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

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Do accidental death policies require a causal connection between an insured's intoxication and death in order for a policy's intoxication exclusion to apply? Was it error for a district court to collect, *sua sponte*, citations to hundreds of cases involving the insurer in the case before it and conclude those decisions were evidence that the insurer's benefit decision was infected with bias? If an insured becomes disabled due to substance abuse, steals from clients and loses his professional license, then learns to manage his addiction but cannot reacquire his professional license, is he still disabled under a disability insurance policy? For ERISA cases, when is substantial compliance with governing regulations acceptable? And under what circumstances can a claimant be said to have "actual knowledge" of a breach of a fiduciary duty such that ERISA's limitations period

is triggered? Is the so-called Individual Mandate of the Patient Protection and Affordable Care Act unconstitutional? If so, is the Affordable Care Act unconstitutional?

These questions and more were answered by courts during this survey period and are discussed in this year's article. We also discuss three significant stranger-owned life insurance ("STOLI") decisions decided this survey period that lend support to the argument that such policies are void *ab initio*, notwithstanding investors' feigned compliance with insurable interest requirements. And finally, this article examines the issues and arguments before the United States Supreme Court following its grant of certiorari in a case that asks whether the federal government owes insurers in excess of $12 billion under the Affordable Care Act.

I. ACCIDENTAL DEATH

In this year's cases involving accidental death and dismemberment policies, courts continued to attempt to define the term accident; addressed intoxication, crime, illness, and medical treatment exclusions; and considered whether self-inflicted injuries constitute an accident.

A. *"Accidents Can Happen to You":[1] What Constitutes an Accident?*

In last year's article, we discussed the district court's decision in *Tran v. Minnesota Life Insurance Co.*,[2] which considered 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] The assistant medical examiner who performed the autopsy determined the insured died from autoerotic asphyxiation, due to the sexual paraphernalia found around his body and measures he had taken "to protect himself from strangulation."[5] The ERISA-governed benefit plan provided coverage for accidental death caused by an "accidental injury," which meant 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] The district court considered whether cerebral hypoxia qualified

1. REO Speedwagon, *Accidents Can Happen*, *on* Life As We Know It (Epic Records 1987).
2. 2018 WL 1156326 (N.D. Ill. Mar. 5, 2018).
3. *Id.*
4. *Id.* at *2.
5. *Id.*
6. *Id.* at *1.
7. *Id.*

as an "injury" under the policy.[8] It ultimately found the insured subjectively intended to survive and entered judgment for the beneficiary.[9] Minnesota Life appealed.[10]

The Seventh Circuit, departing from the district court's analysis, focused on the meaning of "injury,"[11] considering the term as a layperson would.[12] The district court had relied on three cases[13] to determine if autoerotic asphyxiation and the ensuing cerebral hypoxia qualified as an injury.[14] First, the decision in *Santaella v. Metropolitan Life Insurance Co.* held that an accidental overdose death did not result from an intentionally self-inflicted injury where there was no evidence the insured intended to injure herself when overdosing on a legally prescribed painkiller.[15] The Seventh Circuit did not find the decision in *Santaella* instructive, however, as to whether autoerotic asphyxiation was an injury.[16]

It also declined to adopt the reasoning from the Ninth Circuit's decision in *Padfield v. AIG Life Insurance Co.*[17] or from the Second Circuit's decision in *Critchlow v. First UNUM Life Insurance Co. of America*,[18] two cases involving autoerotic asphyxiation deaths and accidental death coverage. Those decisions, the Seventh Circuit explained, were based on the false premise "that the act of strangling oneself is severable into distinct phases and distinct injuries."[19] The court accepted that those who engage in autoerotic asphyxiation seek pleasurable experiences, but found that "choking oneself by hanging from a noose" restricts oxygen to the brain and causes a brain injury.[20] Because the insured intentionally performed autoerotic asphyxiation and because that is in itself an injury, the insured's death fell under the self-inflicted injury exclusion.[21] The Seventh Circuit clarified, however, that its ruling was not a "per se" rule for all autoerotic asphyxiation cases, as facts and policy language vary.[22]

8. *Id.* at *6.
9. *Id.* at *10.
10. Tran v. Minn. Life Ins. Co., 922 F.3d 380 (7th Cir. 2019).
11. *Id.* at 382.
12. *Id.* at 383.
13. Santaella v. Metro. Life Ins. Co., 123 F.3d 456 (7th Cir. 1997); Padfield v. AIG Life Ins. Co., 290 F.3d 1121 (9th Cir. 2002); Critchlow v. First UNUM Life Ins. Co. of Am., 378 F.3d 246 (2d Cir. 2004).
14. *Tran*, 922 F.3d at 383.
15. *Id.*
16. *Id.*
17. 290 F.3d 1121 (9th Cir. 2002).
18. 378 F.3d 246 (2d Cir. 2004).
19. *Id.* at 383–84.
20. *Id.* at 384–85.
21. *Id.* at 386.
22. *Id.*

In *Boyer v. Schneider Electric Holdings, Inc. Life & Accident Plan*,[23] a case involving an insured's death in a single-car collision, the court adopted the widely-accepted standard for determining whether an occurrence constitutes an "accident" set forth in *Wickman v. Northwestern National Insurance Co.*[24] *Wickman* provides that "an event is an accident if the decedent did not subjectively expect to suffer an injury similar in type or kind to that suffered and the suppositions underlying that expectation were reasonable."[25] Such determinations should be made from the insured's perspective, "allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences."[26] If the insured's subjective expectation cannot be determined, the question becomes "whether a reasonable person, with background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct."[27] Agreeing with plaintiff that the *Wickman* standard should have been applied in this ERISA governed-action, the *Boyer* court remanded the case to the plan to reconsider its accident analysis applying that standard.[28]

B. *"Blame It on the Alcohol":*[29] *Alcohol and Drug Intoxication Cases*

The insured in *Calderon v. Hartford Life & Accident Insurance Co.*[30] died in a motorcycle accident. The toxicology report showed he was intoxicated at the time of the collision.[31] The insurer noted the insured's level of intoxication would have affected his ability to reasonably react when another vehicle pulled in front of him, which could have reduced the severity of the crash.[32] The insurer denied coverage on two grounds: (1) the loss fell within the policy's intoxication exclusion,[33] and (2) the injury did not "result[] directly from an accident" and "independently of all other causes" and, therefore, was not a covered injury.[34]

The court observed that several other courts have suggested there is an implicit causation requirement in intoxication exclusions that requires insurers to identify a connection between the injury and the insured's intoxication before applying the exclusion.[35] The court found that reasoning

23. 350 F. Supp. 3d 854, 866 (W.D. Mo. 2018).
24. 908 F.2d 1077 (1st Cir. 1990).
25. *Boyer*, 350 F. Supp. 3d at 866.
26. *Id.*
27. *Id.*
28. *Id.* at 867.
29. Jaime Foxx, *Blame It ft. T-Pain*, *on* Intuition (J Records 2008).
30. 372 F. Supp. 3d 1259, 1263 (D.N.M. 2019).
31. *Id.*
32. *Id.*
33. *Id.*
34. *Id.*
35. *Id.* at 1268.

persuasive and held that the exclusion at issue contained a causation requirement.[36] And because the court could not conclude that the insured's intoxication caused or contributed to his death,[37] it granted summary judgment to plaintiff.[38]

It bears noting that before the court examined the exclusion's applicability, it considered whether the insured's death occurred "independently of all other causes," referring to *LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Insurance Plan*[39] to analyze that issue. In *LaAsmar*, the insured died in a single-vehicle rollover while intoxicated.[40] Under the policy, the crash had to be the sole cause of the loss; the insurer found the crash was not the sole cause of the loss because the insured's intoxication contributed to the loss.[41] The *LaAsmar* court determined, however, that the policy language required inquiry into the cause of the *death*, not the cause of the *crash*.[42] Since the death certificate provided that the insured died from head and internal injuries suffered in a motor vehicle crash,[43] the crash was the sole cause of the loss in *LaAsmar* and the insurer erred in denying the claim.[44] The *Calderon* court found that reasoning persuasive.[45] Because the insured's death certificate in *Calderon* stated the cause of death was multiple blunt force injuries and did not mention intoxication as a cause of his death,[46] the court held the insurer erred in finding that the insured's death was not the direct result of an accident that occurred independently of all other causes.[47]

In *McGuiggin v. Zurich American Insurance Co.*,[48] plaintiff's son died from acute fentanyl intoxication. The decedent's autopsy and death certificate listed his cause of death as "acute fentanyl intoxication" and described his manner of death as an "accident" that occurred due to "substance abuse or snorting illicit drugs."[49] The insurer denied coverage claiming the death was not a covered loss due to a covered injury and that the suicide exclusion and Exclusion 8 applied.[50] The policy's Exclusion 8 excluded losses "caused

36. *Id.* at 1269.
37. *Id.* at 1270.
38. *Id.*
39. 605 F.3d 789, 801 (10th Cir. 2010).
40. *Calderon*, 372 F. Supp. 3d at 1267.
41. *Id.*
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.*
46. *Id.* at 1268.
47. *Id.*
48. 2019 WL 1333268, at *1 (D. Mass. Mar. 25, 2019).
49. *Id.* at *2 (under the policy, a "Covered Injury" was an "caused by accidental means which is independent of all other causes").
50. *Id.*

by, contributed to, or result[ing] from: . . . being under the influence of any prescription drug, narcotic, or hallucinogen, unless . . . prescribed by a physician and taken in accordance with the prescribed dosage."[51]

Plaintiff argued there was no evidence to suggest her son committed suicide and that Exclusion 8 applied only to prescription and not illicit drugs.[52] Reevaluating Plaintiff's claim, the insurer affirmed the denial of coverage, including reliance on Exclusion 8, but no longer relied on the suicide exclusion.[53] Plaintiff sued, arguing that because the insurer did not carve out a separate exclusion for "alcoholism, drug addiction or the use of any drug or narcotic," Exclusion 8 should be limited to prescription drugs.[54] The court disagreed, holding that the insurer's reading of Exclusion 8 was reasonable.[55] It explained that Plaintiff's assertion that "prescription" in Exclusion 8 modifies "drug," "narcotic," and "hallucinogen" was incorrect because while "prescription drug" is a commonly used phrase, "prescription narcotic" and "prescription hallucinogen" are not.[56] The court then held that not only is fentanyl a narcotic, but it is also a prescription drug for which the decedent had no valid prescription.[57] The court entered judgment for the insurer.[58]

C. *"I Ain't Got a Fever, Got a Permanent Disease":[59] When Are Deaths Resulting from Illness or Medical Treatment Excluded?*

In *Long v. Aetna Insurance Co.*,[60] the insured died after accidentally taking several prescription drugs at the same time. In this ERISA-governed action, the insurer found that the insured's death was not covered under the subject accidental death policy because, *inter alia*, it was caused by taking medication prescribed to treat a medical condition and, therefore, fell within a coverage exclusion.[61] The policy excluded coverage for losses caused by "illness or disease due to a reaction to drug or medication."[62] Because the administrative record conclusively established that the decedent's death resulted from an acute combined drug intoxication,[63] the court

51. *Id.*
52. *Id.*
53. *Id.*
54. *Id.* at *4.
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.* at *5.
59. Bon Jovi, *Bad Medicine*, *on* New Jersey (PolyGram 1988).
60. 2019 WL 4931352, at *1 (N.D. Tex. Aug. 21, 2019).
61. *Id.* at *2 (insurer also arguing the death was not an "accident" under the policy because it was not a "sudden external trauma producing objective symptoms of an external bodily injury").
62. *Id.* at *5.
63. *Id.*

held there was no coverage under the policy due to the medication exclusion.[64] The court next considered the policy's medical-treatment exclusion, which excluded any "loss caused or contributed to by . . . medical or surgical treatment except where the loss is caused by an infection which results directly from an accident or surgery needed because of an injury."[65] Because the insured's death was caused by an overdose of medications prescribed to treat a medical condition and not "by an infection resulting from an 'accident,' [or from] surgery needed due to an injury,"[66] the death fell within the exclusion and was not covered. For all of these reasons, the court held the insurer's denial of benefits was not an abuse of discretion, granting summary judgment to the insurer.[67]

In *Arruda v. Zurich American Insurance Co.*,[68] the insured died in a car accident and the cause of death listed on the autopsy report was hypertensive heart disease. A postmortem toxicology report also found marijuana in his system at the time of the crash.[69] In this ERISA-governed action, the insurer argued the insured died from heart disease, which was a pre-existing medical condition. A physician conducting a medical record review concluded the insured experienced a cardiac event at the time of the accident causing his death.[70] The autopsy corroborated this, noting the primary cause of death was "cardiac arrest" and the secondary cause was "motor vehicle accident."[71] Plaintiff pointed out that another medical reviewer contradicted this position, finding "it is impossible to know what caused the crash."[72]

The district court determined that the evidence of causation was "insubstantial at best,"[73] observing that the individuals the insurer relied on for its causation determinations had no meaningful training or expertise to support their conclusions.[74] The insurer's reliance on the medical reviewer's conclusion that the insured died due to heart disease was unreasonable, the court concluded,[75] noting that another medical reviewer found the immediate cause of death was "a combination of multiple blunt force impact bodily injuries and positional asphyxia."[76] The insured's history of heart disease by itself was insufficient to support a conclusion that heart disease

64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.*
68. 366 F. Supp. 3d 175, 177–78 (D. Mass. 2019).
69. *Id.* at 178.
70. *Id.* at 183–84.
71. *Id.* at 184.
72. *Id.*
73. *Id.* at 185.
74. *Id.*
75. *Id.*
76. *Id.*

was the cause of death,[77] particularly where a physician found that "interrogation of the internal cardiac defibrillator did not show any abnormal heart rhythms prior to the accident" and there was evidence the insured was alive at the time of the crash.[78]

The argument that the death was excluded because the insured was under the influence of marijuana at the time of the crash fared no better.[79] Although the subject policy excluded losses caused by, contributed to, or resulting from being under the influence of narcotics,[80] the court held there was no evidence showing how the marijuana would have affected the insured and whether it would have impaired his driving and caused the car accident.[81] Therefore, the court declined to find that the exclusion applied, entering summary judgment for plaintiff beneficiary.[82]

D. *"A Smooth Criminal":[83] When Is Death That Occurs While the Insured Is in the Act of Committing a Crime Excluded from Coverage?*

In *American General Life Insurance Co. v. Whitaker*,[84] the insurer sought a declaratory judgment that it properly denied accidental death benefits. The policy contained an exclusion for death caused or contributed to by "commission of or attempt to commit an assault or felony."[85] After the insured was shot and killed by a police officer,[86] the insurer denied coverage arguing there was no accident and the crime exclusion applied.[87] The evidence compiled for summary judgment showed the insured came at police officers with knives and refused to follow direct orders to stop.[88] That conduct, the court explained, constituted an aggravated assault on a peace officer under Louisiana law, which was a crime.[89] The insured's death, therefore, fell within the policy's crime exclusion.[90]

The court also initially explained that under Louisiana law an insured's death is not accidental if the person was killed in a situation where they were the aggressor.[91] Based on the summary judgment evidence and the undisputed record in another related civil action, it was established that

77. *Id.*
78. *Id.*
79. *Id.* at 186.
80. *Id.*
81. *Id.* at 186–87.
82. *Id.* at 187.
83. Michael Jackson, *Smooth Criminal*, *on* Bad (Epic Records 1987).
84. 2019 WL 4673172, at *1 (E.D. La. Sept. 25, 2019).
85. *Id.*
86. *Id.* at *2.
87. *Id.* at *6–7.
88. *Id.* at *7.
89. *Id.*
90. *Id.* at *5–7.
91. *Id.* at *6.

the insured was the aggressor in the situation leading to his death.[92] His death therefore was not accidental under the policy and the insurer properly denied the claim.[93]

In *Caldwell v. UNUM Life Insurance Co. of America*,[94] the insured was killed when he was thrown from the car he was driving at 74 miles per hour on an unpaved road. The key issue was whether his policy's crime exclusion applied.[95] The district court agreed with the insurer that the exclusion applied, as did the Tenth Circuit on appeal after considering two specific arguments. First, the court assessed whether "crime" is an ambiguous term. The district court found it was not ambiguous, but a year after that decision was published the Supreme Court[96] held otherwise.[97] The Tenth Circuit explained it would be hesitant to rely on the "unambiguity" of the term "crime," but that the district court had not relied on it either, instead finding the insurer's interpretation of the policy was reasonable under the arbitrary and capricious standard of review.[98]

Additionally, Plaintiff argued that the insurer's claims manual would treat the decedent's speeding as a traffic violation that did not fall under the crime exclusion.[99] Per the manual, the exclusion was "not intended to apply to activities which would generally be classified as traffic violations, although . . . driving while intoxicated would generally be treated as a crime under the policy."[100] The Tenth Circuit agreed with the district court that the manual did not claim to be definitive and had "substantial play in the joints" due to its language explaining that every claim is unique and should be evaluated on its merits.[101] The Tenth Circuit held it was reasonable to ask whether the decedent's operation of the car was more like "(1) driving while intoxicated, which is apparently considered a species of traffic violation in Wyoming . . . or (2) failing to signal a lane change."[102] It explained, however, that reliance on a claims manual is problematic when there is no evidence that the manual was "offered to, or even available to, an insured or otherwise used in advertising or closing a sale."[103] Ultimately, the Tenth Circuit affirmed the district court's finding that the insurer's claim decision was not arbitrary and capricious.[104]

92. *Id.*
93. *Id.*
94. 2019 WL 4463495, at *1 (10th Cir. 2019).
95. *Id.*
96. United States v. Stitt, 139 S. Ct. 399 (2018).
97. *Caldwell*, 2019 WL 4463495, at *1.
98. *Id.*
99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.*
103. *Id.*
104. *Id.*

II. DISABILITY

A. *Previously, on Recent Developments in Health Insurance, Life Insurance, and Disability Insurance Law. . .*

Last year we remarked on a disability case featuring a 12-page footnote citing over a hundred cases gathered, *sua sponte*, by a district court and cited as evidence that an insurer was biased in its interpretation of what constituted the material duties of a group plan member's regular occupation at a Peco Foods' chicken processing factory in Sebastopol, Mississippi.[105] This year, the Fifth Circuit weighed in and reversed the district court's decision.[106]

In *Nichols v. Reliance Standard Life Insurance Co.*,[107] plaintiff developed circulatory system disorders that required her to avoid exposure to cold at the risk of serious complications, but her actual job duties required her to spend at least 20% of her workday in temperatures around 40 degrees. The insurer denied plaintiff's disability claim because her occupation "as performed in the national economy . . . [did] not require exposure to cold temperatures."[108] Under the arbitrary and capricious standard, the district court rejected the insurer's conclusion as "ignor[ing] both common sense and the record evidence," finding it was unreasonable for the insurer to base its analysis on a single Dictionary of Occupational Titles ("DOT") job description that did not include important duties of plaintiff's actual position.[109]

In reaching its decision, the court gave substantial weight to the insurer's conflict of interest, looking to prior cases involving the same insurer over a span of over 20 years, creating a string citation of over 100 opinions that it claimed "when viewed together, describe an unmitigated pattern of arbitrary and wrongful decisions."[110] The district court relied on Supreme Court precedent for the general principle that where "circumstances suggest a higher likelihood that [an insurer's conflict of interest] affected the benefits decision," that conflict should be given greater weight, particularly where an insurer has a "history of biased claims administration" as shown by "a pattern or practice of unreasonably denying meritorious claims."[111] While acknowledging that "any claims administrator is bound to make some wrong decisions," and that administrators are not held to a "batting average," the district court pointed to over 100 opinions dating back to

105. Nichols v. Reliance Standard Life Ins. Co., 2018 WL 3213618 (S.D. Miss. June 29, 2018).
106. Nichols v. Reliance Standard Life Ins. Co., 924 F.3d 802 (5th Cir. 2019).
107. *Nichols*, 2018 WL 3213618, at *2.
108. *Id.*
109. *Id.* at *5.
110. *Id.* at *6.
111. *Id.* (quoting Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 128 (2008)).

1997 where courts had variously found that this insurer acted arbitrarily, illogically, unreasonably, opportunistically, or unfairly.

The Fifth Circuit was unimpressed. A panel of three judges reversed the district court's decision, chiding the district court for examining conflict of interest at all and suggesting that the court had "fish[ed] for evidence of past abuses" even though plaintiff had produced none, thus depriving the insurer of the opportunity to respond.[112] The Fifth Circuit noted that, under existing precedent, a plan administrator is permitted to rely on the Department of Labor's DOT as evidence of the material duties of a claimant's regular occupation if the pertinent portions are included within the administrative record. The administrator "need not account for each of a claimant's job duties when using the DOT to identify the duties of a claimant's regular occupation as found in the general economy."[113] Because the Fifth Circuit found the insurer's reliance on the DOT was proper, it held the insurer's denial of plaintiff's claim was supported by substantial evidence.[114] The Fifth Circuit further held that the district court erred by emphasizing the insurer's conflict of interest, "eschew[ing] our repeated holdings that a structural conflict is not a significant factor where the claimant offers no evidence that the conflict impacted the administrator's decision."[115] The footnote of collected cases was not evidence the Fifth Circuit was willing to accept, noting that, in addition to the fact that the insurer had no opportunity to respond to the district court's purported "pattern of arbitrary and wrongful behavior," the district court ignored the fact that the insurer's decisions had been upheld in approximately 40% of the cases cited.[116]

At the end of the day, the Fifth Circuit in *Nichols* did not go so far as to say that a collection of cases like the one presented by the district court's voluminous footnote *cannot* constitute evidence of bias—rather, the Fifth Circuit's main concern was with the insurer's lack of opportunity to respond. The Fifth Circuit's opinion does suggest, however, that, consistent with other cases where courts have firmly held that an insurer's "batting average" is not evidence of potential bias,[117] courts should not accept statistical data showing that more decisions have been overturned than affirmed as evidence. A petition for *certiorari* from the Fifth Circuit's ruling was denied

112. Nichols v. Reliance Standard Life Ins. Co., 924 F.3d 802, 814 (5th Cir. 2019).

113. *Id.* at 809 (citing Pylant v. Hartford Life & Accident Ins. Co., 497 F.3d 536 (5th Cir. 2007); Robinson v. Aetna Life Ins. Co., 443 F.3d 389 (5th Cir. 2006)).

114. *Nichols*, 924 F.3d at 810.

115. *Id.* at 814.

116. *Id.*

117. *See, e.g.*, Holmstrom v. Metro. Life Ins. Co., 615 F.3d 758, 768 (7th Cir. 2010) (explaining that *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), "did not invite a 'batting average' approach, assessing conflict by comparing the number of benefits decisions affirmed and reversed in federal court").

in October 2019, leaving the Fifth Circuit as the final word on the fate of the footnote.[118]

B. *Subjective Evidence of Disability, or, Malebranche Was Right: We Are Not Our Own Light*[119]

A number of cases this year dealt with subjective reports of the debilitating nature of illness or injury and whether such subjective reports prove disability. We begin again with a Fifth Circuit decision examining whether an insurer had substantial evidence to support its denial of a health care attorney's disability claim due to migraine headaches.[120] In *Foster v. Principal Life Insurance Co.*,[121] Plaintiff argued that the insurer wrongfully denied benefits based on a lack of objective evidence of her migraines, claiming that migraines "are not susceptible to objective verification" and are thus properly verified by subjective reports. The district court and Fifth Circuit each found for the insurer, with the Fifth Circuit explaining that Plaintiff's position was missing a "critical distinction":

> Although the *existence* of a disability like migraines may not be denied based on impossible-to-obtain objective evidence, that is *not* true of one's *inability to work* as a result of migraines. An administrator may rely on an absence of objective evidence of the latter (inability to work) as a basis for finding lack of disability and denying benefits.[122]

The Fifth Circuit recalled an earlier case in which it set forth similar reasoning regarding the functional effects of Post-Traumatic Stress Disorder ("PTSD").[123] In that case, the court explained that it is not abuse of discretion to require "objective verification of the functional limitations imposed by a medical or psychological condition, especially when the effects of that condition are not readily ascertainable from treatment and therapy notes."[124] The same reasoning applied in *Foster*, and thus the insurer's denial was not arbitrary or capricious.[125]

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118. Nichols v. Reliance Standard Life Ins., 2019 WL 4922821, at *1 (U.S. Oct. 7, 2019).

119. Flannery O'Connor, *Good Country People*, *in* The Norton Anthology of American Literature, Vol. 2: 1865 to the Present, Shorter 8th Edition 1340–53 (Nina Baym & Robert S. Levine, eds., 2012).

120. Foster v. Principal Life Ins. Co., 920 F.3d 298 (5th Cir. 2019).

121. *Id.* at 306.

122. *Id.*

123. *Id.* (citing Anderson v. Cytec Indus., 619 F.3d 505 (5th Cir. 2010)).

124. *Id.* (citing *Anderson*, 619 F.3d at 514).

125. There were conflicting medical opinions in *Foster*, with the insurer basing its decision on reviewers who opined that there was no objective evidence of impairment, and Plaintiff presenting competing opinions from her treating physicians that she was disabled. *Id.* at 301–03. The insurer's determination was subject to an abuse of discretion standard, *id.* at 307, so we may surmise that a different outcome could have resulted from a *de novo* standard here.

The District of Massachusetts faced a similar issue in *Bowden v. Group 1 Automotive, Long Term Disability Plan*,[126] ultimately entering judgment for the insurer after a *de novo* review of the denial of Plaintiff's long-term disability ("LTD") benefits. Plaintiff worked as a car salesman and received LTD benefits from his employer's group plan, administered and insured by defendant Aetna.[127] Plaintiff's duties as a car salesman involved "some desk work, walking around the car lot, and light lifting."[128] He suffered from coronary artery disease, and, in February 2013, ceased working and sought treatment for shortness of breath, chest pain, and dizziness.[129] About a month later, Plaintiff's ear nose and throat specialist recorded his reported symptoms as follows:

> Ever since the snowstorm during which [Plaintiff] worked outside he has been bothered by this dizzy sensation that comes and goes. He said it is usually present every day but can disappear for most of the day at times. . . . He does drive but is reluctant to do so on most occasions. He denied any true spinning sensation. . . . He denied any fluctuation in hearing, new onset tinnitus or fullness in the ears. He also denied any slurred speech, double vision, or mental confusion.[130]

Plaintiff underwent a number of tests to try to determine the cause of his symptoms.[131] A specialist at the Mayo Clinic diagnosed him with "Chronic Subjective Dizziness."[132] Plaintiff's psychiatrist diagnosed him with "anxiety and adjustment disorder."[133] Plaintiff's primary care physician concluded he suffered from "focal neurological issues" and restricted him from work.[134] Plaintiff was approved for social security disability benefits, but the insurer denied LTD benefits.[135]

Plaintiff argued the insurer failed to consider medical evidence that he could not perform in his own occupation.[136] Like the insurer in *Foster*, the insurer here argued that the issue was not whether Plaintiff suffered from a condition, but whether there was medical evidence of functional impairment as a result of his condition.[137] The *Bowden* court agreed this distinction was critical, finding Plaintiff "needed to provide objective evidence of his inability to work, not his medical diagnosis" and that his "statements

126. 359 F. Supp. 3d 156 (D. Mass. 2019).
127. *Id.* at 160–61.
128. *Id.* at 161 (internal quotations omitted).
129. *Id.*
130. *Id.*
131. *Id.* at 162.
132. *Id.*
133. *Id.*
134. *Id.* at 163.
135. *Id.*
136. *Id.* at 165.
137. *Id.*

do not constitute objective evidence that he cannot perform those tasks."[138] *Foster* and *Bowden* show the importance of objective evidence of functional impairment, even where a diagnosis can be based on subjective reports of a claimant's symptoms.

A recent case from the Northern District of Georgia yielded contrasting results where the insurer relied on arguably substantial evidence to deny a claim, but failed to successfully tie that evidence to the operative issue.[139] In *Lesser v. Reliance Standard Life Insurance Co.*,[140] the court ruled for Plaintiff under the arbitrary and capricious standard because the insurer's analysis of his functional limitations focused only on the physical and not on the cognitive requirements of his occupation as a software engineer. Plaintiff suffered from a variety of ailments, but his primary condition was hypersomnolence or "excessive daytime sleepiness."[141] Although his treating physicians all agreed the condition was disabling, the insurer denied Plaintiff's LTD claim because his tests did not reveal an etiology for his condition and some of his tests, as well as an independent neurological examination, showed no significant objective functional limitation.[142]

The court disagreed that Plaintiff's limitations were entirely subjective, noting that the independent neurologist who examined Plaintiff did not opine on his ability to perform his *own* occupation—the applicable test for benefits at the time—but only opined that Plaintiff could work *in general*.[143] The court further criticized certain purportedly normal neuropsychological test results on which the insurer relied, as they compared Plaintiff's cognitive abilities with those of the general population, not with those of other software engineers—an occupation which the DOT noted typically required a learning ability and numerical aptitude well above that of an average person.[144] The court acknowledged that "a claimant's subjective complaints do not become objective simply because a doctor wrote them down," but pointed to several objective medical test results corroborating Plaintiff's treating physicians' opinions which the insurer rejected in favor of test results not taking into account the cognitive requirements of a software engineer.[145] Thus, the evidence the insurer relied on was undercut, and Plaintiff prevailed even under the more forgiving arbitrary and capricious standard.

138. *Id.* at 165–66.
139. Lesser v. Reliance Standard Life Ins. Co., 385 F. Supp. 3d 1356 (N.D. Ga. 2019).
140. *Id.* at 1374.
141. *Id.* at 1362, 1364.
142. *Id.* at 1363–64.
143. *Id.* at 1372.
144. *Id.*
145. *Id.* at 1371.

The Northern District of California similarly credited subjective reports of functional limitations based on chronic pain in *Holmgren v. Sun Life & Health Insurance Co*.[146] While the insurer appeared to apply all the correct tests and standards, the court found the evidence weighed in Plaintiff's favor after a *de novo* review.[147] Plaintiff worked as a corporate tax director for Hitachi, a job that required "a high cognitive ability, including critical thinking, decision-making, complex problem solving, processing information, evaluating information to determine compliance with standards, and high levels of concentration."[148] In August 2015,[149] he stopped working due to low back pain.[150] Immediately thereafter, he underwent decompression surgery followed by physical therapy, but Plaintiff obtained only partial relief and continued to report back pain to multiple treating physicians over the following months.[151] Plaintiff's treating pain management specialist certified he was disabled in August and December of 2015, and Plaintiff reported that his pain prevented him from being able to sit or concentrate even for short periods of time.[152]

The insurer obtained a surveillance report of Plaintiff's activity during a five-day period in March 2016 and requested an independent peer review from a third-party.[153] The surveillance showed that Plaintiff could drive, walk without assistance, stand, sit, and carry a small bag, but appeared to have an abnormal gait, often leaned on things for support, and frequently changed positions.[154] An independent medical record review in April 2016 by a physical medicine and rehabilitation specialist concluded Plaintiff was capable of full time work, noting that while the reviewer did not question the motive or legitimacy of Plaintiff's reported pain, he found "no objective explanation" for plaintiff's "subjective complaints."[155]

The insurer denied Plaintiff's claim on the basis that the medical evidence did not show he was precluded from performing his own occupation.[156] After Plaintiff appealed, the insurer obtained two new independent peer reviews, from a pain management specialist and an orthopedic surgeon.[157] The pain specialist found Plaintiff was disabled from even sedentary work, while the orthopedic surgeon concluded that Plaintiff's reports

146. 354 F. Supp. 3d 1018 (N.D. Cal. 2018).
147. *Id.* at 1033.
148. *Id.* at 1022.
149. The Westlaw publication of this case contains typos listing the year as 2018, where it should actually be 2015.
150. *Holmgren*, 354 F. Supp. 3d at 1022–23.
151. *Id.* at 1024–25.
152. *Id.*
153. *Id.* at 1026.
154. *Id.*
155. *Id.*
156. *Id.* at 1027.
157. *Id.*

of pain were unreliable and there was no objective evidence of disability.[158] Plaintiff sued after the insurer upheld its denial on appeal.[159] The district court ultimately found in Plaintiff's favor, noting that each of the five physicians with whom he treated between August 2015 and March 2016 found him to be disabled from his occupation as a tax director and that their opinions were supported by "functional testing, MRIs, results of surgeries, and their own physical examinations of plaintiff."[160]

The insurer argued that (1) Plaintiff was able to perform activities without assistance in surveillance, (2) Plaintiff reported in a March 2015 self-evaluation, prior to ceasing work, that he did not have problems performing at work; and (3) Plaintiff's social media activities demonstrated that he had no cognitive impairment.[161] The court rejected the insurer's arguments, finding that chronic pain is "an inherently subjective condition" and that none of Plaintiff's treating physicians questioned the reliability of his self-reported pain.[162] Although the court acknowledged that treating physicians were not entitled to greater weight than reviewing physicians, it was persuaded by the unanimous support for disability from numerous specialists, some of whom Plaintiff treated with for years before his disability.[163] The court gave little consideration to plaintiff's March 2015 self-evaluation, explaining it would not be reasonable to "expect an employee completing a job performance self-assessment to disclose personal health issues or the impact thereof on his or her ability to do his or her job," and noted the surveillance showed only minimal physical capability.[164]

Finally, the *Holmgren* court rejected the insurer's argument that discussing economics and politics on social media was legally acceptable "evidence of cognitive ability" and that Plaintiff's "personal musings" evinced such ability.[165] This is a particularly *apropos* morsel of insight on which to close our sub-topic examining the varied results this survey period of individuals' efforts to offer their subjective accounts as conclusive evidence of objective facts.

C. *Licensed to Ill:*[166] *Overlapping Factual and Legal Disabilities*

Our last sub-topic in the disability category looks at recent rulings involving legal disability occurring from loss of a professional license. Many

158. *Id.*
159. *Id.*
160. *Id.* at 1028.
161. *Id.*
162. *Id.* at 1028–29 (citing Cruz-Baca v. Edison Int'l Long Term Disability Plan, 708 F. App'x 313, 315 (9th Cir. 2017)).
163. *Id.* at 1029–32.
164. *Id.* at 1032.
165. *Id.*
166. Beastie Boys, Licensed to Ill (Def Jam Recordings 1986).

disability policies contain exclusions for legal disability, but disputes often arise regarding causation when both a legal and factual disability exist. Sadly, this is a problem we may see a lot more in connection with the opioid crisis, both when people battling opioid addiction lose their license due to their addiction and when prescribers are penalized or prosecuted for violating the law and contributing to the crisis.[167]

In *Pogue v. Northwestern Mutual Life Insurance Co.*,[168] the Sixth Circuit affirmed summary judgment for the insurer after it denied plaintiff LTD benefits. Plaintiff was a Tennessee physician who sought benefits in April 2013 after he suffered a total nervous breakdown.[169] He reported voluntarily surrendering his medical license "due to a feeling of personal incompetence to handle work stresses" the previous November.[170] During the insurer's investigation, it discovered the Tennessee Board of Medical Examiners involuntarily suspended Plaintiff's license "less than three weeks after his alleged nervous breakdown[] due to his improper prescribing of controlled substances to patients and family members."[171]

The district court found Plaintiff's legal disability caused his inability to continue working, not any factual disability relating to his mental health.[172] The Sixth Circuit affirmed, distinguishing factual versus legal disability as follows: a factual disability is "an incapacity caused by illness or injury that prevents a person from engaging in his or her occupation," while a legal disability "includes all circumstances in which the law does not permit a person to engage in his or her profession even though he or she may be physically and mentally able to do so."[173] The court further explained that it considered three questions to determine whether a factual disability precedes a legal disability such that coverage might exist:

> (1) is the claimed factual disability medically bona fide; (2) did the onset of the medically bona fide factual disability actually occur before the legal disability; and (3) did the factual disability actually prevent or hinder the person seeking disability benefits from engaging in his or her profession or occupation?[174]

If the answer to any of these questions is "no," Plaintiff is not entitled to disability benefits.[175] While Plaintiff in *Pogue* did suffer from depression

167. *See, e.g.*, N'dea Yancey-Bragg, *Doctor Gets 40 Years in Opioid Prescription Case*, USA Today, Oct. 3, 2019, https://www.usatoday.com/story/news/nation/2019/10/03/doctor-who-prescribed-500-000-opioid-pills-faces-40-years-prison/3851312002/#targetText=A%20Virginia%20doctor%20who%20federal,District%20of%20Virginia%20in%20Abingdon.
168. 2019 WL 1376032 (6th Cir. Feb. 7, 2019).
169. *Id.* at *1.
170. *Id.*
171. *Id.*
172. Pogue v. Nw. Mut. Life Ins. Co., 2018 WL 1189415, at *6 (W.D. Ky. Mar. 7, 2018).
173. *Id.* at *2.
174. *Id.*
175. *Id.*

and panic disorder prior to his license being suspended, he had never been restricted from working and in fact continued to work up until the time his licensed was suspended.[176] Moreover, Plaintiff did not argue at his hearing before the disciplinary board that any illness gave rise to the charges he faced.[177] It was thus clear under the Sixth Circuit's test that Plaintiff was not entitled to LTD benefits.

The recent case of *Rothman v. Unum Group*[178] also turned on whether Plaintiff's disability was factual or legal. Plaintiff was licensed and worked as a Certified Financial Planner in his family's business, but was suspended after the SEC brought a fraud complaint against him.[179] Plaintiff checked himself into a rehabilitation clinic for substance abuse immediately thereafter, and submitted a claim for LTD benefits.[180] He subsequently pled guilty to fraud and money laundering, was sentenced to four years in prison, and had his license revoked by the SEC.[181] The insurer initially paid Plaintiff benefits under a reservation of rights, but terminated them after his license was revoked noting that his psychologist declared his substance abuse to be in remission and that the only remaining reason he was unable to work was the loss of his license.[182]

Plaintiff argued that his substance abuse and mental health issues were an underlying cause of the loss of his license because his illness led him to engage in the criminal activities.[183] The district court, considering factors similar to those announced in *Pogue*, found that Plaintiff's factual disability predated his legal disability, but since he recovered from his factual disability his legal disability was the only impediment to his returning to work.[184] Rejecting plaintiff's argument that his factual disability led to his license revocation, the court explained:

> Rothman's license was not revoked because he had a drug abuse problem. It was revoked because he stole from his clients and employer. Rothman's claimed disability—substance abuse—did not impair his ability to perform his occupation as a Certified Financial Planner. It may have impaired his judgment, leading to his stealing from his clients and ultimately his license revocation.[185]

176. *Id.* at *3.
177. *Id.*
178. 2018 WL 4961609 (E.D. Pa. Oct. 15, 2018).
179. Kenneth Corbin, *SEC Charges Pa. Broker with Defrauding Elderly Investors*, Fin. Planning, Sept. 26, 2012, https://www.financial-planning.com/news/sec-charges-pa-broker-with-defrauding-elderly-investors.
180. *Rothman*, 2018 WL 4961609, at *2.
181. *Id.*
182. *Id.*
183. *Id.*
184. *Id.* at *3–4.
185. *Id.* at *5.

The court thus granted summary judgment for the insurer. Plaintiff appealed, and his appeal was dismissed pursuant to a settlement agreement in February 2019.[186]

As *Pogue* and *Rothman* show, insurers should give special attention not only to whether a legal disability preceded a factual disability, but also to whether a claimant's inability to work has a *true* causal connection to any factual disability as opposed to a mere legal impediment.

III. ERISA

A. *The Defense of "I Didn't Read That" and ERISA's Statute of Limitations*

In *Sulyma v. Intel Corp. Investment Policy Committee*,[187] the Ninth Circuit ruled that ERISA's three-year statute of limitations for breach of fiduciary duty claims requires a defendant to show that the plaintiff had "*actual*" knowledge of the nature of the alleged breach before the limitations period begins to run.[188] Plaintiff, a retirement plan participant, filed suit against his former employer alleging it improperly invested his retirement funds, violating ERISA and breaching its fiduciary duties.[189] The employer moved to dismiss the action as time-barred because it was commenced more than "three years after the earliest date on which plaintiff ha[d] actual knowledge of the breach or violation."[190] Plaintiff had "actual knowledge" of the facts underlying his claim, the employer argued, because he was "constructively" aware of information that identified the allegedly improper investments and explained the basic investment strategies behind them.[191] Plaintiff admitted he received that information, but specifically denied he was "aware" of how his money was invested because he either did not read or did not recall seeing the documents identifying the allegedly improper investments or explaining the basic investment strategies behind them.[192] The district court agreed the claim was time-barred, entering summary judgment for the employer. Plaintiff appealed, arguing the district court incorrectly applied a "constructive knowledge" standard when the statute requires "actual knowledge."[193]

The Ninth Circuit acknowledged that ERISA does not define "knowledge" or "actual knowledge,"[194] and observed that decisions interpreting

186. Stipulation to Dismiss Case Pursuant to Fed. R. App. P. 42(B), David Rothman v. Unum Grp., No. 18-3506 (3d Cir. Feb. 26, 2019).
187. 909 F.3d 1069 (9th Cir. 2018).
188. *Id.* at 1077.
189. *Id.* at 1071–72.
190. *Id.* at 1072; 29 U.S.C. § 1113(2).
191. *Sulyma*, 909 F.3d at 1077.
192. *Id.*
193. *Id.* at 1072; *see* 29 U.S.C. § 1113(2).
194. *Sulyma*, 909 F.3d at 1073.

"actual knowledge" were not particularly helpful. At most, those decisions suggested "actual knowledge" "mean[t] something between bare knowledge of the underlying transaction, which would trigger the limitations period before a plaintiff was aware he or she had reason to sue, and actual legal knowledge, which only a lawyer would normally possess."[195] The court recognized that the level of knowledge required to start the limitations period would vary depending on the claim.[196] Perhaps because of that, the best the Ninth Circuit could do was to flesh out further what "actual knowledge" might look like. "[O]nce [a] plaintiff has sufficient knowledge to be alerted to the [existence of a] particular claim," the limitations period would begin to run.[197] For instance, a plan participant who was provided copies of plan documents or other information, could only be charged with constructive, not actual, knowledge of that information.[198] The Ninth Circuit explained that if plaintiff "in fact never looked at the documents . . . provided [to him], he cannot have had 'actual knowledge of the breach' because he cannot have been aware that imprudent investments were made . . . ."[199] Because the court was unable to conclusively determine whether Plaintiff had "actual knowledge" of his claims, it reversed and remanded the matter for further proceedings to address that disputed fact.[200]

The United States Supreme Court granted the employer's petition for writ of certiorari shortly before the end of this survey period.[201] We will follow the developments and report further regarding the level of knowledge a claimant must have for the limitations period for ERISA fiduciary breaches to begin to run.

B. *The Changing Tide—Arbitration of ERISA Claims*

For more than 35 years, a clear line of Ninth Circuit precedent established that ERISA-governed claims were not subject to arbitration.[202] That changed with the Ninth Circuit's opinion in *Dorman v. Charles Schwab Corp.*[203] Plaintiff was a participant in an ERISA-governed 401(k) retirement plan. He filed a putative class action against his former employer, alleging it violated ERISA and breached its fiduciary duties.[204] The defendants moved to compel arbitration under a provision included in plan documents, stating that "[a]ny claim, dispute or breach arising out of or in

195. *Id.* at 1075.
196. *Id.* at 1075–76.
197. *Id.*
198. *Id.* at 1076.
199. *Id.* at 1078.
200. *Id.*
201. Intel Corp. Inv. Policy Comm. v. Sulyma, 139 S. Ct. 2692 (2019).
202. Dorman v. Charles Schwab Corp., 934 F.3d 1107 (9th Cir. 2019).
203. *Id.* at *1; Amaro v. Cont'l Can Co., 724 F.2d 747 (9th Cir. 1984).
204. *Dorman*, 934 F.3d at 1109.

any way related to the Plan shall be settled by binding arbitration . . . ."[205] The district court denied this motion to compel and an appeal followed.[206]

In 1984, the Ninth Circuit held in *Amaro v. Continental Can Co.*[207] that ERISA claims were not subject to arbitration because arbitrators "lack[ed] the competence of courts to interpret and apply statutes," such as ERISA, "as Congress intended."[208] By 2019, the *Amaro* holding had been superseded by intervening Supreme Court authority. In *American Express Co. v. Italian Colors Restaurant*,[209] the Supreme Court held that federal statutory claims were generally arbitrable and that arbitrators were competent to interpret and apply federal statutes.[210] Accordingly, the Ninth Circuit reversed the district court's decision in *Dorman* and held that Plaintiff's ERISA-governed claims were arbitrable.[211]

In a concurrently issued memorandum in the case, the Ninth Circuit concluded Plaintiff's breach of fiduciary duty claim fell within the scope of the arbitration provision because it arose out of and related to the plan.[212] Further, the court found Plaintiff could only seek individualized relief through arbitration because the plan stated that participants waived any right to "class-wide" or "collective arbitration[s]."[213]

C. *Plan Administrator vs. Claim Administrator—A Distinction with a Difference*

In *Hadd v. Aetna Life Insurance Co.*,[214] Plaintiff asked the court to treat the claims administrator for her plan as if it were the "administrator" and assess statutory penalties against it under 29 U.S.C. § 1132(c)(1)(B) for failing to provide her with certain plan-related materials she requested.[215] The claims administrator argued it was not the plan's "administrator" under ERISA, and therefore could not be penalized under § 1132(c)(1)(B) as it had no legal duty to provide the materials plaintiff requested.[216] The court agreed and rejected Plaintiff's request, citing ERISA's clear-cut statutory

205. *Id.*
206. *Id.*
207. 724 F.2d 747 (9th Cir. 1984).
208. *Dorman*, 934 F.3d at 111 (quoting Amaro v. Cont'l Can Co., 724 F.2d 747 (9th Cir. 1984) (internal quotation marks omitted)).
209. 133 S. Ct. 2304 (2013).
210. *Dorman*, 934 F.3d at 1112; *see also* Am. Express Co. v. Italian Colors Rest, 133 S. Ct. 2304 (2013).
211. *Dorman*, 934 F.3d at 1112; *see* also *Am. Express Co.*, 133 S. Ct. 2304.
212. Dorman v. Charles Schwab Corp., 780 F. App'x 510, 512–13 (9th Cir. 2019).
213. *Id.* at 514.
214. 2019 WL 4752041 (D. Kan. Sept. 30, 2019).
215. *Id.* at *1; 29 U.S.C. § 1132(c)(1)(B).
216. *Hadd*, 2019 WL 4752041 at *11.

definition of "administrator" as a "person specifically so designated by the terms of the instrument under which the plan is operated."[217]

Plaintiff next argued the claims administrator could be liable under § 1132(c)(1)(B) because its activities rendered it the plan's "de facto" administrator.[218] The court rejected that argument too, holding that the plan's designation of a plan administrator is "conclusive" for purposes of applying § 1132(c)(1)(B) and cannot be expanded or modified to include any other entity, even if that other entity essentially acted as the administrator.[219]

D. *Administrator vs. De Facto Administrator*

The "de facto" administrator concept had no more success before the Third Circuit. In a matter of first impression, the Third Circuit in *Bergamatto v. Board of Trustees of the NYSA-ILA Pension Fund*[220] considered whether a plan's executive director qualified as its "administrator" and could be liable under § 1132(c)(1)(B) for failing or refusing to comply with Plaintiff's request for information.[221] Plaintiff pointed to the executive director's activities in answering questions, supplying information, and providing plan documents to participants to argue he functioned as the "de facto" administrator who could be personally liable for failing to produce the requested documents.[222] The Third Circuit rejected Plaintiff's argument, explaining that "administrator" is a "term[] of art" under ERISA that applies only to "the person specifically so designated by the terms of the instrument under which the plan is operated."[223] "To treat those who do not fully satisfy that 'detailed definition[]' as administrators 'would slight[] the wording of the statute.'"[224] Because the executive director did not qualify as an "administrator" under ERISA's definition, the Third Circuit found he could not be personally liable under § 1132(c)(1)(B).[225]

217. 29 U.S.C. § 1002(16)(A); *Hadd*, 19 WL 4752041 at *12 (citing McKinsey v. Sentry Ins., 986 F.2d 401, 404–05 (10th Cir. 1993) ("Section 1002(16)(A) provides that if a plan specifically designates a plan administrator, then that individual or entity is the plan administrator for purposes of ERISA.")).

218. *Hadd*, 2019 WL 4757041 at *12.

219. *Id.*

220. 933 F.3d 257 (3d Cir. 2019).

221. *Id.* at 266.

222. *Id.*

223. *Id.* at 268; *see also* Manuel v. Turner Indus. Group, L.L.C., 905 F.3d 859, 872 n.12 (5th Cir. 2018) (affirming the district court's decision to dismiss the 502(c) claims against insurer because the Fifth Circuit does not recognize the *de facto* administrator doctrine in the context of an insurance company involved in claims handling).

224. *Bergamatto*, 933 F.3d at 268.

225. *Id.* at 269.

E. *Fiduciary vs. "Functional Fiduciary"*

While a "claim administrator" and a "de facto" administrator cannot be held liable as a "plan administrator" under 29 U.S.C. 1132(c), someone who is not a "named" plan fiduciary can be a fiduciary. ERISA contemplates two types of fiduciaries: (a) a "named fiduciary"—"a fiduciary who is named" in the plan documents;[226] and (b) a "functional fiduciary," which includes someone who exercises discretionary authority or control over the management or administration of the plan or the disposition of its assets, or provides investment advice concerning plan assets for a fee or other compensation.[227]

The Fourth Circuit in *Dawson-Murdock v. National Consulting Group, Inc.*[228] held that an employer acted in a fiduciary capacity and could be liable under ERISA for breach of fiduciary duties after it "verif[ied] employee eligibility for participation in an employee benefit plan" and "fail[ed] to convey[] material information to a plan participant concerning the retention of eligibility for a benefit plan when that administrator [was] aware that the participant wishe[d] to maintain his participation therein."[229] Plaintiff's husband was a participant in his employer's life insurance plan, which was offered to full-time employees.[230] He later transitioned to part-time employment, making him ineligible for the life insurance plan.[231] His employer never informed him that he was ineligible to participate, however, or that he had the option to convert or port his life insurance coverage.[232] Plaintiff's husband continued paying, and the employer continued accepting premiums.[233] After he died and Plaintiff sought benefits under the plan, the employer's Vice President of Human Resources notified Plaintiff that the insurer denied her claim, but assured her that the employer would directly pay her the claim amount and would work with the insurer to recover that payment.[234] Based on the Vice President's representations, Plaintiff did not appeal the insurer's claim denial.[235] The

226. Dawson-Murdock v. Nat'l Counseling Grp., Inc., 931 F.3d 269, 275 (4th Cir. 2019); 29 U.S.C. § 1102(a)(2).

227. 29 U.S.C. § 1002(21)(A); *Dawson-Murdock*, 931 F.3d at 275–76 ("functional fiduciary" includes "any individual who de facto performs specified discretionary functioning with respect to the management, assets or administration of the plan" (quoting Custer v. Sweeney, 89 F.3d 1156, 1161 (4th Cir. 1996))).

228. *Dawson-Murdock*, 931 F.3d at 279.

229. *Id.*; *cf.* Teets v. Great-West Life & Annuity Ins. Co., 921 F.3d 1200 (10th Cir. 2019) (the defendant was not a "functional fiduciary" because it did not have discretionary control of the plan or its assets).

230. *Dawson-Murdock*, 931 F.3d at 272.

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.* at 272–73.

235. *Id.* at 273.

employer subsequently changed its mind and informed Plaintiff it would not pay her claim, but by then her window to appeal the insurer's decision had closed.[236]

Plaintiff sued the employer alleging it (1) breached fiduciary duties owed to her husband by failing to inform him or misinforming him about his continued eligibility for life insurance coverage and option to convert or port his life insurance coverage, and (2) breached fiduciary duties owed to her when its Vice President advised her that she need not appeal the insurer's denial of her claim.[237] The district court dismissed Plaintiff's claims because the complaint did not sufficiently allege that the employer or its Vice President were acting as functional fiduciaries.[238] In particular, the complaint did not adequately allege that the employer and its Vice President exercised "discretionary control regarding benefit decisions" under the plan.[239]

The Fourth Circuit reversed, finding Plaintiff sufficiently alleged facts to support a breach of fiduciary duty claim. For starters, the plan identified the employer as a fiduciary, so it was a "named fiduciary."[240] But, the court observed, that did not mean the employer was a fiduciary for purposes of the conduct at issue: "[B]eing a fiduciary under ERISA is not an all-or-nothing situation."[241] "[F]iduciary status can be a fluid concept" and a "party is a fiduciary only as to the activities which bring the person within the definition."[242] Thus, it is an individual's activities that matter when stating a breach of fiduciary duty claim; so long as a plaintiff alleges an individual performs the functional duties of a plan fiduciary and breached them, she has stated a claim for relief.[243]

In *Josef K. v. California Physicians' Service*,[244] the Northern District of California found that an Independent Medical Review ("IMR") Organization was a "functional fiduciary" and could be liable for breach of fiduciary duty.[245] Plaintiffs submitted a claim for mental health benefits under an ERISA-governed plan. The plan administrator denied Plaintiffs' claim and upheld their subsequent appeal on the grounds that the treatment at issue was not medically necessary. Plaintiffs requested and obtained an independent medical review of their claim, as allowed under the plan, and the IMR also found the treatment at issue was not medically necessary.

236. *Id.*
237. *Id.* at 274.
238. *Id.*
239. *Id.*
240. *Id.* at 277.
241. *Id.*
242. *Id.* (quoting Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 61 (4th Cir. 1992)).
243. *Id.* at 278.
244. 2019 WL 2342245 (N.D. Cal. June 3, 2019).
245. *Id.*

Plaintiffs sued the IMR alleging, *inter alia*, a claim under 29 U.S.C. § 1132(a)(3) for breach of fiduciary duty.[246] The IMR moved to dismiss the claim, arguing it could not be liable since it was not a fiduciary.[247] The court denied the motion. According to the complaint, the IMR had functional discretion over plan assets because, as a practical matter, it had "final authority" over payment of claims. The IMR operated as a functional fiduciary because its decisions directly affected plan assets.[248] Plaintiffs thus stated a claim against the IMR for breach of fiduciary duty.[249]

F. *Full and Fair Review*

ERISA administrators have a duty to conduct an adequate investigation when considering benefit claims.[250] To satisfy this duty, a plan administrator is required, among other things, to engage in a "meaningful dialogue" with the beneficiary.[251] This requirement stems from subsections (g) and (h) of 29 C.F.R. § 2560.503-1. Subsection (g) requires, in part, that notices of denial must (1) provide the specific reason for the adverse determination and (2) reference the specific provision warranting denial."[252] And subsection (h) requires every plan to provide claimants with "a reasonable opportunity to appeal[,] . . . under which there will be a full and fair review of the claim and adverse benefit determination."[253] A full and fair review requires taking "'into consideration all comments, documents, records, and other information submitted by the claimant relating to the claim,' and provide 'reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.'"[254]

The requirement to engage in a meaningful dialogue could obligate an administrator to seek more information if it believes the information is necessary to making a reasoned benefit decision.[255] In *Jantos v. Prudential Life Insurance Co. of America*,[256] Plaintiff alleged the insurer underpaid her benefits and breached its fiduciary duty by failing "to fully and fairly investigate the correct amount of [her claim]."[257] The plan promised to

246. *Id.* at *1.
247. *Id.* at *5.
248. *Id.* at *7.
249. *Id.*
250. Jantos v. Prudential Life Ins. Co. of Am., 2019 WL 1294827, at *6 (W.D. Wash. Mar. 21, 2019) (citing Cady v. Hartford Life & Accident Ins. Co., 930 F. Supp. 2d 1216, 1226 (D. Idaho 2013)).
251. *Id.* (citing *Cady*, 930 F. Supp. 2d at 1226).
252. 29 C.F.R. § 2560.503-1(g); Mary D. v. Anthem Blue Cross Blue Shield, 778 F. App'x 580, 589 (10th Cir. 2019).
253. 29 C.F.R. § 2560.503-1(h)(1); *Mary D.*, 788 F. App'x at 589.
254. 29 C.F.R. § 2560.503-1(h)(2)(iii), (iv); *Mary D.*, 788 F. App'x at 589.
255. *Jantos*, 2019 WL 1294827 at *6 (citing *Cady*, 930 F. Supp. 2d at 1226).
256. *Id.*
257. *Id.* at *3.

pay sixty-percent of Plaintiff's "monthly earnings" upon her becoming disabled, but it did not specify what sources of income would be considered in that calculation.[258] Plaintiff submitted evidence showing that her annual income was comprised of more than her annual base salary. The insurer did not consider that information, instead calculating Plaintiff's "monthly earnings" based solely on her annual base salary.[259]

On review, the court observed that the administrative record was incomplete as the insurer failed to consider or investigate what sources of income contributed to Plaintiff's annual income.[260] It remanded to allow the insurer to make a new factual determination of Plaintiff's "monthly earnings," based on all of the evidence.[261] The court observed that an ERISA administrator has a fiduciary duty to conduct an adequate investigation when considering a claim for benefits,[262] and "may not 'shut [its] eyes to readily available information when the evidence in the administrative record suggests that the information might confirm the beneficiary's theory of entitlement.'"[263]

While an administrator has an affirmative duty to investigate, it is not required to secure additional evidence to support a disability benefits claim when it has reliable evidence supporting its decision.[264] In *Smith v. American National Red Cross*,[265] Plaintiff alleged that defendant failed to conduct a full and fair review of her claim.[266] The court disagreed, finding the review took "into account all comments, documents, records, and other information submitted by the claimant relating to the claim."[267] Defendant was under no obligation to seek additional information where reliable evidence in the record supported its decision.[268]

In *Odle v. UMWA 1974 Pension Plan*,[269] Plaintiff challenged the amount of a survivor's annuity benefit award after the plan denied her claim based, in part, on an audit report it did not produce during the administrative

258. *Id.* at *4.
259. *Id.* at *6.
260. *Id.*
261. *Id.* at *7.
262. *Id.* at *6.
263. *Id.* (quoting Rogers v. Metro. Life Ins. Co., 655 F. Supp. 2d 1081, 1087 (N.D. Cal. 2009) (citations omitted)).
264. Smith v. Am. Nat'l Red Cross, 2019 WL 1320344, at *11 (M.D. Fla. Feb. 21, 2019) (citing Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1008 (4th Cir. 1985)); *see also* Bloom v. Hartford Life & Accident Ins. Co., 558 F. App'x 854, 856 (11th Cir. 2014) (holding where the record provides strong support for the administrator's decision, the administrator is not required to "seek out the location of and consider the omitted documents referred to in the record").
265. 2019 WL 1320344 (M.D. Fla. Feb. 21, 2019).
266. *Id.* at *11.
267. *Id.*
268. *Id.*
269. 777 F. App'x 646 (4th Cir. 2019).

review process. The magistrate judge, to whom the case was referred, recommended the claim be remanded due to the plan's failure to provide the audit report, as that failure deprived Plaintiff of the opportunity for a full and fair review of the plan's decision.[270] Rejecting the magistrate judge's recommendation and granting summary judgment for the plan, the district court held there was no evidence to suggest that providing the audit report to Plaintiff "would have made any difference" in the plan's decision.[271] The Fourth Circuit reversed, finding the plan's procedural error amounted to an abuse of discretion that deprived Plaintiff of the opportunity to review and challenge the audit report during the administrative process.[272] The Fourth Circuit then remanded the claim for further proceedings to allow Plaintiff an opportunity to challenge the denial of her claim with all materials considered by the plan at her disposal.[273]

G. *Standard of Review*

ERISA 101 teaches that when it comes to the standard of review, "ERISA provides 'for only two alternatives[: when] a plan confers discretion, abuse of discretion review applies; when it does not, de novo review applies.'"[274] At least one decision from this survey period suggests that this rule is not so black and white.

Although no magic words are necessary to confer discretion and obtain discretionary review of a plan's benefit decisions, that type of review is only warranted when there is a clear grant of discretion in a plan's governing documents.[275] Sometimes that still is not enough. One court this survey

270. *Id.* at 648.
271. *Id.* at 649.
272. *Id.* at 651.
273. *Id.*
274. O'Rourke v. N. Cal. Elec. Workers Pension Plan, 934 F.3d 993, 998 (9th Cir. 2019) (quoting Abatie v. Alta Heath & Life Ins., 458 F.3d 955, 965 (9th Cir. 2006) (en banc)); Michael D. v. Anthem Health Plans of Ky, Inc., 369 F. Supp. 3d 1159, 1167 (D. Utah 2019) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989) (a denial of benefits challenged under ERISA is reviewed under a *de novo* standard, unless the benefit plan gives the administrator authority to determine eligibility or to construe the terms of the plan)); Eugene S. v. Horizon Blue Cross Blue Shield of N.J., 663 F.3d 1124, 1130 (10th Cir. 2011) ("[W]here the plan gives the fiduciary or administrator discretionary authority, the district court employs a deferential standard of review, asking only whether the denial of benefits was arbitrary and capricious." (internal citations omitted)); Hayes v. Twin City Carpenters, 2019 WL 3017747, at *5 (D. Minn. July 10, 2019) ("The basic law governing the termination of the correct standard of review . . . is settled. Suits brought under § 1132(a)(1)(B) to recover benefits allegedly due a participant are to be reviewed de novo unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits.").
275. Shrout v. Life Ins. Co. of N. Am., 2018 WL 4976799, at *1 (E.D. Ky. Oct. 15, 2018); McBurrows v. Verizon, 2019 WL 2432088, *7 (D.N.J. June 11, 2019) ("There are no 'magic words' determining the scope of judicial review of decisions to deny benefits, and discretionary powers may be granted expressly or implicitly."); Gallupe v. Sedgwick Claims Mgmt. Servs. Inc., 358 F. Supp. 3d 1183, 1190 (W.D. Wash. 2019) (citing Abatie v. Alta Health & Life

period held that discretionary review is not appropriate, even where the discretion-granting language is sufficiently clear, unless the participant is on notice of the delegation of authority.[276] In *McGuiggin v. Zurich American Insurance Co.*, the administrator failed to establish, via evidence in the record, that it provided plaintiff with notice of its discretionary authority to determine eligibility and to construe the plan's language.[277] The administrator argued it did not have a "separate obligation . . . to provide notice," but the court rejected that argument because, if "taken to its logical extreme, [it] would mean applying deferential review even if clear language delegating authority to the insurer were admittedly—or even purposely—concealed from plan participants."[278] Because Plaintiff did not have sufficient notice of the plan's delegation of discretionary authority, the court applied the *de novo* standard, holding that "an abuse-of-discretion standard applies only '[w]here the delegation of authority is sufficiently clear and notice of it has been appropriately provided' to the participant-employee."[279]

In certain circumstances, a procedural error or a violation of ERISA's regulations can lead to loss of the deferential standard a plan otherwise reserves in its governing documents. Not all procedural violations are considered equal. Courts are required to consider all of the circumstances before determining how much weight to assign an alleged procedural error or irregularity. In particular, the scope and nature of an alleged violation play an important role in and can significantly affect a court's decision regarding the appropriate standard of review.[280]

An inconsequential violation may not alter the standard of review.[281] If an administrator can show it "engaged in an ongoing, good faith exchange of information" with the claimant, a court may be more receptive to giving the administrator's decision deference notwithstanding a minor irregularity.[282] If an administrator's actions "fall so far outside the strictures of

Ins. Co., 458 F.3d 955, 971 (9th Cir. 2006) (an administrator's failure to comply with ERISA's procedural requirements will not "ordinarily" alter the standard of review) (citation omitted); Calderon v. Hartford Life & Accident Ins. Co., 372 F. Supp. 3d 1259, 1265 (D.N.M. 2019); Meyers v. Kaiser v. Found. Health Plan Inc., 2018 WL 6505391, at *10 (N.D. Cal. Dec. 11, 2018) (ordinarily procedural errors are a matter to be weighed in deciding whether an administrator's decision was an abuse of discretion).

276. McGuiggin v. Zurich Am. Ins. Co., 2019 WL 1333268, at *3 (D. Mass. Mar. 25, 2019).

277. *Id.* at *4.

278. *Id.* at *4 n.8.

279. *Id.* at *4 (quoting Stephanie C. v. Blue Cross Blue Shield of Mass. HMO Blue, Inc., 813 F.3d 420, 427 (1st Cir. 2016)).

280. Hoffman v. Screen Actors Guild Prod. Pension Plan, 757 F. App'x 602, 604 (9th Cir. 2019) (citing *Abatie*, 458 F.3d at 968, 972).

281. *Id.* at 604 (citing *Abatie*, 458 F.3d at 968, 972); *Calderon*, 372 F. Supp. 3d at 1265 ("As long as an 'ongoing, good faith exchange of information between the administrator and the claimant' takes place, minor procedural irregularities will not entitle [the claimant] to de novo review.")).

282. *Hoffman*, 757 F. App'x at 610 (quoting *Abatie*, 458 F.3d at 968, 972).

ERISA" that it cannot be said the administrator exercised its discretion appropriately, no deference will be warranted.[283]

The plan in *Hoffman v. Screen Actors Guild Producers Pension Plan*[284] granted discretionary authority to the administrator and the district court granted summary judgment to plan after reviewing a benefit denial under the abuse of discretion standard.[285] The court acknowledged there were multiple procedural irregularities in the administrator's review process, but it singled out only one and concluded, without explanation, that there was "no evidence of malice, self-dealing or a parsimonious claims-granting history on the part of the [administrator]."[286] In her appeal, Plaintiff identified multiple procedural irregularities in the administrator's review process, including its failure to consider all of the relevant evidence, including tax records, and its failure to make available to her evidence that was relevant to the decision, such as the administrative record from prior proceedings, audio recordings of meetings, and a medical report from the administrator's medical director.[287] The Ninth Circuit found the district court erroneously failed to consider *all* of the alleged procedural irregularities before determining the appropriate level of review.[288] Accordingly, it reversed and remanded after concluding the district court erred by not reviewing the plan's benefit denial under the de novo standard.[289]

In *Leirer v. Proctor & Gamble Disability Benefit Plan*,[290] Plaintiff asserted the administrator committed a procedural error in failing to provide him with the governing plan document and argued this error should have triggered *de novo* review.[291] The district court disagreed and applied the abuse of discretion standard dictated by the plan because claimant failed to show the procedural irregularity was "serious" and that it "caused a serious breach of the plan administrator's fiduciary duty."[292] The Eighth Circuit affirmed, finding Plaintiff was not "prejudiced" by the administrator's error because he had other documents in his possession—which he received from the

283. *Id.* at 610 (quoting *Abatie*, 458 F.3d at 972); Mary D. v. Anthem Blue Cross Blue Shield, 778 F. App'x 850 (10th Cir. 2019); Jarosz v. Am. Axle & Mfg., Inc., 372 F. Supp. 3d 163, 177 (W.D.N.Y. 2019) (applying *de novo* standard of review because the administrator's failure to comply with ERISA regulation was "intentional"—it admitted "purposefully omit[ing]" from its adverse benefit determination information required by ERISA because it wanted to keep its adverse benefit determination "short and succinct"); McNeal v. Metro. Life Ins. Co., 2019 WL 4751549 (N.D. Okla. Sept. 30, 2019).

284. 757 F. App'x. 602 (9th Cir. 2019).

285. *Id.* at 604, 605.

286. *Id.* at 604.

287. *Id.*

288. *Id.* at 604–05 (emphasis added).

289. *Id.*

290. 910 F.3d 392 (8th Cir. 2018).

291. *Id.* at 396.

292. *Id.* at 396–97.

administrator—that provided the same information as the governing plan document.[293]

In contrast, the court in *Gordon v. Metropolitan Life Insurance Co.*[294] found the administrator "utterly disregard[ed]" its ERISA obligations when it failed to issue a final decision on an appeal years after the deadline for doing so.[295] The court accordingly reviewed the claim under the *de novo* standard.[296]

Strict compliance with ERISA and its regulations is not always required; sometimes substantial compliance is sufficient.[297] In those instances, courts generally find that "inconsequential violations of [ERISA's] deadlines or other procedural irregularities [will] not entitle the claimant to de novo review" "so long as 'an ongoing, good faith exchange of information between the administrator and claimant' occurs."[298] But not all procedural violations can be satisfied by substantial compliance. The Seventh Circuit, for instance, recently held that the "substantial compliance" exception does not apply to "blown deadlines."[299] The court reasoned that "[a]n administrator may be able to 'substantially comply' with certain procedural requirements, but a deadline is a bright line."[300]

In *Fessenden v. Reliance Standard Life Insurance Co.*, the administrator acknowledged its decision was a little bit late, but requested that the district court excuse its tardiness under the "substantial compliance" doctrine and apply the arbitrary and capricious standard.[301] Plaintiff argued the administrator forfeited the benefit of deference when it missed the deadline for rendering a decision and urged the court to ignore the administrator's decision and review his claim *de novo*.[302] The Seventh Circuit agreed with Plaintiff, relying largely on the applicable regulation which requires an administrator to "review the claim 'not later than' a specified period of time—45 days for disability claims and 60 days for others."[303] The Seventh Circuit noted that while time can be extended under the regulation, "when

293. *Id.* at 396; *see also* O'Rourke v. N. Cal. Elec. Worker Pension Plan, 934 F.3d 993, 998 (9th Cir. 2019); Gallupe v. Sedgwick Claims Mgmt. Servs. Inc., 358 F. Supp. 3d 1183, 1190 (W.D. Wash. 2019) (declining to alter the standard of review to de novo because it the administrator did not engage in "wholesale and flagrant violations of the procedural requirements of ERISA" or "fail to comply with virtually every applicable mandate of ERISA." (citations omitted) (internal quotation marks omitted)).

294. 747 F. App'x. 594 (9th Cir. 2019).

295. *Id.* at 595.

296. *Id.*

297. Van Bael v. United Healthcare Servs., Inc., 2019 WL 142298, at *3 (E.D. La. Jan. 8, 2019) (citing Lacy v. Fulbright & Jaworski, 405 F.3d 254, 256–57 (5th Cir. 2005)).

298. Joel S. v. Cigna, 356 F. Supp. 3d 1305, 1314 (D. Utah 2018).

299. Fessenden v. Reliance Standard Life Ins. Co., 927 F.3d 998, 1000 (7th Cir. 2019).

300. *Id.*

301. *Id.* at 1001.

302. *Id.*

303. *Id.* at 1003; 29 C.F.R. § 2560.503-1(i)(1)(i).

that time is up, it's up" because the regulation clearly states that "*in no event* shall such extension exceed [the allotted] period."[304] It further found that "[s]ubstantial compliance with a deadline requiring strict compliance is a contradiction in terms,"[305] and held that because the administrator lacked discretion to take longer than the regulations allowed, its tardy decision would be reviewed *de novo*.[306]

IV. HEALTH INSURANCE

A. *Up to $12 Billion at Stake: Supreme Court Will Hear Insurers' Claims for Payments Under the Affordable Care Act's Risk Corridors Program*

As anticipated last survey period, the fight waged by a group of insurers seeking payment under the risk corridors program of the Patient Protection and Affordable Care Act ("ACA")[307] continues. The United States Supreme Court announced that it will address whether the federal government must pay up to $12 billion to insurers that sold Qualified Health Plan ("QHP") coverage on the ACA's Health Benefit Exchanges.[308] The dispute from the insurers' perspective was succinctly summarized in one petition for certiorari filed in connection with the dispute:

> To encourage health insurers to offer insurance on newly created health benefit exchanges, and to keep premiums low, the federal government made an unambiguous statutory commitment: If the costs of claims under these new

304. *Fessenden*, 927 F.3d at 1004 (emphasis added); 29 C.F.R. § 2560.503-1(i)(1)(i).

305. *Fessenden*, 927 F.3d at 1004.

306. *Compare id.* at 1004, *with* Romo v. Waste Connections US, Inc., 2019 WL 3769108, *4 (N.D. Tex. Aug. 9, 2019) (holding that "technical noncompliance with ERISA procedures will be excused so long as the purposes of section 1133 have been fulfilled") *and* Meyers v. Kaiser Found. Health Plan Inc., 2018 WL 6505391, *11 (N.D. Cal. Dec. 11, 2018) (the administrator's thirteen-day delay in responding did not constitute a "wholesale and flagrant" violation of ERISA's procedural requirements requiring *de novo* review).

307. Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified at 42 U.S.C. §§ 18001–18122). The U.S. Department of Health & Human Services ("HHS") promulgated regulations for implementing the risk corridors program. Moda Health Plan, Inc. v. United States, 892 F.3d 1311, 1314, 1316 (Fed. Cir. 2018) (citing Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,251–52 (Mar. 23, 2012) (codified at 45 C.F.R. pt. 153, subpt. F)), *reh'g and reh'g en banc denied*, Moda Health Plan, Inc. v. United States, 908 F.3d 738 (Fed. Cir. 2018) (per curiam), *cert. granted*, Moda Heath Plan, Inc. v. United States, 139 S. Ct. 2743 (2019) (mem.).

308. The Supreme Court granted certiorari with respect to the following underlying cases: Land of Lincoln Mut. Health Ins. Co. v. United States, 892 F.3d 1184 (Fed. Cir. 2018), *reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, Land of Lincoln Mut. Health Ins. Co. v. United States, 139 S. Ct. 2744 (2019) (Mem.); *Moda Health Plan*, 892 F.3d 1311, *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743; Me. Cmty. Health Options v. United States, 729 F. App'x 939 (Fed. Cir. 2018), *reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, Me. Cmty. Health Options v. United States, 139 S. Ct. 2743 (2019) (Mem.); Blue Cross & Blue Shield of N.C. v. United States, 729 F. App'x 939 (Fed. Cir. 2018), *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

> health insurance policies exceeded the premiums charged in the first three years, the government would reimburse insurers a specified percentage of the difference. Numerous health insurers, including petitioners, relied on that promise, joined the exchanges, set their premiums, and incurred significant losses in providing health coverage. Congress later enacted a series of appropriations riders restricting the sources of funds available to the Department of Health and Human Services ("HHS") to pay insurers what was owed, but never amended the underlying statute. A divided Federal Circuit panel agreed that the government's initial statutory commitment was unambiguous, but relied on legislative history to hold the appropriations riders had repealed the statutory guarantee. The net effect was a bait-and-switch of staggering dimensions in which the government has paid insurers $12 billion less than what was promised.[309]

Congress created the risk corridors program to encourage health insurers to offer QHP coverage on the ACA's Health Benefit Exchanges.[310] 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 participating insurers and the Federal Government.[311] Under the program, found in ACA Section 1342, gains and losses experienced by insurers offering QHPs on the Health Benefit Exchanges would be evened out. 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.[312]

Congress did not make a specific funding appropriation for the risk corridors program in 2014.[313] The Government Accountability Office ("GAO") opined that the language of the 2014 Centers for Medicare and Medicaid Services ("CMS") Program Management appropriation allowed HHS to use those funds to make the program's "payments out" in 2014. The GAO further observed that HHS could rely on the CMS Program Management appropriation to fund the 2015 and 2016 payments, but only if the appropriations language in those years was similar to the 2014 appropriations language.[314] It is perhaps unsurprising considering the political fights surrounding the ACA that riders to Congress's CMS Program Management

309. Brief for Petitioners Moda Health Plan, Inc. and Blue Cross & Blue Shield of N.C. at 2, Me Cmty Health Options v. United States, Moda Health Plan, Inc. v. United States, and Land of Lincoln Mut. Health Ins. Co. v. United States, Nos. 18-1023, 18-1028, and 18-1038 (U.S. Aug. 30, 2019).

310. Molina Healthcare of Cal., Inc. v. United Sates, 133 Fed. Cl. 14, 30 (2017).

311. *Id*. at 18 n.1.

312. *Moda Health Plan*, 892 F.3d at 1315 (quoting HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,413 (Mar. 11, 2013)), *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

313. *Molina Healthcare of Cal.*, 133 Fed. Cl. at 30.

314. *Id.* 24–25.

appropriations for 2015 to 2017 specifically stated that the funds appropriated could not be used to pay risk corridors payments.[315]

In October 2015, CMS announced that it owed $2.87 billion worth of "payments out" for the 2014 plan year, but that it had received only $362 million in "payments in."[316] CMS 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.[317] Between 2014 and 2016, the amounts owed as "payments out" outstripped the amounts received as "payments in" by $12 billion.[318]

Fifty or so insurers sued the federal government in the Court of Claims to recover the risk corridor payments owed them. They asserted various causes of action to support 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.[319] The government argued, *inter alia*, that by expressly withholding funding for the risk corridor payments in CMS's 2015 and 2016 Program Management appropriations, Congress vitiated the obligation to make risk corridor payments from funds other than those collected from insurers' "payments in."[320] A significant split developed within the Court of Claims as some courts adopted the insurers' arguments and others adopted the government's.[321]

The Federal Circuit resolved the conflicting decisions in favor of the government.[322] As explained in last year's article, the Federal Circuit held

315. *Id.* at 25.

316. *Moda Health Plan*, 892 F.3d at 1319 (citing 42 U.S.C. §§ 18021, 18031(b)(1), 18031(c)), *reh'g and reh'g en banc denied*, Moda Health Plan, Inc. v. United States, 908 F.3d 738 (Fed. Cir. 2018) (per curiam), *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

317. *Id.* at 1319 (citing 42 U.S.C. §§ 18021, 18031(b)(1), 18031(c)), *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

318. *Id.* (citing 42 U.S.C. §§ 18021, 18031(b)(1), 18031(c)), *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

319. *Molina*, 133 Fed. Cl. at 26; Land of Lincoln Mut. Health Ins. Co. v. United States, 129 Fed. Cl. 81, 114 (2016).

320. Me. Cmty. Health Options v. United States, 133 Fed. Cl. 1, 3 (2017); Moda Health Plan, Inc. v. United States, 130 Fed. Cl. 436, 457; *Land of Lincoln*, 129 Fed. Cl. at 113 n.30; *Molina*, 133 Fed. Cl. at 33.

321. Land of Lincoln Mut. Health Ins. Co. v. United States, 892 F.3d 1184 (Fed. Cir. 2018), *reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, Land of Lincoln Mut. Health Ins. Co. v. United States, 139 S. Ct. 2744 (2019) (Mem.); *Moda Health Plan*, 892 F.3d 1311, *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743; Me. Cmty. Health Options v. United States, 729 F. App'x 939 (Fed. Cir. 2018), *reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, Me. Cmty. Health Options v. United States, 139 S. Ct. 2743 (2019) (Mem.); Blue Cross & Blue Shield of N.C. v. United States, 729 F. App'x 939 (Fed. Cir. 2018), *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

322. *Moda Health Plan*, 892 F.3d at 1322.

in *Moda Health Plan, Inc. v. United States*[323] that Congress, by barring CMS from using the Program Management appropriation for risk corridors payments in fiscal year 2015, suspended the government's obligation to fund the risk corridors program beyond the sum of the payments it received from insurers.[324] Moda Health Plan, Inc., Land of Lincoln Mutual Health Insurance Company, Maine Community Health Options, and Blue Cross and Blue Shield of North Carolina filed petitions for rehearing *en banc*.[325] The Federal Circuit denied these petitions.[326] Judges Newman and Judge Wallach dissented from the denial of those petitions, however, and each joined the other's dissent.[327] Judge Newman believed the consolidated appeals raised a "critical question" as to how "the government deals with non-governmental entities that carry out legislated programs."[328] The court should review the matter en banc, he explained, because the government's denial of "promised compensation" called into question "the integrity of the government."[329] Judge Newman also stated that "[t]he government's access to private sector products and services [would be] undermined if non-payment is readily achieved after performance by the private sector."[330] Judge Wallach dissented because he "believe[d] the appropriation riders did not impliedly repeal the Government's obligations to make risk corridors payments."[331]

The United States Supreme Court granted the insurers' petitions for certiorari review.[332] At the time this article was completed, the Court had not yet heard argument in the consolidated appeals. The insurers argued in their briefs to the Court that the Federal Circuit erred in concluding Congress repealed its obligation to make risk corridors payments under Section 1342 of the ACA.[333] They further argued that if the appropriations

323. 908 F.3d 738 (Fed. Cir. 2018) (per curiam), *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

324. *Moda Health Plan*, 892 F.3d at 1322.

325. *Moda Health Plan*, 908 F.3d at 740. Blue Cross and Blue Shield of North Carolina also sought a rehearing by the panel. *Id.*

326. *Id.*

327. *Id.* at 742.

328. *Id*. at 740.

329. *Id*.

330. *Id*. at 741.

331. *Id*. at 742.

332. Land of Lincoln Mut. Health Ins. Co. v. United States, 892 F.3d 1184 (Fed. Cir. 2018), *reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, Land of Lincoln Mut. Health Ins. Co. v. United States, 139 S. Ct. 2744 (2019) (Mem.); Moda Health Plan, Inc. v. United States, 892 F.3d 1311 (Fed. Cir. 2018), *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743; Me. Cmty. Health Options v. United States, 729 F. App'x 939 (Fed. Cir. 2018), *reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, Me. Cmty. Health Options v. United States, 139 S. Ct. 2743 (2019) (Mem.); Blue Cross & Blue Shield of N.C. v. United States, 729 F. App'x 939 (Fed. Cir. 2018), *reh'g and reh'g en banc denied*, *Moda Health Plan*, 908 F.3d 738, *cert. granted*, *Moda Heath Plan*, 139 S. Ct. 2743.

333. Brief for Petitioners Moda Health Plan, Inc. and Blue Cross & Blue Shield of N.C. at

riders eliminated the federal government's obligations under Section 1342, it would raise "grave" constitutional concerns with respect to the Due Process Clause and the Takings Clause.[334] Allowing the government to "shirk its obligations under §1342," they contended, would result in "devastating consequences for the government's credibility" in business transactions and "for the nation's healthcare markets."[335]

We expect the Court will resolve the years-long fight over this aspect of the ACA during the next survey period, and look forward to bringing this chapter of ACA disputes to a close.

B. *The Fifth Circuit Reviews the Constitutionality of the ACA's Individual Mandate and Its Severability from the Remainder of the ACA*

Did the Tax Cuts and Jobs Act of 2017[336] render the Individual Mandate in the ACA unconstitutional? If so, is that provision inseverable from the rest of the ACA so that the entire Act falls along with the Individual Mandate? The Northern District of Texas answered "yes" to both of those questions this survey period.

Twenty states (the "State Plaintiffs") and two private individuals (the "Individual Plaintiffs") sued the United States, the HHS, the Secretary of HHS (Alex Azar), the Internal Revenue Service ("IRS"), and the Acting Commissioner of Internal Revenue (collectively, the "Federal Defendants")

27-28, Me. Cmty Health Options v. United States, Moda Health Plan, Inc. v. United States, and Land of Lincoln Mut. Health Ins. Co. v. United States, Nos. 18-1023, 18-1028, and 18-1038 (U.S. Aug. 30, 2019). ("To state the obvious, legislative history—let alone GAO correspondence—cannot provide the "clear 'intention of Congress *as expressed in the statutes*' that is necessary to demonstrate an implied repeal" of the previous law); *see also* Brief for Petitioner Me. Cmty. Health Options at 39, Me. Cmty Health Options v. United States, Moda Health Plan, Inc. v. United States, and Land of Lincoln Mut. Health Ins. Co. v. United States, Nos. 18-1023, 18-1028, and 18-1038 (U.S. Aug. 30, 2019) ("If a statutory payment obligation is to be repealed by a subsequent appropriation act, the repeal must be 'expressed in the statutes.' It was not expressed in the statutes in this case. And that should have been determinative." (quoting U.S. v. Mitchell, 109 U.S. 146, 150 (1883))); Brief for Petitioner Land of Lincoln at 23, Me. Cmty Health Options v. United States, Moda Health Plan, Inc. v. United Sates, and Land of Lincoln Mut. Health Ins. Co. v. United States, Nos. 18-1023, 18-1028, and 18-1038 (U.S. Aug. 30, 2019) ("The riders did not purport to alter a single word of the ACA or change the payment formula in Section 1342. They did not repeal Section 1342, or amend the 'shall pay' language of Section 1342 . . . ."). The United States has not yet filed its brief during this survey period.

334. Brief for Petitioners Moda Health Plan, Inc. and Blue Cross & Blue Shield of N.C. at 46–50, Me. Cmty Health Options v. United States, Moda Health Plan, Inc. v. United States, and Land of Lincoln Mut. Health Ins. Co. v. United States, Nos. 18-1023, 18-1028, and 18-1038 (U.S. Aug. 30, 2019).

335. *Id*. at 53–54; Brief for Petitioner Land of Lincoln at 47–48, Me. Cmty Health Options v. United States, Moda Health Plan, Inc. v. United States, and Land of Lincoln Mut. Health Ins. Co. v. United States., Nos. 18-1023, 18-1028, and 18-1038 (U.S. Aug. 30, 2019) ("[T]he Federal Circuit construed the appropriations riders in a way that destabilized insurance markets, when the very purpose of the ACA was to do the opposite.").

336. Pub. L. No. 115-97, 131 Stat. 2054 (2017).

challenging the constitutionality of the ACA.[337] Sixteen states and the District of Columbia intervened as defendants (collectively, the "Intervenor Defendants").[338] The State and Individual Plaintiffs argued that the Tax Cuts and Jobs Act of 2017 ("TCJA")[339] rendered the ACA's Individual Mandate unconstitutional. That conclusion, plaintiffs claimed, was dictated by the relationship between (1) the ACA's Individual Mandate and its accompanying "shared responsibility payment," (2) the TCJA, which reduced the shared responsibility payment to $0, and (3) the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*,[340] which upheld the constitutionality of the Individual Mandate on the limited grounds that it was an exercise of Congress's Tax Power.[341]

The Individual Mandate requires Americans to maintain what the ACA refers to as "minimum essential coverage."[342] The shared responsibility payment was a tax penalty Congress imposed to compel compliance with the Individual Mandate.[343] Congress, however, "[i]n the TCJA, . . . reduced the ACA's shared-responsibility payment to zero, effective January 1, 2019."[344] That was significant, plaintiffs argued, because the constitutionality of the Individual Mandate was upheld in *NFIB* only as an exercise of Congress's Tax Power. The Supreme Court's reasoning in *NFIB* depended heavily on the existence of the shared responsibility payment. Because the TCJA reduced that tax to $0, plaintiffs argued the Individual Mandate could no longer be considered an exercise of Congress's Tax Power. And if the requirements imposed by the Individual Mandate could no longer be justified as an exercise of Congress's Tax Power, there was no constitutional basis for the requirements imposed by the Individual Mandate.

The district court adopted Plaintiffs' arguments. The shared responsibility payment was a tax, the court explained, because it featured the "essential" attribute of any tax: the production of revenue for the government.[345] That tax was triggered by non-compliance with the Individual Mandate, which meant the Mandate "could be viewed as part and parcel of a provision supported by the Tax Power."[346] When the shared responsibility payment went to $0 on January 1, 2019, it no longer generated revenue

337. Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (*Texas I*), *stay granted by* Texas v. United States, 352 F. Supp. 3d 665 (N.D. Tex. 2018) (*Texas II*), *appeal docketed*, No. 19-10011 (5th Cir. Jan. 7, 2019).
338. *Id.* at 591.
339. Pub. L. No. 115-97, 131 Stat. 2054 (2017).
340. 567 U.S. 519 (2012) [hereinafter *NFIB*].
341. *Id.*
342. 26 U.S.C. § 5000A(a) (Individual Mandate); *Texas I*, 340 F. Supp. 3d at 585.
343. *Id.*
344. *Id.* at 591.
345. *Id.* at 598–99 (citing *NFIB*, 567 U.S. 519 (2012)).
346. *Id.* at 598.

for the government and, thus, no longer qualified as a tax.[347] Because the shared responsibility payment was no longer a tax, the Individual Mandate's requirement that Americans maintain minimum essential coverage could not be characterized as an exercise of Congress's Tax Power.[348] As of January 1, 2019, therefore, the Individual Mandate ceased to be a constitutionally authorized exercise of Congressional powers.[349]

The ripples created by the TCJA did not end there. The State and Individual Plaintiffs argued the Individual Mandate was inseverable from the ACA and sought a declaration that the remainder of the ACA also was unconstitutional.[350] The Federal Defendants took a hybrid approach to the severability issue; they "agree[d] the Individual Mandate is unconstitutional and inseverable from the ACA's pre-existing-condition provisions," but argued the remainder of the ACA was severable from the Individual Mandate and survived.[351] The Intervenor Defendants argued the Individual Mandate was entirely severable from the rest of the ACA.[352]

The district court agreed that the Individual Mandate was essential to and inseverable from the ACA.[353] The entire ACA was "invalid," according to the court.[354] The 2010 Congress that passed the ACA made its intentions clear in § 18091 that the Individual Mandate was intended to be inseverable from the rest of the ACA.[355] The court described various statements in the Supreme Court's decisions in *NFIB* and *King v. Burwell*[356] as supporting its construction of § 18091.[357] As for the intentions of the 2017 Congress that enacted the TCJA, that Congress could not be said to have had any intentions regarding the severability of the Individual Mandate.[358] But if any intent could be inferred, the court believed, it would have to be drawn from Congress's failure to repeal the Individual Mandate or § 18091.[359] The fact that the 2017 Congress did not take either of those steps, the court explained, suggested Congress believed the Individual Mandate was "essential to" and, thus, inseverable from the ACA.[360]

347. *Id*. at 600–01.
348. *Id*.
349. *Id*. at 605.
350. 26 U.S.C. § 5000A(a) (Individual Mandate); *Texas I*, 340 F. Supp. 3d at 585.
351. *Texas I*, 340 F. Supp. 3d at 591–92; *see also* Li Zhou, *The Latest Legal Challenge to the Affordable Care Act, Explained*, Vox, https://www.vox.com/policy-and-politics/2019/7/9/20686224/affordable-care-act-constitutional-lawsuit-fifth-circuit-court-texas-district-court (last visited Oct. 20, 2019) (noting the Trump administration declined to defend the ACA).
352. *Texas I*, 340 F. Supp. 3d at 605.
353. *Id*. at 619.
354. *Id*.
355. *Id*. at 607–10.
356. 135 S. Ct. 2480, 2485–87 (2015).
357. *Texas I*, 340 F. Supp. 3d at 610.
358. *Id*. at 617.
359. *Id*.
360. *Id*.

In light of its determinations that the Individual Mandate was unconstitutional and rendered the ACA invalid, the court granted summary judgment for the State and Individual Plaintiffs.[361] It then stayed enforcement of the judgment while the Intervenor Defendants appealed.[362] The Fifth Circuit heard arguments in the appeal near the end of this survey period.[363] We will continue to follow this case through the Fifth Circuit appeal and report further in the next survey period.

C. *The ACA's Contraceptive Mandate—Decisions Regarding the Religious Exemption and Moral Exemption Interim and Final Rules*

As previously reported, the federal government issued two interim final rules that exempted certain organizations from the ACA's contraceptive mandate. The "moral exemption rule" exempts nonprofit organizations and for-profit entities with no publicly traded ownership from the contraceptive mandate if the organizations' "sincerely held moral convictions" oppose providing the contraceptive coverage called for by the mandate.[364] The "religious exemption rule" exempts non-governmental plan sponsors and institutions of higher education that arrange for student health coverage from having to comply with the contraceptive mandate if their "sincerely held religious beliefs" conflict with it.[365] The interim final rules were the subject of three lawsuits discussed during the last survey period brought by various states seeking preliminary injunctions on the enforcement of those rules. In one of the lawsuits, the court denied the request for a preliminary injunction and granted summary judgment for the government, finding the plaintiff state lacked standing to challenge enforcement of the interim rules.[366] In the two other lawsuits, the courts granted the plaintiff states' requests for nationwide preliminary injunctions.[367]

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361. *Id*. at 619.

362. Texas v. United States, 352 F. Supp. 3d 665, 669 (N.D. Tex. 2018) (*Texas II*), *appeal docketed*, No. 19-10011 (5th Cir. Jan. 7, 2019).

363. *Texas II*, 352 F. Supp. 3d 665 (N.D. Tex. 2018), *appeal docketed*, No. 19-10011 (5th Cir. Jan. 7, 2019).

364. 45 C.F.R. § 147.133(a)(2).

365. 45 C.F.R. § 147.132(a)(2).

366. Massachusetts v. U.S. Dep't of Health & Human Servs., 301 F. Supp. 3d 248 (D. Mass. 2018), *vacated and remanded by* Massachusetts v. U.S. Dep't of Health & Human Servs., 923 F.3d 209 (1st Cir. 2019).

367. Pennsylvania v. Trump (*Trump I*), 281 F. Supp. 3d 553 (E.D. Pa. 2017), *aff'd*, *subnom*. Pennsylvania v. President U.S., 930 F.3d 543 (3d Cir. 2019), *petition for cert. filed*, No. 19-431 (Oct. 1, 2019), *petition for cert. docketed*, Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, No. 19-431 (Oct. 2, 2019), *petition for cert. filed*, No. 19-454 (Oct. 3, 2019), *petition for cert. docketed*, Donald J. Trump, President of the U.S. v. Pennsylvania, No. 19-454 (Oct. 7, 2019); California v. U.S. Dep't of Health & Human Servs., 281 F. Supp. 3d 806 (N.D. Cal. 2017), *aff'd in part*, *vacated in part*, *remanded by* California v. Azar, 911 F.3d 558 (9th Cir. 2018), *cert. denied*, Little Sisters of the Poor Jeanne Jugan Residence v. California, 139 S. Ct. 2716 (2019).

While those decisions were being appealed, the federal government promulgated final rules for the moral and religious exemptions.[368] Pennsylvania and New Jersey filed suit seeking to enjoin enforcement of those rules.[369] After finding the states had standing to sue,[370] the district court held that they had established a reasonable likelihood of success on the merits and entered a nationwide preliminary injunction barring enforcement of the final rules.[371]

Appeals from those district court decisions were heard by various Circuit Courts of Appeal this survey period, and they largely held in the plaintiff states' favor. In *Pennsylvania v. President United States*[372] and *California v. Azar*,[373] the Third and Ninth Circuits, respectively, affirmed the entry of preliminary injunctions with respect to the final rules.[374] An injunction was warranted, the Third Circuit concluded, because the states had established a reasonable likelihood that they would succeed in demonstrating the final rules were procedurally defective and violated the ACA.[375] The Third Circuit further observed there were "serious substantive problems" with the final rules as neither the ACA nor the RFRA[376] required or authorized their promulgation, which also made it reasonably likely the states would succeed on the merits of their claims.[377] And while the Ninth Circuit agreed a preliminary injunction was warranted, it concluded the nationwide scope of the injunction entered by the district court was an abuse of discretion because the plaintiff states could obtain complete relief from an injunction that was limited to their specific interests.[378]

368. *See* Pennsylvania v. Trump, 351 F. Supp. 3d 791, 803 (E.D. Pa. 2019) (*Trump II*) (citing Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536, 57,536 (Nov. 15, 2018) ("Final Religious Exemption"); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592, 57,592 (Nov. 15, 2018) ("Final Moral Exemption")), *aff'd*, Pennsylvania v. President U.S., 930 F.3d 543, *petition for cert. filed*, No. 19-431, *petition for cert. docketed*, Little Sisters of the Poor, No. 19-431, *petition for cert. filed*, No. 19-454, *and petition for cert. docketed*, Trump v. Pennsylvania, No. 19-454 (Oct. 3, 2019).

369. *Trump II*, 351 F. Supp. 3d 791.

370. *Id*. at 804–05.

371. *Id*. at 830, 835 ("[G]iven the harm to the States should the Final Rules be enforced—numerous citizens losing contraceptive coverage, resulting in 'significant, direct and proprietary harm' to the States in the form of increased use of state-funded contraceptive services, as well as increased costs associated with unintended pregnancies—a nation-wide injunction is required to ensure complete relief to the States").

372. 930 F.3d 543.

373. 911 F.3d 558 (9th Cir. 2018), *cert. denied*, Little Sisters of the Poor Jeanne Jugan Residence v. California, 139 S. Ct. 2716 (2019).

374. *Pennsylvania v. President U.S.*, 930 F.3d 575–79.

375. *Id*. at 569.

376. Religious Freedom Restoration Act of 1993, 42 U.S.C.A. §§ 2000bb – 2000bb-4.

377. *Pennsylvania v. President U.S.*, 930 F.3d at 561.

378. *Azar*, 911 F.3d at 584–85.

The Third Circuit further confirmed in *Pennsylvania v. President United States* that the plaintiff states had standing to challenge the final rules. The states faced imminent harm in the form of a "concrete financial injury," the court explained, because employers could be expected to take advantage of the exemptions to the contraceptive mandate, which would cause "women covered by their [employers'] plans [to] lose contraceptive coverage" and would lead many of those women to rely on "state-funded services for their contraceptive needs."[379] A preliminary injunction, therefore, would "avoid the imminent financial burden the States [would] face if [the final rules were] not enjoined."[380] Because the First Circuit in *Massachusetts v. United States Department of Health & Human Services*[381] agreed Massachusetts had standing to challenge the final rules, it vacated the district court's grant of summary judgment for the government[382] and remanded.[383]

At the time of publication, petitions for certiorari review had been filed in *Pennsylvania v. President United States*[384] and *California v. Azar*.[385] The petition in *California* was denied but several petitions in *President United States* remain pending. We will continue to monitor the petitions for certiorari and will report on any further developments with respect to exemptions to the ACA's contraceptive mandate in the next survey period.

V. LIFE INSURANCE

A. *Most Friendship Is Feigning, Most Loving Mere Folly*[386]*—STOLI, Insurable Interest, and Feigned Compliance*

Following up on the Winter 2017 and Spring 2019 discussions of *Sun Life Assurance Co. of Canada v. Wells Fargo Bank, N.A.*,[387] the New Jersey

379. 930 F.3d at 562.

380. *Id*. at 564.

381. 923 F.3d 209, 227 (1st Cir. 2019).

382. Massachusetts v. U.S. Dep't of Health & Human Servs., 301 F. Supp. 3d 248 (D. Mass. 2018), *vacated and remanded*, 923 F.3d 209 (1st Cir. 2019).

383. *Massachusetts v. U.S. Dep't of Health & Human Servs.*, 923 F.3d at 227.

384. 930 F.3d 543 (3d Cir. 2019), *petition for cert. filed*, No. 19-431 (Oct. 1, 2019), *petition for cert. docketed*, Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, No. 19-431 (Oct. 2, 2019), *petition for cert. filed*, No. 19-454 (Oct. 3, 2019), *petition for cert. docketed*, Donald J. Trump, President of the U.S. v. Pennsylvania, No. 19-454 (Oct. 7, 2019).

385. 911 F.3d 558 (9th Cir. 2018), *cert. denied*, Little Sisters of the Poor Jeanne Jugan Residence v. California, 139 S. Ct. 2716 (2019).

386. William Shakespeare, As You Like It.

387. Sun Life Assurance Co. of Can. v. Wells Fargo Bank, N.A., 2016 WL 5746352 (D.N.J. Sept. 30, 2016), *aff'd*, 2019 WL 3948361 (3d Cir. Aug. 21, 2019); Sun Life Assurance Co. of Can. v. Wells Fargo Bank, NA, 2016 WL 6824367 (D.N.J. Nov. 17, 2016), *aff'd*, 2019 WL 3948361 (3d Cir. Aug. 21, 2019); Sun Life Assurance Co. of Can. v. Wells Fargo Bank NA, 2018 WL 5303551 (3d Cir. Jan. 30, 2018), *certified question accepted sub nom.* Sun Life Assurance Co. of Can. v. Wells Fargo Bank, N.A., 201 A.3d 1267 (N.J. 2018), *and certified question*

Supreme Court responded to two certified questions from the Third Circuit this survey period interpreting New Jersey's insurable interest law.[388] In 2016, the district court found the insured's policy was void *ab initio* as a stranger-owned life insurance ("STOLI") policy because it was issued with apparent insurable interest (the son was the trustee of the owner and beneficiary trust) but with stranger-investors secretly funding the premiums and taking control of the policy five weeks after its issuance.[389] The district court, however, granted Wells Fargo's request for a premium refund as it was a later purchaser of the policy.[390] In 2018, the Third Circuit identified that the issues on appeal were unresolved questions of state law and certified two questions to the New Jersey Supreme Court.[391]

The New Jersey Supreme Court accepted the certified questions and held that a life insurance policy procured by a third party without an insurable interest that feigns compliance with the insurable interest requirement is a cover for a wager and violates New Jersey public policy.[392] The court concluded:

> In short, the outside investors who funded the policy effectively control it from the start. If the investors cause the [trustee of the owner trust] to transfer [the trustee's] interest to them *a month*, *a day*, *or an hour* after the policy is issued, it would elevate form over substance to suggest that the policy satisfies the insurable interest requirement. At most, there is only feigned compliance with the requirement that an insurable interest exist "at the time when [the] contract was made."[393]

The court further found that a policy procured under a STOLI scheme is void *ab initio*.[394] Finally, the New Jersey Supreme Court held that a party may be entitled to a refund of premiums depending on several equitable factors: "a party's level of culpability, its participation in or knowledge of

answered sub nom. Sun Life Assurance Co. of Can. v. Wells Fargo Bank, N.A., 208 A.3d 839 (N.J. 2019).

388. *Sun Life*, 208 A.3d 839.

389. *Id.* at 842.

390. *Id.*

391. The Third Circuit certified the following questions:

> (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?
>
> (2) If such a 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?

Sun Life v. Wells Fargo, 2018 WL 5303551, *certified question accepted*, 201 A.3d 1267 (2018), *and certified question answered sub nom. Sun Life v. Wells Fargo*, 208 A.3d 839.

392. *Sun Life*, 208 A.3d at 849.

393. *Id.* at 850 (quoting N.J. Stat. Ann. § 17B:24-1.1(b)) (emphasis added).

394. *Id.* at 857.

the illicit scheme, and its failure to notice red flags."[395] These responses allowed the Third Circuit to affirm the district court's decision, finding the policy at issue void *ab initio* for violating the public policy of New Jersey and returning the premiums to Wells Fargo—the later purchaser of the policy who was not involved in illegal conduct.[396]

Another Sun Life case decided this survey period, *Sun Life Assurance Co. Canada v. United States Bank National Association*,[397] contributes to the growing body of case law finding STOLI policies void *ab initio* under Delaware law for lack of insurable interest due to hidden non-recourse premium financing. The Delaware insurable interest statute requires insureds to procure their own policies, or, if the policy is procured by another, the benefits must be payable to someone with insurable interest.[398] The district court concluded the insured did not procure the policy because she did not pay the premiums herself.[399] It particularly noted the insured paid the premiums via a loan which she had no contractual obligation to repay because a trust was the borrower (not the insured), the loan was non-recourse, and the insured "lacked the practical ability to repay the loan using anything other than proceeds from transfer of the Policy."[400]

Defendant U.S. Bank argued that the initial financers behind the loan, Coventry Capital Partners and LaSalle Bank National Association, procured the policy legitimately because benefits were payable to the insured's family members.[401] Although the district court acknowledged that the policy technically complied with Delaware's insurable interest statute in that regard, it found that "technical compliance does not end the inquiry."[402] Like the New Jersey Supreme Court in the *Sun Life* case discussed above, the Delaware Supreme Court also has found that its state insurable interest statute requires looking beyond feigned technical compliance with insurable interest statutes.[403] Because all other facts in this case suggested the policy was an illegal wagering contract, "merely naming a beneficiary having an insurable interest does not make an otherwise unlawful wagering contract lawful."[404]

395. *Id*. at 859.
396. Sun Life Assurance Co. of Can. v. Wells Fargo Bank NA, 2019 WL 3948361, at *2–3 (3d Cir. Aug. 21, 2019).
397. 369 F. Supp. 3d 601 (D. Del. 2019), *reconsideration denied*, 2019 WL 2052352 (D. Del. May 9, 2019).
398. *Id*. at 610.
399. *Id*.
400. *Id*. at 610–11.
401. *Id*. at 612–13.
402. *Id*. at 613.
403. *Id*.
404. *Id*. at 614.

Numerous facts supported the conclusion that the original financers did not act in good faith, including that the insured's application contained multiple material misrepresentations regarding her finances, the third parties involved did not adequately investigate the insured's finances, the third-party financer sought its own life expectancy report, the premium finance loan was non-recourse, the insured and her trusts could not repay the loan other than from policy proceeds, the financer secured an irrevocable appointment of power of attorney over any life insurance policy owned by the insured's trusts, and the entire scheme benefited the financer and its lending associates.[405] As a result, the district court granted summary judgment for Sun Life, finding the policy lacked an insurable interest at its inception and was void *ab initio*.[406]

Finally, the Southern District of Florida decided *Estate of Malkin v. Wells Fargo Bank, N.A.* this survey period, a case related to *Sun Life Assurance Co. of Canada v. United States Bank National Association*, which was discussed in the Winter 2017 article.[407] In these two cases, the insured took out high-dollar life insurance policies with Sun Life Assurance Co. of Canada and American General Life Insurance Company ("AIG").[408] Sun Life refused to pay its policy's death benefit, and both the Southern District of Florida and the Eleventh Circuit agreed the policy was void *ab initio* under Delaware law as a STOLI policy.[409] But AIG paid its policy's benefit to Wells Fargo Bank, the named beneficiary, upon the insured's death.[410] Thus, the insured's estate sued Wells Fargo for violating § 2704(b) of Delaware's insurable interest statute, which grants an insured's estate the right to sue the beneficiary of a policy made "in violation of this section."[411] A contract

405. *Id.*

406. *Id.* at 617.

407. 379 F. Supp. 3d 1263 (S.D. Fla. 2019) (noting that this case shares the same factual background as *Sun Life Assurance Co. of Canada v. U.S. Bank Nat'l Ass'n*, 2016 WL 161598 (S.D. Fla. Jan. 14, 2016) because both cases involve insurance policies taken out on the life of insured Phyllis Malkin with premiums financed by the same financing entities).

408. *Id.* at 1265–66.

409. *Sun Life v. U.S. Bank*, 2016 WL 161598; *Sun Life Assurance Co. of Can. v. U.S. Bank Nat'l Ass'n*, 693 F. App'x 838 (11th Cir. 2017).

410. *Estate of Malkin*, 379 F. Supp. 3d at 1266, 1269–70. The policy at issue in this case underwent several sales and transfers, ultimately being purchased by Berkshire Hathaway Life Insurance Company of Nebraska with Wells Fargo Bank, N.A. serving as securities intermediary (collectively, the "beneficiary"). *Id.* at 1269.

411. *Id.* at 1270. Subsection (b) of Delaware's insurable interest statute states:

> (b) If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or his or her executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

DEL. CODE ANN. tit. 18, § 2704(b).

violates § 2704(b) when it is a STOLI policy as defined in § 2704(a).[412] Because the district court and Eleventh Circuit had already determined that the insured's Sun Life policy was a STOLI policy under Delaware law, and the two policies were issued under nearly identical circumstances, the district court easily held that the insured's AIG policy was a STOLI policy under Delaware law.[413] This entitled the insured's estate to recover the policy's death benefit from the beneficiary under Delaware law.[414]

B. *Revoke Thy Gift, or Whilst I Can Vent Clamor from My Throat, I'll Tell Thee Thou Dost Evil*[415]*—Revocation-on-Divorce After* Sveen

The marital status of the insured and beneficiaries factor into an insurer's analysis when deciding whether to pay a life insurance policy or interplead the funds thanks to many states' revocation-on-divorce statutes. During the last survey period, the United States Supreme Court issued its opinion in *Sveen v. Melin*,[416] finding that Minnesota's revocation-on-divorce statute could be applied retroactively.[417] The ex-spouse in *Sveen*, who had been designated the primary beneficiary, argued it would violate the Contracts Clause of the U.S. Constitution to apply the 2002 Minnesota revocation-on-divorce statute to the 1998 life insurance policy and thereby revoke her designation.[418] The Supreme Court applied a two-step test to determine whether applying the statute to a pre-existing contract would violate the Contracts Clause and found it did not.[419] Minnesota's law was designed to reflect the policyholder's intent, it does not upset the policyholder's expectations because it aligns with what the divorce court could have done, and the default rule the law creates can be undone by simply re-designating the ex-spouse as a beneficiary.[420] At the time *Sveen* was issued, 26 states, including Minnesota, had adopted revocation-on-divorce laws based on

412. *Estate of Malkin*, 379 F. Supp. 3d at 1272–73.
413. *Id*. at 1276.
414. *Id.* at 1284.
415. William Shakespeare, King Lear.
416. 138 S. Ct. 1815 (2018).
417. *Id*. at 1818.
418. *Id*. at 1821.
419. *Id*. at 1821–22. The first step is "whether the state law has 'operated as a substantial impairment of a contractual relationship.'" *Id*. The court must consider "the extent to which the law undermines the contractual bargain, interferes with a party's reasonable expectations, and prevents the party from safeguarding or reinstating his rights." *Id*. at 1822 (citations omitted). In the second step, the court asks "whether the state law is drawn in an 'appropriate' and 'reasonable' way to advance 'a significant and legitimate public purpose.'" *Id*. (citations omitted). Here, the Court only needed to examine the first step because it determined Minnesota's revocation-on-divorce statute did not "substantially impair pre-existing contractual arrangements." *Id*.
420. *Id*.

the Uniform Probate Code,[421] leading some to conclude those states would follow *Sveen* and apply their revocation-on-divorce statutes retroactively.

During this survey period, one of the 26 states—Alabama—followed *Sveen's* lead.[422] In *Blalock v. Sutphin*,[423] the Alabama Supreme Court held that Alabama's 2015 revocation-on-divorce statute could be applied retroactively without violating the Alabama Constitution's Contracts Clause. The insured initially designated his daughter as primary beneficiary in 2011 when the life insurance policy was issued.[424] After marrying Blalock in 2012, the insured designated his daughter and Blalock each as a 50% beneficiary.[425] The insured and Blalock divorced in 2016 and did not mention the life insurance policy in the divorce decree.[426] Blalock unsuccessfully argued at trial and on appeal that retroactive application of the Alabama revocation-on-divorce statute violated Alabama's Contracts Clause.[427] The Alabama Supreme Court noted that Alabama's Contracts Clause and the federal Contracts Clause are nearly identical and serve the same purpose.[428] It also remarked that this case was so similar to *Sveen* that to hold differently would create confusion.[429] Thus, the Alabama Supreme Court agreed with the trial court's decision that Blalock's beneficiary designation was revoked by the Alabama revocation-on-divorce statute, and the daughter was the rightful, sole beneficiary of the life insurance policy.[430]

Even when the revocation-on-divorce statute applies prospectively, some states do not automatically revoke a beneficiary designation. In *Primerica Life Insurance Co. v. Montoya*,[431] the district court determined that Montoya, the insured's ex-wife, had the burden to prove by a preponderance of the evidence that her divorce from the insured did not revoke her designation as beneficiary.[432] New Mexico enacted its revocation-on-divorce statute in 1992.[433] The insured designated Montoya as the beneficiary of

421. *Id.* at 1819.
422. The District of South Carolina also followed *Sveen* in *Protective Life Insurance Co. v. LeClaire* during the last survey period. 2018 WL 3222796 (D.S.C. July 2, 2018). In *LeClaire*, the district court rejected the ex-wife's summary judgment argument that retroactive application of the South Carolina revocation-on-divorce statute would violate both South Carolina and federal Contracts Clauses. *Id.* at *4–5. The district court, without much analysis, said that *Sveen* is binding precedent and denied the ex-wife's summary judgment motion. *Id.*
423. 275 So. 3d 519 (Ala. 2018).
424. *Id.* at 521, 524.
425. *Id.* at 521.
426. *Id.*
427. *Id.* at 522, 526.
428. *Id.* at 524.
429. *Id.* at 526.
430. *Id.* at 525–26, 527.
431. 2019 WL 1242677 (D.N.M. Mar. 18, 2019).
432. *Id.* at *4.
433. *Id.* at *3.

his life insurance policy in 1998, after which they married.[434] The insured designated his niece as a contingent beneficiary.[435] Predictably, the insured and Montoya divorced and the divorce decree did not mention the life insurance policy.[436] In an interpleader action following the insured's death, the niece disputed Montoya's entitlement to the policy proceeds, arguing Montoya's designation was presumptively revoked by the divorce.[437] Montoya attempted to rebut the presumption with an affidavit from the insured's partner who said that the insured wanted Montoya to have the proceeds.[438] New Mexico's courts had not addressed whether divorce absolutely revokes a designation or creates a rebuttable presumption, but its federal courts had made a "predictive guess" and applied the rebuttable presumption approach.[439] Following that authority, the district court held "the putative beneficiary [could] meet her burden, by a preponderance of the evidence, either by providing a writing from the decedent in compliance with the terms of the life insurance policy, or by presenting an admissible statement of the decedent's intent made to a third-party with no interest in the beneficiary designation."[440] Because the partner's affidavit lacked sufficient indicia of trustworthiness, the district court denied summary judgment to Montoya, requiring that the trier of fact decide whether the affiant was a disinterested witness.[441]

C. *Grace Is Grace, Despite of All Controversy*[442]*—Statutory Requirements for Grace and Lapse Notices*

In *Halberstam as Trustee of Zupnick Family Trust 2008 B v. Allianz Life Insurance Co. of North America*,[443] the grace notice the insurer provided was deficient, resulting in the district court directing the insurer to treat the policy as "in good standing and in effect" upon receipt of back premiums.[444] The policy entered a grace period on July 7, 2012, and the grace notice sent to the policyholder on August 7, 2012 stated the policy would lapse unless the insurer received $116,511.94 by September 7, 2012.[445] The grace notice provided that this amount would keep the policy in force until November 7, 2012.[446] New York state law, however, requires grace notices to state the

434. *Id.* at *1.
435. *Id.*
436. *Id.*
437. *Id.*
438. *Id.* at *1, *4.
439. *Id.* at *4.
440. *Id.*
441. *Id.* at *5–6.
442. William Shakespeare, Measure for Measure.
443. 349 F. Supp. 3d 164 (E.D.N.Y. 2018).
444. *Id.* at 171, 176.
445. *Id.* at 167.
446. *Id.*

amount due and requires a 61-day grace period "within which to pay sufficient premium to keep the policy in force for *three months* from the date the insufficiency was determined."[447] Because the grace notice asked for four months of premium, the district court found it was legally invalid and held the policy did not lapse in September 2012.[448] Additionally, when the policyholder asked the insurer how much premium it owed, the insurer stated that it required a reinstatement application and approval by underwriting before reinstating the policy.[449] The district court considered this an anticipatory repudiation of the contract and absolved the policyholder of its failure to tender the required premium.[450]

In *Conestoga Trust v. Columbus Life Insurance Co.*,[451] the Fifth Circuit affirmed that a policy did not require the insurer to create or retain a postmark when mailing a grace notice.[452] The policy provided the insurer would send a grace notice with a 61-day grace period, during which the insured was permitted to pay or mail premium to avoid lapse, and stated the insurer would "rely on the postmark to determine the date of mailing."[453] After the policy at issue lapsed due to the owner's failure to pay the premiums, the owner sued claiming it never received the grace notice. The district court entered judgment for the insurer following a jury trial. The Fifth Circuit held the district court did not err in determining that the postmark language likely applied to receipt of premiums and not to the mailing of the grace notice, and, even if it did, the policy's plain language did not compel the insurer to create or retain a postmark to prove the date of mailing.[454] The Fifth Circuit nevertheless reversed and remanded for a new trial because the district court erred in allowing a jury instruction that placed the burden of proof for the mailing of the grace notice on the policyholder, rather than on the insurer.[455]

In *Bentley v. United of Omaha Life Insurance Co.*,[456] the district court held that California statutes creating new lapse and termination notice requirements for policies "issued or delivered" in California after January 1, 2013 also applied to policies renewed after that date.[457] The court rejected the insurer's argument that the statutes did not apply to policies renewed after

447. *Id.* at 169–70 (emphasis added).
448. *Id.* at 171.
449. *Id.* at 173.
450. *Id.* at 173–74.
451. 759 F. App'x 227 (5th Cir. 2019).
452. *Id.* at 231–32.
453. *Id.* at 231.
454. *Id.* at 232.
455. *Id.* at 234, 236 (holding that in Texas "the insurer has the burden to prove that it sent a grace notice that is required prior to termination of the policy").
456. 371 F. Supp. 3d 723 (C.D. Cal. 2019).
457. *Id.* at 733.

the effective date, but only to policies "issued or delivered" after that date. The district court found that the statutes were meant to apply prospectively to policies that continue in force in California, including those that continued in force due to renewal.[458] Thus, for a class of 26 policies, the district court held the statutes were incorporated into the affected policies.[459] As a result, the district court held that the insurer breached the contract by failing to provide the class insureds the rights secured to them by the statutes.[460]

These grace notice cases serve as a reminder to insurers to pay close attention to grace notice language in their policies as well as new and existing state laws that affect the content and mailing requirements of such notices.

VI. CONCLUSION

We will be monitoring the extent to which courts around the country follow the significant STOLI decisions discussed above, which held that STOLI contracts are void ab initio notwithstanding investors' technical compliance with insurable interest requirements. We are also interested to see whether other states follow Alabama's lead and apply their revocation-on-divorce statutes to life insurance contracts retroactively. On the ERISA front, we expect the Supreme Court will help clarify what it means to have "actual knowledge" of a claim and, thus, when the limitations clock begins to run on a breach of fiduciary duty claim. We also expect the decisions issued during the next survey period will further flesh out the law concerning when (or whether) a plan's substantial compliance with ERISA's regulations suffices.

And while we anticipate the next survey period will bring closure to the risk corridors dispute, all indications are that disputes related to the ACA are not going away any time soon. Over the course of the next survey period, the Fifth Circuit presumably will issue its ruling as to the constitutionality of the ACA's Individual Mandate and the ACA itself, but it seems unlikely that will be the last word on the issue. And another set of ACA-related disputes—efforts to accommodate the ACA's contraceptive mandate—can be expected to take additional twists and turns throughout the next survey period, as they have since the Act's passage. We look forward to reporting on these and other significant developments in health, life, and disability insurance law in next year's article.

458. *Id.* at 731–35 (the court also held that renewal occurs upon payment of a premium).

459. *Id.* at 733–34, 739.

460. *Id.* at 741 (these include the right to name a designee to receive lapse or termination notice, to have notice of lapse or termination sent to such designees and assignees, and by lapsing the class's policies and failing pay the policies' proceeds).