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Life Insurance **Claims Reporter**

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NY DFS Targets Contestable Claims Investigations

The New York State Department of Financial Services (the "DFS") issued a Circular Letter on January 27, 2017, addressing the DFS's position on what it considers to be "life insurance unfair claims settlement practices" in the life insurance industry in connection with contestable claim investigations. The DFS expressed concern that some insurers have engaged in the practice of contesting claims and "withholding claims payments" following the deaths of insureds "during the two-year contestable period, in the absence of actual evidence of misrepresentation, and improperly have shifted the burden of proof to beneficiaries."

Notwithstanding the contractual and statutory right of insurers to conduct contestable claims investigations, the DFS criticizes the practices of some insurers in requiring beneficiaries to cooperate with the insurer in its claims investigation and in obtaining the deceased insured's medical records. Absent "actual evidence" of a material misrepresentation, the Circular Letter states that insurers are prohibited from requiring a beneficiary's cooperation in procuring medical records and other claims information to allow the investigation of whether the insured made any material misrepresentations in the policy application. The DFS also asserts that any policy form provision that purports to impose any such duty upon a beneficiary in order to receive death benefits "will be deemed by the Superintendent to be unfair."

In the Circular Letter, the DFS states that "the insurer must make prompt payment on a claim" and that it may not "unilaterally refuse to pay a life insurance claim" unless it has "actual proof that the applicant made a material misrepresentation." If there is "actual proof" of a material misrepresentation, the insurer can rescind the policy either through agreement with the beneficiary or through a judicial proceeding. The Letter does not address the impediments to an insurer obtaining any such "proof" in the absence of a beneficiary's cooperation in obtaining the insured's medical records.

New York Governor Andrew Cuomo promptly followed-up the Letter with a press release. "Insurers are on notice of their obligations and that this administration has zero tolerance for those who seek to sidestep their responsibilities," Governor Cuomo said. "With this action, we are holding insurance companies accountable, helping to ensure beneficiaries receive what they are entitled to, and are working to create a more fair and more just New York for all." The press release stated that DFS investigations have discovered "disturbing practices" among some insurers in connection with small face value life insurance policies marketed to low- and middle-income consumers for funeral, burial and other final expenses.

"A life insurance company cannot require a beneficiary to produce a deceased policyholder's medical records to pursue an alleged misrepresentation investigation or use illegal and unfair tactics to withhold and deny claim payments when those payments are due and most needed upon the insured's death," said Superintendent Maria T. Vullo. "The unlawful practices identified in DFS's examinations and investigations have deprived New Yorkers of their rights under their life insurance policies, drained the value of their policies, and unfairly denied insurance payments to their beneficiaries. DFS will hold all insurers accountable for making prompt, fair and equitable settlements as required by law."

While the Circular Letter does not have the force of law, it is likely to be relied upon by claimants for bad faith claims that an insurer failed to promptly pay a death claim without proof of a material misrepresentation and/or improperly required an insured's medical records from a claimant. ■

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Courts Reject Challenges to Underwriting and Claims Practices in Connection With Death Benefit Denials

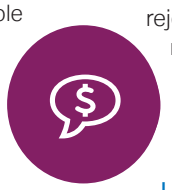
Although the New York DFS's January 27 Circular Letter may present certain challenges to insurers in conducting contestable claims investigations, two recent federal court decisions—in *Tran v. Kansas City Life Ins. Co.*, Case No. 2-15-cv-09963-ODW, 2017 U.S. Dist. LEXIS 1697 (Jan. 5, 2017 C.D. Cal.) and *Gary v. USAA Life Insurance Co.*, Case No. PWG-15-1998, 2017 U.S. Dist. LEXIS 5889 (Jan. 17, 2017 D. Md.)—reaffirm several important legal principles governing the conduct of claims investigations and the denial of claims based upon material misrepresentations.

In both cases, federal courts entered summary judgment for insurers and dismissed complaints by claimants seeking to recover death benefits after the insurers denied the claims based on material misrepresentations. The fact patterns in these cases were similar: (i) the insureds failed to disclose relevant medical information during the application process, (ii) the insureds died within the contestable period, (iii) the contestable investigations revealed medical misrepresentations, (iv) the insurers denied the death claims, and (v) the beneficiaries sued the insurers and asserted various claims challenging the underwriting of the policies and the insurers' claims investigations and denials.

In *Tran*, the court held that the insurer properly denied the claim where the insured failed to disclose diagnoses of diabetes and high blood pressure in the policy application. The court found that the non-disclosure constituted a material misrepresentation as a matter of law and entered summary judgment for the insurer. In an attempt to get around the clear misrepresentation, the beneficiary argued that the insurer waived its right to rely upon the undisclosed medical conditions as a basis for denying the claim by failing to adequately investigate the insured's medicals during underwriting. The court rejected this argument and held that an insurer has no independent duty during underwriting to investigate the accuracy of the insured's representations and, instead, the insurer has the right to rely upon the accuracy of application answers. The beneficiary also argued that the insurer engaged in illegal post-claim underwriting during the claims investigation by denying the claim based upon medical records obtained for the first time during the claims process. The court also rejected this argument, holding that the insurer had the right to engage in the "standard procedure" of collecting such records during a contestable claims investigation and that "life insurers in California, unlike health insurers, may engage in post-claim underwriting during the policy's contestable period."

The court in *Gary* reached the same result in granting an insurer's summary judgment motion. The policy application in that case included a medical questionnaire that was completed based upon a telephonic interview of the insured. The insured failed to disclose an echocardiogram in response to an application question on diagnostic tests. Following the insured's death, the insurer obtained the insured's medical records and learned about abnormal echocardiogram results and denied the claim. In an attempt to get around this material misrepresentation, the beneficiary argued that the representation was not made in an application that was part of the policy. The court rejected this argument, holding that the representation made during the interview was recorded in a medical questionnaire that was part of the application. In response to the argument that the insured did not have the chance to review the questionnaire answers for accuracy before the policy was issued, the court held that (i) the insured had confirmed the accuracy of her answers in a voice recorded signature during the interview, which expedited the processing of the application, and (ii) the insured had the full opportunity during the 20-day free look period to review the application answers for accuracy upon receipt of the policy.

The beneficiary also argued, as in *Tran*, that the insurer had waived its right to rely upon the misrepresentation in denying the claim because the insurer had a duty to order the insured's medical records during the underwriting process based upon the disclosure of a heart murmur condition during the application process. The court rejected this argument, holding that the insurer had no reason to order medical records based upon a benign murmur. ■



Divorces Can Be Messy…For Life Insurers

Divorces are often characterized as "messy" for good reason. While divorce proceedings can prove particularly challenging for the individual participants, they can also pose challenges for those adjudicating competing life insurance claims when the decedent insured's ex-spouse, who has been designated as a policy beneficiary, claims a right to the death benefit instead of the surviving spouse, the insured's estate or a secondary beneficiary.

Divorce-related life insurance disputes can end up before courts in litigation over the decedent insured's estate, in litigation brought by a purported beneficiary against the insurance company, or in interpleader actions filed by the insurer. In an interpleader action, the insurance company files a petition with the court seeking an order determining, for instance, which spouse – surviving or ex – is entitled to the decedent insured's policy proceeds following a divorce.

As highlighted in the case described below, it is important for those processing life insurance claims when divorces are involved to carefully examine (i) the express language of the policy at issue, (ii) the divorce record, including the content of any divorce decree, as well as (iii) the law in the applicable jurisdiction. The insurance company must determine who is entitled to the death benefit – or consider submitting the issue to a court in an interpleader for resolution, where appropriate.

Recently, in *Hertzske v. Snyder*, 2017 UT 4 (Utah Jan. 18, 2017), the Utah Supreme Court weighed in on this issue in connection with a $500,000 death benefit. The court had to decide whether the benefit was properly payable to a

(continued on p. 3)

decedent insured's ex-wife or the secondary beneficiary named in the policy. The policy at issue originally named Ms. Snyder, then the insured's fiancée, as primary beneficiary. The policy also named a secondary beneficiary. The insured and Ms. Snyder later married, but then divorced. The insured's life insurance policy was never mentioned during the divorce proceedings or in the eventual divorce decree. The insured died after the divorce was final. Ms. Snyder and the secondary beneficiary then asserted competing claims to the policy's death benefit.

Under Utah Code § 75-2-804(2), there is a rebuttable presumption that a beneficiary designation of a spouse in a life insurance policy is revoked upon divorce. The presumption can be rebutted by express terms in the policy, a court order (including a divorce decree), or a contract relating to the division of the marital estate made between the divorced individuals.

The presumption can be rebutted via divorce decree only if the decree includes specific language required by Utah Code Section 30-3-5(1)(e). That statute requires an express acknowledgement by the divorce court that the policy owner has (i) reviewed and updated his or her beneficiaries, (ii) affirmed that those listed as beneficiaries are in fact the intended beneficiaries after the divorce becomes final, and (iii) the owner understands that if no changes are made to the policy, the beneficiaries currently listed will receive the policy proceeds.

In evaluating the competing claims to the insured's death benefit, the court in *Hertzske* first examined the express terms of the policy at issue. The policy provided a method for naming new beneficiaries during the insured's lifetime, but the terms of policy were silent as to whether the designation of a spouse as beneficiary would survive a divorce. The court thus concluded that the policy lacked the "express terms" necessary to rebut the presumption that Ms. Snyder's beneficiary designation had been revoked pursuant to Utah Code § 75-2-804(2).

The court next examined the divorce record and concluded that "[i]n the underlying divorce case … no mention was ever made of any life insurance policies in the petition, findings or decree." Because the divorce court had not been apprised of any existing life insurance policy, the statutory language from Section 30-3-5(1)(e) was not included in the divorce decree, and the presumption of revocation of Ms. Snyder's beneficiary designation remained intact. The court therefore affirmed the lower court's ruling "that the divorce revoke[d] Ms. Snyder's status as beneficiary" and held that the secondary beneficiary was the sole remaining beneficiary holding an interest in the policy. ■

Washington Court Pierces Privileges in Bad Faith Dispute

A federal court decision out of the District of Washington highlights the potential pitfalls of discovery against insurers related to bad faith claims and claims administration.

In *Hopkins v. State Farm Mutual Auto. Ins. Co.*, 2016 U.S. Dist. LEXIS 169591 (W.D. Wa. Dec. 6, 2016), the plaintiff was injured in an automobile accident with the defendant's insured in 2011. The plaintiff required surgery and made multiple demands for the $25,000 policy limit in 2014. The plaintiff provided a notice of intent to sue in 2015, after which the defendant insurer tendered $25,000 to the plaintiff, but declined to resolve plaintiff's bad faith claim. The plaintiff brought a bad faith lawsuit against the insurer shortly thereafter.

The plaintiff requested documents related to the insurer's claims processing in discovery. The insurer declined to produce an internal report and related document because they were ostensibly made in response to the "threat of bad faith litigation" and were, therefore, protected work product generated in anticipation of litigation. The plaintiff moved to compel.

The court granted the plaintiff's motion and ordered the production of all claims-related documents produced prior to the defendant's payment of the $25,000. The court disagreed with the insurer's contention that the report was made in anticipation of a possible bad faith lawsuit, finding instead that the reason the report had been generated was because the claim was still open more than four years from the date of the accident. The court concluded: "To hold that an insurance company's work product is protected because there is a possibility of a bad faith lawsuit, especially prior to the claim being settled, creates a perverse incentive for insurance companies to act in bad faith. An insurance company cannot create the necessity of a bad faith lawsuit, and then protect itself from discovery by claiming the prospect of bad faith litigation."

The court also held that communications and work product regarding a reservation of rights letter drafted by the insurer's legal counsel "relates to claims administration" and, consequently, was "not protected from discovery."

The court's decision is consistent with the law of some states, wherein the "the application of attorney-client privilege and work-product protection is severely limited in the context of an insurance bad faith claim" and the starting presumption of the court is that "there is no attorney-client privilege relevant between the insured and the insurer in the claims adjusting process, and that the attorney-client and work product privileges are generally not relevant." The rationale behind this rule is that an "insured needs access to the insurer's file maintained for the insured in order to discover facts to support a claim of bad faith," and that "to permit a blanket privilege in insurance bad faith claims because of the participation of lawyers hired or employed by insurers would unreasonably obstruct discovery of meritorious claims and conceal unwarranted practices." Thus, courts in some jurisdictions will liberally permit discovery of an insurer's files, even those involving or created by attorneys, unless the insurer can overcome the presumption of discoverability by showing that its "attorney was not engaged in the quasi-fiduciary tasks of investigating and evaluating or processing the claim, but instead in providing the insurer with counsel as to its own potential liability." ***(continued on p. 4)***

The *Hopkins* decision underscores an insurer's need to be cautious in relying on the attorney-client or work product privileges when evaluating a claim. The inclusion of an attorney in the claims handling process may not necessarily mean that documents produced in the process are privileged. Insurers should also be aware that documents created after the receipt of demand letters threatening legal action will not necessarily be treated as having been generated in response to the "threat of bad faith litigation" and, therefore, may not be afforded a work product protection in discovery. ■

Drinker Biddle & Reath offers a number of programs that can be presented at your company. These presentations cover a variety of claims-related issues and many can be offered to fulfill annual training or continuing education credit. Sample presentations include:

California Claims Training. Our California Claims Training presentation fulfills California's annual requirement for insurance companies to provide training to its claims representatives on California's Fair Claims and Settlement Practice Regulations, and includes such topics as requirements for claims file contents, the types of communications that can give rise to bad faith exposure, standards for prompt, fair and equitable settlements, and the timing requirements for claims decisions.

Causal Connection Jurisdictions. Some jurisdictions have enacted statutes that purport to require a causal connection between the insured's death and the condition that is misrepresented in the insurance application for a claim to be denied or a policy rescinded. Our Causal Connection presentation addresses issues related to handling claims in these states.

Fraud Detection. Whether evaluating a contestable claim misrepresentation or a post-contestable claim for insurable interest issues, detecting potential fraud is a major part of claims management. Our Fraud Detection presentation discusses real-life fraud investigations and best practices for investigating claims effectively to mitigate legal risk when evaluating claims.

Underwriting Under the Microscope. When an insurance company receives a death claim on a policy that appears to be the product of fraud and litigation ensues, it is often the company's underwriting that is put on trial by the claimant. In our Underwriting Under the Microscope presentation, we discuss how to deal with potential underwriting issues at the claims stage.

Please contact us for more information on these and other programs.

The Claims Reporter

Drinker Biddle's Insurance Group is comprised of lawyers with extensive experience litigating insurance claims and coverage issues and providing consultation on underwriting, reinsurance, regulatory matters, and corporate transactions involving insurers.

The Claims Reporter is intended to inform our clients and friends of developments in the law and to provide information of general interest.

If you have questions regarding the information contained in this publication, please contact any of the following lawyers:

CHARLES J. VINICOMBE
(215) 988-1139
charles.vinicombe@dbr.com

JOHN M. BLOOR
(215) 988-2736
john.bloor@dbr.com

LAURA M. ZULICK
(215) 988-1117
laura.zulick@dbr.com

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www.drinkerbiddle.com

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