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

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Does the bite of a mosquito infected with the West Nile Virus qualify as an "accidental bodily injury?" If an ERISA plan mails a notice to a participant and information disclosing the participant was taking HIV medications was visible to third parties in the envelope's window, can the plan be sued in state court for violations of state privacy statutes and negligence? If an incontestability provision prohibits contesting a stranger-originated life insurance policy, can the insurer sue to recover damages relying on RICO and theories of fraud and conspiracy? Courts' answers to these questions are discussed below, along with updates on ERISA's new claims-procedure regulations for disability plans, litigation concerning payments purportedly owed under the Affordable Care Act's risk corridors program, and the government's efforts to accommodate objections to the ACA's so-called contraceptive mandate.

## I. ACCIDENTAL DEATH

In this year's cases involving accidental death and dismemberment policies, courts continued to attempt to define the undefinable, address intoxication exclusions, and decide whether an insured's medical history excluded coverage.

### A. *This Ain't No Foolin' Around:[1] When Is an Accident an Accident?*

As in previous years, courts grappled with the seemingly eternal struggle of answering, what, exactly, is an accident? This enigmatic question was considered in a variety of contexts this survey period, with the more prominent cases addressing matters ranging from self-stimulation to the media frenzy that is West Nile Virus.

In *Tran v. Minnesota Life Insurance Co.*,[2] the court decided whether an accidental death policy covered an individual's death by autoerotic asphyxiation.[3] The police found the insured hanging from his basement rafters with a towel and rope around his neck.[4] After performing an autopsy, the assistant medical examiner determined the insured died from autoerotic asphyxiation, as a number of items found in the insured's proximity suggested he had been enjoying his own company and had "measures available to him to protect himself from strangulation."[5] The relevant policy rider issued under an ERISA-governed benefit plan provided coverage for accidental death caused by an "accidental injury," which was defined as the insured's death resulting "directly and independently of disease or bodily infirmity, from an accidental injury which is unexpected and unforeseen."[6] The policy excluded coverage for death that "results from or is caused directly by . . . suicide or attempted suicide or other self-inflicted injuries."[7]

In the resulting litigation, the parties essentially agreed the insured died from autoerotic activity and did not intend to kill himself,[8] but disagreed regarding whether the injury was self-inflicted. The beneficiary argued the insured was merely engaging in pleasurable activity and not intentionally injuring himself.[9] The insurer, on the other hand, argued the insured intentionally strangled himself for the purpose of self-gratification, so the injury that caused his death—cerebral hypoxia—was self-inflicted.[10]

1. Talking Heads, *Life During Wartime*, *on* Fear of Music (Sire Records 1979).
2. 2018 WL 1156326 (N.D. Ill. Mar. 5, 2018).
3. *Id.* at *1.
4. *Id.* at *2.
5. *Id.*
6. *Id.*
7. *Id.* at *1.
8. *Id.* at *6.
9. *Id.*
10. *Id.*

The district court, reviewing the matter *de novo*, considered whether cerebral hypoxia qualified as an "injury" under the policy.[11] Citing Seventh Circuit precedent, it reasoned that for the death to be accidental (1) the insured must have had a subjective expectation of survival, and (2) that expectation must have been objectively reasonable or, in other words, death was not substantially certain to result.[12] Recognizing a split of authority across the country, the court found the insured subjectively intended to survive because there was no evidence he intended to kill himself, he had measures available to protect himself from strangulation, and this was not his first foray into such activity.[13] And while recognizing that attempting to partially strangle oneself "might, of course, seem like a bad idea to the ordinary person," the court refused to find that death was substantially certain to result from the insured's conduct.[14] The court consequently entered judgment for the beneficiary.[15]

The Fifth Circuit addressed an issue that perhaps plays a more visible role in our cultural zeitgeist in *Wells v. Minnesota Life Insurance Co.*,[16] where a mosquito bite gave an insured West Nile Virus.[17] The insured went to the hospital complaining of fever, headache, and altered mental status; he was diagnosed with West Nile Virus and died several weeks later.[18] His death certificate listed West Nile Virus as the immediate cause of death and acute respiratory failure, septic shock, and multi-system failure as conditions leading to the cause of death; his death was designated as natural and not accidental.[19] The insured's policy provided coverage when "death results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen" and required that bodily injury be "the sole cause" of death.[20]

The insured's spouse and beneficiary submitted a claim under the policy and asserted that a mosquito bite caused the insured's death, but the insurer denied the claim.[21] The district court granted the insurer summary

11. *Id.*
12. *Id.* at *7.
13. *Id.* at *9.
14. *Id.* at *10.
15. *Id.* On the surface *Tran* reached a different conclusion than *Miles v. Federal Insurance Co.*, 2017 WL 559582 (E.D. Ky. Feb. 10, 2017), which was discussed in last year's edition. In *Miles*, an insurer denied a claim with a similar background because, while the deceased did not intend to kill himself, he nevertheless voluntarily placed a cord around his neck. 2017 WL 559582, at *5. And while the *Miles* court dismissed the plaintiff's complaint, the court acted due to a poorly pleaded complaint and not because the act of voluntarily placing a cord around one's neck inherently precluded coverage. *Id.* at *5–6.
16. 885 F.3d 885 (5th Cir. 2018).
17. *Id.* at 887.
18. *Id.* at 887–88.
19. *Id.*
20. *Id.* at 888.
21. *Id.*

judgment on all claims, reasoning that (1) the insured's death was not an accident because the plaintiff failed to demonstrate a mosquito bite qualified as an accident, and (2) septic shock, acute respiratory failure, and multi-system failure all contributed to the insured's death, so the plaintiff did not satisfy the policy's "sole cause" requirement.[22]

On appeal, the Fifth Circuit reversed the district court's decision and found the matter should be considered by the factfinder.[23] Initially addressing whether the bite qualified as an accident under the "unintended, unexpected and unforeseen" language, the court largely sided with the plaintiff who argued the insured did not expect that an infected mosquito would bite him.[24] While the insurer asserted that mosquito bites *generally* are not unexpected or unforeseen, the court distinguished a "generic" mosquito bite from a bite by an infected mosquito.[25] The insurer also analogized a case finding that death resulting from inhaling a "community-spread bacterial pathogen" (akin to strep throat or meningitis) was not an accident, but the Fifth Circuit distinguished a bug bite from an airborne illness because the mosquito "affirmatively acted" to harm the insured and produce an unforeseen result.[26]

Turning to causation, the court interpreted the policy to require the mosquito bite to be the sole proximate cause of the insured's death.[27] The insurer argued the mosquito bite was not the sole cause because the death certificate listed respiratory failure, septic shock, and multi-system failure as diseases that caused death.[28] The Fifth Circuit largely rejected this rationale, instead reasoning that complications arising exclusively and directly from an accident are not concurrent, proximate causes, so the insured's mosquito bite would qualify as the sole proximate cause if the bite caused the insured's other conditions which would not have occurred but for the bite.[29] It further found that such a determination also fell under the factfinder's purview.[30]

22. *Id.* at 889.
23. *Id.* at 897.
24. *See id.* at 891.
25. *Id.*
26. *Id.* at 891-92.
27. *Id.* at 892–93.
28. *Id.* at 893.
29. *Id.* at 893–94.
30. *Id.* at 894. The district court also based its summary judgment opinion on the notion that the plaintiff failed to satisfy the policy's requirement that the bodily injury be "evidenced by a visible contusion or wound." *Id.* at 888–89. The Fifth Circuit rejected this reasoning, finding a jury could infer that the mosquito bite caused a wound or contusion. *Id.* at 895. The policy also excluded coverage if death is "caused directly or indirectly by, results from, or there is contribution from . . . bodily or mental infirmity, illness or disease." *Id.* at 888. The Fifth Circuit found the language ambiguous and held the matter was best left to the factfinder. *Id.* at 896.

B. *All I See Is Little Dots:*[31] *Intoxication Exclusions*

Courts across the country continued to address intoxication exclusions in accidental death policies over the past year. Their outlook on intoxicated drivers was largely unchanged, causing difficulties for insurers arguing their intoxication exclusions bar coverage as a matter of law when an intoxicated insured was driving. Courts' distaste for these exclusions seems limited to vehicular accidents, however, as insurers had more luck applying such language in other scenarios.

In *Singstock v. Globe Life & Accident Insurance Co.*,[32] an insured was riding his motorcycle and died after hitting a tree located in a ditch off the road.[33] Although there were no eyewitnesses, the sheriff's investigation found that the road was straight with a 55 mph speed limit, the crash occurred in good weather during the day, tire marks veered off the road into the tree, and the insured was not wearing a helmet.[34] A toxicology report revealed the insured had in his system therapeutic levels of alprazolam (Xanax) and diphenhydramine (Benadryl) as well as hydrocodone and had a .054 blood alcohol content ("BAC").[35] The relevant policy excluded coverage for death caused by "[b]eing under the influence of any drug, narcotic, poison or gas unless taken on the advice of a physician."[36]

The insurer moved for summary judgment on the intoxication exclusion, supporting the motion with the report of an expert who opined the insured's impairment contributed to the crash but could not express the degree to which the impairment contributed.[37] The district court denied summary judgment, reasoning the expert's report failed to establish as a matter of law that the exclusion applied even after finding that the weather and road conditions were not a factor.[38] Since the insured's impairment level was ultimately unknown, the court concluded a jury would not be compelled to find the insured's intoxication caused the accident.[39]

In *Whiteside v. Securian Life Insurance Co.*,[40] an insured under an accidental death policy issued pursuant to an ERISA plan died shortly after she

31. Talking Heads, *Drugs*, *on* The Name of This Band Is Talking Heads (Sire Records 1982).
32. 2017 WL 5468755 (E.D. Wis. Nov. 14, 2017).
33. *Id.* at *1.
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.* at *4.
38. *Id.* at *5
39. *Id.* at *5. While the court referenced *Smith v. Stonebridge Life Insurance Co.*, 473 F. Supp. 2d 903 (W.D. Wis. 2007), which held an intoxication exclusion ambiguous and found intoxication must be the *sole* cause of death, it did not expressly state whether it deemed the exclusion at issue ambiguous. *Id.*
40. 2017 WL 8897132 (M.D. Fla. Dec. 7, 2017).

was found unconscious in shallow water next to a boat dock.[41] The insured, who had a problem with alcohol abuse, was witnessed drinking wine in a boat or on the dock in the hours before she was found and two empty wine bottles were on the boat.[42] An autopsy reflected her cause of death was drowning with ethanol intoxication as a "contributing condition," and her BAC was between 0.234 and 0.257.[43] The policy contained an intoxication exclusion providing that coverage does not exist where death "is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from . . . the use of alcohol, drugs . . . or other substances."[44] After the insurer denied the claim, the beneficiary filed suit.[45] Applying an arbitrary and capricious standard, the district court found the claim denial was not unreasonable.[46] In so holding, it concluded there was "more than ample evidence" that alcohol contributed to the insured's death.[47]

The insurer also prevailed in *Verba v. Metropolitan Life Insurance Co.*[48] There, an insured's body was found near a creek and it was later determined that he had walked along a trail near the creek, stripping off wet clothing as he went.[49] A crack pipe and two crack rocks were found on his body, and his toxicology tests were positive for cocaine, ethanol, benzodiazepines, and cannabinoids.[50] The insured's death certificate identified his immediate cause of death as "Combined Drug Poisoning" and hypothermia, similar to his autopsy report which described his death as accidental as a result of a combination of drug poisoning and hypothermia.[51] The insured's accidental death policy, issued under an ERISA plan, excluded coverage for "any loss caused or contributed to by . . . the voluntary intake or use by any means of: Any drug medication or sedative . . . [or] Alcohol in combination with any drug, medication, or sedative."[52]

The insurer denied the claim because cocaine and alcohol caused or contributed to the insured's death.[53] On appeal, the beneficiaries provided a doctor's letter stating the insured had small amounts of cocaine and alcohol in his system that were not consistent with an overdose and positing that the insured had been assaulted, escaped from his attackers, and

41. *Id.* at *1.
42. *Id.* at *2.
43. *Id.*
44. *Id.*
45. *Id.* at *1.
46. *Id.* at *8.
47. *Id.* at *5, *7.
48. 2018 WL 4005873 (W.D. Pa. Aug. 22, 2018).
49. *Id.* at *1.
50. *Id.*
51. *Id.*
52. *Id.* at *2.
53. *Id.* at *2–3.

ultimately died from hypothermia.[54] The insurer denied the appeal, and litigation ensued.[55]

The parties filed cross summary judgment motions, and the court reviewed the benefit determination under the arbitrary and capricious standard.[56] The court ultimately sided with the insurer, determining its reliance on the findings in the autopsy report and the death certificate that drugs and hypothermia caused the insured's death was reasonable.[57] Further, the doctor's letter focused on whether the amounts of cocaine and alcohol alone were sufficient to cause the insured's death, but the intoxication exclusion only required drugs to *contribute* to death and the doctor did not opine that drugs and alcohol played *no role* in his death.[58] The court consequently determined the insurer's decision was not unreasonable and entered summary judgment in its favor.[59]

### C. *Born with a Weak Heart:*[60] *Illness or Medical Treatment*

Intoxication, of course, is not the only scenario that may result in coverage being excluded under accidental death and dismemberment policies. Most policies do not cover losses that result from illness or medical treatment, and courts this survey period continued to examine the interplay between illness and accidents.

In *Ramirez v. United Omaha Life Insurance Co.*,[61] an insured took a work trip to West Texas, inhaled fungal spores, developed an infection in his right eye, and ultimately had his eye surgically removed.[62] The relevant policy, issued under an ERISA plan, provided coverage if the insured is "injured as a result of an Accident, and that Injury is independent of Sickness and all other causes."[63] It further defined Accident as "a sudden, unexpected, unforeseeable and unintended event, independent of Sickness and all other causes," but Accident excluded "Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted."[64] Sickness was "a disease, disorder or condition, which requires treatment by a Physician."[65] The issue before the Fifth Circuit was whether the insured's fungal infection qualified as a Sick-

54. *Id.* at *3.
55. *Id.* at *4.
56. *Id.* at *1, *5.
57. *Id.* at *6.
58. *Id.*
59. *Id.* at *1.
60. Talking Heads, *This Must Be The Place (Naïve Melody)*, *on* Speaking in Tongues (Sire Records 1983).
61. 872 F.3d 721 (5th Cir. 2017).
62. *Id.* at 724.
63. *Id.*
64. *Id.*
65. *Id.*

ness under the policy.[66] The court found that, under the generally accepted meaning of the policy language, a fungal infection qualifies as a Sickness and the resulting loss of the eye was not an Accident.[67]

The Ninth Circuit in *Dowdy v. Metropolitan Life Insurance Co.*[68] also addressed a dismemberment, but the insurer did not fare as well as in *Ramirez*.[69] After the insured crashed his car, the responding officer noted the insured sustained serious injuries, including a "semi-amputated left ankle."[70] The insured was treated at the hospital and later released, but his leg continued to be infected and was removed below the knee several months later.[71] The insured's doctor noted the insured's injuries were complicated by his diabetes, his wound never properly healed, and the amputation was elective.[72]

An ERISA-based accidental death and dismemberment policy provided coverage if an insured "sustain[s] an accidental injury that is the Direct and Sole Cause of a Covered Loss," meaning a loss that "was a direct result of the accidental injury, independent of all other causes."[73] A policy exclusion prohibited benefits "for any loss caused or contributed to by . . . physical . . . illness or infirmity, or the diagnosis or treatment of such illness or infirmity," as well as for infections, except any "infection occurring in an external accident wound."[74] The insurer denied the claim under the illness exclusion, reasoning that the insured's diabetes contributed to the amputation.[75] The district court sided with the insurer on Rule 52 cross motions, finding that diabetes caused or contributed to the amputation.[76]

On appeal, the Ninth Circuit reasoned that while recovery could be barred if a preexisting condition *substantially* contributed to the loss, it must be more than a mere contributing factor even if the claimed injury was the predominant or proximate cause.[77] And although the court found diabetes to be *a* factor in the injury, it held the record did not show that diabetes *substantially* contributed to the injury, apparently concluding that a doctor's note that diabetes "complicated" the insured's injuries, without more, did not qualify diabetes as a substantial cause.[78] The court then turned to the illness exclusion, determining that diabetes must be a substantial cause of

66. *Id.* at 726.
67. *Id.*
68. 890 F.3d 802 (9th Cir. 2018).
69. *See id.* at 805.
70. *Id.*
71. *Id.*
72. *Id.* at 806.
73. *Id.* at 805.
74. *Id.*
75. *Id.* at 806.
76. *Id.* at 807.
77. *Id.* at 808.
78. *See id.* at 808–09.

the loss to exclude coverage and finding that the insurer failed to make such a showing.[79] The Ninth Circuit accordingly reversed the district court's opinion and remanded for further proceedings.[80]

In *Jones v. Life Insurance Co. of North America*,[81] an insured fell and hit his face on stairs, breaking his nose and eye sockets.[82] He underwent surgery without complication, but became unresponsive and died three days later.[83] His death certificate listed pulmonary thromboembolism as the cause of death with facial trauma as a contributing factor.[84] The relevant policy excluded coverage "for loss caused by or resulting from illness, disease, or bodily infirmity."[85] The insurer denied the ensuing claim, asserting the insured's history of extensive heart disease, chronic atrial fibrillation, and obesity contributed to his death.[86] After initiating an ERISA-based action, the beneficiary argued the insured's preexisting conditions were not acute and submitted a doctor's opinion that the insured would not have died but for the fall.[87] The insurer responded by reasserting its initial reasons for denial, including that its reviewing doctors believed the insured's heart condition was the primary cause of death.[88]

Reviewing the matter *de novo*, the district court cited Eleventh Circuit precedent providing that a preexisting illness is not a cause unless it "substantially contributed" to the disability or loss.[89] Based on the insured's prior heart problems and the medical evidence related to his fall, while recognizing that the "consequence is a harsh one," the court was "obliged" to find that the insured's heart condition substantially contributed to his death.[90]

## II. DISABILITY

This year's review of disability law includes a look at the meaning of "all essential duties" as opposed to "any essential duties" (spoiler: they are very different), the continuity of coverage issues where attention to a prior disability policy was key, and the significance of determining which of the

79. *Id.* at 810.
80. *Id.* at 811.
81. 2017 WL 6190512 (M.D. Fla. Nov. 15, 2017).
82. *Id.* at *1
83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.* at *2.
87. *Id.* at *3, *7. During the claims process, the beneficiary submitted a letter from the insured's doctor stating the insured's death was not related to his preexisting medical conditions. *Id.* at *7.
88. *Id.* at *4.
89. *Id.* at *8.
90. *Id.* at *9.

insured's conditions was disabling. A discussion of a recent decision questioning one disability insurer's processes, including a multiple page footnote referencing over a hundred decisions involving the insurer over a 21-year period, is also included.

### A. *Each Position Has Its Corresponding Duties*[91]*—The Distinction Between "Any Important Duty" and "All Important Duties" of an Insured's Own Occupation*

A couple of noteworthy cases this survey period turned on whether, as a result of a mental or physical condition, an insured was unable to perform *any one* material duty of their own occupation versus an inability to perform *all* material duties of their own occupation.

In *Fiorentini v. Paul Revere Life Insurance Co.*,[92] the president of a small tech company tried but failed to convince the Seventh Circuit that he was unable to perform the important duty of meeting with potential clients in person. The plaintiff had to stop working as company president when he was diagnosed with cancer.[93] After undergoing surgery, he began receiving total disability benefits; he then underwent treatment and additional operations, including amputation of his right ear.[94] The plaintiff's treatment left him cancer-free, but his hearing was permanently damaged and he continued to suffer from fatigue and migraines.[95] Nevertheless, he returned to work on reduced hours and resumed full control over his company's operations.[96]

After five years, the insurer terminated the plaintiff's benefits declaring he was no longer totally disabled under his policy,[97] which defined "Total Disability" as meaning that "because of Injury or Sickness . . . You are unable to perform the important duties of Your Occupation."[98] Per the plaintiff, his occupation consisted of four important duties: sales, consulting/meetings, programming, and administrative work, and he argued he was unable to solicit business in person. The plaintiff sued the insurer, and the district court granted summary judgment for the insurer.[99]

On appeal, the Seventh Circuit acknowledged an "opening in our case law" regarding whether the inability to perform *one task* is sufficient to find total disability.[100] It then found, however, that the plaintiff failed to

91. 1 George Eliot, Middlemarch 132 (William Blackwood & Sons 1872).
92. 893 F.3d 476 (7th Cir. 2018).
93. *Id.* at 477.
94. *Id.*
95. *Id.*
96. *Id.* at 478.
97. *Id.*
98. *Id.* at 477–78.
99. *Id.* at 478.
100. *Id.*

present sufficient evidence to raise a question of fact as to whether he was prevented from performing one important duty as claimed.[101] The undisputed evidence, the court concluded, revealed that the plaintiff was able to hear and communicate during in-person meetings.[102] While the plaintiff continued to experience some symptoms, including tinnitus, hearing loss, and migraines, the Seventh Circuit determined that no reasonable juror could find him unable to meet with potential clients and affirmed summary judgment for the insurer.[103]

A similar outcome was reached in *Simmons v. Paul Revere Life Insurance Co.*[104] The plaintiff, a dentist, applied for disability benefits after injuring his shoulder in a car accident.[105] The dispute boiled down to whether he was "unable to perform the important duties of [his] regular occupation."[106] After his accident, the plaintiff modified his work schedule to accommodate discomfort and fatigue and ultimately had surgery to repair his right rotator cuff.[107] He returned to work after he recovered from surgery, but reported continued numbness in his right hand.[108] While the plaintiff continued to perform some dental procedures, he performed certain procedures less frequently and stopped performing others.[109] The insurer paid the plaintiff residual or total disability benefits at various times, but ultimately terminated benefit payments.[110]

The plaintiff then sued for total disability benefits, claiming he was totally disabled because of his inability to perform even one of the important duties of his occupation.[111] The court found that when read as a whole—and particularly along with the residual disability provision which addressed an inability to perform "one or more" important duties of an occupation—the policy unambiguously required the plaintiff to show he was unable to perform *all* of his important duties as a dentist to be totally disabled.[112] As in *Fiorentini*, the plaintiff's residual symptoms were not enough to satisfy the total disability standard.[113]

101. *Id.* at 479.

102. *Id.* The plaintiff also piloted his own plane and met with other flying enthusiasts, conducted a 90–minute seminar related to this hobby, and played hockey every week in an amateur league. *Id.*

103. *Id.* at 479–80.

104. 2018 WL 558960 (W.D. Wash. Jan. 25, 2018).

105. *Id.* at *2.

106. *Id.*

107. *Id.* at *1–2. Notably, the policy defined "Total Disability" to include the requirement that "You are not engaged in any other gainful occupation." *Id.*

108. *Id.* at *2.

109. *Id.* at *3.

110. *Id.*

111. *Id.* at *4–5.

112. *Id.* at *5.

113. *See also* Owings v. United of Omaha Life Ins. Co., 873 F.3d 1206 (10th Cir. 2017) (analyzing whether the plaintiff's disability began when he could still perform one duty of his

B. *Life Can Only Be Understood Backwards; But It Must Be Lived Forwards*[114]*—When Must an Insurer Look to the Language in a Previous Insurer's Policy?*

Unambiguous policy language will usually control what is required for one to prove she is entitled to disability coverage, so insurers work hard to craft language that is clear. But sometimes an insurer must look to and rely on the terms of its predecessor's policy to ascertain its obligations under its own policy.

In *Wallace v. Beaumont Healthcare Employee Welfare Benefit Plan*,[115] the court awarded the plaintiff summary judgment against defendant Reliance Standard Life Insurance Company after the insurer denied coverage based on a pre-existing condition clause in a long-term disability ("LTD") plan. Taking over plan coverage from another insurer, Reliance agreed to provide coverage for employees insured with the prior carrier when the plan was transferred.[116] The plaintiff, a plan participant under the prior carrier's policy, was on medical leave when the new plan went into effect on January 2, 2013. She returned to work in April 2013 after a medical leave of absence that began in October 2012, but required another medical leave beginning May 2013. The plaintiff did not return to work thereafter.[117] Reliance denied her claim for LTD benefits under its policy's pre-existing condition exclusion, arguing she did not become insured until April 2013 when she returned from leave and had received medical treatment during the three months immediately before that date.[118] The plaintiff argued she was covered under the 2013 plan in light of the policy's Transfer of Insurance Coverage provision which provided, in pertinent part, that:

> If an employee was covered under any group long term disability insurance plan maintained by you prior to this Policy's Effective Date, that employee will be insured under this Policy, provided that he/she is Actively at Work and meets all of the requirements for being an Eligible Person under this Policy on its Effective Date.[119]

Because coverage under the 2013 plan was dependent on whether coverage existed under the prior plan, the court looked to the prior plan's language.[120] It found the plaintiff was covered under the prior plan on the date

occupation, an issue that was critical to the amount of his benefit due to a change in title and reduction in salary on his date of injury).

114. *Søren Kierkegaard Quotes*, Goodreads, https://www.goodreads.com/quotes/6812-life-can-only-be-understood-backwards-but-it-must-be (last visited Nov. 12, 2018).

115. 2017 WL 4987675 (E.D. Mich. Nov. 2, 2017).

116. *Id.* at *3.

117. *Id.* at *1.

118. *Id.* at *2.

119. *Id.* at *3.

120. *Id.*

of transfer.[121] The Transfer of Insurance Coverage provision also required that Total Disability begin on or after the 2013 policy's effective date.[122] Because the plaintiff returned to work for a few weeks in 2013, the court found her disability under the 2013 policy did not begin until the day *after* her last day of work in May 2013. In so holding, it rejected the insurer's argument that disability began during the plaintiff's initial leave in 2012.[123] The court thus concluded that the plaintiff's coverage was effective on January 2, 2013 and the pre-existing condition exclusion did not apply.[124]

Another situation dealing with continuity of coverage between plans was taken up by the Eleventh Circuit in *Torpy v. Unum Life Insurance Co. of America*.[125] The plaintiff, a police officer, had a stroke in 2012 causing him to be on and off work due to recovery, surgery, and high blood pressure issues until he ceased working in June 2013.[126] His employer offered LTD coverage through Union Security Insurance Company in 2012, but switched to Unum effective January 1, 2013.[127] The plaintiff filed LTD claims with both Union Security and Unum.[128]

Union Security approved the plaintiff's LTD claim from the date of his stroke in 2012.[129] Unum also approved his claim, but initially found his disability began in February 2013 when he temporarily stopped working to have surgery.[130] Unum then changed its mind, found the plaintiff's disability began in 2012 when he had his stroke, and withdrew its prior approval of the plaintiff's claim because he became disabled before its policy's effective date of coverage.[131]

The plaintiff sued Unum for LTD benefits, and the district court found he was entitled to benefits offset only by the benefits he collected from Union Security.[132] On appeal, Unum conceded the plaintiff was entitled to coverage under its plan, but argued that coverage was based on its policy's Continuity of Coverage provision and that the plaintiff's Union Security benefit—which was offset by his retirement income—controlled

121. *Id.*
122. *Id.*
123. *Id.* at *4–5. The court denied the insurer's request for a remand to perform an independent medical review of the plaintiff's records to determine whether she was "Totally Disabled" under the 2013 policy, instead reviewing the case *de novo* and determining there was factual support in the record to find Total Disability and award benefits. *See id.* at *5–7.
124. *Id.* at *5.
125. 2018 WL 3359548 (11th Cir. July 10, 2018).
126. *Id.* at *1.
127. *Id.*
128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.*
132. *Id.* at *2.

the amount of benefits due to him.[133] Unum argued that even though the plaintiff became "disabled" under the Unum policy *after* it went into effect in 2013, his disability stemmed from a pre-existing condition—namely, his 2012 stroke.[134] The Eleventh Circuit remanded to the district court to determine whether the plaintiff had a pre-existing condition under Unum's policy since his benefit calculation depended on whether his coverage was governed by the Continuity of Coverage provision applicable to pre-existing conditions covered by the Union Security policy.[135]

The holdings in *Torpy* and *Wallace* illustrate that despite insurers' best efforts to define the coverage they intend to provide, the terms of prior policies can sometimes hijack those efforts and may force them to cover losses they did not intend.

### C. *Nothing Is So Painful to the Human Mind as a Great and Sudden Change*[136]*—Attempts to Change Definitions or Benefits Mid-Claim*

Two courts over the past year looked with disfavor on what they viewed as unfair changes in an employer's or insurer's position on issues affecting a claimant's disability benefits.

The plaintiff in *Rustad-Link v. Providence Health & Services*[137] suffered from two conditions—multiple sclerosis and a 2010 amputation below the knee due to negligent medical care.[138] After an initial dispute between the parties over which condition was the disabling one, the insurer concluded the plaintiff was disabled due to her MS.[139] The insurer changed its position, however, after learning the plaintiff received a monetary settlement related to her amputation; it then asserted it was entitled to offset the settlement amount against future benefits because the injury that rendered her disabled was the same injury for which she received the settlement payment.[140] The plaintiff disputed the insurer's offset, arguing the medical records clearly showed she was disabled due to a combination of her amputation and MS.[141] The insurer rejected this argument, and denied the plaintiff's appeal.[142] The plaintiff then sued under ERISA.[143]

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133. *Id.* at *3.
134. *Id.*
135. *Id.* at *5.
136. Mary W. Shelley, Frankenstein, or, the Modern Prometheus 156 (Sever, Francis & Co. 1869).
137. 306 F. Supp. 3d 1224 (D. Mont. 2018).
138. *Id.* at 1228–29.
139. *Id.* at 1229–30.
140. *Id.* at 1231.
141. *Id.*
142. *Id.*
143. *Id.* at 1231–32.

The court confirmed the policy's offset provision only permitted deductions for third-party settlements if the settlement concerned the same condition that caused the plaintiff's disability.[144] In reviewing the plaintiff's claim *de novo* and finding no offset was allowed, the court disapproved of what it perceived as the insurer's attempt to benefit from the plaintiff's misfortune of having been the victim of medical malpractice by changing its position as to which of her conditions was disabling *after* learning of the settlement.[145] It entered summary judgment for the plaintiff, awarded her past-due benefits, reinstated future benefits without an offset, and required the insurer to pay her reasonable attorney fees.[146]

To be fair to the insurer, the plaintiff was not consistent about what disabled her. When the insurer initially denied the plaintiff's claim for disability benefits, it did so on the grounds that her MS was a pre-existing condition. The plaintiff responded by arguing her amputation, not her MS, precipitated her disability.[147] But, as noted above, when the offset issue arose, the plaintiff argued she was disabled due to a *combination* of the amputation and her MS.[148] There was also a lack of consensus among the plaintiff's treating physicians as to what condition disabled her. At one point, the plaintiff's neurologist identified in an Attending Physician's Statement ("APS") that MS was the plaintiff's primary disabling condition.[149] Another APS a few months later, however, identified the plaintiff's amputation as her primary disabling condition and MS/chronic pain as a secondary disabling condition.[150] In short, the insurer was not the only party having a difficult time defining what caused the plaintiff's disability. What appears to have doomed the insurer's changes in position was that it committed to the position that the plaintiff's MS disabled her in response to the first APS, maintained that position in face of the second APS, and only changed its position when the offset issue arose.

It comes as no surprise, of course, that a court would disapprove of revisions to a benefit decision it perceives to be opportunistic and driven by circumstances other than medical evidence. Not all revisions to previous decisions are equally suspect, however, even when they result in a reduction or termination of benefits. In *Vaccaro v. Liberty Life Assurance Co. of Boston*,[151] the plaintiff was employed as an "HR Program Mgr 5," which was often referred to as a "Global Leadership and Talent Development Pro-

144. *Id.* at 1240.
145. *See id.* at 1241–42.
146. *Id.* at 1242–43.
147. *Id.* at 1229.
148. *Id.* at 1231.
149. *Id.* at 1229.
150. *Id.* at 1230.
151. 2017 WL 5564910 (N.D. Cal. Nov. 20, 2017).

gram Manager."[152] She began experiencing pain and fatigue in 2012 and reduced her work load, eventually ceasing work in April 2015.[153] At that time, the plaintiff's employer provided a group LTD policy that identified two classes of employees: Class 1, comprised of "CEO, President, Vice President, Corporate Officers, Directors, Managers, and Engineers," and Class 2, which included "all other Employees."[154] Both classes had an own occupation standard for the first 24 months, but Class 2 employees had an any occupation standard thereafter.

The plaintiff submitted a disability claim, which the insurer initially denied, finding in part that she was a Class 2 employee.[155] The plaintiff appealed, asking the insurer to review this finding along with its review of the benefit denial.[156] The insurer did not timely respond to the plaintiff's appeal.[157]

Two days after the appeal decision deadline, the plaintiff filed suit.[158] Days later, the insurer informed the plaintiff it was reversing its benefit decision, but did not address its Class 2 finding.[159] It later confirmed the plaintiff's status as a Class 2 employee.[160]

The LTD policy was then amended, effective January 1, 2017, and re-defined Class 1 employees, declared that an employee's Class status was determined at the plan sponsor's discretion based on job level code, and explained that "not every employee with a job title including the words 'Director,' 'Manager,' or 'Engineer'" would be considered a Class 1 employee.[161] The plaintiff challenged the finding that she was a Class 2 employee, but the insurer argued the issue was not ripe because disability definitions for Class 1 and Class 2 employees were identical for the first 24 months, which had not yet elapsed.[162] The court rejected this argument, finding that while the issue might not have been ripe if the insurer *declined* to decide the plaintiff's Class status until the 24-month mark, it was ripe because the insurer affirmed its initial determination that she was a Class 2 employee.[163]

Applying a *de novo* standard, the court considered whether the 2015 or 2017 language controlled.[164] The plaintiff argued the 2015 language

152. *Id.* at *2.
153. *Id.*
154. *Id.* at *3.
155. *Id.*
156. *Id.*
157. *Id.* at *4.
158. *Id.*
159. *Id.*
160. *Id.*
161. *Id.* at *5.
162. *Id.*
163. *Id.* at *4–5.
164. *Id.* at *6.

applied because her claim accrued when the insurer's deadline to decide her appeal expired in June 2016.[165] The insurer countered that no claim had yet accrued because it granted the plaintiff's claim and no final *denial* was sent.[166] Finding for the plaintiff, the court held that even if the insurer substantially complied with the appeal deadline (six days late), it could not "unaccrue" the plaintiff's ERISA claim; it also concluded that the finding that she was a Class 2 employee occurred while the 2015 version of the policy was in effect, so the 2015 language controlled.[167] Under the 2015 language, the court found the term "manager" in the plaintiff's official and unofficial titles made her a Class 1 employee and, as such, she would not need to satisfy the "any occupation" standard applicable to Class 2 employees after the first 24 months.[168]

### D. *It Was the Footnotes[169]—A Court's Exhaustive Chronicle of One Insurer's History with Job Descriptions*

A footnote can, despite its relative font size and relegation to the undermost reaches of the page, add powerful content. It should come as no surprise that a footnote spanning multiple pages and citing over 100 cases packs quite a punch. That is precisely what the court delivered in *Nichols v. Reliance Standard Life Insurance Co.*[170] when granting summary judgment for the plaintiff on her ERISA claim for LTD benefits.

As an employee in Peco Foods' chicken processing factory, the plaintiff's three main duties were: (1) training other employees in proper sanitation practices; (2) physically inspecting meat products; and (3) packaging, labeling, and providing paperwork for meat products.[171] She spent at least 20% of her work day in temperatures around 40 degrees.[172] After decades in this job, the plaintiff developed circulatory system disorders that required her to avoid exposure to cold.[173] She stopped working and sought disability benefits, claiming she could no longer perform the material duties of her "Regular Occupation."[174]

165. *Id.*
166. *Id.* at *7.
167. *Id.* at *8–9.
168. *Id.* at *10.
169. Writer and noted feminist Joanna Russ shared the following anecdote on scholarly footnotes: "I once asked a young dissertation writer whether her suddenly grayed hair was due to ill-health or personal tragedy; she answered *It was the footnotes*." Joanna Russ, How to Suppress Women's Writing 137 (Univ. of Tex. Press 8th ed. 2005).
170. 2018 WL 3213618 (S.D. Miss. June 29, 2018).
171. *Id.* at *4.
172. *Id.* at *2–4.
173. *Id.* at *2.
174. *Id.*

The LTD policy defined "Regular Occupation" as "'the occupation [a claimant] is routinely performing' at the time of disability onset . . . as it is normally performed in the national economy."[175] The insurer looked to the "Dictionary of Occupational Titles" ("DOT") to identify the plaintiff's Regular Occupation.[176] The DOT, however, contained no entry for the plaintiff's specific job title, so the insurer compared her main duties with those in the DOT and determined the job of "sanitarian" was the closest match to the plaintiff's job, even though it did not include meat inspection or packaging duties.[177] The insurer argued that exposure to cold temperatures was job-site specific and not part of the plaintiff's Regular Occupation as performed in the national economy.[178] It therefore denied the plaintiff's claim for failing to show she was unable to perform the material duties of her Regular Occupation.[179] The plaintiff filed suit under ERISA after the insurer affirmed its decision. The court reviewed the insurer's decision under an abuse-of-discretion standard.[180]

The court rejected the insurer's decision, finding it was unreasonable to rely on a single DOT job description not including important duties of the plaintiff's actual position.[181] The court gave substantial weight to the insurer's conflict of interest, looking to prior cases involving this insurer over twenty years and creating a string citation of over 100 opinions that it claimed "when viewed together, describe an unmitigated pattern of arbitrary and wrongful decisions."[182]

Somewhat curiously, the court found that, even where a policy provides that the duties of an employee's regular occupation are determined by looking at the duties of that occupation in the national economy, an insurer must consider the employee's specific job duties because her actual duties illustrate the duties of that occupation in the national economy.[183] The court suggested that, instead of relying on a single job title that does not encompass all of the plaintiff's major responsibilities, the insurer should have blended the duties of multiple job titles from the DOT to better fit the plaintiff's actual job duties.[184] The court opined there was no evidence the insurer had attempted to mitigate the flaws in its methodology that were repeatedly criticized by other courts, claiming this record established

175. *Id.*
176. *Id.* at *4.
177. *Id.* at *2, *5.
178. *Id.* at *2.
179. *Id.*
180. *Id.* at *1–3.
181. *Id.* at *5.
182. *Id.* at *6.
183. *Id.* at *4 (citing House v. Am. United Life Ins. Co., 499 F.3d 443, 454 (5th Cir. 2007)).
184. *Id.* at *5.

a pattern of arbitrary and wrongful behavior.[185] It ultimately concluded that the plaintiff was entitled to summary judgment and attorney fees.[186]

*Nichols* is something of an outlier in that the court seemed to go to lengths to criticize the insurer. The history of court decisions, of course, does not reflect claims this insurer paid over the years and likely focuses disproportionately on negative holdings. It is a significant decision, however, as it provides guidance for disability insurers whose policies define "occupation" in terms of the national economy or by reference to the occupations listed in the DOT. Not surprisingly, the insurer appealed this decision, so tune in next year to find out whether the Fifth Circuit finds the district court's multi-page footnote persuasive.

## III. ERISA

### A. *You Complete Me*[187] *— The Complete Preemption Doctrine Applied Narrowly to Protect State Prerogatives*

State statutes and regulations designed to safeguard residents' health information or mandate certain health insurance coverage frequently intersect with ERISA. When parties assert claims under those state laws, ERISA's "complete preemption" doctrine comes into play, and courts must determine whether federal law has substituted an exclusive federal rule or claim in the place of state law. The decisions examining ERISA's complete preemption doctrine this survey period did not announce new rules, but the circumstances under which the doctrine was applied are noteworthy because states have been regulating privacy and health insurance coverage to a greater degree and with growing frequency in recent years, making it easy to envision similar disputes in coming years.

Disclosure of a participant's protected health information was at issue in *D.L. v. Aetna, Inc.*[188] The participant contracted HIV and intended to keep that information private.[189] When the insurer for his ERISA plan mailed him notice of a class action settlement, information disclosing he was taking "HIV Medications" was visible through the envelope's window.[190] The participant's landlord, who lived in the same house as the participant, discovered his HIV status when he saw the envelope.[191] The landlord gave the participant a 30-day "terminating notice," but later demanded that he

185. *Id.* at *8–9.
186. *Id.* at *9–10.
187. Jerry Maguire (Gracie Films 1996).
188. 2018 WL 3869322 (C.D. Cal. Aug. 10, 2018).
189. *Id.* at *1.
190. *Id.*
191. *Id.*

vacate the house before the 30-day deadline.[192] Without a new job or a new place to live, the participant moved in with his mother in another part of California.[193] Following his move, he received a job offer he could not accept because he moved too far away from the job's location.[194] The participant sued the insurer in state court asserting several violations of state privacy statutes and claims under state common law.[195] The insurer removed the case to federal court contending ERISA completely preempted the participant's claims.[196]

The district court found that the claims were not preempted and remanded the action to state court.[197] The court looked to the two-part complete preemption test announced in *Aetna Health Inc. v. Davila*,[198] under which a state-law claim is completely preempted if: (1) "at some point in time," the participant "could have brought the claim under ERISA § 502(a)(1)(B)," and (2) "there is no other independent legal duty that is implicated by [the] defendant's actions."[199] The insurer argued that because the participant's claims arose from its administration of the plan, they could have been brought as ERISA claims.[200] But because the participant did not seek to recover plan benefits, the court concluded his claims could not have been brought under Section 502(a)(1)(B), and so, the first *Davila* factor was not satisfied. [201] Examining the second factor, the court considered whether the participant's claims were "solely and entirely dependent on the ERISA plan."[202] His claims, the court observed, sought relief for breach of duties imposed by state law, all of which were independent of ERISA.[203] Since the participant's claims did not fall within either *Davila* factors, ERISA did not completely preempt them.[204]

192. *Id.* at *2.
193. *Id.* at *1–2.
194. *Id.* at *2.
195. *Id.* (alleging claims for violations of California's Confidentiality in Medical Information Act, Cal. Civil Code §§ 56–56.37 (West 2018), its HIV disclosure laws, a "violation of constitutional right to privacy under Article I, Section I of the California Constitution," negligence, negligence per se, intentional infliction of emotional distress, and "unlawful, unfair and fraudulent business acts and practices").
196. *Id.*
197. *Id.* at *5.
198. 542 U.S. 200, 210 (2004).
199. *D.L.*, 2018 WL 3869322, at *4, *5.
200. *Id.* at *5.
201. *Id.* at *4. Although not required by *Davila*, the court included as part of its examination of the first *Davila* factor whether the participant sought the relief available under Sections 502(a)(2) and 502(a)(3). *Id.* at *4–5.
202. *Id.*
203. *Id.* at *5.
204. *Id.*

The Ninth Circuit examined the extent to which ERISA preempts state laws that ostensibly preclude a plan's insurer from using certain guidelines to adjudicate benefit claims. The plaintiffs in *Hansen v. Group Health Cooperative*[205] challenged an insurer's internal guidelines for adjudicating mental health claims. According to the plaintiffs, who were mental health providers and assignees of their patients' plan benefits, the guidelines violated Washington's Consumer Protection Act[206] and Mental Health Parity Act.[207]

The court did not examine the first factor of the *Davila* test because complete preemption exists only if both factors are met and the second factor was "readily shown to be unmet."[208] The plaintiffs' claims were based on the breach of duties imposed independently of ERISA or their patients' ERISA plans. The insurer argued ERISA completely preempted the Mental Health Parity Act claim because the claim's viability depended on the ERISA plan's existence. The court disagreed, finding "[t]he relevant inquiry . . . focuses on the *origin* of the duty" allegedly breached.[209] Because the duties under the Mental Health Parity Act and Consumer Protection Act were independent of the rights established by the patients' ERISA plans, ERISA did not completely preempt the plaintiffs' claims.[210]

*Moore v. Apple Central, LLC*[211] provides a good illustration from this survey period of ERISA's complete preemption of state law claims. The plaintiff alleged a plan participant elected voluntary life insurance coverage under his employer's ERISA plan in addition to employer-provided guaranteed life insurance coverage.[212] The plaintiff further alleged the employer and *de facto* plan administrator withheld the required premiums from the participant's paychecks but never paid them to the plan's insurer, so the participant did not receive the voluntary life insurance coverage.[213] When the participant died, his beneficiary sued the employer/administrator asserting state law claims for breach of contract, negligence, breach of fiduciary duty, and promissory estoppel and failure to procure voluntary

205. 902 F.3d 1051 (9th Cir. 2018).

206. *Id.* at 1055; Wash. Rev. Code § 19.86.020 (making unlawful "[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce"). The plaintiffs alleged the plan's insurer competed unfairly by employing its own psychotherapists and discouraging patients from seeking treatment from other psychotherapists. *Hansen*, 902 F.3d at 1055.

207. *Id.*; Wash. Rev. Code § 48.44.341.

208. *Hansen*, 902 F.3d at 1059.

209. *Id.* at 1060 (emphasis in original). The relationship between an ERISA plan and a state law is a relevant inquiry, however, under the so-called "conflict preemption" doctrine. *See* 29 U.S.C. § 1144(a); N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995).

210. *Hansen*, 902 F.3d at 1060.

211. 893 F.3d 573 (8th Cir. 2018).

212. *Id.* at 575.

213. *Id.*

life insurance coverage.[214] She sought the difference between the guaranteed life benefit and the unpaid portion of the voluntary life coverage.[215]

The Eighth Circuit had little difficulty concluding ERISA completely preempted the beneficiary's claims.[216] The first prong of the *Davila* test was satisfied because the beneficiary could have brought her claim for voluntary life benefits under Section 502(a)(1)(B) and could have brought her claim for breach of fiduciary duty as a Section 502(a)(3) claim seeking a "surcharge" remedy for the administrator's alleged "fail[ure] to properly submit required information" to the group insurer for the voluntary life coverage.[217] The court also found, under *Davila's* second prong, that the legal duties the administrator allegedly breached were not independent of its duty as an ERISA plan administrator to forward the participant's premiums to the insurer.[218] Because the beneficiary's claims fell within both prongs of the *Davila* test, ERISA completely preempted the claims.

Even though state-law claims like those in *Hansen* may not be preempted under the complete preemption doctrine, they may be preempted under conflict preemption, which arises under Section 514(a) of ERISA[219] and preempts state laws and actions that relate to employee benefit plans. Left unsaid in the discussions above is the reminder that complete preemption and conflict preemption are different. Complete preemption is a jurisdictional doctrine that says some state law actions arise under federal law because federal law has supplanted that field of law.[220] That is the case in the context of ERISA. Where the doctrine applies, it means that a plaintiff's state law claims can be removed to federal court because they are deemed to be federal claims over which federal courts have federal question jurisdiction.[221] In contrast, removal is not appropriate just because a state-law claim arguably relates to an ERISA plan. In those circumstances, conflict preemption is a defense to the plaintiff's state law claims. Because a federal defense does not create federal question jurisdiction,[222] such claims cannot be removed on the grounds they are preempted by Section 514(a).

The distinction between the preemption doctrines puts the significance of the decisions discussed above into context. Their primary significance is whether the actions can be removed to federal court. Even if they cannot be removed, they still may be defeated if they relate to an ERISA plan and,

214. *Id.* at 575–76.
215. *Id.* Notably, the record showed that the defendant paid the plaintiff the guaranteed life insurance benefits plus a portion of the voluntary life coverage. *Id.* at 577.
216. *Id.* at 577–78.
217. *Id.* at 577.
218. *Id.* at 577–78.
219. 29 U.S.C. §1144(a).
220. *See Hansen*, 902 F.3d at 1057.
221. *See id.* at 1057–58.
222. *See id.* at 1057.

therefore, are preempted by operation of Section 514(a). These are important distinctions to keep in mind as state efforts to expand privacy rights and exert more control over the operations of group health insurance plans are certain to intersect with ERISA and give rise to more disputes like those discussed above.

### B. *The Absence of Evidence Is Not the Evidence of Absence*[223]*—When Evidence of Disability Is More Difficult to Come By, Review Under the Deferential Standard May Be Less Deferential*

Assessing the merits of a disability claim premised on reports of chronic pain is one of the more challenging analyses a plan administrator undertakes.[224] Administrators often prefer objective evidence of a participant's claimed limitations because it makes the assessment process far simpler. The Sixth Circuit examined two decisions this survey period denying benefits because the participants failed to provide objective medical evidence of limitations that reportedly rendered them disabled. And in the Seventh Circuit, the court's concern about the overriding weight a plan gave to its consulting physician's opinion in the face of conflicting opinions from several other physicians, together with the plan's decision not to seek additional medical testing of the participant, led the court to find that the denial of benefits was arbitrary and capricious.

The plan administrator in *Guest-Marcotte v. Life Insurance Co. of North America*[225] denied the plaintiff's claim for disability benefits because she did not provide objective evidence of how her reported chronic pain limited her functionality.[226] The Sixth Circuit faulted the plan's decision not to order a physical examination of the plaintiff. While it acknowledged an examination was not mandatory, the court reasoned that because the plaintiff had Ehlers-Danlos Syndrome ("EDS"),[227] which is "known to cause chronic and severe pain," and her providers found she was in debilitating pain, it was unreasonable to deny her claim without a physical examination.[228] The court also criticized the plan for suggesting the plaintiff was not entitled to benefits absent objective evidence of her limited functionality, as the plan did not require objective evidence of the participant's limitations.[229] And, in any event, the plaintiff provided "plenty of proof" she had "EDS, which causes severe chronic pain that could well make it impossible

223. Carl Sagan, The Demon Haunted World 213 (Ballentine reprint ed. 1997).

224. *See* Hennen v. Metro. Life Ins. Co., 904 F.3d 532, 542 (7th Cir. 2018) (citing Holmstrom v. Metro. Life Ins. Co., 615 F.3d 758, 769 (7th Cir. 2010)).

225. 730 F. App'x 292 (6th Cir. 2018).

226. *Id.* at 295.

227. Ehlers-Danlos Syndrome Type III is "a hereditary disease characterized by loose connective tissue and frequent joint dislocations." *Id.* at 293.

228. *Id.* at 301–04.

229. *Id.* at 302.

for her to perform the mental functions of her job."[230] The Sixth Circuit reversed judgment for the defendants and remanded to the plan for a full and fair review of the plaintiff's short-term disability claim.[231]

In *Filthaut v. AT&T Midwest Disability Benefit Plan*,[232] the Sixth Circuit upheld the plan's denial of disability benefits. As in *Guest-Marcotte*, the plaintiff claimed she was disabled due to chronic pain and the plan denied her claim because she failed to provide objective evidence of her limitations.[233] The key factor that distinguished *Filthaut* from *Guest-Marcotte* was that Ms. Filthaut's plan required her to provide objective medical evidence of her condition, while Ms. Guest-Marcotte's plan did not.[234] In light of that, the Sixth Circuit agreed with the plan administrator that the plaintiff, not the plan, bore the burden of proving her claimed disability.[235]

A plan's decision to credit its consulting physician's opinion over the opinions of four other doctors, including the plaintiff's treating physician, two neurologists with training in electrodiagnostic testing, and the plan administrator's own medical director, was arbitrary and capricious, according to the Seventh Circuit.[236] The plaintiff in *Hennen v. Metropolitan Life Insurance Co.*[237] had a history of lower back problems and received two years of disability benefits due to lower back pain that radiated down her legs.[238] At the time of the award, the plan advised the plaintiff that her benefits were subject to a two-year limitation for disabilities attributable to "neuromusculoskeletal disorders."[239] When, after two years, the plan terminated the plaintiff's benefits, she claimed she was entitled to continuing benefits under an exception to the two-year limitation for disabilities attributable to radiculopathy.[240] Relying in part on its consulting physician's opinion, the plan concluded there was no objective evidence of radiculopathy.[241] The court found the denial of benefits was arbitrary and capricious.[242] The finding was driven in part by the court's concern that the medical consensus was significantly one-sided and the plan favored its consultant's opinion

230. *Id.* at 302–04.
231. *Id.* at 304.
232. 710 F. App'x 676 (6th Cir. 2017).
233. *Id.* at 682.
234. *Id.*
235. *Id.* at 685; *see also* Griffin v. Hartford Life & Accident Ins. Co., 898 F.3d 371, 382–83 (4th Cir. 2018) (applying deferential standard of review, the Fourth Circuit affirmed summary judgment for plan administrator, in part because the plan administrator was not required by the plan's terms to physically examine the plan participant, who claimed to have pain caused by a herniated disc).
236. Hennen v. Metro. Life Ins. Co., 904 F.3d 532 (7th Cir. 2018).
237. *Id.*
238. *Id.* at 535–36.
239. *Id.* at 536.
240. *Id.* at 537.
241. *Id.* at 538–39.
242. *Id.* at 539.

without explaining why it outweighed the credible opinions of the other physicians.[243] The plan's decision to ignore the consultant's recommendation to seek additional testing also contributed to the court's finding.[244] Judge Easterbrook dissented, asserting it was not unreasonable for the plan to rely on the opinion of its consulting physician, and that the majority's decision "boils down to the view that the medical majority should rule."[245]

### C. *How Did It Get So Late So Soon?*[246] *—When Being One Day Late May Cost You the Case*

The degree to which district courts have required ERISA plans to comply with ERISA's claims-procedure regulations[247] has varied over the years. Non-compliance with the regulations can have serious consequences for plans. For starters, a claimant's appeal can be deemed exhausted, depriving the plan of the opportunity to correct any errors or omissions in a benefits decision. More significantly, it can mean the loss of the right to deferential review from the court. The April 1, 2018, update to the Department of Labor's ERISA regulations requires a level compliance with the claims-procedure regulations that is more demanding than substantial compliance[248] and introduces additional guidelines for disability benefit plans. The varying levels of compliance district courts required this survey period are illustrated by the decisions discussed below, and we expect the magnitude of those variations to diminish over time due to the new regulations.

Roughly three years ago, the Second Circuit issued its opinion in *Halo v. Yale Health Plan, Director of Benefits & Records Yale University*,[249] a decision which has become a leading authority for the argument that ERISA demands strict compliance with its claims-processing regulations. The court analyzed the 2000 version of Section 2650.503-1(*l*)[250] and found it

243. *Id.* at 540–41.
244. *Id.*
245. *Id.* at 543 (Easterbrook, J., dissenting).
246. *Dr. Seuss (n.d.) Quotes*, http://www.brainyquote.com/quotes/authors/d/dr_seuss.html (last visited Jan. 27, 2019).
247. 29 C.F.R. § 2650.503–1(*l*).
248. Claims Procedures for Plans Providing Disability Benefits, 81 Fed. Reg. 92,316–01, 92,327 (Dec. 19, 2016).
249. 819 F.3d 42 (2d Cir. 2016).
250. The 2000 version of 29 C.F.R. § 2560.503-1(*l*) states:

> Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

29 C.F.R. § 2560.503-1(*l*).

was ambiguous as to the level of compliance it demanded.[251] That allowed the court to consider the DOL's preamble to the 2000 regulation as part of its efforts to construe the regulation. Ultimately, the court deferred to the DOL's explanation "that a decision made in the absence of the mandated procedural protections *should not be entitled to any judicial deference*."[252] The court reasoned that the substantial compliance doctrine, which was permitted under the regulation's 1977 version, was "flatly inconsistent with the 2000 regulation" because "the Department of Labor considered and rejected the doctrine when it completely replaced the 1977 regulation."[253] But strict compliance may not be necessary, the court explained, if "the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the claims-procedure regulation in processing a particular claim was inadvertent *and* harmless."[254] The Second Circuit also held that the plan will have the burden of proof on this issue "since the party claiming deferential review should prove the predicate that justifies it."[255]

Several decisions this survey period relied on *Halo's* reasoning to deem claimants' appeals exhausted and review the plans' benefit decisions under the *de novo* standard instead of the deferential standard granted in the plan's governing documents. In *Aitken v. Aetna Life Insurance Co.*,[256] the court closely scrutinized the extension of time the plan administrator took to decide the claimant's appeal of a denial of disability benefits, and it found the extension did not strictly comply with ERISA's claims-procedure regulation.[257] Administrators are required to decide a claimant's disability benefits appeal within 45 days of its submission.[258] The regulations permit a 45-day extension, but only when "special circumstances" require it.[259] The administrator in *Aiken* took the extension and rendered its decision exactly 90 days after the appeal was submitted.[260] According to the administrator, the extension was necessary to obtain a medical opinion from an appropriate specialist,[261] but the court found that was not a special circumstance

251. *Halo*, 819 F.3d at 54.
252. *Id.* at 53–55 (quoting Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70,246-01, 70,255 (Nov. 21, 2000) (emphasis added)).
253. *Id.* at 56.
254. *Id.* at 57–58.
255. *Id.* at 58 (quoting Sharkey v. Ultramar Energy Ltd., 70 F.3d 226, 230 (2d Cir. 1995)).
256. 2018 WL 4608217 (S.D.N.Y. Sept. 25, 2018).
257. *Id.* at *11–14.
258. 29 C.F.R. §§ 2560.503-1(i)(1)(i), (i)(3)(i).
259. *Id.*
260. *Aitken*, 2018 WL 4608217 at *12–13.
261. *Id.* at *12.

that justified the extension.[262] Accordingly, the extension did not strictly comply with ERISA's claims-procedure regulation.[263]

The administrator also failed to strictly comply with the regulation requiring it to take all information the claimant submitted into account on appeal.[264] While the administrative record contained multiple notes referencing a vocational report the claimant submitted, the court found the references did not demonstrate the administrator actually reviewed and considered it.[265] That failure, the court concluded, was not inadvertent or harmless.[266] In light of the administrator's failures to strictly comply with ERISA's claims-procedure regulation, the court declined to review the plan's benefit decision with deference and instead reviewed it *de novo*.[267]

A plan administrator's failure to reference the plan provisions it relied on to deny claims for pension and annuity benefits[268] was a harmless, but not inadvertent, violation of ERISA's claims-procedure regulation, according to the court in *Babino v. Gesualdi*.[269] The administrator's letter to the claimant described its decisions affecting the claimant's right to welfare and pension and annuity benefits. The letter specifically identified the welfare plan provisions it relied on, but did not identify the pension and annuity plan provisions it relied on.[270] That suggested to the court that the failure to include the required information was deliberate and, therefore, not inadvertent.[271] As in *Aitken*, the administrator's failure to strictly comply with the claims-procedure regulations resulted in the court reviewing the plan's benefits decision under a *de novo* standard, and ultimately the *Babino* court entered summary judgment for the claimant.[272]

*Halo's* determination that plans must strictly comply with ERISA's claims-procedure regulations was deemed not binding on the court in *Johnston v. Aetna Life Insurance Co.*[273] but that court ultimately adopted *Halo's* reasoning and most of its construction of the regulation after examining the

262. *Id.* at *13.
263. *Id.*
264. *Id.* at *14.
265. *Id.*
266. *Id.* at *15.
267. *Id.*
268. *See* 29 C.F.R. § 2650.503-1(g)(1)(ii).
269. 278 F. Supp. 3d 562, 583–85, 592 (E.D.N.Y. 2017).
270. *Id.* at 584–85.
271. *Id.*
272. *Id.* at 583–85, 592. Similarly, in *Montefiore Medical Center v. Local 272 Welfare Fund*, 2018 WL 1665645, at *1 (S.D.N.Y. Feb. 20, 2018), *report and recommendation adopted*, 2018 WL 1662634 (S.D.N.Y. Apr. 3, 2018), a self-insured plan failed to include in the EOBs it sent to the claimant hospital references to the specific plan provisions on which the plan's denials of the hospital's reimbursement claims were based. *Id.* at *1, *9–10. Because of those regulatory violations and the plan's inability to demonstrate they were inadvertent and harmless, the court reviewed the plan's denials of the medical claims *de novo*. *Id.* at *10.
273. 2018 WL 2021335 (S.D. Fla. Mar. 1, 2018).

issue itself.[274] The plan in that case failed to comply with the regulations' timeliness requirements in significant ways.[275] The claimant appealed the denial of his claims for short- and long-term disability benefits, but the plan waited three months before beginning its review of the appeals.[276] The plan extended the time for its review six times to request information it already had, and when it finally denied the claimant's appeal, it did so based on information it possessed early in the appeals process.[277] Because the plan administrator failed to strictly comply with the regulations' timeliness requirements, the court concluded *de novo* review was appropriate.[278]

Other courts during the survey period required only substantial compliance with ERISA's claims-procedure regulation. The Fifth Circuit appeared to favor a substantial-compliance standard for plans, so long as a plan's noncompliance did not undermine ERISA's requirement that participants and beneficiaries receive a full and fair review of their claims: "[T]echnical compliance with ERISA procedures will be excused so long as the purposes of §1133 have been fulfilled."[279] The plan in *White v. Life Insurance Co. of North America*[280] provided group life insurance to participants. During the administrative review period, the claimant's attorney requested copies of all documents the administrator may rely on when deciding the beneficiary's claim.[281] The administrator retained a toxicologist before denying benefits, but failed to provide a copy of his report to the claimant.[282] The Fifth Circuit held the administrator did not substantially comply with the claims-procedure regulation and thus abused its discretion in denying benefits. The court then reversed and remanded to the district court to enter judgment for the claimant.[283]

The District of Utah confirmed its continuing reliance on the substantial-compliance standard to assess a plan's alleged violations of ERISA's claims-procedure regulation. In doing so, the court in *Brian C. v. ValueOptions*[284] explicitly declined to follow *Halo* because even after that decision "other district courts in the Tenth Circuit have continued to apply the substantial compliance standard to the amended regulations."[285]

274. The court did not address whether regulatory noncompliance could be excused when it was harmless and inadvertent. *Id.* at *14.
275. *Id.*
276. *Id.*
277. *Id.*
278. *Id.*
279. White v. Life Ins. Co. of N. Am., 892 F.3d 762, 764, 766, 769 (5th Cir. 2018), as revised (June 14, 2018).
280. 892 F.3d 762 (5th Cir. 2018), *as revised* (June 14, 2018).
281. *Id.* at 765–66.
282. *Id.*
283. *Id.* at 769, 771.
284. 2017 WL 4564737 (D. Utah Oct. 11, 2017).
285. *Id.* at *4 (addressing multiple alleged procedural irregularities, including the plan

As discussed in last year's article, the Department revised Section 2560.503-1(*l*) for plans providing disability benefits. The new regulation went into effect April 1, 2018, and applies to ERISA-governed disability claims filed after that date.[286] The "deemed exhaustion" provision remains the same,[287] but Section 2650.503-1(*l*)(2) now deems administrative remedies exhausted if a "plan fails to *strictly adhere* to all the requirements of th[e] section with respect to a claim."[288] If a plan does not strictly adhere to those requirements and "a claimant chooses to pursue remedies under section 502(a) of [ERISA] under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary."[289]

The regulation's statement that a "deemed denial" means there was no exercise of fiduciary discretion was "not intend[ed] to establish a general rule regarding the level of deference that a reviewing court may choose to give a fiduciary's decision interpreting benefit provisions in the plan's governing documents."[290] Rather, the regulation only was "intended to define what constitutes [the] *denial of a claim*."[291] The Department acknowledged, however, that a court might conclude the discretionary standard of review cannot be applied where there is no exercise of discretion and, therefore, the only appropriate standard of review is *de novo*.[292] Indeed, some commentators construe the provision as automatically requiring *de novo* review in the case of a plan's regulatory noncompliance.[293] Such a view, however, is difficult to square with the Department's explanation that noncompliance is excused if it is: (1) de minimis, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) in the context of an ongoing good-faith exchange of information, and (5) not reflective of a pattern or practice of non-compliance.[294] In sum, although the new

administrator's cursory analysis and failure to provide reviewer's credentials); *see also* Jo H. v. Cigna Behavioral Health, 2018 WL 4082275, at *7–8 (D. Utah Aug. 27, 2018) (addressing four alleged procedural irregularities: (1) denials based on inconsistent rationales, (2) the plan administrator's appeal denial letter did not reference claimant's clinical records, (3) the plan administrator failed to request additional information, and (4) the plan administrator ignored the substance of claimant's appeals).

286. 29 C.F.R. § 2560.503-1(*l*)(2), (p)(3).

287. *See* 29 C.F.R. § 2560.503-1(*l*)(1).

288. 29 C.F.R. § 2560.503-1(*l*)(2)(i) (emphasis added).

289. 29 C.F.R. § 2560.503-1(*l*)(2)(i).

290. Claims Procedures for Plans Providing Disability Benefits, 81 Fed. Reg. 92,316-01, 92,327 (Dec. 19, 2016).

291. *Id.* at 92,328 (emphasis added).

292. *Id.* ("The legal *effect* of the definition *may be* that a court would conclude that *de novo* review is appropriate because of the regulation that determines as a matter of law that no fiduciary discretion was exercised in denying the claim." (emphasis added)).

293. Mark D. DeBofsky, *Increased Transparency*, Am. Assoc. Justice, Aug. 2018 at 44, 48, *available at* https://www.debofsky.com/Articles/Trial_2018_Sept_Debofsky.pdf.

294. Claims Procedures for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,327; 29 C.F.R. § 2560.503-1(*l*)(2)(ii).

regulation requires something more from plans than substantial compliance with its requirements, and while it tilts toward *de novo* review if a plan's level of compliance is less than that, it gives courts latitude to apply the arbitrary and capricious standard of review, even when a plan administrator fails to strictly comply with the claims-procedure regulation.

## IV. HEALTH INSURANCE

### A. *The Text Has Disappeared Under the Interpretation*[295]*—Litigation Continues over Differing Interpretations of the Affordable Care Act*

#### 1. The Federal Circuit Rejects Insurers' Claims for Payment Under the ACA's Risk Corridors Program

Going into this survey period, there was a significant split in the Court of Claims concerning the federal government's obligation to pay to insurers the amounts called for in the ACA's risk corridors program. Fifty or so cases related to that issue were pending when the Federal Circuit issued two decisions resolving the split in favor of the federal government.

The backgrounds for the Federal Circuit's decisions are effectively identical. Congress created the risk corridors program to encourage health insurance companies to offer Qualified Health Plan (QHP) coverage on the ACA's Health Benefit Exchanges.[296] The program was conceived as a three-year program running from 2014 to 2016 that would spread the risks of participation on the Exchanges between and among the participating insurers and the federal government.[297] Under the program, which is found in Section 1342 of the ACA, gains and losses experienced by insurers offering QHPs on the Health Benefit Exchanges would be evened out.[298] Depending on how a QHP's aggregate premiums compared to its allowable costs, a QHP would either pay money to or receive money from HHS.[299]

Congress did not set a deadline for HHS to make the anticipated risk corridors payments.[300] HHS regulations established an annual July 31 deadline for insurers to submit the data needed to determine which insurers

295. *Friedrich Nietzsche Quotes*, https://www.goodreads.com/quotes/760799-the-text-has-disappeared-under-the-interpretation (last visited Jan. 27, 2019).

296. Molina Healthcare of Cal., Inc. v. U.S., 133 Fed. Cl. 14, 30 (2017).

297. *Id*. at 18 n.1.

298. Land of Lincoln Mut. Health Ins. Co. v. U.S., 129 Fed. Cl. 81, 89–90 (2016), *appeal docketed*, No. 17-1224 (Fed. Cir. Nov. 16, 2016); Moda Health Plan, Inc. v. U.S., 130 Fed. Cl. 436, 442 (2017).

299. Specifically, if a QHP issuer experienced a loss "such that the plan's 'allowable costs' are more than 103% of the plan's 'target amount' for that year," HHS would pay a portion of that loss to the issuer; while if it experienced a gain "such that the plan's 'allowable costs' are less than 97% of the plan's 'target amount' for that year, the issuer is directed to pay the HHS a certain amount of that gain." *Land of Lincoln*, 129 Fed. Cl. at 90 (quoting 42 U.S.C. §§ 18062(b)(1), 18062(b)(2) (2010); 45 C.F.R. §§ 153.510(b), 153.510(c) (2013)).

300. 42 U.S.C. § 18062.

were required to "pay in" and which were entitled to receive "pay outs," but, as with Section 1342, the regulations did not establish a deadline for HHS to make those payments to insurers.[301]

Congress also did not specifically appropriate funds for the risk corridors payments.[302] In 2014, two congressmen asked the Government Accountability Office (GAO) for an opinion identifying the potential sources of funding that were available for HHS' risk corridors payments.[303] The GAO identified two sources of funding: the "payments in" that HHS received under the Program and the Program Management appropriation for the Centers for Medicare and Medicaid Services (CMS).[304] The GAO opined that the language of the CMS Program Management appropriation for fiscal year 2014 allowed HHS to use those funds to make risk corridors payments, but clarified that Congress would have to use similar language in future appropriations in order for HHS to continue using CMS Program Management to fund risk corridors payments.[305] Seemingly in response to that opinion, Congress's appropriations for fiscal years 2015 and 2016 stated that funds in the CMS Program Management account could not be used to make risk corridors payments.[306]

HHS announced, on October 1, 2015, that it owed insurers a total of $2.87 billion in risk corridors payments for the 2014 plan year.[307] HHS had received only $362 million in "payments in" for that year, however.[308] It therefore adopted a pro rata payment method, making payments to each qualified insurer equal to 12.6% of the amounts the insurer was entitled to receive.[309] In September 2016, HHS announced it would not make any

301. Blue Cross & Blue Shield of N.C. v. U.S., 131 Fed. Cl. 457, 464 (2017), *appeal docketed*, No. 17-2154 (Fed. Cir. June 14, 2017).

302. *Molina*, 133 Fed. Cl. at 20.

303. *Id.* at 24–25; Me. Cmty. Health Options v. U.S., 133 Fed. Cl. 1, 6 (2017), *appeal docketed*, No. 17-2395 (Fed. Cir. Aug. 7, 2017); *Blue Cross & Blue Shield of N.C.*, 131 Fed. Cl. at 466; *Moda Health Plan*, 130 Fed. Cl. at 447; *Land of Lincoln*, 129 Fed. Cl. at 93.

304. *Molina*, 133 Fed. Cl. at 24–25.

305. *Id.* at 25; *Me. Cmty. Health Options*, 133 Fed. Cl. at 6; *Blue Cross & Blue Shield of N.C.*, 131 Fed. Cl. at 466; *Moda Health Plan*, 130 Fed. Cl. at 447; *Land of Lincoln*, 129 Fed. Cl. at 93.

306. Specifically, the appropriations bill for fiscal year 2015, which was the first benefit year covered by the risk corridors program, included a rider, which read: "[n]one of the funds made available by this Act . . . or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services – Program Management' account, may be used for payments under Section 1342(b)(1) of Public Law 111-148 (relating to risk corridors)." Moda Health Plan, Inc. v. U.S., 892 F.3d 1311, 1318 (Fed. Cir. 2018) (quoting Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, § 227, 128 Stat. 2130, 2491); *see also Molina*, 133 Fed. Cl. at 25; *Me. Cmty. Health Options*, 133 Fed. Cl. at 6–7; *Blue Cross & Blue Shield of N.C.*, 131 Fed. Cl. at 466; *Moda Health Plan*, 130 Fed. Cl. at 447–48; Health Republic Ins. Co. v. U.S., 129 Fed. Cl. 757, 767–68 (2017); *Land of Lincoln*, 129 Fed. Cl. at 93.

307. *Molina*, 133 Fed. Cl. at 25.

308. *Id.*

309. *Id.* at 25–26.

payments for 2015. Instead, it would use the 2015 "payments in" to offset the outstanding obligations for 2014.[310] Those announcements and HHS's subsequent non-payments to insurers prompted several lawsuits against the United States.

The plaintiff insurers claimed they were owed risk corridors payments for 2014 and 2015, and they asserted a variety of causes of action in support of those claims, including breach of express contract, breach of implied-in-fact contract, and breach of an implied covenant of good faith and fair dealing. Some insurers also asserted a Fifth Amendment claim, arguing the government's actions amounted to a taking without just compensation.[311]

The government responded that the plaintiffs' claims failed to state claims for relief.[312] HHS was not required to make risk corridors payments annually, the government argued, and, therefore, HHS's failure to make the 2014 and 2015 payments was not contrary to Section 1342.[313] The government pointed to HHS's comments to the implementing regulations for Section 1342 as support.[314] HHS declared its intent to administer the Program in a "budget neutral" manner over the three-year lifetime of the Program, meaning HHS would make risk corridors payments sometime after the end of three-year period.[315] The government further argued that Congress, by expressly withholding funding for the risk corridors payments in CMS's 2015 and 2016 Program Management appropriations, vitiated the government's obligation to make risk corridors payments from funds other than those HHS collected from insurers' "payments in."[316] Two lines of decisions developed, each tracking the arguments of either the plaintiff insurers or the federal government.

The Federal Circuit reversed summary judgment for the insurer in *Moda Health Plan, Inc. v. United States*.[317] While it acknowledged Section 1342 required the government to make full risk corridors payments to insurers, it concluded Congress suspended the obligation through its

310. *Id*. at 26.

311. *See Id*.; *Land of Lincoln*, 129 Fed. Cl. at 114.

312. *See Blue Cross & Blue Shield of N.C.* 131 Fed. Cl. at 466; *Me. Cmty. Health Options*, 133 Fed. Cl. at 6; *Moda Health Plan, Inc.*, 130 Fed. Cl. at 447; *Land of Lincoln*, 129 Fed. Cl. at 93; *Molina*, 133 Fed. Cl. at 27. In Health Republic Ins. Co. v. U.S., 129 Fed. Cl. 757, 767–68 (2017), the government sought dismissal only on ripeness grounds under Fed. R. Civ. P. 12(b)(1).

313. *Blue Cross & Blue Shield of N.C.*, 131 Fed. Cl. at 471; *Me. Cmty. Health Options*, 133 Fed. Cl. at 3; *Moda Health Plan*, 130 Fed. Cl. at 454; *Land of Lincoln*, 129 Fed. Cl. at 104; *Molina*, 133 Fed. Cl. at 27.

314. *Blue Cross & Blue Shield of N.C.*, 131 Fed. Cl. at 476; *Me. Cmty. Health Options*, 133 Fed. Cl. at 5–7; *Moda Health Plan*, 130 Fed. Cl. at 455–56; *Land of Lincoln*, 129 Fed. Cl. at 106; *Molina*, 133 Fed. Cl. at 29.

315. *Molina*, 133 Fed. Cl. at 32.

316. *Me. Cmty. Health Options*, 133 Fed. Cl. at 3; *Moda Health Plan*, 130 Fed. Cl. at 457; *Land of Lincoln*, 129 Fed. Cl. at 113 n.30; *Id*. at 33.

317. 892 F.3d 1311, 1322 (Fed. Cir. 2018).

rider to the appropriations bill for fiscal year 2015.[318] In particular, the court considered it significant that Congress specifically foreclosed use of CMS Program Management funds as a source of funding for risk corridors payments.[319] The GAO report, the court believed, confirmed those funds were the "sole" source of Congressional funding for the program.[320] Consequently, the GAO's report, together with the 2015 appropriations rider, "adequately expressed Congress's intent to suspend payments on the risk corridors program beyond the sum of payments in."[321] And Congress notably never backed away from its efforts to limit funding for the risk corridors payments, as it included riders to appropriations for fiscal years 2016 and 2017 that were identical to that for fiscal year 2015.[322] Finally, the court rejected the insurer's implied-in-fact contract claim. It reasoned that "the circumstances of this legislation and subsequent regulation did not create a contract promising the full amount of risk corridors payments"[323] to participating insurers because "[a]bsent [a] clear indication to the contrary, legislation and regulation cannot establish the government's intent to bind itself in a contract."[324] The insurer has requested a petition for *en banc* rehearing.

The Federal Circuit reversed in favor of the government in *Moda* and it affirmed in favor of the government *Land of Lincoln Mutual Health Insurance Co. v. United States*.[325] As in *Moda*, the court concluded the insurer could not demonstrate the government entered into a contract.[326] Accordingly, the insurer's action for breach of contract failed to state a claim for relief. And because one of Land of Lincoln's takings claims was premised on the existence a contract with the government, that claim also failed.[327] Land of Lincoln's other takings claim, premised on its statutory entitlement to payment, failed because "no statutory obligation to pay money, even where unchallenged, can create a property interest within the meaning of the Takings Clause."[328]

Considering the significance of the issues involved—the limits of Congress's authority to withhold federal funding for an obligation the

318. *Id.*
319. *Id.* at 1325.
320. *Id.*
321. *Id.* at 1323.
322. *Id.* at 1319 (citing Consolidated and Further Continuing Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624; Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135, 543).
323. *Id.* at 1331.
324. *Id.* at 1329–31.
325. 892 F.3d 1184, 1185 (Fed. Cir. 2018).
326. *Id.*
327. *Id.* at 1186.
328. *Id.* (Newman, J., dissenting) (citing Adams v. United States, 391 F.3d 1212, 1225 (Fed. Cir. 2004)).

government created for itself by statute—we expect the Federal Circuit's decisions in *Moda* and *Land of Lincoln* will not be the final word in those disputes. We will be monitoring the decisions for subsequent developments and expect to report further during the next survey period.

### 2. The Federal Government Expands Accommodations to the Contraceptive Mandate

The federal government issued two new interim final rules during this survey period that added another facet to the continuing litigation over the ACA's so-called contraceptive mandate. The new interim rules, which are commonly referred to as the moral exemption rule and the religious exemption rule, represent the government's fourth attempt over two presidential administrations to accommodate religious objections to the contraceptive mandate. Each round has expanded the scope of employers entitled to claim the exemptions offered and has given rise to litigation. The new set of rules is no different in that regard.

The religious exemption rule expands the scope of entities entitled to exemption to any non-governmental plan sponsor or institution of higher education in its arrangement of student health insurance coverage,[329] so long as it objects to: "Establishing, maintaining, providing, offering, or arranging (as applicable) coverage, payments or a plan that provides coverage or payments for some or all contraceptives services, based on its sincerely held religious beliefs."[330] The moral exemption rule similarly creates an exemption for nonprofit organizations and for-profit entities with no publicly traded ownership interests that object to: "[e]stablishing, maintaining, providing, offering, or arranging (as applicable) coverage or payments for some or all contraceptive services, or for a plan, issuer, or third-party administrator that provides or arranges such coverage or payments, based on its sincerely held moral convictions."[331]

The manner in which the rules were implemented is notably different from the prior rounds of interim final rules. The U.S. Department of Health & Human Services issued the religious exemption and moral exemption rules without allowing a notice-and-comment period, permitting only post-issuance comments to be submitted within 60 days, i.e., by December 5, 2017.[332] Issuing the Rules in that manner spawned three lawsuits: *Pennsylvania v. Trump*;[333] *California v. U.S. Department of Health &*

329. *See* 45 C.F.R. § 147.132(a)(ii).
330. 45 C.F.R. § 147.132(a)(2).
331. 45 C.F.R. § 147.133(a)(2).
332. 82 Fed. Reg. 47, 792; 82 Fed. Reg. 47, 838.
333. 281 F. Supp. 3d 553 (E.D. Pa. 2017), *appeal docketed*, No. 18-1253 (3rd Cir. Feb. 15, 2018).

*Human Services*;[334] and *Massachusetts v. U.S. Department of Health & Human Services*.[335] In each lawsuit, the plaintiff states[336] asked the courts to preliminarily enjoin enforcement of the new interim final rules on the grounds that they violated the Administrative Procedures Act and were unconstitutional.[337] The courts in *Pennsylvania*[338] and *California*[339] both entered preliminary injunctions. The injunction entered in *California* is significant because it enjoins enforcement of the Rules nationwide. The court in *Massachusetts*, in contrast, denied the request for a preliminary injunction. [340] Appeals are currently pending in connection with the courts' rulings in each of those cases.

It is important to keep in mind that the rules create exemptions from the contraceptive mandate, and that litigation challenging the constitutionality of the mandate is ongoing. Litigation over the third round of interim final rules reached the United States Supreme Court in *Zubik v. Burwell*.[341] The Court asked the parties to file supplemental briefs discussing whether the interim final rules could be revised to serve the government's compelling interest in a less restrictive way.[342] When the Obama administration represented that it believed such a revision was possible, the Court vacated the opinions of several appellate court decisions addressing the mandate's constitutionality and remanded them to allow the parties to explore a resolution.[343] Consistent with the Court's request, the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury issued a request for information on July 26, 2016, seeking public comment on options for modifying the accommodation process in light of the supplemental briefing in *Zubik* and the Supreme Court's remand.[344] Public comments were submitted in response to the request for information during a comment period that closed on September 20, 2016.[345] On January 9, 2017, after reviewing the comments submitted in

334. 281 F. Supp. 3d 806, 821–23 (N.D. Cal. 2017), *appeal docketed*, No. 18-15255 (9th Cir. Feb. 16, 2018).
335. 301 F. Supp. 3d 248 (D. Mass. 2018), *appeal docketed*, No. 18-1514 (1st Cir. Jun. 6, 2018).
336. Delaware, Virginia, Maryland, and New York joined *California*, 281 F. Supp. 3d 806, as additional plaintiffs after the lawsuit was filed.
337. *Pennsylvania*, 281 F. Supp. 3d at 560; *California*, 281 F. Supp. 3d at 813; *Massachusetts*, 301 F. Supp. 3d at 205.
338. 281 F. Supp. 3d at *560.
339. *See California*, 281 F. Supp. 3d at 821–23.
340. 301 F. Supp. 3d at *266.
341. 136 S. Ct. 1557 (2016).
342. *Id.* at 1559–60.
343. *Id.*
344. 82 Fed. Reg. 47,792-01, at 47, 798 (citing 81 Fed. Reg. 47,741).
345. *Id.*

response and considering various options, the departments concluded they could not find a way to amend the accommodation in a manner acceptable to objecting eligible organizations while pursuing the departments' policy goals.[346] As a result, the litigation on remand from the Supreme Court remains unresolved. With the change in administrations, the government abandoned its earlier position that it had a compelling interest in ensuring employees' access to no-cost contraceptive coverage[347] that outweighed the employers' objections under the Religious Freedom Restoration Act of 1993 (RFRA).[348] As a result, several courts have held that the accommodation process established by the third set of interim final rules violates the RFRA and they permanently enjoined enforcement of the contraceptive mandate as to those plaintiffs.[349]

### B. *Show Me A Sane Man and I Will Cure Him for You*[350] — *Mental Health Parity*

Decisions from several district courts this survey period helped identify and define the sorts of plan-imposed limitations on mental health benefits that violate the Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act").[351] The Parity Act provides that a "group health plan" that "provides both medical and surgical benefits and mental health or substance use disorder benefits" must ensure that "the treatment limitations applicable to such . . . benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage)," and that "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."[352] In *Vorpahl v. Harvard Pilgrim*

346. FAQs About Affordable Care Act Implementation Part 36 (Dep'ts of Labor, Health & Human Servs. and Treas. Jan. 9, 2017), *available at* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-36.pdf, *and* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part36_1-9-17-Final.pdf.

347. *See, e.g.*, Reaching Souls Int'l v. Azar, 2018 WL 1352186, at *1–2 (W.D. Okla. Mar. 15, 2018).

348. 42 U.S.C. § 2000bb-1.

349. *Reaching Souls Int'l*, 2018 WL 1352186, at *1–2 (finding that a permanent injunction under Rule 65(d) and declaratory relief under 28 U.S.C. § 2201 were warranted); Sharpe Holdings, Inc. v. U.S. Dep. of Health & Human Servs., 2018 WL 1520031, at *4 (E.D. Mo. Mar. 28, 2018) (entering a permanent injunction enjoining enforcement of the contraceptive mandate); Geneva Coll. v. Azar, 2018 WL 3348982, at *2 (W.D. Pa. July 5, 2018) (entering a permanent injunction and declaratory relief).

350. *Carl Jung Quotes*, https://www.brainyquote.com/quotes/carl_jung_103688 (last visited Jan. 27, 2019).

351. 29 U.S.C. § 1185a.

352. 29 U.S.C. § 1185a(a)(3)(A)(ii).

*Health Insurance Co.*[353] the District of Massachusetts denied a plan's motion to dismiss, finding the plaintiff stated a claim for violation of the Parity Act. The issue was whether the plan's exclusion for "wilderness programs" applied equally to medical/surgical benefits and to mental health or substance use disorder benefits.[354] The court found the plaintiffs sufficiently stated a claim because, unlike the blanket exclusion of mental health or substance use disorder benefits under the wilderness programs, the "analogous medical/surgical treatment, at least as alleged [by] plaintiffs, is offered in other residential settings, like skilled nursing facilities or rehabilitation hospitals"[355] and, therefore, the plaintiffs adequately pleaded that the defendants "differentially applie[d] a facially neutral plan."[356] The court found that defendants' contention, that the "process and factors by which such nonquantitative treatment limitations could even be applied to both mental health benefits and medical/surgical benefits" required discovery to resolve.[357]

The court in *Munnelly v. Fordham University Faculty*,[358] found that a health insurance plan's exclusion of all "residential treatment services" violated the Parity Act.[359] The exclusion, the court observed, limited mental health benefits only, without creating a "corresponding limitation on analogous treatment for medical/surgical conditions."[360] The exclusion violated the Parity Act because interim final rules promulgated by the Secretaries of Labor, Health and Human Services, and Treasury made "clear that separate limitations on the scope of treatment and treatment settings—applied only to mental health benefits—are impermissible."[361] The plaintiff in *Doe v. United Health Group, Inc.*[362] alleged her plan had a policy of improperly reducing "benefits for behavior health services provided by psychologists and masters' level counselors," but did not subject medical/surgical benefits to similar reductions.[363] The court denied the defendant's motion to dismiss for failure to state a claim, concluding the plaintiff had "plausibly" alleged the "defendants' reimbursement policy [was] a discriminatory nonquantitative treatment limitation."[364]

353. 2018 WL 3518511, at *1 (D. Mass. July 20, 2018).
354. *Id.* at *3.
355. *Id.* at *4.
356. *Id.*
357. *Id.* at *3.
358. 316 F. Supp. 3d 714 (S.D.N.Y. 2018).
359. *Id.* at 734.
360. *Id.* at 733.
361. *Id.* at 734.
362. 2018 WL 3998022 (E.D.N.Y. 2018).
363. *Id.* at *5.
364. *Id.*

## V. LIFE INSURANCE

Stranger-originated life insurance (STOLI) decisions continue to be a mixed bag this year, with the Second Circuit finding STOLI schemes cannot be challenged after the policy's contestability period has expired and the Eleventh Circuit providing some hope for insurers pursuing lost profits resulting from STOLI arrangements, even after expiration of the contestability period. The sometimes fine-line in interpleader situations between not doing enough to determine whether there is a real risk of double-liability and going too far by deciding a potentially conflicting claim is also explored, as are some recent material misrepresentation decisions.

### A. *For Truth Is Always Strange; Stranger Than Fiction:*[365] *Recent STOLI Decisions*

In *Sun Life Assurance Co. of Canada v. Imperial Premium Finance, LLC*,[366] the Eleventh Circuit considered a novel twist to the issue of whether an insurer was "contesting" a life insurance policy. The case was a typical STOLI case, which involved several Sun Life policies acquired by Imperial, a premium finance company[367] that was a stranger to each of the original insureds. Sun Life claimed the policies were acquired through a fraudulent and conspiratorial scheme and it refused to pay Imperial's death benefit claims.[368] Sun Life sued Imperial after the contestable period expired, asserting claims such as RICO, fraud, civil conspiracy, and tortious interference with contractual relations and seeking, in part, a declaratory judgment that the policies were void ab initio.[369] As to the fraud and RICO claims, Sun Life claimed it lost profits because Imperial, a sophisticated investor, manipulated the values of its policies through a fraud-based scheme involving non-recourse premium financing of the policies, notwithstanding Sun Life's efforts to avoid non-recourse premium financed policies.[370] Imperial disputed Sun Life's claims and sued Sun Life for breach of contract and fraud based on the policies' incontestability and rights-and-privileges clauses.[371] The district court ultimately dismissed the claims at various stages of the litigation, and the parties appealed.[372]

The issue of particular interest on appeal was whether Sun Life's RICO and fraud-based claims were barred by the policies' incontestability

365. Lord Byron, Don Juan (1st publ'd 1819).
366. 904 F.3d 1197 (11th Cir. 2018).
367. *Id.* at 1203–04.
368. *Id.* at 1204.
369. *Id.* at 1205.
370. *Id.* at 1205, 1210.
371. *Id.* at 1205.
372. *Id.* at 1206.

clauses.[373] Sun Life admitted that its claims were asserted after the two-year contestability period expired, but argued it was not contesting the policy.[374] It claimed: "an insurer 'contests' a life insurance policy only where it seeks rescission of the policy as a remedy, which ultimately means a release from the obligation to pay benefits upon the death of the insured (or repayment of death benefits already distributed)."[375] And, Sun Life argued, it was not seeking rescission in its RICO and fraud claims; instead, it only sought "to recover lost profits attributable to the fact that the policies are investor-owned rather consumer-owned."[376]

The Eleventh Circuit, applying Florida law, agreed with Sun Life, noting that as "a textual matter, a lawsuit seeking damages without asking to rescind a life insurance policy cannot reasonably be construed as 'contest[ing]' 'th[e] *Policy* because it would remain in force.'"[377] The court then vacated the district court's dismissal of Sun Life's RICO and fraud claims to the extent they sought a remedy other than the "effective rescission of the policies."[378] Moving forward, it will be interesting to see whether this type of argument gains steam and becomes an effective way to challenge the legitimacy of STOLI arrangements post-contestability.

The insurer had less luck challenging a STOLI arrangement in *AEI Life, Inc. v. Lincoln Benefit Life Co.*[379] The life insurance policy, which was obtained by misstatements in the application, was paid for by a stranger to the insured.[380] The policy was then sold to the plaintiff more than two years after issuance, and the plaintiff ultimately sued seeking a declaration that the policy was incontestable as a matter of law.[381] Significantly, the court found that the plaintiff was a bona fide purchaser, as the insurer did not allege that the plaintiff was aware of the fraud related to the policy when it purchased it.[382] Finding that the policy contained a general conformity clause and not a choice of law provision selecting New Jersey law as the insurer argued, the Second Circuit applied the center of gravity test and held that New York law applied.[383] The court then concluded that, under New York law, the policy could not be challenged after the contestability

373. *Id.* at 1211.
374. *Id.*
375. *Id.*
376. *Id.*
377. *Id.*
378. *Id.* at 1212. The Eleventh Circuit also found that Sun Life's claims for RICO conspiracy, tortious interference with contractual relations, and aiding and abetting fraud were sufficiently pled. *Id.* at 1212, 1214, 1215, 1216. It further vacated the district court's dismissal of Imperial's breach of contract claim as to the incontestability clause. *Id.* at 1221.
379. 892 F.3d 126 (2d Cir. 2018).
380. *Id.* at 128.
381. *Id.* at 130.
382. *Id.*
383. *Id.* at 135–36.

period expired.[384] The district court's entry of summary judgment for the plaintiff was affirmed.[385]

New Jersey's STOLI law, ultimately not applicable in *AEI Life*, is likely to be further developed in light of the New Jersey Supreme Court's acceptance of two certified questions from the Third Circuit. In *Sun Life Assurance Co. of Canada v. Wells Fargo, N.A.*,[386] the Third Circuit reviewed the district court's finding that a STOLI arrangement violated New Jersey's anti-wagering laws and was void *ab initio*. The undisputed facts followed the typical pattern of a STOLI case. The district court found the insurable interest requirement was not met because the insured procured the policy as a financial investment to benefit third parties and not to benefit someone with an insurable interest.[387] Relying upon and adopting the Supreme Court of Delaware's reasoning in a case involving a similar question, the district court found that "permitting parties without an insurable interest to get around that requirement by causing someone with an insurable interest to procure a policy and then transfer that policy would be an 'illogical triumph of form over substance that would completely undermine the policy goals behind the insurable interest requirement.'"[388]

The Third Circuit considered this issue, but decided the New Jersey Supreme Court should resolve it. Accordingly, the Third Circuit certified two questions to the New Jersey Supreme Court: (1) "Does a life insurance policy that is procured with the intent to benefit persons without an insurable interest in the life of the insured violate the public policy of New Jersey, and if so, is that policy void ab initio?" and (2) "If such policy is void ab initio, is a later purchaser of the policy, who was not involved in the illegal conduct, entitled to a refund of any premium payments that they made on the policy?"[389] The New Jersey Supreme Court accepted these questions, as certified, on March 6, 2018.[390]

As a follow-up to a STOLI decision discussed in last year's article, in *Sun Life Assurance Co. of Canada v. Conestoga Trust Services, LLC*[391] the Sixth Circuit affirmed the district court's decision to grant summary judgment to the insurer because the policy was an illegal wagering contract. Stating it had "little to add to the district court's thorough and soundly reasoned opinion," the Sixth Circuit deemed it significant that the insured had a

384. *Id.* at 137–39.
385. *Id.* at 140.
386. 2018 WL 5303551 (3d Cir. 2018).
387. *Id.* at *1.
388. *Id.* at *3 (quoting PHL Variable Ins. Co. v. Price Dawe 2006 Ins. Tr., *ex rel.* Christiana Bank & Tr. Co., 28 A.3d 1059, 1071 (Del. 2011)).
389. *Id.* at *5.
390. *Id.*, *certification of questions granted by*, Sun Life Ass. Co. of Can. v. Wells Fargo Bank, N.A., No. 080669, Doc. No. 03112877109 (N.J. Mar. 6, 2018).
391. 717 F. App'x 600 (6th Cir. 2018).

preexisting agreement to sell the policy to an investor, the policy's state of issuance was changed mid-transaction when the insured used a false address, and the investor paid a total of $80,000 to the insured or his agent.[392] The court rejected the defendant's argument that the insured did not have an agreement with the investor prior to the policy's issuance because the $80,000 was to be paid only if the policy in fact issued. That payment, the court explained, was simply a condition precedent to the agreement; it did not mean there was no agreement.[393] After agreeing with the district court that the policy was void, the Sixth Circuit also affirmed the order requiring the insurer to refund the premiums the defendant had paid.[394]

### B. *In Any Moment of Decision, the Best Thing You Can Do Is the Right Thing. The Worst Thing You Can Do Is Nothing.*[395]*—Interpleader Actions*

In theory, interpleaders are quick and simple because the stakeholder may sue competing claimants for the funds at issue, deposit the funds into the court's registry, and then leave the claimants to litigate who receives the funds.[396] In reality, interpleader actions are rarely that straightforward. The effort required of the stakeholder seems to vary. Courts require "a real and reasonable fear of exposure to double liability or the vexation of conflicting claims," but a stakeholder "need not sort out the merits of conflicting claims."[397] If a stakeholder does not do enough to determine if there truly are competing claims, the court might not allow the interpleader action to proceed or may even penalize the stakeholder. If a stakeholder attempts to sort out the competing claims on its own, takes too long to do so, or improperly issues payment to one of the claimants, then the stakeholder may not be afforded any protection against claims from another claimant. The following decisions from this survey period examined these scenarios.

392. *Id.* at 601.

393. *Id.*

394. *Id.* Last year's article also reported on the Eastern District of New York's decision in *U.S. Bank National Ass'n v. Sun Life Assurance Co. of Canada*, 2017 WL 347449 (E.D.N.Y Jan. 24, 2017). While this decision was appealed to the Second Circuit, the appeal was withdrawn via stipulation of the parties. U.S. Bank Nat'l Ass'n v. Sun Life Ass. Co. of Can., 2018 WL 935604 (2d Cir. Jan. 3, 2018).

395. *Theodore Roosevelt Quotes*, Theodore Roosevelt Ctr., https://www.theodoreroosevelteenter.org/Learn-About-TR/TR-Quotes?page=4 (last visited Nov. 13, 2018). This quote is commonly attributed to Theodore Roosevelt, but no known source can be found to verify the attribution. *Id.*

396. *See* Lincoln Nat'l Life Ins. Co. v. Ridgway, 293 F. Supp. 3d 1254, 1260 (W.D. Wash. 2018) (citing Cripps v. Life Ins. Co. of Am., 980 F.2d 1261, 1265 (9th Cir. 1992)); Primerica Life Ins. Co. v. Montoya, 2018 WL 3068059, at *1 (D.N.M. June 21, 2018).

397. *Ridgway*, 293 F. Supp. 3d at 1260 (quoting Michelman v. Lincoln Nat'l Life Ins. Co., 685 F.3d 887, 899 (9th Cir. 2012)).

In *Mangano v. Jackson National Life Insurance Co.*,[398] the insured's widow sued the insurer for life insurance benefits and the insurer counterclaimed for interpleader. While the insured's ex-wife was the beneficiary of record, the plaintiff widow alleged the insurer failed to record a change of beneficiary form submitted to it after the insured's divorce and remarriage.[399] About three months after learning of the beneficiary issue, the insurer reached out to the ex-wife, who refused to waive her right to the policy proceeds.[400] The insurer then sent the plaintiff a letter explaining that it could not pay the policy proceeds without the consent of all adverse claimants and told her to advise when the parties had resolved their dispute, but that it would pursue an interpleader action if they could not do so in a reasonable amount of time.[401] About a month later, the plaintiff made a final demand for payment, and then sued the insurer for benefits when she received no response.[402] The insurer removed the action to federal court and filed a counterclaim seeking interpleader relief, naming the plaintiff and the ex-wife as defendants.[403] The insurer waited six weeks after summons was issued to serve the ex-wife and, when she did not respond to the complaint, failed to seek default judgment. Instead, the insurer filed a motion to deposit the policy proceeds with the district court and requested an order of interpleader, dismissing it from the case.[404]

After the plaintiff moved for default judgment against the ex-wife, the insurer advised the court that the ex-wife had recently agreed to waive her claim to the proceeds, rendering the interpleader action moot.[405] About a month later, the insurer paid the policy proceeds to the plaintiff and sought to voluntarily dismiss its interpleader counterclaim.[406] Although the district court dismissed the insurer's claim with prejudice, it reserved jurisdiction to decide whether the plaintiff was entitled to attorney's fees and costs.[407] The district court ultimately found that while the insurer negligently failed to process the beneficiary form, there was no evidence this was done in bad faith and that the insurer's delay in paying the proceeds was not vexatious and unreasonable given the investigation of the competing claims.[408]

The Eleventh Circuit disagreed. While it found that the insurer had grounds for conducting a reasonable investigation of the ex-wife's alleged

398. 723 F. App'x 918 (11th Cir. 2018).
399. *Id.* at 920–21.
400. *Id.* at 922.
401. *Id.*
402. *Id.*
403. *Id.* at 923.
404. *Id.*
405. *Id.*
406. *Id.*
407. *Id.*
408. *Id.* at 925.

claim, it held that the 9-month delay in paying the claim was unjustified given the insurer's minimal investigation.[409] The court suggested that the only reasonable interpretation of the insurer's actions was that it was attempting "to draw out payment as long as possible," and it ultimately concluded the delay was vexatious and unreasonable.[410] It further found the district court lacked discretion to deny prejudgment interest to the plaintiff and remanded the matter to the district court to decide both whether to award attorneys' fees and the amount of interest due to the plaintiff.[411] While the insurer's conduct can be scrutinized with the benefit of hindsight, it seems unlikely the insurer delayed payment of $150,000 to earn 9 months of interest that it would have known it might have to pay to the plaintiff. This case is a good reminder, however, to proceed with an interpleader as soon as reasonably possible.

If an "action does not involve two or more adverse claimants . . . it does not meet the jurisdictional requirements of the interpleader statute."[412] This situation arose in *New York Life Insurance Co. v. Lewis*[413] where the district court ultimately dismissed the interpleader action.[414] The insurer filed an interpleader action to determine who was entitled to the remaining proceeds of a life insurance policy, naming the insured's wife (designated as the primary beneficiary) and his sister (designated as the secondary beneficiary) as defendants.[415] While there were arguably two claimants—the wife and sister—neither answered the interpleader complaint, appeared in the case, or made a claim to the policy proceeds.[416] The court *sua sponte* disqualified the insured's wife as a potential claimant because she had been found guilty of the insured's murder,[417] reasoning that her claim, even if asserted, would have been barred by the state's slayer statute.[418] With only one potential claimant left, the district court found it lacked subject matter jurisdiction and dismissed the case.[419] However, the court also found the policy provided for how the proceeds should be distributed when the primary beneficiary does not survive the insured.[420] So, it seems the court

409. *Id.*
410. *Id.* at 925, 928.
411. *Id.* at 931.
412. N.Y. Life Ins. Co. v. Lewis, 2018 WL 2981345, at *2 (E.D. Mo. June 13, 2018) (quoting Delta Lloyds Ins. Co. v. Rhodes, 2013 WL 12122118, at *1 (N.D. Tex. Feb. 4, 2013)).
413. 2018 WL 2981345 (E.D. Mo. June 13, 2018).
414. *Id.* at *1.
415. *Id.*
416. *Id.* at *2.
417. *Id.*
418. *Id.*; Mo. Rev. Stat. § 461.045 (2010) (a beneficiary who murders the insured is precluded from recovering the proceeds of an insurance policy).
419. *Lewis*, 2018 WL 2981345, at *1.
420. *Id.* at *2.

essentially concluded that *the insurer* should have applied the slayer statute and, if it had done so, there would be no (even potentially) adverse claims.

But what happens to a stakeholder that decides not to file an interpleader action, sorts out the claims itself, and only pays one claimant? The answer: the stakeholder might face double liability as it did in *Sun Life Assurance Co. of Canada v. Jackson*.[421] There, the insurer faced competing claims from the decedent's brother and sole beneficiary, and the decedent's daughter, who claimed her parents' divorce decree required the decedent to name her as primary beneficiary.[422] The insurer paid the policy proceeds to the brother but then sought a declaration that its payment was proper.[423] After reviewing the validity of the competing claims, the court disagreed with the insurer's decision, found the decedent's daughter was entitled to the proceeds,[424] and ordered the insurer to pay the proceeds plus interest to the daughter. The Sixth Circuit affirmed.[425] Ultimately, since the insurer did not initially file an interpleader action but decided the claim itself and paid the wrong claimant, it faced double liability.[426]

### C. *Truth Is Replaced by Silence, and Silence Is a Lie.*[427]*—Material Misrepresentation*

In *Principal National Life Insurance Co. v. Coassin*,[428] the insured represented in his life insurance application that his vertigo "was resolved without recurrence" and represented at policy delivery that his health had not changed since the date of the application.[429] Both of these representations were false.[430] The insurer sued to rescind the subject $10 million life insurance policy, claiming it would not have issued the policy at the standard price but for the false statements.[431] The district court ruled for the insured, finding after reviewing the insurer's underwriting guidelines that the insurer would have issued the policy even if it had known the truth.[432] In other words, the misrepresentations were not deemed material. The

421. 877 F.3d 698 (6th Cir. 2018).
422. *Id*. at 699.
423. *Id*. at 700.
424. *Id*..
425. *Id*. at 705.
426. *Id*. at 704.
427. Yevgeny Yevtushenko, *Excerpts from Yevtushenko Statement*, N.Y. Times, Feb. 18, 1974, at 4, *available at*, https://www.nytimes.com/1974/02/18/archives/excerpts-from-yevtushenko-statement.html (last visited Nove. 13, 2018).
428. 884 F.3d 130 (2d Cir. 2018).
429. *Id*. at 137.
430. *Id*. at 133. The insured continued to experience vertigo and scheduled additional medical appointments after his application. *Id.*
431. *Id*. at 132–33.
432. *Id*. at 133–34.

Second Circuit affirmed, agreeing that the insured made misrepresentations and that they were not material under the insurer's guidelines.[433]

In contrast, the district court in *Estate of Kelly v. Lincoln Benefit Life Co.*[434] found misrepresentations in the application for a life insurance policy were material to the risk insured. The beneficiary admitted the insured made misrepresentations regarding cancer, a lung disorder, and other medical treatment.[435] She argued, however, that the insured's answers were incorrectly recorded on the application.[436] This argument failed because the insured was presumed, under Pennsylvania law, to have knowledge of the contents of the application he signed.[437] Finally, the court held that the insured's misrepresentations were material to the risk insured against because they dealt with the health of the insured, noting that materiality was not even a close question given his diagnosis of lung cancer.[438]

Finally, the Eighth Circuit reversed in part the district court's decision in *Yang v. Farmers New World Life Insurance Co.*[439] The insurer issued an insurance policy on the insured's life that was only issued to individuals under age 60.[440] After a death claim was made on the policy, the insurer learned, based on information in certain federal and state identification documents, that the insured was actually over 60 when she applied for the policy.[441] The plaintiff beneficiary denied that the insured's age was misrepresented, claiming there was an error in the state and federal records that occurred when the insured immigrated to the U.S.[442] The insurer relied on the policy's misstatement-of-age clause to attempt to avoid coverage, but the district court granted summary judgment to plaintiff finding that the policy was incontestable and that the insurer was effectively improperly challenging the policy's validity by seeking to enforce that clause.

The Eighth Circuit however found that the district court erred in essentially ignoring the misstatement-of-age clause in favor of the incontestability provision, as Minnesota's contract interpretation principles did not allow it to construe the contract "in a manner that 'entirely neutralizes one provision.'"[443] It then held that the insurer did not contest the policy when it applied the misstatement-of-age clause; rather, the insurer enforced it

433. *Id.* at 137–38.
434. 2017 WL 6451572 (M.D. Pa. Dec. 18, 2017).
435. *Id.* at *2.
436. *Id.* at *3.
437. *Id.*
438. *Id.* at *4.
439. 898 F.3d 825 (8th Cir. 2018).
440. *Id.* at 826.
441. *Id.* at 827.
442. *Id.*
443. *Id.* at 828.

and "it is irrelevant that adjusting the policy's benefits under the clause may result in their complete elimination."[444] The Eighth Circuit further explained: "[t]he test of whether an act contests a policy is not the outcome it produces, but whether it reaches that outcome by seeking to cancel the policy or enforce it."[445] Ultimately the Eighth Circuit held that the record was not clear as to what year the insured was actually born, so it affirmed the district court's denial of summary judgment to the insurer, reversed the grant of summary judgment to the plaintiff, and remanded the case.[446]

## VI. CONCLUSION

We will be monitoring courts' construction and application of the new ERISA claims-procedure regulation to see whether they move toward a strict-compliance standard or are willing to accept substantial compliance where a plan's regulatory noncompliance was harmless and inadvertent. Each survey period seems to bring something new to the Affordable Care Act-related disputes and we do not expect the next survey period to be any different, particularly with respect to disputes concerning payments under the risk corridors program and the contraceptive mandate. Finally, we are interested to see whether the strategy of suing for damages in stranger-originated life insurance policy disputes grows in popularity where rescission is barred by an incontestability clause. We look forward to reporting on these issues and other significant developments in health, life, and disability insurance law in next year's article.

444. *Id*.
445. *Id*. *But see* Amica Life Ins. Co. v. Barbor, 488 F. Supp. 2d 750 (N.D. Ill. 2007).
446. *Yang*, 898 F.3d at 830.