Stranger Danger: States and Insurers Seek To Combat Stranger-Owned Life Insurance

Stranger-Owned Life Insurance (“STOLI”) transactions are the product of the growing viatical settlements market, in which insureds assign their insurance policies to third-party investors.

As one court observed: “It is estimated that $13 billion worth of life insurance policies were sold by policyholders to providers in 2005 – up from $5 million in 1989 and $200 million in 1998 – and it is projected that by 2030 the number could reach $160 billion.” Life Partners, Inc. v. Morrison, 484 F.3d 284, 288 (4th Cir. 2007).

In a typical STOLI transaction, an agent sells a life insurance policy to an elderly candidate, offering the senior certain inducements in exchange for the senior’s promise to assign the policy to an investor after the contestable period expires. The inducements may include cash or offers of free insurance. After the contestable period expires, the insured transfers the policy to an investor, who thus acquires a financial interest in the death of the insured.

Scholars and practitioners have debated the reality of the risk that an investor would kill an insured to obtain an early pay-out on a policy. See, e.g., Alan Jensen & Stephan R. Leimberg, Stranger-Owned Life Insurance: A Point/Counterpoint Discussion, 33 THE AMERICAN COLLEGE OF TRUST & ESTATE COUNSEL JOURNAL 110 (Fall 2007).

The increasing number of STOLI policies also threatens to increase the overall cost of life insurance. STOLI transactions skew statistics that insurance companies rely on to set premium rates, such as lapse rates and life expectancies.

The effect is exacerbated when applicants misrepresent their health or financial status in order to obtain the highest-

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value policy possible. As a result, insurers must pay benefits under more high-value policies than anticipated, creating an increase in life insurance premiums for all consumers.

STOLI transactions violate “insurable interest” laws, which essentially require that the beneficiary of a life insurance policy have an insurable interest in the continued life, health, or safety of the insured. See, e.g., ALASKA STAT. § 21-42-020(a); GA. CODE ANN § 33-24-3; N.Y. INS. LAW § 3205(b).

Investors, agents, and insureds may circumvent insurable interest laws by submitting false information regarding the expectation that the policy will eventually be sold. By evading these laws, STOLI transactions contravene the idea that life insurance should be a means to provide for dependents and pay debts after the death of the insured.

STOLI transactions are often difficult to detect because the difference between a legal and illegal viatical settlement is whether the insured had the intent to sell the policy at the time of purchase. Insurance companies have not always been successful in litigation to rescind STOLI policies based solely on the lack of insurable interest. Consequently, 27 states have enacted legislation banning STOLI transactions, and there is similar legislation pending in at least 12 additional states.

This article discusses some of the recent legislation and litigation surrounding STOLI transactions.

Recent Legislation

Recognizing the need for further regulation of the viatical settlements industry, especially with respect to STOLI transactions, two organizations of insurance regulators, the National Association of Insurance Commissioners and the National Conference of Insurance Legislators, have developed model acts to regulate STOLI transactions.

In 2008, states began adopting versions, and sometimes hybrids, of each of these model acts to discourage and ban STOLI transactions within the state. Based on the model acts, most states require a two- to five-year moratorium on the settlement of policies with STOLI characteristics, such as a third-party paying policy premiums or the evaluation of the policy for settlement.

Most state laws also require brokers to make disclosures to consumers, such as the fact that the settlement proceeds may be taxable and any affiliations between the broker and the investor. Most states regulate the advertisement of purchase agreements, prohibiting any statements which imply that insurance is “free,” “guaranteed,” or “no risk.” Some states have implemented annual reporting requirements for brokers and investors regarding the total number and the proceeds of settlement arrangements.

Recent Litigation


After the two-year contestable period expired, Paulson assigned the policies to various companies, including Coventry First, LLC (“Coventry”). Sun Life filed suit to rescind the policies as void ab initio for lack of an insurable interest. In Sun Life I, Coventry moved to dismiss the action as time-barred by the contestability provision.

Though the district court acknowledged that a life insurance policy was void if purchased under a scheme to avoid insurable interest laws, the court stressed the importance of the “mutual intent of the insured and the third party” in establishing the existence of such a scheme.

Sun Life had alleged in its complaint only that Paulson intended to sell the policy at the time of his application, not that Coventry had any intent to purchase the policy at that time. Accordingly the court determined that, without allegations regarding third-party intent to purchase at the time of the application, Sun Life had failed to allege facts that would make the policy void ab initio. The court granted Coventry’s motion to dismiss the claim against it.

Sun Life then moved to amend its complaint as to the other defendants which had, like Coventry, purchased life insurance policies from Paulson. After postponing a hearing on its motion for several months, Sun Life was unable to produce evidence of a third party with no insurable interest which, at the time of Paulson’s application, intended to purchase the policy. Accordingly, the magistrate judge denied Sun Life’s motion to amend.
In *Sun Life II*, the district court upheld the magistrate judge’s decision, reiterating the court’s previous determination that the law required evidence of the intent of both parties to engage in the transaction at the time the policy was procured.

In *Lincoln National Life Insurance Company v. Calhoun*, 596 F. Supp. 2d 882 (D. N.J. 2009), a broker solicited Calhoun in 2006 to apply for a life insurance policy and sell it for a profit. In his application to Lincoln National for $3 million in life insurance, Calhoun certified that he had not engaged in any discussions regarding the sale or assignment of the policy to a life settlement, viatical or other secondary market provider.

Lincoln National later became aware of Calhoun’s intent to sell the policy and filed an action for judicial declaration that the policy was voided *ab initio* due to material misrepresentation in the application and due to the lack of an insurable interest.

Moving for dismissal, Calhoun argued that the material misrepresentation claim should fail for two reasons: (1) Lincoln National would not have been entitled to deny Calhoun’s application for coverage if he had answered “yes” to the application question, and (2) a statement of future intent cannot, as a matter of law, form the basis of a material misrepresentation.

The court rejected both of these assertions, noting Lincoln National’s affidavit testimony that it would not have issued the policy if Calhoun had answered “yes” to the application question. The court further reasoned that insurance underwriters were entitled to deny coverage based on Calhoun’s intent to sell the policy to a stranger investor.

The putative legality of the underlying transaction was not dispositive since “insurance underwriters are entitled to deny coverage based on any number of *legal* activities that would increase the risk of the contract, such as smoking, cliff-diving, and other activities that may present a risk to continued life.” Calhoun also argued that the court should dismiss the claim to the extent based on an insurable interest argument because the policy had not yet been assigned to a third party, and there was no guarantee that the defendants would ever assign it. The court rejected this argument, finding that whether the defendant intended to sell at the time of the application was crucial to its determination.

Thus, the court allowed Lincoln National to proceed with its claim and attempt to discover whether and to whom Calhoun had arranged to sell the policy at the time he submitted the application to Lincoln National.

In *Lincoln National Life Insurance Company v. The Gordon R.A. Fishman Irrevocable Life Trust*, 2009 WL 2330771 (C.D. Cal. 2009), before issuing the policies in dispute, Lincoln National informed Mutual Credit Corporation (“MCC”) that Lincoln National disapproved of its financing arrangements for life insurance policies, and requested MCC to stop sending applications for policies intended to be financed by MCC.

The defendants sought summary judgment on the grounds that, consistent with existing California law, the policies were issued to a party with an insurable interest in the insured’s life. The district court stated, “[I]t is hard to deny that, based on the formalities taken by the defendants, an insurable interest ... existed at the time the Policies were issued. The Trust ... clearly has an insurable interest in [the insured’s] life.”

Because there was a valid insurable interest in the policy for two years, the court determined that Lincoln National could not rescind the policies for violation of California’s insurable interest laws. However, the court noted that MCC’s financing arrangement “skirts close to the letter, and certainly can be viewed as violating the spirit, of the law.”

**Conclusion**

Before the recent wave of legislation, insurers had inconsistent results in rescinding STOLI policies based on a lack of insurable interest by the beneficiary of the policy. It is clear from the number of states that have enacted legislation that STOLI transactions are widely disapproved by insurance regulators. However, it remains to be seen whether the new legislation will effectively eliminate STOLI transactions.
Anthem administered health and dental plans for individual employers and employer groups, many of which were part of ERISA plans. Drs. Rutt and Egan were dentists who entered into provider agreements with Anthem, under which they provided services to individuals enrolled in the plans.

Drs. Rutt and Egan and the Connecticut State Dental Association (“CSDA”) filed separate lawsuits against Anthem in Connecticut state courts, alleging breach of contract and other claims under state law, based on their contention that Anthem employed practices such as “improper downcoding” and “improper bundling” as a means of underpaying participating dentists.

Anthem removed the cases to federal court in Connecticut on the basis that plaintiffs’ state law claims were completely preempted by ERISA. Plaintiffs filed motions to remand, but before those motions were decided, the cases were transferred to the Joint Judicial Panel on Multi-District Litigation as “tag along” cases in the multi-district litigation titled In re: Managed Care, pending in the Southern District of Florida.

The Florida district court ultimately denied plaintiffs’ motions to remand and granted Anthem’s motions to dismiss. On appeal, the Eleventh Circuit considered whether federal question jurisdiction existed – even though the plaintiffs had asserted no claims under ERISA – based on the doctrine of complete preemption, “a judicially-recognized exception to the well-pleaded complaint rule.”

The court observed that claims by healthcare providers, such as Drs. Rutt and Egan, are usually not subject to complete preemption, because “[h]ealthcare providers generally are not considered ‘beneficiaries’ or ‘participants’ under ERISA,” quoting Hobbs v. Blue Cross Blue Shield of Ala., 276, F.3d 1236, 1241 (11th Cir. 2001). However, a healthcare provider may acquire derivative standing to sue under ERISA by obtaining a written assignment of benefits from a plan participant or beneficiary.

Whether the complete preemption doctrine applies depends on a two-part analysis set out in Aetna Health Inc. v. Davila, 542 U.S. 200, 210 (2004). The two questions are (1) whether the plaintiff could have brought his claim under § 502(a) of ERISA, 29 U.S.C. § 1132(a), and (2) whether no other legal duty supports the plaintiff’s claim.

Drs. Rutt and Egan argued that their claims were not preempted, because they were not suing for benefits under plans governed by ERISA, but to enforce their provider agreements with Anthem, which were contracts independent of the ERISA plans in which their patients participated. They contended that their lawsuits involved only the “rate of payment” to which they were entitled under the provider agreements, not the “right of payment” under their patients’ separate ERISA plans.

The Eleventh Circuit looked to cases from the Ninth, Third, and Fifth Circuits, and agreed with those courts “that the ‘rate of payment’ and ‘right of payment’ distinction is a useful means for assessing preemption of healthcare provider claims based upon a breach of an agreement separate from an ERISA plan,” citing Blue Cross of Cal. v. Anesthesia Care Assoc. Med. Group, Inc., 187 F.3d 1045 (9th Cir. 1999); Peacock Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393 (3d Cir. 2004); and Lone Star OB/GYN Assoc. v. Aetna Health Inc., 579 F.3d 525 (5th Cir. 2009).

Based on a review of the complaint filed by Drs. Rutt and Egan, the Eleventh Circuit concluded that their “allegations implicate not only the ‘rate of payment’ under their Provider Agreements, but also the ‘right of payment.’” For example, they alleged that Anthem had engaged in acts such as “denying and/or reducing Dentists’ reimbursement for medically necessary services,” and that they had “denied ‘medically necessary claims.’” Additionally, their patients had executed assignments of benefits in favor of Drs. Rutt and Egan.

“What we have, then, is really a hybrid claim, part of which is within § 502(a),” the court said. “Because Rutt and Egan complain, at least in part, about denials of benefits and other ERISA violations, their breach of contract claim implicates ERISA.” Thus, the first Davila requirement was satisfied.

Turning to the second Davila inquiry, the court acknowledged that the
claims of Drs. Rutt and Egan were predicated to some extent on a legal duty independent of ERISA, that is, a duty arising from their provider agreements. Nevertheless, the court said, “their claims stray from the boundaries of their Provider Agreements into ERISA territory by asserting improper denials of medically necessary claims and violations of ERISA procedural requirements.”

Consequently, the court held that the motions to remand were correctly denied, because some of the claims were completely preempted by ERISA, resulting in federal question jurisdiction over those claims, and the district court also “has jurisdiction over any other claims joined with the preempted claims.”

Anthem argued that the court also had jurisdiction under ERISA over the claims asserted by CSDA, even though no plan participants or beneficiaries had assigned to CSDA their rights to receive benefits. While some courts have recognized that a trade group such as CSDA “may obtain statutory standing under ERISA through associational standing,” the Eleventh Circuit said that “[g]enerally, an association seeking damages on behalf of its members cannot claim associational standing.” Consequently, CSDA’s claims were not completely preempted, and the district court could not exercise federal question jurisdiction over those claims.

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Employee Deemed to Have Exhausted Administrative Remedies, Based on Plan’s Failure to Follow Procedures


Ms. Chavis was insured for short-term and long-term disability benefits under her employer’s ERISA plan. She applied for STD benefits. The claims administrator, Life Insurance Company of North America (“LINA”), denied her claim, and Ms. Chavis appealed. LINA affirmed its denial, and Ms. Chavis appealed again.

While the second appeal was pending, Ms. Chavis submitted a claim for LTD benefits. LINA determined that she was not eligible for LTD benefits, based on its prior denial of the STD claim. LINA later reversed its denial of the claim for STD benefits and, as a result, re-opened Ms. Chavis’s claim for LTD benefits. She then filed suit, and while that action was pending, LINA denied her claim for LTD benefits. Ms. Chavis did not appeal the denial of her LTD benefits claim.

LINA moved to dismiss Ms. Chavis’s complaint, arguing that she failed to exhaust her administrative remedies. LINA relied on *Makar v. Health Care Corp. of the Mid-Atlantic*, 872 F.2d 80 (4th Cir. 1989), which held that “an ERISA claimant generally is required to exhaust the remedies provided by the employee benefit plan in which he participates as a prerequisite to an ERISA action for denial of benefits.”

While acknowledging that Ms. Chavis had not exhausted her administrative remedies, the court focused on Section 503 of ERISA, 29 U.S.C. § 1133, which provides “that an adequate notice, setting forth the specific reasons for the denial, written in a manner calculated to be understood by the participant, as well as the opportunity for a full and fair review, must be given to any participant whose claim is denied.” If an ERISA plan fails to follow these procedures, the court said, the “claimant shall be deemed to have exhausted the administrative remedies under the plan.”

LINA’s denial letter, which it sent before deciding that Ms. Chavis was eligible for STD benefits, simply stated that she was “not eligible for Long Term Disability.” When Ms. Chavis filed her complaint, LINA had re-opened her claim for LTD benefits but had not yet determined whether she was entitled to those benefits. The court held that LINA failed to follow the requisite claim procedure for notifying a claimant of a benefit determination, and thus the court concluded that Ms. Chavis was deemed to have exhausted her administrative remedies and that she could proceed with her complaint under ERISA.
At the time of her death, Ms. Cogdill was insured under a group accidental death policy issued by American General. Benefits were payable for losses due “solely as a result of an accidental bodily injury.” The policy’s “exclusions and limitations” included the following:

No benefits will be paid for any loss that results from or is caused directly, indirectly, wholly or partly by any of the following: ... 4. voluntary intake of ... drugs ..., unless taken as prescribed by a doctor; ... 6. being intoxicated or under the influence of any drug, unless taken as prescribed by a doctor[.]

The district court also noted that the group policy listed several exceptions to the “active employee” requirement, under which an employee remained eligible for coverage if she was on approved leave under the Family and Medical Leave Act, on education or military leave, on short-term disability, or if she was a displaced employee. Thus, according to the district court, “if Reliance intended for eligibility to continue for employees who resigned but who subsequently received paychecks for accrued paid time off, it could have included this category along with the exceptions noted above.”

The district court also found that Wachovia’s deduction from Ms. Grooms’ final paycheck of premiums for herself and her husband was an inadvertent mistake, which “[d]id not transform Plaintiff into an ‘active employee’ eligible for coverage under the policy.” The court noted that “[t]he Fourth Circuit has clearly held that mistaken premium deductions do not constitute a waiver of the right to deny coverage based on the terms of an ERISA plan.” Furthermore, the policy itself stated that “[c]lerical errors in connection with this Policy ... whether by [Wachovia], [Reliance], or any authorized plan administrator ... will not continue insurance that would otherwise have ceased or should not have been in effect.”
An autopsy determined that the cause of Ms. Cogdill’s death was “multiple medicinal drug overdose,” and that “[t]he death [was] most likely related to the presence of multiple medicinal compounds.”

According to a toxicology report, the drugs in Ms. Cogdill’s system were temazepam, alprazolam (Xanax), oxycodone, normeperidine, quetiapine, and promethazine. Oxycodone was found in the “toxic, but not lethal range,” and alprazolam was reported “to be at high therapeutic levels, just below [the] ‘potentially toxic’ range.” The remaining drugs were in the therapeutic range.

The doctor who performed the autopsy concluded:

While none of these drugs were present at clearly lethal levels, the potentially toxic effects of their combination and interaction are considered to be sufficient to explain demise. In view of the fact that there were no drug lethal levels, in conjunction with the absence of positive indicators of suicidal intent, the manner of death is being classified as accidental.

Of the drugs found in Ms. Cogdill’s system, the autopsy report noted that she had a prescription for Xanax (alprazolam), temazepam, and Mepergan Fortis (made up of meperidine and promethazine). There was no evidence that she had a prescription for oxycodone.

Ms. Cogdill’s husband sued to recover accidental death benefits. On cross-motions for summary judgment, the district court considered policy exclusions 4 and 6 together, reasoning that the key issue was whether Ms. Cogdill took the drugs “as prescribed by a doctor.” American General argued that Ms. Cogdill’s ingestion of oxycodone was not “as prescribed by a doctor,” particularly when considered in combination with her ingestion of numerous other drugs.

In granting American General’s motion for summary judgment, the district court applied basic principles of contract interpretation to determine the meaning of “as prescribed by a doctor,” because the policy did not define that phrase.

The court found that “[t]he plain, ordinary, and popular understanding of the phrase ‘as prescribed by a doctor’ entails more than merely taking a medicine for which an individual has a doctor’s prescription. ... Instead, the plain meaning of this phrase requires taking the drugs in accordance with the prescribing doctor’s specific instructions.” The court noted that inclusion of the word “as” in the phrase “as prescribed by a doctor” suggested “something more than the mere fact that a prescription was issued.” In support of this view, the court cited Hummel v. Cont’l Cas. Ins. Co., 254 F.Supp.2d 1183 (D. Nev. 2003), and Ortega v. Aetna Life Ins. Co., 2007 WL 1125782 (S.D. Tex. 2007), for the same proposition.

The court concluded that American General was entitled to summary judgment, because any “reasonable jury would be compelled to conclude that Ms. Cogdill took an amount of oxycodone in excess of what a doctor would have prescribed, even assuming she had a prescription for this medication.”

As a full-time employee of Cott Beverages, Ms. Alexander was a participant in the company’s ERISA plan, which included accidental death benefits under a group insurance policy issued by Hartford Life and Accident Insurance Company. Cott was designated as the plan administrator, and Hartford was the claims administrator with discretionary authority to determine eligibility for benefits.

Ms. Alexander drowned at home in her bathtub. The medical examiner determined that her death was an “accident” and that the drowning was due to, or as a consequence of diabetes mellitus and seizures.

Ms. Alexander’s husband submitted a claim for accidental death benefits, which Hartford denied, relying
on a policy exclusion for loss resulting from “sickness or disease.” The husband appealed, and he also requested that Hartford provide him with “copies of all plan documents,” as well as other documents. Hartford did not provide the requested documents.

The husband sued Cott and Hartford for accidental death benefits, and he also sought to recover a daily penalty under 29 U.S.C. § 1132(c) for failure to provide copies of the requested plan documents. The defendants filed a motion to dismiss the claim for a penalty on the grounds that only the plan administrator could be held liable for failure to produce such documents upon request, and that the husband had not made such a request of Cott, the designated plan administrator.

Section 502(c) of ERISA, 29 U.S.C. § 1132(c), provides in part: “Any administrator … who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a … beneficiary … may in the court’s discretion be personally liable to such … beneficiary in the amount of up to $100 a day ….” The documents required to be furnished upon request include “the latest updated summary[] plan description.” 28 U.S.C. § 1024(b)(4).

The district court granted the motion to dismiss as to Cott, because the complaint did “not allege that [the husband] requested any plan documents from Cott, the designated Plan Administrator,” and therefore, Cott “did not ‘fail’ or refuse[] to comply with a request for any information which such administrator [was] required by [ERISA] to furnish.”

With regard to Hartford, however, the court denied the motion to dismiss, holding that – even though Hartford was not the designated plan administrator – the complaint alleged facts sufficient to raise a question whether Hartford acted as the “de facto plan administrator” in handling the claim.

“There is nothing in the law of ERISA that provides the [designated plan administrator] with a ‘naked privilege’ to refuse to produce essential documents,” the court said, “nor may it refuse to produce such documents in the absence of a refusal to respond to a request for information, knowing that it is under a duty to do so.”

The Eleventh Circuit has long recognized that courts may look past the plan documents, the court said, “and examine the ‘factual circumstances surrounding the administration of the plan, even if those factual circumstances contradict the designation in the plan document,’ to determine the entity acting as the true plan administrator.” The court identified the “crucial question” as “whether the asserted de facto plan administrator exercised ‘sufficient decisional control over the claim process’ to qualify as a plan administrator.”

Even though “[a]n insurance company does not become an ERISA ‘fiduciary’ simply by performing administrative functions and claims processing within a framework of rules established by an employer,” the court said, the complaint “pled sufficient facts, taken as true, to indicate that Hartford assumed sufficient claim-related duties and performed sufficient claim-related tasks with regard to [the] claim to act as de facto plan administrator, notwithstanding the terms of the plan documents.”

Therefore, the court dismissed the claim for a penalty as to Cott, but denied the motion to dismiss as to Hartford.

Denial of Disability Benefits Was De Novo Correct, Based on IME Report and Surveillance Videotape

Case No.: 1:07-CV-566-ODE

Ms. Tyrell, a former computer operations administrator, claimed to be totally disabled from her occupation due to cervical and lumbar radiculopathy following an automobile accident. Ms. Tyrell submitted a claim to Aetna for long term disability benefits under an employee welfare benefit plan, which was initially approved based on temporary restrictions and limitations assessed by her treating physician. According to the treating physician, Ms. Tyrell would be able to return to work in three months.

Approximately two months later, the treating physician’s assessment changed dramatically. The physician now
opined that Ms. Tyrell could not perform any of the activities she could previously perform occasionally, that her present capabilities were “none,” that her limitations were “all of them,” and that she would be unable to return to work for more than a year. Despite the alleged deterioration of Ms. Tyrell’s condition, the treating physician’s office notes indicated that her treatment was unchanged, and that her progress was the “same.”

Due to the change in the treating physician’s assessment and his inconsistent treatment notes, Aetna arranged for surveillance of Ms. Tyrell for three days. She was filmed driving, exiting and entering her vehicle “with ease,” carrying bags over her shoulder and under her arm, walking with a normal gait, and repeatedly reversing her car into a garage, which required twisting and turning of the head, and looking backward over the shoulder. The surveillance footage prompted Aetna to ask Ms. Tyrell to submit to an independent medical examination.

During the IME, Ms. Tyrell claimed that she was unable to drive, and that her ability to rotate her neck, walk, sit, and stand were limited. The IME physician examined Ms. Tyrell, and reviewed her medical records and the surveillance video. Although noting that Ms. Tyrell had “many subjective complaints,” the physician was “not able to find any positive findings.” The physician concluded that Ms. Tyrell was able to return to work with no restrictions except lifting more than 50 pounds. Aetna terminated Ms. Tyrell’s benefits after paying them for approximately eight months, and upheld that decision on appeal.

Ms. Tyrell brought suit under ERISA, and the parties submitted cross-motions for judgment after trial on the papers, pursuant to Fed. R. Civ. P. 52(a). The court reviewed Aetna’s benefits determination under the Eleventh Circuit’s five-step arbitrary and capricious standard, and allowed Ms. Tyrell to submit additional evidence from outside the administrative record. The court’s review focused on three categories of evidence.

First, the court evaluated the diagnostic evidence: (1) an EMG, which was normal and showed no electrodiagnostic evidence of radiculopathy; (2) a CT scan which showed a soft tissue mass and a prominent node, apparently unrelated to Ms. Tyrell’s accident; and (3) an MRI which, aside from mild disc bulge at L4-L6, was normal -- no disc herniation was noted. The court found “insufficient objective [diagnostic] evidence” to show that Ms. Tyrell was disabled.

Second, the court evaluated the physician opinions, and found (1) that Ms. Tyrell’s treating physician’s “dramatic” change in restrictions and limitations was unsupported by the medical records, which showed no change in treatment, despite the purported “significant regression in [Ms. Tyrell’s] health; and (2) that the opinions of the IME physician and Aetna’s in-house physician that Ms. Tyrell could perform “light work” were consistent with the diagnostic tests and other medical records.

Third, the court found that the surveillance video, which showed Ms. Tyrell “performing a wide variety of tasks” that the treating physician stated Tyrell “could never perform,” refuted the treating physician’s assessment of Ms. Tyrell.

Based on the administrative record, and taking into consideration the extra-record evidence submitted by Ms. Tyrell, the court found Aetna’s benefits decision to be “de novo correct” and not arbitrary and capricious.
Ms. Ward and other policyholders in South Carolina brought a class action, alleging that Dixie National and another defendant, National Foundation Life Insurance Company, breached supplemental cancer insurance policies that required the payment of “actual charges” for cancer treatments.

The policies did not define “actual charges.” As “supplemental” insurance, the policies required the insurers to make payments directly to their policyholders, not to medical providers. Many of the insureds had both primary health insurance and the supplemental cancer policies.

Plaintiffs contended that the phrase “actual charges” meant the full amount a medical provider billed patients for its services. Dixie National and National Foundation Life argued that it meant the lesser negotiated amount a medical provider received and accepted as payment from insurers for its services.

When National Foundation first began issuing the supplemental cancer policies, it paid the full “list price” of healthcare services. Around 2002, National Foundation changed its payment practice, and began basing “actual charges” on the lesser payment medical providers received.

After the district court certified a statewide class of plaintiffs, both parties filed motions for summary judgment to resolve the meaning of the phrase “actual charges.” The district court granted the motion of Dixie National and National Foundation.

Plaintiffs appealed, and the Fourth Circuit held in 2007 that the phrase was “patently ambiguous,” and that under South Carolina law, the ambiguity had to be resolved in favor of the insureds. The case was remanded to the district court with instructions to enter judgment in favor of plaintiffs on their breach of contract claim, which amounted to about $8 million. *Ward v. Dixie Nat’l Life Ins. Co.*, 257 Fed.Appx. 620 (4th Cir. 2007).

Before the district court could follow the appellate court’s instructions on remand, the South Carolina legislature enacted S.C. Code Ann. § 38-71-242, which defined “actual charges” to mean “the amount a medical provider accepts as payment-in-full for its medical services, whether by pre-negotiated agreement with a third-party insurer or by operation of law in the case of Medicare.”

The insurers then moved for judgment on the pleadings, arguing that the new statute prohibited them from paying “actual charges” as defined by the Fourth Circuit. The district court denied the motion, however, holding that the statute did not apply retroactively to the claims of the plaintiff class.

On another appeal, the Fourth Circuit affirmed the district court, holding (1) that in view of South Carolina’s “robust presumption against statutory retroactivity,” the new definition of “actual charges” applied only prospectively, and (2) that the district court did not err in certifying the class of statewide plaintiffs.
Johnson was insured under a group disability policy issued by Unum Life Insurance Company of America as part of an ERISA plan.

In 1999, Johnson submitted a claim for long-term disability benefits under the plan. Unum denied the claim, and Johnson appealed three times. Unum upheld the denial each time, the last occasion being by letter in March 2001.

Several years later, Unum notified Johnson that his claim was eligible for reassessment under a Regulatory Settlement Agreement between Unum and state insurance regulators. Johnson returned a form, indicating that he wanted to have his claim reassessed, but he never completed a form to supply the information necessary for reassessment. In May 2006, Unum informed Johnson that no further action would be taken.

Johnson sued Unum in federal court in October 2008, asserting five state law claims and a claim to recover benefits under ERISA. Unum moved for summary judgment, which the district court granted.

The court held that ERISA preempted Johnson’s state law claims for breach of contract (based on Unum’s alleged failure to reassess his claim), for equitable estoppel, and for restitution to recover premiums paid. The district court held that the remaining state law claims – for breach of the covenant of good faith and fair dealing and for willful and/or wanton misconduct – were not preempted, but were time-barred by the Alabama statute of limitation. Finally, the court held that Johnson’s claim for benefits under ERISA also was time-barred.

On appeal, the Eleventh Circuit agreed that the breach of contract, equitable estoppel, and restitution claims were preempted by ERISA. The court did not decide whether ERISA preempted the claims for breach of the covenant of good faith and fair dealing and for willful and/or wanton misconduct, but held that they were tort claims barred by Alabama’s two-year statute of limitation, Ala. Code § 6-2-38. Those claims accrued in May 2006 when Unum declined to take any further action on the request for reassessment, and the complaint was filed more than two years later in October 2008.

As for the ERISA benefits claim, the court noted that “ERISA does not provide its own statute of limitation,” and that “[c]ourts either borrow a closely analogous state limitations period, or they apply a contractually agreed upon period, provided it is reasonable.” The group policy issued by Unum provided a three-year limitations period, which the court said was reasonable.

The Eleventh Circuit held that Johnson’s ERISA claim for benefits accrued no later than March 2001, after the third and final decision on appeal, and that the three-year limitation period expired in March 2004, more than four years before he filed suit. Consequently, the district court’s order granting summary judgment to Unum on all claims was affirmed.
ERISA and Life Insurance Litigation

Smith Moore Leatherwood’s ERISA and Life Insurance Litigation Team has earned a national reputation for excellence. The Team is comprised of attorneys who have represented ERISA entities and insurers in hundreds of cases in federal and state courts throughout the nation. In addition to claims brought under ERISA, the firm’s attorneys defend a broad variety of actions, including those brought under federal and state RICO Acts, the ADA, class actions, discriminatory underwriting claims, actions involving allegations of agent misconduct, and breach of contract claims for the recovery of life, accidental death, disability, and health insurance benefits.