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

William A. Chittenden, Elizabeth G. Doolin, Julie F. Wall, Joseph R. Jeffery, and Vittorio F. Terrizzi

William A. Chittenden III (wchittenden@cmn-law.com), Elizabeth G. Doolin (edoolin@cmn-law.com), Julie F. Wall (jwall@cmn-law.com), Joseph R. Jeffery (jjeffery@cmn-law.com), and Vittorio F. Terrizzi (vterrizzi@cmn-law.com) are members of Chittenden, Murday & Novotny LLC in Chicago. *The authors wish to thank the following people for their invaluable assistance: Kaitlyn E. Luther, Craig M. Bargher, Matthew H. Bunn, Robert S. Hunger, and Stuart F. Primack.*

I. INTRODUCTION

If an intoxicated insured was speeding along on his motorcycle at 124 miles per hour and died after crashing into a car attempting a U-turn, was his death an "accident"? If an insured had disabling physical conditions but her accompanying mental or nervous conditions contributed to her disability, was she entitled to disability benefits beyond the limited period for which benefits are available for mental and nervous disorders? How did the U.S. Supreme Court address the various Religious Freedom Restoration Act challenges to the contraceptive coverage mandate that is part of the Patient Protection and Affordable Care Act? Can a state in an effort to evaluate the delivery of heath care services to residents compel an ERISA-governed health plan to report claims information to the state, or is such an effort preempted by ERISA? Can a health care provider that submits a claim for payment to the government without disclosing its noncompliance with material statutory, regulatory, or contractual provisions be liable under the federal False Claims Act for submitting a false or fraudulent claim? In cases involving illegal STOLI policies, can an insurer challenge the policy's validity after the applicable contestable period ends?

This year's development of the law of accidental death insurance, disability insurance, ERISA, health insurance, and life insurance was shaped in significant ways by the answers courts provided to those and several other important questions. This article discusses those key developments

and checks in on a number of recurring issues, such as the scope of an intoxication exclusion in an accidental death policy, the sufficiency of an insurer-instigated peer review of a disability claimant's medical records, the availability of conflict-discovery and a party's standing to bring claims under ERISA, and whether an insurer that rescinded a STOLI policy is required to return the premiums paid on that policy.

II. ACCIDENTAL DEATH

As in years past, cases involving accidental death policies decided this survey period presented courts with a variety of unfortunate scenarios, as beneficiaries, insurers, and plan administrators continued to fight over the complex question of "what is an accident?" Courts focused heavily on policy language, showing that accidental death actions are often analyzed on a case-by-case basis. The most notable cases in this review period tackled: (1) what qualifies as an accident, (2) the scope and application of intoxication exclusions, and (3) the impact of illness or medical treatment on accidental death claims.

A. *What Is an Accident?*

Is a drunk driving death accidental? In *Wilson v. Aetna Life Insurance Co.*,[1] the insured died after crashing his motorcycle into another vehicle.[2] The police report estimated that the insured was cruising at 124 miles per hour when he hit a car attempting to make a U-turn; toxicology reports revealed the insured's blood alcohol content was 0.246.[3] The ERISA-governed accidental death plan defined "accident" as "a sudden external trauma that is; unexpected; and unforeseen."[4] Aetna, the administrator, denied the beneficiary's claim, in part on the grounds that the insured's drunk driving crash was not an accident.[5]

Applying the arbitrary and capricious standard of review on cross-motions for summary judgment, the court found the administrator's benefit denial was not arbitrary and capricious.[6] It referenced two lines of cases that: (1) applied a reasonably foreseeable test (i.e., death is not accidental because death is reasonably foreseeable when one drinks and drives) or (2) considered whether the insured's death "resulted from" driving while intoxicated.[7] The court concluded that under either standard the administrator's decision was reasonable and supported by substantial evi-

1. 2016 WL 5717370 (N.D.N.Y. Sept. 30, 2016).
2. *Id.* at *1.
3. *Id.* at *2.
4. *Id.* at *9.
5. *Id.* at *3.
6. *Id.* at *4, *9.
7. *Id.* at *9–10.

dence.[8] In so holding, it emphasized the insured's extreme intoxication and excessive speed, suggesting that courts should consider the unique circumstances behind each claim, and insurers or administrators should do more than focus on intoxication alone.[9] The *Wilson* court further noted that the administrator acted properly even under a de novo standard of review.[10] A reasonable person, it found, would have viewed the resulting injury or death as substantially certain to result from the insured's conduct, given the excessive speed of travel and the insured's intoxication.[11]

Of course, not all alcohol-related deaths involve driving. In *Wagner v. Minnesota Life Insurance Co.*,[12] the insured quit drinking, but then passed away after experiencing significant withdrawal symptoms over the course of several days.[13] An autopsy found no evidence of any injury or suspicious circumstances, and the insured's death certificate listed hemorrhagic pancreatitis, steatosis, and chronic alcohol abuse as causes of her death.[14] The beneficiary filed a claim under an ERISA-governed accidental death rider, which provided coverage when death "results, directly and independently of all other causes, from an accidental injury which is unintended, unexpected, and unforeseen."[15]

To determine whether the insured's death was an accident, the court employed a subjective/objective test which asked: (1) whether the insured subjectively lacked an expectation of death or injury and (2) whether a reasonable person would have viewed the death as substantially certain to result from the insured's conduct.[16] Reviewing Minnesota Life's decision to deny benefits under a de novo standard, the district court concluded that the insured's death was accidental.[17] It analogized the circumstances presented to cases finding deaths by autoerotic asphyxiation and inadvertent overdoses to be accidental and concluded the insured subjectively expected to live because, despite her withdrawal symptoms, the evidence

8. *Id.*

9. *Id.* at *10. The court took judicial notice of the fact that the risk of being involved in a fatal crash increases as one's blood alcohol content increases, noting "[t]he extent of the risk will of course vary from case to case," and held that the administrator "did not solely rely on the fact that the [insured] was extremely intoxicated." *Id.*

10. *Id.*

11. *Id.* at *11.

12. 184 F. Supp. 3d 845 (D. Mont. 2016).

13. *Id.* at 847.

14. *Id.*

15. *Id.* at 846, 848.

16. *Id.* at 850. This is the same subjective/objective test the *Wilson* court applied; the *Wilson* court, however, employed the objective test only because it was unable to determine the insured's subjective expectations. Wilson v. Aetna Life Ins. Co., 2016 WL 5717370, at *11 (N.D.N.Y. Sept. 30, 2016).

17. *Wagner*, 184 F. Supp. 3d at 852.

suggested she quit drinking in order to improve her health.[18] That expectation also satisfied the test's objective prong because any reasonable person would believe what the insured apparently believed: that one quits drinking to improve her health and withdrawal symptoms will be temporary.[19] While the insured's death was deemed accidental, the court nevertheless concluded that Minnesota Life appropriately denied benefits because the insured's alcoholism qualified as a bodily infirmity, illness, or disease under a policy exclusion.[20]

The U.S. District Court for the Northern District of Indiana examined how a death involving marijuana was treated under an accidental death policy—an issue that may become increasingly common given the recent legalization of marijuana in certain jurisdictions. In *Werbianskyj v. Zurich American Insurance Co.*,[21] a maintenance employee installing a light fixture was electrocuted and died after he touched exposed wires.[22] An autopsy report showed his blood tested positive for THC (the active chemical in cannabis), Quant 5.8 ng/mL.[23] The insured's ERISA benefits plan provided accidental death coverage for "injury directly caused by accidental means which is independent of all other causes," and defined "accident" as "a sudden, unexpected, specific, and abrupt event that occurs by chance at an identifiable time and place."[24] The administrator denied the benefit claim following the insured's death, in part because the electrocution was not independent of all other causes (i.e., the effects of marijuana use).[25]

Applying the arbitrary and capricious standard of review, the district court granted summary judgment to the plan administrator.[26] It largely based its holding on the administrator's showing that the event was not sudden or unexpected because an experienced maintenance employee would know not to touch exposed wires, and individuals with THC levels similar to the insured's would have difficulty concentrating and paying at-

18. *Id.* Conversely, in *Leonard v. General Electric Co.*, 2016 WL 4098713 (D. Mass. July 28, 2016), an insured with a long history of alcohol abuse and alcohol-related illnesses died, and his death certificate listed "hepatorenal failure due to cirrhosis due to alcohol abuse" as the "immediate cause" of death and "hypertension and splenic rupture" as "other significant conditions contributing to death." *Id.* at *3. The beneficiary argued the insured's death was accidental because he may have fallen and this fall caused the spleen to rupture. *Id.* at *7. The court found that even if the fall did occur, it happened when the insured was drinking so heavily he could not remember whether he had fallen. Reviewing the underlying claim denial under an abuse of discretion standard, the court refused to award benefits because the insured's death was caused by alcohol intoxication. *Id.* at *7 n.5.

19. Wagner v. Minn. Life Ins. Co., 184 F. Supp. 3d 845, 852 (D. Mont. 2016).

20. *Id.* at 852–53.

21. 2016 WL 4076367 (N.D. Ind. Aug. 1, 2016).

22. *Id.* at *1.

23. *Id.* at *2.

24. *Id.* at *2, *4.

25. *Id.* at *5.

26. *Id.* at *8.

tention to detail.[27] The beneficiary, moreover, did not present any evidence that the event was *not* foreseeable.[28] Notably, while an exclusion barring coverage resulting from the insured "being under the influence of any . . . narcotic, or hallucinogen" applied, the court suggested the presence of THC in the maintenance employee's system, coupled with the administrator's proof of foreseeability, likely would have been sufficient to deny the claim without applying the exclusion because the event was not an "accident."[29]

Aside from substance-related deaths, courts have continued to express some skepticism that a fatal embolism triggered by prolonged sitting could qualify as an accident. In *Estate of Filek v. National Union Fire Insurance Co. of Pittsburgh, PA*,[30] an insured truck driver suffered a pulmonary embolism while sitting in the cab of his truck.[31] The insured showed no signs of trauma, and the coroner testified that the insured's embolism was "strongly related" to his occupation as a truck driver, which involved sitting for extended periods.[32] The relevant policy included an accidental death benefit that covered "bodily injury to an Insured Person caused by an Occupational accident," but did not specifically define the term "accident."[33] Referencing *Bliss v. National Union Fire Insurance Co. of Pittsburgh, PA*[34] and applying Michigan law, the court found that the policy required the pulmonary embolism to have been caused by an "unexpected or unusual" external event and that the insured's prolonged sitting in his truck was not unexpected or unusual; indeed, the risk of a pulmonary embolism was well-known among truck drivers.[35] The court also found that the insured's death by pulmonary embolism fell under the policy's "sickness, disease or infections" exclusion.[36]

B. *Intoxication Exclusions*

The substance-related death cases discussed above all examined whether the deaths were "accidental." In addition to requiring a finding of whether an event was an "accident," however, many accidental death policies con-

27. *Id*. at *2, *8.
28. *Id*. at *8.
29. *Id*.
30. 2016 WL 5477222 (E.D. Mich. Sept. 29, 2016).
31. *Id*. at *1.
32. *Id*. at *2.
33. *Id*. at *10.
34. 132 F. Supp. 3d 676 (D. Md. 2015). *Bliss* is discussed in last year's survey article. *See* William A. Chittenden III, Elizabeth G. Doolin, Julie F. Wall & Joseph R. Jeffery, *Recent Developments in Health, Life, and Disability Insurance*, 51:2 TORT TRIAL & INS. PRAC. L.J. 475 (2015).
35. Estate of Filek v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 2016 WL 5477222, at *10 (E.D. Mich. Sept. 29, 2016).
36. *Id*. at *12.

tain exclusions that may avoid coverage. As in years past, during this survey period courts worked to determine the boundaries of such exclusions.

Norvell v. Metropolitan Life Insurance Co.[37] demonstrated the importance of scientific evidence in establishing intoxication. There, a dependent insured under his wife's accidental death policy drank alcohol on a nightly basis but, one night, did not have any alcohol in his house.[38] After his wife went to bed, the insured intentionally drank antifreeze from a spray bottle of Prestone Ice and Frost Shield.[39] The insured was found incoherent the following morning and died in a hospital a few days later.[40] His death certificate listed methanol poisoning as his cause of death.[41] The insured's methanol blood alcohol level was .333 grams per 100 milliliters, according to MetLife.[42] A doctor hired by MetLife concluded that the insured drank fourteen to twenty-five ounces of antifreeze, and that the methanol caused intoxication and the insured's death.[43]

MetLife denied the subsequent claim for benefits, in part under an exclusion which barred coverage for deaths "resulting from . . . intoxication" as defined "under the laws of the jurisdiction in which the incident occurred."[44] The insured consumed the antifreeze in Maryland, which recognizes a legal presumption of intoxication at a BAC of 0.08 grams per 100 milliliters and defines alcohol to include methanol.[45] MetLife argued that the insured's methanol level satisfied Maryland's intoxication statute.[46] The court, however, denied MetLife's summary judgment motion, finding fact questions existed as to whether the insured was intoxicated and whether his death "resulted from" his intoxication.[47] The beneficiary and MetLife set forth different methods of measuring the insured's methanol levels—with MetLife advocating the blood alcohol level of .333 grams per 100 milliliters and the beneficiary relying on the insured's alcohol serum level, which was less than .01 grams per milliliter.[48] The court also found that because the same liquid intoxicated *and* poisoned the insured, MetLife was unable to demonstrate the insured died from intoxication and not poisoning.[49] In other words, the amount of antifreeze needed

37. 2015 WL 6549274 (D. Md. Oct. 28, 2015).
38. *Id.* at *2.
39. *Id.*
40. *Id.*
41. *Id.* at *2–3.
42. Norvell v. Metro. Life Ins. Co., 2015 WL 6549274, at *3 (D. Md. Oct. 28, 2015).
43. *Id.* at *3, *6.
44. *Id.* at *6.
45. *Id.*
46. *Id.*
47. *Id.* at *7.
48. *Id.*
49. *Id.* The court appears to have relied, at least in part, on the beneficiary's assertion that a fatal dose of antifreeze is two ounces, while it would take eight ounces to reach intoxication.

to kill the insured may have been less than the amount needed to render him legally intoxicated.

C. *Illness or Medical Treatment*

While some courts question whether a pulmonary embolism qualifies as an accident, in *Prather v. Sun Life Financial Distributors, Inc.*,[50] the U.S. District Court for the Central District of Illinois pondered whether something other than an accident caused a pulmonary embolism.[51] There, the insured ruptured his Achilles tendon while playing basketball.[52] About five days later, the insured told his doctor that he was experiencing swelling and was concerned about developing a blood clot; he had surgery to repair his tendon the next day.[53] Although the surgery had "no operative complications," the insured suffered a pulmonary embolism and died approximately two weeks later.[54] The death certificate designated the cause of death as "accidental" and the postmortem report indicated the cause of death was "pulmonary embolism resulting from deep vein thrombosis due to a left Achilles tendon rupture."[55] A forensic pathologist reached a similar conclusion.[56]

The insured's ERISA-governed plan provided coverage for injuries that "result directly from an accident and independently of all other causes," but excluded "any loss that is caused, either directly or indirectly, or contributed to, by" "physical or mental infirmity or disease" or "medical or surgical treatment."[57] The beneficiary argued that the insured died as a direct result of the accident-related injury and would have been at a higher risk of developing a pulmonary embolism with conservative treatment and no surgery.[58] The administrator denied benefits because, in its view, the deep vein thrombosis and pulmonary embolism resulted from the surgery.[59]

In other words, the insured would have died before he became intoxicated. *Id.* at *8. MetLife also argued the dependent's death was not an accident because, even if he did not intend to commit suicide, drinking antifreeze poses a serious foreseeable risk of injury or death. *Id.* ("whether the intentional act caused a foreseeable injury"). Somewhat surprisingly, the court found that, although the antifreeze bottle contained a skull and crossbones and various warning language, "a genuine issue of material fact remains regarding whether or not [the warnings] were insufficient to put someone on alert as to the danger, particularly someone who was unfamiliar with the product." *Id.*

50. 174 F. Supp. 3d 1022 (C.D. Ill. 2016).
51. *Id.* at 1028–30.
52. *Id.* at 1025.
53. *Id.*
54. *Id.*
55. *Id.* at 1025–26.
56. Prather v. Sun Life Fin. Distribs., Inc., 174 F. Supp. 3d 1022, 1026 (C.D. Ill. 2016).
57. *Id.* at 1024.
58. *Id.* at 1028.
59. *Id.*

Both parties in *Pranther* sought summary judgment and, the district court, reviewing the administrator's decision under the arbitrary and capricious standard, sided with the administrator.[60] The court found that the beneficiary acknowledged: (1) that the insured died of a known complication of the surgery;[61] and (2) that no medical evidence supported the beneficiary's argument that the insured developed a blood clot before surgery (i.e., the insured's conversation with his doctor did not suffice).[62] The court based its holding on the breadth of the plan's language and reasoned that, even though the basketball-related injury was a but-for cause of the insured's death, it was undisputed that the surgery also contributed to his death.[63] The administrator accordingly had a reasonable basis to find (1) the insured's death did not result directly from an accident and independently of all other causes; and (2) the death was caused, at least indirectly, or contributed to, by medical or surgical treatment.[64]

The court in *Hagen v. Aetna Insurance Co.*[65] similarly had to determine whether an illness contributed to an insured's death.[66] The insured fell and injured his hip.[67] He had a lengthy history of health maladies: he was a smoker and an alcoholic, previously suffered from lung cancer, had a deep vein thrombosis in his leg, and had chronic obstructive pulmonary disorder (COPD).[68] The insured underwent hip surgery following his fall and died several weeks later.[69] An autopsy found that the cause of death was "complications of blunt force trauma of lower extremity with intertrochanteric fracture of femur," listed COPD, alcoholism, and cardiovascular disease as contributory causes, and designated "Accident (Fell)" as the manner of death.[70]

The insured's ERISA-governed plan provided benefits if death was a "direct result of a bodily injury suffered in an accident" and defined "accident" as "a sudden external trauma that is: unexpected; unforeseen; and is an identifiable occurrence or event producing . . . objective symptoms of a[n] external bodily injury" not "due to, or contributed by, an illness or disease of any kind."[71] The plan administrator denied the beneficiary's claim because the insured's various illnesses contributed to his death.[72]

60. *Id.* at 1031.
61. *Id.* at 1029.
62. *Id.*
63. *Id.*
64. *Id.* at 1029–30.
65. 808 F.3d 1022 (5th Cir. 2015).
66. *Id.* at 1030–31.
67. *Id.* at 1025.
68. *Id.*
69. *Id.*
70. Hagen v. Aetna Ins. Co., 808 F.3d 1022, 1025 (5th Cir. 2015).
71. *Id.* at 1030.
72. *Id.*

Applying an abuse of discretion standard, the Fifth Circuit affirmed the district court's grant of summary judgment to the administrator.[73] Two days before his fall, the insured's doctor documented that the insured was fatigued and dizzy. Moreover, medical records after the insured's fall revealed that he could not walk long distances on account of his COPD, he had a history of falling, and at one point he said he purportedly fell because he was "somewhat dazed."[74] Further, no evidence in the administrative record suggested that the insured tripped on or over something, potentially indicating an accident.[75]

III. DISABILITY

Disability decisions made this survey period addressed a variety of subjects, including a claimant's ability to perform any occupation and the timing of a disability's onset. Courts also examined mental illness as a source of disability; the sufficiency of evidence under the own occupation standard; the sufficiency of peer reviews conducted by insurers; the interaction between an exclusion for claims payable as workers' compensation and a state law requiring work-related disability claims to proceed under workers' compensation law; and the recurring clash between subjective complaints and objective evidence of a disability.

A. *Any Occupation*

Courts found disability benefits were payable this year where claimants could not perform any occupation because the insured could not engage in the identified occupational alternatives or the insurer disregarded critical evidence establishing the claimant's inability to work. In *Halley v. Aetna Life Insurance Co.*,[76] the plaintiff's job as a vice president for sales required him to travel and carry out administrative tasks.[77] He stopped working after being diagnosed with multiple spinal disorders and osteoarthritis.[78] The plaintiff received long-term disability (LTD) benefits for three years under the policy's own occupation standard; the standard then changed and he could only continue to receive benefits if he was totally disabled from "any reasonable occupation" that paid more than 80 percent of his pre-disability earnings.[79] Aetna discontinued benefits after concluding the plaintiff was capable of "full-time employment in a sedentary role."[80]

73. *Id.* at 1027, 1030–31.
74. *Id.* at 1031.
75. *Id.*
76. 141 F. Supp. 3d 855 (N.D. Ill. 2015).
77. *Id.* at 857–58.
78. *Id.* at 857.
79. *Id.*
80. *Id.* at 865.

The district court agreed that the plaintiff could transition to working eight hour days with some limitations,[81] but found that although he was "capable of working in theory," he qualified as disabled under the plan because no reasonable occupation was available to him based on the identified replacement occupations (each was a high-level executive position).[82] Even if the plaintiff could work forty hours per week from a qualitative perspective, he could not perform the occupational alternatives from a quantitative perspective because they would require more than 40 hours of work per week.[83] The court also held that while the plaintiff could perform some sedentary work, the identified occupational alternatives required more physical activity than he could exert.[84]

Similarly, in *Young v. Aetna Life Insurance Co.*,[85] the insurer paid the participant's benefits during the three-year "own occupation" period, but terminated the benefits thereafter because Aetna found the participant was not prevented from "work[ing] at any reasonable occupation[.]"[86] The participant, a nurse, was injured in multiple car accidents.[87] The first accident resulted in injuries to her neck, back, shoulder, and hip. The participant required shoulder surgery and faced additional problems with pain radiating to her lower extremities.[88] A second car accident caused increased pain in the participant's back and buttocks, resulting in additional surgeries.[89] After the own-occupation period expired, Aetna terminated the benefits, concluding the participant could engage in sedentary work and, thus, could work at a reasonable occupation.[90] The participant sued to reinstate benefits.[91]

Finding for the participant on summary judgment, the court held that Aetna abused its discretion in denying benefits. Aetna did so by ignoring evidence of disability and "choosing instead to rely selectively on discrete findings, which appear reasonable when sewn together," but ultimately "are highly questionable when viewed in the context of the entire record."[92] Critical information related to the insured's ability to work, such as the "sedation, 'dopiness,' and 'mental dulling'" that she experienced from her medication for chronic pain was not appropriately considered in the court's

81. Halley v. Aetna Life Ins. Co., 141 F. Supp. 3d 855, 866 (N.D. Ill. 2015).
82. *Id.* at 869–70.
83. *Id.* at 870–71.
84. *Id.* at 872.
85. 146 F. Supp. 3d 313 (D. Mass. 2015).
86. *Id.* at 315.
87. *Id.* at 316.
88. *Id.*
89. *Id.* at 317.
90. Young v. Aetna Life Ins. Co., 146 F. Supp. 3d 313, 321–23 (D. Mass. 2015).
91. *Id.* at 328.
92. *Id.* at 330–31.

view.[93] The court further acknowledged that the opinions of treating physicians were not to be accorded special weight, but observed that the treating physicians' records uniformly established the plaintiff's disability.[94] The court further found that evaluations showing the participant was incapable of performing full-time sedentary work had been dismissed without explanation.[95]

B. *Disability Onset*

In *Cheney v. Standard Insurance Co.*,[96] the Seventh Circuit wrestled with determining when the claimant, a longtime appellate lawyer and partner at a large law firm, became disabled from work and whether she met the policy's disability definition.[97] The claimant, who dealt with back and spine issues for years, maintained that she became disabled on December 20, 2011, before starting an agreed upon leave from January 3, 2012, to July 2012.[98] Coverage ended under the policy either upon termination of employment or on the date the individual ceased being a "member."[99] Being a member required "active work," defined as being able to perform the material duties of one's own occupation at his or her usual place of business.[100] At issue here was whether the claimant was a "member" and, thus, actively working when she became disabled.[101]

After a trial based on a stipulated paper record, the district court determined that the claimant was a "member" at the time of her disability and was therefore entitled to benefits.[102] The Seventh Circuit, however, remanded the case for a new trial to determine if the evidence supported the timing of the onset of disability. The claimant argued that she was on leave when she became disabled, but never defined what type of leave she was on or if she became disabled before her leave started but after her last day of work on December 19, 2011.[103] The Seventh Circuit also sought a determination of whether the claimant met the policy's definition of "disabled."[104] Under the policy, if the insured's occupation required a license, the definition of occupation was "as broad as the scope of [the] license;" it was unclear whether the claimant was unable to work at

93. *Id.* at 335.
94. *Id.* at 331.
95. *Id.* at 335.
96. 831 F.3d 445 (7th Cir. 2016).
97. *Id.* at 447.
98. *Id.* at 447–48.
99. *Id.* at 449.
100. *Id.* at 448.
101. Cheney v. Standard Ins. Co., 831 F.3d 445, 450 (7th Cir. 2016).
102. *Id.* at 449.
103. *Id.* at 451.
104. *Id.* at 452.

any job as an attorney or if she was simply unable to be a partner at a large law firm.[105]

C. *Mental Health*

During this survey period, courts also considered how mental illness impacted disability coverage, such as whether mental illness was the source of a claimed disability and whether a mental illness was caused by other ailments. In *Okuno v. Reliance Standard Life Insurance Co.*,[106] Reliance denied the insured's LTD claim, finding her depression and anxiety contributed to her disabling conditions, which included Crohn's disease, narcolepsy, and an autoimmune disease.[107] The LTD plan limited benefits to twelve months where total disability was "caused by or contributed to by mental or nervous disorders," such as depression and anxiety disorders.[108] The district court granted judgment on the administrative record for Reliance, concluding that regardless of her other physical diagnoses, the insured also suffered from psychiatric conditions.[109]

The Third Circuit reversed, however, holding that where a claimant is "disabled by physical conditions alone, the mere presence" of a psychological condition does not justify applying the twelve-month limitation.[110] The Third Circuit held it would "follow the analyses of our sister circuits and apply the but-for inquiry to the Mental and Nervous Disorders Limitation"[111] where "an application is not appropriately denied on the basis that a mental or nervous disorder 'contributes to' a disabling condition; rather, the effect of an applicant's physical ailments must be considered separately to satisfy the requirement that review be reasoned and deliberate."[112] The court then remanded the case for further examination of whether the insured's physical diagnoses disabled her "apart from any alleged mental component."[113]

In *McAlister v. Liberty Life Assurance Co.*,[114] the plaintiff sued when her LTD benefits were discontinued after twenty-four months under the plan's mental illness exclusion.[115] The plan defined mental illness as a

105. *Id.*
106. 836 F.3d 600 (6th Cir. 2016).
107. *Id.* at 603–04.
108. *Id.* at 603.
109. *Id.* at 608–09.
110. *Id.* at 607.
111. *Id.* at 609 (citing George v. Reliance Standard Life Ins. Co., 776 F.3d 349 (5th Cir. 2015); Maurer v. Reliance Standard Life Ins. Co., 500 F. App'x 626 (9th Cir. 2012); Gunn v. Reliance Standard Life Ins. Co., 399 F. App'x 147 (9th Cir. 2010); Michaels v. Equitable Life Assurance Soc'y, 305 F. App'x 896 (3d Cir. 2009)).
112. *Okuno*, 836 F.3d at 609.
113. *Id.* at 612.
114. 647 F. App'x 539 (6th Cir. 2016).
115. *Id.* at 540.

"psychiatric or psychological condition," as classified in the most recent DSM "regardless of the underlying cause of the Mental Illness."[116] The plaintiff, who also suffered from uncontrolled diabetes, hypertension, and hypercholesterolemia, argued that the twenty-four-month period did not apply to mental illnesses with an "organic" cause.[117] She claimed that such an organic cause existed in her case, citing her physician's opinion that her condition was a "due to 'physiological effect of a general medical condition.'"[118] Several medical professionals, including her own, however, determined that she suffered from either major depressive disorder or borderline personality disorder, which she did not dispute.[119] The district court ruled in Liberty Life's favor and the Sixth Circuit affirmed, finding insufficient evidence for the plaintiff's "organic" cause theory.[120] Furthermore, the Sixth Circuit found that substantial evidence confirmed that the plaintiff suffered from mental illness and, thus, the denial of benefits beyond twenty-four months was supported.[121]

D. *Own Occupation*

In *Duda v. Standard Insurance Co.*,[122] the court held that the claimant was not entitled to LTD benefits under his ERISA plan or his personal policies pursuant to state law.[123] The claimant was an orthopedic surgeon who earned his income from several related sources, including participating in an orthopedic practice with his treating physician and conducting independent medical evaluations.[124] After the claimant fell and injured his wrist, he sought disability benefits claiming he was unable to perform the material duties of his own occupation because he could not perform surgery.[125] Standard denied coverage because he did not provide "satisfactory written proof" of a disability.[126] Specifically, Standard found that the claimant did not provide contemporaneous medical documentation supporting his claim, apart from a letter from his partner and treating physician.[127] The district court granted summary judgment to Standard and the Third Circuit affirmed, finding that even if the phrase "satisfactory written proof" was ambiguous, under the arbitrary and capricious standard Standard's decision was not unreasonable in light of the lack of med-

116. *Id.*
117. *Id.* at 542–43, 545.
118. *Id.* at 543, 545.
119. *Id.* at 546.
120. *Id.* at 545.
121. *Id.* at 546–47, 549.
122. 649 F. App'x 230 (3d Cir. 2016).
123. *Id.* at 232.
124. *Id.* at 231.
125. *Id.* at 232.
126. *Id.*
127. *Id.* at 235–36.

ical records.[128] Disability claims made under the claimant's personal policies also failed because the claimant could not establish he was unable to "perform some of the main duties of his occupation."[129] While the claimant maintained that he could not perform surgery due to his injury, the Third Circuit found that surgery was only a small portion of his duties and therefore not "the exclusive 'main duty' of his regular occupation."[130]

E. *Peer Review*

The appropriateness of insurers' reliance on retained physicians and peer reviewers to support benefit denials was also an issue in disability cases this year. In *Young v. United of Omaha Life Insurance Co.*,[131] the court criticized the insurer for advocating for its denial of benefits in communications with its retained neurologist, whose opinion originally supported the claimant's request for benefits.[132] The claimant alleged that she was unable to work at her sedentary job as a computer database systems engineer due to frequent headaches and neck and shoulder pain and, therefore, she was entitled to LTD benefits.[133] To qualify as disabled under the policy, the insured had to be unable to perform "at least one of the Material Duties" of her regular occupation.[134] The claimant's physician found that her ailments were more likely than not caused by her work, relying in part on an MRI that showed multiple disc bulges, protrusions, and canal stenosis, and concluded that sitting at a computer for any length of time triggered the claimant's headaches.[135]

The insurer then sent the claimant to its retained neurologist who reviewed the MRI and essentially supported the claimant's position. The neurologist found that the claimant should not sit frequently or flex her neck "such as would occur with looking down or looking up for more than 15 minutes in an hour."[136] The retained neurologist found no inconsistencies in the claimant's clinical presentation and diagnosed her with chronic back pain, degenerative disc disease, and chronic headaches related to spine and neck conditions.[137] In response, the insurer sent the neurologist a surveillance video and asked what the court found "could generously be called leading" questions that were "reflective of bias and in-

128. *Id.* at 236.
129. *Id.*
130. *Id.*
131. 165 F. Supp. 3d 984 (E.D. Wash. 2016).
132. *Id.* at 987–88, 991.
133. *Id.* at 987.
134. *Id.* at 989.
135. *Id.* at 987.
136. Young v. United of Omaha Life Ins. Co., 165 F. Supp. 3d 984, 987 (E.D. Wash. 2016).
137. *Id.*

tended to reach a desired conclusion."[138] For example, the insurer asked the neurologist if it was "inconsistent" with "her complaints of neck pain" to walk a medium sized dog and asked that the neurologist "comment on these apparent inconsistencies."[139] The neurologist then changed his opinion regarding the claimant's head and neck condition, finding no "evidence of a physically based medical condition."[140] Criticizing the insurer for "taking an advocacy position towards a conclusion of non-disability," the court granted the claimant's motion for judgment on the record, holding the surveillance video was irrelevant because it did "not depict activity inconsistent with her reported limitations" related to the claimant's own occupation.[141]

In *Cannon v. PNC Financial Services Group*,[142] the insurer's reliance on a peer review was not enough for the court to uphold its benefit denial.[143] The claimant sued to recover LTD benefits after a hysterectomy, claiming she could not return to her sedentary job due to abdominal and pelvic pain.[144] The plan provided twenty-four months of disability benefits should a claimant be unable to perform the "material or essential" duties of her "own occupation."[145] The insurer denied her claim based on a reviewing physician's determination that her impairments were "subjective complaints of abdominal pain, [with] no clear etiology."[146] Although the district court granted judgment on the administrative record for the insurer, the Sixth Circuit reversed.[147] It found that the insurer essentially ignored the claimant's complaints that pelvic pain rendered her unable to sit because it did not consider two related diagnoses—pudendal neuralgia and pelvic floor muscle dysfunction—or her physician's correspondence explaining that the diagnoses resulted from her hysterectomy.[148] The court remanded the claim to the insurer "for a full and fair inquiry into her claim" for benefits.[149]

Where objective medical evidence could not definitively resolve whether the claimant could return to work, the Eighth Circuit upheld the denial of benefits.[150] In *Whitley v. Standard Insurance Co.*,[151] the insurer denied the plaintiff's claim based on its reviewing physicians' opinions that she could

138. *Id.* at 988.
139. *Id.*
140. *Id.*
141. *Id.* at 991.
142. 645 F. App'x 344 (6th Cir. 2016).
143. *Id.* at 346–47.
144. *Id.* at 344.
145. *Id.* at 345.
146. *Id.* at 345–46.
147. *Id.* at 346–47.
148. *Id.* at 346.
149. *Id.* at 347.
150. Whitley v. Standard Ins. Co., 815 F.3d 1134, 1142 (8th Cir. 2016).
151. *Id.* at 1134.

perform her own occupation.[152] The plaintiff, an emergency room physician who suffered a concussion in a car accident, claimed she was entitled to LTD benefits because she was unable to work full-time in her own occupation.[153] She received LTD benefits for a short time, but her physicians eventually found that she had recovered from the concussion and could return to work on a part-time basis, provided she had supervision to determine whether she could perform her job duties.[154] Standard's physician reviewers disputed that such supervision was necessary.[155] The plaintiff then fell and had knee surgery.[156] One of her physicians subsequently determined she was totally disabled due to her knee and the earlier brain injury.[157] Standard's reviewing physicians disagreed, finding she could return to work as a physician on a full-time basis.[158] Reversing the district court's grant of summary to the claimant, the Eighth Circuit held that Standard's denial of benefits was not an abuse discretion.[159]

F. *Policy Exclusions*

The court in *Foltz v. Barnhart Crane & Rigging, Inc.*[160] considered whether a disability policy would come into play where Tennessee law required that all work-related claims proceed under the state's applicable workers' compensation law.[161] The claimant was working at an oil refinery when he was exposed to "vapor, chemical or toxic substance" and began to have difficulty breathing. He was then hospitalized with life threatening respiratory issues and for a time was in a medically induced coma.[162] The claimant sought disability benefits, asserting that his disability was related to his occupation, but his policy excluded benefits resulting from disease, sickness, or illness, which are otherwise "payable under any Worker's Compensation Act or any Occupational Disease Act or any such similar law."[163] The plan denied the claim, determining the disability was work-related and covered by Tennessee's Workers' Compensation Law.[164] The district court granted summary judgment to the plan, finding its benefit decision was not arbitrary and capricious.[165] The Sixth Circuit held

152. *Id.*
153. *Id.* at 1136–37.
154. *Id.* at 1137.
155. Whitley v. Standard Ins. Co., 815 F.3d 1134, 1137–38 (8th Cir. 2016).
156. *Id.* at 1138.
157. *Id.*
158. *Id.* at 1139.
159. *Id.* at 1142.
160. 636 F. App'x 677 (6th Cir. 2016).
161. *Id.* at 678.
162. *Id.* at 679.
163. *Id.*
164. *Id.*
165. Foltz v. Barnhart Crane & Rigging, Inc., 636 F. App'x 677, 680 (6th Cir. 2016).

that the district court erred in requiring that the claimant prove he was entitled to benefits, instead of requiring that the plan prove that an exclusion applied.[166] It affirmed the district court's ruling, however, concluding that regardless of this error, the record clearly established the exclusion applied because Tennessee's Workers' Compensation Law covered the claimant's work-related injuries.[167]

G. *Subjective-Objective Evidence*

In *Street v. Aetna Life Insurance Co.*,[168] the court insisted on objective evidence to support the claimant's disability claim and ruled in the insurer's favor because the claimant did not supply such evidence.[169] The claimant, a senior business systems advisor with FedEx, had an intrailac thromboembolism.[170] She also suffered from emphysema, hypertension, chronic obstructive pulmonary disease, and weakness and numbness in her thighs.[171] LTD benefits were terminated after two years when the plan's disability definition changed from own occupation to any occupation, requiring objective proof of a disability that would prevent her from working at least twenty-five hours per week.[172] Although the claimant maintained she could not walk, stand, or sit, there was no objective medical evidence to support her complaints.[173]

To support its denial, Aetna relied on an in-person exam of the claimant where the physician determined she could engage in sedentary work.[174] The physician conducting a peer review also found that the claimant's medical conditions would not preclude her from performing "any occupation" as defined by the plan.[175] Aetna explained that there was no objective medical evidence supporting either the claimant's assertion that she could not walk or stand for more than a short period, or her claim that her ailments would prevent her from working at any occupation.[176] In ruling for Aetna on its summary judgment motion, the district court found that although the claimant was diagnosed with numerous ailments, a diagnosis alone does not establish disability.[177] The court further explained that a claimant's subjective complaints do not turn into objective ones simply because a physician records them;[178] the claimant did not carry her burden of proving her dis-

166. *Id.* at 680–81.
167. *Id.* at 681.
168. 188 F. Supp. 3d 1279 (M.D. Fla. 2016).
169. *Id.* at 1287–88.
170. *Id.* at 1282.
171. *Id.*
172. *Id.*
173. Street v. Aetna Life Ins. Co., 188 F. Supp. 3d 1279, 1283 (M.D. Fla. 2016).
174. *Id.*
175. *Id.*
176. *Id.* at 1283–84.
177. *Id.* at 1286.
178. *Id.*

ability "by only pointing to doctors' notes that included a diagnosis or her own subjective complaints."[179]

IV. ERISA

The ERISA decisions this year touched on perennial favorites. ERISA preemption was before the U.S. Supreme Court, with the Court finding that ERISA preempted a state statute requiring ERISA-governed health plans to register and report claims information to the state. Conflict of interest-related discovery continues to be a frequently addressed topic, along with the applicable standard of review, preemption, limitations periods, and standing.

A. *What Is the "Plan Document" and Does It Grant Discretionary Authority?*

ERISA requires that a plan be maintained pursuant to a written document, but does not specify what it considers a plan document.[180] A grant of discretion may be derived from any number of plan documents, including the plan itself, summary descriptions, and related contracts.[181] Not all summary plan descriptions are plan documents, however, and whether one is a plan document for purposes of determining the appropriate standard of review is determined on a case-by-case basis.[182]

In *Noah U. v. Tribune Co. Medical Plan*,[183] the court considered whether a summary plan document (SPD) was part of the plan when determining the standard of review.[184] The general plan SPD[185] provided that "if there is a 'conflict between the contents of this SPD and the contents of the Plan, your rights shall be determined under the Plan and not this SPD."[186] Noting that SPDs are generally not part of the plan unless expressly incorporated into the plan, the court found that because the SPD lacked language suggesting it was incorporated into the plan, it was not a plan document.[187]

Similarly, in *Bochniarz v. Prudential Insurance Co. of America*,[188] the court determined that the SPD was not a "plan document" because the

179. *Id.*
180. Rothe v. Duke Energy Long Term Disability Plan, 2016 WL 5661686, at *2 (S.D. Ohio Sept. 30, 2016).
181. Pettit v. Life Ins. Co. of N. Am., 2016 WL 3668022, at *5 (D. Md. July 11, 2016) (citing Klebe v. Mitre Grp. Health Care Plan, 894 F. Supp. 898, 902 (D. Md. 1995), *aff'd*, 91 F.3d 131 (4th Cir. 1996)).
182. US Airways, Inc. v. McCutchen, 2016 WL 1156778, at *7–9 (W.D. Pa. Mar. 16, 2016).
183. 138 F. Supp. 3d 1134 (C.D. Cal. 2015).
184. *Id.* at 1145.
185. There were multiple SPDs at issue in this case. *Id.* at 1137–41.
186. *Id.* at 1140.
187. *Id.* at 1145.
188. 2015 WL 8516432 (W.D.N.Y. Dec. 11, 2015).

plan contract at issue identified the specific documents that made up the "plan" without reference to the SPD.[189] Further, the SPD stated that it was not part of the group insurance certificate and provided that it was only included in the booklet given to employees due to the employer's request.[190] The court accordingly disregarded the grant of discretionary authority in the SPD, the only document containing such language, and reviewed the decision de novo.[191]

In contrast, the SPD in *Rose v. Liberty Life Assurance Co. of Boston*[192] was expressly incorporated into the plan document and granted discretionary authority.[193] Accordingly, the arbitrary and capricious standard of review applied.[194] In *Pettit v. Life Insurance Co. of North America*,[195] the plan's integration clause provided that "[t]he entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Employees [Insureds]."[196] As a result, the court could not consider a separate "appointment of claim fiduciary form," which contained the discretionary authority language, to be a "plan document."[197]

Whether a plan document properly grants discretionary authority is, of course, another issue. In *Doe v. Blue Cross & Blue Shield of Rhode Island*,[198] the court held that the grant of discretion must be both unambiguous and specific as to the authority granted.[199] It also rejected the notion that language providing the "power to decide . . . necessarily implies the existence of discretion"[200] and held that "[r]easonable alternative interpretations of the plan language are not sufficient to require discretionary review by this Court."[201] A grant of discretionary authority must be "express."[202]

Under the discretionary standard, a court's review of an ERISA claim is generally limited to the administrative record with some exceptions addressed below.[203] The purpose of this limitation is to "ensure expeditious

189. *Id.* at *2.
190. *Id.*
191. *Id.*
192. 2016 WL 1178801 (W.D. Ky. Mar. 23, 2016).
193. *Id.* at *2.
194. *Id.*
195. 2016 WL 3668022 (D. Md. July 11, 2016).
196. *Id.* at *2.
197. *Id.* at *6.
198. 2016 WL 4223331 (D.R.I. Aug. 9, 2016).
199. *Id.* at *2.
200. *Id.*
201. *Id.* at *1.
202. Rose v. Liberty Life Assurance Co. of Bos., 2016 WL 1178801, at *1 (W.D. Ky. Mar. 23, 2016).
203. *See, e.g.*, Nelson v. Blue Cross & Blue Shield of Neb., 2015 WL 5943469, at *1 (D. Neb. Oct. 13, 2015); Logan v. AT&T Umbrella Benefit Plan No. 3, 2016 WL 5462972, at *3 (N.D. Ohio Sept. 28, 2016).

judicial review of ERISA benefit decisions and to keep district courts from becoming substitute plan administrators."[204] As the court in *Blair v. Metropolitan Life Insurance Co.* found, once a final denial of an ERISA claim is issued and the plaintiff is advised that she has exhausted her administrative remedies, a plaintiff's subsequent submissions to support her benefits claim, even if voluntarily accepted by the administrator, do not expand the scope of the record for determining liability under ERISA.[205]

B. *Conflict of Interest Discovery*

More than eight years after the Supreme Court's decision in *Metropolitan Life Insurance Co. v. Glenn*,[206] whether to allow discovery outside the administrative record continues to be an issue.[207] While discovery in ERISA-governed disputes is generally confined to the administrative record, limited discovery outside of the record is permitted when "offered in support of a procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part."[208]

One of the predominant discovery-related questions posed this survey period is whether discovery outside of the administrative record is appropriate if there is a structural conflict of interest (i.e., the party evaluating a claim would also pay the benefits). Some courts require a claimant to show more than just the "mere presence" of a structural conflict of interest before discovery is allowed.[209] A claimant in the Northern District of Illinois must offer "specific factual allegations of misconduct or bias" by identifying "a specific conflict of interest or instance of misconduct" and making a "prima facie showing that there is good cause to believe that limited discovery will reveal a procedural defect in the plan administrator's

204. *Nelson*, 2015 WL 5943469, at *1 (quoting Brown v. Seitz Foods, Inc. Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998).

205. 167 F. Supp. 3d 1272, 1277 (N.D. Ala. Mar. 2, 2016).

206. 554 U.S. 105 (2008).

207. *See, e.g.*, Davis v. Hartford Life & Accident Ins. Co., 2015 WL 7571905, at *1 (W.D. Ky. Nov. 24, 2015).

208. *Id.* (quoting Johnson v. Conn. Gen. Life Ins. Co., 324 F. App'x. 459, 466 (6th Cir. 2009)).

209. Greer v. Hartford Life & Accident Ins. Co., 2009 WL 1620402, at *5 (E.D. Mich. June 9, 2009) ("[D]iscovery should be allowed where a plaintiff has provided sufficient initial facts suggesting a likelihood that probative evidence of bias or procedural deprivation would be developed."); *see also* Corey v. Sedgwick Claims Mgmt. Servs., 2015 WL 9206490, at *2 (N.D. Ohio Dec. 17, 2015) (the plaintiff's request for discovery was denied because he did not offer any evidence to suggest that the plan's decision was the result of bias, conflict, or procedural irregularity); Kim v. Life Ins. Co. of N. Am., 2015 WL 7074278, at *2 (C.D. Cal. Nov. 5, 2015) (an insurance company's dual role as plan administrator and payor alone is insufficient to warrant additional discovery); Weddington v. Aetna Life Ins. Co., 2015 WL 6407764, at *3 (N.D. Ill. Oct. 21, 2015) (plaintiff cannot obtain discovery merely by pointing to a structural conflict).

determination."[210] Under these guidelines, a structural conflict of interest does not per se constitute good cause to consider evidence outside of the administrative record.[211]

At the opposite end of the spectrum, some courts have found that "the act of denying discovery until there has been an initial showing of bias 'essentially handcuffs the plaintiff, who . . . will rarely have access to any evidence beyond a bare allegation of bias, in the absence of discovery pursuant to Fed. R. Civ. P. 26(b).'"[212] Accordingly, those courts found the mere presence of a structural conflict of interest sufficient to allow discovery outside of the administrative record.[213]

There appears to be little chance in the near term for bright-line rules governing when discovery into a structural conflict of interest is appropriate. One court found this survey period that no special standard is required for resolving such a conflict in the Tenth Circuit, where "the court is not to apply special rules for discovery relating to a dual role conflict of interest, but to consider the requested discovery pursuant."[214] There, the court reviewed whether the discovery requested was "relevant to any party's claim or defense and proportional to the needs of the case"—

210. Dragus v. Reliance Standard Life Ins. Co., 2016 WL 3940106, at *2 (N.D. Ill. July 21, 2016); *see also* Johnston v. Commerce Bancshares, Inc., 2016 WL 4083492, at *2 (W.D. Mo. Aug. 1, 2016) (plaintiff should be permitted to conduct discovery into the extent of the administrator's conflict if he shows good cause); Proffitt v. Metro. Life Ins. Co., 2016 WL 880520, at *1 (M.D. Tenn. Mar. 8, 2016) (finding an exception to the general rule that discovery is limited to the administrative record when evidence is "offered in support of a procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part"); Nguyen v. Sun Life Assurance Co. of Can., 2015 WL 6459689, at *1 (N.D. Cal. Oct. 27, 2015) (the plaintiff has not "clearly established" that evidence outside the existing administrative record is "necessary to conduct an adequate [ ] review of the benefit decision").

211. Feltington v. Hartford Life Ins. Co., 2016 WL 1056568, at *8 (E.D.N.Y. Mar. 15, 2016); U.S. Renal Care, Inc. v. Wellspan Health, 2016 WL 1162268, at *5 (M.D. Pa. Mar. 24, 2016); *see also* Nicholas v. Cigna Life Ins. Co. of N.Y., 2016 WL 755612, at *2 (D. Mass. Feb. 25, 2016).

212. Myers v. Anthem Life Ins. Co., 316 F.R.D. 186, 195, at *5 (W.D. Ky. Mar. 22, 2016) (citation omitted); *see also* Scott-Warren v. Liberty Life Assurance Co. of Bos., 2016 WL 3866617, at *5 (W.D. Ky. July 13 2016) (allowing the claimant to seek discovery because she sufficiently alleged a conflict of interest where defendant was the "underwriter, insurer and administrator of the disability insurance policy"); Card v. Principal Life Ins. Co., 2016 WL 1298723, at *3 (E.D. Ky. Mar. 31, 2016) (declining to adopt threshold evidentiary showing of bias as prerequisite to discovery).

213. *See* Mullins v. Prudential Ins. Co. of Am., 267 F.R.D. 504, 510 (W.D. Ky. 2010) ("The mere existence of an inherent conflict of interest that arises when the same entity is both plan administrator and benefits payor is itself the 'threshold.' ERISA plaintiffs need do no more than show the existence of such inherent conflict in order to obtain discovery."); *see also Myers*, 316 F.R.D. at 195; Blackwell v. Liberty Life Assurance Co. of Bos., 2016 WL 3004568, at *7 (W.D. Ky. May 20, 2016).

214. Rickaby v. Hartford Life & Accident Ins. Co., 2016 WL 1597589, at *2 (D. Colo. Apr. 21, 2016); *see also* Curtis v. Metro. Life Ins. Co., 2016 WL 687164, at *4 (N.D. Tex. Feb. 19, 2016).

the standard established for discovery in any federal lawsuit by Rule 26 of the Federal Rules of Civil Procedure.[215]

C. *Preemption*

In *Gobeille v. Liberty Mutual Insurance Co.*,[216] the U.S. Supreme Court found, in a six-to-two decision authored by Justice Kennedy, that ERISA preempted a Vermont statute and regulation to the extent they required ERISA-governed health plans to register and report payments relating to health care claims and other information relating to health care services to a state agency for compilation in an all-inclusive health care database.[217] The Court held that preemption was necessary because the law attempted to regulate ERISA's reporting, disclosure, and recordkeeping requirements, which are "central matter[s] of plan administration," and improperly "interfered"[218] with the uniform system of plan administration by imposing on plans "novel, inconsistent, and burdensome reporting requirements."[219] In so holding, the Court noted the relevant inquiry is not only whether the objective or purpose of a state law differs from that of ERISA, but also includes an examination of the nature of the effect of the state law on ERISA plans.[220] If the burden imposed by a state law would be too great, the law has an "impermissible 'connection with'" an ERISA plan and is preempted.[221]

A few months after the *Gobeille* decision, the Sixth Circuit held that a Michigan law was not preempted because it did not impose any administrative burdens beyond those prescribed by ERISA and did not interfere with a uniform system of plan administration.[222] The Michigan law at issue in *Self-Insurance Institute of America, Inc. v. Snyder*[223] required every carrier and third-party administrator (TPA) to submit quarterly returns and to "keep accurate and complete records and pertinent documents."[224] The thrust of this law, as noted by the court, was to "collect taxes—not to amass data."[225] Similarly, the record keeping requirement was viewed as a "peripheral requirement[ ] that do[es] not warrant preemption."[226] As a result, the state law had only a tangential effect on ERISA plans, and ERISA's express-preemption provision was not implicated.[227]

215. *Rickaby*, 2016 WL 1597589, at *2; FED. R. CIV. P. 26.
216. 136 S. Ct. 936 (2016).
217. *Id.* at 939.
218. *Id.* at 945 (quoting Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001)).
219. *Id.*
220. *Id.* at 946.
221. *Id.* at 943.
222. Self-Ins. Inst. of Am., Inc. v. Snyder, 827 F.3d 549, 553 (6th Cir. 2016).
223. 827 F.3d 549 (6th Cir. 2016).
224. *Id.* at 553.
225. *Id.* at 558.
226. *Id.*
227. *Id.* at 557.

As these cases establish, ERISA preempts state laws that directly regulate integral aspects of ERISA plan administration.[228] During this survey period, courts rejected parties' claims that contract provisions in the plan should be interpreted to prevent ERISA preemption, however.[229] In *Hendrickson v. United of Omaha Life Insurance Co.*,[230] the federal district court rejected the plaintiff's argument that state law, not ERISA, governed the parties' dispute because the policy stated it was "issued in and is subject to Nebraska law."[231] According to the plaintiff, this provision meant his state law breach of contract claim was not preempted by ERISA.[232] The court disagreed, explicitly rejecting the contention that the parties could "contract[ ] around" ERISA by including a state law choice of law provision in the policy.[233] "[A] choice of law provision cannot serve as a waiver of ERISA's broad preemptive power."[234] The court in *Zgrablich v. Cardone Industries, Inc.*[235] similarly rejected the plaintiff's contention that the plan's choice-of-law provision constituted a waiver of an ERISA preemption defense because it required that the case be resolved under state rather than federal law.[236]

D. *Standing*

The cases during this survey period reveal a lack of continuity in the way federal courts analyze standing under ERISA. In *American Psychiatric Ass'n v. Anthem Health Plans, Inc.*,[237] the Second Circuit relied on the Supreme Court's decision in *Lexmark International, Inc. v. Static Control Components, Inc.*[238] to find that standing under ERISA is based on whether a plaintiff has a claim under ERISA.[239] In *Lexmark*, the Supreme Court considered a manufacturer's standing to assert a claim against a supplier under the Lanham Act.[240] The Court rejected arguments that prudential or statutory standing principles were relevant; the operative question, according to the Court, was simply whether the manufacturer fell within the class of plaintiffs Congress authorized to sue under the Lanham Act

228. *Id.*
229. Zgrablich v. Cardone Indus., Inc., 2016 WL 427360, at *8 (E.D. Pa. Feb. 3, 2016); Hendrickson v. United of Omaha Life Ins. Co., 2016 WL 389974, at *2 (D. Neb. Feb. 1, 2016).
230. 2016 WL 389974 (D. Neb. Feb. 1, 2016).
231. *Id.* at *2.
232. *Id.*
233. *Id.*
234. *Id.*
235. 2016 WL 427360 (E.D. Pa. Feb. 3, 2016).
236. *Id.* at *3–4.
237. 821 F.3d 352 (2d Cir. 2016).
238. 134 S. Ct. 1377 (2014).
239. *Am. Psychiatric Ass'n*, 821 F.3d at 359.
240. *Lexmark*, 134 S. Ct. at 1383.

and, thus, whether the manufacturer had a cause of action under the statute.[241]

In *American Psychiatric Ass'n*, psychiatrists sued for themselves and their patients, alleging the reimbursement practices of the defendant health insurers violated ERISA by discriminating against patients with mental health and substance abuse disorders.[242] The psychiatrists argued that their patients had ERISA claims and that prudential standing principles afforded them standing to assert those claims for their patients.[243] The district court rejected the psychiatrists' standing arguments and dismissed the action for failure to state a claim.[244] On appeal, the Second Circuit cited to *Lexmark* and observed: "[t]he Supreme Court has recently clarified . . . that what has been called 'statutory standing' in fact is not a standing issue, but simply a question of whether the particular plaintiff 'has a cause of action under the statute.'"[245] It then re-framed the issue to ask whether the psychiatrists fell "within the class of plaintiffs whom Congress has authorized to sue" and, thus, whether they had a cause of action under ERISA.[246] Because the psychiatrists were not within the class of plaintiffs authorized to sue under ERISA, they did not have a claim under ERISA § 502(a)(3) irrespective of whether they could stand in the shoes of their patients in other matters.[247]

While the Second Circuit disavowed further use of the phrase "statutory standing,"[248] many district courts still use it when considering ERISA standing issues.[249] More significant than the courts' language, however, is the fact that they apply different legal standards to analyze standing. In *American Psychiatric Ass'n*, the Second Circuit construed *Lexmark* to mean federal courts must *not* couch standing in terms of Article III subject matter jurisdiction.[250] Rather, courts should simply inquire whether the plaintiff

241. *Id.* at 1387.

242. Am. Psychiatric Ass'n v. Anthem Health Plans, 821 F.3d 352, 355 (2d Cir. 2016).

243. *Id.* at 360.

244. *Id.* at 356–57.

245. *Id.* at 359 (quoting Lexmark Int'l, Inc. v. Static Control Components, Inc., 134 S. Ct. 1377, 1387 (2014)).

246. *Id.* at 360 (quoting *Lexmark*, 134 S. Ct. at 1387–88).

247. *Id.*; *see also* Farm Bureau Gen. Ins. Co. of Mich. v. Blue Cross Blue Shield of Mich., 655 F. App'x 483, 487–89 (6th Cir. 2016) (rejecting plaintiff's argument that because it did not fall into one of the plaintiff categories under ERISA, the court should "craft a remedy under federal common law" to allow plaintiff's claim and concluding because plaintiff is "a non-participant, non-beneficiary, and non-assignee," it "has no standing to assert a claim under ERISA § 502(a)(1)(B)").

248. Am. Psychiatric Ass'n v. Anthem Health Plans, 821 F.3d 352, 359 (2d Cir. 2016).

249. *See*, *e.g.*, Norris v. Mazzola, 2016 WL 1588345, at *2 (N.D. Cal. Apr. 20, 2016) ("To establish standing to sue under ERISA, that is, statutory standing, a former employee such as Plaintiff must make a 'colorable claim' that he is a plan participant.") (citation omitted); Hart v. Nationwide Mut. Ins. Co., 2016 WL 1161594, at *3 (E.D. Mo. Mar. 23, 2016) ("To bring a civil action under ERISA, a plaintiff must have statutory standing.").

250. *Am. Psychiatric Ass'n*, 821 F.3d at 359.

may maintain a substantive cause of action under ERISA.[251] The district court in *Norris v. Mazzola*[252] agreed, stating "ERISA statutory standing is a substantive element of an ERISA claim rather than a subject matter jurisdiction question," and therefore, a "motion to dismiss for lack of statutory standing is reviewed under the Rule 12(b)(6) standard rather than 12(b)(1)."[253] In *Connecticut General Life Insurance Co. v. Southwest Surgery Center*,[254] however, the court analyzed ERISA standing under Rule 12(b)(1), viewing the issue, in part, as one of subject matter jurisdiction.[255] After finding the complaint sufficiently alleged that the plaintiff was a fiduciary that could sue under § 502(a)(3), the court concluded that because the plaintiff "has standing under both Article III and ERISA, [the plaintiff] has properly established that this Court has subject matter jurisdiction over the complaint."[256]

E. *Contractual Limitations and Statutes of Limitations*

An ERISA claim for benefits accrues when a plaintiff has knowledge of a clear repudiation or denial of benefits.[257] Defeating an untimely claim at the motion to dismiss stage can be difficult, however, if the complaint—whether from shrewdness or poor drafting—does not allege facts demonstrating the date the claim accrued and the untimeliness of the action. In *Tolleson v. Kraft Foods Global, Inc.*,[258] the court denied the defendants' motion to dismiss because the complaint did not state the date of the second appeal determination, which was needed to determine whether the complaint was timely, and "[d]efendants ask[ed] the Court to assume the date of the determination based on the Plan requirements and find the complaint was time-barred."[259] It would be contrary to the standard for 12(b)(6) motions to dismiss, the court found, to "dismiss a complaint based on assumed facts that are offered by the Defendants and are unsupported by any exhibit" or "penalize Plaintiffs for failing to allege dates that show the complaint was filed within the statute of limitations."[260]

251. *Id.* ("This inquiry 'does not belong' to the family of standing inquiries . . . because 'the absence of a valid cause of action does not implicate subject matter jurisdiction . . . .'") ((quoting Lexmark Int'l, Inc. v. Static Control Components, Inc., 134 S. Ct. 1377, 1386 n.4, 1387 (2014)).

252. 2016 WL 1588345 (N.D. Cal. Apr. 20, 2016).

253. *Id.* at *2.

254. 2015 WL 6560536 (N.D. Ill. Oct. 29, 2015).

255. *Id.* at *4.

256. *Id.*

257. *See* Clouthier v. Becker, 2016 WL 245157, at *4 (W.D.N.Y. Jan. 21, 2016); Jammal v. Am. Family Ins. Grp., 2016 WL 165447, at *3 (N.D. Ohio Jan. 14, 2016); Baker v. Hartford Life & Accident Ins. Co., 2016 WL 721024, at *3 (D. Mont. Jan. 1, 2016); Rogers v. Metro. Life Ins. Co., 2015 WL 7076643, at *5 (N.D. Miss. Nov. 10, 2015).

258. 2016 WL 4439951 (N.D. Ill. Aug. 23, 2016).

259. *Id.* at *3.

260. *Id.*

A participant successfully argued that a statute of limitations accrued after a re-calculation of benefits in *Patrick v. Reliance Standard Life Insurance Co.*[261] Reliance approved the participant for LTD benefits, but subsequently reduced her benefits under a rehabilitation provision and rejected her appeal of this reduction.[262] It later determined that the participant received other income due to her ownership interest in a company and reduced her benefits pursuant to an offset provision in the plan, which she appealed as well.[263] One issue before the court related to this benefit reduction was whether, using Delaware's one-year statute of limitations for claims for recovery of benefits, the participant's claim accrued at the time of the initial or subsequent appeal.[264] The court found that, on the second appeal, Reliance retroactively recalculated the participant's LTD benefits based on a new formula prepared by an accountant and that the decision to recalculate the participant's benefits "equates to a new adverse benefits determination."[265] Consequently, the court held the participant's challenge to Reliance's recalculation was not barred by the one-year limitations period.[266]

In other cases decided during this survey period, participants argued a contractual limitations defense was waived[267] or unenforceable because of a controlling state statute of limitations,[268] but those arguments were unsuccessful.

F. *Prejudgment Interest*

Courts have broad discretion to determine whether to award prejudgment interest and to determine the parameters of any such award.[269] The rationale for awarding prejudgment interest is to ensure an injured party is fully compensated.[270] Interest is considered "an element of compensation,

261. 2016 WL 4573877, at *8–9 (D. Del. Aug. 31, 2016).
262. *Id.* at *2–3.
263. *Id.* at *4.
264. *Id.* at *7–8.
265. *Id.* at *8.
266. *Id.*
267. *See* Upadhyay v. Aetna Life Ins. Co., 645 F. App'x 569, 570–71 (9th Cir. 2016) (holding that "Aetna did not waive its contractual limitations defense despite failing to inform Upadhyay, in its denial letters, of the Plan's contractual limitations period for filing suit under ERISA" because the contractual limitations period had already run when Aetna sent the denial letters).
268. *See* Smith v. Boeing Co., 2016 WL 892749, at *3 (N.D. Tex. Mar. 9, 2016) (determining that Texas statute prohibiting the shortening of statutes of limitations was not binding on ERISA claim).
269. Adele E. v. Anthem Blue Cross & Blue Shield, 2016 WL 3647150, at *1 (D. Me. June 30, 2016); Reg'l Emp'rs Assurance Leagues Voluntary Emp.'s Beneficiary Ass'n Trust, 2016 WL 540817, at *2 (E.D. Pa. Feb. 20, 2016); Gurasich v. IBM Ret. Plan, 2016 WL 3683044, at *3 (N.D. Cal. July 12, 2016).
270. *Adele E.*, 2016 WL 3647150, at *1; *Reg'l Emp'rs*, 2016 WL 540817, at *2 (prejudgment interest is generally awarded when the amount of the underlying liability is reasonably

not a penalty."[271] A defendant's conduct may influence whether a court awards prejudgment interest, but it should not influence the rate of the interest.[272] The court should choose a prejudgment interest rate that compensates the claimant for the losses incurred as a result of the nonpayment of benefits and nothing more.[273]

To obtain an award that includes prejudgment interest, a plaintiff must show that benefits were wrongfully withheld.[274] Following the Sixth Circuit's well-known decision to vacate a decision granting a multi-million dollar disgorgement award,[275] on remand the district court in *Rochow v. Life Insurance Co. of North America*[276] considered whether pre-judgment interest was appropriate to make the plaintiff whole for the insurer's failure to pay benefits.[277] The court found prejudgment interest was warranted because there was no question that the defendant "incorrectly and wrongfully" withheld benefits from the plaintiff "from the moment" it refused to recognize him as disabled.[278] Similarly, the court in *Adele E. v. Anthem Blue Cross & Blue Shield*[279] awarded prejudgment interest because the defendant erroneously denied benefits and the plaintiff incurred significant out-of-pocket expenses as a result.[280]

G. *Attorney-Client Privilege and the Fiduciary Exception*

The U.S. District Court for the Southern District of New York analyzed whether the fiduciary exception to the attorney-client privilege applies calls for "a 'fact-specific inquiry' that focuses on 'both the content and context of the specific communication.'"[281] In *Leber v. Citigroup 401(K) Plan Investment Committee*,[282] the plaintiffs sought documents related to Citigroup's response to media inquiries about the financial institution's use of proprietary funds in their 401(k) plans. The media's questions were forwarded to Citigroup's senior deputy counsel, who directed

capable of assessment and the relief granted would otherwise fall short of making the claimant whole because he or she has been denied the use of the money which was legally due).

271. Barboza v. Cal. Ass'n of Prof'l Firefighters, 144 F. Supp. 3d 1151, 1158 (2015).

272. *Id.*

273. *Id.*

274. Rochow v. Life Ins. Co. of N. Am., 2016 WL 5476240, at *3 (E.D. Mich. Sept. 29, 2016).

275. Rochow v. Life Ins. Co. of N. Am., 780 F.3d 364, 366 (6th Cir.), *cert. denied*, 136 S. Ct. 480 (2015).

276. 2016 WL 5476240 (E.D. Mich. Sept. 29, 2016).

277. *Id.* at *3.

278. *Id.*

279. 2016 WL 3647150 (D. Me. June 30, 2016).

280. *Id.* at *1.

281. Leber v. Citigroup 401(K) Plan Inv. Comm., 2015 WL 6437475, at *2 (S.D.N.Y. Oct. 16, 2015) (quoting Asuncion v. Metro. Life Ins. Co., 493 F. Supp. 2d 716, 720 (S.D.N.Y. 2007)).

282. *Id.* at *1.

other in-house lawyers to gather facts regarding investment options provided to participants in Citigroup's 401(k) plan.[283] In later communications, counsel discussed aspects of the 401(k) plan's administration with various Citigroup employees to formulate responses to the media inquiries.[284] Communications concerning plan administration typically fall within the fiduciary exception and, therefore, are not privileged.[285] While the subject of the requested documents "related to plan administration, in that the content of the documents discussed the way in which fiduciary duties were carried out,"[286] the substance of the communications alone was not dispositive; rather, the underlying context and purpose of the communication was deemed just as important.[287] The fiduciary exception "does not apply where a plan administrator seeks legal advice for its own benefit or protection."[288] Here, because the purpose of the documents "was to manage the public relations impact and potential litigation risk occasioned by what was expected to be a negative news article about the inclusion of proprietary funds in 401(k) plans,"[289] the fiduciary exception did not apply and the documents were privileged.[290]

Also in *Leber*, the plaintiffs sought an email in which an executive requested legal advice from in-house counsel "regarding the authority of senior management with respect to a certain aspect of Plan administration," namely, an issue concerning selection of funds for 401(k) plans.[291] The plaintiffs argued that the fiduciary exception applied because the executive was seeking legal advice on behalf of the CEO, who had fiduciary obligations due to his authority to hire and fire members of the plan's committee.[292] The court rejected that argument as overly broad, however.[293] The court acknowledged that "the authority to select or supervise fiduciaries gives rise to fiduciary obligations,"[294] but because that authority related only to the ability to hire and fire committee members, Citigroup's fiduciary obligations extended only to those acts.[295] The email's subject matter, the selection of funds for 401(k) plans, had nothing to do with the nar-

283. *Id.* at *3.
284. *Id.*
285. *Id.* at *1.
286. Leber v. Citigroup 401(K) Plan Inv. Comm., 2015 WL 6437475, at *4 (S.D.N.Y. Oct. 16, 2015).
287. *Id.*
288. *Id.*
289. *Id.*
290. *Id.*
291. Leber v. Citigroup 401(K) Plan Inv. Comm., 2015 WL 6437475, at *6 (S.D.N.Y. Oct. 16, 2015).
292. *Id.*
293. *Id.* at *7.
294. *Id.*
295. *Id.*

row circumstances under which Citigroup's executives exercised their fiduciary responsibilities.[296] Accordingly, the fiduciary exception did not apply and the motion to compel production of the email was denied.[297]

During this survey period courts rejected attempts to set forth a bright-line test for the fiduciary exception. In *Sender v. Franklin Resources Inc.*,[298] the plaintiff argued for a per se rule where *any* documents created during the period of administrative review must be disclosed per the fiduciary exception because the insurer is under a duty to act as the insured's fiduciary during that time period.[299] The court rejected that argument, finding that "no such per se rule exists," and that analysis of a fiduciary exception requires a close evaluation of the relevant communication's content.[300] While the court acknowledged that the timing of a communication—before or after the final benefits determination—was a "strong indicator of whether the exception will apply," it explained that such a finding was not dispositive and that the overall context for the communication was more important.[301]

In *A.F. v. Providence Health Plan*,[302] the defendant argued that "unless and until a claim is made under an employer's benefit Plan," the provider's fiduciary duty to an individual plaintiff is not triggered.[303] The court declared that argument "unavailing," finding the defendant "acted as a fiduciary with respect to each Plaintiff's Plan when it made its company-wide decisions regarding" a certain therapy for which the plaintiffs sought coverage under the plan.[304] The court did not decide whether the subject communications were privileged or subject to the fiduciary exception, however, opting instead to refer the matter to an appointed special master for initial determination after in camera review and inspection.[305]

H. *Section 1132(c)(1) Statutory Penalties for Full and Fair Review*

Courts this survey period considered whether the statutory penalties for failing to comply with a participant's document request may be assessed against an entity acting as a de facto plan administrator or against the named plan administrator only. Many courts look to the plain meaning of the phrase "plan administrator" to find that penalties can be assessed

296. *Id.*
297. *Id.*
298. 2016 WL 1257930 (N.D. Cal. Mar. 30, 2016).
299. *Id.* at *2.
300. *Id.*
301. *Id.* (quoting Klein v. Nw. Mut. Life Ins. Co., 806 F. Supp. 2d 1120, 1133 (S.D. Cal. 2011)).
302. 173 F. Supp. 3d 1061 (D. Or. Mar. 24, 2016).
303. *Id.* at 1077.
304. *Id.* at 1079.
305. *Id.* at 1080–82.

against only entities fitting that description.[306] In contrast, two district courts in the Fifth Circuit allowed for the possibility that statutory penalties could be assessed against de facto plan administrators. In *Dunnam v. Reliance Standard Life Insurance Co.*,[307] Reliance moved to dismiss the statutory claim against it by arguing it was not the plan administrator.[308] Citing governing Fifth Circuit precedent, the court believed liability turned on whether the plan contemplated allowing the plan administrator to transfer authority and responsibility for plan administration to another entity and whether the plan administrator in fact delegated those duties to another entity.[309] Because the complaint "plausibly suggest[ed]" the plan administrator "may have delegated administrative authority and duties to Reliance," and because the plaintiff alleged sufficient facts to support a claim that Reliance acted as a de facto administrator of the plan, the court denied Reliance's motion to dismiss. The court described Reliance's arguments as raising issues "best resolved after discovery and on a motion for summary judgment, not at the 12(b)(6) motion to dismiss stage."[310]

Another district court in Texas similarly recognized the possibility of de facto plan administrator liability.[311] In *Simmons v. Outreach Health Community Care Services LP*,[312] the court observed that other circuits allow claims for de facto plan administrator liability and that the plaintiff alleged facts sufficient to support a claim that Outreach Health acted as a de facto administrator of the plan.[313] As a result, the court denied the defendant's motion to dismiss for failure to state a claim.[314]

V. HEALTH INSURANCE

In news relating to the Patient Protection and Affordable Care Act (ACA), the Supreme Court remanded cases addressing the contraceptive coverage mandate to their respective circuit courts to explore a negotiated resolution. Other courts this survey period limited state legislation that impinged on the ACA and dismissed actions challenging specific ACA provisions. In non-ACA developments, the Supreme Court resolved a circuit

306. *See, e.g.*, Lin v. Metro. Life Ins. Co., 2016 WL 1611036, at *3 (N.D. Cal. Apr. 22, 2016) ("It is well settled that a claim for penalties under 29 U.S.C. § 1132(c)(1) can be brought only against the plan administrator to whom the document request was submitted. Neither of the Defendants is alleged to be a plan administrator." (citations omitted)).

307. 2016 WL 492411 (E.D. Tex. Jan. 21, 2016).

308. *Id.* at *4.

309. *Id.* at *5–6.

310. *Id.* at *6.

311. *See* Simmons v. Outreach Health Cmty. Care Servs. LP, 2016 WL 3162147, at *7 (W.D. Tex. June 3, 2016).

312. 2016 WL 3162147 (W.D. Tex. June 3, 2016).

313. *Id.* at *7.

314. *Id.* at *8.

split over the False Claims Act in a manner that broadens its application, while also clarifying the Act's terms, such as the definition of materiality, in a way that cabins liability under the Act.

A. *Supreme Court Remands RFRA Challenges to the ACA Contraceptive Coverage Accommodation*

The Supreme Court granted petitions for certiorari to review challenges to the ACA's contraceptive coverage mandate.[315] The mandate, imposed by the ACA and federal regulations,[316] requires employers, including religious non-profit employers, to include benefits for FDA-approved contraceptives in their health plans.[317] Federal regulations seek to accommodate employers' religious objections to the mandate's directives by requiring them to provide written notice that they object to providing contraceptive services on religious grounds.[318] In that case, the insurer of the employer's health plan steps in and assumes responsibility for providing coverage and handling benefit payments.[319]

In the Third, Fifth, Tenth, and D.C. Circuits, non-profit religious employers challenged the accommodation,[320] arguing that submitting the required notice substantially burdened their exercise of religion in violation of the Religious Freedom Restoration Act of 1993 (RFRA).[321]

315. Geneva Coll. v. Burwell, 136 S. Ct. 445 (2015); Zubik v. Burwell, 136 S. Ct. 444, (2015); E. Tex. Baptist Univ. v. Burwell, 136 S. Ct. 444 (2015); Little Sisters of the Poor Home for the Aged, Denver v. Burwell, 136 S. Ct. 446 (2015); S. Nazarene Univ. v. Burwell, 136 S. Ct. 445 (2015); Priests for Life v. Dep't of Health & Human Servs., 136 S. Ct. 446 (2015); Roman Catholic Archbishop v. Burwell, 136 S. Ct. 444 (2015); Zubik v. Burwell, 136 S. Ct. 1557, 1559–60 (2016).

316. *See Zubik*, 136 S. Ct. at 1559; *see also* Geneva Coll. v. Sec'y U.S. Dep't of Health & Human Servs., 778 F.3d 422, 427–30 (3d Cir. 2015), *cert. granted in part sub nom. Zubik*, 136 S. Ct. 444, *and cert. granted sub nom. Geneva Coll.*, 136 S. Ct. 445, *and vacated and remanded sub nom. Zubik*, 136 S. Ct. 1557.

317. *See Zubik*, 136 S. Ct. at 1559.

318. *Id.* The eligible organization can submit a statement in writing to the Secretary of Health and Human Services or complete the Department of Labor's EBSA Form 700, which identifies the organization and certifies its eligibility for the accommodation. 45 C.F.R. § 147.131(c) (2015); 29 C.F.R. § 2590.715-2713A(b) (2015).

319. *See* 45 C.F.R. § 147.131(c) (2015); 29 C.F.R. § 2590.715-2713A(b) (2015).

320. *See Geneva Coll.*, 778 F.3d 422, *cert. granted in part sub nom. Zubik*, 136 S. Ct. 444, and *cert. granted sub nom. Geneva Coll.*, 136 S. Ct. 445 *and vacated and remanded sub nom. Zubik*, 136 S. Ct. 1557; E. Tex. Baptist Univ. v. Burwell, 793 F.3d 449 (5th Cir. 2015), *cert. granted*, 136 S. Ct. 444, *and vacated and remanded sub nom. Zubik*, 136 S. Ct. 1557, *and cert. granted, judgment vacated sub nom.* Univ. of Dallas v. Burwell, 136 S. Ct. 2008 (2016); Little Sisters of the Poor Home for the Aged, Denver, Colo. v. Burwell, 794 F.3d 1151 (10th Cir. 2015), *cert. granted sub nom. S. Nazarene Univ.*, 136 S. Ct. 445, *and cert. granted in part sub nom. Little Sisters of the Poor*, 136 S. Ct. 446, *and vacated and remanded sub nom. Zubik*, 136 S. Ct. 1557; Priests for Life v. U.S. Dep't of Health & Human Servs., 772 F.3d 229 (D.C. Cir. 2014), *cert. granted sub nom. Roman Catholic Archbishop*, 136 S. Ct. 444, *and cert. granted sub nom. Priests for Life*, 136 S. Ct. 446, *and vacated and remanded sub nom. Zubik*, 136 S. Ct. 1557.

321. *Zubik*, 136 S. Ct. at 1559.

The Supreme Court granted certiorari in those cases at the start of this survey period.[322]

In an unusual twist, the Supreme Court requested supplemental briefing after initial oral argument.[323] Specifically, it asked the parties to address "whether contraceptive coverage could be provided to petitioners' employees through petitioners' insurance companies, without any such notice from petitioners."[324] The government, in its supplemental brief, emphasized the distinction between fully insured plans and self-insured plans, noting that insured plans could switch to a "no notice" procedure "in which the employer could opt out by asking an insurer for a policy that excluded contraceptives to which it objects," rather than completing the self-certification form.[325] The government nevertheless objected to such a "no notice" procedure, maintaining that the existing accommodation procedure "provides clarity and certainty for all parties" and is "minimally intrusive" to the religious non-profit organizations.[326]

The government argued that the Supreme Court's proposal would likely not work.[327] In a self-insured plan, the employer is the insurer so the only separate entity that can handle contraceptive coverage is the plan's third party administrator (TPA).[328] "[T]o relieve self-insured employers of any obligation to provide contraceptive coverage . . . the accommodation establishes a mechanism for the government to designate the employer's TPA as a 'plan administrator' responsible for separately providing the required coverage under . . . ERISA."[329] Under the existing accommodation and ERISA, this designation must take place in writing so the accommodation requires that the self-insured plan provide some amount of notice.[330] Self-insured employers thus cannot opt out of mandatory contraceptive coverage "by simply informing their TPAs that they do not want to provide coverage for contraceptives."[331] The government anticipated those arguments and observed that employers that objected to the self-insured accommodation procedures had the option of switching to an insured plan.[332]

322. *Geneva Coll.*, 136 S. Ct. 445; *Zubik*, 136 S. Ct. 444; *E. Tex. Baptist Univ.*, 136 S. Ct. 444; *Little Sisters of the Poor*, 136 S. Ct. 446; *S. Nazarene Univ.*, 136 S. Ct. 445; *Priests for Life*, 136 S. Ct. 446; *Roman Catholic Archbishop*, 136 S. Ct. 444; *see Zubik*, 136 S. Ct. at 1559–60.

323. *Zubik*, 136 S. Ct. at 1559–60.

324. *Id.* (internal quotation marks omitted).

325. Supp. Br. for the Respondents at 2, *Zubik*, 136 S. Ct. at 1557 (Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, 15-191), 2016 WL 1445915, at *2 (U.S. Apr. 12, 2016).

326. *Id.* at 3.

327. *See id.* at 15–17.

328. *Id.* at 16.

329. *Id.*

330. *Id.* at 17.

331. *Id.*

332. *Id.*

After considering the parties' supplemental briefs, the Court found that the "no notice" option was feasible for fully insured plans.[333] It then vacated the judgments entered by the Third, Fifth, Tenth, and D.C. Circuits and remanded those cases for compromise and resolution.[334] Shortly thereafter, the Court granted petitions for certiorari in similar cases from the Second, Sixth, and Eighth Circuits and immediately vacated the judgments and remanded those cases for handling consistent with the *Zubik* decision.[335]

B. *Additional ACA Challenges*

The preemptive force of the ACA and a party's standing to challenge an Obama administration policy that postponed certain ACA requirements were addressed in district court decisions this survey period. In *St. Louis Effort for Aids v. Huff*,[336] a district court granted summary judgment to designated enrollment counselor organizations that performed duties in connection with federally funded exchanges (FFEs) in Missouri.[337] Those organizations sued the Missouri Department of Insurance, seeking a declaration that the ACA preempted certain sections of Missouri's Health Insurance Marketplace Innovation Act (HIMIA) and sought to enjoin implementation of those sections.[338] The relevant sections of the HIMIA regulated the conduct of state navigators, entities that worked with and on behalf of the FFEs, including certified applications counselors (CACs) and federal navigators.[339] The plaintiffs argued that the HIMIA sections conflicted with the ACA-defined duties of CACs and federal navigators.[340] Because these HIMIA sections impeded CACs' and federal navigators' performance of their ACA-mandated duties,[341] the district court declared that they were preempted by the ACA and permanently enjoined the Missouri Department of Insurance from enforcing them against CACs and federal navigators.[342]

In *American Freedom Law Center v. Obama*,[343] an employer and employee challenged the administration's ACA transitional policy, "which permitted health insurance companies to temporarily continue providing

333. *Zubik*, 136 S. Ct. at 1560.
334. *Id.*
335. Catholic Health Care Sys. v. Burwell, 136 S. Ct. 2450 (2016); Mich. Catholic Conference v. Burwell, 136 S. Ct. 2450 (2016); Dep't of H&HS v. CNS Int'l Ministries, No. 15-775, 2016 WL 2842448 (U.S. May 16, 2016).
336. 170 F. Supp. 3d 1219 (W.D. Mo. 2016).
337. *Id.* at 1221.
338. *Id.*
339. *Id.*
340. *Id.* at 1221, 1223.
341. *Id.* at 1223–25.
342. *Id.* at 1226.
343. 821 F.3d 44 (D.C. Cir. 2016).

health insurance plans that do not comply with ACA requirements" for a specified period of time.[344] When the plaintiffs' health insurer cancelled its original health insurance plan to transition to an ACA-compliant plan, the plan's premiums increased.[345] The plaintiffs filed suit, challenging the transitional policy, and asserting that it allowed individuals to retain non-ACA-compliant policies in 2014 and 2015, thereby affecting the risk pool and driving up rates for ACA-compliant policies like the plaintiffs' during that time period.[346] The D.C. Circuit affirmed the district court's dismissal of the plaintiffs' action due to their lack of standing.[347] It explained that the plaintiffs failed to demonstrate that they suffered any injury from the transitional policy; their only evidence that the transitional policy caused increased premiums was a Blue Cross 2014 rate increase filing.[348] The rate filing did not necessarily apply to the plaintiffs' health care plan, and the rate increase disclosed in that filing apparently was reversed in 2015.[349]

C. *False Claims Act*

In *Universal Health Services, Inc. v. United States*,[350] a unanimous Supreme Court resolved a circuit split as to the validity and scope of the "implied false certification" theory of liability under the False Claims Act.[351] The False Claims Act imposes penalties on entities or individuals that submit false or fraudulent claims for payment or reimbursement to the government.[352] The implied false certification theory holds that when a defendant submits a claim for payment to the government, it impliedly certifies its compliance with all material statutory, regulatory, and contractual provisions.[353] If a defendant knowingly fails to disclose a violation of those provisions in its submission, however, the omission constitutes a misrepresentation under the Act and provides grounds for monetary damages.[354]

The Second, Fourth, Sixth, Ninth, and D.C. Circuits previously adopted the implied false certification theory of liability.[355] The Seventh Circuit

344. *Id.* at 46.
345. *Id.* at 47.
346. *Id.* at 47–48.
347. *Id.* at 46, 52; *see also* Am. Freedom Law Ctr. v. Obama, 106 F. Supp. 3d 104 (D.D.C. 2015), *aff'd*, 821 F.3d 44 (D.C. Cir. 2016).
348. *Am. Freedom Law Ctr.*, 821 F.3d at 49.
349. *Id.* at 49–50.
350. 136 S. Ct. 1989 (2016).
351. *Id.* at 1995–96.
352. *Id.* at 1996. "Enacted in 1863, the False Claims Act 'was originally aimed principally at stopping the massive frauds perpetrated by large contractors during the Civil War.'" *Id.* (citations omitted).
353. *Id.* at 1995.
354. *Id.*
355. *See, e.g.*, Mikes v. Straus, 274 F.3d 687, 702 (2d Cir. 2001), *abrogated by Universal Health Servs.*, 136 S. Ct. 1989; United States v. Triple Canopy, Inc., 775 F.3d 628, 636

rejected it, expressing a concern that it would be unreasonable to require certification of compliance with "thousands of pages of federal statutes and regulations."[356] The Second and Sixth Circuits adopted the theory, but limited its application to claims in which payment was expressly conditioned on compliance with the statute, regulation, or contractual provision violated. [357]

Universal Health involved a teenage beneficiary of the Massachusetts Medicaid program who received mental health care at a facility run by a subsidiary of Universal Health Services.[358] After the young woman's death, a state investigation found that the facility violated a number of Massachusetts' Medicaid regulations concerning staff qualifications and supervision at mental health facilities.[359] The young woman's parents filed a qui tam action under the False Claims Act.[360] The district court adopted an approach similar to that of the Second and Sixth Circuits, dismissing the parents' action for failure to state a claim because compliance with the relevant regulations was not an express condition of payment.[361] The First Circuit reversed in part, rejecting that approach and observing that "a statutory, regulatory, or contractual requirement can be a condition of payment either by expressly identifying itself as such or by implication."[362]

The Supreme Court agreed in part with the First Circuit's reasoning. It held that the implied false certification theory "can, at least in some circumstances, provide a basis for liability," and thereby abrogated the Seventh Circuit's rejection of the theory.[363] Significantly, the false representations at issue in *Universal Health* were in the nature of "half-truth" representations. For example, the facility represented that it provided individual therapy, family therapy, preventative medication counseling, and

(4th Cir. 2015), *cert. granted, judgment vacated sub nom.* Triple Canopy, Inc. v. United States *ex rel.* Badr, 136 S. Ct. 2504 (2016); Chesbrough v. VPA, P.C., 655 F.3d 461, 468 (6th Cir. 2011); Ebeid *ex rel.* United States v. Lungwitz, 616 F.3d 993, 998 (9th Cir. 2010); United States v. Sci. Applications Int'l Corp., 626 F.3d 1257, 1269 (D.C. Cir. 2010).

356. United States v. Sanford-Brown, Ltd., 788 F.3d 696, 711 (7th Cir. 2015), *cert. granted, judgment vacated sub nom.* United States *ex rel.* Nelson v. Sanford-Brown, Ltd., 136 S. Ct. 2506 (2016), *abrogated by Universal Health Servs.*, 136 S. Ct. 1989.

357. *See, e.g.*, *Mikes*, 274 F.3d 687, *abrogated by Universal Health Servs.*, 136 S. Ct. 1989; Chesbrough v. VPA, P.C., 655 F.3d 461, 467 (6th Cir. 2011).

358. *Universal Health Servs.*, 136 S. Ct. at 1997.

359. *Id.*

360. *Id.*

361. *Id.* at 1998.

362. *Id.*; *see* United States v. Universal Health Servs., Inc., 780 F.3d 504, 512–13 (1st Cir.), *cert. granted in part*, 136 S. Ct. 582 (2015), *and vacated and remanded*, 136 S. Ct. 1989.

363. *Universal Health Servs.*, 136 S. Ct. at 1999; *see also* United States v. Sanford-Brown, Ltd., 788 F.3d 696 (7th Cir. 2015), *cert. granted, judgment vacated sub nom.* United States *ex rel.* Nelson v. Sanford-Brown, Ltd., 136 S. Ct. 2506 (2016), *abrogated by Universal Health Servs.*, 136 S. Ct. 1989.

other types of treatment,[364] but failed to disclose that those services were provided by unlicensed or unsupervised staff, despite contrary state regulations.[365] Relying on the plain language of the False Claims Act and the common law definition of fraud, the Court applied "the rule that half-truths—representations that state the truth only so far as it goes, while omitting critical qualifying information—can be actionable misrepresentations."[366] The Court's endorsement of the implied certification theory was qualified, however.[367] It found the theory applied only "where two conditions are satisfied: first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths."[368]

The Court declined to endorse the "condition of payment" limitation, explaining that "[a] statement that misleadingly omits critical facts is a misrepresentation irrespective of whether the other party has expressly signaled the importance of the qualifying information."[369] It preferred instead to rely on the natural limits of the materiality and scienter requirements in the False Claims Act to restrict liability for an implied false certification.[370] The Court viewed materiality as a superior mechanism for limiting liability under the Act to the conduct Congress intended to target, stating:

> A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant's noncompliance. Materiality, in addition, cannot be found where noncompliance is minor or insubstantial.[371]

The Court vacated the First Circuit's decision and remanded the case for reconsideration of whether a claim under the Act was sufficiently pled.[372] Certiorari was granted in three other cases in the Fourth, Seventh, and Eighth Circuits addressing comparable issues and similarly vacated and

364. *Universal Health Servs.*, 136 S. Ct. at 2000.
365. *Id.*
366. *Id.* at 1999–2000.
367. *Id.* at 2001.
368. *Id.*
369. *Id.*
370. *Id.*
371. *Id.* at 2003.
372. *Id.* at 2004.

remanded.[373] Looking ahead, we expect to see the resolution of these False Claims Act cases and the development of the principles the Court announced in *Universal Health* in the next survey period.

VI. LIFE INSURANCE

Can an insurer challenge a STOLI policy after the applicable contestable period ends? Courts have reached conflicting results, based on the interplay between a state's insurable interest and contestable period statutes. When does an insurer risk a bad faith claim by investigating the existence of insurable interest? The answer can depend on the procedural posture of the case as well as the relevant statutory language. After a STOLI policy has been rescinded, must the insurer return the premiums? Court opinions rendered this year suggest this largely depends on the role of the STOLI investor seeking the refund including, most notably, whether the investor was part of the STOLI scheme.

Other decisions during this survey period address more general life insurance issues, such as difficulties beneficiaries face in attempting to reinstate policies that lapsed before the insured died. As one case illustrated, even an insurer's acceptance and endorsement of a check to reinstate a policy that lapsed prior to the insured's death may not result in reinstatement of the policy.

A. *STOLI*

1. Challenging STOLI Policies as Void Ab Initio After the Contestable Period

Courts continue to address whether an insurer can challenge a STOLI policy as being void ab initio after the applicable contestable period has expired. In *Wells Fargo Bank, N.A. v. Pruco Life Insurance Co.*,[374] the Florida Supreme Court declined to carve out "a STOLI-policy exception" to Florida's two-year contestability period.[375] The court considered two questions certified by the Eleventh Circuit:[376]

> 1. Can a party challenge an insurance policy as being void *ab initio* for lack of the insurable interest required by Fla. Stat. § 627.404 if that challenge is made after expiration of the two-year contestability period mandated by Fla. Stat. § 627.455?

373. *See* Triple Canopy, Inc. v. United States *ex rel.* Badr, 136 S. Ct. 2504 (2016); United States *ex rel.* Nelson v. Sanford-Brown, Ltd., 136 S. Ct. 2506 (2016); Weston Educ., Inc. v. United States *ex rel.* Miller, 136 S. Ct. 2505 (2016).

374. 200 So. 3d 1202 (Fla. 2016).

375. *Id.* at 1203.

376. Pruco Life Ins. Co. v. Wells Fargo Bank, N.A., 780 F.3d 1327, 1336 (11th Cir. 2015).

2. Assuming that a party can do so, does Fla. Stat. § 627.404 require that an individual with the required insurable interest also procure the insurance policy in good faith?[377]

The court initially stated that Florida law does not prohibit STOLI transactions, describing such transactions as "when an investor actively seeks out elderly people to purchase life insurance with the promise of 'no risk' money in exchange for transferring the policy to the investor after the general two year incontestability period has expired."[378] Florida's insurable interest statute requires an insurable interest at the "inception date of coverage," but not after that date.[379] In addition, the statute defines "insurable interest" as including "the interest of '[a]n individual . . . in the life, body, and health of another person to whom the individual is closely related by blood or by law and in whom the individual has a substantial interest engendered by love and affection.'"[380]

In analyzing the two different STOLI policies at issue in *Pruco Life Insurance Co.*, the Eleventh Circuit case from which the certified questions arose,[381] the Florida Supreme Court noted that both of the policies named the insureds' immediate family members as beneficiaries.[382] Accordingly, it found those policies had the insurable interest required at their inception.[383] Then, applying the plain language of the incontestability statute, the Florida Supreme Court concluded that even if a life insurance policy results from a STOLI scheme, it is incontestable after two years if the required insurable interest existed at its inception.[384] In so holding, the court considered that the incontestability statute included other exceptions to the two-year time bar, but noted that the fact that the policy was a STOLI policy was not among them.[385] It also acknowledged that a STOLI-policy exception to the two-year contestable period "might be wise public policy" but found that would be a decision for the state legislature.[386]

In *Sun Life Assurance Co. of Canada v. U.S. Bank National Ass'n*,[387] a federal district court in Florida addressed the same issue, but it found that Delaware law, not Florida law, applied.[388] In that case, the court held

377. *Wells Fargo Bank, N.A.*, 200 So. 3d at 1203.
378. *Id.* (quoting 5 COUCH ON INSURANCE § 67.3 (3d ed. 2015) (quotation marks omitted)).
379. *Id.* at 1205 (quoting FLA. STAT. § 627.404(1)).
380. *Id.* (quoting FLA. STAT. § 627.404(2)(b)(2)).
381. 780 F.3d 1327 (11th Cir. 2015).
382. *Wells Fargo Bank, N.A.*, 200 So. 3d at 1205-06.
383. *Id.*
384. *Id.* at 1206.
385. *Id.*
386. *Id.* at 1203.
387. 2016 WL 161598, at *18 (S.D. Fla. Jan. 14, 2016), *appeal dismissed* (Apr. 15, 2016).
388. *Id.* at *13.

that the insurable interest requirement was not satisfied, and the STOLI policy was void ab initio because the insureds were never responsible for the premium payments and the premiums were not paid by the type of institution that would satisfy the insurable interest requirement.[389] Specifically, in contrast to Florida's insurable interest statute, Delaware's insurable interest statute required courts to examine the circumstances surrounding the issuance of the policy and determine who procured it.[390] The Delaware statute looked beyond the inception of the policy.[391] For purposes of satisfying the insurable interest statute, Delaware law required that the insured pay the premiums, unless they are paid by "a charitable, benevolent, educational, or religious institution."[392] Thus, "if a third party financially induces the insured to procure a life insurance contract with the intent to immediately transfer the policy to a third party, the contract lacks an insurable interest."[393] Insurable interest did not exist because there was no evidence the insureds were responsible for the premiums,[394] and none of the defendants was a charitable benevolent, educational, or religious institution.[395]

2. When Does an Insurer Risk a Bad Faith Claim by Investigating an Insurable Interest?

Depending on the facts of the case, an insurer can risk exposure to a bad faith claim if it unreasonably persists in investigating the existence of an insurable interest. That risk was present for an insurer in a case pending in Wisconsin during the survey period, where the court had already entered judgment against the insurer on the plaintiff's breach of contract claim and on the insurer's illegal wagering contract counterclaim.

In last year's survey issue, we reported on *U.S. Bank National Ass'n v. Sun Life Assurance Co. of Canada* (*U.S. Bank I*).[396] There, the insured died seven years after a STOLI policy was issued, and the Wisconsin district court, applying Wisconsin law, granted the policy owner judgment on the pleadings on its breach of contract claim seeking $6 million in benefits, as well as on Sun Life's illegal wagering contract counterclaim.[397]

389. *Id.* at *16–18.
390. *Id.* at *15; DEL. CODE ANN. tit. 18, § 2704.
391. *Sun Life Assurance Co. of Can.*, 2016 WL 161598, at *15.
392. *Id.* at *15 (quoting PHL Variable Ins. Co. v. Price Dawe 2006 Ins. Trust, *ex rel.* Christiana Bank & Trust Co., 28 A.3d 1059, 1075 (Del. 2011)).
393. *Id.* (quoting *PHL Variable Ins. Co.*, 28 A.3d at 1075).
394. *Id.* at *17.
395. *Id.*
396. 2015 WL 3645700 (W.D. Wis. June 10, 2015). *See* Chittenden et al., *supra* note 34, at 512.
397. *Id.* at *4–5.

During this review period, the Wisconsin district court issued two additional decisions concerning the policy owner's bad faith claim. In *U.S. Bank National Ass'n v. Sun Life Assurance Co. of Canada* (*U.S. Bank II*),[398] it addressed the policy owner's bad faith theory and interest claim.[399] A party bringing a bad faith claim in Wisconsin must satisfy two prongs.[400] The first prong is objective; a party must show "the absence of a reasonable basis for denying benefits of the policy."[401] The second prong is subjective, requiring evidence of "the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim."[402] Sun Life moved for judgment on the pleadings, focusing on the objective prong.[403] It argued that it was justified in delaying paying benefits because it was required to investigate the claim, particularly the existence of an insurable interest.[404] The court rejected that argument, finding Wisconsin law does not require an investigation before paying under a policy.[405] It further held that Sun Life did not act reasonably in not paying benefits, rejecting the insurer's reliance on and "strained reading of" the insurable interest statute.[406] The court found that the statute does not provide a "fishing expedition" for insurers, but rather only gives the court an option to direct payment elsewhere if a third-party makes a claim.[407] Sun Life's claim that it required additional discovery to recommend paying the benefits claim "given the interplay" between the wagering statute[408] and the insurable interest statute failed because, as the court noted in *U.S. Bank I*, the lack of insurable interest defense encompassed the wagering policy defense.[409]

Finally, Sun Life's challenge to the policy based on misrepresentations in the application was deemed unreasonable because it was time barred by the two-year contestable period statute.[410] The court denied Sun Life's motion for judgment on the pleadings, granting judgment in the policy owner's favor on the objective prong of the bad faith claim and its statutory interest claim.[411] The court explained: "[in] light of this decision and the court's prior ruling on [the] breach of contract claim, the only issue remaining for trial is whether Sun Life knew or acted recklessly in relying on an

398. 2015 WL 6554657 (W.D. Wis. Oct. 29, 2015).
399. *Id.* at *2.
400. *Id.*
401. *Id.*
402. *Id.*
403. *Id.* at *3.
404. *Id.*
405. *Id.*
406. *Id.* at *3 n.2; WIS. STAT. § 631.07(4).
407. *U.S. Bank II*, 2015 WL 6554657, at *3 n.2.
408. WIS. STAT. § 895.055 (incorrectly cited as WIS. STAT. § 899.055).
409. *U.S. Bank II*, 2015 WL 6554657, at *3.
410. *Id.* at *3; WIS. STAT. § 632.46.
411. *U.S. Bank II*, 2015 WL 6554657, at *3–4.

unreasonable basis in failing to pay timely U.S Bank's claim."[412] Sun Life then declined to contest the subjective prong of the bad faith claim and moved for a hearing on an award of attorney fees.[413] The court thus entered judgment for U.S. Bank on the subjective prong and scheduled briefing on the award of attorney fees.[414] Sun Life has appealed to the Seventh Circuit. We expect to analyze the outcome of that appeal in next year's article.

3. Insurer's Retention or Repayment of Premiums

After entering judgment for an insurer seeking to rescind a STOLI policy, courts are often called on to determine whether the insurer may retain the premiums received on the policy. Several courts addressed this question during the survey period, reaching different results. In *PHL Variable Insurance Co. v. Sheldon Hathaway Family Insurance Trust*,[415] the Tenth Circuit applied Utah law and held, as a matter of first impression, that the district court had discretion to allow the insurer to keep the premiums.[416] In that case, an intervenor defendant, Windsor Securities, LLC, loaned another defendant, the Sheldon Hathaway Family Trust, money to pay the initial life insurance policy premium for the insured, Sheldon Hathaway.[417] Before Windsor was able to "profit from its investment . . . by selling the policy or by capitalizing on Hathaway's death," PHL sued to rescind the policy due to alleged misrepresentations on the application.[418] The district court granted summary judgment for PHL on its rescission claim, holding PHL relied on a material misrepresentation by the applicant in the policy application, and allowed it to retain the $200,000 initial premium.[419]

On appeal, Windsor and the trust argued, inter alia, that "the district court lacked authority to allow [the insurer] to retain the paid premiums" as a matter of law.[420] Utah courts had not addressed the pertinent issue: whether an insurer who rescinds a policy due to the insured's material misrepresentations may retain premiums paid for the policy.[421] In deciding that PHL could keep the premiums, the Tenth Circuit relied on "general pronouncements" from the Utah Supreme Court to the effect that restoring the status quo is the goal of rescission and that trial courts enjoy "wide discretion" in reaching that goal.[422] There might have been a dif-

412. *Id.* at *4.
413. U.S. Bank Nat'l Ass'n v. Sun Life Assurance Co. of Can., 2015 WL 9413895 (W.D. Wis. Dec. 22, 2015) (*U.S. Bank III*).
414. *U.S. Bank II*, 2015 WL 6554657, at *1–2.
415. 819 F.3d 1283 (10th Cir. 2016).
416. *Id.* at 1292–93.
417. *Id.* at 1285.
418. *Id.*
419. *Id.*
420. *Id.* at 1284.
421. *Id.* at 1292.
422. *Id.*

ferent result, however, if Windsor and the trust had argued that the district court abused its discretion. The Tenth Circuit stated: "[c]ritically, the defendants don't suggest the district court had discretion to allow [the insurer] to keep the premiums, but somehow abused that discretion in doing so."[423] In rejecting Windsor's and the trust's argument that the district court lacked the authority to allow the insurer to keep the premiums, the Tenth Circuit noted that "because the defendants don't argue the district court otherwise abused its discretion, we affirm its order."[424]

In *Ohio National Life Assurance Corp. v. Davis*,[425] the Seventh Circuit reached a mixed result regarding STOLI policy premiums in a decision affirming summary judgment for Ohio National.[426] One of the defendants, insurance agent Mavash Morady, contracted with Ohio National to sell its life insurance policies.[427] Another defendant, Douglas Davis, convinced certain elderly individuals to complete life insurance applications and buy life insurance policies, for which Morady would serve as the insurance agent.[428] Davis promised to pay the individuals for obtaining the policies.[429] Once the policies were issued, they were made assets of trusts that were designated as the owners and beneficiaries of the policies; Davis was the trustee of these trusts created in the insureds' names "to conceal from Ohio National the fact that they rather than the insured controlled the policy and that they planned to sell it as an investment."[430] The trust documents initially designated members of the insureds' families or the insureds' other trusts as beneficiaries.[431] Later, Davis had the buyers of the policies assign their beneficial interest in the trusts to a company owned by Morady's husband.[432] Morady's husband then paid the initial premium payments, but resold the beneficial interests in the trusts to investors, which effectively became the beneficiaries of the policies.[433] The investors then paid the remaining premiums on the policies.[434] Ohio National would not have sold the policies if it knew that unrelated third party investors would be paying or financing the premiums with the expectation that the policies would be transferred to them.[435] In light of

423. *Id.*
424. *Id.* at 1292–93.
425. 803 F.3d 904 (7th Cir. 2015).
426. *Id.* at 911.
427. *Id.* at 906.
428. *Id.* at 906–07.
429. *Id.*
430. *Id.* at 906.
431. *Id.* at 907.
432. *Id.*
433. *Id.*
434. *Id.*
435. *Id.*

these facts, the Seventh Circuit affirmed the district court's holding that the policies were part of a STOLI scheme.[436]

The Seventh Circuit also affirmed the district court's finding that Morady breached her agent's contract with Ohio National and committed fraud, as well as the $120,000 damages award to Ohio National, which represented Morady's commissions for the STOLI policies.[437] Damages to Ohio National for expenses incurred in the litigation to avoid future lawsuits with third parties over the death benefits of the STOLI policies (by voiding those policies) were also affirmed. The Seventh Circuit relied on an Illinois Supreme Court decision[438] in reaching this decision and found that the expenses Ohio National paid in the case to void the STOLI policies were "in lieu of the future litigation that it would otherwise have had to engage in at considerable expense."[439]

The Seventh Circuit also agreed with the district court that Ohio National, with one exception, was entitled to retain the premiums paid for the STOLI policies.[440] The court explained: "[b]eing to blame for the illegal contracts the defendants have no right to recoup the premiums they paid to obtain them; allowing recoupment would, by reducing the cost, increase the likelihood of unlawful activity."[441]

Also homing in on the issue of who was to blame for the illegal contract, the district court in *Sun Life Assurance Co. of Canada v. Wells Fargo Bank, N.A.*,[442] applying New Jersey law, held that in order to avoid a "windfall" to the insurer, the policy premiums paid by the blame-

436. *Id.* at 910; *see also* LincolnWay Cmty. Bank v. Allianz Life Ins. Co., 2015 WL 7251931, at *4 (N.D. Ill. Nov. 17, 2015) ("Critical to [*Ohio Nat'l Life Assurance Corp.*'s] holding was control: 'The defendants, who had no interest in the insureds' lives (as distinct from their deaths), initiated, paid for, and controlled the policies from the outset.'" (citing *Ohio Nat'l Assurance Corp.*, 803 F.3d at 908)).

437. *Ohio Nat'l Life Assurance Corp.*, 803 F.3d at 911. The district court awarded those damages also based on "the tort of civil conspiracy." *Id.*

438. The Seventh Circuit quoted *Ritter v. Ritter*, 46 N.E.2d 41, 44 (Ill. 1943):

> Where the wrongful acts of a defendant involve the plaintiff in litigation with third parties or place him in such relation with others as to make it necessary to incur expense to protect his interest, the plaintiff can then recover damages against such wrongdoer, measured by the reasonable expenses of such litigation, including attorney fees.

439. *Ohio Nat'l Life Assurance Corp.*, 803 F.3d at 910–11.

440. *Id.* at 911.

441. *Id.* The Seventh Circuit affirmed the district court's decision to allow one of the investors, who was not one of the conspirators, to recoup the premiums he paid because he was not to blame for the illegality of the policy, and Ohio National's retention of his premiums would be a windfall to which it was not entitled. *Id.*; *see also LincolnWay Cmty. Bank*, 2015 WL 7251931, at *6 n.6 (the court did not reach the issue of whether the insurer could retain the premiums, but encouraged the parties "to engage in settlement discussions given *Ohio National's* recent guidance").

442. 2016 WL 5746352 (D.N.J. Sept. 30, 2016).

less defendant bank that purchased the STOLI policy after the two-year contestable period ended must be returned to it.[443] Sun Life issued a $5 million life insurance policy, the proposed owner and beneficiary of which was an irrevocable trust; the trust initially provided that its assets and the policy proceeds would be paid to the insured's grandson.[444] The application for the policy represented that the trust would pay policy premiums,[445] but after the insured's death (outside of the two-year contestability period) Sun Life discovered that stranger investors funded the premium payments.[446] Near the end of the policy's two-year contestability period, the trust had sold the policy to SLG Life Settlements, LLC, which distributed almost all of the sale proceeds to the investors.[447] Wells Fargo later acquired the policy as part of a portfolio of 410 policies.[448]

On cross-motions for summary judgment, the district court held that because the policy was funded by stranger investors without an insurable interest in the insured's life, it constituted a STOLI transaction, violated public policy, and was void ab initio.[449] Citing to the Seventh Circuit's reasoning in *Davis*, however, the court required Sun Life to refund the premiums paid by Wells Fargo, an entity that became involved after the policy was issued and later sold to SLG Life Settlements, LLC.[450] In so holding, the court noted that Wells Fargo, like the *Davis* defendant who did not participate in the conspiracy in that case, committed no fraud. It reasoned that allowing Sun Life to retain the premiums Wells Fargo paid would amount to a windfall to which Sun Life was not entitled.[451]

B. *Policy Lapse*

Beneficiaries face an uphill battle when attempting to reinstate a life insurance policy that lapsed before the insured died. A beneficiary seeking such reinstatement failed to state claims against an insurer or an insurance agent in *Stewart v. Northwestern Mutual Life Insurance Co.*[452] Four days

443. *Id.* at *9.
444. *Id.* at *1.
445. *Id.* at *2.
446. *Id.*
447. *Id.* at *3.
448. *Id.*
449. *Id.* at *11.
450. *Id.* at *12.
451. *Id.*; *see also* Sun Life Assurance Co. of Can. v. U.S. Bank Nat'l Ass'n, 2016 WL 161598, at *18 (S.D. Fla. Jan. 14, 2016), *appeal dismissed*, No. 16-10668 (11th Cir. Apr. 15, 2016) (applying Delaware law, the court held that if an insurer obtains rescission of a life insurance policy that is void ab initio, it is not entitled to keep the premium).
452. 180 F. Supp. 3d 566, 569 (N.D. Ill. 2016).

after her husband died on September 9, 2012, the plaintiff, who was the beneficiary of her husband's life insurance policy, opened a letter Northwestern Mutual sent her husband advising that his terminated life policy could be reinstated by September 9, 2012.[453] The plaintiff alleged that on September 10, 2012, at Northwestern Mutual's direction, she paid the unpaid premiums to reinstate the lapsed policy, but Northwestern Mutual "refused to reinstate the policy."[454] She also claimed that Northwestern Mutual's agent, who picked up the check for the reinstatement at her home, promised the policy would be reinstated.[455] Northwestern Mutual cashed the check, but then notified the plaintiff that it would not reinstate the policy and refunded the amount paid to reinstate the policy.[456]

In dismissing the beneficiary's claims, the court held that the beneficiary did not allege Northwestern Mutual did anything more than cash her check that could indicate it waived its right to maintain that the policy was lapsed.[457] The court noted, for example, that the reinstatement letter Northwestern Mutual sent the insured advised that the insured must be living for reinstatement to occur.[458] The court also determined that the plaintiff failed to allege promissory estoppel because she asserted that the agent promised reinstatement of the policy, not that "promissory estoppel requires payment of funds [the agent] promised her." The court held that promissory estoppel does not "provide such an end-around."[459] Finally, the court dismissed the breach of fiduciary duty claim against the agent because the plaintiff did not allege Northwestern Mutual's agent was the agent of her husband or herself when the policy lapsed, and an insurer's agent has no fiduciary duty to an insurer's customer.[460]

453. *Id.* at 570.
454. *Id.* at 569.
455. *Id.* at 570.
456. *Id.*
457. *Id.* at 573.
458. *Id.*
459. *Id.* at 576.
460. *Id.* at 577-78; *see also* Carlson v. Midwest Prof'l Planners, Ltd., 828 F.3d 752, 754–55 (8th Cir. 2016) (former beneficiaries of life insurance policy sold to their business partner (who removed them as beneficiaries), failed to state a cause of action against insurance agency for negligent failure to designate them as co-owners, where agency did not employ the agent who failed to name them as co-owners on the application until years after the policy was applied for); Williams v. Prudential Fin., Inc., 138 A.D.3d 643, 644 (N.Y. App. Div. 2016) (where life insurance policy lapsed before the insured's death, the court granted summary judgment for insurer and agent and against beneficiary because it found no basis for holding the agent liable for allegedly extending the grace period).

VII. CONCLUSION

As always, the sheer number of opinions issued this past year in the life, health, and disability insurance practice areas make it infeasible to discuss them all. Our goal has been to highlight for the reader the most significant decisions, whether because they break new ground, reaffirm long-established analytical principles, or present the kind of unique and interesting fact patterns that often cause an area of law to evolve.