



# GOLDBERG SEGALLA <sup>LLP</sup>

## Life, Health, Disability and ERISA Quarterly

A national life, health, disability and ERISA newsletter

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*Life, Health, Disability and ERISA Quarterly* provides a summary of decisions from across the country concerning life, health and disability policies, including those governed by ERISA. The publication is distributed quarterly via e-mail. Cases are organized by Circuits, plus a section mentioning federal district court and state court decisions. Hyperlinks are included providing recipients with direct access to the full decision. In addition, we provide the latest information regarding news in regarding life, health and disability coverage and ERISA plans. We appreciate your interest in our publication, and welcome your feedback. We also encourage you to share the publication with your colleagues. If others in your organization are interested in receiving the publication, if you wish to receive it by regular mail, or if you would like to be removed from the distribution list, please contact [Kimberly E. Whistler](#).

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## PUBLISHED CIRCUIT CASES

### A. FIRST CIRCUIT

#### [RICHARDS v. HEWLETT-PACKARD CORP.](#)

(1<sup>st</sup> Cir. (Mass.) January 19, 2010)

#### **Denial of Benefits Upheld Despite SSA Findings and Treating Physician's Opinion**

Plaintiff, Edward Richards, sought long term disability benefits based upon a diagnosis of fibromyalgia and chronic fatigue syndrome. After obtaining an independent medical examination ("IME"), the insurer concluded Richards was not physically impaired from performing the functions of a sedentary job, and denied disability benefits. On appeal, Richards argued the reviewing physician was unqualified and failed to consider the decision of an administrative law judge who awarded Social Security benefits. In addition, he provided the report of Dr. Hryniewicz who opined his fibromyalgia left him chronically disabled. In response to continuing appeals, the insurer retained medical experts to conduct records reviews resulting in the same conclusions and, accordingly, upheld its decision.

In suit, Richards argued it was an error by the insurer not to grant any weight to the opinions of his treating physician or the determination of the Social Security Administration. Initially, the court concluded that the record revealed that Dr. Hryniewicz's opinion was considered by the reviewing physicians. The court characterized the plaintiff's argument as essentially contending that Dr. Hryniewicz's opinion should have been given controlling weight.

The court found that the treating physician provided a "shaky" foundation for the claimant's symptoms, contained contradictions as to claimant's work prospects, and the records from 2001 through 2005 contained no reference to a disability resulting from fibromyalgia. As such, the court rejected plaintiff's argument regarding the adequacy of weight given to Dr. Hryniewicz's opinions.

With respect to the determination of the Social Security Administration, the court again noted that the decision and rationale were a part of the record and were indeed considered by the administrator. The court stated that determinations by the Social Security Administration are not binding on disability insurers. It also noted that the administrative decision found Richards retained capacity for less than a full range of sedentary work. Given that the policy required that he be disabled from all sedentary work, the Social Security Administration decision did not bolster his case. The decision denying benefits was affirmed.

**Impact:** What is consistently coming from these cases is the necessity that a claims administrator's have sufficient evidence to support the divergence from a treating physician's opinion or a SSA determination. Often the determinations were not based on the same evidence or the same standard or are simply not supported by the totality of evidence. While contrary findings may occur, they should be affirmatively addressed in order to support the denial.

**CUSSON v. LIBERTY LIFE ASSURANCE COMPANY OF BOSTON**

**(1<sup>st</sup> Cir. (Mass), January 14, 2010)**

**Denial of Benefits Affirmed Where Evidence Did not Support Impairment**

The action was commenced after Donna Cusson's long-term disability benefits were terminated. Cusson was initially diagnosed and treated for breast cancer, receiving benefits based on pain and fatigue caused by the chemotherapy. After the chemotherapy ended in 2002, she continued to feel the same symptoms, ultimately leading to a diagnosis of fibromyalgia in 2003.

In describing her limitations, Cusson's treating physician stated she could not lift more than ten pounds twice a day; could sit for four hours per day but needed to stand up every fifteen minutes; could stand for up to one hour but needed to sit every five to ten minutes; and, could walk for an hour, but needed to rest every few minutes. He concluded that she could not work a full eight-hour day until her pain and fatigue subsided. The insurer conducted a number of rounds of surveillance, revealing her engaging in "normal activities," including walking her dog, driving, shopping and placing a large bag of kitty litter into her car. A subsequent questionnaire by Cusson and her doctor reiterated the prior limitations. After review of her file, the insurer terminated benefits.

The plaintiff argued certain flaws existed in how the claim was handled, which proved the insurer was influenced by the conflict of interest. First, she argued that the insurer improperly relied upon the report regarding the video surveillance. Second, she contended the reviewing doctors were biased against patients with fibromyalgia, stating the experts had a preconceived notion that fibromyalgia could *never* be a disabling diagnosis. Finally, the plaintiff maintained that reliance on "record reviews," as opposed to physical reviews, in the context of fibromyalgia, is improper and was influenced the insurer's conflict of interest.

The court rejected the plaintiff's contentions. With respect to the surveillance evidence, the court noted that the insurer did not simply rely on the *amount* of activity observed, but also on the *nature* of the activity observed. Further, while the court agreed it would be inappropriate for the reviewing experts to generalize statements with respect to a disabling diagnosis, the reality is they did not. In fact, both doctors' reports indicated they reviewed the surveillance footage and based their conclusions on the apparent contradiction between the footage and claimant's reported impairments. Finally, the court stated that the insurer did not question the diagnosis, but instead questioned the effect on the plaintiff. The court held that it was perfectly permissible for the insurer to rely on a record review.

Notably, the court also stated, "the fact that Liberty's reviewers were paid for their reports does not, by itself, lead us to believe that Liberty was influenced by its conflict, since the claimant has provided no evidence that Liberty retained its reviewers specifically because they have a record of denying claims." In the end, the court affirmed the denial of benefits.

**Impact:** Most notably from this case is the scrutinizing of the basis of the reviewing experts' positions. Moreover, where a conflict exists, a claimant can seek additional discovery to demonstrate whether a claim determination was biased, including relationships with the experts whose reports were relied upon in denying a claim. Insurers, therefore, should continue to exercise care in the experts they retain during the review process to minimize the appearance of any bias.

## B. THIRD CIRCUIT

### BARINOVA v. ING

(3<sup>rd</sup> Cir. (N.J.), February 4, 2010)

#### **Claimant not Actively Working When on Administrative Leave and not Receiving Appropriate Care When on FMLA Leave.**

The Plaintiff, Helena Barinova, commenced an action against ING and ReliaStar Insurance Company under ERISA alleging her denial of long-term disability benefits was improper. Barinova was employed as a research scientist for over twelve years when, in May 2004, she was placed on administrative leave for alleged insubordination and disregard of company policy. Shortly thereafter, she went to a psychiatrist who diagnosed her with a “major depressive disorder,” which required weekly treatment. Barinova applied for FMLA, which was approved through September 2004. While on leave, her treatment consisted of a few follow-up conversations with her psychiatrist and being prescribed medication. In October, she began more extensive treatment with a different psychiatrist. She was ultimately terminated in December 2004.

In January 2005, Barinova applied for long-term disability benefits, which were denied. Pursuant to the terms of the policy, to be eligible for disability, a claimant must be “actively at work,” meaning “physically present.” In addition, the employee must receive “regular and appropriate care.” ReliaStar made a separate determinations during her alleged time of disability. Specifically, the insurer found: prior to September 2004, Barinova was actively at work, but not receiving appropriate care; from September through October 2004, she was neither active at work nor receiving appropriate care; and, after that, she was receiving appropriate care, but not active at work.

ReliaStar had a board-certified psychiatrist review Barinova’s file, who determined she was not receiving regular and appropriate care before September 2004. Barinova argued that, prior to her termination, she was actively at work and that, by October 2004, she was receiving regular and appropriate care. In addition, she argued that prior to October 2004, there was an issue of fact regarding her care, making summary judgment inappropriate.

Rejecting Barinova’s arguments, the court upheld the denial of benefits. First, the court held that it was not an abuse of discretion to interpret the policy to exclude employees from coverage who are on administrative leave, as the terms require the participant to be physically present, except when on FMLA leave. In addition, the court found that Barinova did not offer sufficient evidence to demonstrate that she was receiving “regular and appropriate care” prior to October 2004.

**Impact:** The case emphasizes the importance of understanding a claimant’s employment status at the time of claim, as well as understanding

## C. FIFTH CIRCUIT

### SCHEXNAYDER v. HARTFORD LIFE AND ACCIDENT INS. CO.

(5<sup>TH</sup> Cir. (La.), March 12, 2010)

#### **Court Finds Abuse of Discretion, but Does Not Award Attorneys' Fees**

In 2003, plaintiff had back surgery, which he claims caused recurrent pain in his back and extremities, rendering him partially disabled. The insurer paid the initial twenty-four months in disability for which he was unable to perform his regular occupation. Benefits were later extended until January 2006, when the insurer determined the medical evidence was insufficient to support that plaintiff was unable to perform any occupation.

Pursuant to the plan, the insurer had sole discretionary authority to determine benefit eligibility. In applying the Supreme Court's decision in *Met. Life Ins. v. Glenn*, 128 S.Ct. 2343 (2008), the court indicated that it would give more weight to the conflict of interest arising from the dual role of an administrator determining eligibility as well as paying for benefits where the decision "suggests procedural unreasonableness." Specifically, the court noted that the insurer did not take precautions to avoid the conflict or impose management checks. In addition, the court stated that "failure to address a contrary SSA award can suggest such perceived unreasonableness in the administrator's decision."

While the court acknowledged that substantial evidence existed supporting the insurer's decision, the conflict of interest and the failure to address the SSA award was a tiebreaker. As a result, it was determined that the insurer abused its discretion in its benefit determination. With respect to attorneys' fees, the court held that the district court abused its discretion in awarding attorneys fees as there was no evidence that the insurer acted in bad faith.

**Impact:** Insurers should take due caution to systems that minimize perceived conflicts of interest it has when it both determines and funds claims. With such safeguards in place, insurers can attempt to protect their benefit determinations from being reversed based on such conflicts.

## D. SIXTH CIRCUIT

### BALMERT v. RELIANCE STANDARD LIFE INSURANCE COMPANY

(6<sup>th</sup> Cir. (Ohio), February 5, 2010)

#### **Participant had a Full and Fair Review of the Long-Term Disability Claim and the Determination was not Arbitrary and Capricious**

Balmert stopped working in August 2004 because of symptoms stemming from her rheumatoid arthritis. She consulted with a rheumatologist, Kevin V. Hackshaw, M.D., who determined her symptoms were disproportionate to the amount of synovitis (inflammation in the joints) that he could see. Dr. Hackshaw put Balmert on medical leave pending additional evaluations and recommendations, including from a neurologist and a psychologist. In subsequent evaluations in October 2004, February 2005 and May 2005, Dr. Hackshaw found no active synovitis and reported that she was doing well.

Balmert applied for long-term disability benefits in February 2005, which were denied in June 2005. The insurer stated that there was insufficient documentation to support her claim that her physical condition precluded her from performing the material duties of her own occupation. On appeal, Balmert provided additional documents, including a modified Functional Capacity Evaluation (“FCE”) conducted on March 15, 2006, whereby the physical therapist stated he did not believe she should work. After reviewing the FCE, in a letter dated July 25, 2006, Dr. Hackshaw agreed with the findings and said he “would agree her condition was the same at that time as it is now.”

Reliance had Balmert evaluated by an independent medical examiner, Dr. Marvin Thomas. Dr. Thomas found little evidence of active disease and found her able to work. Dr. Thomas supplemented his report based on additional records that “initially” it would have been difficult for Balmert to work. As a result, the insurer determined she was unable to perform her own occupation from the closed period of August 2004 through September 2006.

Balmert argued that she did not receive a full and fair review. Further, she maintained her appeal was administratively unfair because the insurer’s final determination was for reasons outside the initial determination, and she did not have an opportunity to respond to the IME report. The court disagreed finding her benefits were initially denied based on lack of evidence, which was the same basis for denying continuing her benefits. In addition, the court held Balmert’s failure to rebut Dr. Thomas’s medical opinion was a result of her failure to fully exercise her procedural rights, which did not render the appeal procedurally defective.

With respect to the benefits determination, the court found the insurer’s reliance on the IME report was “more credible” than the “ambiguous statement of agreement” of Dr. Hackshaw regarding the FCE. The court was satisfied that Reliance did not disregard the treating physician’s opinion and that there was no evidence of bias with respect to Dr. Thomas. In the end, the court held there was substantial evidence to support the denial of long-term disability benefits.

**Impact:** This is another case that demonstrates the benefit of a complete administrative record contains sufficient evidence to support a denial of benefits, especially when it is contrary to the claimant’s treating physician. This case is currently scheduled to be argued before the United States Supreme Court and will receive further comment in our next issue.

### **HALL v. LIBERTY LIFE ASSURANCE CO. OF BOSTON**

**(6<sup>th</sup> Cir. (OH), February 8, 2010)**

#### **Long-term Benefits Terminated Where Participant was Found Able to Perform Job**

After receiving long-term disability benefits for nearly five years, the third-party claims administrator, Liberty Life Assurance Co. of Boston, terminated plaintiff’s benefits after finding she was no longer totally disabled. In addition, the Welfare Benefits Plan sought reimbursement for overpayments triggered by retroactive Social Security benefits she was subsequently awarded. The district court held the administrator’s decision was not arbitrary and capricious and imposed an equitable lien on Social Security benefits to allow reimbursement to the Plan for overpayment. The lower court, however, denied the Plan’s request for attorneys’ fees.

The circuit court held the termination of Sonya Hall’s disability benefits was not arbitrary and capricious. In addition, it found the Plan was entitled to partial reimbursement, however, it could

not obtain an equitable lien on her Social Security benefits. The circuit court remanded reconsideration of whether the insurer was entitled to attorney-fees.

Hall received long-term disability payments following spinal fusion surgery. At that time, Liberty informed her that she was required to apply for Social Security benefits and that her continued eligibility was predicated on certification of her disability. In June 2003, Hall underwent an IME whereby the physician found she remained disabled, but might be able to return to work in the future. During a subsequent re-evaluation, in 2005, Liberty had a board-certified doctor in physical medicine, as well as one certified in psychiatry and neurology, review Hall's medical records. Both found she was able to perform her job duties. In addition, a skills analysis from a vocational expert indicated she could perform the duties of several occupations.

Liberty concluded that Hall was no longer "totally disabled" under the terms of the policy and terminated her benefits in May 2006. Hall appealed the decision. Liberty had her claim reviewed by an independent medical panel and subsequently upheld its determination. While the court noted two inaccuracies in the district court's opinion, its decision was affirmed. With respect to reimbursement, the court agreed that the Plan was entitled to reimbursement due to the retroactive receipt of Social Security benefits, but noted that an equitable lien on such benefits was prohibited by 42 U.S.C. §407(a).

With respect to attorneys' fees, the district court criticized the plaintiff's attorney, yet declined to award attorneys' fees to the Plan "given Plaintiff's purported financial situation." The court remanded the issue of attorney's fees back to the district court stating that the financial situation of a plaintiff is not a sufficient basis to deny attorneys' fees, where they would otherwise be appropriate. The court further noted that attorneys fees are imposed on the parties' attorneys and not the parties themselves, pursuant to 28 U.S.C. §1927.

**Impact:** The association between disability and Social Security benefits continues to be a theme relating to disability benefits. Here, the issue was the rights an insurer has and the means by which it can claim rights over Social Security payments. While federal law does not allow a lien on Social Security benefits, the court stated that the plan could impose a constructive trust or equitable lien on a particular fund, outside of the insured's general assets.

## **E. EIGHTH CIRCUIT**

### **W.T. PAINE v. JEFFERSON NATIONAL LIFE INSURANCE COMPANY**

**(8<sup>th</sup> Cir., (Ar.), January 11, 2010)**

#### **Statute of Limitations not Tolled Where no Evidence of Fraudulent Concealment**

Plaintiff appeals dismissal of his claims on the ground that the claims are barred by the applicable statute of limitations and denied his motion to file an amended complaint.

W.T. Paine purchased 15 single-premium life insurance policies. In doing so, he was told he could borrow money against the policies' interest earnings, so long as the loans did not exceed the guaranteed interest earned and it would not impact the cash value or death benefits. The policies also stated that the loans would be subtracted from the cash value of death benefits of the respective policy prior to payment.

Thereafter, Paine borrowed against the policies and deducted cost-of-insurance charges from the cash values, reducing the interest payable and causing the loans to draw on the given policy's principal. At one point, Paine surrendered two policies for cash. Two years later, in 2002, when he received loan checks, there was a restrictive endorsement stating the policies were security for the loans and interest.

In 2007, Paine brought a state court action alleging breach of contract, deceptive acts and intentional infliction of emotional distress. After the insurers removed the action to federal court, Paine moved to amend his complaint to add claims for bad faith and fraudulent misrepresentation, while the insurer moved for summary judgment. The district court granted the insurer's summary judgment motion on the grounds that the statute of limitations had run and denied the motion to amend the complaint as futile.

Under a *de novo* review and under Arkansas law, the court held that the plaintiff failed to demonstrate the statute should be tolled, affirming the district court's decision. The court found for a statute of limitations to be tolled based on fraudulent concealment, there must be evidence that there was a positive act of fraud, which was concealed and not discoverable by reasonable diligence.

The court held Paine's receipt of letters and annual statements, as well as repeated representations by the insurer that the cost-of-insurance and loans would be applied against the principal, the insurer did not attempt to conceal information from Paine. And, despite that the restrictive endorsement made for the first time in 2002, it complied with the terms of the policies.

**Impact:** Fraudulent concealment was not found because the insured was unable to demonstrate any positive act of fraud. The court looked at the language in the policies and subsequent statements sent to the Paine were consistent with the restrictive endorsement. The insured bore some responsibility to exercise reasonable diligence in knowing the impact of his actions on the policy benefits.

**DARVELL v. LIFE INSURANCE COMPANY OF NORTH AMERICA**  
**(8<sup>th</sup> Cir., (Minn.), March 10, 2010)**

**Administrator's Interpretation of "Regular Occupation" found Reasonable**

Insurer was granted summary judgment by the district court finding.

In May 2003, the plaintiff, Jerry Darvell, worked as an account representative. His job included in-person sales calls, requiring him to carry papers weighing approximately 35 pounds. He claims he is disabled due to three conditions: reflex sympathetic dystrophy, osteoarthritis in both shoulders and depression.

In October 2004, Darvell alleged his symptoms worsened and followed up with his rheumatologist, Dr. Raymond Haush, and his orthopedic surgeon, Dr. Thomas Kaiser. Diagnostic tests revealed progressive osteoarthritis in both shoulders and osteophyte formation in the right shoulder. As a result, both doctors restricted him to sedentary work, including lifting up to ten pounds and occasional walking and standing. In addition, plaintiff's family practitioner, Dr. Douglas Johnson,

stated that Darvell's depression attributed to his disability and prescribed an antidepressant. On or about March 4, 2005, Dr. Johnson rendered Davell unable to work.

Plaintiff claims he is disabled as he cannot drive, walk or carry the load required by his position and Davell received short-term disability benefits. On October 21, 2005, Darvell was denied long-term benefits based on findings that his symptoms were similar to those he had experienced for years. In addition, the documentation did not support sufficient physical limitations or that he was unable to perform the material duties of his regular occupation as defined by the Department of Labor's Dictionary of Occupational Titles ("DOT").

In reviewing the claim determination, the court held it was not an abuse of discretion to disregard medical evidence by a physician where no reliable or objective evidence was provided. Moreover, the court rejected plaintiff's argument that the insurer abused its discretion in relying on the DOT description of his occupation and not the specific activities performed by Davell. The court held the phrase "material duties of his...regular occupation" can reasonably be interpreted to refer to his generic, rather than specific, occupation.

Affirming the district court's decision, the court held that the Plan gave the insurer discretion to interpret the terms of the policy entitling its decision to be a heightened standard of review. Additionally, because the job description in the record and the DOT's description were consistent, it was not an abuse of discretion to deny his claim for long-term disability benefits.

**Impact:** While every word or phrase in a policy can change the outcome of a claim determination, it is incumbent on any insurer to make sure the information in the administrative record reasonably supports the claim determination. The Eighth Circuit, here, held that because "regular occupation" was not defined, the administrator's interpretation included duties not normally performed by the participant was reasonable because of job description and the DOT's description. The circuits, however, are split, even under an abuse of discretion standard, on whether such an interpretation is reasonable under the same language.

**JONES v. UNUM PROVIDENT CORPORATION**  
**(8<sup>th</sup> Cir. (Minn.), March 1, 2010)**

**Pre-Existing Condition Limitation in Prior Group Insurer's Policy Applied to Deny Benefits**

A disability insurance carrier denied coverage based on the Plan's pre-existing condition clause. The dispute was whether the prior carrier's plan would have been paid if it had remained in force.

In January 2004, Carol Jones was hospitalized for depression and stopped working as a legal secretary and, after the qualifying period, received long-term disability payments. In June 2004, her psychiatrist cleared her to work, to which Jones disagreed and sought a different psychiatrist. Fortis Benefits Insurance Company ("Fortis"), who was the disability insurer at that time, suspended her benefits pending additional medical information. Her initial psychiatrist released her to work part-time in June and full time in the end of July.

Jones returned to work part-time in June 2008, stopped working on July 15<sup>th</sup> and found a psychiatrist to support her claim for continuing disability. Fortis told Jones that it was denying her claim after June 7<sup>th</sup> because she did not satisfy the test of disability in the policy. She did not appeal

Fortis' decision and returned to work part-time on September 2004 and full time the following month.

In January 2005, the long-term disability insurer was changed to an affiliate of Unum Provident Corporation ("Unum"). In February 2005, Jones again stopped working due to an infected dog scratch and later filed a long-term disability claim alleging a recurrence of her major depression. Unum denied her claim based on the pre-existing condition clause stating that she received psychiatric treatment within three months of the policy and that Fortis' policy would not have provided benefits if it had still been enforced.

The court agreed with the insurer in that the prior policy lapsed when the participant stopped working full-time after her benefits were denied, regardless of the fact she resumed working full-time a few months later. The court held that when the plaintiff quit work, contrary to her physician releasing her to work full-time, she was no longer a full-time employee and no longer eligible for benefits. The court further stated that the plaintiff failed to provide evidence that her employer had requested continued coverage during the time she was not working.

**Impact:** The employment status and the medical condition of an individual must be considered together and compared to the terms and conditions of a policy and sometimes, as in this case, to the preceding policy. Here, there was no evidence that the plaintiff had ensured continuing coverage or was eligible for coverage, which would have eliminated the applicability of the pre-existing condition clause.

**JOBE v. MEDICAL LIFE INSURANCE COMPANY**  
**(8th Cir., March 19, 2010)**

**Discretionary Authority not Given Despite SPD Language**

The issue before the circuit court was whether discretionary language included in the summary plan description ("SPD"), but not in the actual policy, prevailed. Plaintiff argued because the plan itself did not vest the plan administrator with discretionary authority, the District Court erred in reviewing the benefit determination under an abuse of discretion standard.

The insurer argued that language in the SPD prevails as previously stated by the Eight Circuit in *Admin. Comm. Of the Wal-Mart Stores, Inc. v. Gamboa*, 479 F.3d 538, 542 (8<sup>th</sup> Cir. 2007). There, the court held that the SPD language was enforceable where the beneficiary was granted certain rights or privileges not included in the policy. The insurer argued that this holding should be applied to discretionary language in the SPD. The court distinguished its prior holding from the instant case on two grounds: (1) there was no underlying policy as in this case; and (2) the employee was attempting to rely on the SPD for benefits, but disregard it with respect to the plan administrator's rights. Here, application of the subject language in the SPD would be for the sole benefit of the administrator.

Stating this was a case of first impression before the Eight Circuit, the court notes that other circuits which have addressed the same issue have not done so uniformly. It joins prior holdings of the Seventh, Ninth and Eleventh Circuits, stating "the implication of §1022 is that the [SPD] will be an accurate summary, not an unnegotiated enlargement of the administrator's authority." The court further stated that a contrary ruling would allow the practice of keeping policies silent on key

provisions and insert favorable terms to the employer via the SPD. Moreover, the court found that the average plan participant would read the provision in the SPD stating it does not accrue any rights to mean the policy would prevail where a conflict exists.

Because the actual policy did not grant discretion, the court held that the determination regarding the participant's eligibility for benefits should have been reviewed *de novo*, not under an abuse of discretion standard. The district court's judgment was reversed and remanded.

**Impact:** The purpose of including the terms in a SPD, not included in the policy, will be assessed on the benefits sought. The court's decision was clear in that its inclusion of SPD terms could not be used solely for the benefit of the employer; as opposed to clarifying or including benefits that the insured reasonably understood he/she was entitled to.

### **COUNTRY LIFE INSURANCE COMPANY v. MARKS**

**(8<sup>th</sup> Cir. (Mo.) January 27, 2010)**

#### **Issue of Fact Existed Regarding Insurable Interest for Family Friend**

The insurer commenced a declaratory judgment action to void a life insurance policy based on the grounds that the owners/beneficiaries did not have an insurable interest in the life of the insured. Reversing the district court's grant of summary judgment in favor of the insurer, the court found a material issue of fact regarding whether there was a pecuniary interest between the owners and the insured.

The insured, Connie Romig was a close family friend of John Marks. While she was not related by blood, he would often refer to her as his Aunt. Marks and his wife Debbie had three children, including one who suffers from a serious nerve disorder. As a result, the Markses incurred significant medical and travel expenses. During this time, the Marks's relationship with Romig continued to strengthen. She supported the family financially and personally. She would often buy their groceries, occasionally paid their rent, and helped with John's automobile business. Romig never asked the family for reimbursement or compensation.

After Romig's husband passed away, she obtained life insurance naming the Markses as beneficiaries. She originally obtained life insurance from Auto-Owners Insurance and then was issued a policy from Country Life, naming the Markses as both owners and beneficiaries of the policy to which they paid the premiums. Approximately seven months later, Romig passed away.

Both Auto-Owners and Country Life denied the Marks's claims for death benefits asserting that they did not have an insurable interest in Romig's life and refunded the premiums. The district court granted summary judgment on both insurers' motions. Thereafter, Auto-Owners settled the claim.

The Eighth Circuit reviewed the district court's decision *de novo* and under Missouri law. Unlike a situation where an insured owns the policy and pays for the premium, where the owners are also the beneficiaries, the court held that the Markses must prove there was an insurable interest in Romig's life. Where there is no blood or marriage relationship, an insurable interest can be established based on a pecuniary relationship in that there is a reasonable probability the beneficiary would benefit by the insured staying alive.

Viewing the evidence most favorable to the Marks, the court held that both the financial support and additional services Romig offered the Marks, over almost a decade, created an issue of material fact with respect to whether there was a pecuniary relationship between Romig and the Marks. The court reversed and remanded.

**Impact:** With greater attention to STOLI policies, insurers are heavily scrutinizing whether an insurable interest exists between the insured and the beneficiary, which this case exemplifies. The facts in the decision demonstrate that the insured and the beneficiaries were not strangers and, in fact, had a close relationship, yet the insurers found this relationship insufficient. Notably, in a footnote, the insurer raised a separate issue regarding a misrepresentation made in the application in that the Marks listed themselves as Romig's niece and nephew-in-law. The court noted that this alone does not create an insurable interest, but left it for the district court on remand to determine whether that representation was material.

## F. ELEVENTH CIRCUIT

### CAPONE v. AETNA LIFE INSURANCE COMPANY

(11<sup>th</sup> Cir. (Ga.), January 5, 2010)

#### **Insurer's Investigation Regarding the Accident and Alcohol Exclusion were Found Insufficient**

Insured appeals the district court's decision granting summary judgment in favor of Aetna Life Insurance Company ("Aetna") arguing it misapplied the accidental means and alcohol exclusions.

Plaintiff suffered permanent quadriplegia when he dove off a dock and struck his head on the bottom of the ocean. As a result, he sought benefits under the Accidental Death and Personal Loss provision of his employee health insurance policy. At the time of the accident, James Capone was attending an employee training and incentive program in the Bahamas. Along with other guests, Capone first dove off a dock without incident, but sustained injuries on his second dive. The hospital performed a blood serum test, which the insurer asserted demonstrated a blood alcohol content ("BAC") of 0.244.

The insurer denied coverage, applying the accidental means and alcohol exclusion provisions. Specifically, Aetna argued that Capone voluntarily dove from the dock, intentionally exposing himself to the foreseeable risks and, therefore, his injuries did not arise from an "accident" as defined in the policy. Second, Aetna argued that, even if it were an accident, his injuries were "caused or continued to by the use of alcohol."

In opposition, Capone submitted evidence, both through pictures and depositions, contradicting the insurer's assertions that there were "no diving" signs or that the dock was approximately fifteen feet above the water. Instead, he argued that jumping from the dock was common practice and that the signs were not up at the time of his injuries. In addition, plaintiff challenged both the accuracy and reliability of the toxicology report.

Under a *de novo* standard of review and under Georgia law, the court first determined that the term "accident" in the policy refers to "accidental means," in that the focus is on the occurrence, as

opposed to the results. The court continued, however, stating that when something unforeseen occurs while doing the intentional act, coverage is triggered for the death or injury from the accident.

The court held the plaintiff met his burden of making a *prima facie* showing that an unforeseen event, such as wave, caused or contributed to his injuries, which was supported by the evidence that it was common practice to jump off the dock without resulting injuries. In addition, the court held that Aetna failed to properly investigate the changing depths of water due to tides, the dock height or to contact guests who may have been witnesses to the incident. The court held that the denial of benefits was “*de novo* wrong.”

With respect to the alcohol exclusion, the court held that even if it were reasonable to determine that Capone was intoxicated, it was unreasonable to conclude that was the cause of his injuries. Again the court found Capone met his burden and Aetna failed to sufficiently rebut by failing to conduct a diligent investigation. Moreover, the court found that the evidence was insufficient to find that Capone’s alcohol consumption caused or contributed to the accident and resulting injury.

**Impact:** This case exemplifies the need for a thorough investigation and administrative record that properly reflects that investigation.

### **STATE AND DISTRICT COURT CASES**

#### **NAZARETYAN V. CALIFORNIA PHYSICIAN’S SERVICE**

**(Ca. App., March 23, 2010)**

#### **Summary Judgment Denied for Health Care Insurance Plan to Rescind Policy**

Two immigrants, who spoke broken English, failed to disclose the wife’s IVF treatments in an application to obtain health coverage. The court held that the health care service plan failed to satisfy the two conditions necessary to rescind a plan based on a material misrepresentation in the application: (1) the plan completed a medical underwriting before issuing the plan; (2) demonstrate the subscribers willfully made material misrepresentation in the application. Summary judgment to rescind the policy was denied.

#### **KRUEGER V. TIPPETT**

**(Wa. App., March 18, 2010)**

#### **Assignee Entitled to Life Insurance Proceeds Over Beneficiary**

Husband and wife borrowed money from the defendant, assigning the rights of a life insurance policy to the lender. The wife died and the husband was remarried. After the husband’s death, the new wife sued claiming the debt was unenforceable and she was entitled to the proceeds. The court held that proceeds were legally assigned the defendant.

**DYER v. HILL SERVICES PLUMBING AND HVAC**

**(Ct. App. Tenn., January 7, 2010)**

**Employer Failed to Properly Notify Insured of Right of Conversion**

Plaintiff argues employer was negligent in failing to notify him of his right of conversion of his life insurance policy at the time he was terminated and not obtaining a new life insurance policy upon being rehired. The court held that the policy clearly required notice of his right to convert, which the employer breached. Questions remained, however, regarding whether the employer breached a duty to reinstate the policy after he was rehired.

**FIDELITY NATIONAL TITLE INS. CO v. REGENT ABSTRACT SERVICE, LTD.**

**(N.Y.A.D., 1<sup>st</sup> Dept., February 9, 2010)**

**Life Policy was not Reinstated Where Past Due Premiums Paid After Death**

A life insurance policy expressly stated that in order for the policy to be reinsured, the insured must be living at the time the past due premiums were paid. Where the insured died three days prior to receipt of past due payments, the court held the policy had lapsed and was not properly reinstated before the decedent's death.

**NIETO V. BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INS. CO.**

**(Cal. App., January 19, 2010)**

**Insurer Entitled to Rescind Policy**

The court held that plaintiff made material misrepresentations and omissions regarding her medical history by failing to disclose chronic back problems, medications she took for them, multiple visits to two doctors, and when she was previously advised that misrepresentations could result in policy's termination.

**BILEZIKJIAN V. UNUM LIFE INS. CO. OF AMERICA**

**(C.D. Cal. January 25, 2010)**

**Plaintiff's Disability Is Not an "Accidental Bodily Injury"**

Plaintiff's disability income insurance provides for coverage of a disability that results from "accidental bodily injury" occurring during the policy period. The court granted judgment in favor of the insurer because plaintiff's carpal tunnel syndrome resulting from performing "big-bone" orthopedic surgeries for many years does not constitute "accidental bodily injury".

**UQUILLAS V. UNUM LIFE INS. CO. OF AMERICA**

**(C.D. Cal. January 21, 2010)**

**Insurer's Termination of Benefits Upheld**

The insurer's termination of plaintiff's long-term disability benefits was not an abuse of discretion because the insurer considered the spectrum of available medical evidence and reached a conclusion that was supported by substantial evidence. The court held that the insurer's decision did not conflict with the plain language of the plan and was not based on clearly erroneous findings of fact.

### **STONE V. BAYER CORP. LONG TERM DISABILITY PLAN**

**(D. Ore. January 15, 2010)**

#### **Insurer's Influence on Plaintiff's Social Security Claim Leads to Abuse of Discretion**

The insurer encouraged plaintiff to argue to the Social Security Administration that she could not do any work. The insurer also decreased plaintiff's benefits in the amount of social security disability benefits plaintiff received. However, the insurer gave the Social Security Administration's findings and award little weight. This constituted an abuse of discretion and the insurer's termination of benefits was reversed.

### **SKEEN V. RITE AID CORP.**

**(E.D.Cal., January 12, 2010)**

#### **Insurer Properly Denied Long Term Disability Benefits**

The administrator did not abuse its discretion in denying plaintiff long term disability benefits for her rheumatoid arthritis. The plan required her to be continuously disabled for a benefit waiting period of ninety one days before the benefits became payable. The administrator could reasonably conclude that plaintiff was able to return to work prior to that time.

### **MCHEMRY V. PACIFICSOURCE HEALTH PLANS**

**(D.Or., January 5, 2010)**

#### **Benefits Properly Denied for Plaintiff's Autistic Son**

Defendant denied coverage for Applied Behavioral Analysis therapy for plaintiff's autistic son. The court held that even though such therapy is a covered benefit, the Behavior Analyst providing the therapy was not an eligible provider under the plan, and thus, plaintiff was not entitled to reimbursement for her services.

### **NICELY V. UNUM LIFE INS. CO. ET. AL.**

**(M.D.N.C., December 23, 2009)**

#### **Decision To Deny Benefits Under ERISA Was Not An Abuse Of Discretion**

The claimant's alleged cognitive deficits were supported only by her self-reported complaints of cognitive slowing and memory loss, and wholly lacking in any objective evidence. As such, the court held that while plaintiff suffered from some impairment, there was no substantial objective evidence of disabling symptoms during the relevant time period to support the claim. Thus, the insurer's decision was based on "a permissible judgment call between conflicting medical opinions." Given the lack of objective evidence, the lack of any restrictions placed on plaintiff before her last day of employment and the differing conclusions of the treating physicians, Unum's denial was determined to be reasonable and not an abuse of discretion.

### **JENSEN V. FEDEX FREIGHT, INC.**

**(D.Id., December 15, 2009)**

#### **Insurer's Failure to Send the Correct Summary Plan Description Is Not Actionable**

The insurer sent plaintiff the wrong summary plan description, leading him to believe that when his daughter moved in with her mother, his disability benefits would increase by the amount they were

reduced by his daughter's related Social Security disability benefits. The court dismissed plaintiff's claim because plaintiff did not allege facts showing a pattern of the insurer's active concealment, intentional misstatements or substantive harm resulting from continuing procedural violations.

## NEWS and NOTES

### **Overhaul to Health Care System Passes**

On March 23, 2010, President Obama signed legislation to overhaul the health care system in the United States with the promise to guarantee health insurance to an estimated 30 million people who current are uninsured. Two days later, the House and Senate passed a set of changes to the bill. Opposition to the bill has vowed to seek that it be repealed, including challenging it in court. It has been reported that there are already 18 states that have joined a multistate suit challenging the legislation.

At a cost estimated to exceed \$940 billion over years, the bill will require, among other things, that most Americans have health insurance coverage; subsidize private coverage for low and middle-income people; additional regulation of private insurance companies, including not allowing insurer to deny benefits based on a pre-existing condition; allow uninsured and self-employed to purchase insurance through state-based exchanges; create additional exchanges created for small-business; allow children to remain on their parent's health plan until 26 years of age; segregate private premiums from taxpayer funds and require individuals to pay for abortion coverage; and, not force any health care plan to offer abortion coverage, as well as allow states to opt out of offer coverage through the exchange.

For a link to the legislation, click [here](#)

### **Suit filed by University and Alumnus against a life insurance company**

Oklahoma State University and one of the University's largest donors, as well as an alumnus, T. Boone Pickens allege that Lincoln National Life Insurance Company gave misinformation regarding the costs and financial benefits of a fund-raising plan. The plan was to raise hundreds of millions of dollars by taking out policies on alumni. The life insurer argues that plaintiffs failed to pay premiums and that Pickens "willfully and intentionally" interfered.

For a link to the New York Times story, click [here](#)

### **Two Life Insurers Commence Actions Against Same Agent Regarding STOLI Policies.**

Lincoln National Life Insurance Company and Principal Life Insurance Co. each commenced an action against the same insurance agent and manager of the trust alleging they were scammed into issuing \$10 and \$14 million stranger-originated life insurance policies, respectively. Both insurers argue the policies are void *ab initio*, claiming the investors did not have an insurable interest.

For a copy of the Lincoln National Insurance Company complaint, click [here](#).

For a copy of the Principal Life Insurance Company complaint, click [here](#).

**Goldberg Segalla LLP** is a Best Practices law firm with offices in Philadelphia, New York, Princeton, Hartford, Buffalo, Rochester, Syracuse, Albany, White Plains and on Long Island and with affiliated offices in Europe. Our Life, Health, Disability and ERISA practice is encompassed within our **Global Insurance Services** Practice Group. We handle matters nationally on issues which include evolving concerns over ERISA preemption, contestability periods, fraud, foreign death schemes, unique beneficiary claims, benefits limitations due "own occupation" and "any occupation" periods, disputes over payor submissions deadlines and third-party billing, health insurance and provider audits, HIPPA compliance and litigation. For more information on Goldberg Segalla's **Global Insurance Services** Group, please contact either **Daniel W. Gerber** or **Richard J. Cohen**. Our **Global Insurance Services** team consists of the following attorneys:

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