F.3d 125, 130–31 (2d Cir. 2015). The Parity Act requires group health plans and health insurance issuers to ensure that the financial requirements, such as copayments and deductibles, and treatment limitations for mental health benefits they provide are no more restrictive than the predominant financial requirements and treatment limitations applied to covered medical and surgical benefits. *See* 29 U.S.C. § 1185a(a).

Inc. v. UnitedHealth Group.[346] All agreed the plaintiff sufficiently pled two of the three elements required for associational standing; i.e., the plaintiff's members had standing to sue the insurer as assignees of insured benefits and the plaintiff's action sought to protect interests germane to its purpose.[347] At issue was whether the plaintiff's request for injunctive and declaratory relief required individual association members to participate in the lawsuit.[348] If so, the association lacked standing. The court acknowledged that the participation of a limited number of association members might be necessary for the association to prove the alleged policies and practices violated the Parity Act, but concluded that did not necessarily deprive the association of standing.[349] The appropriate level of reliance on individual proof was a matter of degree, and the court was not willing to draw the line at the pleadings stage. The plaintiff, therefore, alleged facts sufficient to establish associational standing.[350]

VI. LIFE INSURANCE

During this survey period, courts across the country continued to hear disputes between insurance companies and investors looking to benefit from stranger owned/originated life insurance policies (STOLI). Issues addressed include insurers' attempts to void policies and whether anti-STOLI statutes apply to annuities with death benefits. Courts also considered policy ambiguities, the validity of face amount reductions, and misrepresentations regarding disclosed conditions.

A. *STOLI*

Public policy may not always bar STOLI policies. In *PHL Variable Insurance Co. v. Bank of Utah*,[351] the Eighth Circuit considered whether a stranger owned life insurance policy, which was issued before Minnesota passed its prospective-only anti-STOLI related Insurable Interest Act in 2009,[352] was void ab initio under Minnesota common law.[353] In 2006, the insured obtained a $5 million policy on his life, financing the premium through a third party.[354] Shortly before the premium loan became due in 2009, the insured tried to sell it, but was unsuccessful because the secondary

346. *N.Y. State Psychiatric Ass'n*, 798 F.3d at 130–31.
347. *Id.*
348. *Id.*
349. *Id.* at 131.
350. *Id.*
351. 780 F.3d 863 (8th Cir. 2015).
352. MINN. STAT. § 60A.078.
353. *PHL Variable Ins. Co.*, 780 F.3d at 867.
354. *Id.* at 865–66.

market for such policies had collapsed.[355] The insured ultimately surrendered the policy to the lender to satisfy its loan.[356] After the insured died in 2011, the lender's successor filed a claim for benefits.[357] PHL denied the claim and sued seeking a declaration that "the policy was void *ab initio* as contrary to public policy for lack of insurable interest."[358] The district court found the policy could be challenged for lack of insurable interest beyond the contestability period.[359] The Eighth Circuit reversed, however, explaining that Minnesota's Supreme Court would not declare a policy procured to transfer or assign it to a person without an insurable interest void ab initio as against public policy because to do so would conflict with a tenet of Minnesota law: "The court's power to declare a contract void for being in contravention of sound public policy is a very delicate and undefined power, and . . . should be exercised only in cases free from doubt."[360] The Eighth Circuit did not believe the public policy issue was free from doubt when the policy was purchased by the insured.[361] Noting the insurer would keep $500,000 in premiums if the district court's decision was affirmed, the court commented that this would allow "life insurers to resist paying a death benefit any time there is some evidence that an insured used premium financing to obtain a policy he or she planned to sell."[362]

What if clever investors try the same tactics outside of the life insurance realm in the annuities world? Can statutes that protect against STOLI protect against stranger-oriented annuity transactions (STATs) that contain a death benefit? Rhode Island's Supreme Court addressed this issue in *Western Reserve Life Assurance Co. of Ohio v. ADM Associates, LLC*,[363] after the First Circuit certified the question whether "an 'annuity [is] infirm for want of an insurable interest' when 'the owner and beneficiary of an annuity with a death benefit is a stranger to the annuitant[.]'"[364] "A rapacious investment scheme" was devised based on a Western Reserve annuity product that allowed the investor/owner to direct how the premiums he paid were invested and choose the recipient of periodic annuity payments, with the measuring tool for the annuity policy being the life of the annuitant (who is selected by the investor).[365] The

355. *Id.* at 866.
356. *Id.*
357. *Id.*
358. *Id.*
359. *Id.*
360. *Id.* at 869–70 (citing Katun Corp. v. Clarke, 484 F.3d 972, 976 (8th Cir. 2007) (internal quotations omitted)).
361. *Id.* at 870.
362. *Id.*
363. 116 A.3d 794 (R.I. 2015).
364. *Id.* at 796.
365. *Id.*

investor, who was also the annuity's beneficiary, could virtually assure a risk-free investment by also purchasing a "Double Enhanced Death Benefit" whereby upon the annuitant's death he would "receive the greater of (1) the highest market value of the policy at a specified anniversary date or (2) a return of all the premiums paid into the policy plus five percent per annum interest."[366]

To ensure greater potential profits, the investor recruited terminally ill individuals as annuitants and offered a cash payment to those willing to be an annuitant.[367] Finding that life insurance and annuities are different, the court first determined that Rhode Island's STOLI statute, which explicitly applies only to life insurance policies, did not apply to STATs.[368] It then held the subject annuity was not a "wagering contract" and thus not void as a matter of public policy.[369] In so holding, the court found that the investor/beneficiary's lack of an insurable interest in the annuitant did not convert the annuity into a wagering contract because "[b]oth the payments by the investor and the payout by the annuity company are guaranteed by the contract."[370] The court thus held that an annuity with a death benefit is not "'a *purely* speculative contract on the life of another'" and does not violate public policy.[371]

An investor in an insurance contract who does not have an insurable interest in the insured's life generally assumes the risk that the policy will be declared void ab initio. The court in *U.S. Bank National Ass'n v. Sun Life Assurance Co. of Canada*,[372] however, examined a Wisconsin statute that shifted the risk from investors to insurers, considering whether a $6 million life insurance policy, issued on an 81-year-old man, was valid.[373] The insured was owner and beneficiary of the policy for four years before transferring ownership and beneficiary rights to U.S. Bank as a "securities intermediary."[374] This transfer was allowed under the policy's terms and acknowledged by Sun Life.[375] Sun Life accepted premiums until the insured died several years later and, despite having proof of the insured's death, continued to review the claim out of concern that the policy may be an illegal wagering contract.[376] U.S. Bank then

366. *Id.*
367. *Id.* at 797.
368. *Id.* at 802 (citing R.I. GEN. LAWS § 27-4-27(a)).
369. *Id.* at 803.
370. *Id.*
371. *Id.* (emphasis original) (quoting Cronin v. Vermont Life Ins. Co., 40 A. 497, 497 (R.I. 1898)).
372. 2015 WL 3645700 (W.D. Wis. June 10, 2015).
373. *Id.* at *1.
374. *Id.*
375. *Id.*
376. *Id.* at *2.

sued and the court granted its motion for judgment on the pleadings on its breach of contract claim and Sun Life's illegal wagering contract counterclaim.[377] In holding for U.S. Bank, the court relied on Wis. Stat. § 631.07(4), which provides that "no insurance policy is invalid merely because the policyholder lacks insurable interest or because consent is not given. . . ."[378] The court explained that the legislature, in promulgating the statute, decided

> [t]he best way to discourage insurers from issuing insurance policies to persons without insurable interests is to make them pay if they do, not to permit them freely to issue such policies knowing that they have a good public policy defense that lets them off the hook whenever a loss occurs."[379]

Notably, a more recent Wisconsin statute,[380] which did not apply as it was enacted after the policy's issuance, regulates life settlements, restricting them when a policyholder might be "unduly influenced or under other hardships rendering them vulnerable to fraud late in life."[381]

B. *Policy Ambiguities, Validity of Policy Modifications, and Application Misrepresentations*

The policy's definition of "Active Work or Actively at Work" was found to be ambiguous in *Sequeira v. Lincoln National Life Insurance Co.*,[382] and, as a result, the insurer was obligated to pay death benefits.[383] The insured was off work on January 1, 2010, for the New Year's holiday, the very day his supplemental life insurance policy was issued.[384] He fell ill the next day and died before he could return to work.[385] Lincoln denied benefits under the policy arguing it was not effective under its terms, which specified it would become effective "the day you resume Active Work, if you are not Actively at Work on the day you become eligible."[386] The policy defined "Active Work or Actively at Work" as "'the full-time performance of all customary duties of an employee's occupation at the EMPLOYER'S place of business.'"[387] The trial court granted Lincoln's motion for summary adjudication on the plaintiff's breach of contract and bad faith claim.[388] On appeal, the plaintiff argued the "Active Work"

377. *Id.* at *1.
378. *Id.* at *3–4 (quoting WIS. STAT. ANN. § 631.07(4)).
379. *Id.* at *4.
380. WIS. STAT. ANN. § 632.69.
381. *U.S. Bank Nat'l Ass'n*, 2015 WL 3645700, at *4.
382. 192 Cal. Rptr. 3d 127 (Cal. Ct. App. 2015).
383. *Id.* at 129.
384. *Id.*
385. *Id.* at 130.
386. *Id.*
387. *Id.* at 132.
388. *Id.* at 131.

provision meant the insured only had to be a full-time employee for the policy to be effective, while Lincoln argued it meant the insured had to be actually working when a policy was issued and not just have the status of employee.[389] Siding with the plaintiff, the appellate court found the language was ambiguous and held that "full time performance" in the "Active Work and Actively at Work" definition referred to "employment status" and not "actually being on the job at any given moment."[390]

Life policies can be modified by their owners, but the decision in *W. Earl Gaerte Irrevocable Trust v. National Life Insurance Co.*[391] illustrates the problems that can arise when parties fail to follow the proper protocols for doing so.[392] The insurer and life insurance policy trust in *W. Earl Gaerte Irrevocable Trust* entered into a "paid up insurance agreement" on an eleven-year-old policy, agreeing no further premiums would be paid and the policy would stay in force at a specified, reduced face amount.[393] The form necessary to effectuate the agreement required signatures by the trust and any assignees.[394] The trust signed the form and stopped paying premiums, but an assignee-bank never signed.[395] Upon the insured's death, the insurer paid the assignee-bank the pre-agreement face amount, instead of the reduced face value agreed to by the parties, leaving nothing for the trust.[396] The trust then sued, arguing the paid up agreement was invalid and the insurer owed the policy's full original value, less the amount paid to the bank.[397]

On cross-motions for summary judgment, the court rejected the trust's claim that it did not believe the agreement was valid without the bank's signature, noting both that the agreement was unambiguous (rendering the trust's belief irrelevant) and that the trust stopped paying premium consistent with the agreement long before the insured died.[398] The court further rejected the trust's claim that the payment of pre-agreement face amount was "somehow an admission of the fact that the policy['s]" value was never reduced and the paid up agreement was invalid, calling it "far-fetched" since the trust requested the agreement, stopped paying

389. *Id.* at 132.
390. *Id.* at 133.
391. 2015 WL 3605367 (N.D. Ind. June 5, 2015). The insurer in this case was represented by the authors' firm, Chittenden, Murday & Novotny LLC.
392. *Id.* at *1.
393. *Id.*
394. *Id.* at *2.
395. *Id.*
396. *Id.* at *1.
397. *Id.*
398. *Id.* at *3.

premiums, and ultimately benefited from it.[399] In light of those findings, the court granted summary judgment to the insurer.[400]

Misrepresentations on life insurance applications often involve medical issues completely unknown to insurers, but this year at least one case involved a disclosed condition. In *Ramsey v. Penn Mutual Life Insurance Co.*,[401] the insured, who had a history of chronic ulcerative colitis with intestinal resection, applied for a $2 million life insurance policy in February 2010.[402] On the application, the insured identified his condition and that he last saw his physician in 2006.[403] In April and May 2010, the insured visited his physician because of frequent, bloody bowel movements.[404] On June 1, 2010, the insured amended his application, lowering the value of the policy, acknowledging the previous colon resection due to colitis and stating his last colonoscopy was in 2004, and denying any gastrointestinal problems since that time.[405] Shortly thereafter, the insured had surgery, which revealed he had Stage IV metastatic rectal cancer, and he died on September 20, 2011.[406]

The insurer denied the claim for policy benefits due to the insured's misrepresentation in the application amendment that he had no gastrointestinal problems since 2004 because he had been treated for such issues in April and May 2010.[407] While the district court granted the insurer summary judgment on that basis, the Sixth Circuit reversed, finding a fact issue existed because the district court erroneously relied on the insured's original application (not the amendment) in evaluating the case.[408] It also held that the insured's amendment reporting no gastrointestinal problems since his 2004 colonoscopy replaced the original answer, but was not necessarily a misrepresentation since the insurer knew the insured had ulcerative colitis which, under its own guidelines, is "characterized by attacks of bloody diarrhea."[409] The Sixth Circuit held that because the insured was "up front" with the insurer about his condition, whether his rectal bleeding in 2010 was "simply par for the course" or something new was a fact question.[410]

399. *Id.* at *5.
400. *Id.* at *6.
401. 787 F.3d 813 (6th Cir. 2015).
402. *Id.* at 815–16.
403. *Id.* at 816.
404. *Id.* at 817.
405. *Id.*
406. *Id.*
407. *Id.* at 817–18.
408. *Id.* at 818, 820.
409. *Id.*
410. *Id.*

VII. CONCLUSION

A substantial number of decisions come down each survey period in the health, life, and disability insurance practice areas and, acknowledging we cannot discuss them all, we have endeavored to address the most significant. ACA is once again expected to be front and center in the health insurance world in the upcoming year, in light of the Supreme Court's decision to grant certiorari on ACA's contraception mandate and the religious accommodation issue. We also anticipate that the Court's recent ruling in *Montanile* on the type of equitable relief available under § 502(a)(3) of ERISA will continue to make waves in the next survey period.