

# Life and Health Insurance Update

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## Life, Health, Disability and ERISA Claims Seminar 2007

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### Life and Health Insurance Update

Litigating a life or health insurance case can be a treacherous endeavor. Courts in recent years have rendered the task easier on some fronts and far more complex on others. To be sure, all is never quiet for the life or health insurance lawyer. Judges, however, continue to issue a healthy mixture of rulings favorable to the insurance industry and consumer-protective decisions. This paper addresses recent cases germane to life and health insurance litigation. The paper highlights important decisions and emerging trends in seven selected topics. The objective of the paper is not to provide an all-encompassing summary of notable decisions, but rather to emphasize cases and trends in areas of the law where litigation is ripe and plentiful.

#### I. Privacy and Disclosure Issues

The areas of privacy, particularly under the Health Insurance Portability and Accounting Act of 1996 ("HIPAA"), and disclosure of medical and other information continue to provide a rich source of controversy and case law. Recent cases continue to define the expanding minefield of rights and obligations in these areas.

The trend of federal courts limiting the types of remedies available for an impermissible disclosure under HIPAA continues. In *Acara v. Banks*, 470 F.3d 569 (5th Cir. 2006), the United States Court of Appeals for the Fifth Circuit

became the first federal appellate court to hold that HIPAA does not provide a private right of action for impermissibly disclosing protected health information. The plaintiff in *Acara* filed an action against a doctor for disclosing medical information during a deposition without the plaintiff's consent. The district court dismissed the action for lack of subject matter jurisdiction and the Court of Appeals affirmed.

The appellate court noted that, although HIPAA provides for civil and criminal penalties for improper disclosure of medical information, HIPAA does not contain an express provision creating a private right of action for enforcement of the statute, nor imply the existence of a private right of action to remedy a wrongful disclosure. To the contrary, Congress explicitly delegated enforcement of HIPAA to the Secretary of Health and Human Services. Given the absence of a private right of action, the appellate court affirmed the district court's dismissal of the case for lack of subject matter jurisdiction.

In contrast to the *Acara* decision, which limits the ability to bring a private cause of action under HIPAA, the Court of Appeals for the Tenth Circuit recently issued an alarming decision potentially expanding an insurance company's duty to disclose certain medical information. In *Pehle v. Farm Bureau Life Insurance Co.*, 397 F.3d 897 (10th Cir. 2005), the insurer, through blood tests, the purpose of which was to determine the plaintiffs' eligibility for life insurance, learned that plaintiffs were infected with the Human Immunodeficiency Virus ("HIV"). Plaintiffs were unaware of their HIV status when they submitted the application, but discovered they were infected two years later. Plaintiffs filed a negligence action against the insurer, the lab that ran the blood tests, and the lab's medical director for failing to inform them that they were HIV-positive. The district court granted summary judgment in favor of the defendants because there was no affirmative duty to disclose plaintiffs' HIV status to them.

On appeal, plaintiffs argued that a life insurance company owes a duty to notify applicants that they are infected with a sexually transmitted disease if the application process revealed the infection. Plaintiffs argued that the insurer owed them the duty both as a matter of contract and under common law. The Court of Appeals rejected plaintiffs' contention that the insurer owed them a duty of disclosure as a matter of contract. The relevant agreement, a form contract authorizing the insurer to conduct HIV testing, did not contain language requiring the insurer to report HIV testing results to an applicant. The Court of Appeals, however, found a limited duty of disclosure on the part of the insurer under Wyoming common law. The Court of Appeals concluded that plaintiffs and the insurer were engaged in a relationship of trust and confidence. This relationship imposed a tort duty on the part of the insurer to act for the benefit of plaintiffs. Thus, the appellate court held that, "if an insurance company, through independent investigation by it or a third party for purposes of determining policy eligibility, discovers that an applicant is infected with HIV, the company has a

duty to disclose to the applicant information sufficient to cause a reasonable applicant to inquire further.”

To the extent *Pehle* recognizes a duty to disclose the results of blood tests, courts and insurers will be required to determine how best to provide such disclosures in light of HIPAA and other privacy laws. An insurer that follows the teachings of *Pehle*, for instance, seemingly would be obligated to ensure that the disclosure is provided only to the appropriate recipient. Although *Acara* restricts private causes of action, an insurer that does not take precautionary measures prior to providing a *Pehle* disclosure still risks facing a civil action or administrative complaint for failure to protect health information.

Although unrelated to health and medical disclosure issues, one recent case highlights the importance of clear disclosure language in the insurance policy context. *Wise v. American General Life Insurance Co.*, 459 F.3d 443 (3d Cir. 2006), emphasizes the value of full and clear disclosure of contractual terms. In *Wise*, the insurer approved an application for a life insurance policy that clearly stated coverage would not be provided until the first premium was paid while the insured was in good health. The insurer issued the policy and delivered it to the applicant. The applicant died the same day he received the policy. The applicant’s widow mailed the first premium to the insurer the following day and requested the proceeds of the policy. The insurer refused to pay the policy proceeds. The widow filed an action against the insurer for breach of contract, bad faith, and unfair trade practices.

The district court dismissed the widow’s complaint, finding no binding contract had been formed. The district court reasoned that a contract had not been formed because the life insurance policy explicitly and unambiguously required the payment of the first premium before any insurance was to take effect. The district court further found that because the applicant never accepted the policy by paying consideration in the form of the first premium before he died, there was no insurance in effect at the time of death. The Court of Appeals for the Third Circuit affirmed the district court’s decision based on the same reasoning.

## II. Enforcement of Forum Selection Clauses in Group Health Plans

In an attempt to control “forum shopping,” parties to a contract often include forum selection clauses in their contracts. Despite little prior precedent, two recent federal court decisions have held that forum selection clauses in ERISA-governed group health plans, if properly drafted, will be enforced against plan beneficiaries. The lesson? Shop early and put it in writing.

In *Rogal v. Skilstaf, Inc.*, 446 F. Supp. 2d 334 (E.D. Pa. 2006), a chiropractor who obtained an assignment of benefits from plan participants filed an action against a plan sponsor in the Court of Common Pleas of Philadelphia County, Pennsylvania. Skilstaf, the plan sponsor, removed the case to the United

States District Court for the Eastern District of Pennsylvania and immediately moved to transfer the action to the Middle District of Alabama. Skilstaf relied upon 28 U.S.C. § 1404(a), which provides that “[f]or the convenience of parties and witnesses, in the interest of justice, a district court may transfer any civil action to any other district or division where it might have been brought.” The action could have been filed in the Middle District of Alabama because Skilstaf, the defendant in the matter, was an Alabama corporation with its principal place of business within the Middle District of Alabama.

In determining whether to transfer the action, the federal court first identified six private interests and six public interests to be weighed in resolving a motion filed pursuant to § 1404(a). Indeed, *Rogal* is instructive for this enumeration alone. The district court further noted that a forum selection clause is generally treated as a manifestation of the parties’ preference as to a convenient forum. According to the district court, “[f]orum selection clauses are presumptively valid and thus entitled to great and controlling weight in all but the most exceptional case.” Skilstaf’s group health plan contained a forum selection clause requiring actions for benefits to be filed in either small claims court in Alexander City, Alabama or the United States District Court for the Middle District of Alabama. Finding an absence of any indication that the forum selection clause was the result of fraud, influence, or oppressive bargaining power, the district court found the forum selection clause valid and enforceable. In reaching its decision, the district court rejected the plaintiff’s contention that the forum selection clause could not be enforced on the ground that neither the chiropractor nor the underlying plan participants were signatories of the group health plan.

*Schoemann v. Excellus Health Plan, Inc.*, 447 F. Supp. 2d 1000 (D. Minn. 2006), did not, like the *Rogal* court, find that forum selection clauses in ERISA plans were presumptively valid, but the trial court here still enforced a forum selection clause in a group health plan under the facts of the case. In *Schoemann*, Excellus Health Plan provided medical benefits to beneficiaries through an employer-sponsored health-benefit plan. The plan contained a forum selection clause requiring that disputes arising under the plan be litigated in New York. The defendant moved to transfer the action from the United States District Court for the District of Minnesota to the Western District of New York pursuant to 28 U.S.C. § 1404(a) and the forum selection clause.

The plaintiffs contended that the forum selection clause should not be enforced against them because they were not parties to the contract between Excellus and the plan sponsor and did not negotiate the terms of the group health plan. The plaintiffs further argued that enforcement of the forum selection clause would controvert ERISA’s objective of protecting the interests of plan participants and beneficiaries by providing ready access to federal court. While recognizing the force of the plaintiffs’ contentions, the district court ultimately rejected their position.

The district court initially noted that consideration of a § 1404(a) motion centers upon three factors referenced in the statute's text: (i) the convenience of the parties; (ii) the convenience of the witnesses; and (iii) the interests of justice. In this case, however, the factors did not militate in favor of either party or forum. The district court found persuasive the fact that a plan administrator or plan sponsor may seek to preserve plan resources and ensure a level of predictability in interpretation of its plans by restricting litigation to a specific locale. Thus, the district court concluded that where the § 1404(a) factors are a "wash," the forum selection clause is decisive.

### III. Life Insurance Class Action Defenses

Recent cases provide a calming reminder that class action litigation is not always a perilous adventure. In fact, one recent life insurance case exemplifies how a class action settlement in a prior case can be utilized to bar a subsequent action.

In *Wilkes v. Phoenix Home Life Mutual Insurance Co.*, 902 A.2d 366 (Pa.), *cert. denied*, 127 S. Ct. 688 (2006), plaintiffs purchased a life insurance policy based on the alleged representation that premiums would diminish over time. Approximately two years after discovering that premiums did not decrease as anticipated, plaintiffs received a detailed notice concerning a proposed settlement of a class action against the insurer. The plaintiffs allegedly contacted their agent, who indicated that they were not included within the class action litigation. Plaintiffs then filed an independent complaint against the insurer without ever having opted out of the class action.

The Supreme Court of Pennsylvania held that the class action notice provided to plaintiffs was sufficiently detailed to notify them of their inclusion within the class action litigation. Thus, *res judicata* barred plaintiffs' independent suit on a policy encompassed by the class action settlement. The lesson of *Wilkes* is that insurers and their representatives should be cognizant of class action settlements entered by the insurer. Such settlements can prevent or halt litigation far beyond the class action lawsuit itself.

Recent cases, moreover, are helpful in preventing the certification of a class in the first instance. *Thorn v. Jefferson-Pilot Life Insurance Co.*, 445 F.3d 311 (4th Cir. 2006), emphasizes that it is the plaintiff who bears the burden of demonstrating that the constitution of the proposed class satisfies the requirements of Rule 23 of the Federal Rules of Civil Procedure. The defendant, *Thorn* reminds us, does not carry a burden showing that the class fails to comply with Rule 23.

In *Thorn*, the district court denied class certification on the ground that it could not resolve the insurer's statute of limitations defense on a class-wide basis

and, therefore, issues common to the class did not predominate over individual issues. The Court of Appeals for the Fourth Circuit affirmed. The appellate court focused upon the implications of a statute of limitations defense raised by the insurer, the resolution of which required the district and appellate court to determine the date on which the plaintiffs' alleged claims accrued. The Court of Appeals noted that a cause of action generally accrues when a plaintiff has actual or constructive knowledge of her claim. Thus, determining when a cause of action accrues is not readily susceptible of class-wide determination but, instead, requires individual testimony from each plaintiff. The Court of Appeals concluded that the plaintiffs failed to show that the statute of limitations defense could be resolved on a class-wide basis. Thus, the denial of the request for class certification was appropriate.

*National Western Life Insurance Co. v. Rowe*, 164 S.W.3d 389 (Tex. 2005), suggests that insurers and their representatives should press the trial court to conduct a rigorous, thorough, and all-encompassing analysis prior to certifying a class. In *Rowe*, a plaintiff filed a class action complaint against the insurer concerning child riders on life insurance policies. The trial court certified a nationwide class of purchasers of the child riders.

The Supreme Court of Texas vacated the class certification, finding the trial court failed to adhere to an analysis mandated by *Southwestern Refining Co. v. Bernal*, 22 S.W.3d 425 (Tex. 2000), regarding class action certification. The trial court failed to explain how common issues of fact or law predominated, given that the circumstances of individual policyholders could be dissimilar. The trial court also concluded that Texas law would apply to all claims without considering whether class members residing outside of Texas would be better served by applying the laws of their own states. The trial court likewise failed to consider whether other states had an interest in the claims being asserted, particularly given that states have an interest in regulating the business of insurance.

The Supreme Court of Texas further noted the trial court failed to meaningfully explain how it would try damages, statute of limitations, and reliance issues with respect to each policyholder's claims. The trial court also neglected to articulate clearly who would be included as class members and why certain presumptions should apply. The class notice form, for example, indicated that the failure to complete and return the form could result in termination of coverage or a presumption that the policyholder had no post-application children. The trial court did not explain why the presumption should attach by reason of the failure to return the class notice form, particularly given that class action notices are routinely ignored. The trial court, finally, did not explain how a class action would be superior to individual cases in resolving the underlying disputes. In sum, *Rowe* provides a litany of issues insurers and their representatives can consider in attempting to prevent class certification.

#### IV. State Healthcare Reforms and ERISA

Some states, unwilling to wait for a federal solution, have enacted legislation aimed at resolving a purported crisis in the availability and affordability of health insurance. One recent case issued by the Court of Appeals for the Fourth Circuit demonstrates that some of these efforts can run afoul of ERISA preemption rules.

In *Retail Industry Leaders Association v. Fielder*, Nos. 06-1840, 06-1901, 2007 U.S. App. LEXIS 920 (4th Cir. 2007), a three-member panel of the Fourth Circuit, in a two-to-one opinion, affirmed a Maryland district court's decision holding that Maryland's Fair Share Health Care Fund Act (the "Maryland Act") was preempted by ERISA because it conflicted with ERISA's goal of permitting an employer's uniform, nationwide administration of welfare its benefit plans. The Maryland Act, enacted in January 2006, requires that a Maryland employer with 10,000 or more employees in the state spend at least 8% of its total payroll on those employees' health insurance costs or, alternatively, that the employer pay any shortfall in such expenditures directly to the State of Maryland. In the fall of 2006, only Wal-Mart was affected by this legislation.

The Maryland Secretary of Labor argued that the litigation was barred by the Tax Injunction Act, which prohibits challenges to taxes imposed under state law. The Court of Appeals rejected this argument, finding that the clear purpose of the Maryland Act was not to raise state funds, but rather to mandate that certain employers provide a certain level of healthcare benefits. The Secretary also argued that the Maryland Act did not force an employer to change its benefit plan because the employer had the option of paying any shortfall in funding directly to the Maryland government. The Court of Appeals found, based on the record, that this was not a meaningful alternative because no reasonable employer would forego the option of generating goodwill with its employees by paying funds directly to Maryland instead of using the same funds for employee benefits.

According to the appellate court, the only reasonable approach for an employer such as Wal-Mart to follow under the Maryland Act was to restructure its ERISA-governed healthcare benefits plan to meet the minimum spending requirements. Forcing an employer to alter its record-keeping and healthcare spending in Maryland, however, would disrupt its ability to administer its plan uniformly and on a nationwide basis. The Court of Appeals concluded: "Because the Act directly regulates employers' provision of healthcare benefits, it has a 'connection with' covered employers' ERISA plans and accordingly is preempted by ERISA."

In April 2006, Massachusetts enacted healthcare reform legislation, the goal of which was to provide affordable health insurance coverage to nearly all of its residents. The multi-pronged plan includes required participation by individuals and employers (with financial penalties for those who do not

participate), insurance market reforms, and the expansion of certain government programs and subsidies. The goals of this legislation are laudable. Significant questions remain, however, concerning the implementation, ultimate impact and cost of the legislation on various stakeholders, including employers, residents of Massachusetts and healthcare providers. Because many of the provisions of the law impact healthcare plans that are, in fact, employee welfare benefits plans governed by ERISA, there may be challenges to the Massachusetts law based on ERISA preemption, particularly if some stakeholders perceive that they are being unfairly targeted or that they are being asked to shoulder a disproportionate share of the reforms. The *Fielder* case makes it clear that state attempts to reform their health insurance and delivery systems, particularly when those reforms impact the obligations of employers, will continue to be scrutinized and challenged under ERISA.

#### V. Waiver and Estoppel in the Life Insurance Context

The last few years have produced mixed results for insurers in the development of waiver and estoppel law. *Chawla v. Transamerica Occidental Life Insurance Co.*, 440 F.3d 639 (4th Cir. 2006), however, is both helpful and instructive. Although the district court opinion in *Chawla* addressed an important insurable interest issue, the appellate decision rested on questions concerning whether waiver and estoppel could preclude an insurer's right to rescind a policy.

In *Chawla*, a trustee filed a claim for benefits under a policy owned by the trust that insured the life of the trustee's business partner. The insurer previously had issued three other life insurance policies to the insured, and was aware the insured suffered from a disease and consumed a bottle of wine per day. The insured was examined by a paramedic and physician in the course of applying for the new policy. The insured disclosed his disease to the paramedic, but indicated his illness amounted only to a benign cyst that had been removed. The physician noted a surgical scar on the insured's abdomen, but the insured claimed to be unable to recall the origin of the scar. The insurer issued the policy based on the information in its possession.

Approximately one month after the date of issuance of the policy, symptoms relating to alcohol abuse and the insured's disease hospitalized the insured. Without disclosing any new medical information, the trust thereafter applied for and obtained an increase in coverage under the policy. Upon the death of the insured approximately one year after increasing coverage under the policy, the insurer denied the trust's claim for benefits and rescinded the policy because, *inter alia*, the insured made material misrepresentations in his policy application. The trustee filed an action against the insurer alleging wrongful rescission. The trial court held that rescission was appropriate because the insured made material misrepresentations and the trust did not have an insurable interest in the policy.

On appeal, the trustee contended that the insurer waived the right to rescind the policy on grounds relating to the insured's disease and consumption of alcohol. The trustee contended that the insurer waived the defense of misrepresentation because it had the insured's medical information in its possession when it issued the policy. The Court of Appeals for the Fourth Circuit rejected the trustee's contention because the insured failed to disclose the details of his surgery relating to the disease, failed to disclose a second surgery, and did not report various hospitalizations. Thus, the Court of Appeals held the insurer lacked sufficient information to knowingly and intentionally waive the defense of misrepresentation.

The trustee further argued that the insurer should be estopped from advancing the defense of misrepresentation because the facts known to the insurer triggered a duty to investigate further into the insured's health before issuing the policy. The Court of Appeals emphasized that one of the critical elements of estoppel is detrimental reliance. Thus, in order to prevail, the trustee was obligated to show that the insured could have obtained insurance coverage from a different insurer. The trustee did not offer any proof that any other insurer would have issued a policy insuring the life of the insured based on the condition of his health. The Court of Appeals therefore held the trustee failed to carry the burden of establishing the elements of estoppel.

In contrast to *Chawla*, the Court of Appeals for the Fifth Circuit issued a decision in 2005 that may prove to be problematic through the upcoming years. *Monumental Life Insurance Co. v. Hayes-Jenkins*, 403 F.3d 304 (5th Cir. 2005), indicates that an insurer may be estopped from taking a position contrary to language in a policy it issued or advertisements it prepared or authorized.

In *Hayes-Jenkins*, NovaStar Mortgage provided a loan to a couple. In connection with the loan, NovaStar sent an application for mortgage life insurance to the borrowers. The cover letter explained the insurance would help repay the loan in the event either spouse died. The letter indicated the couple would have thirty days from receipt of their policy to examine it "risk free" and without cost. The letter stated that, if the couple declined coverage within thirty days, they would "owe nothing." A brochure from the insurer, sent with the letter, contained the same representations. The brochure further provided the couple would be "fully covered" during the thirty-day period, and that they would not be required to submit a separate check to pay premiums. Premium payments would be added to the couple's monthly mortgage payments.

Although the application reiterated the assurances in the brochure and cover letter, in smaller print near the signature lines, the application stated "No insurance is in effect unless the application is approved by the Insurance Company, and the first premium is paid." Relying on the representations of risk-free and cost-free coverage for thirty days, and the assurance that a separate check for premiums was not required, the couple submitted the application without

payment. The couple was notified of approval of their application, which likewise did not mention that the first premium had to be paid for coverage to become effective.

The policy was received one day after the husband died, but his death occurred three days after the apparent effective date of coverage. The cover page indicated coverage was conditioned upon payment of the first premium. The policy provided for a premium refund if the policy was returned within thirty days of receipt. Four days after delivery of the policy, the insurer notified NovaStar it approved coverage and NovaStar began collecting premiums.

The claim for death benefits was denied on the basis that coverage was not effective at the time of death because the policy and application conditioned coverage upon payment of the first premium. The insurer filed a declaratory judgment action asking the trial court to declare that no coverage existed at the time of death. The district court granted summary judgment to the insurer.

Applying Texas law, the Court of Appeals for the Fifth Circuit reversed the district court's judgment on several grounds. First, the Court of Appeals held genuine issues of material fact existed regarding whether the insurer waived or should be estopped from asserting payment of the first premium as a condition of coverage. Second, the insurer may have, as a matter of law, waived its right to argue the defense of nonpayment of the first premium. The insurer may have assumed the risk of coverage when it approved the couple's application or issued the policy with knowledge that the first premium had yet to be paid.

The appellate court also reversed the district court on claims arising under the Texas Insurance Code and Deceptive Trade Practices Act. The Court of Appeals found issues of fact existed regarding whether the insurer had violated the Deceptive Trade Practices Act by (i) falsely representing that the insurance policy came with a full thirty-day risk-free period during which coverage would be provided, (ii) failing to disclose information critical to the couple's decision of whether to apply for coverage in order to induce them to apply, and (iii) contributing to her injury by making confusing and misleading statements which prevented the couple from taking all necessary steps to bring coverage into effect.

Ultimately, therefore, the appellate court decision in *Hayes-Jenkins* merely reverses a grant of summary judgment. This case, however, demonstrates the dangers of marketing materials and representations that are confusing and arguably inconsistent with specific policy language. The reasoning of *Hayes-Jenkins* provides the plaintiffs' bar ammunition to defeat otherwise seemingly obvious principles such as the notion in *Wise* that a contract of insurance has not been formed if an applicant fails to adhere to a policy's explicit requirement of payment of the first premium to commence coverage.

VI. Health Insurance: Effect of Criminal Statutes on Contract Exclusions and Operations of Insurers

A recent case issued by the United States Court of Appeals for the Seventh Circuit bolsters an insurer's right to deny a claim based on policy language excluding coverage for injuries resulting from illegal acts. In *Tourdot v. Rockford Health Plans, Inc.*, 439 F.3d 351 (7th Cir. 2006), the insured sought payment of medical benefits subsequent to crashing his motorcycle after drinking beer at a drag race. He claimed that it was not the beer that caused the accident, but rather that exotic dancers at a gentlemen's club temporarily distracted him. One would think the insurer would raise the "damn fool" doctrine in these circumstances, which states that "coverage is not provided for acts which are simply too ill-conceived to warrant allowing the insured to transfer the risk of such conduct to an insurer." See *Tenn. Farmers Mut. Ins. Co. v. Evans*, 814 S.W.2d 49, 54 (Tenn. 1991) (citation omitted).

Rather than raising the damn fool doctrine, the insurer logically relied on policy language and the fact that the insured had been legally intoxicated when he crashed his motorcycle. Specifically, the insurer denied the claim for benefits because the policy excluded coverage for injuries sustained in "the commission ... of any illegal act." Although the insured was cited by a police officer only for inattentive driving, the record disclosed that the insured's blood-alcohol level was beyond the permissible driving limit in the relevant jurisdiction.

The insured contended the exclusion for "any illegal act" was vague. He argued, based on the doctrine of "ejusdem generis," that the phrase "any illegal act" should be defined with reference to the language surrounding that phrase in the policy. The insured hoped to convince the appellate court that the policy exclusion pertained only to acts that were much more serious than the acts he committed. The Court of Appeals rejected the argument, holding that the phrase "any illegal act" has a plain meaning and simply referred to any act contrary to law. The Court of Appeals deemed immaterial the fact that the insured was penalized only for inattentive driving, rather than intoxicated driving. Thus, the appellate court affirmed the grant of summary judgment to the insurer.

In contrast to the insurer-favorable result in *Tourdot*, the United States Court of Appeals for the Sixth Circuit issued a 2006 decision supporting the application of the Racketeer Influenced and Corrupt Organizations Act ("RICO") to conduct of insurers. In *Genord v. Blue Cross & Blue Shield of Michigan*, 440 F.3d 802 (6th Cir.), *cert. denied*, 127 S. Ct. 582 (2006), a group of gynecologists filed an action against an insurer in federal court alleging, *inter alia*, the insurer violated RICO by fraudulently denying their claims for payment of medical services. The gynecologists' premised their claims upon their provider reimbursement agreements with the insurer. The Michigan Nonprofit Health Care Corporation Reform Act (the "Michigan Health Care Act") governed the reimbursement agreements. The insurer moved to dismiss the RICO claim on the

ground that it was “reverse preempted” by the McCarran-Ferguson Act. If the district court dismissed the RICO claim, the district court would lack subject matter jurisdiction because there would be no federal question at issue. The district court rejected the insurer’s argument, but certified an interlocutory appeal.

Essentially the opposite of federal preemption, “reverse preemption” generally prevents the application of federal law in favor of state law. The McCarran-Ferguson Act provides that “no Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, ... unless such Act specifically relates to the business of insurance ...” See 15 U.S.C. § 1012(b). In *Genord*, the insurer maintained the McCarran-Ferguson Act precluded the invocation of a private right of action under RICO, because applying RICO in this case would invalidate, impair, or impede a state law regulating the business of insurance, the Michigan Health Care Act.

The Court of Appeals affirmed the district court’s rejection of the insurer’s reverse preemption argument. Because it reasoned that the Michigan Health Care Act neither regulated the transferring or spreading of policyholder risk, nor regulated a practice that is an integral part of the policy relationship between the insurer and the insured, the Court of Appeals held that the Michigan Health Care Act was not “enacted [by Michigan] for the purpose of regulating the business of insurance.” The Michigan Health Care Act, therefore, did not fall within the ambit of the McCarran-Ferguson Act. Accordingly, the foundation of the insurer’s reverse preemption argument collapsed.

## VII. Life Insurance Beneficiary Issues and Qualified Domestic Relations Orders

Interesting questions have arisen in recent years regarding life insurance beneficiary issues. *Trautman v. Trautman*, 713 N.W.2d 600 (S.D. 2006), raises the question of whether an insured can change beneficiaries without submitting a new beneficiary designation form.

Prior to his death, the insured in *Trautman* attempted to increase coverage under a supplemental life insurance policy. Plaintiffs, the insured’s sons, were the beneficiaries under the original policy. On the application for an increase in coverage, however, the insured indicated that benefits under the policy should be distributed equally as between his sons, on the one hand, and his spouse on the other. Although the insurer denied the application to increase coverage, the sons and decedent’s widow disputed whether submission of the application effected a change in beneficiaries.

The Supreme Court of South Dakota held that an insured is required to comply with the terms of the policy to effect a change in beneficiaries. The Supreme Court noted, however, that South Dakota recognized the doctrine of

“substantial compliance” as an equitable exception to the general rule. According to the high court, one relying on the substantial compliance exception has the burden of proving that (i) the policy owner manifested a clear intent to designate a new beneficiary, and (ii) the owner had taken substantial affirmative action to effectuate the change. The policy owner is required to make every reasonable effort under the circumstances to effect the change. Under the specific facts of the case, the Supreme Court of South Dakota held that the spouse did not meet her burden of demonstrating that the insured substantially complied with the terms of the policy to effect a change in beneficiaries. Despite its ultimate holding, however, the high court’s analysis in *Trautman* suggests that a change in beneficiaries could indeed have occurred without submission of a new beneficiary designation form.

Akin to South Dakota’s “substantial compliance” rule, the Supreme Court of Alabama recently opined that an insurer has no duty to investigate an alleged forgery in a change-of-beneficiary form. In *Fortis Benefits Insurance Co. v. Pinkley*, 926 So. 2d 981 (Ala. 2005), plaintiff initially was named the beneficiary on a life insurance policy issued to her husband, the policy owner. The insurer received and recorded a telephone call from a person claiming to be the insured requesting change-of-beneficiary forms. The forms were sent to the insured’s address of record, and executed change-of-beneficiary forms were received by the insurer substituting plaintiff’s daughter-in-law in place of plaintiff as primary beneficiary. Upon the death of the insured, benefits were paid to the daughter-in-law. Plaintiff filed a claim for the policy proceeds, contending the change-of-beneficiary form was forged. The insurer denied the claim on the ground that it already had discharged its duty under the policy by paying the designated beneficiary. Plaintiff filed an action to recover the benefits. The trial court certified an interlocutory appeal.

The issue on appeal was whether a life insurer had a duty to investigate the authenticity of the signature on a change-of-beneficiary form. The Supreme Court of Alabama concluded an insurer does not have such a duty. Based on Alabama’s facility of payment statute, if an insurer pays life insurance benefits in good faith and in reliance on a forged change-of-beneficiary request form, which appears regular in all respects, then the insurer is fully discharged from all claims under the policy or contract.

*Sweebe v. Sweebe*, 712 N.W.2d 708 (Mich. 2006), concerns the question of whether ERISA preempts a beneficiary designation provision in a divorce decree. In *Sweebe*, the personal representative of the decedent’s estate moved to enforce a provision in a judgment of divorce indicating that the decedent and his former spouse agreed to waive any interest in an insurance policy of the other. The decedent’s former spouse was the named beneficiary under decedent’s ERISA-governed life insurance policy at the time of his death. The trial court denied the personal representative’s motion on the ground that ERISA preempted the application of the waiver provision in the divorce judgment.

The intermediate appellate court reversed the trial court's determination, and ordered the former spouse to pay the estate an amount equal to the life insurance proceeds distributed under the plan. The Supreme Court of Michigan affirmed the appellate court, but also relied upon the trial court's reasoning. The Supreme Court of Michigan held that ERISA preempts, and therefore precludes, the application of the waiver provision to govern the plan administrator's claim decision. Thus, under ERISA, the plan administrator was required to pay the plan benefits to the named beneficiary.

The Supreme Court of Michigan further held, however, that a party could invoke and enforce the waiver provision after the plan administrator distributes the plan benefits at issue. Once the benefits have been distributed, ERISA is no longer controlling because the plan administrator has completed fulfilling its obligations under ERISA. The parties' agreement as memorialized in the divorce decree then becomes operative. In other words, after plan benefits are paid based upon the plan administrator's compliance with ERISA, the property at issue can be distributed according to the terms of the parties' divorce agreement.

Cases such as *Sweebe* speak to an area of the law that raises confusion. Specifically, courts and attorneys alike approach with trepidation the question of whether a divorce decree trumps a beneficiary designation in an ERISA plan. Generally, a beneficiary designation in a divorce decree will trump a designation pursuant to the terms of an ERISA plan when the spouse seeking benefits follows a procedure specifically provided for under ERISA. That procedure involves obtaining and submitting to the plan administrator a qualified domestic relations order ("QDRO").

A QDRO is defined, in pertinent part, as a domestic relations order "which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan" and which "clearly specifies" the following elements:

- (i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order,
- (ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined,
- (iii) the number of payments or period to which such order applies, and
- (iv) each plan to which such order applies.

29 U.S.C. § 1056 (d)(3)(B)(i)-(C). A divorce decree that satisfies the requirements of an ERISA qualified domestic relations order will not be preempted by ERISA. *See* 29 U.S.C. § 1144(b)(7); *Metro. Life Ins. Co. v. Bigelow*, 283 F.3d 436, 440 n.3 (2d Cir. 2002) (analyzing the QDRO exception to ERISA preemption in the context of a life insurance plan). Thus, a beneficiary designation in a valid QDRO can trump the beneficiary designation under an ERISA plan. *See, e.g., Bigelow*, 283 F.3d at 440; *Riordan v. Commonwealth Edison Co.*, 128 F.3d 549, 552 (7th Cir. 1997).

If a divorce decree does not satisfy the requirements of a QDRO pursuant to 29 U.S.C. § 1056(d)(3), then the QDRO exception does not apply and the divorce decree is preempted. *See Bigelow*, 283 F.3d at 440; *Metro. Life Ins. Co. v. Pettit*, 164 F.3d 857, 863 (4th Cir. 1998). This results obtains in part because one purpose of ERISA is to “subject employee benefit plans to only one body of national, uniform law” and “minimize administrative and financial burdens on employers.” *See Pettit*, 164 F.3d at 862. A property distribution agreement incorporated in a divorce decree that does not qualify as a QDRO conflicts with ERISA if it purports to create an alternative enforcement mechanism with respect to plan benefits. *See id.* at 863 (“Congress meant to make a QDRO the acceptable method for a divorced spouse to attach an interest in a former spouse’s benefit plan. ERISA thus maintains its own enforcement mechanism for aggrieved former spouses.”).

If a non-qualifying domestic relations order were allowed to trump an ERISA participant’s beneficiary designation under the plan,

then the relationships between the employee and the plan, the plan and the named beneficiary, and the administrator and the plan will all be impacted by an outside agreement of which the administrator will likely be unaware. This situation leads to unpredictability .... Not only is a claim under a property settlement agreement [that is not a QDRO] an alternate enforcement mechanism that impacts the traditional parties, it is also exactly the situation that Congress sought to avoid when it enacted ERISA.

*Id.* at 863-64.

If a former spouse intends to rely on a QDRO to attach an interest in an ERISA plan, then the domestic relations order must be submitted to the ERISA plan administrator for consideration of whether the decree is a QDRO, and, if so, for appropriate processing by the plan administrator. *See* 29 U.S.C. §

1056(d)(3)(G); *Pettit*, 164 F.3d at 863 (indicating a QDRO “must be filed with a plan administrator”).

Note, however, that the existence of a QDRO does not dictate whether a federal court has subject matter jurisdiction over an action concerning the QDRO, even though that species of domestic relations order is not preempted by ERISA. Section 1056(d)(3)(J) of ERISA provides that “[a] person who is an alternate payee under a qualified domestic relations order shall be considered for purposes of any provision of this Act a beneficiary under the plan.” *See also Boggs v. Boggs*, 520 U.S. 833, 846-47 (1997) (explaining that QDRO mechanism under ERISA was designed to confer beneficiary status on a nonparticipant spouse or dependent under narrow circumstances). Thus, § 1056(d)(3)(J) “essentially incorporat[es] the QDRO into the ERISA plan for the purpose of determining the appropriate beneficiary.” *See Seaman v. Johnson*, 91 F. App’x 465, 470 (6th Cir. 2004).

“If Congress intended to terminate federal jurisdiction at the time that a domestic relations order was deemed a QDRO, it would presumably not have included a provision directing the plan administrator to make payments to a beneficiary who holds (or was divested of) such status based solely upon a QDRO.” *Id.* Indeed, the Sixth Circuit acknowledged: “[W]e are unable to locate a single case that stands for the proposition that federal subject matter jurisdiction terminates upon a determination that the existence of a QDRO controls the beneficiary of an ERISA plan.” *See Seaman*, 91 F. App’x at 470 (determining proper beneficiary of group life insurance policy was controlled by QDRO). *See also Carland v. Metro. Life Ins. Co.*, 935 F.2d 1114, 1118-19 (10th Cir. 1991) (holding state law claim by former spouse seeking life insurance proceeds pursuant to QDRO is preempted and converted to removable ERISA claim over which court may exercise jurisdiction); *Julia v. Bridgestone/Firestone, Inc.*, 101 F. App’x 27, 32-33 (6th Cir. 2004) (rejecting argument that state law causes of action are not preempted because former spouse’s claim for plan benefits is premised on a QDRO; “this is clearly a cause of action which ‘relates to’ an ERISA plan, and any state-law causes of action are therefore preempted”).

Finally, on a related note, insurers and their representatives should be aware that divorce decrees can be preempted by provisions of federal law other than ERISA. In *Metropolitan Life Insurance Co. v. Zaldivar*, 413 F.3d 119 (1st Cir. 2005), for example, the insurer filed an interpleader action seeking distribution of proceeds under a group life policy governed by the Federal Employees Group Life Insurance Act (“FEGLIA”). Although a state court divorce decree obligated the insured to designate his children as beneficiaries, the insured designated his second wife as sole beneficiary once the children reached adulthood. The district court held the policy proceeds should be paid to the spouse. The district court denied the request for a constructive trust based on the divorce decree, holding that FEGLIA preempted the children’s state law claim.

On appeal, the Court of Appeals for the First Circuit affirmed. The appellate court determined that *Ridgway v. Ridgway*, 454 U.S. 46 (1981), controlled the preemption question. *Ridgway* indicates Congress spoke forcefully in directing that solely the named beneficiary is entitled to proceeds of a policy governed by the Servicemen's Group Life Insurance Act. Accordingly, the serviceman's designation of a beneficiary prevailed over the imposition of a constructive trust based on a divorce decree. The Court of Appeals found *Ridgway* persuasive, and arguably binding, due to the substantial similarity in the relevant language in FEGLIA and the Servicemen's Group Life Insurance Act. Applying *Ridgway*, the Court of Appeals concluded the insured's right under FEGLIA to designate a beneficiary prevailed over the purported mandate of the state divorce decree. Indeed, FEGLIA provides a domestic decree may alter an insured's right to designate a beneficiary so long as the decree is submitted before the insured's death. The insured's children failed to avail themselves of that opportunity.

#### VIII. Conclusion

Success in litigating a life or health insurance case requires careful compliance with applicable state and federal law and a willingness to work hard to properly gather information from a variety of appropriate sources. Every year, judges are certain to make the task more difficult by issuing a plethora of decisions harmful to the insurance industry. In the final analysis, although litigating a life or health insurance case is never easy, the diligent practitioner often is the successful practitioner. Keeping abreast of the law is the first measure of necessary diligence.