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

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I. INTRODUCTION

The decisions in this year's article mark the steady development of the law in the areas of accident and disability insurance, as well as more significant developments in the areas of ERISA, life insurance, and health insurance, including, most notably, the Supreme Court's decision upholding the constitutionality of the Patient Protection and Affordable Care Act. On the ERISA front, two circuit courts weighed in on the applicability of a fiduciary exception to a plan's privileged communications, while on the life insurance front, courts appeared more receptive than in years past to arguments that would allow insurers to keep life insurance premiums paid in furtherance of illegal stranger originated life insurance (STOLI) schemes. An exhaustive discussion of the cases from the survey period is beyond the scope of this article; instead, we have tried to focus on the most important and interesting cases of the past year to illustrate the law's development in the areas of life, health, and disability insurance.

II. ACCIDENT INSURANCE

A. *Meaning of Accident*

Does drunk driving qualify as an "accident" within the meaning of an accidental death policy? Courts this year continued to address the

"metaphysical conundrum of what is an accident"[1] by referring to the standard the First Circuit adopted in *Wickman v. Northwestern National Insurance Co*.[2] The Fifth Circuit discussed that standard in *Firman v. Life Insurance Co. of North America*,[3] construing it to mean a death is an accident if the insured: (1) is subjectively expected to survive the circumstances; and (2) the expectation was objectively reasonable "from the perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences."[4] Where there is insufficient evidence to establish the insured's expectations, a purely objective analysis is undertaken. Under that analysis, a death will not qualify as an accident if "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."[5]

The *Firman* decision demonstrates the trend: if an insurer denies a drunk driving death was an accident without first establishing the existence of the *Wickman* factors, courts have no difficulty finding that the insurer abused its discretion.[6]

In some instances, however, courts have concluded that the insureds' conduct was so objectively unreasonable that their deaths could not be considered accidents. In *Hauser v. Stonebridge Life Insurance Co*.,[7] the court found the insured's death was not an accident where the insured was driving with a blood alcohol content (BAC) of 0.32 percent, which the court characterized as an "extreme level of intoxication."[8] The court explained those circumstances fit "squarely among the cases in which '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.' "[9] Similarly, in *Riddle v. Life Insurance*

1. *E.g.*, Firman v. Life Ins. Co. of N. Am., 908 F.2d 1077, 1084 (1st Cir. 1990).
2. 908 F.2d 1077 (1st Cir. 1990).
3. 684 F.3d 533 (5th Cir. 2012).
4. *Id.* at 541 (citing *Wickman*, 908 F.2d at 1088).
5. *Id.*
6. *Id.*; *see also* McClelland v. Life Ins. Co. of N. Am., 679 F.3d 755, 761 (8th Cir. 2012) (although insured crashed his motorcycle while driving with a blood alcohol content over 0.20 percent, denial of benefits was an abuse of discretion because insurer did not consider insured's subjective expectations); Loberg v. CIGNA Grp. Ins., No. 8:09CV280, 2012 WL 3527718, at *8 (D. Neb. Aug. 14, 2012) (because there "was not a 'scintilla of evidence' " showing the insured thought he would die, finding that insured's drunk driving death was self-inflicted was an abuse of discretion).
7. No. CA 10-423 S, 2012 WL 1936682 (D.R.I. May 29, 2012).
8. *Id.* at *2.
9. *Id.* (citing Stamp v. Metro. Life Ins. Co., 531 F.3d 84, 89 (1st Cir. 2008), and quoting *Wickman*, 908 F.2d at 1088).

Co. of North America,[10] the court declined to find an accident where the insured was driving more than 50 miles over the speed limit, with a BAC of 0.222 percent, and apparently took no action to avoid crashing his vehicle into a tree.[11]

B. *Alcohol/Intoxication Exclusions*

The presence of an alcohol exclusion in an accidental death policy can dramatically affect whether an accident resulting from drunk driving will be covered. In *James-Smith v. Total Affiliates Accidental Death & Dismemberment Insurance Plan*,[12] the insured died in a motorcycle collision while driving with a BAC of 0.09 percent. The court first rejected the ERISA plan's conclusion that the insured's death was not an accident, but then considered the policy's alcohol exclusion, under which no benefits were owed for injuries caused, directly or indirectly, or in whole or part, from the operation of a vehicle while intoxicated, as defined by state law.[13] Because the insured's intoxication was partly responsible for his death, the court granted summary judgment for the plan.[14]

At issue in *Goeringer v. Sun Life Assurance Co. of Canada*[15] was whether an exclusion barring coverage for losses resulting from the "operation" of a motorized vehicle while intoxicated barred coverage for an insured who died in the driver's seat of a truck parked in his garage with the ignition in the on position and a BAC of 0.17 percent. Applying ERISA's arbitrary and capricious standard of review, the court held the plan's determination that the insured was "operating" the truck was not unreasonable and, therefore, coverage was barred.[16] In other cases, courts rejected arguments that alcohol exclusions defining intoxication by reference to state law only bar coverage when the insured's intoxication constitutes a crime under state law.[17]

10. No. 11-1034(FLW), 2011 WL 4809037 (D.N.J. Oct. 11, 2011).
11. *Id.* at *6.
12. No. 3:10 CV 2640, 2011 WL 4899992 (N.D. Ohio Oct. 13, 2011).
13. *Id.* at *6.
14. *Id.*
15. No. CIV-11-409-L, 2012 WL 393618 (W.D. Okla. Feb. 6, 2012).
16. *Id.* at *4–5.
17. *E.g.*, Likens v. Hartford Life & Accident Ins. Co., 688 F.3d 197, 200–01 (5th Cir. 2012) (exclusion for injuries sustained due to legal intoxication was unambiguous and its application did not depend on whether the insured was engaged in illegal or prohibited activity); Fitzgerald v. Colonial Life & Accident Ins. Co., No. JFM-12-38, 2012 WL 1030261 (D. Md. Mar. 26, 2012) (insurer did not abuse its discretion in concluding exclusion barred coverage where insured drowned while legally intoxicated but not acting illegally); Arredondo v. Hartford Life & Accident Ins. Co., 860 F. Supp. 2d 363 (S.D. Tex. 2012) (rejecting the argument that Texas's definition of intoxication should not apply since the insured was drinking at home when he died, finding the intoxication exclusion negated coverage).

C. *Self-Inflicted Injury*

Another type of exclusion typically included in accidental death policies is the self-inflicted injury exclusion. In *Weaver v. UNUM Life Insurance Co. of America*,[18] the insured died at work after either jumping or falling from the top of a grain silo shortly after his employment was terminated. Since the ERISA administrative record supported the conclusion that "suicide was more likely than a tragic accident," the court found it was reasonable for the administrator to deny benefits based on the policy's suicide exclusion.[19] The district court deciding *Clarke v. Federal Insurance Co*.[20] also upheld an administrator's decision to deny a claim under an intentional injury exclusion. There, the insured died while engaging in autoerotic asphyxiation. The court explained the insured's intentional restriction of oxygen to his brain by self-asphyxiation was an intentional act that injured his brain and led to his death.[21] It thus upheld the insurer's finding that the policy's intentional injury exclusion precluded coverage.[22]

D. *Medical Condition/Sickness Exclusion*

A number of cases addressing medical condition exclusions were decided this survey period. In *Viera v. Life Insurance Co. of North America*,[23] the insured's use of Coumadin complicated his medical treatment following a motorcycle collision and contributed to his death. In light of that, the insurer concluded the policy's medical treatment exclusion barred coverage. The court disagreed and entered judgment for the beneficiary, finding the bleeding caused by the collision related injuries was "sufficiently extensive to be the independent cause of his death."[24] A sickness exclusion also failed to bar coverage in *Genal v. Prudential Insurance Co. of America*.[25] The insured, who suffered from multiple sclerosis (MS), died from heat exposure after falling in his backyard while dismounting or pushing a scooter. Rejecting the argument that death resulted directly from the MS, which prevented the insured from moving to avoid heat exposure,

18. No. CV–11–J–1425–NW, 2012 WL 1642189 (N.D. Ala. 2012).
19. *Id.* at *6.
20. 823 F. Supp. 2d 1213 (W.D. Okla. 2011).
21. *Id.* at 1220-21.
22. *Id.* at 1221; *see also* Smith v. Life Ins. Co. of N. Am., 459 F. App'x 480 (5th Cir. 2012) (voluntary ingestion exclusion, which exempts from coverage death resulting from voluntary ingestion of any narcotic, drug, poison, gas, or fumes unless prescribed by or taken under a doctor's direction following the prescribed dosage, excluded coverage for insured's death caused by ingesting more than ten times the maximum recommended dosages of Ambien and hydrocodone, and lethal amounts of other drugs).
23. No. 09-3574, 2012 WL 3194394 (E.D. Pa. Aug. 6, 2012).
24. *Id.* at *8.
25. No. 6:11-182-TMC, 2012 WL 2871777 (D.S.C. July 12, 2012).

the court found the insured's lack of mobility was not a factor that substantially contributed to his death.[26]

E. *Atypical Exclusions*

Several cases this year discussed some atypical exclusions. Among these was *Hernandez v. Hartford Life & Accident Insurance Co.*,[27] which considered a "circulatory malfunction" exclusion that exempted from coverage loss due to "any heart, coronary or circulatory malfunction."[28] The Sixth Circuit upheld the administrator's decision to deny coverage for the insured's death, which was undisputedly caused by a pulmonary embolism, and rejected an argument that the exclusion should not apply because the cause of the embolism was an "accident," i.e., a leg fracture that occurred weeks prior to death.[29] Since a circulatory malfunction caused death irrespective of plaintiff's purported "accident," the court concluded the exclusion clearly applied.[30] In *Arnett v. Jackson National Life Insurance Co.*,[31] the court enforced a policy provision which required that for there to be coverage, deaths resulting from internal injuries "must be visibly manifested on an autopsy except in the case of drowning."[32] In so holding, the court upheld the insurer's denial of coverage where no autopsy was submitted for an insured's death caused by a drug interaction.

III. DISABILITY INSURANCE

A. *Subjective Versus Objective Evidence*

One recurring challenge for courts and parties dealing with disability claims is how to analyze claims premised on subjective complaints of pain or other allegedly disabling conditions that cannot be objectively verified. The decisions during the survey period tilted favorably toward insurers' insistence on some objectively verifiable evidence for an insured's subjective complaints of disability. In *Testa v. Hartford Life Insurance Co.*,[33] for instance, the court upheld the denial of benefits for complaints of migraine pain because the insured provided little, if any, "objectively

26. *See also* Linton-Hooker v. AIG Life Ins. Co., No. 1:11-cv-101, 2012 WL 691615 (W.D. Mich. Mar. 2, 2012) (sickness exclusion barred coverage for death while scuba diving because death was caused by heart disease); Estate of Paul v. New York Life Ins. Co., No. L-1619-10, 2012 WL 3640795 (N.J. Super. Ct. App. Aug. 27, 2012) (no coverage for death due to receiving the wrong medication during treatment in light of medical treatment exclusion).

27. 462 F. App'x 583 (6th Cir. 2012).

28. *Id.* at 584.

29. *Id.* at 585.

30. *Id.*

31. No. 10-420-BAJ-CN, 2012 WL 314090 (M.D. La. Feb. 1, 2012).

32. *Id.* at *1–4.

33. 483 F. App'x 595 (2d Cir. 2012).

verifiable evidence" of disability.[34] The insured argued the objective evidence requirement was improper because it was not required under the plan's terms. Rejecting that argument, the court found "[a]n administrator may require objective medical support, even when the requirement 'is not expressly set out in the plan,' so long as the claimant was so notified."[35] Other decisions from the survey period similarly supported an insurer's right to demand objective evidence for an insured's subjective complaints.[36] The court in *Tesch v. Prudential Insurance Co. of America*[37] was more receptive to the insured's subjective complaints of chronic pain.[38] It concluded the insurer acted unreasonably by disregarding medical documentation of the insured's complaints of severe pain and relying entirely on the medical records reviewer's opinion instead of seeking a functional capacity evaluation, as recommended by an examining physician.[39]

B. *Risk of Relapse*

Are insureds who were previously disabled but are presently capable of working nonetheless disabled because there is a risk that returning to work would cause them to become disabled again? The court in *Rhodes v. Principal Financial Group, Inc.*[40] acknowledged that the answer was "yes" under governing Third Circuit precedent, provided the insured's risk of relapse was sufficiently high.[41] The insured was a diabetic who stopped working to gain control over his diabetes and for nine weeks received short-term disability (STD) benefits. The insured insisted he was

34. *Id.* at 597.

35. *Id.* at 598.

36. *See, e.g.*, Maher v. Mass. Gen. Hosp. Long Term Disability Plan, 665 F.3d 289, 293–94 (1st Cir. 2011) (case remanded based on insured's "signs of exaggeration and doctor shopping" and lack of objective medical evidence to support either insured's self-reported limitations related to chronic pain or insurer's sporadic video surveillance of her activities); Tortora v. SBC Commc'ns, Inc., 446 F. App'x. 335, 338 (2d Cir. 2011) (affirming summary judgment for plan based on lack of objective evidence of disability due to fibromyalgia); Rund v. JP Morgan Chase Group Long Term Disability Plan, 855 F. Supp. 2d 185, 204 (S.D.N.Y. 2012) (upholding denial of benefits because subjective complaints of pain not supported by objective medical evidence or functional limitations); Harvey v. Standard Ins. Co., 850 F. Supp. 2d 1269, 1285-86 (N.D. Ala. 2012) (affirming judgment for insurer because medical documentation of pain "on [the] whole, [did] not objectively demonstrate permanent or long-term disabling results"); Perez v. Long Term Disability Plan for Choices Eligible Emp. of Johnson & Johnson and Affiliated Cos., No. 11-20863-Civ., 2012 WL 415445, at *2 (S.D. Fla. Feb. 9, 2012) (upholding denial of benefits in light of evidence of exaggerated symptoms and "a lack of objective medical documentation to support [the insured's] subjective reports of disabling depression").

37. 829 F. Supp. 2d 483 (W.D. La. 2011).

38. *Id.* at 496, 503.

39. *Id.* at 499.

40. No. 3:10-CV-290, 2011 WL 6888684 (M.D. Pa. Dec. 30, 2011).

41. *Id.* at *4; *see also* Colby v. Assurant Emp. Benefits, 818 F. Supp. 2d 365, 381–82 (D. Mass. 2011).

entitled to additional STD benefits because the travel necessitated by his occupation would interfere with his ability to control his diabetes and put him at risk of relapse. In light of the insured's demonstrated ability to control his diabetes, the court found the insured's risk of relapse was not sufficiently high to support a finding that he remained disabled.[42] In contrast, the court in *Colby v. Assurant Employee Benefits*[43] reinstated benefits for an opioid-addicted anesthesiologist after finding she had a "sufficiently high" risk of a drug-abuse relapse if she returned to work.[44]

C. *Surveillance*

Two circuit courts during the survey period addressed the weight to be given to video surveillance evidence, both concluding the weight afforded depends on the amount and nature of the activity observed. In *Maher v. Massachusetts General Hospital Long Term Disability Plan*,[45] the court recognized the video surveillance of the insured revealed sporadic activity that contradicted her claimed limitations, but it also found the surveillance largely confirmed the existence of those limitations. As a result, it remanded the case to the insurer to provide a more detailed explanation as to why it believed the surveillance supported denial of the insured's disability claim.[46] The Seventh Circuit in *Marantz v. Permanente Medical Group, Inc. Long Term Disability Plan*[47] echoed *Maher*, concluding that "when the recorded data does not conflict with the applicant's self reports of limitations, or when the surveillance catches limited bursts of activity that might be anomalous," surveillance evidence "is of limited utility."[48] Unlike the insured in *Maher*, however, the video surveillance, together with other evidence, revealed significant inconsistencies between the insured's reported limitations and her actual activities, which the court found supported the insurer's decision.[49]

42. *Id.* at *5.
43. 818 F. Supp. 2d 365 (D. Mass. 2011).
44. *Id.* at 379.
45. 665 F.3d 289 (1st Cir. 2011).
46. *Id.* at 294-95; *see also* Barrett v. Sedgwick CMS Long-Term Disability Plan, No. 10-3298, 2011 WL 4860011, at *7 (D. Minn. Oct. 7, 2011) (surveillance showed the insured engaged in limited activity but did not establish he was disabled).
47. 687 F.3d 320 (7th Cir. 2012).
48. *Id.* at 330; *see also* Daigle v. Hartford Life & Acc. Ins. Co., 452 F. App'x 689, 690 (8th Cir. 2011) (insurer's use of video surveillance was reasonable and was only one piece of evidence used to support claims decision); Gross v. Sun Life Ass. Co. of Canada, No. 09-11678-RWZ, 2012 WL 29061, at *5 (D. Mass. Jan. 6, 2012) (surveillance video directly conflicted with insured's claimed limitations).
49. *Marantz*, 687 F.3d at 333.

D. *Bad Faith*

Allegedly aggressive settlement tactics were at issue in *Mony Life Insurance Co. v. Marzocchi*.[50] After the insurer paid disability benefits under a reservation of rights it sued to recover them; in turn, the insured counterclaimed, alleging the insurer "breached its duty of good faith and fair dealing, conducted a bias [*sic*] investigation in an adversarial manner, and used the power to reserve its rights as a tool to bludgeon" her into accepting a settlement offer.[51] The district court granted the insurer's motion to dismiss the bad faith claim because under California law such a claim fails where benefits have not been withheld (the insured acknowledged receipt of benefits), even if the insurer's acts were "hostile or egregious . . . prior to such payment."[52]

E. *Mental Illness Limitation*

The issue in *Ayers v. Life Insurance Co. of North America*[53] was whether the insured's disabling cognitive difficulties were caused by a mental condition, and thus limited to the policy's twenty-four month limitation on such benefits, or by a physical condition, in which case benefits were not so limited. The insured argued his disability was due to chronic fatigue syndrome (CFS), which Ninth Circuit precedent held was a "physical condition,"[54] while the insurer asserted the disability was caused by depression. Affording greater weight to the opinions of a treating physician and a CFS expert, the court concluded the insured's limitations were caused by CFS rather than depression and granted the insured's motion for summary judgment.[55]

IV. ERISA

A. *Plan Documents and Summary Plan Descriptions*

Nearly every ERISA case at some level requires the court and the litigants to refer to the terms of the applicable plan. Whether a summary plan description (SPD) comprises part of a plan's terms is an issue with which courts have continued to grapple following the Supreme Court's decision last year in *CIGNA Corp. v. Amara*.[56] In *Eugene S. v. Horizon*

50. 857 F. Supp. 2d 993 (E.D. Cal. 2012).
51. *Id.* at 994–95.
52. *Id.* at 996–97 (quoting Love v. Fire Ins. Exchange, 221 Cal. App. 3d 1136, 1151 (Cal. Ct. App. 1990)).
53. 869 F. Supp. 2d 1248 (D. Or. 2012).
54. *Id.* at 1261 (citing Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 942–44 (9th Cir. 1995)).
55. *Id.* at 1265.
56. 131 S. Ct. 1866 (2011); *see also* Merigan v. Liberty Life Assurance Co. of Boston, 826 F. Supp. 2d 388 (D. Mass. 2011) (the terms of the SPD are not terms of the plan).

Blue Cross Blue Shield of New Jersey,[57] for instance, the court recognized a distinction between claiming an SPD is *integrated into* the plan, which the court believed undermined *Amara*, and showing through clear and explicit plan language that the SPD *is part of the plan*, which the court viewed as consistent with *Amara*.[58] Because the SPD clearly and unequivocally stated it was part of the group policy, the court enforced discretionary language in the SPD.[59] In *Kaufmann v. Prudential Insurance Co. of America*,[60] however, the court rejected the insurer's claim that the SPD constituted part of the plan because the SPD clearly stated it was not part of the group insurance certificate.[61]

B. *Ambiguous Plan Language*

In *Becker v. Chrysler LLC Health Care Benefits Plan*,[62] the Seventh Circuit reiterated its long-standing view that the common law rule of contra proferentum does not apply where the plan administrator has been given discretion to construe and interpret plan terms.[63] The court noted the administrator's interpretation in those circumstances will be upheld so long as it has "rational support in the record."[64]

C. *Parties and Fiduciaries*

It is not always clear whether an individual is a plan participant or beneficiary. One case arising during this survey period highlighted the challenges that societal changes and state law efforts to define marriage pose for plans when determining whether someone is a plan participant's spouse. The plaintiff in *Radtke v. Miscellaneous Drivers & Helpers Union Local No. 638 Health, Welfare, Eye & Dental Fund*[65] underwent a sex change operation and amended her birth certificate to reflect her new status as a female. She later married her husband, a plan participant, but the plan concluded her marriage was not a "legal marriage" under Minnesota law and, therefore, she was not eligible for plan benefits. The court found the plaintiff's amended birth certificate established she was female and because Minnesota defined "[l]awful marriage" as marriage "between persons of the opposite sex,"[66] the marriage between plaintiff and her hus-

57. 663 F.3d 1124 (10th Cir. 2011).
58. *Id.* at 1131.
59. *Id.* at 1132.
60. 840 F. Supp. 2d 495 (D.N.H. 2012).
61. *Id.* at 498.
62. 691 F.3d 879 (7th Cir. 2012).
63. *Id.* at 890.
64. *Id.* at 891.
65. 867 F. Supp. 2d 1023 (D. Minn. 2012).
66. *Id.* at 1027 (citing MINN. STAT. § 517.01 (1997)).

band was between persons of the opposite sex.[67] Accordingly, the court held the plan's termination of the spouse's benefits was unreasonable and wrong.[68]

D. *Standard of Review—Procedural Irregularities*

Even where the plan grants discretionary authority, de novo review may apply when there are serious procedural irregularities leading the court to conclude a claim was effectively "deemed denied" per the pre-2002 governing regulations.[69] Examples of such irregularities include instances where an administrator fails, without good cause, to resolve an appeal before the claimant invests substantial time and resources in litigation.[70] In *Langlois v. Metropolitan Life Insurance Co.*,[71] the administrator failed to issue a decision in response to the plaintiff's appeal of her claim for benefits. Because the administrator failed to act on the appeal, the court concluded the administrator "fail[ed] to exercise [any] discretion" and thus "forfeited the privilege to apply his or her discretion."[72] Notably, however, the court in *Harvey v. Standard Insurance Co.*[73] held that the failure to abide by ERISA's regulatory time frames for making a decision when the plan has undertaken a voluntary, extracontractual review is not a "deemed denial" and does not constitute a serious procedural irregularity affecting the standard of review.

In *Atkins v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*,[74] the court refused to alter the standard of review even after an extensive delay. Because the plaintiff was kept informed of developments throughout the administrative process and agreed to some of the procedural steps that contributed to the delays, the court found no "wholesale or flagrant violations that evidence[d] an 'utter disregard of the underlying purpose of the plan'" which would warrant disregarding discretionary review.[75]

E. *Full and Fair Review*

Outside the context of "deemed denied" cases, two decisions during the survey period confirmed that procedural defects and misconduct do not necessarily deprive a claimant of a full and fair review. In *Brimer v. Life*

67. *Id.* at 1035–36.
68. *Id.* at 1036.
69. *See* Hankins v. Standard Ins. Co., 828 F. Supp. 2d 991 (E.D. Ark. 2012).
70. *See* Langlois v. Metro. Life Ins. Co., 833 F. Supp. 2d 1182 (N.D. Cal. 2011).
71. *Id.*
72. *Id.* at 1188.
73. *See* Harvey v. Standard Ins. Co., 850 F. Supp. 2d 1269 (N.D. Ala. 2012).
74. 694 F.3d 557 (5th Cir. 2012).
75. *Id.* at 567 (quoting Abatie v. Alta Health & Life Ins. Co., 458 F. 3d 955, 971 (9th Cir. 2006)).

Insurance Co. of North America,[76] the insurer asserted new grounds for denying the plaintiff's claim in its administrative appeal decision. The court concluded the insurer's process was defective and that it violated ERISA's "full and fair review" requirement, but affirmed judgment for the insurer because the plaintiff was not prejudiced by the defective process.[77] Similarly, in *Ermovick v. Mitchell Silberberg & Knupp LLP Long Term Disability Plan for All Employees*,[78] the Ninth Circuit held that because the district court reviewed the administrative record de novo, any procedural defect by the plan was not prejudicial as plaintiff received a full and fair review of his claim from the district court.[79]

F. *Standard of Review—Conflict of Interest*

Conflict of interest issues continue to be a significant factor to challenge a plan administrator's benefits decision. In *Harlick v. Blue Shield of California*,[80] the court noted its review for an abuse of discretion is "tempered by skepticism" where the plan administrator has a conflict of interest, there are inconsistent reasons for denial, no full review of the claim occurred, or proper procedures were not followed.[81] The court in *Wykstra v. Life Insurance Co. of North America*[82] gave some weight to the plan's structural conflict of interest because the plan administrator failed to provide any explanation for its departure from the Social Security Administration's finding of disability.[83] Not all alleged conflicts of interest are equal, however. In *Jurasin v. GHS Property & Casualty Insurance Co.*,[84] the court found there was not evidence of a conflict of interest just because a medical review officer was employed by an insurer and the review board that considered plaintiff's appeal was staffed exclusively by insurance company employees.[85] Rather, plaintiff would have to show the medical review officer had a specific stake in the outcome of his claim or demonstrate some likelihood for concluding bias affected the review board's decision

76. 462 F. App'x 804 (10th Cir. 2012).
77. *Id.* at 809–11. *See also* Aschermann v. Aetna Life Ins. Co., 689 F.3d 726 (7th Cir. 2012) (administrator's statement that existing medical records were outdated, with a request for new tests, provided the plaintiff with a reasonable opportunity to supplement the file and receive a full and fair review and constituted adequate notice to cure the claim's deficiency); and Tortora v. SBC Commc'ns, Inc., 446 F. App'x 335 (2d Cir. 2011) (administrator's letter stating the clinical information did not document the severity of the plaintiff's claimed condition and did not support her inability to perform her occupation provided adequate notice of basis of denial of claim).
78. 472 F. App'x 459 (9th Cir. 2012).
79. *Id.* at 460.
80. 686 F.3d 699 (9th Cir. 2012).
81. *Id.* at 707.
82. 849 F. Supp. 2d 285 (N.D.N.Y. 2012).
83. *Id.* at 293.
84. 463 F. App'x 289 (5th Cir. 2012).
85. *Id.* at 292.

on appeal to alter the standard of review. Short of such a showing, the court concluded unsupported assertions of bias are too theoretical and speculative to evidence a conflict of interest.[86]

G. *Preemption—State Law Claims*

Several courts addressed whether ERISA preempted various state statutes with differing results. In *Fossen v. Blue Cross & Blue Shield of Montana, Inc.*,[87] the Ninth Circuit held that a provision of the Health Insurance Portability and Accountability Act (HIPAA), which is part of ERISA, preempted Montana's "'little HIPAA'" law "for purposes of both conferring federal subject matter jurisdiction and defeating state-law causes of action on the merits."[88] The court also held, however, that a claim under Montana's unfair practices statute was unlike the Montana HIPAA claim because it "applie[d] without regard to the existence of an ERISA plan" and thus was not preempted by ERISA. In *Self-Insurance Institute of America, Inc. v. Snyder*,[89] the court held that the Michigan Health Insurance Claims Assessment Act, which "imposes an assessment of 1% on the value of all claims paid by every carrier or third party administrator for medical services that are rendered in Michigan to a resident of Michigan," was not preempted by ERISA because it did not act exclusively on ERISA plans or single them out for different treatment.[90] In *Munda v. Summerlin Life & Health Insurance Co.*,[91] plaintiffs, who were enrolled in a plan insured by the defendant, alleged negligence and negligence per se for defendant's alleged violation of a Nevada quality assurance statute. The Nevada Supreme Court noted it had recently "joined the Third, Fifth, Ninth, and Tenth Circuits in holding that ERISA preempts suits that are predicated on administrative decisions made in administering an ERISA plan."[92] The court found, however, that under the facts alleged in *Munda*, there was a question as to whether defendant was acting as a managed care organization or an ERISA administrator. Accordingly, the court held there was no preemption of the negligence claims under the facts alleged.[93]

H. *Discovery—Fiduciary Exception*

Under the Ninth Circuit's holding in *Stephan v. Unum Life Insurance Co. of America*,[94] otherwise privileged communications between a plan's admin-

86. *Id.*
87. 660 F.3d 1102 (9th Cir. 2011).
88. *Id.* at 1104.
89. No. 11-15602, 2012 WL 3888212 (E.D. Mich. Sept. 7, 2012).
90. *Id.* at *1.
91. 267 P.3d 771 (Nev. 2011).
92. *Id.* at 775.
93. *Id.*
94. 697 F.3d 917 (9th Cir. 2012).

istrators and plan counsel concerning matters of plan administration, e.g., how to interpret certain plan language, are discoverable by a plan participant unless the communications occurred after the interests of the participant and plan had become adverse.[95] Plaintiff sought notes of conversations between the plan's counsel and a claims analyst concerning the interpretation of the plan and whether plaintiff's bonus ought to be considered part of his monthly earnings under the plan. Because the notes concerned matters of plan administration and were generated prior to the plan's appeal determination, i.e., before the parties' interests became adverse, the court concluded the fiduciary exception to the attorney-client privilege applied and the requested notes were discoverable.[96] The Sixth Circuit considered the application of the fiduciary exception in *Moss v. Unum Life Insurance Co.*[97] Although the communications at issue in *Moss* occurred before a final benefits decision, i.e., before the parties were adverse, the court concluded the exception did not apply because the communications concerned pending litigation, not plan administration.[98]

I. *Discovery—Post-Glenn*

The nature and scope of permissible discovery remains unsettled post-*Glenn*[99] and disputes concerning those issues continue. In *Melech v. Life Insurance Co. of North America*,[100] plaintiff alleged a conflict of interest and sought discovery of defendant's manuals, guidelines, and similar documents for claims administration matters, irrespective of whether defendant actually relied on them. Rejecting defendant's offer to produce only the index, the court ordered defendant to produce the entire claims manual.[101] The court in *Bigley v. Ciber, Inc.*[102] held that, in de novo cases, discovery is allowed only "when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision."[103] That principle came into play in *Viera v. Life Insurance Co. of North America*,[104] where plaintiff sought what he characterized as his entire file, which he contended included defendant's handbook, and requested to depose the claims adjustor. The court, applying de novo review, denied plaintiff's request, concluding the documents would not

95. *Id.* at 933.
96. *Id.*
97. No. 11-6017, 2012 WL 3553497 (6th Cir. Aug. 17, 2012).
98. *Id.* at *11.
99. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 108 (2008).
100. 857 F. Supp. 2d 1281 (S.D. Ala. 2012).
101. *Id.* at 1285.
102. 853 F. Supp. 2d 1079 (D. Colo. 2011).
103. *Id.* at 1082.
104. 871 F. Supp. 2d 379 (E.D. Pa. 2012).

assist its review.[105] The court noted that the record already included plaintiff's claim file, the insurer indicated that no other files existed for the claim, and plaintiff did not articulate why the existing record was deficient.[106] As for the claims manual, the court indicated it was not relevant to the de novo review, which, on remand, was focused on the insured's cause of death.[107] Finally, with respect to a possible deposition of the adjuster, the court again concluded that plaintiff "fail[ed] to articulate how the current record is inadequate."[108]

J. *Remedies*

The nature of permissible equitable relief (and equitable defenses) available under ERISA also remains unsettled. In *CGI Technologies & Solutions Inc. v. Rose*,[109] the plan participant obtained damages from a third-party tortfeasor and the plan sued to recoup the amounts it paid for the participant's medical expenses.[110] The participant argued the damages awarded to her were less than 100 percent of her claimed damages and that it was unfair to require her to repay the plan in full without deduction for the attorney fees she paid.[111] She also argued that equity permitted the court to reduce the amounts required to be paid to the plan. The district court rejected those arguments and entered judgment for the plan based on the plan's terms. The Ninth Circuit vacated that judgment and directed that "the district court [on remand] should apply traditional equitable principles including consideration of traditional equitable defenses" in determining what amounts the plan was entitled to recover.[112] Similarly, in *US Airways, Inc. v. McCutchen*,[113] the plan administrator sought reimbursement for medical expenses from the amount the plan participant recovered from a third party. Legal costs, however, had reduced the participant's net recovery to less than what the administrator demanded. The Third Circuit vacated the judgment for the administrator and remanded the case, concluding the participant could "assert certain equitable limitations, such as unjust enrichment, on [the plan administrator's] equitable claim."[114]

105. *Id.* at 385.
106. *Id.*
107. *Id.*
108. *Id.* at 386.
109. 683 F.3d 1113 (9th Cir. 2012).
110. *Id.* at 1116.
111. *Id.* at 1123.
112. *Id.* at 1125; *cf.* McCravy v. Metro. Life Ins. Co., 690 F.3d 176 (4th Cir. 2012) (concluding the equitable remedies of surcharge and estoppel were available to plan participant).
113. 663 F.3d 671 (3d Cir. 2011).
114. *Id.* at 672.

The holding in *Rochow v. Life Insurance Co. of North America*[115] addresses equitable remedies a participant can ostensibly recover in connection with an erroneous denial of benefits. In that case, the court entered judgment for plaintiff on his disability claim and the plan's insurer paid those benefits. After agreeing that plaintiff was also entitled under ERISA's "catch-all provision" to an equitable accounting and disgorgement by the insurer of any profits it derived from the denial of and delay in paying his benefit claim,[116] the court set out to determine the proper method for calculating the insurer's profits attributable to the denial of plaintiff's benefit claim.[117] The method the court adopted would calculate the amount of wrongfully withheld principal (including interest on the principal) and assume that figure was part of defendant's general assets used for all corporate purposes.[118] The court would then calculate defendant's profit rate during the relevant period and multiply the percentage gain by the principal owed to plaintiff.[119]

K. *Claims for Reimbursement—Overpayments and Social Security Awards*

Although plans are entitled to recoup overpayments and amounts participants receive in "other income" benefits, it bears reminding that their ability to do so under ERISA depends on their use of appropriate equitable principles. In *Mayhew v. Hartford Life & Accident Insurance Co.*,[120] for instance, the court found that Hartford's equitable lien attached when the participant received the overpayments and, therefore, it properly identified a particular fund that was distinct from the participant's general assets.[121] In *Bilyeu v. Morgan Stanley Long Term Disability Plan*,[122] however, the court denied Unum's counterclaim seeking reimbursement of overpaid benefits that were already spent by the beneficiary because Unum sought a judgment requiring the participant to pay money out of her general assets, which is a claim for legal relief.

Not all other income benefits are recoverable, however. In *Riley v. Sun Life & Health Insurance Co.*,[123] the court concluded Veterans Administration (VA) benefits could not be offset against plaintiff's benefits because the VA benefits did not fall within the plan's other income provision. The plan required an offset for benefits that were similar to those pro-

115. 851 F. Supp. 2d 1090 (E.D. Mich. 2012).
116. *Id.* (citing 29 U.S.C. § 1132(a)(3)(B)).
117. *Id.* at 1092.
118. *Id.* at 1095, 1102.
119. *Id.*
120. 822 F. Supp. 2d 1028 (N.D. Cal. 2011).
121. *Id.* at 1032, 1033.
122. 683 F.3d 1083 (9th Cir. 2012).
123. 657 F.3d 739 (8th Cir. 2011).

vided under the Social Security Act (SSA) or Railroad Retirement Act (RRA). Because VA benefits are considered obligatory compensation for wartime service related injuries and are not benefits paid under an insurance program, the court concluded they were not similar to SSA or RRA benefits and could not be used to offset plaintiff's benefits.[124]

L. *Attorney Fees*

In *Lewis v. Aetna Life Insurance Co.*,[125] plaintiff prevailed against the plan at trial and the court awarded her $538 in benefits. Rejecting the argument that plaintiff's recovery was not substantial, the court held that because plaintiff "achieve[d] success in what she sought to do," she was entitled to her fees.[126] The court in *Scarangella v. Group Health Inc.*[127] considered a fee request made by cross-claim defendants. When plaintiff sued her plan's insurer and her employer in its capacity as the plan administrator seeking recovery of benefits, defendants asserted cross-claims. The insurer ultimately settled with plaintiff and voluntarily dismissed its cross-claims against the employer, prompting the employer to seek its fees.[128] The court concluded fees were not appropriate because the voluntary dismissal of the insurer's cross-claims pursuant to settlement meant the judicial imprimatur necessary to deem the employer a prevailing party on those claims was lacking.[129]

V. HEALTH INSURANCE

A. *Patient Affordable Care Act*

The Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*,[130] upholding the constitutionality of the so-called individual mandate in the Patient Protection and Affordable Care Act.[131] The mandate "requires most Americans to maintain 'minimum essential' health insurance coverage" and, beginning in 2014, imposes a "penalty" on those who do not comply.[132] While a detailed analysis of the Court's ninety-four page opinion is beyond the scope of this article, we summarize the key points here. First, the Court held that the individual mandate must be construed as imposing a "tax" on those who do not have health

124. 657 F.3d at 742.
125. No. 3:09-cv-00641-JPG, 2012 WL 360000 (S.D. Ill. Feb. 2, 2012).
126. *Id.* at *3.
127. 877 F. Supp. 2d 78 (S.D.N.Y. 2012).
128. *Id.* at 81.
129. *Id.* at 85.
130. 132 S. Ct. 2566 (2012).
131. Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).
132. 132 S. Ct. at 2581 (citing 26 U.S.C. § 5000A).

insurance and that this tax is within the scope of Congress's power to tax and spend for the general welfare.[133] Construing the individual mandate in that fashion, the Court concluded the Act was constitutional.[134]

The Court also concluded that the individual mandate fell outside Congress's power to regulate commerce.[135] Rejecting the argument that the mandate was a valid exercise of Congress's Commerce Clause power because the failure by some to purchase health insurance has a substantial negative effect on health insurance costs for others, the Court stated: "The individual mandate . . . does not regulate existing commercial activity. It instead compels individuals to *become* active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce. Construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to Congressional authority."[136]

Finally, the Court addressed the portion of the Act that allowed the federal government to withhold *all* Medicaid funding to those states that failed to comply with the Act's new Medicaid coverage provisions. Those provisions expanded the Medicaid program and significantly increased the funding burden on the states by increasing the number of individuals the states must cover.[137] If a state failed to comply with the new coverage requirements, it would lose not only the federal funding for the newly added coverage, but *all* of its federal Medicaid funds.[138] The Court observed that the Spending Clause gives Congress the power to grant federal funds to the states and condition the receipt of those funds on actions Congress wants, but cannot compel, the states to take.[139] The Court, however, found the condition imposed by the Act (withholding all federal Medicaid funding) to be so coercive that it amounted to "a gun to the head," rather than the "relatively mild" financial "inducement" permitted under the Spending Clause.[140] Accordingly, it concluded the Act unconstitutionally tied funds for the existing Medicaid program to compliance with the terms of the new program.[141]

133. *Id.* at 2594.
134. *Id.* at 2598.
135. *Id.* at 2587.
136. *Id.* at 2587. *See id.* at 2584–93 for Justice Roberts' discussion of the Commerce Clause issues.
137. *Id.* at 2601–02.
138. *Id.* at 2601.
139. *Id.*
140. *Id.* at 2606–07.
141. *Id.* at 2607. *See id.* at 2601–08 for Judge Roberts' discussion of the expansion of Medicaid under the Act.

Although the constitutionality of the Act's individual mandate and Medicaid provisions have been resolved, other aspects of the Act continue to provide grist for federal lawsuits, such as regulations promulgated under the Act that require group health insurance plans to include coverage for contraceptives and other women's health preventive services. In *O'Brien v. U.S. Department of Health and Human Services*,[142] the district court dismissed a complaint claiming the regulations violated the Religious Freedom Restoration Act (RFRA). Plaintiffs were a secular, for-profit limited liability company and its controlling member, who managed the company in accordance with his religious beliefs.[143] Plaintiffs argued they faced a choice between complying with the Act's requirements in violation of their religious beliefs or paying fines that would adversely affect the company's ability to survive economically.[144] The court did not address whether a secular, limited liability company was capable of exercising a religion within the meaning of the RFRA, but it found that indirect financial support of a practice from which the individual plaintiff abstained did not constitute a substantial burden on the exercise of his religion and therefore did not violate RFRA.[145]

B. *Mandated Benefits*

In the following decisions, courts found coverage for the insured by virtue of state-level mandated benefit laws, notwithstanding the fact that the policies at issue plainly stated no such coverage existed. In *Harlick v. Blue Shield of California*,[146] the Ninth Circuit found that California's Mental Health Parity Act required the plan to provide coverage for residential care plaintiff received for treatment of anorexia nervosa, despite a plan provision expressly stating the plan did not provide such coverage.[147] In *Z.D. v. Group Health Cooperative*,[148] the district court considered a provision of Washington's Mental Health Parity Act requiring that mental health coverage be delivered under the same terms and conditions as medical and surgical services. It found the provision required the defendant plan to cover the mental health treatment of the ten-year old plaintiff, even though the plan expressly stated it did not provide such coverage for individuals over the age of six.[149]

142. No. 4:12-CV-476 (CEJ), 2012 WL 4481208 (E.D. Mo. Sept. 28, 2012).
143. *Id.* at *1.
144. *Id.* at *3.
145. *Id.* at *7.
146. 686 F.3d 699 (9th Cir. 2012).
147. *Id.* at 708–09.
148. 829 F. Supp. 2d 1009 (W.D. Wash. 2011).
149. *Id.*

C. *Discriminatory and Anticompetitive Practices/Preferred Provider Arrangements*

Courts considered claims brought by chiropractors and podiatrists involving allegations of discriminatory practices. In *Mueller v. Wellmark, Inc.*,[150] a group of chiropractors filed a putative class action against the insurer, claiming it violated the Iowa Competition Law and insurance regulations by paying lower rates for chiropractic services than for equivalent services offered by medical doctors or osteopathic physicians and by wrongfully imposing restrictions related to chiropractic services. The insurer claimed its preferred provider arrangements were exempt from plaintiff's antitrust claims pursuant to Iowa's "state action" exemption,[151] which exempts from Iowa's antitrust laws any "activities or arrangements expressly approved or regulated by any regulatory body or officer acting under authority of this state."[152] Because the insurer submitted its preferred provider forms to the state insurance division, which approved the forms, the insurer claimed the activity was "expressly approved or regulated" by a regulatory body or an officer acting under state authority. The court, however, found the insurer did not establish the insurance division reviewed preferred provider agreements for the purpose of regulating the rates paid or the conditions imposed upon different classes of health care providers; rather, the insurance division reviewed the agreements to regulate the overall relationship between preferred providers, participants, and nonparticipants.[153] The insurer thus failed to establish a regulatory review sufficient to exempt it from Iowa's antitrust laws.[154] In *Ohio Podiatric Medical Association v. Taylor*,[155] the court held that unambiguous language in Ohio's insurance code required reimbursement when a podiatrist performed a service covered under a health insurance policy, but it did not require parity of payment between podiatrists and other licensed physicians who provided the same service.[156]

VI. LIFE INSURANCE

A. *Rescission*

The court in *Dameware Development, L.L.C. v. American General Life Insurance Co.*[157] held plaintiff could not rescind the life insurance policies it purchased simply because the tax benefits it expected to receive from its

150. 818 N.W.2d 244 (Iowa 2012).
151. *Id.* at 259.
152. *Id.*
153. *Id.* at 261.
154. *Id.* at 263.
155. 972 N.E. 2d 1065 (Ohio Ct. App. 2012).
156. *Id.*
157. 688 F.3d 203 (5th Cir. 2012).

purchases never materialized. Plaintiff purchased life insurance policies intending to use them to fund a pension plan and to obtain certain tax benefits. The policies contained no information and made no representations concerning the tax benefits plaintiff hoped to receive.[158] After it became clear the anticipated tax benefits would not materialize, plaintiff sued the insurer seeking damages and rescission of the policies, alleging the tax benefits were the reason it entered into the life insurance contracts and, because its purpose for entering into the contracts was frustrated, its consent to enter into the contracts was vitiated under Louisiana law.[159] Rejecting that argument, the Fifth Circuit observed that the terms of the policies showed that plaintiff had purchased coverage in order to secure life insurance coverage for its employees and that coverage was provided.[160] It further held that plaintiff's erroneous assumptions about post-contract events, such as future tax benefits, are not proper bases for rescission under Louisiana law.[161]

The Eleventh Circuit found in *PHL Variable Insurance Co. v. Faye Keith Jolly Irrevocable Life Insurance Trust*[162] that an insurer is not entitled to retain premiums paid when a life insurance policy is rescinded. The district court rescinded the policy following the trust's default on the insurer's rescission claim, but denied the insurer was entitled to retain the premiums paid. The insurer argued it was entitled to retain the premiums because the policy was procured by fraud, asserting the defendant's trustee falsely represented certain material facts.[163] It further argued it was equitably entitled to retain the premiums because the default judgment showed the contract was obtained by fraud.[164] The Eleventh Circuit affirmed, finding the insurer failed to prove the trustee made the representations alleged and/or that he knew they were false. The court further found that Georgia law required the insurer to return the premiums following rescission, even where the policy was obtained by fraud.[165]

158. *Id.* at 205.
159. *Id.* at 206.
160. *Id.* at 208.
161. *Id.* at 209. *See also* U.S. Life Ins. Co. in City of New York v. Blumenfeld, 938 N.Y. S.2d 84 (N.Y. App. Div. 2012) (insurer knew of basis for rescission and ratified and waived right to rescind life insurance policy by waiting more than a year to file suit and by continuing to accept premium payments even after filing suit); Agrawal v. Metro. Life Ins. Co., 932 N.Y.S.2d 72 (N.Y. App. Div. 2011) (insurer waived right to rescind for failing to assert the insured's misrepresentation of her medical history as a basis for denying her claim).
162. 460 F. App'x 899, 900–01 (11th Cir. 2012). The insurer initially brought this action against Faye Keith Jolly (the insured) and The Faye Keith Jolly Irrevocable Life Insurance Trust through its Trustee, Kenneth E. Shapiro. *See* PHL Variable Ins. Co. v. Jolly, 800 F. Supp. 2d 1205, 1207 (N.D. Ga. 2011).
163. 460 F. App'x at 901.
164. *Id.* at 902.
165. *Id.*

B. *Stranger Originated Life Insurance*

1. Refund of Premiums

When an illegal contract is in play, the decisions this survey period opened the door a little further to allowing insurers to keep premiums paid in connection with a stranger originated life insurance (STOLI) scheme. In *Penn Mutual Life Insurance Co. v. Greatbanc Trust Co.*,[166] the insurer alleged, and defendant agreed, that the life insurance contract was part of an illegal STOLI scheme and hence was void ab initio.[167] The insurer argued Illinois law did not permit the court to enter an order requiring it to return the insurance premiums. According to the insurer, Illinois law required the court to leave parties to an illegal contract as it found them. Defendant argued the insurer's action should be recast as one for rescission, which, as part of returning the parties to the status quo ante, would entitle defendant to the premiums. Rejecting the invitation to characterize the action as one for rescission, the court entered judgment declaring the contract void ab initio.[168] Concerning the premiums, the court agreed that Illinois law required it to leave the parties as it found them and declined to enter any order concerning the premiums' disposition.[169] The court held, however, that defendant might be entitled to recover the premiums under its unjust enrichment counterclaim if it proved it would be inequitable for the insurer to retain the premiums.[170]

Similarly, in *Carton v. B & B Equities Group, LLC*,[171] investors sought return of premiums paid in connection with an illegal STOLI scheme. They claimed they were duped into paying premiums and argued it would be unjust to permit the insurer to retain the premiums. The court rejected that argument finding "it [was] not inequitable to allow the Insurers to retain the premium payments" because the insurer was the victim of the illegal scheme and plaintiff-investors ignored a "textbook STOLI arrangement" which "should have placed [them] on inquiry notice . . . that something in the transaction was amiss."[172]

2. Insurable Interest

The court's interpretation of a Pennsylvania statute in *Principal Life Insurance Co. v. DeRose*[173] means STOLI schemes that would be illegal in many

166. No. 09 C 06129, 2012 WL 3437161 (N.D. Ill. Aug. 15, 2012).
167. *Id.* at *1–2.
168. *Id.* at *9.
169. *Id.* at *4, 6–7.
170. *Id.* at *9.
171. 827 F. Supp. 2d 1235 (D. Nev. 2011).
172. *Id.* at 1247.
173. No. 1:08-CV-2294, 2011 WL 4738114 (M.D. Pa. Oct. 5, 2011).

other states likely would survive in Pennsylvania. Pennsylvania's statute requires a person to have an insurable interest in the life of another before he can obtain insurance on that person's life.[174] As the court read the statute, Pennsylvania permits parties with an insurable interest to immediately transfer a policy to a third party that lacks an insurable interest in the life of the insured.[175] Defendants entered into financing agreements under which a third party would finance the purchase of $25 million in life insurance policies through loans secured by the policies.[176] Within days after the policies were issued, they were assigned to the third party lender.[177] Under its interpretation of Pennsylvania's statute, the court concluded the policies were valid because they were issued initially to parties with insurable interests in the life of the insured.[178]

C. *Misrepresentation*

The Third Circuit confirmed in *Mendez v. American General Life Insurance Co.*[179] that a reinstated policy could be rescinded because of misrepresentations made in the reinstatement application.[180] Plaintiff applied to reinstate his $1.2 million policy, which had lapsed for failure to pay the required premiums,[181] but did not respond to a question on the reinstatement application, prompting the insurer to return the form for completion. The insured completed the form but did not report an intervening visit to a neurologist and his resulting diagnosis of a glioblastoma.[182] Finding that "New Jersey insurance law does not permit individuals applying for reinstatement to knowingly omit material information they possess from their applications and still retain the benefit of the policy's reinstatement provisions," the court affirmed summary judgment in favor of the insurer.[183]

174. *Id.* at *4–5 (quoting 40 PA. CONS. STAT. § 512 (2004). Other states have similar requirements. *See, e.g.*, Massachusetts Mut. Ins. Co. v. Mitchell, 859 F. Supp. 2d 865, 869 (S.D. Tex. 2012) (insurer in rescission action adequately stated a claim for lack of insurable interest when it alleged "inconsistencies in the application process" led it to question whether the insured applied for or consented to the policies at issue); PHL Variable Ins. Co. v. Abrams, No. 10cv521 BTM(NLS), 2012 WL 10686 (S.D. Cal. Jan. 3, 2012) (insurer sufficiently alleged trust was established to act as a "straw man" in fraudulent STOLI scheme where insurer's independent investigation revealed inconsistencies in the insured's representations of his income and assets, and insurer could plausibly allege an agreement with a third party without actually identifying the third party).

175. *DeRose*, 2011 WL 4738114, at *4–5.

176. *Id.* at *2–3.

177. *Id.*

178. *Id.* at *7.

179. 455 F. App'x 153 (3d Cir. 2011).

180. *Id.* at 155.

181. *Id.* at 154.

182. *Id.*

183. *Id.* at 155–56; *see also* Margalit v. United Omaha Life Ins. Co., 837 F. Supp. 2d 1056 (C.D. Cal. 2012) (insured's misstatement of age in application and documents bearing his

D. *Payment of Premium—Condition Precedent*

In *Estate of Genovese v. AAA Life Insurance Co.*,[184] the court rejected plaintiff's argument that providing credit card information and signing an authorization form was sufficient to satisfy the policy's premium payment requirement. The life insurance application stated coverage would become effective only upon the insurer's receipt of the premium, provided it was received within thirty-one days of the policy's issue date and during the applicant's lifetime.[185] When the insurer charged the insured's credit card to pay the premium, it was rejected and the insurer promptly notified the insured of the issue.[186] The insured died before she could correct the problem and pay the premium.[187] The beneficiary nevertheless asserted a claim for benefits, which the insurer denied. Ultimately, the court held the policy never became effective due to the insured's failure to pay the required premium before her death and granted the insurer's motion for summary judgment.[188]

VII. CONCLUSION

We doubt we have seen the end of all litigation challenging the Patient Protection and Affordable Care Act, even in the wake of *National Federation of Independent Business v. Sebelius*. Perennial disputes concerning discovery, the scope of review, and available remedies will continue to challenge lawyers handling ERISA claims, just as disputes over what constitutes an accident, whether premiums paid in connection with STOLI schemes must be returned to owners, and the right of an insurer to require objective evidence of an insured's subjective claims of disability will continue to challenge courts and practitioners handling matters involving accidental death, life, and disability insurance. We will continue to track developments in each of those areas over the next year and look forward reporting on the most important and interesting cases in next year's article.

signature were enough to permit insurer to adjust death benefits under the terms of the policy); Banner Life Ins. Co. v. Noel, 861 F. Supp. 2d 701, 715 (E.D. Va. 2012) (dismissing insured's counterclaim for estoppel because insured would not be able to prove the insurer had actual or constructive knowledge of facts which would have rendered coverage void ab initio).

184. No. 3:11-CV-348, 2011 WL 5835097 (M.D. Pa. Nov. 21, 2011).

185. *Id.* at *2.

186. *Id.*

187. *Id.*

188. *Id.* at *4; *cf.* Auxo Medical, LLC v. Ohio National Life Assurance Corp., No. 3:11cv259-DWD, 2011 WL 5549052, at *5 (E.D. Va. Nov. 15, 2011) (holding insurer may have waived a condition precedent to coverage when plaintiff emailed the insurer to file a claim but was "immediately rebuffed").