Committee News

Winter 2013

Health and Disability & Life Insurance Law Committees

LETTER FROM THE EDITORS

We hope you find the collaborative effort of the Health and Disability and Life Insurance Law Committees to be both interesting and informative. It includes timely articles and case notes on a variety of topics, including: a review of Circuit cases interpreting *Amara*; an examination of the federal court removal changes after one year; an update on the continuing battle over unclaimed life insurance benefits; and other recent cases of note. Thanks to all of the contributors for their great work, and please consider contributing to forthcoming issues of the Newsletter.

We hope to see you in Florida at the TIPS Midwinter Symposium on January 17-19, 2013. The 39th Annual Midwinter Symposium on Emerging Issues and Litigation Relating to Life, Health & Disability Insurance, Insurance Regulation and Employee Benefits will be held in beautiful (and warm) Fort Lauderdale. The conference offers an

IN THIS ISSUE:

Uniting Plaintiff, Defense, Insurance, and Corporate Counsel to Advance the Civil Justice System

opportunity to hear from leading in-house counsel, plaintiff's attorneys, defense counsel and regulators on the latest developments in LHD, ERISA and insurance regulation issues.

You won't have trouble finding friendly folks to join you for those down-time activities, whether it's enjoying a cup of coffee, dinner, golf or something else. First-time attendees will find a warm and welcoming group of gifted professionals who make this educational meeting fun and memorable. You will see why we "regulars" keep coming back. We look forward to seeing you again or meeting you for the first time. ⚖

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2013 ABA-TIPS Midwinter Symposium on Life, Health, Disability, and ERISA

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- The Roundtable of Former Insurance Commissioners
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- Issues related to insurers' participation in corporate internal investigations
- Issues surrounding the litigation of bad faith and misrepresentation claims
- ERISA and life insurance hot topics

Speakers

- Honorable Judge Robert N. Scola, Jr., United States District Court for the Southern District of Florida
- Steve Carlton, Vice President and General Counsel, Insurance Subsidiaries of Universal America, Lake Mary, FL
- Mike Colliflower, CLU, ChFC, FLMI, AIRC, Counsel, Aetna Senior Supplemental Insurance, Nashville, TN
- Len Giusti, Prudential Ins. Co., Newark, NJ
- Bill O. Williams, Deputy General Counsel, United HealthCare -Individual, Indianapolis, IN
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CIRCUIT CASES INTERPRETING *AMARA*

By: Horace W. Green[1]

It is now over a year since the United States Supreme Court clarified the equitable relief available under ERISA Section 502(a)(3) (29 U.S.C. § 1132(a)(3)). A brief survey demonstrates that the circuit courts have not limited this remedy to pension cases; rather, the circuits have analyzed the availability of such relief in a number of different types of cases.

1. *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011).

Amara involved a claim brought by pension plan participants. Cigna changed its retirement plan from a defined benefit based on salary and length of service to a cash balance plan. The Plan participants sued, claiming insufficient notice of Plan changes and that the new plan was less generous. They sought relief under both § 502(a)(1)(B) (to clarify the terms of the plan) and (a)(3) (seeking equitable relief). The Court held that the participants had no claim for relief under (a)(1)(B), which does not give Court authority to change the terms of the plan; the Court further held that the summary plan description ("SPD") (upon which the participants had relied) was not a Plan document.

However, the Court also held that § 502(a)(3) provides those forms of relief available in equity, including reformation of contracts as a remedy for false or misleading information. In order to obtain such relief, the Court held that the claimant must show "actual harm" but not necessarily detrimental reliance, except that detrimental reliance continued to be an element of a claim for estoppel. The Court remanded the case to the district court for determination of the participants' (a)(3) claims.

2. Cases Interpreting *Amara* – Retirement Plans

Skinner v. Northrop Grumman Retirement Plan B, 673 F.3d 1162 (9th Cir. 2012).

Skinner involved a suit over the terms and conditions of Northrop Grumman's retirement plan. The claimant alleged that the terms of the actual Plan were less favorable than the description of the Plan terms set forth in the summary plan description. The Court held that the claimant did not have a viable claim under § 502(a)(1)(B) because the SPD was not a "Plan document." (The Circuit had previously held that summary plan language was an "enforceable part of the plan."). The Court next analyzed whether the claimant could state a claim under (a)(3). The Court noted that the remedies provided under (a)(3) included estoppel, reformation, and/or surcharge. The Court held that the claimant was not entitled to estoppel, because the claimant did not demonstrate any reliance on the terms of the summary plan description. The Court held that reformation was not available because there was no evidence of fraud or mistake created by the employer. Finally, surcharge is an available remedy only where the employer benefitted from the alleged breach; because there was no such showing in this case, this remedy was not available.

Tomlinson v. El Paso Corp., 653 F.3d 1281 (10th Cir. 2011).

The employer in *Tomlinson* changed the company's retirement plan from a defined benefit plan to a cash balance plan. The claimants sued under (a)(3), alleging that the employer provided insufficient notice prior to the changeover. In analyzing the showing required to establish a claim under (a)(3), the Court cited *Amara* for the proposition that claimants were required to show "actual harm" but not necessarily detrimental reliance:

> [T]he Supreme Court [in *Amara*] recently altered the required showing of prejudice for some ERISA claims, but even under this new, more lenient standard, "actual harm must be shown."

In this case, the Court held that the claimants failed to demonstrate "actual harm" as a result of the late notice. Accordingly, the Court denied relief.

3. Cases Interpreting *Amara* – Reimbursement

U.S. Airways, Inc. v. McCutchen, 663 F.3d 671 (3d Cir. 2011).

In *McCutchen*, the Plan participant was injured in automobile accident, and sought payment of her medical bills under the employer provided healthcare plan. The Plan paid $67,000 in medical expenses for the claimant. Subsequently, the claimant sued the driver of the other

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THE BATTLE OVER UNCLAIMED LIFE INSURANCE BENEFITS CONTINUES TO EXPAND AND EVOLVE

By: Irma R. Solares and Stephanie A. Fichera, *Jorden Burt LLP*[1]

To date, the controversy over insurance companies' unclaimed life insurance benefit practices and use of the Social Security Administration's Death Master File ("DMF") has centered on multi-state audits, market conduct examinations, settlements, and legislation driven by regulators, which require that life insurance companies periodically compare their policies to the DMF to identify deceased insureds, locate beneficiaries, and commence the claims settlement process. Recent developments in related litigation mark a significant change in the unclaimed property landscape.

These developments, and in particular the United litigation, are forging new roadmaps for the future of unclaimed property disputes and may result in increased challenges to legislative and regulatory efforts that seek to impose requirements on insurers that are contrary to longstanding industry practices.

The West Virginia Litigation

For instance, in a departure from its regulatory colleagues, West Virginia has not joined the multi-state examinations. Instead, the West Virginia Treasurer opted to file separate lawsuits against ten life insurers on September 20, 2012, followed by a second round of suits against ten additional insurers on October 16, 2012. On November 14, 2012 and November 21, 2012, respectively, the Treasurer filed a third and fourth round of lawsuits. Each round consists of approximately 10 lawsuits, so there are now 40 lawsuits pending. The suits were all filed in the Circuit Court of Putnam County, West Virginia.

The Treasurer's suits invoke the West Virginia Uniform Unclaimed Property Act (the "West Virginia Act") and allege that "[u]nder the West Virginia Uniform Unclaimed Property Act, a holder such as [defendant insurance company] has a duty to make reasonable good faith efforts to identify all West Virginia unclaimed property such as life insurance proceeds, to report those unclaimed life insurance proceeds and to pay those unclaimed life insurance proceeds to the State Treasurer as administrator of the Unclaimed Property Fund." The Complaint alleges further that insurers must utilize the DMF "or other reliable databases" to undertake an annual examination of its records to determine whether any of its policyholders are deceased. The complaints do not identify any provision of the West Virginia Act that imposes such an a duty on insurers. Rather, the Treasurer claims that insurers are so bound by "an affirmative duty of good faith and fair dealing."

The Treasurer's suits are largely patterned after and seek the same remedies as the multi-state examinations and audits, including examination of the insurer's records to determine whether the company "fully and truthfully" complied with the West Virginia Act, demand that each defendant pay the costs associated with the examination of defendant's records, policies and procedures, imposition of civil penalties and fines, and payment of attorney's fees.

The complaints filed to date include allegations identifying the 2010 life insurance premium collected in West Virginia for each company, and it appears that the suits are being grouped and filed by premium levels. The first group of companies sued in September have premium levels ranging from $8 million to $19.3 million. The October suits include companies with 2010 premium levels between $4.9 million and $ 7.8 million, and the November lawsuits capture the remaining companies with 2010 premiums in excess of $2 million. It is believed that additional suits will be forthcoming against the remaining life insurance companies doing business in the state.

On November 6, 2012, West Virginians elected a new state Attorney General and it remains to be seen whether the new Attorney General will embrace or prosecute these suits with the same vigor as his predecessor.

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ONE YEAR LATER: REMOVAL UNDER THE FEDERAL COURTS JURISDICTION AND VENUE CLARIFICATION ACT OF 2011

By: Gregory F. Harley and Katie E. Wolf, *Burr Forman, LLP*[1]

While not generating as much publicity as some other 2011 legislation, the Federal Courts Jurisdiction and Venue Clarification Act of 2011 (the "JVCA") is very important to Federal court practitioners. The JVCA, which passed on December 6, 2011 and became effective on January 6, 2012, amended several venue and jurisdictional-related provisions of the United States Code, including provisions related to removal of cases from state to federal court. As its title suggests, the JVCA does not necessarily change existing law relating to removal but in some instances simply clarifies conflicting judicial interpretations of the removal provisions. This article summarizes the removal-related changes and highlights how the changes have been interpreted by various Federal courts during the year following passage of the JVCA.

1. Timing of Removal and the Rule of Unanimity

The JVCA provides: "[e]ach defendant shall have 30 days after receipt by service on that defendant . . . to file the notice of removal." 28 U.S.C. § 1446(b)(2)(B). Thus, the JVCA made clear that *each* defendant, and not just the first-served defendant, has its own thirty-day clock. This provision was amended in order to clarify "the rule of timeliness and provide[ ] for equal treatment of all defendants in their ability to obtain Federal jurisdiction over the case against them." H.R. Rep. No. 112-10, at 14 (2011). While this provision of the JVCA merely codified existing removal procedure in some circuits, it resulted in a significant change in the law in jurisdictions which previous held that removal must occur within thirty days of service on the *first* defendant. *See e.g.*, *Getty Oil Corp., A Div. of Texaco, Inc. v. Ins. Co. of N. Am.*, 841 F.2d 1254, 1262-63 (5th Cir. 1988) ("In cases involving multiple defendants, the thirty-day period begins to run as soon as the first defendant is served.").

Numerous post-JVCA decisions illustrate that cases which could not have been timely removed under the old law, will now be subject to federal court jurisdiction. *See, e.g.*, *Crowley v. Amica Mut. Ins. Co.*, 2012 WL 3901629 (5th Cir. Sept. 7, 2012) (noting that the Fifth Circuit traditionally followed the first-served defendant rule but will now give *each* defendant its own thirty-day clock to remove); *Miller v. Cal. Dep't of Corrs. and Rehab.*, 2012 WL 5336969 (E.D. Cal. Oct. 26, 2012) (noting that plaintiff's argument that the last-served defendant did not timely remove was foreclosed by the JVCA).

Finally, the JVCA codifies the "rule of unanimity" requiring all defendants to consent to removal and further provides: "[i]f defendants are served at different times, and a later-served defendant files a notice of removal, any earlier-served defendant may consent to the removal even though that earlier-served defendant did not previously initiate or consent to removal." 28 U.S.C. § 1446(b)(2)(C).

2. Establishing the Amount in Controversy – Standard and Permissible Evidence

The second significant change to removal procedure under the JVCA relates to when the defendant may go beyond the amount prayed for in the complaint to assert the amount in controversy upon removal and the burden of proof and the evidence that may be relied upon to establish the same. The new § 1446(c)(2) provides: "the sum demanded in good faith in the initial pleading shall be deemed to be the amount in controversy." However, that subsection also provides that "the notice of removal may assert the amount in controversy if the initial pleading seeks--(i) nonmonetary relief; or (ii) a money judgment, but the State practice either does not permit demand for a specific sum or permits recovery of damages in excess of the amount demanded." By implication, a defendant can also seek to remove a lawsuit and prove the amount in controversy where the complaint alleges unspecified damages. *See Dean v. BAC Home Loan Servicing, L.P.*, 2012 WL 353766 (M.D. Ala. Feb. 3, 2012).

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During the 39th Annual TIPS Mid-Winter Symposium on Insurance & Employee Benefits, held on January 17—19 at The W Hotel in Fort Lauderdale, FL, TIPS will be sponsoring a cash donation drive for Broward Meals on Wheels (BMOW).

Cash donations will be accepted at the registration desk by ABA TIPS staff.

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This project is sponsored by the following ABA TIPS Committees: Life Insurance Law, Employee Benefits, Health and Disability Law, and Insurance Regulation.

Questions? Contact Jennifer LaChance at jennifer.lachance@americanbar.org.

LITIGATION OVER GROUP POLICY CONVERSION RIGHTS TRIGGERS ERISA JURISDICTION

By: Sherril M. Colombo and Stefanie Mederos, *Wilson Elser Moskowitz Edelman & Dicker LLP*[1]

In a case involving a group life insurance conversion policy, the Southern District of Florida upheld federal question jurisdiction under the Employee Retirement Income Security Act of 1974 ("ERISA") by distinguishing between conversion rights and rights under the converted policy. *Shockett v. Life Ins. Co. of N. Am.*, Case No. 12-cv-22770 (S.D. Fla. Oct. 3, 2012).

In *Shockett*, the plaintiff and sole beneficiary of a life insurance policy filed suit in a Florida state court against Life Insurance Company of North America ("LINA") for breach of contract and declaratory relief arising from the alleged failure to pay additional life insurance benefits on the life of her deceased husband. She alleged that LINA paid her only $25,000 in life insurance benefits although her husband had paid for a life insurance policy with $50,000 in available insurance benefits. She also alleged that the group policy limitations on the amount her deceased husband was able to convert ($25,000) were waived or modified based on representations during the conversion process and the acceptance of premiums representing $50,000 in benefits.

The group life insurance policy permitted employees to convert their life insurance benefits that would otherwise end due to loss of employment. The policy limited the amount of life insurance benefits to the amount of coverage available at the time of termination under the group policy ($50,000). Employees over the age of 70 at the time of termination, however, were entitled to convert only 50% of their life insurance benefits. Thus, an employee over the age of 70 at the time of termination was entitled to convert $25,000 as opposed to $50,000 in life insurance benefits.

Based on those provisions, the decedent, who was a participant in the group policy and was terminated from his employment at the age of 71, had the right to convert life insurance benefits in the amount of $25,000. After the decedent's termination and during the conversion application, his employer completed a portion of the application and mistakenly represented the amount of life insurance coverage available as $50,000 rather than $25,000. The third party provider accepted the employer's representation as to the amount of benefits available for conversion and, subsequently, returned the decedent's premium check as it was not in the proper amount for $50,000 in benefits. The decedent then submitted the correct amount in premium payment for $50,000 in benefits.

After the decedent's death, $25,000 in life insurance benefits was tendered to the plaintiff. LINA denied plaintiff's claim for the additional $25,000 in benefits referring to the language in the group policy only allowing $25,000 in benefits. LINA also pointed out that the group policy specifically precluded a modification of the policy by actions of the employer.

LINA removed the case to the Southern District of Florida based on federal question jurisdiction under ERISA because the dispute involved the conversion rights rather than the amount of life insurance benefits available under the converted individual policy. Plaintiff sought to remand based on her contention that the claim was based on the terms and the amount of benefits due under the converted individual life insurance policy, which was not governed by ERISA.

On October 3, 2012, the District Court denied plaintiff's motion to remand and held that ERISA preempted the state law claims. The Court decided that when a matter concerns the conversion rights under a group policy governed by ERISA this requires interpretation of an ERISA policy, which triggers ERISA preemption. In doing so, the Court distinguished between rights arising under the group policy from those that arise under the converted policy. Because the issue as to the amount of benefits the decedent could convert arose directly under the language in the group policy,

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ERISA applied even though the decedent had obtained an individual converted policy.

The Court also held that *Glass v. United of Omaha Life Insurance Co.*, 33 F.3d 1341 (11th Cir. 1994) did not preclude it from finding ERISA preemption. In *Glass*, the Eleventh Circuit held that a plaintiff's claims were preempted by ERISA when they arose under a group policy consisting of former employees who had previously been insured under their employer's group policy. In the *Glass* case, however, the former employees' conversion of the group policy did not actually create individual policies; instead, the former employees were covered under a group policy for former employees. The *Glass* court declined to decide whether conversion of a policy might defeat ERISA coverage in other circumstances, such as where a group policy was converted into an individual policy. ⚖

ERISA PREEMPTS THE STATE LAW PRESUMPTION AGAINST SUICIDE

By: Gary Schuman[1]

In *Rice v. Reliastar Life Insurance Company*, No. 11-44-BAJ-SCRC/W11-111-BAJ-SCR, 2012 WL 4460757 (M.D. La. Sept. 25, 2012), benefits were denied under an ERISA governed accidental death policy. The insured was fatally shot by police when they responded to a call that the insured was suicidal and at home with a gun. The policy defined "accident" as an "unexpected, external, violent and sudden event." The insurer determined that the death was not unexpected and therefore not accidental. The insured approached the police with a gun and should have known that death or injury would result. The beneficiary argued the insured was not threatening the police when he was shot and merely holding the gun. The court ruled that the issue of accidental death is a factual one – objectively and subjectively as adopted by the Fifth Circuit Court of Appeals and will be reviewed under the arbitrary and capricious standard. The judge also held that, under ERISA, Louisiana's presumption against suicide is pre-empted. ⚖

EXCLUSION FOR DRUGS TAKEN OUTSIDE SCOPE OF PRESCRIPTION IS ENFORCEABLE

By: Gary Schuman[1]

In *Breaux, Jr. v. Stonebridge Life Insurance Company*, 859 F. Supp. 2d 819 (M.D. La. 2012), Stonebridge denied death benefits under an Accidental Death insurance policy, citing an exclusion "for injury that: . . . occurs while . . . taking or using any narcotic or barbiturate unless taken or used as prescribed by a physician." The insured died and the autopsy determined that the insured died from "pulmonary congestion and atelectasis, due to respiratory depression and recent drug intake." The toxicology report stated the insured had taken hydrocodone (a prescribed medicine) in an amount five times the therapeutic level. Morphine, not prescribed, was also found at three times the therapeutic level. Applying Louisiana law, the district court granted summary judgment to the insurer finding that the large amount of Morphine was a contributing cause of death. ⚖

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DISEASE THAT CONTRIBUTES TO LOSS DOES NOT BAR AD&D BENEFIT

By: Gary Schuman[1]

In *Genal v. Prudential Insurance Company of America*, No. 6:11-182-TMC, 2012 WL 2871777 (D.S.C. July 12, 2012), the insured, suffering from multiple sclerosis and confined to a wheelchair was found unresponsive in his back yard. His wheelchair was broken so he used a motorized scooter, which he apparently fell from while dismounting or pushing the device. The cause of death was "Environmental Heat Exposure Complicating MS." Benefits were denied under an ERISA governed AD&D policy under a provision excluding coverage for losses resulting from "Sickness . . . directly or indirectly . . . ." The insurer argued that MS prevented the insured from getting up and removing himself from the heat.

Applying a *de novo* standard of review, the district court found in favor of the beneficiary. The insurer had argued that "but for" the MS, the insured would have removed himself from the heat. The fall didn't kill him nor did he suffer injury there from. However, the Fourth Circuit has held that policy language limiting benefits to losses caused by accidents "directly and independently of all other causes," the existence of a preexisting condition which contributes to the loss doesn't prevent recovery unless it substantially contributed to the death. The insured's death was initially activated by his fall, not MS and but for the fall the insured would have survived. Thus, the fall, not MS, substantially contributed to his death.

Nor did the Sickness Exclusion apply. A reasonable person would conclude this exclusion applies to causes contributing to the loss, not to the accident. The MS did not worsen due to the fall. Thus, the fall and subsequent heat exposure directly caused the death. "[W]here disease merely contributes to the death or accident, after being precipitated by the accident, it (the disease) is not the proximate cause of death or injury, nor a contributing cause . . . ." (citation omitted.) ⚖⚖

PRESCRIPTION DRUG AND ALCOHOL INTERACTION BARRED RECOVERY UNDER DRUG AND ALCOHOL EXCLUSIONS

By: Gary Schuman[1]

In *Arredondo v. Hartford Life and Accident Insurance Company*, 860 F. Supp. 2d 363 (S.D. Tex. 2012), the insured covered by an individual Accidental Death policy, had been prescribed over twenty medications by his doctors, including Methadone, Valium, and Venlafaxine to treat PTSD, depression, and chronic pain. There are FDA warnings regarding, and his doctors prohibited, the consumption of alcohol while taking these drugs. However, the insured admitted that he continued to consume alcohol but promised to stop. He was found dead at home and the toxicology report noted a "high to toxic" level of Methadone and therapeutic levels of the other two listed drugs. His blood-alcohol level was .107mg/dl. The medical examiner determined the effects of this combination resulted in depressed breathing, slowed heartbeat, coma, and death. AD&D benefits were denied.

The policy covered "injury" which was defined as "bodily injury resulting directly from accident and independent of all other causes," and also stated that "[l]oss resulting from . . . medical . . . treatment of a sickness or disease . . . is not considered as resulting from injury." The policy also excluded "[i]njury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription . . . unless the drug is taken as prescribed . . . by a licensed physician . . . [and] injury sustained as a result of being legally intoxicated from the use of alcohol."

Applying Texas law, the court granted the insurer's motion for summary judgment. The insured's misuse of Methadone or his use of this and other drugs in conjunction with his consumption of alcohol, contravened his doctors' orders. Death did not result "independently of all other causes" (medical treatment) because the other drugs, even if taken in the correct amounts were a partial cause of death. Similarly, the Drug and Intoxication exclusions applied. The insured ignored medical directions to stop drinking which directly related to his death. ⚖⚖

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SELF-INFLICTED GUNSHOT WOUND SUPPORTED EXCLUSIONS FOR SUICIDE AND INTENTIONALLY SELF-INFLICTED INJURY

By: Gary Schuman[1]

In *Rogers v. American General Life and Accident Insurance Company*, No. 11-436-JJB, 2012 WL 5363324 (D. La. Oct. 30, 2012), the insured, covered under two AD&D policies, was found dead in his car. The police and coroner observed that he suffered a gunshot wound to the head and the gun was found between the insured's legs. The authorities determined that the gunshot was self-inflicted and the manner of death listed on the death certificate was suicide. Benefits were denied on the dual grounds of an intentionally self-inflicted injury and suicide. Evidence established a motive for the insured's conduct. The mothers of his two children testified that they were concerned about his emotional state just prior to his death and the insured had left "distraught text and voice messages." He also had threatened suicide in the past.

Applying Louisiana law, the district court judge granted the insurer's motion for summary judgment. Noting that the insurer had the burden of proof regarding the exclusion for intentionally self-inflicted injuries and suicide (by a fair preponderance of the evidence), the court found the evidence persuasive. It is clear that serious injury or death would follow the insured's act of shooting himself, regardless of whether he actually intended to kill himself. So too, the insurer also prevailed on the suicide exclusion. "Where it is evident from the testimony that the insured killed himself, whether accidentally or intentionally, the case presents two questions. First, do the physical facts surrounding the death of the insured exclude with reasonable certainty any possibility of accident? Second, does the evidence show that the insured had a motive for taking his own life sufficient to overcome the presumption against suicide and make it reasonably certain that the death was not the result of an accident, but of the deliberate intention to take one's own life?" The insurer prevailed on this burden of proof. ⚖

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LIFE INSURER OWES NO FIDUCIARY DUTY TO INSURED

By: Joseph M. Hamilton[1]

In *Thrivent Financial for Lutherans v. Strojny*, No. 11-11011-JLT, 2012 WL 3218526 (D. Mass. Aug. 9, 2012), the U.S. District Court for Massachusetts rejected claims brought by purported beneficiaries of a life insurance policy.

The deceased, Monroe, acquired a life insurance policy from Thrivent, a fraternal benefit society. Monroe subsequently attempted to name Strojny and LaBlue as beneficiaries. While Thrivent initially processed Monroe's request, shortly thereafter it notified Monroe that neither person designated was eligible to be a beneficiary under Thrivent's bylaws and therefore the designation was invalid. The letter included information as to how Monroe could designate his estate as the beneficiary to ensure that his friends received the death benefit. Thrivent also enclosed partially completed forms for that purpose and informed Monroe that the previously designated beneficiaries would remain in place until Monroe submitted another change of designation form. Monroe never did so.

After Monroe's death, Strojny and LaBlue made a claim for the insurance benefits. Thrivent instituted an interpleader action. However, Strojny and LaBlue brought counterclaims against Thrivent. On cross-motions for summary judgment, the court entered summary judgment in favor of the previously-designated beneficiaries and dismissed all of Strojny's and LaBlue's counterclaims.

The court first found that neither Strojny nor LaBlue had standing to bring the counterclaims because under Massachusetts law only an executor or administrator of an estate has standing to bring claims on behalf of the decedent. Strojny and LaBlue had asserted their counterclaims on Monroe's behalf. Thus, on this basis alone, their claims were rejected. However, the court went on to address the substance of the counterclaims.

With respect to the claim of breach of fiduciary duty, the court noted the relationship between an insurance company and the insured is not typically understood to be fiduciary, absent special circumstances of assertion, representation and reliance. The court noted that in all the cases where a court had found a heightened duty because of a special relationship it was the result of the relationship between the insured and an agent, not the company. The court found there was no special relationship between Thrivent, Strojny, and LaBlue. Moreover, the court held that even if a fiduciary duty existed, Thrivent disclosed all relevant information about the policy in its letter to Monroe.

With respect to the claim that Thrivent was negligent for not ensuring that Monroe understood what he needed to do to change the beneficiary, the court held that insurers are under no duty to ensure that their members understand a policy's terms. However, the court again pointed to the fact that, even without an obligation to do so, Thrivent provided Monroe with more than adequate information regarding the change of beneficiary process.

Strojny and LaBlue also alleged that Thrivent was barred by estoppel. The court held that while Thrivent initially accepted Monroe's beneficiary change, its subsequent letter made it clear that the change was invalid and Monroe's beneficiaries would remain the same. Based upon these facts, the court held that there was no basis for an estoppel.

Finally, the court rejected the allegation of violations of Massachusetts Chapter 93A. While first noting that mere negligence was not enough to constitute a violation of Chapter 93A, the court held that the allegations did not even meet the requirement for negligence.

The court entered summary judgment finding that the insurance proceeds belonged to the previously designated beneficiaries and dismissed all other claims. ⚖

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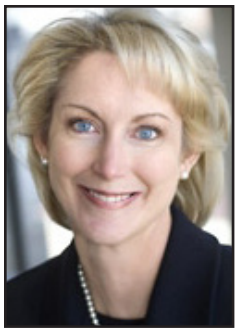

LIFE INSURER ALLOWED TO RETAIN PREMIUMS IN RESCISSION CASE

By: Joan O. Vorster[1]

In *PHL Variable Insurance Company v. P. Bowie 2008 Irrevocable Trust*, No. 10-070-M, 2012 WL 3860553 (D.R.I. Sept. 5, 2012), the U.S. District Court for Rhode Island ordered that PHL Variable Insurance Company ("Phoenix") could retain the premiums it received on a policy that Phoenix rescinded because of fraudulent statements made in the application.

Bowie and his attorney, the trustee of the Bowie Trust, signed an application for a $5,000,000 life insurance policy. Representations in the application included that Bowie had a net worth of $7,500,000 and an annual income of $300,000. They also represented that the policy would not be financed.

Subsequent to issuing the policy, Phoenix learned that Bowie was not a multi-millionaire, but rather a retired city employee, used car salesman, and blackjack dealer who could not afford to pay the annual premium. His attorney, while asserting that he had very little knowledge about the trust and the representations made in the application, became aware that others were financing the premium payments shortly after signing the application. In fact, the brokers involved in the application had arranged for financing through a third party. The policy was essentially part of a STOLI scheme.

Phoenix filed suit to rescind the policy, retain the premiums to cover the commissions it had paid to Bowie's insurance broker, and recover its attorneys' fees. The trust agreed to a rescission of the policy but argued it was entitled to a return of the premiums.

The court noted the general rule that when an insurer rescinds a policy on the basis of misrepresentations it must return the premiums paid. However, the court also noted that the First Circuit has recognized exceptions to the general rule. The court concluded that the law should not allow an insured to commit intentional and calculated fraud upon the insurer and walk away unscathed while the insurer bears the financial burden of the fraud. The court found that Phoenix was induced to issue the policy based upon false and fraudulent information intentionally presented by the trust in the insurance application. While recognizing that the trust's attorney did not know of the misrepresentations when the application was submitted, the court held that fraud could also be shown through reckless disregard for the accuracy of the statements made in the application. The court found that the trust's attorney did demonstrate such a reckless disregard for the accuracy of the statements in the application by failing to attempt to verify any information contained in the application before signing it and failing to disclose the falsity of the statements once he realized they were not true.

The court held that it was equitable to allow Phoenix to retain the premiums as special damages, but denied Phoenix's request for attorneys' fees. ⚖⚖

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FIRST CIRCUIT REJECTS CLAIMANT'S ATTEMPT TO TOLL CONTRACTUAL LIMITATION PERIOD BY EARLIER FILED SUIT

By: David L. Fine, *Mirick, O'Connell, DeMallie & Lougee, LLP*[1]

In *Santaliz-Rios v. Metropolitan Life Insurance Company*, the First Circuit Court of Appeals held that a suit seeking reinstatement of disability benefits was time barred because the plaintiff filed suit after the expiration of the three-year contractual limitation period contained in the ERISA plan. The Court rejected the appellant's argument that an earlier filed suit tolled the three-year limitation period. 693 F.3d 57 (1st Cir. 2012).

MetLife paid to Santaliz-Rios 24 months of disability benefits under an ERISA plan provided by his employer. MetLife ceased benefits after 24 months under the mental and nervous limitation. Shortly before the 24-month period ended, Santaliz-Rios claimed he suffered from bipolar disorder, a condition that was exempted from the 24-month limitation. *Id.* at 58.

MetLife considered the new information offered by Santaliz-Rios, and in February 2004, it issued its final denial stating that this claim was subject to the 24-month limitation. Santaliz-Rios filed suit in 2004 but voluntarily withdrew the complaint approximately six months later. *Id.* at 59. Five years later Santaliz-Rios filed a complaint in the U.S. District Court in Puerto Rico. MetLife moved to dismiss on grounds of timeliness. The District Court granted MetLife's motion.

The plan provided that no suit could be brought more than three years after proof of disability must be filed. The First Circuit acknowledged that where a contract provides a shorter limitation than that provided by law, that period would govern as long as it was reasonable. *Id.* at 59. The court held that the three-year period provided by the plan was reasonable, and therefore the limitation period was applicable. *Id.*

The Court noted the question whether the three-year limitation period ran from when Santaliz-Rios was required to file his proof of disability or from when MetLife rejected Santaliz-Rios's request for a reconsideration. *Id.* at 60. The Court avoided deciding this issue by concluding that under either choice the three year limitation had long expired. *Id.* at 61.

The Court rejected Santaliz-Rios's argument that the limitation period was tolled by the complaint he filed in 2004. The Court held that the limitations period began to run again when Santaliz-Rios voluntarily dismissed the complaint. *Id.* Next the Court disposed of his argument that the limitation period should be tolled because Santaliz-Rios suffered from bipolar disorder. The court noted that Santaliz-Rios had provided no legal authority for the proposition that such an exception should apply, nor had he alleged facts suggesting that the diagnosis of his condition was not feasible within the three-year limitation period.

The court rejected other arguments which were raised for the first time by Santaliz-Rios on appeal, and affirmed the District Court's dismissal of the case. ⚖

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LETTER REQUESTING INFORMATION FROM PLAN FIDUCIARY IS INSUFFICIENT TO PROVE PRE-SUIT EXHAUSTION

By: Ann T. Taylor[1]

In *American Dental Association v. Wellpoint Health Networks, Inc*, the Eleventh Circuit Court of Appeals affirmed the District Court's holding that a letter requesting information from an ERISA plan fiduciary seeking information regarding a denial of benefits does not constitute a request for administrative review. As a consequence for failing to exhaust their ERISA pre-suit remedies before filing suit, the Eleventh Circuit affirmed the entry of summary judgment for the defendants in this putative class action. 2012 WL 5233562 (11th Cir. Oct. 23, 2012).

Dr. David W. Richards, a periodontist, provided to a WellPoint subscriber a comprehensive exam. As an out-of-network provider Dr. Richards charged the subscriber $98. In its Explanation of Benefits ("EOB"), Wellpoint represented that it would reimburse the patient only $57. The EOB explained that in the event the patient disagreed with the claim or required further clarification, the patient, or a dental provider acting on his behalf, should contact the WellPoint Dental Customer Service Department. *Id.* at *1.

Dr. Richards wrote a letter to WellPoint on behalf of the subscriber seeking additional information regarding the adverse-benefit-decision. The letter, in pertinent part, requested that WellPoint to "[p]lease provide me with documentation of the data used to calculate WellPoint's UCR…" *Id.* The letter neither disputed the denial of benefits nor requested that WellPoint review its decision. WellPoint responded to Dr. Richards in a subsequent letter about its usual, customary and reasonable rates but declined to provide the documents requested on the basis that they were propriety. There was no further correspondence between Richards and WellPoint. *Id.* at *2.

WellPoint's "Prudent Buyer Choice Dental Plan," provides a claimant with a period of 180 days to appeal and adverse-benefit-decision. The appeal must be in writing, and WellPoint is required to notify the claimant of its decision within 60 days of receipt of the appeal. *Id.*

Dr. Richards, along with two other dentists and the American Dental Association, filed a putative class-action suit in the Northern District of Illinois against WellPoint and its subsidiary, Blue Cross of California. They alleged WellPoint used a faulty method for determining the usual, customary and reasonable amount for reimbursement. The Joint Panel for Multidistrict Litigation transferred the action to the Southern District of Florida, where the case was eventually designated a "tag-along" to other matters consolidated into *In re Managed Care Litigation*, Master File No. 00-1334-MD, Tag-Along Case No. 02-22027-CIV. *Id.*

WellPoint moved for summary judgment arguing that plaintiffs had failed to exhaust the administrative remedies. Plaintiffs argued, without success, that Dr. Richards's letter to WellPoint constituted an appeal, or that an appeal would have been futile. *Id.* The District Court concluded that, at best, Dr. Richards' letter expressed dissatisfaction with the reduced payment, and that his request for documents possibly indicated the intent to appeal in the future, but the letter did not request a review of the adverse-benefit-decision. *Id.* The Eleventh Circuit agreed in whole with the analysis.

The Eleventh Circuit reiterated that pre-suit exhaustion may be excused in some instances but not this one. *Counts v. Am. Gen. Life & Acc. Ins. Co.,* 111 F.3d 105, 108 (11th Cir.1997). The Court noted that Dr. Richards' allegation of futility was speculative, because he had failed to appeal in the first instance. The Court reiterated based on Eleventh Circuit law that a litigant must demonstrate a "clear and positive" showing of futility before pre-suit exhaustion is excused. 2012 WL 5233562, at *3. *See also Powell v. AT&T Commc'ns, Inc.*, 938 F.2d 823, 827 (7th Cir. 1991) (A "rear-guard attempt to turn a request for information…into a demand for administrative review must be rejected."). ⚖

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FIFTH CIRCUIT ADOPTS A STANDARD CONSTRUCTION OF "ACCIDENT" WHERE THE TERM IS NOT DEFINED IN ERISA-GOVERNED AD&D POLICIES

By: Jonathan M. Feigenbaum[1]

In the never-ending litigation regarding what constitutes an accident, the Fifth Circuit Court of Appeals adopted a controlling standard that the lower courts must apply when the term "accident" is not defined in an ERISA governed accidental death and dismemberment life insurance plan ("AD&D"). The decision, *Firman v. Life Insurance Co. of North America*, 684 F.3d 533 (5th Cir. 2012), is significant because the Court held that its definition applies regardless of whether the fiduciary has discretion to determine benefit eligibility or the determination is for the Court *de novo*.

In a *per curiam* decision adopting in whole the opinion of United States District Judge Ewing Werlein, Jr. from the Southern District of Texas, the Fifth Circuit held that

> the common law definition of "accident" adopted in *Todd v. AIG Life Insurance Co.*, 47 F.3d 1448, 1456 (5th Cir. 1995), is controlling in all ERISA accidental death and dismemberment plans where the term "accident" is undefined, irrespective of whether the plan administrator is given discretion to interpret the plan.

Id.

Given that "accident" has never acquired a technical meaning in AD&D life insurance plans or similar life insurance policies, Court decisions have not been uniform. In adopting an across-the-board standard the Fifth Circuit is attempting to provide consistency in this often disputed area.

In *Firman*, the insured died in a single-vehicle crash. The medical examiner concluded that the cause of death was"[m]ultiple blunt force injuries," and marked the death as an "Accident" on the death certificate. The insured's blood and urine alcohol were 0.20 percent and 0.35 percent, respectively. According to the police report, the insured's vehicle veered off the road. The insured, who was not wearing a seat belt, was partially ejected and the vehicle rolled over crushing him.

Life Insurance Company of North America ("LINA"), the insurer of the AD&D Plan denied benefits on the ground that the death was not accidental because death resulting from driving while intoxicated is a foreseeable event. LINA interpreted "accident" to mean "a sudden, unforeseeable event." It reasoned that all states prohibit drunk driving and that the insured should have been aware of "the risks involved in operating his vehicle while under the influence." As a consequence, his death was "foreseeable" and not an accident.

The District Court focused on whether the LINA had consistently interpreted this plan language. Although the District Court found that LINA had interpreted this language uniformly, it held that LINA's definition of *accident* conflicted with the Fifth Circuit's federal common law definition. The District Court conducted its analysis under the leading case in this area, *Wickman v. Northwestern National Insurance Co*., 908 F.2d 1077 (1st Cir. 1990).

Under *Wickman*, the fiduciary or Court asks a number of questions. The fact finder must: (1) start with the reasonable expectations of the insured when the policy was purchased; (2) if the fact finder determines that the insured did not expect an injury similar in type or kind to that suffered, the fact finder must then examine whether the suppositions which underlay that expectation were reasonable; (3) if the fact finder finds the evidence insufficient to accurately determine the insured's subjective expectation, the fact finder should then engage in an objective analysis of the insured's expectations – "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." *Id*.

The District Court held that LINA had not applied the *Wickman* analysis and LINA's decision was legally incorrect. This Court noted that there are many examples of events that are considered "accidents" but which would be excluded from coverage if determined to be "foreseeable" or "reasonably foreseeable." *Wickman* demands a standard of "highly likely" to

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result in death before an action or omission is deemed not to be an accident.

The District Court concluded that LINA could not assume that all alcohol-related deaths are automatically foreseeable and therefore non-accidental. For this reason it had abused its discretion. The District Court found that a similar conclusion had been adopted in other Circuits. *See LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment Dependent Life Ins. Plan*, 605 F.3d 789, 802 (10th Cir. 2010) (collecting cases). Some alcohol-related incidents may be foreseeable, while others may not, and LINA's categorical approach was deemed fundamentally unreasonable. *See also Stamp v. Metro. Life Ins. Co.*, 531 F.3d 84, 91 & n.9 (1st Cir. 2008), *cert. denied*, 555 U.S. 1062, (2008) (rejecting "categorical determination that all alcohol-related deaths are per se accidental or nonaccidental").

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vehicle involved in the accident and recovered $110,000 (including attorneys' fees).

The Plan sued the participant for reimbursement of the paid medical expenses as (a)(3) equitable relief. The participant alleged, *inter alia*, that the Plan's claim included no allowance for the claimant's attorney's fees incurred.

The Court held that under *Amara*, the relief available under (a)(3) was that relief "typically available in equity," which means such relief is also subject to equitable defenses such as the "common fund" doctrine. The Court also held that equitable relief creates an exception to ERISA's strong preference for enforcing the written terms of the Plan:

> [T]he importance of the written benefit plan is not inviolable, but is subject—based upon equitable doctrines and principles—to modification and, indeed, even equitable reformation under § 502(a)(3).

Note: the Supreme Court subsequently granted U.S. Airways' *cert* petition.

CGI Technologies & Solutions, Inc v. Rose, 683 F.3d 1113 (9th Cir. 2012).

The employer-provided health insurance plan involved in *CGI Technologies* included both subrogation and reimbursement provisions. The employee/participant was injured in an automobile accident; the Plan paid approximately $32,000 in medical expenses. The employee sued the other party involved in the accident, and arranged for the amount recovered in that suit to be paid to the attorney's trust fund.

The Court initially held that the attorney was not a proper party, because non-fiduciaries may only be sued under ERISA if they participate in an "unlawful transaction," and accepting a litigation payment in trust did not constitute an unlawful transaction.

The Court next held that under *Amara* the application of "traditional equitable relief" includes traditional equitable defenses, such as the "make whole" and "common fund" doctrines. Of note, the Court specifically held that, under *Amara*, it "need not honor the express terms of the Plan where traditional notions of equitable relief so require."

Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083 (9th Cir. 2012).

The plan participant in *Bilyeu* submitted a claim for disability benefits under a long term disability plan sponsored by the employer and administered by an insurer. The claim review fiduciary accepted the claim and paid benefits to the participant without any offset for other benefits. (The participant did sign a document promising to reimburse the Plan for any overpayment.) Subsequently, the Social Security Administration also awarded disability benefits to the participant, which created an overpayment under the Plan terms. The claim review fiduciary sued for reimbursement of the amount of overpaid benefits under (a)(3), citing the Code's "other appropriate equitable relief" provision and arguing that the reimbursement agreement created an equitable lien by agreement.

In analyzing this argument, the Court held that an equitable lien requires (1) a promise to reimburse out of a third party recovery, (2) a specific fund separate from the claimant's general assets, and (3) that funds be within claimant's possession and control. The Court cited *Amara* for the proposition that an equitable lien requires "*particular* funds or property *in the defendant's possession*." Because the overpaid funds were not held in a segregated, identifiable account, but rather were part of the claimant's general assets, the Court ruled that the Plan's claim did not satisfy the requirements for imposition of an equitable lien.

4. Cases Interpreting *Amara* – Healthcare Plans

Sullivan v. CUNA Mutual Insurance Society, 649 F.3d 553 (7th Cir. 2011).

Sullivan involved a dispute over the manner in which an employer paid the premiums for a retiree healthcare plan that it sponsored. Initially, the employer paid a portion of the retirees' premiums, and allowed the retirees to apply their unused sick leave credits to pay the balance of the premiums. Subsequently, the employer discontinued its contribution to retiree healthcare premiums, shifting the cost entirely to the retirees. At that time, the employer also cancelled the "credits" program. The retirees brought a class action suit, alleging that the employer violated 29 U.S.C. § 1106(a)(1)(D) by diverting plan assets to itself. (This subsection prohibits any "transfer to, or use by or for the benefit of a party in interest, of any assets of the plan." An employer is a statutory "party in interest" pursuant to 29 U.S.C. § 1002(14)(C).) The retirees argued that after the employer amended the Plan, its balance sheet reflected a gain of more than $120 million.

The Court held that the sick leave balances were not a Plan "asset," and that health care benefits are not vested and may properly be changed or discontinued at any time. The Court *Amara* cited for the proposition that "silence in a summary plan description about some feature of a pension plan does not override language in the plan itself" (relying on A*mara*'s holding that the SPD is not a Plan document).

Eugene S. v. Horizon Blue Cross Blue Shield, 663 F.3d 1124 (10th Cir. 2011).

Eugene S. involved a challenge to a Plan's denial of residential treatment under a healthcare plan. The claimant received inpatient treatment for a psychiatric condition. The claims administrator denied the claim on the grounds that the condition should have been treated on an outpatient basis. The appropriate standard of judicial review was an issue in the case. The claimant asserted that deferential review was not appropriate because the grant of discretion was contained in the SPD, and the Plan had not submitted any other Plan document into evidence.

In analyzing this issue, the Court cited *Amara* for what it referred to as two "fairly simple propositions":

> (1) the terms of the SPD are not enforceable when they conflict with governing plan documents, or (2) the SPD cannot create terms that are not also authorized by, or reflected in, governing plan documents.

The Court held, however, that *Amara* does not apply where the SPD is also the Plan document itself. The Court noted that, by its express terms, the SPD was part of the Plan and contained the language of the Plan, and therefore the grant of discretion set forth therein was enforceable.

Koehler v Aetna Health Inc., 683 F.3d 182 (5th Cir. 2012).

The employer in *Koehler* provided a HMO plan for its employees. The employee sought reimbursement for treatment by an out of network physician (to whom she was referred by a network physician). The claim reviewer denied the claim for reimbursement, citing a Plan provision requiring pre-authorization for any out of network treatment.

The Court ruled in favor of the claimant, finding the pre-authorization provision (as set forth in the SPD) to be ambiguous. In so holding, the Court cited *Amara* for the proposition that § 502(a)(1)(B) claims may be based only on Plan terms, but "a beneficiary may still seek to hold the administrator to conflicting terms in the plan summary through a breach-of-fiduciary-duty claim under § 1132(a)(3)."

5. Cases Interpreting *Amara* – AD&D Plans

McCravy v. Metropolitan Life Insurance Co., 690 F.3d 176 (4th Cir. 2012).

McCravy involves Metropolitan Life Insurance Company's accidental death and dismemberment coverage provided to Bank of America employees. The Plan provided dependent coverage to "eligible dependent children." "Eligible dependents" included children under the age of 19, and children under the age of 24 who were fulltime students enrolled in an accredited program of higher learning. (After reaching the age limit, participants had the option of changing to individual coverage within 31 days.) Plan participants were responsible for paying the premiums for dependent coverage. The claimant listed her daughter as an eligible dependent, and paid premiums for dependent coverage. The daughter was murdered in 2007, at the age of 25. Metropolitan Life denied the claim on the grounds that the deceased was not an "eligible dependent," but

refunded the premiums it had collected after the decedent was no longer eligible for the dependent coverage. The claimant refused the refund, and sued for Plan benefits, alleging, *inter alia*, claims for surcharge and/or estoppel under (a)(3). The district court found in the claimant's favor, but held that her remedy was limited to a return of premiums.

On appeal, the Court held that *Amara* expanded the scope of relief available under (a)(3), and that the claimant was entitled to seek those remedies that were typically available in equity, including "surcharge" in the form of the Plan benefits as a remedy under (a)(3) for breach of fiduciary duty and equitable estoppel, *i.e.*, allowing claimant to retroactively convert the dependent coverage into individual coverage.

6. Cases Interpreting Amara – Long Term Disability

Weitzenkamp v. Unum Life Insurance Co. of America, 661 F.3d 323 (7th Cir. 2011).

In *Weitzenkamp*, the Plan participant submitted a claim for disability benefits under the employer sponsored long term disability plan. The participant alleged that she was totally disabled by fibromyalgia. The claims administrator accepted the claim, but limited benefits to a maximum of 24 months, based on a Plan provision restricting benefits to disabilities based on "self-reported symptoms." The participant sued, alleging that the limitation did not apply to her medical condition. The district court upheld the administrator's determination of the limitation of benefits.

On appeal, the Court interpreted the limitation to apply to *diagnoses* based on self-reports, rather than conditions where the *extent of impairment* is self-reported. The Court found that the record contained objective medical evidence confirming the claimant's diagnosis, and therefore the limitation did not apply. In so holding the Court cited *Amara* for the proposition that the employer's failure to mention a plan limitation in the SPD (another of the claimant's arguments) might not provide a basis for equitable relief, based on *Amara*'s holding that the SPD is not a plan document:

> This conclusion obviates our need to address the issue on which we rested our initial opinion, that Unum's failure to include the self-reported symptoms limitation in the SPD warranted granting Weitzenkamp equitable relief. We acknowledge, without deciding, that [*Amara*] may undermine that result

7. No Published Circuit Court Opinions Interpreting *Amara*

There are no published circuit court opinions interpreting *Amara* in the First, Second, Eighth, and District of Columbia Circuits. ⚖

THE BATTLE OVER…

Continued from page 7

The *Andrews v. Nationwide Mutual Insurance Company* Decision

The Court of Appeals of Ohio's October 25, 2012 decision in *Andrews v. Nationwide Mutual Insurance Company*, No. 97891, 2012 WL 5289946 (Ohio Ct. App. Oct. 25, 2012), represents the first ruling in private litigation filed against an insurance company challenging its practices with respect to unclaimed property and DMF searches. The decision affirmed an Ohio trial court's judgment granting a motion to dismiss filed by defendants Nationwide Mutual Insurance Company and Nationwide Life Insurance Company (collectively, "Nationwide").

The plaintiffs – two individuals who had entered into life insurance contracts with Nationwide – filed a class action complaint against Nationwide in May 2011, alleging that Nationwide breached its duty of good faith and fair dealing to the putative class by failing to annually search the DMF and independently determine whether any class members had died and were entitled to policy benefits. *See id.* at *1.

The Court of Appeals affirmed the trial court's dismissal "based on the express terms" of the plaintiffs' life insurance policies. *Id.* at *2. Applying basic principles of contract interpretation, the court rejected plaintiffs' argument that their policies were ambiguous because they did not identify the party responsible for providing proof of death. *See id.* at *3-4. Employing language standard in life insurance policies, Nationwide's policies agreed to pay death benefits to the insured's beneficiary upon receipt of proof that the insured had died. *See id.* at *4. The court determined that

> [t]he terms "receipt" and "receiving" demonstrate Nationwide's passive role in establishing an

> insured party's proof of death; they do not connote an obligation to procure such information. Thus, a finding obligating Nationwide to solicit or gather information pertaining to an insured's death would be contrary to the terms contained in the insurance policy.

Id.

Moreover, the Court of Appeals held that, pursuant to Ohio law, the burden of furnishing proof of death was on an insured's beneficiaries or claimants – not the insurance company – and that providing the insurance company with proof of death was a condition precedent to the payment of life insurance benefits. *See id.* at *4-5.

The Court of Appeals likewise rejected the plaintiffs' argument that Nationwide breached its duty of good faith and fair dealing to the plaintiffs by failing to incorporate DMF searches into its account servicing procedures because the life insurance contracts at issue did not impose such a duty on Nationwide. *See id.* at *6.

The Court of Appeals' holding appears directly contrary to the position taken by state regulators during multi-state examinations and settlement proceedings and in the West Virginia actions, which seek to hold life insurers to a duty to search the DMF to determine whether an insured has died. It is anticipated that insurance companies may seek to invoke the *Andrews* decision during pending regulatory examinations and litigation.

The *United Insurance Company of America v. Commonwealth of Kentucky* Case

Finally, in an effort to challenge the scope of Kentucky's Unclaimed Life Insurance Benefits Act (the "Unclaimed Benefits Act" or "Act"),[2] three life insurance companies[3] filed a declaratory judgment action against the Commonwealth of Kentucky, the Kentucky Department of Insurance, and the Kentucky Insurance Commissioner. The complaint in *United Insurance Company of America v. Commonwealth of Kentucky*[4] contends that the Unclaimed Benefits Act changes longstanding industry practices requiring proof of death and for paying life insurance claims, and imposes a new duty on insurers to seek out evidence that an insured has died even though no claim has been filed. *United Insurance* is the first lawsuit brought by insurers against state regulators challenging unclaimed property-related legislation.

Kentucky adopted the Unclaimed Benefits Act, which is based upon a model promulgated by NCOIL, in April 2012, and it is set to go into effect on January 1, 2013.[5] The Unclaimed Benefits Act requires insurers to compare their in-force life insurance policies[6] against the DMF on at least a quarterly basis to identify and confirm the death of any insureds, determine whether benefits are due, and make a good-faith effort to locate beneficiaries. In the event beneficiaries cannot be located, the Act requires that life insurance policy benefits be escheated to the state as unclaimed property in accordance with Kentucky law. The Act prohibits an insurer from charging insureds or beneficiaries for any fees or costs associated with search or verification efforts undertaken in accordance with the Act.

The *United Insurance* complaint does not take issue with Kentucky's enforcement of the Unclaimed Benefits Act on a prospective basis; rather, the plaintiffs challenge the Act only to the extent that it applies retroactively to policies written before its effective date and extraterritorially to policies issued outside of Kentucky.

Retroactivity

The complaint seeks a declaratory judgment that the Unclaimed Benefits Act either does not apply retroactively or, in the alternative, is void to the extent that it does apply retroactively to policies already in force as of the Act's enactment. The focus of the complaint is that if the Unclaimed Benefits Act is applied retroactively to in-force life insurance policies, the Act will impair existing contractual obligations and expectations between the insurers and policyholders in violation of the Kentucky and United States Constitutions.[7]

The complaint contends that "[t]he Act imposes new legal duties on Plaintiffs that were not agreed to between Plaintiffs and their insureds in the existing contracts of insurance and substantially alters the

2 Ky. Rev. Stat. Ann. § 304.15-420 (West 2012).

3 The companies are United Insurance Company of America, The Reliable Life Insurance Company, and Reserve National Insurance Company.

4 No. 2012-CI-1441 (Ky. Cir. Ct., Franklin Cnty., filed Nov. 8, 2012).

5 To date, two other states have passed the NCOIL Model: Maryland (enacted May 2, 2012, effective October 1, 2013) and Alabama (enacted May 15, 2012, effective January 1, 2014).

6 Although not addressed in the *United Insurance* complaint, the Act similarly governs retained asset accounts.

7 Moreover, because the Act lacks an express statement that it is intended to be applied retroactively, the complaint contends that plaintiffs are entitled to a declaratory judgment that, as a matter of statutory interpretation, the Act does not apply retroactively pursuant to Ky. Rev. Stat. Ann. § 446.080(3) (West 1942), which provides that "[n]o statute shall be construed to be retroactive, unless expressly so declared."

previously accepted meanings of the terms in Plaintiffs' contracts." Similar to the analysis undertaken in *Andrews*, the *United Insurance* plaintiffs insist that their in-force policies require notice of a claim and receipt of due proof of death as conditions precedent to their obligation to pay death benefits. Accordingly, the plaintiffs maintain that they have no contractual duty to search the DMF to identify deceased insureds or initiate claims settlement procedures until they have received notice and due proof of death. Rather, plaintiffs argue that their policies and longstanding industry practice place the duty of notifying an insurer of an insured's death, furnishing proof of death, and initiating the claim settlement process on the insured's beneficiaries or estate. Plaintiffs complain that, if applied retroactively, the Act will not only "rewrite" their in-force policies, but will also cause plaintiffs to incur "unbargained-for" administrative costs to establish systems and procedures to comply with the Act.

The complaint further alleges that retroactive application of the Unclaimed Benefits Act will impair plaintiffs' contractual rights by depriving them of "cash flow expectations upon which they relied when entering into their contracts of insurance" and "upon which [their] premium pricing and payout assumptions underlying the policies were based." According to the complaint, the plaintiffs traditionally pay death benefits after they receive notice of a claim and due proof of death. If no death claim is submitted, the plaintiffs retain any "cash flows" derived from the policy until the insured reaches the mortality limiting age, at which time death benefits are paid to the policyholder or beneficiary. In the event the company is unable to locate the policyholder or beneficiary, death benefits are escheated to the state following expiration of a three-year statutory dormancy period.

Plaintiffs' in-force life insurance policies are, according to the complaint, priced based on their historical mortality experience and an assumption that plaintiffs will be able to retain and invest cash flows from the policies until due proof of death is furnished or the insured has reached the mortality limiting age. Because the Unclaimed Benefits Act "modifies the circumstances under which escheat obligations arise," "shortens the holding period for unclaimed property," and "grants the beneficiary a vested property interest in the death benefit as soon as Plaintiffs . . . confirm a DMF match," plaintiffs claim that retroactive application of the Act would cause them injury and impair their contractual rights by forcing plaintiffs "to pay out benefits sooner than the terms of the existing, in-force policies would otherwise require" and "eliminating Plaintiff's right to invest those funds until three years after the insured reaches the mortality table's limiting age."

Extraterritorial Application

The complaint also seeks a declaratory judgment that, as a matter of statutory interpretation, the Unclaimed Benefits Act does not apply to life insurance policies issued and delivered outside of Kentucky. According to the complaint, the Act vaguely state that it governs "life insurance death benefits regulated by the [Kentucky] Department of Insurance,"[8] but does not indicate whether the Act applies only to policies issued in Kentucky or whether it applies more broadly to policies issued in other states that have some sort of connection to Kentucky.[9] Plaintiffs contend that altering their business practices in multiple states to comply with the Act would subject them to administrative burdens and varying state laws, would result in higher premium rates for new policies, and would be contrary to Kentucky law, which applies a presumption against extraterritorial operation of statutes and provides that the Kentucky Insurance Code applies only to policies issued for delivery or delivered in Kentucky.

Conclusion

These developments, and in particular the *United* litigation, are forging new roadmaps for the future of unclaimed property disputes and may result in increased challenges to legislative and regulatory efforts that seek to impose requirements on insurers that are contrary to longstanding industry practices.

8 *See* Ky. Rev. Stat. Ann. § 304.15-420(1).

9 For instance, if a beneficiary resides in Kentucky or if policyholder moved to Kentucky after purchasing a policy in another state.

ONE YEAR LATER ...

Continued from page 8

Next, the JVCA resolves a split between the Circuit Courts of Appeals and adopts the majority view that it is the defendant's burden to establish the amount in controversy by a "preponderance of the evidence." 28 U.S.C. § 1446(c)(2)(B). Lastly, the JVCA explains that, if the case was not removable based on the initial pleading, information obtained in state court discovery may be used to support removal – notwithstanding the fact that the initial thirty-day post-service removal deadline may have expired. *See* 28 U.S.C. § 1446(c)(3)(A).

The provision in the JVCA declaring that "the sum demanded in good faith in the initial pleading shall be deemed to be the amount in controversy" will be significant in some jurisdictions. In *Frederick v. Hartford Underwriters Insurance Co.*, 683 F.3d 1242, 1247 (10th Cir. 2012), a case that was commenced *pre-JVCA*, the Tenth Circuit noted that "a plaintiff's attempt to limit damages is not dispositive of the amount in controversy." *Id.* at 1247. However, in a footnote the Court noted: "the JVCA likely requires a different approach . . . but again, the JVCA was not in effect when this case was filed . . . ." *Id.* at n.2.

Several courts have applied the JVCA's clarifying provisions relating to the establishment of the amount in controversy when the complaint does not demand a sum certain or where a money judgment is sought, but State practice permits recovery of damages in excess of the amount demanded. *See e.g. Warren v. Mac's Convenience Stores, LLC*, 2012 WL 5077669, at *2 (W.D. Ky. Oct. 18, 2012) (remanding on other grounds, but noting that defendant was permitted to assert the amount in controversy upon removal since "Kentucky both prohibits the demand for a specific sum and allows recovery beyond that demanded in the pleadings, these amendments apply."); *Shepherd v. State Farm Fire & Cas. Co.*, 2012 WL 3139752 (N.D. Ala. July 30, 2012) (allowing removal where the complaint sought personal property damage in the amount of $38,549.19, plus unspecified mental anguish and punitive damages); *Butler v. Target Corp.*, 2012 WL 5362974, at *2 (D. Kan. Oct. 31, 2012) (noting that defendant was permitted to contest the amount in controversy even though plaintiff had demanded a sum certain in the complaint because Kansas law recognized that a final judgment should grant relief to which each party is entitled, even if the party has not demanded that relief in its pleadings).

The clarification of the defendant's burden of proof on the amount in controversy is a significant development in some jurisdictions, although it is merely a codification of the often-used standard in others. For instance, in *County of Washington, Pennsylvania v. U.S. Bank National Association*, 2012 WL 3860474, at *21 (W.D. Pa. Aug. 17, 2012), the court noted the effect the JVCA had on cases within the Third Circuit regarding the allocation of the burden of proof:

> Until recently, allocation of the burden of proving or disproving the requisite amount-in-controversy was a murky area, despite substantial efforts by the court of Appeals for the Third Circuit to clarify seemingly conflicting standards ("legal certainty" and "preponderance of the evidence") that had arisen from two lines of United States Supreme Court caselaw. . . .
>
> It appears that any lingering confusion has been addressed and, hopefully, dispelled by Congress. [The JVCA] endorsed the preponderance of the evidence standard in the newly enacted Section 1446(c)(3) in Title 28. . . .

Id.

Conversely, in *Jefferson v. BEUSA Energy*, LLC, 2012 WL 3598394, at *1 (W.D. La. Aug. 17, 2012), the court noted that the "preponderance of evidence" standard in the JVCA "is consistent with the approach long taken by the Fifth Circuit in similar cases . . . ." *See also Butler*, 2012 WL 5362974, at *3 (noting that the Tenth Circuit already employed a preponderance of evidence approach to the question of whether the amount in controversy had been satisfied).

Finally, the new statutory language that discovery responses constitute an "other paper" which can form the basis for a post-thirty day removal appears to be a codification of existing law in most jurisdictions. *See, e.g., Wilson v. Gen. Motors Corp.*, 888 F.2d 779, 782 (11th Cir. 1989) (response to request for admission constitutes an "other paper" allowing removal).

3. Removal More Than One Year after Commencement if Bad Faith is Shown

The third significant change or clarification under the JVCA establishes that a case may now be removed more than one year after commencement *if* the removing

defendant demonstrates that the "plaintiff has acted in bad faith in order to prevent a defendant from removing the action." 28 U.S.C. § 1446(c)(1). While the JVCA does not define "bad faith," it does provide that a finding that "the plaintiff deliberately failed to disclose the amount in controversy to prevent removal" shall be deemed bad faith. 28 U.S.C. § 1446(c)(3)(B).

This bad faith exception is a codification of the view of many federal courts which held that a plaintiff who had engaged in bad faith was estopped from asserting the one-year limitation on removal. *See*, *e.g.*, *Tedford v. Warner-Lambert*, 327 F.3d 423 (5th Cir. 2003) (recognizing equitable exception where plaintiff attempted to manipulate requirements for removal jurisdiction). However, the bad faith exception had not been universally applied, thus this language may present new opportunities for removal in some jurisdictions. *See Bolen v. Ill. Nat'l Ins. Co.*, 2012 WL 4856811, at *8 n.8 (M.D. Fla. Aug. 28, 2012) ("[F]or cases filed after January 2012, a federal court can consider whether the pleading choices of a plaintiff amount to bad faith to avoid removal jurisdiction. Notably, no such consideration is available under the version of the statute applicable here.").

Seemingly, not enough time has passed for this amendment to become an issue in a contested removal because the JVCA only applies to cases commenced on or after January 6, 2012. Thus, this provision could not provide the basis for removal until January 7, 2013 at the earliest. However, numerous federal courts have nevertheless cited to this provision. *See*, *e.g.*, *Barlow v. John Crane Houdaille, Inc.*, 2012 WL 5388883 (D. Md. Nov. 1, 2012). Further, some recent decisions may shed light on what does not constitute "bad faith" under the JVCA. *See*, *e.g.*, *WMCV Phase, LLC v. Tufenkian Carpets Las Vegas, LLC*, 2012 WL 5198478 (D. Nev. Oct. 18, 2012) (noting that plaintiff did not act in bad faith by adding defendant more than one year after commencement because plaintiff did not learn until that time that the new defendant may have been an alter ego of the originally named defendants); *Loellke v. Moore*, 2012 WL 253373 (S.D. Ill. Jan. 26, 2012) (settlement with non-diverse plaintiff was not shown to be in bad faith).

4. No Discretion to Hear Separate and Independent State-Law Claims

The fourth significant revision under the JVCA relates exclusively to cases removed based on federal question jurisdiction and eliminates a federal court's discretion to hear separate and independent state-law claims asserted in such cases. 28 U.S.C. § 1441(c)(2). Under this subsection, a defendant can remove a case so that a federal court can resolve federal claims, but the court must sever and remand any "claim not within the original or supplemental jurisdiction of the district court or a claim that has been made non-removable by statute." *Id.* The sever and remand provisions of the JVCA only apply to "separate and distinct" claims, thereby preserving a federal court's discretion to hear state-law claims that arise out of the same nucleus of operative facts as the federal-law claims. *See Bialik v. Raddatz,* 2012 WL 2913201 (S.D. Mich. June 6, 2012) (noting that the federal court will have discretion to retain the state-law claims if it finds that these claims fall within its supplemental jurisdiction (*i.e.*, arise out of the same nucleus of operative facts as the federal-law claim)).

Numerous courts have commented on the JVCA's elimination of the federal court's discretion to hear separate and independent state-law claims asserted in a case removed to a federal court solely on the basis of federal question jurisdiction. *See, e.g.*, *Petrano v. Old Republic Nat. Title Ins. Co.,* 2012 WL 2192258, at *6 (N.D. Fla. June 13, 2012) (commenting on the court's *obligation*, as opposed to *discretion*, to sever and remand to state court any state-law claims that were not removable on their own); *Ala. Home Insurer's Fund v. Project Builders, Inc.*, 2012 WL 2359402 (M.D. Ala. June 20, 2012) ("[W]hile nonremovable claims may now be joined to permit removal, *see* 28 U.S.C. § 1441(c), nonremovable claims must be severed and remanded."). Moreover, some courts have observed the effect that the JVCA's new rule has had on the unanimity requirement for removal. *See Moore v. City of Philadelphia*, 2012 WL 3731818, at *4 (E.D. Pa. Aug. 29, 2012) ("where a case involves both federal and state-law claims, but where some of the defendants have no federal-law claims against them, such defendants need not consent to removal").

In sum, depending on the jurisdiction, some of the JVCA's changes to the removal rules may simply be a statutory clarification of existing procedure. In other jurisdictions, however, these same provisions will result in a change in removal procedure. Regardless of your jurisdiction, for cases filed on or after January 6, 2012, counsel should carefully consider the JVCA in determining whether a case is removable either initially or upon a showing of bad faith. Finally, please be aware that the JVCA contained other changes not covered in this article relating to treatment of resident aliens in diversity cases, citizenship of foreign corporations and insurance companies with foreign contacts, and venue and transfer requirements. ⚖

2013 TIPS CALENDAR

January 2013

17-20 **Midwinter Symposium on Insurance and Employee Benefits** — **W Hotel Fort Lauderdale, Fort Lauderdale, FL**
Contact: Ninah F. Moore – 312/988-5498

23- 25 **Fidelity & Surety Committee Midwinter Meeting** — **Waldorf-Astoria Hotel New York, NY**
Contact: Felisha A. Stewart – 312/988-5672

February 2013

6-12 **ABA Midyear Meeting** — **Hilton Anatole Dallas, TX**
Contact: Felisha A. Stewart – 312/988-5672
Speaker Contact: Donald Quarles – 312/988-5708

14-16 **Insurance Coverage Litigation Spring CLE Meeting** — **Arizona Biltmore Spa Resort & Phoenix, AZ**
Contact: Ninah Moore – 312/988-5498

March 2013

6-8 **Transportation Megaconference** — **Sheraton New Orleans New Orleans, LA**
Contact: Donald Quarles – 312/988-5708

April 2013

4-5 **Emerging Issues in Motor Vehicle Product Liability Litigation National Program** — **Arizona Biltmore Resort & Spa Phoenix, AZ**
Contact: Donald Quarles – 312/988-5708

5-6 **Toxic Torts Committee Midyear Meeting** — **Arizona Biltmore Resort & Spa Phoenix, AZ**
Contact: Felisha A. Stewart- 312/988-5672

13-17 **TIPS National Trial Academy** — **Grand Sierra Resort Reno, NV**
Contact: Donald Quarles – 312/988-5708

23-28 **TIPS Section Spring Leadership Meeting** — **JW Marriott Washington, DC**
Contact: Felisha A. Stewart- 312/988-5672
Speaker Contact: Donald Quarles – 312/988-5708