

**2008 ACLI COMPLIANCE AND LEGAL SECTIONS ANNUAL MEETING  
LITIGATION UPDATE**

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## I. ANNUITY LITIGATION

### A. Fixed Deferred Annuities

#### 1. Sales to Seniors

Since 2004, numerous suits have been filed attacking sales of fixed deferred annuities to seniors. The plaintiffs' allegations have evolved over time based upon their ability to have classes certified.

The initial cases arose out of alleged marketing schemes for the sale of fixed deferred annuities that enticed seniors to attend free lunch seminars for estate planning or financial planning. At these seminars, the seniors would be sold on the need to create a living trust for estate planning purposes. Information was gathered about the seniors under the "pretext" that the information was needed to prepare the living trust. It was alleged that the information was used primarily to determine which seniors would be sold annuities.

Many cases also assert that the defendants failed to disclose that the annuities were not suitable for senior consumers because they had maturity dates beyond the annuitant's life expectancy and that there would be substantial surrender penalties for early withdrawal. Further, some complaints allege that the defendants engaged in churning activities by persuading seniors to surrender existing annuities and investments to purchase the defendants' annuities. These cases assert causes of actions for violation of RICO, conspiracy to violate RICO, and numerous state causes of action including breach of fiduciary duty, unjust enrichment, negligence, fraudulent misrepresentation and violation of the state consumer protection act.

Rulings on class certification based upon these allegations have been mixed, but in *Yokoyama v. Midland Life*,<sup>2</sup> the court ruled that suitability issues could not be adjudicated on a class-wide basis because individualized assessments of sales presentations and purchaser circumstances predominated over alleged common issues involving sales materials. Plaintiffs allege that the defendants had a "practice of targeting senior citizens in Hawaii to sell wholly inappropriate financial products – 'deferred annuities' – without regard to the complete unsuitability of such products to people of advanced age." The court denied class certification because the plaintiffs *did not argue* that deferred annuities are universally unsuitable for all seniors and relied on the evidence presented by the insurer of variations in sales presentations and other inducements, as well as an array of features available in different annuity products.<sup>3</sup>

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<sup>2</sup> *Yokoyama v. Midland Life Ins. Co.*, 239 F.R.D. 607 (D. Haw. 2006). *But see Negrete v. Allianz Life Ins. Co of N. Am.*, 238 F.R.D. 482 (C.D. Cal. 2006); *Castello v. Allianz Life Ins. Co. of N. Am.*, Case No. 03-20405 (Minn. Dist. Ct. 2005); *Iorio v. Asset Mktg.*, Case No. 3:2005cv00633 (S.D. Cal. 2005); *Mooney v. Allianz Life Ins. Co. of N. Am.*, 244 F.R.D. 531 (D. Minn. 2007).

<sup>3</sup> *Yokoyama v. Midland Life Ins. Co.*, 239 F.R.D. 607, 607-08 (D. Haw. 2006).

Plaintiffs filed an amended complaint adopting an "inherently unsuitable for seniors" argument and moved to certify the proposed class. The court indicated that the claims:

- Involved separate questions of fact as to what information the independent brokers selling the annuity conveyed to annuitants
- Necessitated examination of the individual damages actually sustained
- Required inspection of whether the class members individually relied on the alleged misstatements.
- Required that suitability claims be adjudged individually

Accordingly, the court ruled that the disposition of the claims of the proposed class would require fact specific individualized assessments and denied class action.<sup>4</sup>

Plaintiffs, realizing that point-of-sale class action lawsuits are subject to defeat because of the individualized fact-finding that is required, have been moving toward claims involving defective product design and alleged use of uniform marketing materials and sales presentations. Plaintiffs allege that the annuities products are worth substantially less than the price paid for them or the value of comparable products. As a result, plaintiffs assert that the defendants deceived them into purchasing the deferred annuities by systematically misrepresenting the essential features of these complex and disadvantageous investment products. Relying on the declaration of plaintiffs' expert, Craig McCann, plaintiffs allege that defendants systematically misrepresented the characteristics of the annuities and actively concealed critical information that would reveal the annuities' disadvantages.<sup>5</sup> Accordingly, the plaintiffs' case is based upon the theory that the annuities are so flawed that *no rational senior* would purchase the annuities if they were accurately described in the marketing materials.<sup>6</sup>

Plaintiffs also allege that defendants use uniform sales marketing materials that are misleading and require agents to use only these standardized materials in the sales process. Accordingly, they assert that no fact specific individualized assessment is needed as to what information was conveyed to class members.

McCann created a model as his basis for asserting that the annuities are worth less than what the plaintiffs paid for them. He compares the annuity to "comparably timed zero

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<sup>4</sup> *Yokoyama v. Midland Nat'l Life Ins. Co.*, 243 F.R.D. 400, 408 (D. Haw. 2007).

<sup>5</sup> *Negrete v. Allianz Life Ins. Co. of N. Am.*, 238 F.R.D. 482, 493 (C.D. Cal. 2006); *see Yokoyama v. Midland Nat'l Life Ins. Co.*, 243 F.R.D. 400, 404 (D. Haw. 2007).

<sup>6</sup> *Negrete v. Allianz Life Ins. Co. of N. Am.*, 238 F.R.D. 482, 493 (C.D. Cal. 2006); *see Yokoyama v. Midland Nat'l Life Ins. Co.*, 243 F.R.D. 400, 404 (D. Haw. 2007).

coupon Treasury bills."<sup>7</sup> McCann also offers two models to measure the damages of the plaintiffs. He asserts that damages can be "measured by the amount paid by the class member . . . less partial withdrawals plus interest at a reasonable market rate."<sup>8</sup> Alternatively, damages could be "measured by the difference between the value of each class member's annuity and the value of a comparable liquid investment product' unencumbered by the hidden costs inhering to the annuity product."<sup>9</sup>

While the trial court was skeptical that McCann's model was supportable, it held that at that stage of the proceedings the plaintiffs offered a plausible theory. Consequently, the court certified the class, but it noted that if further development of the litigation brought forth evidence that undermined the plaintiffs' contention, "then decertification may be appropriate."<sup>10</sup>

## 2. Bonus Deferred Annuities

Plaintiffs have also brought class actions involving bonus deferred annuities. Several allegations have been made in these class actions, including claims that: (i) the bonuses improperly enticed the plaintiffs to purchase the annuities, even though they were unsuitable for the class members; (ii) the bonuses were illusory because they would be recaptured in the actuarial design, pricing and structure of the contract in that the insurer credited lower renewal rates in subsequent years than it otherwise would have; and (iii) the marketing of the bonuses as a "cash bonus" or "immediate bonus" misled consumers into thinking that they would immediately receive the bonus. The claims under these cases include breach of contract, fraud or suppression, negligent misrepresentation, breach of fiduciary duty, unjust enrichment, violation state unfair trade practices and consumer protection acts.

The results have been mixed. Class actions have been certified in some cases.<sup>11</sup> In two cases, the insurers have been successful.

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<sup>7</sup> *Negrete v. Allianz Life Ins. Co. of N. Am.*, 238 F.R.D. 482, 493 (C.D. Cal. 2006).

<sup>8</sup> McCann Supp. Decl. ¶ 4, quoted in *Negrete v. Allianz Life Ins. Co. of N. Am.*, 238 F.R.D. 482, 493 (C.D. Cal. 2006).

<sup>9</sup> McCann Supp. Decl. ¶ 6, quoted in *Negrete v. Allianz Life Ins. Co. of N. Am.*, 238 F.R.D. 482, 493 (C.D. Cal. 2006).

<sup>10</sup> *Negrete v. Allianz Life Ins. Co. of N. Am.*, 238 F.R.D. 482, 493 (C.D. Cal. 2006).

<sup>11</sup> See *Castello v. Allianz Life Ins. Co. of N. Am.*, Case No. 03-20405 (Minn. Dist. Ct. 2005); see also *Mooney v. Allianz Life Ins. Co. of N. Am.*, 244 F.R.D. 531 (D. Minn. 2007).

a) *Delaney v. American Express*, 2007 WL 1420766 (D. N.J. 2007)<sup>12</sup>

Plaintiffs' brought suit regarding their purchase of fixed annuities promising a 1.00% bonus rate of interest. While the plaintiffs brought a litany of claims, the court recognized that the complaint's "common theme" was that the product's design "built in an undisclosed cost and/or charge that resulted in an increased 'spread' designed to recoup and recapture the entire bonus paid in year one."<sup>13</sup> Each of the causes of action – breach of contract, fraudulent misrepresentation/omission, negligent and wanton hiring, training, and/or supervision, violation of the New Jersey Consumer Fraud Act, and civil conspiracy – was subject to dismissal because the bonus annuity's allegedly deceptive design was disclosed: "[T]he Annuity Documents expressly provide that purchasers of the annuity will be credited a bonus interest rate that is limited to the first year of the annuity, and that Defendants' have the sole discretion to establish the rate that will apply in subsequent years, subject to a guaranteed minimum rate of interest."<sup>14</sup> The disclosures, thus, precluded a finding that defendants had a deceptive scheme to recapture the first-year bonus. The court was also persuaded by the fact that the plaintiffs received all that they were promised under the terms of the relevant documents.<sup>15</sup> The *Delaney* decision has been dismissed by the United States Court of Appeals for the Third Circuit, apparently because the parties reached a settlement agreement.<sup>16</sup>

b) *Phillips v. American Int'l Group, Inc.*, Case No. 2007 WL 2177124 (S.D.N.Y. 2007)

The plaintiff purchased two bonus annuity contracts, each of which promised a bonus rate of interest payable during the first year of the contract. Plaintiff alleged that defendants recouped the entire promised bonus rates because of the actuarial design, pricing and structure of the products. Plaintiff contended that the defendants' failure to disclose the bonus recapture amounted to breach of contract, fraudulent and negligent misrepresentations, civil conspiracy, unjust enrichment, and violation of state insurance and consumer protection laws.

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<sup>12</sup> *Delaney v. American Express Co.*, 2007 WL 1420766 (D. N.J. 2007). This case was originally filed in the Southern District of New York as *Poli v. American Express Co.*, Case No. CV-06-5703 (S.D.N.Y. 2006), but was voluntarily dismissed in October 2006, and refiled in the federal district court in New Jersey.

<sup>13</sup> Compl. ¶ 4, quoted in *Delaney v. American Express Co.*, 2007 WL 1420766 (D. N.J. 2007).

<sup>14</sup> *Delaney v. American Express Co.*, 2007 WL 1420766, at \*3 (D. N.J. 2007).

<sup>15</sup> Plaintiffs were clearly unhappy with their purchases, as they alleged they could have purchased other products with higher interest rates, were they not duped into purchasing defendants' bonus annuity. The court, however, swiftly rejected such a claim: "Dissatisfaction with a product or with the terms of a contract . . . does not provide the basis for a claim for relief regardless of the particular legal theory that a plaintiff invokes." *Delaney*, 2007 WL 1420766, at \*3.

<sup>16</sup> *Delaney v. American Express Co.*, Case No. 07-2743 (3d Cir. dismissed Sep. 28, 2007).

Drawing upon the reasoning of the New Jersey Federal District Court in *Delaney*, the court also found that disclosures in the contract materials belied the plaintiff's contention that the contract reflected a misrepresentation or omission. Such disclosures conveyed that the bonus rates applied only in the first years, that subsequent years may yield changes in the base rates, and that determination of the rates in subsequent years was subject solely to the discretion of the issuer. The court reasoned that given these disclosures, the failure to disclose that the bonus interest could not be permanently realized did constitute fraud. Significantly, the federal district court in *Phillips* expressly found that the defendants' failure to make an additional disclosure, akin to one made in *Delaney* – "[i]n return for the additional first-year rate on this annuity the base rate is lower than it would have been had the additional first-year rate not been applied"<sup>17</sup> – did not warrant a different result. Rather, the court reasoned, such an additional disclosure "merely emphasizes what is plain from the disclosures cite above: that the bonus rate applies in the first year only, and that defendants retained discretion to set lower rates in subsequent years."<sup>18</sup>

## **B. Retirement Plan Annuities**

There is an increasing amount of litigation challenging retirement plan fees as excessive, imprudent, and involving self-dealing. A recurrent theme among nearly all of the cases filed to date is an attack on a practice known as "revenue sharing." Although the exact details vary, revenue sharing typically refers to a practice in which a mutual fund company "shares" a portion of the fees received with other service providers. Many of the cases assert that these fees violate the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Suits are being asserted against insurers who offer plan sponsors a menu of mutual funds from which it can select investment options for its participants.<sup>19</sup> In general, these cases allege that the insurer breached its ERISA fiduciary duties, under ERISA § 404(A)(1), and engaged in prohibited transactions under ERISA § 406(b)(1) and (b)(3), by arranging for and retaining "revenue sharing" fees from mutual fund families whose funds were offered as investment options under the subject plans. The plaintiffs also allege that the subject "revenue sharing" fees were not properly disclosed nor legitimately received for services provided by the insurers to the mutual fund families. As grounds for asserting that the insurer is a fiduciary, several complaints allege that the insurer retained and had exercised "a unilateral right to cease offering mutual funds chosen by participants and substitute other

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<sup>17</sup> *Phillips v. American Int'l Group, Inc.*, Case No. 2007 WL 2177124, at \*4 (S.D.N.Y. 2007), quoting *Delaney v. American Express Co.*, 2007 WL 1402766, at \*6 (D. N.J. 2007).

<sup>18</sup> *Phillips v. American Int'l Group, Inc.*, Case No. 2007 WL 2177124, at \*4 (S.D.N.Y. 2007).

<sup>19</sup> See e.g., *Haddock v. Nationwide Fin. Servs., Inc.*, Case No. 3:01-cv-01552-SRU (D. Conn. 2006); *Ruppert v. Principal Life Ins. Co.*, Case No. 06-0903 (S.D. Ill. 2007); *Phones Plus, Inc. v. The Hartford Fin. Servs. Group, Inc.*, Case No. 3:06-cv-01835-AVC (D. Conn. 2007); *Stark v. American Skandia Life Assurance Corp.*, Case No. 3:07-cv-01123-CFD (D. Conn. 2007); *Charters v. John Hancock Life Ins. Co.*, Case No. 1:07-cv-11371-NMG (D. Mass. 2007); *Young v. Principal Fin. Group, Inc.*, Case No. 4:07-cv-00386-RP-CFB (S.D. Iowa 2008).

mutual funds in their place."<sup>20</sup> In general, the insurers assert that the fees are not plan assets and that they are not plan fiduciaries. Moreover, in some cases, the insurers argue that if they are deemed liable for the conduct complained of by the plaintiffs, then the plaintiffs, as the plan fiduciaries ultimately responsible for the selection and approval of investment options, are also at fault for any harm caused to the plan and its participants, and are thus liable to the insurers for contribution and indemnity. Overall, the activity in these cases has been largely procedural to date.

These cases also extend to variable annuities offered under 403(b) of the Internal Revenue Code.<sup>21</sup> The lawsuits filed thus far consist of putative class actions brought by public school employees participating in a 403(b) annuity product in which the employees' union endorsed the insurers' 403(b) annuity product. The complaints allege that the insurer and the unions are fiduciaries under ERISA. They allege that the insurers breached their fiduciary duties to the plan by charging excessive fees and by accepting undisclosed revenue sharing payments from mutual funds offered to plan participants. The complaints allege that the unions breached their fiduciary duties to the plan by engaging in an endorsement scheme in which the unions receive fees from the insurer to market and promote the 403(b) product directly to union members. The insurers and unions assert that the 403(b) plan upon which plaintiffs attempted to base their ERISA complaint is not, as a matter of law, either regulated by, or subject to, ERISA and thus the courts lacked jurisdiction over these complaints. On March 23, 2008, the district court in the NEA case granted defendants' motions to dismiss. The court held that because the NEA was an "employee organization" and not the employer, it could not, as a matter of law, establish or maintain a plan under section 403(b) of the Internal Revenue Code.

In addition, two similar lawsuits have been filed in the context of governmental deferred compensation plans under 457(b) of the Internal Revenue Code.<sup>22</sup> Similar to the 401(k) and 403(b) suits, the plaintiffs' claims are centered on purported breaches of fiduciary duties by the service providers in arranging for and receiving revenue sharing payments for their own use and benefit at the expense of the plan. In *Beary v. ING Life Ins. & Annuity Co.*, Case No. 3:07-cv-00035-MRK (D. Conn. 2007), the court dismissed the action.

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<sup>20</sup> These allegations were added in response to the *Haddock* trial court's denial of the insurer's motion for summary judgment on the plaintiff's Fourth Amended Complaint. The court found that plaintiffs raised triable issues of fact regarding whether Nationwide acted as a fiduciary to the plan (i) by exercising control over the revenue sharing fees which the court found could be regarded as "plan assets" under a "functional test" of the court's own making, and (ii) by exercising discretion over the addition, deletion, or substitution of funds. As to the latter ground, the court purported to distinguish Department of Labor Advisory Opinion 97-16A, which held that an insurer was not acting as a fiduciary under circumstances very similar to those in *Haddock*, on the grounds that the opinion was predicated on a representation that the fees were paid for administrative services performed by the insurer. Plaintiff's Fifth Amended Class Action Complaint at 8, *Haddock v. Nationwide Fin. Servs., Inc.*, Case No. 3:01-cv-01552-SRU (D. Conn. 2006).

<sup>21</sup> *Montoya v. ING Life Ins. & Annuity Co.*, Case No. 1:07-cv-02574-NRB (S.D.N.Y. 2007); *Daniels-Hall v. Nat'l Educ. Assoc. et al.*, Case No. 3:07-cv-05339-RBL (W.D. Wash. 2007).

<sup>22</sup> *Beary v. Nationwide Life Ins. Co.*, Case No. 2:06-cv-00967-EAS-MRA (S.D. Ohio 2006); *Beary v. ING Life Ins. & Annuity Co.*, Case No. 3:07-cv-00035-MRK (D. Conn. 2007).

1. *Beary v. ING Life Ins. & Annuity Co.*, Case No. 3:07-cv-00035-MRK (D. Conn. 2007)

In order to avoid SLUSA preemption plaintiff preemptively amended his Complaint. To that end,

the Sheriff removed all references to a fraudulent "scheme"; to the fact that the services for which ING allegedly received the revenue-sharing payments purportedly had little or no fair market value; to the inference that increased charges to the mutual funds by ING necessarily reduced the value of the Plan participants' investments; and to any attempt to hide from Plan participants material information regarding the revenue-sharing payments. . . . The Sheriff also acknowledged that because the contract between ING and the Sheriff's Plan did not discuss revenue-sharing payments specifically, there is no claim that ING breached the Contract by receiving and retaining the revenue-sharing payments.<sup>23</sup>

In the Amended Complaint, plaintiff alleged the insurer held the investments in the plan in trust for the participants in the plan (or that the insurer acted as the employees' agent in making investments for them) and that the insurer breached the fiduciary duty it owed the plan (as trustee or agent). The plaintiff also sought damages for unjust enrichment, claiming it would be unfair to permit the insurer, as a fiduciary, to retain the revenue-sharing payments. The court found that the insurer disclosed the revenue sharing arrangements and that the plaintiff's delay of almost six years in bringing this lawsuit in the face of complete disclosure of all material facts regarding its receipt of revenue-sharing payments constituted acquiescence sufficient to bar the plaintiff's lawsuit under Florida law.

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<sup>23</sup> *Beary v. ING Life Ins. & Annuity Co.*, Case No. 3:07-cv-00035-MRK, at 6 (D. Conn. 2007) (citation omitted).

## II. LIFE INSURANCE LITIGATION

### A. Life Insurance to Fund Retirement Savings

1. *Toy v. Metropolitan Life Ins. Co.*, 928 A.2d 186 (Pa. 2007)

Plaintiff, in preparing for retirement, met with the insurer's agent to discuss a product offered by the insurer. At the meeting, the insurer's agent presented plaintiff with information regarding the insurer's "50/50 Savings Plan." The Supreme Court of Pennsylvania found that at the sales meeting, the agent explained that "the plan was a savings vehicle . . . [and] would generate a fund of approximately \$100,000 when she reached sixty-five. [The agent] also informed [the plaintiff] that life insurance went along with and was part of the plan."<sup>24</sup> The plaintiff completed an application for life insurance and the following month received a life insurance policy. The policy disclosed that it was a whole life policy that paid life insurance upon the plaintiff's death and included a 10 day free look period. Upon receipt of the policy, plaintiff "looked only at the Policy's cover sheet."<sup>25</sup>

The plaintiff filed suit, alleging the insurer

undertook a marketing scheme to disguise the true nature of the Policy and misrepresent it to be a savings or investment vehicle; that [the insurer's] misrepresentations about the Policy led her to believe that she was investing in a savings plan; that due to [the] misrepresentations she purchase life insurance she did not want; that [the] misrepresentations prevented her from securing the type of retirement product she needed;<sup>26</sup>

The plaintiff brought claims under the consumer protection law and for bad faith under § 8371 for engaging in activity that is unlawful under the Unfair Insurance Practices Act, claiming that she was deceived by the defendant's agent, and as a result she bought a life insurance policy instead of a retirement savings plan.

The insurer moved for summary judgment arguing that plaintiff could not prove the element of justifiable reliance on the agent's statements because the policy clearly contradicted the agent's statements. The intermediate appellate court disagreed with the trial courts holding that the plaintiff's failure to conduct a cursory examination of the information contained on the cover page prevented her from demonstrating justifiable

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<sup>24</sup> 928 A. 2d at 189.

<sup>25</sup> 928 A. 2d at 190.

<sup>26</sup> 928 A. 2d at 190.

reliance on the agent's oral representation.<sup>27</sup> The intermediate appellate court found that it was not unreasonable for the plaintiff to place trust in the insurance agent rather than to read the policy. The court pointed to prior precedent that held an insured had no obligation to read where an insured asks for a particular coverage and the agent informed the insured that the policy provided it.<sup>28</sup> The intermediate appellate court also disagreed that the plaintiff could not show she justifiably relied upon the oral representations even though she received a policy which contradicted those statements. That court acknowledged the plaintiff's argument that she was not alarmed when she received the policy because the agent had informed her that "she would receive life insurance as an added benefit of her decision to invest in the retirement plan."<sup>29</sup>

The Pennsylvania Supreme Court held that this case involved fraud in the execution rather than fraud in the inducement in that a party has alleged that he was mistaken as to the terms and actual contents of the agreement the party executed due to the other's fraud.<sup>30</sup> Because this case involves fraud in the execution, the parol evidence rule is not applied. The Court noted it had determined that "a party who engages in intentional fraud should be made to answer to the party he defrauded, even if the latter was less than diligent in protecting himself in the conduct of his affairs."<sup>31</sup> Accordingly, the Pennsylvania Supreme Court held that the plaintiff was under "no duty to read the policy and the fact that she did not do so does not preclude her from establishing justifiable reliance."<sup>32</sup>

## 2. 412(i) Plans

A number of suits are being filed regarding the design, marketing and sale of defined benefit plans under Section 412(i) of the Internal Revenue Code and the related life insurance products. Section 412(i) plans provide retirement and death benefits to the participants and must be funded by insurance contracts. The employer establishes a 412(i) plan and creates a trust to hold the insurance contracts. The trust purchases the insurance contracts and the employer funds the premium payments for the 412(i) plan. Generally, the Code allows the employer to take a deduction for the premium payments. In 2004, the Internal Revenue Service ("IRS") issued Revenue Rulings and proposed regulations addressing 412(i) plans that were funded by life insurance policies that included cash values that increased substantially after a certain number of years and

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<sup>27</sup> *Toy v. Metropolitan Life Ins. Co.*, 863 A.2d 1, 12 (Pa. Super. Ct. 2004).

<sup>28</sup> 863 A.2d at 12-13.

<sup>29</sup> 863 A.2d at 13-14.

<sup>30</sup> *Toy v. Metropolitan Life Ins. Co.*, 928 A.2d 186, 206 (Pa. 2007)

<sup>31</sup> 928 A.2d at 207.

<sup>32</sup> 928 A.2d at 208. The dissenting opinion noted that the majority opinion opened the door to the possibility that it would be sufficient to make an allegation that the defendant suggested that the false terms were within the written contract, although they were most clearly not set forth in the contract. 928 A.2d at 214 (Saylor, J. dissenting).

disqualifying plans that held such policies from 412(i). Thereafter, employers began filing suits against the entities that created the 412(i) plans for the employers, as well as the producers and insurers who sold the insurance contracts funding the 412(i) plans. *Omni* is the first court decision on these cases.

- a) *Omni Home Fin., Inc. v. Hartford Life & Annuity*, 2008 WL 1925248 (S.D. Cal. 2008).

The plaintiffs sought to create a 412(i) retirement plan and were referred to the insurer's agent. Using information gathered by the insurer's agent, proposals for the 412(i) plan were developed for review and approval by the employer. The employer decided to proceed with the plan and once it adopted the plan, purchased insurance products from the insurer's agent. Thereafter, the IRS disallowed the employer's deductions for amounts contributed to the plan. Plaintiffs, the employer sponsor of a 412(i) plan and the principal employees and participants in the plan, filed suit stating multiple causes of actions under the ERISA and state law.

On a motion for summary judgment, the trial court examined whether the plaintiffs reasonably relied on the defendant's misstatements that the employer's contributions to the plan would be tax deductible and plaintiffs' allegation that the insurer failed to inform the plaintiffs of the tax risks of the plan. The court examined the other materials given to the employer and its principal employees which stated that neither the agent nor the insurer were providing tax and legal advice and that the employer should seek advice from its tax and legal advisors. These disclosure were:

The design, adoption and implementation of a 412(i) or other qualified retirement plan can be complicated and depends upon the particular facts and circumstances applicable to You. So, in designing and implementing the Plan, You should consult with Your legal and tax advisors.

We are bound by only those promises in the Contracts and no others. We do not endorse the Plan, its design, its adoption or implementation. Decisions on the advisability of the Plan, its adoption, implementation and design are decisions that are made by You, the Plan sponsor and Plan actuaries in consultation with Your legal and tax advisors.

Neither We . . . (nor anyone on Our behalf) have made representations to You regarding the federal and state tax consequences (to You or others) of participation in or termination from the Plan, transactions involving the Contracts, or any other ERISA or other legal issues, including but not limited to: deductibility of contributions to the Plan; non-discrimination requirements (including eligibility, participation, amounts of coverage, and rules governing control groups and affiliated service

groups); plan permanency requirements ... and any funding limitations and requirements.<sup>33</sup>

Moreover, the disclosures also informed plaintiffs of the recent Revenue Ruling of the IRS regarding 412(i) Plans. The court was not persuaded by the plaintiffs' argument that they did not read these disclosures noting that the two documents were "only two pages each."<sup>34</sup> In addition, the court found that the employer's principals were "reasonably sophisticated businesspeople" and granted summary judgment on the plaintiffs' state law claims.<sup>35</sup>

## **B. Interest Sensitive Life Policies – Round Two**

The class action bar continues to "test" various theories attacking interest sensitive life policies. This latest round of cases follow the 1990s class action suits based on allegedly deceptive marketing and sales practices of interest sensitive insurance policies as "vanishing premium policies." To the extent that insurers have previously settled class action suits on these policies, the insurers have generally been successful in defeating further suits because of res judicata, or claim preclusion which prohibits a party from re-litigating a claim where a judgment on the merits (involving the same claim and the same parties) exists from a prior action.<sup>36</sup>

### **1. Premiums did not Vanish**

*Moelis v. Berkshire Life Ins. Co.*, Case No. 98-0302, 98-0441, 99-269B

The whole life interest sensitive policies were marketed using illustrations showing that after a certain number of years, the accumulated value of the policy would cover the cost of the premiums so that out-of-pocket premiums would "disappear." The plaintiffs contended that the premiums did not disappear as represented, that the marketing illustrations were fraudulent based on unrealistic assumption, and that the insurer knew the policies could not become self-sustaining as projected. The plaintiffs alleged that the marketing scheme was deceptive in violation of Massachusetts law and sought to certify a national class action or in the alternative a state class action. The lower court denied certification of a national class action on due process grounds and denied statewide class certification because the insurer had raised a statute of limitations defense that required a fact specific inquiry into each plaintiff's purchase, and therefore the plaintiffs were not similarly situated.<sup>37</sup> The trial

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<sup>33</sup> *Omni Home Fin., Inc. v. Hartford Life & Annuity*, 2008 WL 1925248, slip op. at 3 (citations omitted).

<sup>34</sup> *Omni Home Fin., Inc. v. Hartford Life & Annuity*, 2008 WL 1925248, slip op. at 5.

<sup>35</sup> *Id.*

<sup>36</sup> See e.g., *Adams v. Southern Farm Bureau Life Ins. Co.*, 493 F.3d 1276, 1278-80 (11th Cir. 2007); *Ross v. Metropolitan Life Ins. Co.*, 411 F. Supp. 2d 571, 581 (W.D. Pa., 2006).

<sup>37</sup> 2006 WL 4756747 *aff'd* .

court's rulings were upheld recently in a May 22, 2008 opinion of the Supreme Judicial Court.<sup>38</sup>

The lower court held that the *statute of limitation defense would likely require an "individualized inquiry* into when each class member knew or reasonably should have known that his or her policy would not perform as expected because the illustration provided by Berkshire was fraudulent."<sup>39</sup> The lower court noted relevant to this inquiry was *whether a plaintiff in fact received dividend reduction notices* and substance and timing of any post-purchase communications from Berkshire concerning the policy, such as updated illustrations.<sup>40</sup>

The lower court noted that the insurer had sent the following notices:

- "1992 Notice" – explaining the dividend reduction to all policyholders with their statement of annual account and, where applicable, their premium notice. The 1992 Notice stated in relevant part:

Due to declining interest rates and a new tax law which *significantly* increases federal income taxes payable by life insurance companies, the dividend scale for your policy is being reduced . . . However, if your policy is under a "disappearing premium" concept, the reduction in scale could mean additional out-of-pocket premium payments.<sup>41</sup>

- A memorandum to agents concerning this notice stated in pertinent part:

Over the past year, inquiries about the disappearing premiums have continued to increase in frequency and volume. It has become obvious that *most clients* who have purchased insurance using the disappearing premium approach *have little or no memory of how it works or how dividends fit into the picture*. Even worse, *many* of those individuals *believe* that the "projected" disappearing premium year is an absolute, a guarantee.<sup>42</sup>

- December 1993 – The insurer considered a proposed disclosure to accompany future policy illustrations which stated:

The values in this illustration depend on policy dividends. Dividends are sensitive to changes in investment return. Recent activity in the investment markets suggest that future earnings may

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<sup>38</sup> 2008 WL 2122417 (Mass. 2008).

<sup>39</sup> 2006 WL 4756747, slip op. at 18-19 (emphasis added).

<sup>40</sup> 2006 WL 4756747, slip op. at 19 (emphasis added).

<sup>41</sup> 2006 WL 4756747, slip op. at 3.

<sup>42</sup> 2006 WL 4756747, slip op. at 4 (emphasis added).

be lower than current rates. Caution suggests that you ask your agent for an "alternate" (lower) rate illustration.<sup>43</sup>

Ultimately, the insurer decided not to use this disclosure and instead decided to use a disclosure that stated:

The values in this illustration depend on policy dividends which are not guaranteed but are projections based on our current experience. No company can predict dividends because they depend on future economic conditions as well as company investment, expense and mortality experience. Dividends paid on this policy may be higher or lower than those illustrated here.<sup>44</sup>

- 1994 Notice – explaining the dividend reduction to the policyholders with renewal dates in 1994, approximately 30 days before the policy anniversary. The 1994 Notice stated in relevant part:

Dividends on life insurance policies are, in large measure, a reflection of the rate of interest the company is able to earn on invested assets. You are undoubtedly aware that interest rates have been in an almost "free fall" decline over the past few years.

To protect the *guaranteed* values and death benefits of their policies, prudent life companies - Berkshire included - have already reduced their dividend scales and now find a further reduction necessary.

Such a reduction, as indicated, in no way affects the guaranteed values and benefits of your policy, but may impact the premiums you are paying. This is true only if you elected to use dividends to reduce your premiums or if your policy was set up under a "disappearing premium" concept.<sup>45</sup>

The lower court noted that the 1994 Notice "did not discuss how long the premium outlay period might be extended and did not include an updated policy illustration."<sup>46</sup> The insurer sent agents new premium illustrations only for those policyholders whose premiums were already paid through dividends rather than out-of-pocket payments.

- 1997 Notice – sent to all individual policyholders who were already paying their premiums through dividends explaining the 1997 dividend reduction 60 days prior

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<sup>43</sup> 2006 WL 4756747, slip op. at 4.

<sup>44</sup> 2006 WL 4756747, slip op. at 4.

<sup>45</sup> 2006 WL 4756747, slip op. at 4.

<sup>46</sup> 2006 WL 4756747, slip op. at 4.

to the policy anniversary with the statement of account. The 1997 Notice stated in relevant part:

The premium offset option you elected when you purchased your Berkshire Life insurance policy has allowed dividends and the build-up of policy values to pay some or all of your premiums in the past. . . .

Interest rates are often the critical determinant in the decision to increase or decrease the dividend scale. Due to declining interest rates over the past 24 months in our investment portfolio, the dividend scale for Berkshire Life's insurance policies has been reduced effective January 1, 1997.

Such a reduction in no way affects the guaranteed values and benefits of your policy, which continues to be an excellent value . . . . However, the reduction may impact your out-of-pocket costs if you elected to use your dividends to offset your premium in any way.

New premium illustrations were sent directly to those policyholders already paying their premiums through dividends. Individual policyholders who were not yet using dividends to reduce premiums received a similar letter.<sup>47</sup>

## 2. Premiums Increased

### a) *Pate v. Conseco Life Ins. Co.*, 971 So. 2d 593 (Miss. 2008)

The insured received a letter informing him that he would have to pay an increased premium or his policy would lapse. In addition, *the prior annual report for the insured's policy showed an increase in the planned premium from \$186.22 to \$340 per month*. The insured argued that the insurer was not permitted to increase the "planned monthly premium," and that the insurer, a predecessor of Conseco Life, breached the policy when it did so. The trial court found no issue of material fact and held that the insurer was entitled to judgment as a matter of law, including that the statute of limitations barred all of insured's claim against the insurer.

The Supreme Court reversed and opined that the terms of the contract *did not allow the insurer to increase* the planned monthly premium.<sup>48</sup>

Conseco fails to point to any language contained in the policy which would allow for an increase in the planned monthly

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<sup>47</sup> 2006 WL 4756747, slip op. at 5.

<sup>48</sup> 971 So. 2d at 595-96.

premium. Therefore we find that the terms of the contract unambiguously support Pate and should be construed as written.<sup>49</sup>

In addition, the Court rejected the insurer's statute of limitations defense and agreed with the insured's assertion that because he was expressly told, as an inducement to purchase the policy, that his monthly premium would be \$186.22 and would never increase, a claim resulting from an increase in premiums would not ripen until he was put on notice of the increase. Thus, the Court held that the insured's "cause of action accrued when his premium was increased in 2001."<sup>50</sup>

The outcome in *Pate* may have been driven by its procedural posture and how the matter was presented. Conceivably, the "prevent lapse" letter from the insurer identified the additional premium the insured needed to pay to prevent lapse of his policy. It appears that in the annual report, the insurer *automatically increased* the planned monthly premium.

b) *Walker v. Metropolitan Life Ins. Co.*, 2008 WL 747105 (D. Or. 2008)

The plaintiffs alleged that when they purchased their universal life policy, they believed that the annual premium would remain the same. A higher level of premium, however, was needed to prevent the lapse of the policy. As a result, the plaintiffs alleged four claims against the insurer for: (1) declaratory relief that the annual premium for the policy is \$1,900 per year; (2) breach of contract; (3) fraud; and (4) unconscionability. The insurer moved to dismiss the plaintiffs' complaint.

While the plaintiffs relied on the language in the policy schedule that stated the "Planned Annual Premium" was \$1,900, the court noted that no other provision stated that the premium was fixed. Indeed, the trial court found that the policy expressly stated that the premiums are not fixed and it pointed to the cover page which was titled "Flexible Premium Adjustable Joint Life Policy." The trial court reviewed numerous provisions in the contract and found that

A reading of the entire Policy makes it abundantly clear that the premium may change over time to keep the Policy in force depending on the cost of insurance, which increases as one ages, and the prevailing interest rate, which may change over time.<sup>51</sup>

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<sup>49</sup> *Id.* at 596.

<sup>50</sup> *Id.* at 597.

<sup>51</sup> *Walker v. Metropolitan Life Ins. Co.*, 2008 WL 747105, slip op. at 3

Moreover, the court found that the "Policy demonstrates how it will lapse if the Planned Annual Premium is not adjusted."<sup>52</sup>

c) *Adams v. Southern Farm Bureau Life Ins. Co.*, 493 F.3d 1276 (11th Cir. 2007)

The plaintiffs brought an action alleging that the insurer failed to disclose that their policy premiums might increase in the event interest rates turned out to be lower than those projected. Thus, their suit involved "increasing premiums" policies. The insurer contended that a previous settlement barred the plaintiffs claim. Plaintiffs contend that this is a different "operative nucleus of fact" than the claims asserted in the prior litigation which, plaintiffs argue, involved "vanishing premium" policies, that is, where the policy holder expected the premium to disappear once the cash value was large enough to cover the required premiums. The appellants assert that there is a factual distinction between premiums that would suddenly increase without warning and premiums that failed to disappear after a period of time, such that claim preclusion should not apply. The court disagreed and enjoined the plaintiffs' prosecution of these "increasing premiums" claims as having been litigated and resolved in the class action settlement.

**Considerations for Premium Issues Related to Interest Sensitive Policies**

- Policy owners may misunderstand that premiums are payable for life of the policy and they may need to increase their premium payments in order to prevent the policy from lapsing. Consider providing notices to policy owners regarding the change in the dividend or interest scales that discuss the impact on their policies, including that the change in scale may require additional premiums to prevent a lapse. This will facilitate a statute of limitation argument in any future litigation. Annual statements and other communications with policyholders can be useful to trigger the statute of limitations with respect to a claim for fraud. Consider affirmative statements that the policy would lapse within a stated period, and that the policyholder should consider increasing the planned premium to avoid lapse.
- If policy owners inquire about the status of their contracts and the potential for lapse or need for additional premiums, consider providing them with substantive information to allow them to decide whether or not to change the planned premiums, including new illustrations. Care should be taken to reinforce that under the terms of their flexible premium policy, it is the policy owner who decides to change the "planned premium" or "scheduled premium."
- Consider reviewing and revising lapse notice letters to clearly state that the premium amount in the letter is the minimum amount needed to continue the policy in force, not the planned or scheduled premium, and that under the terms of their flexible premium

<sup>52</sup> *Walker v. Metropolitan Life Ins. Co.*, 2008 WL 747105, slip op. at 4.

policy, it is the policyholder who determines what premium to pay to maintain their policy.

- Consider reviewing and revising marketing materials to provide a clearer explanation of the different types of premiums or other payments required to maintain policies (e.g., "While you select your planned premiums, because crediting rates vary in amount over time, it is possible additional premiums may be required to prevent lapse of your policy." Also consider similar enhanced illustration disclosures.

### C. Dividends – Allocation of Income and Expenses

*Beavers v. Metropolitan Life Ins. Co.*, 2007 WL 3342540 (S.D. Tex. 2007)

*Rabouin v. Metropolitan Life Ins. Co.*, Case No. 111355/98

The named plaintiffs in these suits brought class actions alleging that the insurer wrongfully manipulated surplus through the insurer's allocation of income, losses and expenses of certain real estate equity investments and real estate mortgage investments. The insurer made a decision to allocate the return earned on certain equity and mortgage interest by line of business in different proportions. The insurer decided in 1992 to restructure its mortgage income interest in properties of which the insurer was the sole owner into equity income interest.<sup>53</sup>

The suits alleged that due to these improper allocations, the insurer repeatedly reduced dividends paid to participating policy owners constituting a breach of contract. In addition, in the *Rabouin* action, the plaintiffs asserted claims for unfair trade practices in violation of GBL § 349, breach of fiduciary duty and an accounting.<sup>54</sup> The *Rabouin* court dismissed the claims for breach of fiduciary duty and accounting on the ground that there was no fiduciary duty between the plaintiffs and the insurer.<sup>55</sup>

With respect to the unfair trade practices claim, the *Rabouin* court, and with respect to the breach of contract claims, the *Beavers* and *Rabouin* courts, examined when the insurer made the change in allocation of the investments. Thus, the courts held that any alleged breach by the insurer occurred in 1992. The *Rabouin* court rejected the plaintiffs' theory that there were continuing contractual breaches because the insurer allegedly breached the contract each year when the dividends were set.<sup>56</sup> Accordingly, the statute of limitations ran when the alleged breach occurred in 1992, not subsequently when the

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<sup>53</sup> *Rabouin*, 814 N.Y.S. 2d at 564.

<sup>54</sup> *Id.*

<sup>55</sup> *Rabouin v. Metropolitan Life Ins. Co.*, 182 Misc.2d 632, 634-35 (Sup Ct, N.Y. County 1999), *aff'd* 282 A.D.2d 381 (N.Y. App. Div. 2001).

<sup>56</sup> *Rabouin*, 182 Misc.2d at 638-39.

dividends scales were reduced as a result of the allocation change. The *Beavers* court rejected arguments that the statute of limitation should be tolled.<sup>57</sup>

**Considerations for Changes in Allocations to Lines of Business**

- Prior to any changes in allocations to lines of business, insurers should review the impact on dividends to any participating policyholders and review the terms of the contract. Most participating contracts grant the insurer discretion in determining the dividends paid from surplus.
- To the extent that there is a potential for a breach of contract claim related to changes in dividends, resulting from changes in allocations or other change in the manner in which the income or expenses are calculated, an argument exists that the cause of action should accrue from the date of the change in allocation and not the date the dividend is set.

**D. Cost of Insurance**

1. Increasing the Cost of Insurance Rates

Suits against insurers continue as to whether they are entitled to raise the cost of insurance rates. These suits allege that the insurers set the cost of insurance rates in a manner that was inconsistent with the terms of the insurance contracts. In general, the suits allege that in calculating the cost of insurance rates, the insurers included costs for expenses or taxes or included assumptions about lapse rates, none of which were permitted under the terms of the contracts. The results have been mixed, and several cases have already been settled.

a) *Brooks v. AIG SunAmerica Life Assur. Co.*, 480 F.3d 579 (1st Cir. 2007)

The plaintiffs filed a putative class action, because the insurer had increased the cost of insurance rates on the plaintiffs' policy and as a result, negatively impacted the accumulated cash value of the policy. Plaintiffs alleged that defendant increased the cost of insurance in breach of the contract, and the insurer breached its implied covenant of good faith and fair dealing, and violated Massachusetts and California unfair business practices. At the core of the plaintiffs' complaint was the allegation that the cost of insurance rate increases were not made in accordance with any of procedures and standards on file with the state regulatory agency.

The court noted that under the policy, the cost of insurance was expected to increase over the term of the policy and the policy stated:

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<sup>57</sup> *Beavers v. Metropolitan Life Ins. Co.*, 2007 WL 3342540 (S.D. Tex. 2007).

The monthly cost of insurance rates is based on the sex, age, and rate class . . . of the insured. Monthly cost of insurance rates will be determined . . . annually, by earnings, mortality, persistency, and expenses, including taxes. Any change in rates will be in accordance with any procedures and standards on file with the Insurance Department . . .<sup>58</sup>

The First Circuit affirmed the dismissal of the claims and chided the plaintiff for its failure to exercise "due diligence" in complying with the "district court's repeated orders to specify what 'procedures and standards' on file with the Division of Insurance" the insurer allegedly violated.<sup>59</sup> The First Circuit was also critical of the pleading choices made by the plaintiffs' counsel and stated that "[t]his might have been a different case if appellants had alleged in their complaint that the substantial percentage increases in the COI rates . . . were circumstantial evidence that [the insurer] had inflated the rates for improper purposes . . ."<sup>60</sup>

## 2. Juvenile Cost of Insurance Rates

Numerous actions are being brought alleging that insurers are charging "smoker" rates on juveniles' life insurance policies, even though the insureds identified on the applications that they were not smokers. Recent results have been favorable for insurers.<sup>61</sup>

- a) *Thompson v. American General Life and Accident Ins. Co.*, 448 F. Supp. 2d 885 (M.D. Tenn. 2006)

In granting the insurer's motion for summary judgment, the court found that the insurer delivered life insurance coverage to plaintiff at the rate and under the terms promised in the policy contract. The court concluded that plaintiff could not reasonably have expected that the insurer would rate its policy or provide coverage based upon terms not present in the policy. In other words, the court agreed with the insurer that plaintiff's answer to an application question about tobacco use cannot, standing alone, obligate the insurer to provide coverage at a rate different from that quoted and disclosed to plaintiff. The court further observed that, although plaintiff's claims were based upon distinctions between smoking and nonsmoking, the policy itself contained no such distinctions, and the plaintiff failed to prove that the insurer promised to provide coverage based upon smoking or nonsmoking status.

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<sup>58</sup> 480 F.3d at 581.

<sup>59</sup> 480 F.3d at 587.

<sup>60</sup> 480 F.3d at 590.

<sup>61</sup> See e.g., *Thompson v. American General Life and Accident Ins. Co.*, 448 F. Supp. 2d 885 (M.D. Tenn. 2006).

b) *Ross v. Metropolitan Life Ins., Co.*, 2007 WL 3489540 (W.D. Pa. 2007)

The Western District of Pennsylvania, specifically agreeing with the Thompson court, held that while "it is true that an insured-who, after all, is the party who makes and affirms the statements on an Insurance application- is committed thereto[,] it "found no cases, however, and Plaintiffs have not pointed to any, finding that the pertinent language can reasonably be read to obligate an insurer, without express agreement, to give a particular weight or effect to each such statement in its rate calculation method. The policy application, and the policy itself, are silent about Defendant's use of the answers, and simply do not impose a duty on Defendant to adjust rates based on those answers."<sup>62</sup>

c) *Alleman v. State Farm Life Ins. Co.*, 508 F. Supp. 2d 452 (W.D. Pa. 2007)

In a slightly earlier decision of the Western District of Pennsylvania, the court dismissed both plaintiff's reasonable expectations doctrine theory and her complete policy doctrine arguments. On the former, the court reasoned that the application of such a theory "would lead to the incongruous result that the court could, in the name of reasonableness, alter the terms of an unambiguous policy of insurance in a manner which neither the purchaser nor the insurer actually expected or intended. Such a result runs counter to the accepted goal of contract interpretation; namely, to give effect to the parties' intentions as manifested by the plain language of the contract."<sup>63</sup> Addressing plaintiff's latter argument-that the answers provided by an insured on a life insurance application become a material term of the contract-the district court in *Alleman* concluded that "[t]his may be true; however, it is a quantum leap in both law and logic to suggest that the representations made by the buyer in the application somehow compel the insurance company to convert the policy that was actually purchased, into another type of policy .... Plaintiff has failed to direct the court to any state or federal authority-statute, regulation or case law that so holds."<sup>64</sup>

#### **Considerations for Juvenile Policies**

Although courts in litigated decisions have not required such measures of any company, insurers might consider prophylactic measures such as:

- Making clear in the application that, for premium rating purposes, smoking questions only apply to insureds above a certain age.

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<sup>62</sup> *Ross v. Metropolitan Life Ins., Co.*, 2007 WL 3489540, 3 (W.D. Pa. 2007) (citation omitted).

<sup>63</sup> *Alleman v. State Farm Life Ins. Co.*, 508 F. Supp. 2d 452, 456-57 (W.D. Pa. 2007).

<sup>64</sup> *Alleman v. State Farm Life Ins. Co.*, 508 F. Supp. 2d 452, 457 (W.D. Pa. 2007).

- For all policies, following the procedures outlined in the regulations issued in those states (e.g., New Jersey) that have addressed the issue.

## E. Race-Based

Suits continue to be filed alleging that insurers discriminate against minority policyholders by selling policies for higher premiums and lower benefits than to other groups.

### 1. *Joseph et al v. Liberty Nat'l Life Ins. Co.*, Case No. 1:08-cv-20117-JEM (S.D. Fla. 2008)

The Haitian-American named plaintiffs filed a class action suit arising out of an intentional plan to discriminate against Black Haitian-Americans in the formation, performance and termination of life insurance contracts in violation of 42 U.S.C. §1981 and §1982. Plaintiffs alleged that the insurer made a decision to deny Haitian American applications for insurance solely based upon race, ancestry, ethnicity and national origin. Plaintiffs allege that the insurer instituted a means to determine if the applicant was Haitian American by asking leading questions about their foreign travel plans and listening for a "Haitian" accent. The complaint alleges that the insurer either has denied policies or replaced them with policies normally only sold to the terminally ill.

## F. Retained Asset Accounts

Various carriers payout insurance policy and contract benefits through retained asset accounts. One suit has been brought regarding this practice.

### *Rabin v. Mony Life Ins. Co.*, S.D.N.Y., Case No. 1:2006-cv-00775

In *Rabin*, the named plaintiff alleges that MONY failed to make payment, as required under the terms of its policies, to either the holder of a MONY policy (when the policy was surrendered or loan was sought) or the beneficiary of a MONY policy (when the insured of the policy died).<sup>65</sup> The plaintiff alleges that upon surrender of his policies, he did not receive a check for the surrender proceeds, pursuant to the terms of his policies. Rather, the plaintiff alleges he was required to complete a surrender form which stated the following:

*Proceeds are made available to you by means of an interest-bearing checking account. This account will be opened in your name, and you will receive a supply of checks with which you can immediately access all, or a portion of the funds, by writing checks*

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<sup>65</sup> Second Amended Class Action Complaint at 2-3, *Rabin v. Mony* No. 1:2006-cv-00775.

for \$250 or more. *The funds in the account earn interest at competitive, variable rate.*<sup>66</sup>

The named plaintiff asserts that MONY "instituted and engaged in a practice by which all 'payments above a certain dollar amount, believed to be \$5,000, were made via creation of a MONY Money Account and delivery of a checkbook to be used to drawn down proceeds in the account."<sup>67</sup> Moreover, the plaintiff alleges that MONY represented that:

the interest rate paid on its money fund was 'competitive,' sent promotional materials to policyholders extolling the merits of the various MONY products, such as annuities, in which the policyholders were urged to invest, and provided a checkbook representing an account maintained by MONY and upon which policyholders could write checks to invest in MONY products.<sup>68</sup>

By investing the policy proceeds in its own money fund, the plaintiff asserts that MONY was unjustly enriched and MONY's actions constituted a "practice, scheme, and course of conduct that damaged the Plaintiff and other policyholders and benefited MONY."<sup>69</sup> The named plaintiff sought relief for (i) breach of contract; (ii) breach of fiduciary duty; (iii) fraud and deceit; (iv) unjust enrichment; and (v) violation of New York's business deceptive trade practices act.

MONY filed a motion to dismiss the amended class action and the court dismissed the fraud and deceit claims.<sup>70</sup> On March 25, 2008, the named plaintiff filed a Second Amended Class Action Complaint broadening the potential class members to include holders or beneficiaries of Whole Life, Term Life, Universal Life, Foundation Life, Group Life and Endowment Life policies.

**Considerations for Retained Asset Programs**

- Using a supplemental contract disclosing the terms of the retained asset program.
- Describing the retained asset program as a "payment option" or settlement option made available under the terms of the contract.
- Affording owners and beneficiaries to opt-in or to be given the opportunity to opt-out of a retained asset program. Some states specifically require owners to affirmatively opt-in to a retained asset program.

<sup>66</sup> *Id.* at ¶12 (emphasis added in the Second Amended Class Action Complaint).

<sup>67</sup> *Id.*

<sup>68</sup> *Id.* at 5.

<sup>69</sup> *Id.* at 2.

<sup>70</sup> 2007 WL 737474 (S.D.N.Y. 2007).

- Limiting "sales-like" descriptions of the retained asset programs, such as describing the interest rate as "competitive."
- Limiting the proceeds that are paid through retained asset program. Some states prohibit the payment of surrender proceeds through retained asset programs.
- Complying with state notice and disclosure requirements for retained asset programs.
- Ensuring that the contract allows and/or state insurance laws allow for policy proceeds to be paid through a retained asset program.

## G. Return of Unearned Premiums – Notice to the Insurer as Condition Precedent

Numerous class action cases allege that insurers failed to refund the premiums that were "unearned" when consumers terminated their loans early. The actions allege that the single premiums paid provided insurance coverage during the term of the loan. If the loan was paid-off early, then the respective insurers were obligated under the terms of their contracts and state law to refund the "unearned" portion of the premium because the loans were outstanding for a shorter period of time. Insurers, however, are often not notified that the loan has been terminated. Accordingly, they are unaware that their obligation to pay the unearned premium has been triggered. The results have been mixed for insurers in these class actions. Several suits have already been settled by insurers.<sup>71</sup> In March 2008, however, a court rendered a favorable decision to the insurer.

### 1. *Massih v. Jim Moran & Assoc., Inc.*, Case No. 3:07-cv-30 (CAR) (M.D. Ga. 2008)

The named plaintiff, who paid off his loan early, alleged that defendants "intentionally administer, or fail to administer [the policies] in such a way as to avoid making refunds of the unearned premiums to their policyholders when the loans terminate prior to their scheduled maturity dates."<sup>72</sup> Accordingly, the named plaintiff asserted claims for breach of contract; unjust enrichment; negligence; negligence per se; willful, wanton, and intentional misconduct; attorney's fees; and punitive damages.<sup>73</sup>

Because the Court found that the plaintiff failed to provide the notice of cancellation, ***as required by the clear language of the contract***, the Court held that the defendants were entitled to judgment on the pleadings on the breach of contract claims. In addition, the

<sup>71</sup> See e.g., *Toole v. JMIC Life Ins. Co.*, SU-2003-CV-246 (settled Oct. 23, 2007); *Reller v. Union Security Life Ins. Co.*, Case No. 62-C3-04-012202 (settled Aug. 3, 2007); *Perkins v. American National Ins. Co.*, Case No. 3:05-CV-100 (settled May 4, 2007); *Carter v. North Central Life Ins. Co.*, Case No. SU-2006-CV-3764-6 (settled Nov. 20, 2006).

<sup>72</sup> 542 F. Supp. 2d 1324, 1328 (M.D. Ga. 2008).

<sup>73</sup> *Id.* at 1327.

Court found that the other claims were barred by Georgia's economic loss rule and dismissed the complaint.

In its holding the Court examined the language of the contract and concluded that the:

contract clearly states that in order to be eligible for a refund, Plaintiff must provide a cancellation request. The pertinent language of the TLP Contract states that

Purchasers/Lessee may cancel this TLP Retail Installment Sales Contract/Lease Agreement Addendum at any point during the original term of the Retail Installment Sales Contract/Lease Agreement. A cancellation request within thirty (30) days of purchase is eligible for a refund. A cancellation request received after 30 days of purchase will be refunded using the pro rata method, unless otherwise required under applicable state law. If you cancel, dealer will refund the enrollment charge to the Lender/Lessor listed above.

The contract as written unambiguously requires that Plaintiff give notice of cancellation to be eligible for a refund. Notice of cancellation is therefore a condition precedent to the obligation to make a refund of any portion of the enrollment charge.<sup>74</sup>

The Court specifically contrasted the insurance policy at issue in *Massih* from those in similar cases. The Court noted that other insurance policies had not included any such notice requirement. Moreover, the Court noted that in at least one other case, the insurer had admitted that the class action complaint sufficed as notice which resulted in a waiver for any argument that the plaintiff in that case had not complied with the notice requirement.

**Considerations based upon *Massih***

- In drafting contracts, it is important to ensure that even administrative matters such as notice to the insurer are clearly specified.
- Even if new contract forms being drafted are based on currently existing forms, an insurer should carefully review the new form.

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<sup>74</sup> *Id.* at 1329-30.

### III. HEALTH INSURANCE

#### **A. Ingenix, Inc. Database For Claims Payment**

1. New York Attorney General, Andrew M. Cuomo Investigation into the Use of Ingenix Information in Settling Claims

Following a six-month investigation, New York Attorney General, Andrew M. Cuomo, found that Ingenix, Inc., an affiliate of UnitedHealth Group, "constructed an unreliable and defective database" of health care billing information.<sup>75</sup> The Ingenix database is used by health insurers to calculate the "reasonable and customary charges" for individual claims by assessing how much a similar type of medical service would typically cost based upon the type of service and geographic location. The New York Attorney General claimed that the reasonable and customary rates produced by Ingenix were "remarkably lower than the actual costs of the typical medical expense."<sup>76</sup> As a result, the Attorney General found that by "distorting the 'reasonable and customary rate' . . . insurers were able to keep their reimbursement artificially low and force patients to absorb a higher share of the costs."<sup>77</sup> As a result of the investigation, Attorney General Cuomo issued subpoenas to the nation's largest health insurance companies and intends to file suit against Ingenix, its parent corporation and other affiliates.

Attorney General Cuomo asserts that Ingenix and its affiliates engaged in "repeated and persistent fraudulent, deceptive and illegal business practices in connection with the setting of reimbursement rates for out-of-network services."<sup>78</sup> He alleges that United insurers "charged members higher premiums in exchange for the right to see doctors 'out of network' or outside the preferred list" and "promised to reimburse members either the actual amount of the charge or a percentage, up to 80 percent, of the 'reasonable and customary' charge of doctors in the same or similar geographic areas for the same service."<sup>79</sup> The Attorney General asserts that United concealed from members that it used the unreliable and defective database supplied by a corporate affiliate who has a financial interest in keeping reimbursement rates low. As a result the data was manipulated in ways that would lead to lower reimbursement rates.<sup>80</sup> When members

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<sup>75</sup> Summary to Notice of Proposed Litigation Pursuant to Section 63(12) of the Executive Law, Section 349 and 350 of Article 22-A of the General Business Law, and Section 2601 of the Insurance Law, pg. 2 (Feb. 13, 2008).

<sup>76</sup> Press Release of the Office of the New York State Attorney General Andrew M. Cuomo (Feb. 13, 2008).

<sup>77</sup> *Id.*

<sup>78</sup> Notice of Proposed Litigation Pursuant to Section 63(12) of the Executive Law, Section 349 and 350 of Article 22-A of the General Business Law, and Section 2601 of the Insurance Law, pg. 2 (Feb. 13, 2008).

<sup>79</sup> Summary to Notice of Proposed Litigation Pursuant to Section 63(12) of the Executive Law, Section 349 and 350 of Article 22-A of the General Business Law, and Section 2601 of the Insurance Law, pg. 1 (Feb. 13, 2008).

<sup>80</sup> *Id.* at 2-4.

complained, United "falsely told complaining members that reimbursement rates were based upon 'independent research from across the healthcare industry'" seeking to discourage members from challenging the low reimbursement."<sup>81</sup>

2. *Weintraub v. Ingenix*, Case No. 3:2008cv00654 (D. Conn. 2008)

Following Attorney General Cuomo's announcement of an industry wide investigation into the use of Ingenix information and notice to Ingenix and its affiliates of its intent to sue, Jeffery Weintraub filed a federal class action suit against Ingenix, its affiliates and several other health insurers who received subpoenas from the Attorney General. The named plaintiff's complaint derives its allegations from the New York Attorney General and asserts that "[a]ll Defendants actively conceal, caused others to conceal, information about the true average costs of medical services, including the fact that reasonable and customary rates are deliberately understated, knowing the success of the high profit scheme will be jeopardized if anyone discloses the significantly higher true average costs."<sup>82</sup> The named plaintiff seeks relief (i) against all defendants for (a) RICO violations, and (b) restraint of interstate trade in violation of the Sherman Act by conspiring to lower, fix and maintain the Ingenix usual and customary information; (ii) against Aetna for violation of Connecticut Unfair Trade Practices Act for engaging in unfair methods of competition and unfair or deceptive acts or practices in conduct of any trade or commerce.

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<sup>81</sup> *Id.* at 4..

<sup>82</sup> Class Action Complaint, at 3.