Life, Health and Disability News

Spring 2006

The newsletter of the DRI Life, Health and Disability Committee

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In This Issue…

Courts Split Over Imposter Defense When Contestable Period Has Expired

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Insurance fraud is a problem of staggering proportions. By some estimates, insurance fraud is now the second largest white-collar crime in the nation, trailing only tax evasion. *See* Robert R. Googins, *Fraud and the Incontestable Clause: A Modest Proposal for Change*, 2 CONN. INS. L.J. 51, 74 & n. 106 (Spring 1996) (citing Kathryn Baker & Herbert Edelhertz, *Fighting the Hidden Crime: A National Agenda to Combat Insurance Fraud*, Battelle Seattle Res. Ctr. (March 1992)). Nationally, the cost of insurance fraud exceeds $120 billion a year. *See* Frankie Sue Del Papa, *Insurance Fraud is Not a Victimless Crime*, NEVADA LAWYER, March 2000, at 18.

It is well-recognized that the costs of insurance fraud are borne by policyholders who pay higher premiums for their policies. *See Paul Revere Life Ins. Co. v. Haas*, 644 A.2d 1098, 1107 (N.J. 1994) ("'[i]nsurance fraud is a problem of massive proportions that currently results in substantial and unnecessary costs to the general public in the form of increased rates'") (quoting *Merin v. Maglaki*, 599 A.2d 1256, 1259 (N.J. 1992)). As such, insurance fraud presents a problem not only for the insurance industry, but for innocent policyholders as well.

Recently, there has been a resurgence of what has come to be known as "imposter fraud," which has resulted in litigation between life insurers and the beneficiaries of life insurance policies. Imposter fraud occurs during the life insurance application process when someone other than the named insured appears for the medical examination that is a pre-requisite to obtaining the policy. For example, while Carlos Smith may fill out an application for life insurance,

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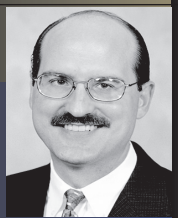

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Celebrating Our Successes

As I write this column, we are still experiencing the euphoria of our highly successful Life, Health, Disability & ERISA Conference in Washington, D.C. The topics were timely and informative. The speakers were top notch. The weather was spectacular. The social and networking opportunities were unparalleled. Oh, and we had nearly 450 attendees!

Thanks go to many who contributed to the success of this program – our advisory committee, the speakers, the DRI staff people, the technology people, CIGNA and Standard for their superb panel counsel meetings, and yes, the attendees. There is no more sophisticated audience in this area of the legal practice than what we see year in and year out at our annual conference. But let me once again thank the one person who spearheaded the entire effort – Sheila Carpenter, our 2006 Program Chair.

As many of you already know, the planning for our annual conferences is ongoing. The committee leadership has already met for an initial phone conference to discuss the 2007 program. Gary Schuman of Aon, has graciously agreed to serve as the 2007 Program Chair. He is already knee-deep in the planning process as we move toward formation of an advisory committee. Suggestions for topics and speakers are welcome and already pouring in.

Next year's conference will be a little earlier than usual – March 28-30, 2007 — so mark your calendars now. The conference will be at the Renaissance Hotel in Chicago, the location of our 2005 conference. This was a wonderful venue and we are looking forward to next year's event.

We also have other reasons to celebrate. In the February 2006 issue of *For the Defense* monthly magazine, the Life, Health and Disability Committee sponsored four substantive articles by committee members. We appreciate the efforts of our Publications Chair, Sanders Carter, in coordinating these articles. Thanks also to the authors – Byrne Decker, Jay Symonds, Sim Rapoport, Joshua Bachrach, and Nikole Crow.

Speaking of Sanders Carter, this newsletter marks a milestone: Sanders has retired as chief editor of the newsletter and this is the first newsletter edited by Kent Coppage, a partner of Sanders. Kent is already doing an excellent job of prodding authors (including yours truly!) to meet their deadlines. Committee members can be assured that the quarterly newsletter is in good hands and will continue to be of the highest quality.

We also want to recognize our Teleconference Subcommittee. Although this subcommittee is barely a year old, subcommittee chair Brooks Magratten and subcommittee vice chair Jay Symonds, recently coordinated their second teleconference program in February. The topic was, "Is the California Department of Insurance Disabling the Disability Insurers?" Speakers, Josh Bachrach, C. Mark Humbert, and Ronald Dean, did a great job of presenting a complicated topic. Ron Dean is a plaintiff's lawyer who is well known to many of our committee members and his views provided an excellent contrast to Josh and Mark. All in all, the Teleconference Subcommittee has met and exceeded expectations, due in large part to its leadership.

As we all know from our experience in the litigation business, successes are short-lived. We need to continue to push the limits of our life, health, disability, and ERISA law practices to better serve our clients and to stay a step ahead of the plaintiff's bar. We need to overlook our competitive natures and share information with each other. We need to train our younger colleagues so that they can carry on in providing the highly competent representation that our clients need and expect. We also need to pass on the sense that, at its core, our vocation is based on service to others.

Wherever we go, whatever we do, we are servants who represent our clients in the highest sense. To accomplish this calling, we need to keep current on the issues that impact our clients. The DRI Life, Health and Disability Committee will continue to nobly serve this function.

someone other than Carlos Smith is medically examined. Such fraud is employed so that policies may be obtained on the life of a person who is ill, thereby allowing beneficiaries to recover on a policy that may not have otherwise been obtained or that would have been obtained at a much higher premium. The imposter fraud schemes may be complex, involving not only the insured, but also the beneficiaries who either procure the imposters or "buy into" the policy by paying the premiums.

Imposter fraud presents a challenge to insurers because such fraud is difficult to detect, especially during a policy's contestability period. Life insurance policies contain incontestability clauses that limit the time in which an insurer may contest the validity of an insurance policy based on material misrepresentations made by the insured during the application process. The clauses are designed to "address the perception that insurers tended to avoid paying benefits because of minor misstatements in applications for insurance." *Galanty v. Paul Revere Life Ins. Co.*, 1 P.3d 658, 665 (Cal. 2000). Insurers began voluntarily including incontestability clauses in policies in the middle of the 19th century to promote sales to a public that was "generally distrustful of insurers." *Id.* States began to require that life insurance policies contain incontestability clauses in the early 1900s. *See id.; Mut. Life Ins. Co. of New York v. Ins. Comm'r for the State of Maryland*, 723 A.2d 891, 894 (Md. 1999); *see generally Paul Revere Life Ins. Co. v. Haas*, 644 A.2d 1098, 1101-02 (N.J. 1994); Eric K. Fosaaen, Note, *AIDS and the Incontestability Clause,* 66 N.D. L. Rev. 267, 268-70 (1990).

It cannot be overly emphasized that in cases dealing with an imposter undergoing the medical examination, "imposter" refers to *impersonation* of the insured — *not* merely a *false representation* about the insured. The distinction is significant because while a claim of misrepresentation is generally barred by contestability clauses, claims of imposter fraud may not be barred.

The Imposter Defense to Incontestability

A number of courts have allowed insurers to contest the enforceability of a policy, even after expiration of the contestability period, in cases where an imposter appears for the requisite medical examination, thereby recognizing what is commonly referred to as the "imposter defense" to incontestability. These courts recognize that the insurer intended to insure the life of the person appearing for the medical examination, not the life of the person whose name appears on the application form. This precludes contract formation in the first place and renders the insurance contract void *ab initio*. Under traditional principles of contract law, there was never a "meeting of the minds" between the insurer and the insured on an essential element of the contract — the insured's true identity. These courts conclude that, if the insurer contracted with anyone, it was with the person who underwent the medical exam. *See* COUCH ON INSURANCE 3d § 87:23 (p. 46-47) ("A contract based upon a medical examination of one impersonating the insured is void *ab initio*. Stated otherwise, the fraud of the applicant in substituting a healthy person for the purpose of the medical examination vitiates the policy granted on the faith of such examination . . .").

The imposter defense was first articulated in *Maslin v. Columbian National Life Insurance Co.*, 3 F. Supp. 368 (S.D.N.Y. 1932). In that case, the insurer issued two life insurance policies to the plaintiff's son, Samuel Maslin, naming the plaintiff as the beneficiary. *Id.* at 368-69. After the contestability period in the policies expired, the insurer discovered that an imposter had signed the insurance application and posed as the insured during the medical examination. *Id.* at 369. The beneficiary moved for summary judgment, arguing that the incontestability clause barred the insurer from raising any defense. *Id.* at 368-69.

The New York court recognized the "general rule" that "after passage of the stipulated time the insurance company is precluded from contesting the policy on the ground of false representations by the insured, even those made fraudulently." *Id.* at 369. The court nevertheless determined that the defense of an alleged impersonation of the insured by another at the physical examination was not barred by the incontestability clause. *Id.* The court relied upon contract law principles: "It is a rule applicable to contracts generally that where a man, pretending to be someone else, goes in person to another and induces

him to make a contract, the resulting contract is with the person actually seen and dealt with and not with the person whose name was used." *Id.* at 370. Because an imposter, rather than the named insured, presented himself for the required physical examination, the insurance policy was never enforceable vis-a-vis the named insured. *Id.*

The Pennsylvania Supreme Court similarly held in *Ludwinska v. John Hancock Mutual Life Insurance Co.*, 178 A. 28 (Pa. 1935). The court explained that, in insurance policies, as in any other contract, there must be a meeting of the minds on all essential elements before any contract exists. *Id*. at 30. "Without this neither the incontestable clause contained in the policy nor the policy itself have any life. The clause can rise no higher than the policy; the incontestable clause cannot of itself create the contract." *Id.* Because the plaintiff beneficiary applied for a life insurance policy using her sister's name and posed as her sister at the physical examination, there was no contract between the insurer and the named insured. *Id.* at 30-31.

The Seventh Circuit subsequently followed *Maslin* and *Ludwinska* in *Obartuch v. Security Mutual Life Insurance Co.*, 114 F.2d 873 (7th Cir. 1940), *cert. denied*, 312 U.S. 696 (1941). There, the named insured was not aware of the policy and did not submit to the medical examination. "Thus there was no meeting of the minds — a fundamental requisite of all contracts — the policies as issued were void and the incontestable clause without effect." *Id.* at 878. Other courts have similarly held that an insurer is entitled to rescind a policy where an imposter submits to the requisite medical examination. *See, e.g., Valant v. Metropolitan Life Ins. Co.*, 23 N.E.2d 922 (Ill.App.Ct. 1939).

In these particular cases, there was evidence both that the named insured did not sign the initial life insurance application and that an imposter submitted to the medical examination. However, subsequent courts have applied the imposter defense to allow a policy to be rescinded solely on the basis that an imposter appeared at the medical examination.

For example, in *Strawbridge v. New York Life Insurance Co.*, 504 F. Supp. 824, 830-31 (D.N.J. 1980), the evidence indicated an imposter took the physical examination. *See Strawbridge*, 504 F. Supp. at 830. The court determined that there accordingly was no meeting of the minds between the insurer and the named insured with regard to the identity of the insured, precluding contract formation. *Id.* at 830-31. The court stated: "[I]t is a well established principle of insurance law that the [incontestability] clause does not bar such proof." *Id.* at 830 (citing *Maslin; Petaccio v. New York Life Ins. Co.*, 189 A. 697 (Pa.Super.Ct. 1937); 12 Appleman, *Insurance Law and Practice* § 7123). The fact that the named insured signed the initial life insurance application did not create a contract.

Similarly, in *Blair v. Berkshire Life Ins. Co.*, 429 F.2d 996, 999 (3d Cir. 1970), the named insured signed part I of the application and an imposter signed part II of the application. The court held that, if an imposter took the physical examination and signed part II of the written application, the insurer would have a "complete defense" to the enforceability of the policy. *Id.* at 999. Here again, it was immaterial that the named insured filled out the initial application.

In *Fioretti v. Massachusetts General Life Insurance*, 892 F. Supp. 1492 (S.D. Fla. 1993), *aff'd*, 53 F.3d 1228 (11th Cir. 1995), the named insured, who was HIV positive, either arranged for an imposter to appear for the requisite blood test or arranged for the substitution of another person's blood sample for his. *Id.* at 1493. There was no question that the named insured himself filled out and signed the insurance application forms, including a statement of good health. *Id.* at 1494. The district court did not resolve whether Florida, New Jersey or New York law applied to the case, determining that all three states would recognize the imposter defense, allowing insurers to contest a life insurance policy, even after expiration of the contestability period, where someone other than the named insured appears for the requisite medical examination. *Id.* at 1496-97.

In reaching this conclusion, the district court distinguished cases of fraudulent misrepresentation on application forms from that of imposture, observing:

> The medical examination is the linchpin of the life insurance application. It is the determinative event for the formation of the contract. The substitution of an imposter for the insured at the medical examination is such a serious and shocking strain of fraud precisely because it is so stealthily ingenious - - piercing right to the heart of the deal, and virtually impossible for the insurance company

to detect through reasonable and ordinary business procedures.

Id. at 1496. It determined that, because of the difficulty of detecting the substitution of an imposter for the insured and "to prevent manifest injustice," beneficiaries of such policies should not be protected by the incontestability clause. *Id.* Moreover, it observed that the incontestability clause is designed to promote stability by creating a reasonable expectation by the insured that a claim on a valid policy will be paid: under an imposter situation, the beneficiary had no such reasonable expectation of payment. *Id.*

In reaching its decision that Florida would recognize the imposter defense, the court determined that a statement in *Bankers Security Life Ins. Society v. Kane*, 885 F.2d 820 (11th Cir. 1989), that Florida would not recognize the imposter defense could only be properly viewed as *dicta*.

In *Kane*, the Eleventh Circuit was presented with the question of whether Florida would recognize an exception to the incontestability clause where the named insured, who entered a witness protection program, withheld information concerning his criminal background in his life insurance application. 885 F.2d at 821. In that case, the insurer sought to rescind the policy on the basis of the insured's own written misrepresentations - - not impersonation at the medical examination. *Id.* Consequently, although *Kane* noted that Florida law would not recognize the imposter defense, that observation can only be properly viewed as *dicta*, as determined in *Fioretti*.

The *Fioretti* case was affirmed on appeal with respect to New Jersey law. The Eleventh Circuit, however, declined to determine whether the court properly interpreted Florida law or the scope of its opinion in *Kane*. *See Fioretti v. Massachusetts Gen. Life Ins. Co.*, 53 F.3d 1228, 1235 n.23 (11th Cir. 1995).

Accordingly, the majority of cases involving an imposter posing as the named insured have allowed the insurer to contest the policy, even though the named insured signed the initial life insurance application forms.

Indeed, the imposter defense has also been extended to allow an insurer to rescind a policy where the named insured applied for and signed the application, but unlawfully intercepted mail sent to the doctor named as his physician, who was to verify his health, falsified the health information requested and forged that doctor's signature. *See Unity Mut. Life Ins. Co. v. Moses*, 621 F. Supp. 13 (E.D.Pa.), *aff'd*, 780 F.2d 1015 (3d Cir. 1985).

The two most recent decisions considering imposter fraud, however, have declined to recognize the imposter defense to incontestability.

Recent Decisions Declining to Apply Imposter Defense

The case of *Amex Life Assurance Co. v. Superior Court*, 930 P.2d 1264 (Cal. 1997), was the first reported case where a court declined to recognize the imposter defense when faced with an imposter posing as the insured at the requisite medical examination. The *Amex* case is factually similar to *Fioretti*.

In *Amex*, the named insured knew he was HIV positive, lied on the life insurance application form, and sent an imposter to take the mandatory medical examination. *Id.* at 1265. Unlike *Fioretti*, however, the *Amex* court held that the parties' intent was to insure the person whose name appeared on the policy. *Id.* at 1271. Because the named insured did everything but take the medical examination, the court determined that the facts of the case did not come within those cases recognizing the imposter defense. *Id.* In so holding, the court concluded that the fraud involved in having an imposter pose as the insured in the medical examination was substantially similar to other frauds covered by the incontestability clause. *Id.*

Recently, in *Allstate Life Ins. Co. v. Miller*, 424 F.3d 1113 (11th Cir. 2005), the Eleventh Circuit determined that Florida would not recognize the imposter defense. In that case, the insurer sought a declaratory judgment that the policy was void *ab initio*, after expiration of the contestability period, on the basis that someone other than the named insured appeared for the requisite medical examination. *Id.* at 1114. The Eleventh Circuit affirmed the district court's decision granting summary judgment against the insurer on the basis that the action was barred because the contestability period had expired. The court reasoned that there was no material difference between imposter fraud and fraudulent misrepresentations on the insurance application. The court went on to liken the Florida statute requiring contestability clauses in insurance policies to a statute of limitations. As such, the court implicitly determined that *Fioretti* was wrongly decided as to Florida law.

Public Policy Considerations

Incontestability clauses were designed to (1) encourage insurers to investigate facts promptly, (2) protect insureds' reasonable expectations of recovery, (3) prevent insurers from relying on minor misstatements to void policies, and (4) preclude life insurers from making charges against deceased individuals who are unable to rebut them.

None of these purposes is served by enforcing an incontestability clause when a life insurance policy is procured through the use of an imposter. First, imposter fraud is virtually undetectable because it is the medical examination itself that insurers rely upon to verify the representations made in the insurance application forms. Consequently, it is inequitable to punish the insurer for failing to discover the fraud during the policy's contestability period. Second, insureds and beneficiaries do not have a reasonable expectation of recovery when they have engaged in such a fraudulent scheme. Third, the goal of preventing insurers from voiding policies based on minor misstatements or technicalities is inapplicable when the policy was secured as a result of imposter fraud. Finally, in most imposter cases, unlike ordinary misrepresentation cases, the perpetrators (typically, the beneficiaries and the imposter) are still alive when a claim is made on the policy and the insurer seeks to challenge the policy's validity. Accordingly, there is no public-policy justification for enforcing incontestability provisions in such circumstances.

Indeed, declining to recognize an exception for imposter fraud would affirmatively contravene public policy. In addition to being unfair to insurers, such a rule would reward, and thus encourage, insurance fraud and shift the costs of that fraud to both innocent policyholders and individuals seeking coverage. If left defenseless against this increasingly common fraudulent scheme, insurers will be forced to pass on the costs of fraudulent recoveries to current policyholders through higher premiums, and will be inclined to refuse to consider the application of any individual who is unable to identify an attending physician who can confirm the applicant's medical history. Honest consumers of life insurance will suffer.

Conclusion

In sum, if the *Amex* and *Miller* decisions result in a trend to refuse to recognize an imposter exception to incontestability clauses, the end result will be to encourage insurance fraud and shift the costs of that fraud from criminal actors to innocent consumers of life insurance. This shift of costs does not promote any social good, but rather allows criminals to profit from their fraudulent conduct.

EDITORIAL INFORMATION

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Video Surveillance Evidence Raises Issues of Admissibility and Potential Liability

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Video surveillance can be a powerful tool in investigating disability insurance claims, particularly in guarding against fraud. Courts generally recognize this fact and take the social utility of insurance investigations, including video surveillance, into account when dealing with video surveillance evidence.

This article examines general trends and factors in courts' treatment of video surveillance evidence – under what circumstances insurance companies may admit it at trial, as well as under what circumstances courts will evaluate insurers to be liable for abuses in conducting such surveillance.

Admissibility of Video Surveillance Evidence

Video surveillance evidence regarding the physical condition or abilities of individuals claiming injury or disability is commonly admitted into evidence in personal injury and disability insurance cases. Trial courts have wide discretion to admit or refuse to allow video surveillance evidence. *See, e.g., Clark v. Matthews*, 891 So.2d 799 (La. App. 5th Cir. 2005); *Gerbino v. Tinseltown USA*, 13 A.D.3d 1068, 1070 (N.Y.A.D. 4th Dept. 2004).

Courts have sometimes been justifiably wary of surveillance video due to its potential for being manipulated and misrepresenting a situation while appearing to present hard objective evidence. The Louisiana Supreme Court stated that "evidence in the form of moving pictures or videotapes must be approached with great caution because they show only intervals of the activities of the subject, they do not show rest periods, and do not reflect whether the subject is suffering pain during or after the activity." *Olivier v. LeJeune*, 668 So.2d 347, 351 (La. 1996).

Because of this caution, courts generally pay particular attention to whether the probative value of this type of evidence is outweighed by its potential prejudicial effect, and it is this basis that is most often cited when video surveillance evidence is not admitted. Other bases for objection to video surveillance evidence, including hearsay, attorney work product privilege, lack of authentication and misconduct of the investigator, are usually not successful at keeping out video surveillance evidence.

Admissible if Probative Value Not Outweighed by Prejudicial Effect

Whether or not the probative value of video surveillance evidence is outweighed by its prejudicial effect is obviously a very fact-specific determination. In general, the probative value is judged to be weightier, and the evidence is admitted, where the subject individual's physical condition or abilities are a significant issue and where the video surveillance evidence fairly depicts that condition or those abilities.

A typical case where video surveillance evidence was held to have been properly admitted is *Brokamp v. Mercy Hosp. Anderson*, 726 N.E.2d 594 (Ohio App. 1st Dist. 1999). The plaintiff and his wife brought suit for negligence and loss of consortium due to nerve damage allegedly caused by an improper intramuscular injection. The appellate court held that the trial court did not err in admitting surveillance video of plaintiff playing golf over plaintiff's objection that it was incompetent and highly prejudicial. The investigator's testimony sufficiently authenticated the video, and because plaintiff's alleged damages were directly related to his causes of action, the probative value outweighed its prejudicial effect.

A similar case is *Olivier v. LeJeune*, 668 So.2d 347 (La. 1996), where the defendant had stipulated to liability and the trial was solely to determine damages resulting from an automobile accident. The trial court allowed the defendant to introduce a surveillance videotape showing the plaintiff performing activities the plaintiff had previously stated in a sworn statement

he was unable to perform. On appeal, the plaintiff argued that because the plaintiff, at trial, described his physical abilities consistent with the videotape (in contrast to what he had earlier stated in his sworn statement), the tape had no impeachment value and had significant prejudicial effect. The Louisiana Supreme Court held that the trial court did not abuse its discretion in admitting the videotape and finding that its probative value as to the plaintiff's credibility was not outweighed by its potential prejudicial effect.

In *Albrecht v. Dorsett*, 508 S.E.2d 319 (N.C. App. 1998), several occupants of a van brought a personal injury action against a motorist who struck them. During the course of the litigation, the defendant had video surveillance of the plaintiffs conducted. The video "depicted plaintiffs engaging in various physical activities, which was probative of whether and to what extent plaintiffs were disabled by the injuries they sustained in the automobile accident." *Id.* at 323. In addition to arguing that the video was irrelevant, the plaintiffs objected on the grounds that the video was prejudicial because it was lengthy and repetitive. The court reasoned that the video was relevant because the existence and extent of the plaintiffs' disabilities were at issue in determining the plaintiffs' damages. *Id.* at 323. As to the prejudicial effect, the appellate court held that the trial court was within its discretion to admit the video despite its length and repetitive nature.

In *Luther v. Norfolk and Western Ry. Co.*, 649 N.E.2d 1000 (Ill. App. 5th Dist. 1995), video surveillance evidence was held properly admitted even though it merely corroborated the subject individual's testimony and medical testimony. This case was somewhat unusual, though not unique, in that while the defendant in the personal injury suit was the party who had the surveillance conducted, it was the plaintiff who offered the video because it confirmed rather than refuted his claimed injuries. (More such cases will be discussed below in the section dealing with the risks of video surveillance evidence.) Because the individual depicted in the video was the same party who was offering it into evidence, there was no basis for the defendant to claim prejudicial effect.

The court in *LeMasters v. Boyd Gaming Corp.*, 898 So.2d 497 (La. App. 5th Cir. 2005), did not articulate its reasoning, but held that the trial court was not in error in admitting video surveillance evidence even where the plaintiff had not testified she was unable to perform the activities depicted in the video. The plaintiff allegedly suffered a hand injury when the door of a casino slot machine fell open and struck her. *Id.* at 499. The plaintiff worked as a waitress at a coffee shop both before and after the accident, and she testified that pain from her injury did not prevent her from performing most of her job duties, just "heavy work." *Id.* at 500. The defendant was allowed to introduce video surveillance evidence showing the plaintiff at her job, using her allegedly injured hand. Because the plaintiff had not testified that she could not perform the activities depicted in the video, the probative value in such a case would not be as great as where the subject individual had clearly stated he or she was unable to perform the activities that they were filmed performing.

Inadmissible if Prejudicial Effect Outweighs the Probative Value

The similarity of the *LeMasters* case, 898 So.2d 497, to other cases where video surveillance evidence was held *in*admissible based on the prejudicial effect outweighing the probative value demonstrates how fact-specific the determination is, as well as how wide a trial court's discretion is in making that determination.

In *Quinn v. Wal-Mart Stores, Inc.*, 774 So.2d 1093 (La.App. 2d Cir. 2000), video surveillance evidence was held inadmissible where the plaintiff had not said she was unable to perform the activities shown in the video. The plaintiff was injured when a television fell on her in defendant's store, striking her on the neck and shoulder, and she claimed that she suffered from significant pain that prevented her from performing certain activities for very long. The defendant attempted to offer surveillance video of the plaintiff performing some of the activities she had testified about, but the trial court ruled that the potential prejudicial effect of the video outweighed its probative value. In affirming the trial court's ruling, the appellate court noted that the plaintiff had not testified that she was completely unable to perform the activities, just that they caused her pain and she could not do them for a prolonged period. The court also noted that:

> the tapes do not fairly indicate whether Mrs. Quinn did experience pain after engaging in these activities. Accordingly, showing these tapes to the jury without context or explanation, could, as the trial court concluded, create a

> prejudicial impression on the jury that outweighs any probative value they may have to impeach Mrs. Quinn's testimony.

Id. at 1098.

Another case where the proffered video surveillance evidence was not admitted on the basis of potential prejudicial effect is *Gerbino v. Tinseltown USA*, 13 A.D.3d 1068 (N.Y.A.D. 4th Dept. 2004). The appellate court held that the trial court did not err in refusing to admit video surveillance evidence of the personal injury plaintiff where the videotape was not inconsistent with the plaintiff's testimony concerning his injuries. *Id.* at 1070.

In *Franz v. First Bank System, Inc.*, 868 So.2d 155, 162 (La.App. 4th Cir. 2004), the trial court was held to have properly refused to admit video surveillance evidence where there had already been sufficient testimony regarding the plaintiff's credibility, and the trial court felt that "'the issue is going to be the medical testimony.'" The probative value of the evidence was thus small and easily outweighed by even a small potential for prejudice.

Reported cases include several other bases on which parties have objected to video surveillance evidence. Most of these have generally been unsuccessful for reasons which would be likely to apply to most video surveillance evidence (as opposed to being case- or fact-specific).

Hearsay Objection to Surveillance Is Generally Unsuccessful

Although it is certainly conceivable that an individual depicted in a surveillance video would make some statement in the video relevant to the purposes for which the video is being offered, this is usually not the case. (Where this is the case, the party-admission exception to the hearsay rule would probably apply to most instances where the individual on the video is a personal injury or disability insurance plaintiff and the video is being offered by the defendant.) A large part of the reason that video surveillance evidence is potentially powerful and effective is that it does not rely on statements but rather shows the individual actually doing the thing he or she claimed she could not do. The typical testimonial infirmities of memory, sincerity, accurate expression, and perhaps perception too, are by-passed by letting the jury see the individual's activities for themselves. The hearsay rule therefore usually is not applicable to video surveillance evidence and not a successful basis for objecting to its admission.

In *Hairston v. Metro-North Commuter R.R.*, 6 Misc.3d 399 (N.Y.Sup. 2004), another case where the subject of the surveillance sought to introduce the video surveillance evidence herself, the personal injury plaintiff obtained a copy of the surveillance video from the defendant in discovery. Presumably because the video showed the plaintiff "going through her life's activities outdoors using a walker", the defendant did not seek to introduce the video into evidence and objected when the plaintiff tried to do so. *Id.* at 400. The appellate court held that the trial court properly overruled the defendant's objections, among which was that the video was barred by the hearsay rule. Because the video had no sound other than static and the plaintiff did not commit any nonverbal acts therein that could constitute a statement, the hearsay rule was inapplicable.

Work Product Privilege No Bar to Surveillance Evidence

In cases such as *Luther,* 649 N.E.2d 1000, and *Hairston,* 6 Misc.3d 399, where it is the plaintiff who is offering the video surveillance evidence even though the video was made by the defendant, some defendants have attempted to use the attorney work product doctrine to keep the video out. In *Constantine v. Schneider*, 715 A.2d 772 (Conn. App. 1998), the appellate court held that it was error for the trial court to refuse to admit surveillance video of the plaintiff, when it was offered by the plaintiff, based on the attorney work product doctrine. The appellate court explained that this was because the attorney work product doctrine was a valid objection only during discovery, not at trial.

Misconduct by Investigator Not a Basis for Precluding Evidence

Although it may serve as the basis for a tort claim against the investigator and/or the investigator's hirer (discussed in detail below), misconduct by an investigator is not a basis for keeping out video surveillance evidence.

In *Tompkins v. VanOrden*, 2003 WL 22719331 (Pa.Com.Pl. 2003), a personal injury plaintiff attempted to exclude video surveillance evidence based on her assertion that the investigator who recorded the video trespassed on her private property to do so. The court carefully examined possible legal bases for excluding the evi-

dence on these facts but found none that would support such an exclusion. The court first looked at whether there was any Constitutional basis for excluding the evidence. In a criminal matter, of course, evidence wrongfully obtained is generally excluded under the Fourth Amendment and the poisonous fruit doctrine. The Fourth Amendment and the poisonous fruit doctrine only apply to state actors in criminal matters, however, not to private parties. The court next turned to any statutory basis for excluding the evidence and determined that there was none under Pennsylvania law. Finally, the court found no basis in common law to exclude the evidence.

Failure to Disclose Surveillance During Discovery Bars Admittance

The one basis on which video surveillance evidence has been excluded, other than because of prejudicial effect, is when its proponent failed to disclose it during discovery. In *Clark v. Matthews*, 891 So.2d 799 (La.App. 5th Cir. 2005), a personal injury plaintiff had requested, during discovery, "production of investigator's reports." The defendant had failed to produce a surveillance videotape that he had had made. The appellate court held that the trial court properly found that the plaintiff's discovery request covered the surveillance videotape, and therefore neither the tape nor information learned from it could be used by the defendant at trial.

Similarly, in *Chiasson v. Zapata Gulf Marine Corp.*, 988 F.2d 513 (5th Cir. 1993), the defendant in the personal injury action failed to produce a surveillance videotape of the plaintiff which showed the plaintiff engaging in various activities which the defendant argued were inconsistent with her claimed injuries. The trial court allowed the defendant to present the videotape on the theory that it was solely for impeachment purposes and therefore did not have to be disclosed in discovery. The appellate court held that this was reversible error because the tape was at least in part substantive.

Proper for ERISA Administrators to Utilize Surveillance

In the context of group disability insurance policies governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.*, the issue of admissibility of video surveillance evidence at trial generally does not arise because ERISA trials are usually bench trials based solely on the administrative record compiled by the claim administrator. The issue of whether claim administrators may rely on video surveillance in making claim decisions does arise not infrequently, however.

Courts have consistently held that it is not improper for an ERISA claim administrator to rely on video surveillance in denying a claim. In the following cases, courts held that reliance on video surveillance evidence did not constitute an abuse of discretion: *Briggs v. Marriott Intern., Inc.*, 368 F.Supp.2d 461 (D. Md. 2005); *DiCamillo v. Liberty Life Assur. Co.*, 287 F.Supp.2d 616 (D. Md. 2003); *Vlass v. Raytheon Employees Disability Trust*, 244 F.3d 27 (1st Cir. 2001); *McGarrah v. Hartford Life Ins. Co.*, 234 F.3d 1026 (8th Cir. 2000). In *Schindler v. Metropolitan Life Ins. Co.*, 141 F.Supp.2d 1073 (M.D. Fla. 2001), the court held that reliance on video surveillance evidence was not improper under a *de novo* standard of review. In *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 841 (8th Cir. 2001), the court noted that "there is nothing procedurally improper about the use of surveillance," and held that reliance on a surveillance report did not warrant a heightened standard of review.

While the fact that a claim administrator relied on surveillance in denying a claim is not improper, the surveillance must support the administrator's decision. For example, in *Dorsey v. Provident Life and Acc. Ins. Co.*, 167 F.Supp.2d 846 (E.D. Pa. 2001), the court held that, under a heightened abuse-of-discretion standard of review, the claim administrator did abuse its discretion when it denied an LTD claim based on surveillance video that did not show substantial evidence of the participant's ability to return to work.

Special care must be taken with conditions such as fibromyalgia syndrome and chronic fatigue syndrome, where a claimant's activities shown on surveillance video may not necessarily evidence his or her degree of disability.

In *Morgan v. UNUM Life Ins. Co. of Am.*, 346 F.3d 1173 (8th Cir. 2003), the claimant alleged that he was disabled due to fibromyalgia. The claimant's treatment records showed, and the claimant stated in a telephone interview with the claim handler, that he regularly engaged in light exercise. The claim administrator subsequently approved the claim for LTD benefits. Later, the administrator obtained video surveillance

showing the claimant performing light exercise. Because these were the same activities the claimant had already told the insurer he engaged in, the surveillance did not constitute any new evidence and did not support the claim administrator's subsequent denial of benefits.

In *Clausen v. Standard Ins. Co.*, 961 F.Supp. 1446 (D. Colo. 1997), the claimant alleged that she was disabled due to chronic fatigue syndrome. Although surveillance showed the claimant engaging in light activity, this was not inconsistent with her diagnosis of chronic fatigue syndrome, and the court found that the claim administrator abused its discretion in relying on this surveillance to deny her LTD claim.

On the other hand, video surveillance can be powerful evidence against a claimant with alleged conditions of fibromyalgia and chronic fatigue. In *Epstein v. UNUM Life Ins. Co. of Am.*, 2004 WL 2418310 (C.D. Cal. Oct. 13, 2004), the claimant and her treating physician reported that the claimant was unable to work and would likely never be able to work. Upon receiving these reports, UNUM paid benefits for over six years. UNUM performed surveillance and discovered that the claimant left her residence every day to run errands or take her daughter to school. UNUM also saw the claimant running and pushing her daughter in a stroller.

Upon further review of the medical records and the completion of an IME, UNUM denied the claimant further benefits. At the ERISA trial, the court reviewed the video surveillance and found the "surveillance videos to be powerful and persuasive new evidence that, especially with Plaintiff's statements ... that she stayed home 'almost all the time' and she experienced increased pain just walking up and down stairs, justified UNUM's conclusion that its previous acceptance of Plaintiff's claim was no longer warranted." To further punctuate the impact of the video, the trial judge found that the suit had been brought "in bad faith" and awarded UNUM $10,000 in attorney fees.

Risks to Insurers Associated with Using Surveillance

One potential risk of attempting to use video surveillance evidence at trial is that the insured may try to turn the tables and use the evidence to his or her advantage. This would only be the case, of course, where the surveillance at least arguably does not support the insurance company's position. *Luther*, 649 N.E.2d 1000, *Hairston*, 6 Misc.3d 399, and *Constantine,* 715 A.2d 772, discussed above, are examples of this. Each of these was a personal injury suit in which the defendant had surveillance conducted on the plaintiff, the surveillance video was disclosed during discovery, and then the plaintiff used or attempted to use the video at trial to show that his activities were consistent with his claimed injuries. In each case, the defendant tried to prevent the plaintiff from using the video, but the appellate courts all held that the defendants had no valid basis for doing so.

A more general risk associated with video surveillance evidence, that is not limited to instances where the video may arguably not support the insurance company's position, is that the insured may sue the insurance company for alleged torts committed by the third-party investigator in the course of having the surveillance conducted and the video made, particularly invasion of privacy. Two major questions exist here: (1) whether the insurance company can be liable for the torts of the third-party investigator; and (2) if so, when will surveillance give rise to an invasion of privacy.

Insurance Companies' Liability for Actions of Investigators

In general, there is no vicarious liability for the torts of another, absent an agency relationship. *Davis v. Fulton County*, 884 F.Supp. 1245 (E.D. Ark. 1995), *aff'd*, 90 F.3d 1346 (8th Cir. 1996), *rehearing and suggestion for rehearing denied* (1996); *Washington Metropolitan Area Transit Auth. v. L'Enfant Plaza Properties, Inc.*, 448 A.2d 864 (D.C. 1982). Some courts have held, however, that the hirer of an investigator may be liable for his torts without reference to an agency relationship. Additional theories under which an insurance company may be sued for the actions of a third-party investigator are that an agency relationship did exist by virtue of the control the insurer exercised over the investigator or by ratification of the investigator's actions, or that the insurer is liable for negligent supervision or entrustment.

Vicarious Liability

The court in *Noble v. Sears, Roebuck & Co.*, 109 Cal.Rptr. 269 (Cal.App. 1973), examined holdings of courts in various jurisdictions on the issue of whether and under what theory the

hirer of an investigator may be liable for the investigator's torts. Courts have reached a variety of conclusions. *Id.* at 273-74. Bases for distinguishing when the hirer of a third-party investigator would be liable for the investigator's actions included whether the hirer exercised control over the investigator (*Clinchfield Coal Corp. v. Redd*, 96 S.E. 836 (Va. 1918); *Adams v. F.W. Woolworth Co.*, 144 Misc. 27 (N.Y. Sup. 1932); *Inscoe v. Globe Jewelry Co.*, 157 S.E. 794 (N.C. 1931)), whether the plaintiffs were invitees of the hirer (*Nash v. Sears, Roebuck & Co.*, 163 N.W.2d 471 (Mich. App. 1968), *reversed on other grounds* in 174 N.W.2d 818 (Mich. 1970); *Halliburton-Abbott Co. v. Hodge*, 44 P.2d 122 (Okla. 1935)), and whether the investigator was hired for a single investigation or was retained for general protection of property (*Milton v. Missouri Pac. R. Co.*, 91 S.W. 949 (Mo. 1906)).

The *Noble* court itself came to the conclusion, based on prior California cases, that the hirer of an investigator could be liable for his torts *regardless of the existence of an agency relationship*, as long as those actions were within the scope of his employment. *Id.* at 274. Another case reaching the same conclusion is *Ellenberg v. Pinkerton's, Inc.*, 188 S.E.2d 911 (Ga. App. 1972) (holding that where an employer hired an investigator to conduct surveillance of one of its employees, the employer could not delegate its duty to conduct a reasonable investigation and therefore the independent contractor theory, which would insulate the employer from liability for torts committed by the investigator, was inapplicable).

Another avenue for establishing vicarious liability of an insurance carrier for torts committed by a third-party investigator is ratification. Cases finding vicarious liability through ratification include *Great Atlantic & Pacific Tea Co. v. Federal Detective Agency, Inc.*, 157 So.2d 148 (Fla. App. 1963), *cert. denied*, 165 So.2d 177 (1964) (finding hirer of detective agency liable for acts of investigator through ratification where investigator was told store was not interested in legal action to collect on bad check and store took no steps to effect dismissal of charges filed against suspect); *Dillon v. Sears-Roebuck Co.*, 253 N.W. 331 (Neb. 1934) (finding vicarious liability based on ratification where store executives hired private detective and thereafter approved his restraint of suspect).

Negligent Supervision or Entrustment

In *Noble*, 109 Cal.Rptr. 269, the court also examined whether the hirer of an investigator might be liable based on negligent supervision or negligent entrustment. As to negligent supervision, the court found no authority "basing liability on lack of, or on inadequate, supervision, in the absence of knowledge by the principal that the agent or servant was a person who could not be trusted to act properly without being supervised." *Id.* at 275. As to negligent entrustment, the court stated that the hirer could be negligent in selecting the investigator based on the particular facts of the situation. *Id.*

Invasion of Privacy

The most common claim insureds bring against insurance companies related to surveillance is invasion of privacy. The success of such claims depends on the circumstances of the surveillance and the actions of the investigator.

"Invasion of privacy" is generally held to encompass four distinct wrongs: (1) intrusion upon seclusion or solitude; (2) public disclosure of private facts; (3) publicity which places an individual in a false light; and (4) appropriation of name of likeness. *See* Restatement (Second) of Torts, §§ 652B-E (1977). Claims for invasion of privacy against insurance companies based on surveillance are usually based on the first of these, wrongful intrusion.

The Restatement defines wrongful intrusion as follows:

> One who intentionally intrudes, physically or otherwise, upon the solitude or seclusion of another or his private affairs or concerns, is subject to liability to the other for invasion of his privacy, if the intrusion would be highly offensive to a reasonable person.

Id., § 652B (1977).

The comments to this section of the Restatement make it clear that wrongful intrusion does not require publicity or publication, but rather is based solely on either a physical intrusion into a place where a person has a reasonable expectation of privacy or into an individual's private affairs. Importantly, an intrusion may be found where an individual technically is in public, but observations are made concerning "some matters ... that are not exhibited to the public gaze." *Id.* at comment c.

The key determination to be made is whether the intrusion would be

"highly offensive to a reasonable person." This is a very fact-specific determination, but there are a number of commonly-occurring factors, both in terms of the situation of the individual being observed and the actions of the observer, that may strengthen or weaken a claim for wrongful intrusion.

Factors Affecting the Expectation of Privacy

In determining whether surveillance constitutes an intrusion highly offensive to a reasonable person, one of the most relevant factors is whether the person had an expectation of privacy concerning the observations made in the surveillance. Many courts have held that where an individual brings a personal injury action or a workers' compensation or disability insurance claim, that individual should expect an investigation of the claim, and so the claimant has a decreased expectation of privacy as to observations made relating to their claimed disability.

For example, in *I.C.U. Investigations, Inc. v. Jones*, 780 So.2d 685, 689 (Ala. 2000), the court stated that persons "making personal-injury claims must expect reasonable inquiry and investigation to be made of their claims and that to this extent their interest in privacy is circumscribed." (Internal quotations omitted.) Because the plaintiff there had a pending workers' compensation case in which the key issue was the extent of his injury, the court found that he should have expected a reasonable investigation regarding his physical capacity.

In *Furman v. Sheppard*, 744 A.2d 583 (Md. App. 2000), the court indicated that the fact that the plaintiff was also the plaintiff in a personal injury suit lessened his expectation of privacy as to investigations of his physical condition. Likewise, in *McLain v. Boise Cascade Corp.*, 533 P.2d 343 (Or. 1975), the court stated, "It is also well established that one who seeks to recover damages for alleged injuries must expect that his claim will be investigated and he waives his right of privacy to the extent of a reasonable investigation."

It is universally acknowledged that a person has less of an expectation of privacy when he or she is in public that when he or she is in a private setting such as the home. In *Johnson v. Stewart*, 854 So.2d 544 (Ala. 2002), the Supreme Court of Alabama stated "generally, the observation of another person's activities, when that other person is exposed to the public view, is not actionable under the wrongful-intrusion branch of the invasion-of-privacy tort." *Id.* at 549.

In *Digirolamo v. D.P. Anderson & Associates, Inc.*, 1999 WL 345592 (Mass. Super. 1999), the court stated, "To the extent that the visual surveillance by the investigator consists of observing, photographing, or videotaping a person in a public place, it violates no right of privacy." *Id.* at *2 (citing *Cefalu v. Globe Newspaper Co.*, 391 N.E.2d 935 (Mass.App. 1979)). In *Jones,* 780 So.2d 685, the fact that the surveillance complained of by the plaintiff was conducted while the plaintiff was in his front yard, in public view, was a factor in the court's finding that the investigation company should have been granted summary judgment on the plaintiff's wrongful intrusion claim. *Id.* at 689.

Other similar cases include *Creel v. I.C.E. & Associates, Inc.*, 771 N.E.2d 1276 (Ind. App. 2002) (upholding summary judgment against LTD claimant who was videotaped in church); *Salazar v. Golden State Warriors*, 2000 WL 246586 (N.D. Cal. 2000) (dismissing wrongful intrusion claim of employee who was videotaped using drugs in a car parked in a public lot); *Furman v. Sheppard, supra*, 744 A.2d 583 (upholding dismissal of wrongful intrusion claim of plaintiff who was also plaintiff in a personal injury case and who was videotaped by an investigator who trespassed in a private yacht club but observed no more than those who were not trespassing).

Cases where courts have found that surveillance *did* intrude on an individual's solitude or seclusion based on the individual's being in a private location include *Sanders v. American Broadcasting Cos., Inc.*, 85 Cal.Rptr.2d 909 (Cal. 1999) (holding that the plaintiff had stated a claim sufficient to present to a jury where the plaintiff was surreptitiously videotaped at her workplace by a journalist posing as a co-worker); *Tompkins v. Cyr*, 202 F.3d 770 (5th Cir. 2000) (upholding a jury award for wrongful intrusion based on, among other actions, viewing and videotaping the plaintiff when he was inside his home).

Factors Affecting Reasonableness of Investigators' Actions

In addition to the circumstances surrounding the subject of surveillance, the actions taken by the investigator in conducting the surveillance constitute the other major element taken into account in determining whether an intrusion would be "highly offensive to a reasonable person."

While whether the investigator trespassed on private property is often mentioned when discussing whether surveillance was reasonable, most courts have held that trespass alone will not convert an otherwise reasonable surveillance into a wrongful intrusion. In *Furman v. Sheppard, supra*, 744 A.2d 583, it was undisputed that the investigator trespassed into the private club to conduct surveillance, but this did not prevent the court from dismissing the wrongful intrusion claim. In *McLain v. Boise Cascade Corp.*, *supra*, 533 P.2d 343, the court upheld the nonsuit of plaintiff's wrongful intrusion claim where the investigator had trespassed on private property in the course of conducting otherwise unobtrusive surveillance. The court stated that while "[t]respass to peer in windows and to annoy or harass the occupant may be unreasonable", "[t]respass alone cannot automatically change an otherwise reasonable surveillance into an unreasonable one." *Id.* at 347.

A factor similar to trespass that sometimes, but not always, contributes to the determination that surveillance was unreasonable is when the investigator uses enhanced audio or visual devices to record video surveillance. In *Digirolamo v. D.P. Anderson & Associates, Inc., supra*, 1999 WL 345592, the court stated that vision-enhancing devices would intrude upon an individual's expectations of privacy.

In contrast, in *Salazar v. Golden State Warriors, supra*, 2000 WL 246586, the fact that the investigator used "high technology surveillance equipment, including night-vision infrared high-powered scoping devices" did not prevent the court from dismissing the plaintiff's wrongful intrusion claim. *Id.* at *1. Likewise, in *Swerdlick v. Koch*, 721 A.2d 849 (R.I. 1998), the court upheld a grant of summary judgment even though the defendant had used a telephoto lens to photograph the plaintiff.

Another factor that sometimes enhances the unreasonableness of surveillance is if the investigator used deception in gathering information or observing the individual. In *Hawkes v. Private Investigation Services of Maine and New England, Inc.*, 2000 WL 33721625 (Me.Super. 2000), the investigator hired by the plaintiff's insurance carrier twice gained access to the plaintiff's home on false pretenses. The court ruled that this created a sufficient question of fact, as to whether this would be highly offensive to a reasonable person, to defeat summary judgment. In *Sanders v. American Broadcasting Cos., Inc.,* 85 Cal.Rptr.2d 909, the fact that the journalist who videotaped the plaintiff became employed at plaintiff's workplace on a pretext in order to investigate the business was a factor in the court's decision that the wrongful intrusion claim was sufficient to go to a jury.

A contrasting case, however, is *Turner v. General Adjustment Bureau, Inc.*, 832 P.2d 62 (Utah App. 1992), overruled on other grounds, in which investigators posed as employees of a product marketing research company and made regular visits to plaintiff's home over a period of three months. The court held that the jury could have concluded that this did not constitute a highly offensive intrusion. *Id.* at 67.

Conclusion

The admissibility of video surveillance evidence is subject to the broad discretion of the court but generally turns on the relative weights of its probative value and potential prejudicial effect. Video surveillance is appropriate to use as evidence in an ERISA claim decision, as long as the surveillance evidence does in fact support the decision.

Insurers should be aware of the risks involved in having surveillance conducted, primarily the potential that the surveillance could be used against them and the danger that they may be held liable in the event that the insured is able to bring a successful invasion of privacy claim. These risks can be mitigated to some degree by giving guidelines to third-party investigators as to the circumstances and particular methods appropriate for conducting surveillance.

New York Insurance Department Finds Discretionary Clauses Deceptive and Unfair

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The State of New York Insurance Department has recently issued Circular Letter No. 8, dated March 27, 2006, whereby it determined that "the use of discretionary clauses violates Section 3201(c) and 4308(a) of the Insurance Law…" The letter further states that "the Department believes that the use of discretionary clauses is an unfair or deceptive act or practice, within the meaning of Article 24 of the Insurance Law…" Although the subject of the letter includes "Disability Income Insurance", the letter appears to limit its scope by adding that "discretionary clause provisions in accident and health insurance polices and in subscriber contracts will no longer be approved by the Department."

This action by the New York Department of Insurance may have tremendous ramifications in the insurance industry. In addition to accident and health insurance policies, most disability policies contain some form of discretionary language. While there is limiting language in the circular, the overall language used is very broad and will, presumably, sweep across all insurance policies. Two questions immediately come to the forefront: first, whether there will be any retroactive effect on pending or potential litigation stemming from this language; second, whether the Insurance Department has the authority to make a unilateral determination.

The United States Supreme Court held in *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101 (1989) that a discretionary clause limits the court's review of a claim determination to an arbitrary and capricious or abuse of discretion standard. Similarly, discovery is limited to the administrative record. *See, e.g., Miller v. United Welfare Fund*, 72 F.3d 1066, 1072 (2d Cir. 1995). Under this standard of review, denials of coverage are upheld as long as there is a single reasonable basis. Absent an arbitrary and capricious standard, a court employs a *de novo* review, which allows the claimant a new review based on the court's assessment of entitlement to benefits. *Muller v. First Unum Life Ins. Co.*, 341 F.3d 119 (2d Cir. 2003). Additionally, discovery outside the administrative record is permitted and the court itself would determine whether the participant is or is not disabled.

Other States Attempt to Bar Discretionary Language

New York's recent position is not the first across the country. In fact, California has issued a similar opinion and the legal action that has arisen in California with respect to the opinion is illustrative of potential conflicts that may arise out of the position that New York has taken. In 2004, the California Department of Insurance ("DOI") issued an opinion finding that discretionary clauses in disability policies deprive insureds of the protections afforded under state law and that such language would render the policy "fraudulent or unsound insurance" under the California Insurance Code. The California DOI also stated that discretionary clauses are "unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued." The opinion by the DOI stemmed from a case in the Northern District of California, *Rowe v. Planetout Partners and Unum Life Ins. Co.*, No. C03-1145 WHA (N.D. Cal. Apr. 14, 2004), concerning whether discretionary clauses in disability insurance policies were appropriate under California law.

On February 27, 2004 the DOI issued a Notice to Withdraw Approval to a number of disability insurers doing business in California. This Notice, among other things, essentially withdrew the DOI's prior approval of eight disability insurance policy forms, issued by five different insurers, which contained the discretionary clauses.

The DOI sent a letter to the judge in the *Rowe* case stating that it has regularly begun disapproving discretionary clauses, but that any said lan-

guage in disability insurance policies would be effective "prospectively and not retroactively." Subsequently, in *Rosten v. Sutter Health Long-Term Disability Plan,* No. C03-4597 JSW (N.D. Cal. Jun. 18, 2004), another court in the Northern District of California found the California DOI's opinion to be persuasive and ruled from the bench that the discretionary clause used in the particular policy violated California law. The court further held that the California DOI's determination, and statutory authority, was not preempted by ERISA.

Interestingly, a decision contrary to *Rosten* was subsequently issued within the same federal district. In *Firestone v. Acuson Corp. Long Term Disabilty Plan*, 326 F.Supp. 2d 1040 (N.D. Cal. 2004), the court rejected the plaintiff's argument that the court must use a *de novo* standard to review the denial of her disability benefits as a result of the California DOI's opinion letter. The court found that because the insurance company was not among the companies listed in the DOI's Notice to Withdraw Approval, the California DOI's initial approval remains valid. It further held that the contract is binding and governs the obligations of the parties until the DOI revokes such approval.

ERISA Preemption May Be Applicable

Still to be determined is whether states have the authority to limit the language in a disability policy or whether such efforts are preempted by ERISA. In deciding whether preemption applies, it must first be determined whether the policies that are being regulated by the states are the type of plan governed under ERISA. Plans that are excluded under ERISA include those issued by government employers, religious organizations, and plans where no employees participate – such as those solely for the business owners. Additionally, a benefit plan may escape ERISA if, under 29 C.F.R. §2510.3-1(f), the employer does not contribute to the plan, does not endorse the plan, and receives no consideration in connection with the plan, and where employee participation is completely voluntary.

If a plan is encompassed under ERISA, claims arising out of the plan may be preempted under ERISA. Under 29 U.S.C. §1144, ERISA law supersedes state law "insofar as they may now or hereafter relate to any employee benefit plan." State law is defined to include "all laws, decisions, rules, regulations, or other State action having the effect of law." See §1144(c). Additionally, under §1132, as well as §1144, ERISA preempts efforts to use state law to regulate employee benefits plans.

On the face of the statute, it would appear that the courts would not have the authority to limit the discretionary language from a disability benefit plan. This has not been found to be the case, however. ERISA contains a provision that exempts from preemption any state law regulating insurance. The Supreme Court's application of this "saving" provision has been demonstrated under various circumstances. Illustrative of the Court's application of the saving language and upholding state laws are the following: the Massachusetts law that mandated minimums for health care benefits to be included in policies, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985);California's "notice-prejudice rule,"*UNUM Life Insurance Company of America v. Ward,* 526 U.S. 358 (1999); the Illinois statute providing for independent medical reviews of determination of medical necessity by HMOs, *Rush Prudenital HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151 (2002); and the Kentucky law that allowed any provider in a managed care network to treat patients. *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S.Ct. 1471 (2003).

The question now becomes whether a state law regulating the language of an employee benefit plan, such as the model law promulgated by the National Association of Insurance Commissioners ("NAIC"), would escape ERISA preemption if adopted by the states. While insurance commissioners in states such as California, Cal. Ins. Code §§ 10291.5 and 12921.9, Utah, Utah Code Ann. § 31A-21-201(3), Illinois, Ill. Ins. Code § 143, and Hawaii, Haw. Rev. State §431:13-102, have applied prohibitions against discretionary clauses, whether they are preempted under ERISA, has not yet been challenged, nor answered by the Supreme Court.

There are very real concerns that are emerging from these new state laws, such as in New York and California, with respect to the unintended consequences. It seems inevitable that costs of disability insurance will rise and so will the number of uninsured. On November 14, 2005, Milliman, Inc., engaged by American's Health Insurance Plans on behalf of its member companies who sell disability income insurance policies, issued a report entitled "Impact of Disability Insurance Policy Mandates Proposed

by the California Department of Insurance." The report estimates that the cost of premiums will increase by as much as 46 percent for group disability insurance policies and 33 percent for individual coverage as a result of higher incidence of litigation, higher cost per litigated claim and lower claim recovery rates. In addition, the report also surmises that the range of products will decrease, the amount of protection insured under a policy will be reduced, claimants will be discouraged from returning to work, and financial security will decrease overall.

Conclusion

The impact that the State of New York Insurance Department's Circular Letter No. 8 will have is unknown. The breadth of its reach will only be determined as the issues arise. Will parties attempt to void discretionary clauses in policies issued prior to this opinion? Will cases already determined under an arbitrary and capricious standard have to be re-tried under a *de novo* standard? The letter leaves these questions unanswered.

The Decision to Rescind an Insurance Policy: Essential Elements of Proof under Texas Law

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The insurance application has been submitted and the underwriting department has approved issuance of the insurance coverage. The certificate has been sent to the insured and claims begin to arrive. Suddenly, you realize that the insured's application was less than truthful in the disclosures contained therein. What is an insurer's next step?

The initial reaction would be to undertake a further investigation into the insured's medical history to determine whether the claims that are arriving are the result of a condition that was pre-existing and, subsequently, not disclosed on the insured's application.

It is settled Texas law that issuing insurance to cover a loss that has already occurred or is in the process of occurring is against public policy. *Scottsdale Ins. v. Travis*, 68 S.W.3d 72, 75 (Tex.App. 2001), *pet. denied*. Under the fortuity doctrine, attempting to purchase or issuing insurance to cover a loss that has already occurred or is occurring is void. Further, it precludes coverage for both a "known loss" or a "loss in progress." *Id.*

Therefore, the determination must be made as to whether the loss for which the claims are being made was in existence prior to the purchase of the insurance. Once it is determined that the condition resulting in the claims was in existence at the time of the insured's application for insurance, the decision must be made whether to rescind the coverage.

Five Elements of Proof Required for Rescission

In Texas, in order for an insurer to avoid a policy because of a misrepresentation on the application, five elements must be proved. These are:

(1) That the insured made a representation;

(2) That the representation was false;

(3) That the insurer relied on the representation;

(4) That the insured intended to deceive the insurer through making the representation; and

(5) That the representation was material to the insurer's decision to issue coverage.

Mayes v. Massachusetts Mut. Life Ins. Co., 608 S.W.2d 612, 616 (Tex. 1980).

The first two prongs of the test can be shown by the fact that the insured completed the application and signed it, thus verifying that the responses to the questions on the application were true and correct. If the insured fails to disclose that he or she has a certain medical condition, or has a history of a certain medical condition, he or she has falsely represented that there is no medical condition or history of that medical condition.

The third prong of the test is fulfilled if the insurer relied on the insured's application in issuing coverage on the insured. It is sufficient to show reliance if the policy or certificate includes the language that the coverage is issued "in consideration of the premium shown above and the representation of good health." *Estate of Harvey Diggs v. Enterprise Life Ins. Co.*, 646 S.W.2d 573, 575 (Tex.App 1982).

Similarly, reliance upon the insured's application can be shown through the testimony of the underwriting department that if the true physical condition had been disclosed, coverage would not have been issued. *Bates v. Jackson Nat'l Life Ins. Co.*, 927 F.Supp.2d 1015, 1019 (S.D. Texas 1996).

The more problematic prong of the test is showing that the insured intended to deceive the insurer by making the false representations on the application. The intent to deceive cannot be inferred as a matter of law. Further, the intent to deceive cannot be presumed from the existence of material misrepresentations alone. *Id.*

However, if the insured has *warranted* the accuracy of the representations in the application, or if collusion between the insurance agent and the insured can be shown, the intent to deceive can be established as a matter of law. *Estate of Harvey Diggs,* 646

S.W.2d 573, at 576 (Tex.App. 1982). Moreover, the insured's intent can be inferred by the fact finder, based upon the totality of the evidence and the reasonable conclusions that can be drawn therefrom. *Id.*

The final prong of the test, whether the misrepresentation was material to the decision to issue coverage, can be shown from the facts of the specific case. If the misrepresentation relates to a condition or history of a condition that, if disclosed, would have cause the insurer to deny coverage, the misrepresentation was material. However, if the misrepresentation would not have altered the insurer's decision to offer coverage, it is immaterial and, therefore, not subject to avoidance through rescission of the policy.

Conclusion

A final note: the notice of intent to rescind and an offer to return premiums paid must be timely made. In cases filed prior to April 1, 2005, the Texas Insurance Code Art. 21.17 provided that 90 days would be a reasonable time, once the insurer discovers the misrepresentation.

In conclusion, rescission is a valuable option for insurers that have been deceived into covering a person with a condition that, if revealed, would have caused the insurer not to have covered the person.

FOR PREVIOUS ISSUES OF THIS NEWSLETTER . . .

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Equitable Remedies Revisited – Part II

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As anticipated in our previous column, on May 15, 2006, the United States Supreme Court issued its decision in *Sereboff v. Mid-Atlantic Medical Services, Inc., 126 S. Ct. 1869 (2006)* The issue was whether an ERISA-governed health plan could bring an action for constructive trust or equitable lien with respect to funds obtained by a participant in a personal injury action, pursuant to the plan's reimbursement provision. The Supreme Court held in *Sereboff* that such an action constitutes equitable relief under ERISA, §502(a)(3).

While the fact that the Court granted certiorari in *Sereboff* may have been a surprise, the decision was not. The result is largely supported by case law that has existed since the Nineteenth Century, as evidenced by the fact that the Court relied on numerous cases from that era. Nevertheless, some interesting issues are resolved in *Sereboff* that may provide guidance to ERISA plans seeking to enforce subrogation and reimbursement provisions.

Background

The decision in *Sereboff* follows closely the decision in *Great-West Life & Ann. Ins. Co. v. Knudson,* 534 U.S. 204 (2002), in which the Court held that equitable relief under ERISA, §502(a)(3) is limited to the types of relief that were typically available in equity in the days of the divided bench. Specifically, in *Knudson,* the Court held that an ERISA plan fiduciary could not pursue a claim for damages against the plan participant, where there was no identifiable fund over which relief could be asserted.

In that case, personal injury settlement proceeds were placed in a trust fund that was not named as a defendant in the ERISA reimbursement action. The participant, who was the named defendant, did not possess any of the funds. The health plan instead sought damages from the participant's general assets.

Some have criticized the plan in *Knudson* for not asserting any claims against the trust fund or against the participant's personal injury attorney, who also possessed some of the settlement proceeds. Nevertheless, since *Knudson,* most ERISA plans have evaluated their reimbursement rights based on whether an identifiable fund existed over which they could assert some type of equitable remedy.

This was exactly the situation in *Sereboff.* The health plan paid accident-related medical bills totaling $75,000. The Sereboffs eventually recovered $750,000 from the tortfeasor, but refused to reimburse their health plan. After the health plan fiduciary filed suit, seeking a temporary restraining order and a preliminary injunction, the Sereboffs agreed to preserve $75,000 of the settlement funds in an investment account. The district court granted summary judgment to the fiduciary, ruling that because the reimbursement claim was asserted against an identifiable and existing fund, it constituted equitable relief under section 502(a)(3). The Sereboffs appealed.

The Fourth Circuit affirmed, holding that the fiduciary's claim was in the nature of equitable restitution and therefore proper under section 502(a)(3). Specifically, the court held that the remedy sought by the fiduciary was equitable because the fiduciary was pursuing an identifiable fund that in good conscience belonged to the fiduciary under the terms of the ERISA plan. In so holding, the Fourth Circuit joined the Fifth, Seventh, and Tenth Circuits, all of whom have held that where an ERISA plan fiduciary seeks to obtain reimbursement where there is an identifiable fund over which the defendant has control, the remedy is considered equitable under *Knudson.* The Fourth Circuit acknowledged that its decision conflicted with rulings in the Sixth and Ninth Circuits.

The Supreme Court's Ruling in *Sereboff*

The issue phrased by the Court was "whether the relief [the health plan] requested . . . was 'equitable' under §502(a)(3)." Discussing its previous decision in *Knudson,* the Court noted

that "[w]e explained that one feature of equitable restitution was that it sought to impose a constructive trust or equitable lien on 'particular funds or property in the defendant's possession.'"

In contrast to *Knudson,* the health plan in *Sereboff* "sought 'specifically identifiable' funds that were 'within the possession and control of the Sereboffs.'" The fact that the health plan was asserting its action against a defendant who controlled an identifiable fund was sufficient basis to show that the health plan was seeking an equitable remedy:

> [The health plan] alleged breach of contract and sought money, to be sure, but it sought its recovery through a constructive trust or equitable lien on a specifically identifiable fund, not from the Sereboffs' assets generally, as would be the case with a contract action at law. ERISA provides for equitable remedies *to enforce plan terms,* so the fact that the action involves a breach of contract can hardly be enough to prove relief is not equitable; that would make §502(a)(3)(B)(ii) an empty promise. This Court in *Knudson* did not reject Great-West's suit out of hand because it alleged a breach of contract and sought money, but because Great-West did not seek to recover a particular fund from the defendant. Mid-Atlantic does.

The Supreme Court emphasized that, in addition to seeking an equitable remedy, a plaintiff under §502(a)(3) must also "establish that the basis for its claim was equitable." The Court distinguished between equitable liens as a matter of restitution and equitable liens by agreement or assignment.

An equitable lien as a matter of restitution requires that the plaintiff trace the funds at issue to the fund against which the lien is asserted. An equitable lien by agreement or assignment does not require tracing of the funds. The Supreme Court held that the health plan in *Sereboff* was asserting an equitable lien by agreement or assignment, and that it was not required to trace the specific funds at issue. The only requirement of such a claim is that the lien be asserted against the fund identified by the contract. The agreement (*i.e.* the health plan) in *Sereboff* identified the fund that was the target of the lien (*i.e.* "[a]ll recoveries from a third party"). As a result, the Court rejected the Sereboffs' argument that in order for the health plan's action to be equitable, it was required to show that the fund against which the lien was asserted contained the actual health plan benefits originally paid by the health plan. In pursuing an equitable lien by agreement or assignment, "the fund over which a lien is asserted need not be in existence when the contract containing the lien provision is executed."

Issues Left Open in *Sereboff*

For those looking to *Sereboff* for broader guidance on issues other than the narrow issue of whether asserting a lien against an identifiable fund is permissible under §502(a)(3), there must be some disappointment. For example, as in *Knudson,* there was no discussion about whether reimbursement claims by ERISA plan fiduciaries are or are not governed exclusively by ERISA. *Sereboff* was limited to the question of whether such an action was cognizable under ERISA, and there was no discussion, one way or the other, about whether such a claim is also cognizable under state law. *See, e.g., Providence Health Plan v. McDowell,* 361 F.3d 1243 (9th Cir. 2004) (discussing possible reimbursement claim under state law).

There also was no discussion, as some plaintiffs had hoped, that would broaden the types of relief generally available under §502(a)(3). Some viewed *Sereboff* as an opportunity for the dissenters in *Knudson,* who appeared to support a broader "make whole" relief under §502(a)(3), to establish their view. The *Knudson* dissenters did join the majority in *Sereboff,* but that case is clearly intended to follow the remedial boundaries established in *Knudson* and earlier in *Mertens v. Hewitt Associates,* 508 U.S. 248, 251 (1993). For now at least, ERISA's remedies remain limited to something short of "make-whole" relief.

Finally, the Court declined to address whether and under what circumstances the equitable lien asserted by the health plan was "appropriate" equitable relief in that case. The Sereboffs argued that the plan's assertion of a lien over the entire amount of the benefits previously paid violated principles such as the make-whole doctrine. Under the make-whole doctrine, the plan would have been required to compromise its reimbursement claim to the extent the Sereboffs were required to compromise their personal injury action. The Supreme Court pointed out that the Sereboffs did not raise this issue in

either the district court or the court of appeals, and the Supreme Court declined to address it in the first instance.

Practical Advice Following *Sereboff*

In general, the decision in *Sereboff* serves to reinforce the kinds of advice that most ERISA plans found appropriate after *Knudson*:

1. ERISA plan fiduciaries should assert reimbursement claims sooner rather than later. Once personal injury and other settlements are spent by the participant, equitable relief under ERISA §502(a)(3) is very difficult.

2. ERISA plan fiduciaries must identify a specific fund in order to assert equitable reimbursement claims.

3. When asserting reimbursement claims, ERISA plan fiduciaries must pursue the proper defendants, *i.e.*, the persons or entities who have control over the identified fund.

Followers of the Supreme Court in this area of the law, have been at a loss as to why the Court granted certiorari in *Sereboff.* The issue was certainly the subject of a circuit split and important in its own right. However, there are much more divisive and important issues under ERISA that deserve the Court's attention. There were some who theorized that by agreeing to review *Sereboff,* the Supreme Court was heading in a new direction. Such speculation turned out not to be true. The result in *Sereboff* was not surprising and flows nicely from previous decisions such as *Knudson* and *Mertens.*

Network News

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Colorado

Preexisting Condition Exclusion Does Not Violate State Statute

In *Usick v. American Family Mut. Ins. Co.*, 131 P.3d 1195 (Colo. App. 2006), plaintiff purchased from American Family a policy of individual health insurance that specifically excluded coverage for endometriosis.

Beginning in 2002, plaintiff underwent treatment for endometriosis and submitted claims to American Family, which rejected the claims as requesting payment for an excluded preexisting condition. Plaintiff then brought an action against American Family, alleging that the exclusion violated a Colorado statute.

The trial court rejected plaintiff's arguments and granted summary judgment for American Family. Plaintiff appealed, but the Colorado Court of Appeals affirmed the trial court. The statute in question provides:

> [A]n individual health benefit plan ... shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage and may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months.

C.R.S. §10-16-118(1)(a)(II).

The Court of Appeals found this statutory provision to be ambiguous and held that, properly interpreted, it allows the exclusion from coverage for specifically defined preexisting conditions. The legislative history of this provision and case law from other jurisdictions support this interpretation.

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Michigan

Misrepresentation Supports Rescission, Despite Claim That Agent Knew True History

In *Montgomery v. Fidelity & Guaranty Life Ins. Co.*, 269 Mich. App. 126, 713 N.W.2d 801(2005), the Michigan Court of Appeals held that a material misrepresentation in an application for life insurance will support the rescission of a policy, even if plaintiff claims that an agent of the insurer was aware of the misrepresentation.

Plaintiff and her decedent husband applied for a life insurance policy. The decedent claimed that he had not used tobacco in the last five years, even though he had a significant smoking habit. After the decedent was killed in an automobile accident, plaintiff sought death benefits under the policy. The insurer discovered the decedent's smoking habit and rescinded the policy.

In challenging the rescission, plaintiff argued that the insurance agent actually completed the application and that neither the decedent nor plaintiff read it before signing it. The Michigan Court of Appeals rejected this argument, noting that plaintiff's, and decedent's, signatures on the application attested to the accuracy of the information in the application. The court noted that failure to read an agreement is not a valid defense to enforcement of a contract.

The court likewise rejected plaintiff's argument that the agent had actual knowledge of the decedent's smoking habit. Plaintiff presented evidence that the decedent's home had ashtrays and that the house smelled of cigarette smoke. The court, however, concluded that plaintiff failed to present evidence that the agent saw the decedent smoking or had knowledge that he was a smoker. Importantly, the court concluded that, even if plaintiff had presented evidence that the agent actually knew that the decedent was a smoker, plaintiff and decedent had the opportunity to review the insurance application and correct any errors before submitting it.

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First Circuit

Denial Was Arbitrary When Based on Mischaracterization of Claimant's Medical Reports

In *Buffonge v. Prudential Ins. Co.*, 426 F.3d 20 (1st Cir. 2005), plaintiff was a "field logistics coordinator" who injured his back and neck while moving computer parts. He was diag-

nosed with cervical disease and radiculitis.

A second physician diagnosed one and possible two herniated discs, and a third physician diagnosed cervical and lumbar disc disease. Plaintiff attempted to return to work, but could not continue due to pain, and he submitted a claim for benefits under an ERISA-governed disability plan.

The insurer had a physician review the medical records, including the reports of the three examining physicians. The reviewing physician concluded that a "consensus exists" that plaintiff could perform sedentary work. The insurer relied on this conclusion and denied the claim.

The court ruled that the medical review mischaracterized the reports of the three treating physicians, who had concluded that plaintiff was disabled, and that the claim denial was arbitrary and capricious.

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Showing of Prejudice Required For Remand, Despite Failure to Produce File

In *DiGregorio v. Hartford Comprehensive Emp. Ben.*, 423 F.2d 6 (1st Cir. 2005), the First Circuit addressed whether a claim under ERISA must be remanded if the plan administrator does not provide the entire claim file upon the request of the claimant.

Plaintiff claimed to be disabled due to carpel tunnel syndrome. When Hartford denied her claim she requested the claim file. Hartford responded by providing the documents that it used to make its determination.

The district court upheld Hartford's decision that plaintiff was not disabled from any occupation. The district court also found that even if plaintiff was correct that she was entitled to her complete file, she must show she was prejudiced by Hartford's failure to provide it. Plaintiff obtained the complete file during the litigation.

The district court found that plaintiff was not prejudiced and that the reasons she advanced to show prejudice were simply a post-hoc rationalization. The court found plaintiff could have provided additional information in her administrative appeal and did not identify any evidence that would have changed Hartford's reasonable decision to deny her claim.

On appeal, the only issue plaintiff raised was whether the district court, instead of granting judgment in favor of Hartford, should have remanded her claim to Hartford for supplementation of the record because Hartford failed to provide her with a copy of her entire claim file during its internal review process. She also claimed she should not have to show prejudice in response to Hartford's failure to produce the entire file.

The First Circuit held that plaintiff did need to show prejudice because she was essentially seeking a second chance to prove her disability based on Hartford's failure to produce her complete claim file the first time around. Plaintiff must show prejudice in a relevant sense, meaning she had to show that because of Hartford's failure to disclose her complete file she did not understand the evidence that she had to provide to dispute Hartford's conclusion that she was not entitled to benefits.

The court held that plaintiff did not demonstrate that Hartford's failure to disclose her complete claim file prevented her from submitting evidence necessary to dispute the denial of her claim for benefits, impacted on her meaningful participation in the internal review process, or impaired her ability to prepare an informed response to Hartford's decision.

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Fourth Circuit

Court Upholds Rescission of Life Policy and Rejects Waiver and Estoppel Theories

In *Chawla v. Transamerica Occidental Life Ins. Co.*, 440 F.3d 639 (4th Cir. 2006), the Fourth Circuit affirmed the district court's summary judgment award for the insurer on the basis of misrepresentations in the application for a life insurance policy.

When the policy was applied for in May of 2000, the insured did not disclose the nature of his brain surgery to remove a portion of a meningioma (a tumor invading the dura and skull) in October 1999, his shunt surgery in December 1999 to drain excess fluid from his brain, or his two hospitalizations in January and February 2000, during the latter of which the insured was principally diagnosed with "alcohol abuse unspecified use."

On appeal, although the Fourth Circuit noted that it was somewhat unclear on the point, plaintiff ap-

peared to advance two theories on why the insurer was not entitled to the misrepresentation defense: first, the insurer had waived any such defense, and second, the insurer was estopped from asserting it.

Applying Maryland law, the Fourth Circuit noted that a waiver is the voluntary and intentional relinquishment of a known right. Because a waiver must be intentional, a party cannot waive a misrepresentation unless it has actual knowledge that the misrepresentation is false. The court concluded that the insurer was not aware of the meningioma surgery, the shunt surgery, or the insured's hospitalizations, and thus it could not and did not waive the defense of misrepresentation.

As to estoppel, the Fourth Circuit noted that, under Maryland law, equitable estoppel is comprised of three basic elements: (1) a voluntary misrepresentation by one party, (2) that is relied on by the other party, (3) to the other party's detriment. In order to claim the benefit of estoppel, a party must demonstrate that it changed its position for the worse in reliance on the other party's representation.

The Fourth Circuit observed that where an insured seeks to estop an insurer from rescinding an insurance policy, he is obliged to show that he could have obtained insurance elsewhere, in order to satisfy the essential element of detrimental reliance. In this case, plaintiff offered no proof that any other insurer, properly apprised of the insured's true physical condition, would have issued a policy on his life. Plaintiff therefore failed to carry her burden of establishing the elements of estoppel.

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Administrative Power to Interpret Ambiguous Plan Terms Upheld

In *Colucci v. AGFA Corp. Severance Pay Plan*, 431 F.3d 170 (4th Cir. 2005), the trial court entered judgment in favor of a former employee, ruling that the severance plan administrator had abused its discretion in awarding benefits to the former employee calculated on the basis of the first day of his second period of employment, after he voluntarily resigned to work for a competitor and was later rehired, rather than the first day of his original employment.

The Fourth Circuit remanded the case with instructions to enter judgment for the plan. The court noted that the plan conferred discretion on the administrator to interpret its provisions and to resolve any ambiguities. Plaintiff had worked for 17 years for AGFA before resigning to join a competitor. However, several months later, plaintiff was rehired.

Two years after rejoining the company, plaintiff was involuntarily terminated for economic reasons. The plan administrator ruled that he was entitled to severance benefits based upon his second (two-year) period of employment, rather than the entire 19 years of his total employment, because the plan stated that benefits were to be calculated commencing on his "first day" of employment.

The Fourth Circuit examined the terms of the plan and concluded that the term "first day" of employment was reasonably subject to several interpretations. In the face of this ambiguity, the court ruled that the plan administrator had properly applied its discretion and reasonably interpreted the plan provisions in a manner consistent with its terms. Consequently, the court reversed the decision of the trial court and remanded the case with instructions to enter judgment for the plan.

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Eleventh Circuit

De Novo Prong of Heightened Standard is Distinct from *De Novo* Review

In *Reeve v. UNUM Life Ins. Co. of Am.*, 170 Fed. Appx. 108 (11th Cir. Mar. 8, 2006), plaintiff appealed from the entry of summary judgment in UNUM's favor on his ERISA claim for disability benefits. Plaintiff contended that the district court had erred in limiting its review to the facts available to UNUM at the time of its benefits denial, even though it was undisputed that the policies at issue provided UNUM with discretionary authority.

Citing *Moon v. American Home Assur. Co.*, 888 F.2d 86 (11th Cir. 1989), plaintiff asserted that a *de novo* review of documents beyond those available to UNUM would have revealed a genuine issue of material fact as to whether he was disabled under the policies. In *Moon*, where the plan did not confer discretionary authority, the Eleventh Circuit stated that to examine "only such facts as were available to the plan administrator at the

time of the benefits denial is contrary to the concept of a *de novo* review."

Finding *Moon* inapposite where discretion was granted, the *Reeve* court distinguished the *de novo* standard of review from the first step of the heightened arbitrary and capricious standard of review (sometimes called "the *de novo* review prong"). The court explained that, under the first step of the heightened arbitrary and capricious standard of review, "a reviewing court reviews only 'the plan documents and disputed terms *de novo*.'" Because the district court had appropriately limited its review in *Reeve*, the Eleventh Circuit affirmed the grant of summary judgment in UNUM's favor.

Further, the Eleventh Circuit agreed with the district court that UNUM's decision was correct. Plaintiff, a vice president for an electrical contractor, claimed disability in 2001 due to his heart condition. However, although he had a heart attack in 1993, he continued to work in his occupation for the next eight years and claimed disability without any change in his medical condition.

In finding that UNUM's decision was correct, the court noted an in-house medical review which concluded that plaintiff had not had any cardiac event or occurrence in 2001 that was different from anything that happened in the years since his heart attack. The Eleventh Circuit also approved UNUM's reliance on a labor market survey to determine that plaintiff's regular occupation, on a national basis, was a light duty occupation (even though he argued that his particular job required more exertion than light duty).

Accordingly, based on a review of the information available to UNUM at the time of its decision, the court concluded that plaintiff had failed to meet his burden of demonstrating that UNUM's determination was arbitrary and capricious.

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District of Columbia District Court

No Abuse of Discretion in Claim Denial and No Penalties Awarded for Withholding Information

In *Doley v. Prudential Ins. Co. of Am.*, 2006 WL 785374 (D.D.C. Mar. 28, 2006), plaintiff brought an action against Prudential, alleging a wrongful denial of long-term disability benefits, as well as statutory penalties for what plaintiff alleged was the wrongful withholding of information by the plan administrator. The district court initially found that the ERISA plan contained a clear grant of discretion to Prudential and held that there was no abuse of discretion in Prudential's denial of disability benefits to the plaintiff.

Plaintiff was covered under a group LTD insurance policy issued by Prudential through her employment with Automatic Data Processing, Inc. Plaintiff applied for disability benefits, complaining of macular dystrophy and myopic degeneration. Prudential later advised plaintiff of its determination that she was not entitled to continue receiving LTD benefits. Three appeals followed within the administrative appellate structure established by the plan. After an unsuccessful fourth appeal, plaintiff brought this action.

The court found no evidence that any conflict of interest influenced Prudential's decision. Moreover, the court held that it was not an abuse of discretion for Prudential to determine that plaintiff was not disabled because she could perform her duties using available technology to accommodate her vision problems. The court also concluded that there was no impropriety on Prudential's part in relying upon the opinion of an expert that refuted the opinion of plaintiff's expert.

Plaintiff also asserted that Prudential's delay in making claims guidelines and other documentation available to her during the administrative appeal process prejudiced her by denying her "additional insight into the insurer's review process," and that Prudential was therefore subject to statutory ERISA penalties.

However, the court stated that the issues raised by this argument were raised and disposed of in the context of plaintiff's motion to compel discovery, where the court invited the plaintiff to take a Rule 30(b)(6) deposition of Prudential if she was not satisfied with Prudential's statement that the documents plaintiff sought either did not exist or were not used in handling plaintiff's claim. Plaintiff was unable to show any prejudice with regard to this issue, and this claim was denied as well.

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Summary Judgment Denied, But Judgment Entered Pursuant to Federal Rule 52

In *Mobley v. Continental Cas. Co.*, 405

F.Supp.2d 42 (D.D.C. 2005), the court denied the insurer's motion for reconsideration of its denial of summary judgment in favor of the plan because plaintiff's treating physician had determined that plaintiff was unable to perform any occupation, while the independent medical examination on behalf of the plan had reached the opposite conclusion.

However, the court noted that Federal Rule of Civil Procedure 52 established a mechanism by which the court could make findings of fact on disputed issues before ruling on the merits of a case. Noting that both parties agreed that the *de novo* standard of review should be applied, the court stated that its task was "to undertake a comprehensive review of the administrative record to determine whether plaintiff is totally disabled within the meaning of the plan ... as if it had never been reached by Continental, and Continental's findings are entitled to no judicial deference."

The court then proceeded to examine the evidence in the administrative record and concluded that it was not persuaded by plaintiff's treating physician's opinion of total disability. By contrast, the court stated that it could find no reason to doubt the credibility of the conclusion of the independent medical examiner who had examined plaintiff on behalf of the plan.

The court concluded that the evidence in support of plaintiff's claim of total disability was scant and questionable, while the evidence supporting a conclusion that plaintiff could perform some form of sedentary job function was "somewhat more robust and, more importantly, free from doubt as to its credibility." Consequently, the court entered judgment in favor of the plan under Rule 52.

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Administrator Neither Abused Discretion by Denying Claim Nor Interfered with Rights

In *Plain v. AT&T Corp.*, 424 F.Supp.2d 11 (D.D.C. Mar. 24, 2006), plaintiff asserted a claim against her former employer, AT&T, under the Labor Management Relations Act for wrongfully terminating her following a period of sickness disability leave, and a claim against the administrator of her employee benefits plan, Metropolitan Life Insurance Company, under ERISA for wrongfully denying her claim for long-term disability benefits. The court granted the summary judgment motions of the employer and plan administrator.

Plaintiff claimed that MetLife breached its fiduciary duty as a result of its decision to deny plaintiff's claim for LTD benefits, and interfered with her protected rights in violation of §510 of ERISA. The court, finding that the benefit plan conferred discretion on MetLife, granted MetLife's motion for summary judgment as to both of plaintiff's claims.

MetLife stated that there were two bases for its denial of plaintiff's claim: (1) her claim was untimely; and (2) she failed to provide sufficient medical documentation that she was disabled as defined by the plan.

Addressing the first basis, the court found that MetLife did not abuse its discretion when it concluded that, because plaintiff's application for LTD benefits was not filed within 90 days of the expiration of her sickness disability benefits, her application was untimely. The policy made clear that failure to timely submit an application could result in ineligibility. It was uncontroverted that plaintiff's application was not filed within the time allotted by the policy, and accordingly, MetLife acted reasonably in denying the application.

As to the second basis, the court again found that the record supported MetLife's determination. Plaintiff's application acknowledged that she was able to work eight hours per day and that she had been advised to return to full-time service in her regular occupation. Even if plaintiff were to have complied with the timeline for filing an LTD claim, MetLife would not have abused its discretion had it denied her application for the independent reason that plaintiff had not demonstrated that she was "disabled."

Finally, plaintiff maintained that MetLife interfered with her protected rights in violation of §510 of ERISA when it played a role in AT&T's termination of her employment and subsequent failure to reinstate her. The court, however, stated that a plaintiff must demonstrate that the insurer coerced an employer to fire an employee. The court found that the record did not support such an inference. Furthermore, other portions of the record evidenced a lack of coordination between MetLife and AT&T with respect to plaintiff's termination.

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Florida District Court

Normal Summary Judgment Rules are Inapplicable to ERISA Benefits Case

In *Crume v. Metropolitan Life Ins. Co.,* 417 F.Supp.2d 1258 (M.D. Fla. 2006), the court granted summary judgment in favor of MetLife, while relying on cases in the First, Ninth, and Eleventh Circuits to conclude that the normal rules governing summary judgments do not apply in ERISA benefits cases. The court rejected plaintiff's argument that there should be a bench trial because there were disputed issues of fact.

The court explained the general rationale for abandonment of the Rule 56 summary judgment tests by quoting with approval a decision by the First Circuit: "In an ERISA benefit denial case [subject to deferential review], ... in a very real sense, the district court sits more as an appellate tribunal than a trial court. It does not take evidence, but, rather, evaluates the reasonableness of an administrative determination in light of the record compiled before the plan fiduciary." *Leahy v. Raytheon Co.,* 315 F.3d 11, 17-18 (1st Cir. 2002) (quoted with approval in *Curran v. Kemper Nat. Servs., Inc.,* 2005 WL 894840, *7 (11th Cir. Mar. 16, 2005) (unpublished *per curiam* opinion)).

The court provided further practical reasons why the usual constraints of Rule 56 should not apply:

> In a case like this, where the ultimate issue to be determined is whether there is a reasonable basis for a claims administrator's benefits decision, it is difficult to ascertain how the "normal" summary judgment rules can sensibly apply. After all, the pertinent question is not whether the claimant is truly disabled, but whether there is a reasonable basis in the record to support the administrator's decision on that point. In other words, conflicting evidence on the question of disability cannot alone create an issue of fact precluding summary judgment, since an administrator's decision that rejects certain evidence and credits conflicting proof may nevertheless be reasonable. More fundamentally, perhaps, if the "normal" summary judgment rules apply to these kinds of cases, and it is determined that an issue of material fact exists, thereby precluding summary judgment, what is the next step in the case resolution process? In other kinds of cases, the next step would be a trial. But what is this Court to "try" when it ordinarily cannot consider evidence outside the administrative record, and the ultimate issue to be determined is whether there is a reasonable basis in that record for the fiduciary's decision?

The court observed that the Eleventh Circuit frequently applies the normal summary judgment rules in ERISA benefits claims, but correctly noted that these cases did not address the issue. *Crume* does not specifically state that a motion for judgment based on the administrative record is the proper procedure to follow in an ERISA benefits case, instead of a Rule 56 motion for summary judgment, but this is clearly implied.

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Maryland District Court

ERISA Plan Administrator Not Bound by Job Description in Determining Material Duties

In *McCready v. Standard Ins. Co.*, 417 F.Supp.2d 684 (D. Md. 2006), the issue was whether Standard abused its discretion in denying plaintiff's claim for long-term disability benefits under an ERISA-governed plan through her employer, Piper Rudnick, LLP, where she was employed for over 13 years as a legal secretary.

Plaintiff left Piper because of several ailments. After receiving short-term disability benefits from Standard, plaintiff applied for long-term disability benefits under the plan. Following each of its three levels of review, Standard determined that plaintiff was not eligible for long-term disability benefits under the plan, basing its denial on the specific definition of "Own Occupation" and "Material Duties," and finding that her "Own Occupation" was not limited to her specific job with Piper.

Under the plan, plaintiff would meet the definition of "Disabled" for purposes of long-term disability if she were disabled from her "Own Occupation," which was defined as "any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as your regular and ordinary employment with the Employer. Your Own Occupation is not limited

to your job with your Employer." The term "Material Duties" was defined as "the essential tasks, functions and operation, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation."

Plaintiff provided a detailed description from Piper of her duties as a legal secretary at the firm. However, Standard determined that plaintiff did not qualify as "Disabled" from her "Own Occupation" since she could fulfill the "Material Duties" required by the general economy for legal secretaries.

Standard determined that the job description Piper provided was in excess of a legal secretary position in the general economy, as described by the Department of Labor's Dictionary of Occupational Titles. Standard further determined that plaintiff performed duties in excess of the DOT's definition of "Legal Secretary" and would be better considered as a "Legal Secretary/Secretary" under the DOT.

Standard determined that it was appropriate to consider plaintiff's "Own Occupation" as consistent with the general economy's definition of the occupation as found in the DOT, and therefore considered plaintiff's "Own Occupation" as sedentary. Accordingly, Standard held that plaintiff's "Material Duties" did not require frequent walking or standing, and that the more active duties described by Piper were not essential tasks generally required by employers from those engaged as a Legal Secretary.

The court found that Standard's determination that plaintiff's "Own Occupation" and "Material Duties" as defined under the plan were sedentary in nature was not an abuse of discretion and its determination was supported by substantial evidence. The court held that Standard was not bound by Piper's description of plaintiff's job in determining plaintiff's "Own Occupation" and "Material Duties" under the clear terms of the plan. The definition of "Own Occupation" under the plan indicated that Standard was to evaluate plaintiff's position as legal secretary against professions of the same general character as her position at Piper, but not limited to her job with Piper.

Furthermore, the medical evidence did not indicate that plaintiff would be unable to perform a sedentary occupation. The court also acknowledged that plaintiff had the same health problems while she was working at Piper, prior to submitting a claim for long-term disability, and that some of her conditions had improved prior to her stopping work.

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Court Upholds Denial of Benefits to Nurse Who Could Perform One of Her Material Duties

In *McKeldin v. Reliance Standard Life Ins. Co.,* 2006 WL 890759 (D. Md. Apr. 14, 2006), plaintiff, an R.N. and nurse manager in a private physician's office, filed an application for long-term disability benefits under a group plan issued by Reliance, based on the symptoms of deep vein thrombosis, fibromyalgia and chronic fatigue syndrome.

The plan defined total disability as, (1) during the elimination period, the inability to perform "each and every material duty" of one's regular occupation; and (2) for the first 36 months, the inability to perform the material duties of one's regular occupation; and (3) after 36 months, the inability to perform "each and every material duty" of any occupation that one's education, training or experience would reasonably allow.

Reliance approved plaintiff's application in April 2001. In October 2001, however, the Social Security Administration denied disability benefits based on the same conditions, concluding that plaintiff had the ability to return to her regular occupation of R.N. In October 2002, Reliance required her to take an independent psychiatric examination and found her disability to be due to psychological conditions. It advised her that a mental/nervous disorder exception, which limited benefits to an aggregate lifetime maximum of 24 months, applied to her claim.

Plaintiff appealed the termination of benefits after the change in definition, claiming that fibromyalgia was her primary disability and that depression was only a secondary consequence of pain. Despite her illness, she was able to work two part-time jobs in nursing, one administering flu shots and the other as a forensic nurse for sexual assault victims. Reliance had a peer review performed, and the reviewing physician concluded that plaintiff was capable of full time sedentary light level work. This was based in part on her ability to work two part-time jobs.

Reliance also had plaintiff undergo an IME, including a musculoskeletal exam in which it was concluded that

since she was performing activity at a sedentary level at home, there was no medical contraindication for her performing at such a level at work. In April 2005, Reliance advised plaintiff that the appeal was denied because (1) the mental/nervous disorder exception applied; and (2) she did not qualify as "totally disabled."

In the suit filed by plaintiff in the district court, the parties filed cross-motions for summary judgment. The court granted Reliance's motion for summary judgment and denied plaintiff's. The court upheld Reliance's decision that plaintiff did not meet the definition of "totally disabled" and therefore, did not reach the issue of whether the mental/nervous disorder exception applied.

Because Reliance paid plaintiff for more than 36 months, the court was required to examine the meaning of "totally disabled" that applied after 36 months. At issue was the meaning of the inability to perform "each and every material duty" of any occupation that one's education, training or experience would reasonably allow. Since Reliance had presented substantial evidence that plaintiff was able to perform at least one of the material duties of a suitable occupation, the court concluded that Reliance had not abused its discretion in finding that she was not totally disabled.

In interpreting the meaning of "each and every" material duty, the court looked to *Gallagher v. v. Reliance Standard Life Ins. Co.,* 305 F.3d 264 (4th Cir. 2002), as well as *Carr v. Reliance Standard Life Ins. Co.,* 363 F.3d 604 (6th Cir. 2004). In these cases, the Fourth and Sixth Circuits interpreted the same language in other Reliance policies to mean that an insured is eligible to receive benefits only if he establishes that he is unable to perform all of the material duties of an occupation.

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Massachusetts District Court

Uncontradicted Evidence From Treating Physicians Warrants Award of Benefits

In *Ghose v. Continental Cas. Co.*, 2005 U.S. Dist. LEXIS 13470 (D. Mass. July 15, 2005), the court reversed Continental's decision on plaintiff's disability claim, finding that the review of his medical records undertaken by a committee of laypersons, without the input of a medical consultant, was arbitrary and capricious.

Plaintiff submitted a claim for disability benefits after undergoing cardiac by-pass surgery. He returned to work for 10 months and then sought additional disability benefits due to chest wall pain. He supported his claim with opinions by several physicians who stated that he had chronic pain as a consequence of the surgery and should stay out of work for a few months while undergoing therapy and pain management treatment. Continental denied the claim, finding that plaintiff's condition did not impair him to such a degree that he was unable to perform his occupation.

Recognizing that a plan administrator is not required to obtain the opinion of a third party medical consultant and may render a decision based on medical records alone, the court nevertheless concluded that the records and opinions of the five specialists who treated plaintiff reflected no material internal inconsistencies or questions about the veracity of his complaints. It found that Continental denied plaintiff's claim not because it doubted that he was disabled, but because the panel of lay administrators who reviewed his records were not persuaded that he was disabled enough.

The only evidence supporting this conclusion was plaintiff's ultimately unsuccessful attempt to return to work. The court determined that this is not the type of reliable rebuttal evidence that would allow an administrator to credit one form of medical evidence over the other, nor as a matter of public policy is it desirable that a disabled worker be penalized for his efforts at rehabilitation.

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Attorney Acting *Pro Se* as Plaintiff Is Not Entitled to Fees under ERISA

In *Radford Trust v. First UNUM Life Ins. Co. of Am.*, 399 F.Supp.2d 3 (D. Mass. 2005), the court awarded attorney's fees to the plaintiff trust in an ERISA action against a disability insurer on the ground that the insurer's denial of the disability claim had been in bad faith.

But the court declined to award attorney's fees to the individual plaintiff, who was himself an attorney proceeding *pro se*, and who had asserted

that he was disabled from performing the work of an attorney.

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Michigan District Court

Injuries Resulting from Driving While Intoxicated Held Not "Self-Inflicted" under Exclusion

In *Harrell v. Metropolitan Life Ins. Co.*, 401 F.Supp.2d 802 (E.D. Mich. 2005), the court held that injuries caused by driving while intoxicated were not "self-inflicted" and that the ERISA administrator's denial of benefits on that basis was arbitrary and capricious.

Plaintiff's decedent was killed in a car crash. At the time, her blood alcohol level was 0.17, an amount that exceeds the legal limit in Michigan. Plaintiff testified that the decedent was a regular drinker and that she commonly drove after drinking.

Plaintiff applied for death benefits under a personal accident insurance policy provided by his employer, General Motors. The policy excluded benefits for any loss caused by "suicide, attempted suicide or self-inflicted injury while sane or insane." The administrator denied plaintiff's claim for benefits, stating, "[T]he voluntary consumption of alcohol constitutes intentionally self-inflicted injuries under the General Motors Plan." Plaintiff appealed, and the administrator upheld the prior decision, stating that "the dangers of drinking and driving are sufficiently well-known."

The court noted that the administrator did not contend that the decedent's car accident was a suicide, and the court further noted that term "intentionally self-inflicted injury" was not defined in the plan. Although the court held that the plan gave the administrator discretion to interpret the terms of the plan, the court also held that the administrator's interpretation of "self-inflicted injury" to include injuries caused by drunk driving was arbitrary and capricious, requiring reversal of the denial of benefits.

The trial court reasoned that voluntarily partaking in risky behavior could not be equated with an intent to injure one's self. The court noted that the plan contained other exclusions for injuries caused by high-risk activities, such as stunt flying or acting as a test pilot. These exclusions, the court stated, would be unnecessary if the "self-inflicted injury" exclusion applied to all risky behavior.

The court also rejected defendant's argument that the decedent did not die from an "accident," because injury caused by drunk driving is reasonably foreseeable. The court noted that this rationale had not been advanced by the administrator, and such a *post hoc* justification could not be used as a basis for the denial of benefits.

The court further noted that drunk driving deaths constitute less than one percent of the number of people arrested for drunk driving and that "[c]onduct that increases the risk of dire results does not make those results inevitable." Thus, even if the court had considered defendant's *post hoc* argument that injury caused by drunk driving is not the result of an "accident," it would have rejected it.

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Pennsylvania District Court

Court Rules That Provider Underpayment Claims Against HMO Are Preempted by ERISA

In *Temple Univ. Children's Medical Center v. Group Health, Inc.,* 413 F.Supp.2d 530 (E.D. Pa. 2006), the court grappled with an interesting issue of ERISA preemption concerning a provider claim for alleged underpayment of benefits.

Plaintiff, Temple University Children's Medical Center ("TUCMC"), a major hospital center in Philadelphia, filed a state law breach of contract claim against Group Health, Inc. ("GHI"), an HMO, claiming that it had been substantially underpaid for hospital and medical services rendered to three patients who were beneficiaries under three separate group health plans insured and/or administered by GHI between 2002-2003.

TUCMC claimed that GHI breached a PPO discount agreement that required it to pay 90% of the hospital's full-billed charges within 30 days of the date of invoice. TUCMC alleged that GHI underpaid the invoices for these three patients and also made late payments, thereby requiring GHI to pay 100% of the full amount invoiced by the hospital.

GHI had refused to pay the amounts in question because the hospital's charges were excessive and

did not comport with usual and customary charges for the services rendered in the same or similar communities. Instead, GHI paid the invoices pursuant to the non-participating provider compensation guidelines set forth in the respective plans.

GHI moved for summary judgment on the grounds that, for two of the patients, TUCMC's claims were preempted by ERISA §514(a) because the patients' health insurance was provided pursuant to ERISA-regulated employee welfare benefit plans and that the hospital had no standing under ERISA §502(a) to pursue a claim for the patients' benefits. GHI also argued that regardless of ERISA preemption considerations, there was no contract privity between TUCMC and GHI because GHI had not elected to access the PPO discount agreement in question, which was a non-exclusive arrangement.

In the third claim, GHI argued that it was merely an administrative service provider to a self-funded plan, and therefore was not financially responsible for payment of the hospital's claims.

The court granted GHI's motion for summary judgment, holding that the hospital's claims were preempted by ERISA §514(a), and noted that the hospital had no standing to pursue its claims against GHI under ERISA §502(a)(1)(B). The court rejected TUCMC's argument, based on *Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393 (3d Cir. 2004), that ERISA §502 did not provide grounds for complete ERISA preemption, finding that the court had diversity jurisdiction. The court also rejected plaintiff's attempt to confuse "complete" ERISA preemption, which is essentially jurisdictional, with the ERISA "conflict" preemption, which is a complete defense on the merits.

In addition, the court held that TUCMC's state law breach of contract claims failed due to the lack of contract privity with GHI. The court found that the hospital's attempts to create the appearance of privity through the PPO network agreements could not be sustained because GHI's PPO access agreement was non-exclusive, thereby permitting GHI to access the PPO discounts at its discretion.

Lastly, the court granted summary judgment on the claim arising from the self-funded plan because GHI was merely a claim administrator with no fiduciary authority or insurance obligations. Summary judgment was also granted to the PPO, which had argued that it was not the insurer, but simply the network in which the hospital and insurer had agreed to participate.

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Virginia District Court

Court Addresses Fiduciary's Duties Where Administrator Is Confronted with Bankruptcy

In *DiFelice v. Fiduciary Counselors,* Inc., 398 F.Supp.2d 453 (E.D. Va. 2005), the court addressed the nature of an independent fiduciary's duties to participants in a 401(k) retirement plan after it was appointed to manage pension investments in US Airways' stock shortly before its bankruptcy filing.

US Airways, in consideration of its possible bankruptcy filing, appointed FCI as an independent fiduciary with responsibility for managing certain plan investments, including US Airways' 401(k) retirement plan. One of the available investment options for the plan was the US Airways Group, Inc. Common Stock Fund ("Company Stock Fund"), a unitized fund that consisted primarily of the publicly traded shares of US Airways Group, Inc., the parent company of US Airways; the remainder of the Company Stock Fund's assets were held in cash. Approximately seven weeks after appointing FCI with responsibility for making investment decisions with respect to the Company Stock Fund, US Airways filed for bankruptcy under Chapter 11.

This action was filed by plaintiff pursuant to ERISA on behalf of the plan to recover losses to the plan which occurred as a result of FCI's alleged breaches, including (1) failure to inform plan participants; and (2) failure to exercise prudence in the management of plan assets. FCI moved to dismiss pursuant to Rule 12(b)(6), arguing that plaintiff's complaint failed to state a claim as a matter of law.

The court first held that FCI was a plan fiduciary because it assumed US Airways' role as the named fiduciary with respect to the Company Stock Fund, with the authority to continue or terminate the Company Stock Fund as a plan investment option and with the authority to alter the mix of cash and stock in the Company Stock Fund.

With regard to plaintiff's claims alleging failure to inform plan participants, the court stated that compliance with the express disclosure requirements of ERISA will generally

satisfy a fiduciary's duty to provide information to participants. However, the court acknowledged that there are narrow circumstances in which a fiduciary's general obligations under ERISA trigger a further obligation to disclose information.

The court, citing *Griggs v. E.I. DePont de Nemours & Co.*, 237 F.3d 371 (4th Cir. 2001), stated that the affirmative duty to provide information to ERISA participants arises only when the fiduciary has fostered the misunderstanding of facts material to participants' investment decisions. The court distinguished this case from *Griggs* because it determined that FCI had no reason to suspect that plan participants were unaware of the risks of investing in US Airways Group stock, nor did FCI misrepresent the risks of doing so.

The court held that FCI's duty to disclose information beyond that specifically required by ERISA was limited to instances in which it has fostered a material misunderstanding of plan benefits or investment options and then failed to correct that misunderstanding. However, no such facts were alleged. Moreover, FCI's disclosure to participants was found to have been timely. Therefore, the court dismissed plaintiff's claims for failure to disclose information.

With regard to plaintiff's claims alleging a failure to exercise prudence in the management of plan assets, the court, applying the Department of Labor's "prudent man" standard, found that a plan fiduciary is required, at a minimum, to examine the characteristics of an investment, including the risk characteristics and its liquidity, to ensure that it is an appropriate plan investment and that it is in the best interests of the plan participants. The court held that FCI's actions upon appointment as fiduciary could not be deemed imprudent in light of the difficult circumstances confronting it at the time of its appointment. The court, therefore, granted FCI's motion to dismiss.

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Court Refuses to Vacate Published Opinion to Aid Post-Judgment Settlement

In *Neumann v. Prudential Ins. Co. of Am.*, 398 F.Supp.2d 489 (E.D. Va. 2005), the parties jointly moved for post-judgment vacatur pursuant to a post-judgment settlement agreement between the parties which was conditioned in part on vacatur of the judgment entered in favor of the plaintiff for long-term disability benefits under an ERISA plan.

Relying significantly on *Bancorp Mtg. Co. v. Bonner Mall Partnership*, 513 U.S. 18 (1994), and its progeny, the court noted that there was a general presumption against vacatur which could be overcome only by the showing of extraordinary circumstances. The parties contended that vacatur was warranted because their settlement was conditioned upon it and the plan did not wish to contend with the opinion in dealing with future benefit disputes. They also argued that vacatur would conserve judicial resources in making the appeal which had been filed by the plan unnecessary.

Although encouragement of settlement of disputes is desirable, the court ruled that none of these reasons amounted to the extraordinary circumstances necessary to overcome the presumption against vacatur. It further suggested that vacatur of a judgment on the basis of post-judgment settlement might induce parties to forego settlement early in a litigation process hoping to win at trial or bargain away an adverse decision with a settlement conditioned upon vacatur. The court further commented that while the plan's desire to eliminate any precedential effect the opinion may have is understandable, the appropriate means for doing so would be an appeal.

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