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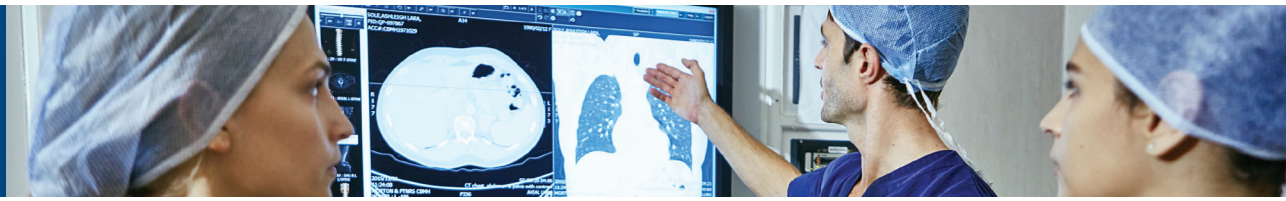

Life, Health and Disability News

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Message from the Editor

By Moheeb H. Murray

Unfortunately, our committee wasn't able to have the always-fantastic LHDE seminar this year. But now is a great time for our committee to take advantage of the many other ways we can stay informed and connected, including through newsletters such as this one.

For this edition, we have articles on two very interesting subjects. One, authored by Michelle d'Arcambal and Vedant Gokhale, provides insights about developments affecting rescission of life-insurance policies. The other, authored by me and Mike Steinberger, notes an interesting wrinkle in case law regarding jurisdiction in interpleader cases. I and my co-editor, Stephen Roach, hope you'll enjoy reading about these topics.

Our next edition is scheduled for August. If you would like to have an article published, please don't hesitate to let us know.

Moheeb H. Murray leads the insurance coverage practice team at Bush Seyferth PLLC in Troy, Michigan. He represents leading national insurers in life, disability, ERISA, and other insurance-coverage matters at all stages of litigation. He also focuses his practice on complex-commercial and construction litigation.

Feature Articles

The Demise of Two Rescission Truisms: 1)The Contestability Investigation Is Far Reaching and Uncomplicated, and 2) After Two Years Policies Are Bulletproof

By Michelle d'Arcambal and Vedant Gokhale

Over the past few years, public policy concerns have shifted general rescission precepts. The broad contestability review has been curtailed arguably to situations where there is "some evidence" of a misrepresentation, and the two-year contestability period has been extended where there was fraud involving third parties. This article is an overview of these changes. If you are interested in copies of briefs or unpublished decisions, or a more detailed analysis, let us know.

Issues of Proof Within Two Years: The Restricted Contestability Review

Historically, if an insured died within two years of the date of the policy, the insurer would conduct its usual and customary contestability investigation. The investigation would include an interview with the beneficiary, typically a family member or business associate, at which time the investigator would request and receive authorizations directed to health providers and financial institutions. The insurer would review the requested documents to determine whether a misrepresentation had been made.

If a misrepresentation is identified, an underwriter would determine whether the misrepresentation is material. If it is, the premiums would be returned and the policy rescinded. Contestability investigations have been recognized by many courts. *See, e.g., Schondorf v. SMA Life Assurance Co.*, 745 F. Supp 866, 868 (E.D.N.Y. 1990) ("after the [insured's] death, SMA undertook 'a standard contestable investigation' of the insured's past medical history, including interviews with the physicians and a review of medical records. Gleaned from this investigation was personal and medical history concededly not disclosed in the application submitted to SMA.").

Claims that a routine contestability investigation constituted improper "post-claim underwriting" was the basis of plaintiff's motion for leave to appeal the appellate court opinion in *Kerrigan v. Metropolitan Life Ins. Co.*, 117 A.D.3d 562 (1st Dep't 2014), *aff'g* 2013 N.Y. Slip Op. 33591(U) (Sup. Ct. N.Y. Cnty. 2013), *appeal denied* 24 N.Y.3d 912 (2014). The Appellate Division affirmed the trial court's grant of summary judgment rescinding a life insurance policy based on its finding that the insured had not disclosed his history of coronary disease. The insured's significant medical history was identified in medical documents obtained after his death, with authorizations executed by the beneficiary at her interview. Plaintiff argued that the abnormalities in the EKG taken during underwriting constituted constructive notice that should estop the insurer from rescinding. The Appellate Division rejected that claim, holding that actual knowledge is required, and "plaintiff may not shift the burden of truthfulness to the insurer."

The plaintiff in *Kerrigan* requested leave to appeal, arguing that post-claim underwriting was against public policy when the insurer chose not to ascertain the information at the time of the application but accepted the application and issued the policy. In *Kerrigan*, plaintiff claimed that insurers will overlook warning signs in order to issue policies and receive premiums, but once the insured dies, a post-death contestability investigation is done "with the sole aim of denying the claim." This argument overlooks the fact that premiums are returned if a policy is rescinded, and the quid pro quo that while an insurer can investigate within two years, after two years, that door is closed, even if intentional misrepresentations are discovered. As stated by the same appellate court decades before, a contestability investigation is based on a "legislative policy to prevent a beneficiary of a life insurance policy from withholding material information bearing upon affirmative representations in the application therefor." *Kamen v. Metropolitan Life Ins. Co.,* 6 A.D.2d 406, 408 (1st Dep't 1958), *aff'd* 6 N.Y.2d 737 (1959).

The New York State Department of Financial Services, Insurance Division, subsequently issued a 2017 Circular limiting an insurer's ability to conduct its investigation to determine whether a misrepresentation had been made in the application. Requests for authorization, or any business practice by an insurer used during an investigation, could only be made in those instances where the insurer identifies "any evidence" of a material misrepresentation.[1] HIPAA and strict requirements for producing medical documents of a decedent, even with an authorization, have further complicated contestability investigations.

What Now?

The January 2017, Circular from the New York State Department of Financial Services, Insurance Division, changed the way many insurance companies conduct their routine two-year contestability investigations. Even though it was circulated by New York State, most states have been following the Circular for consistency reasons, as well as because many states look to how New York insurance regulators are regulating this field. But while the Circular has limited an insurer's ability to conduct its investigation, the "any evidence" standard is taken at face value. As such, insurers continue to review public information for "any evidence" of a misrepresentation. Frequently, the death certificate details the cause of death and may indicate that an underlying condition or disease had been ongoing for years. The death certificate may even state the date of onset. In one case, the cause of an insured's death was complications of obesity, including gastric bypass. Subpoenaed documents revealed the surgery and hospitalization occurred prior to the application being completed, where the applicant checked "No" in response to whether he had been admitted or confined to a hospital within two years. The policy was rescinded and premiums returned.

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1 Under *Insurance Law § 2601(a)(4)*, an insurer *must attempt in good faith to effectuate prompt, fair and equitable settlements of claims* submitted to the insurer *in which liability has become reasonably clear.* Insurers are advised that any business practice by an insurer that, *absent any evidence of a material misrepresentation*, requires a beneficiary to furnish claim information, including medical records, *so that an insurer may investigate whether an applicant made a misrepresentation when applying for life insurance, is not attempting to effectuate prompt, fair and equitable settlements of claims in good faith*.

Other times, the insurer discovers from interviews or other public information that the insured was in the hospital around the time of the application. Obituaries and newspaper accounts frequently include a wealth of information regarding the insured's medical and financial history.

A red flag can also be a death certificate that states that the death occurred in a foreign country. Foreign death certificates should be scrutinized. Under certain circumstances, insurers will conduct foreign death investigations in the country where the death was said to have occurred to confirm the validity of the death certificate. Acceptable proof of death is not only a prerequisite to payment of the death benefit, it is frequently required by courts where a provider requires a court order to release records, or in notices to interested parties.

Along those lines, it is routine to be on the lookout for fake deaths. If there is no death certificate or obituary, the insurer typically gets in touch with a family member or runs the insured's name through the Social Security Master Death file (to which most insurance companies have access).

Once "any evidence" is obtained, the insurer will reach out to the family members or estate representative who has authority to execute authorizations. At the same time, it is important to ascertain what the provider will need to release the records. If the authorization process does not go smoothly because of an uncooperative beneficiary, or the provider requires a court order or court appointed-documents to release the records, outside counsel is typically engaged. About half of the time, outside counsel is able to persuade the next of kin to execute the authorization. The next of kin typically changes his or her mind to avoid litigation, sometimes because he or she is aware of the misrepresentations, or is not a named beneficiary and does not want the named beneficiary to be paid the death benefit.

However, even where the authorizations are executed, there may be additional legal roadblocks due to provider requirements, including an affidavit from the beneficiary or next of kin. Some providers, including government entities like VA hospitals and prisons, as well as substance abuse treatments facilities, typically require a court order.[2] In that case, legal action is necessary.

2 Courts are more likely to grant an order that assures the court and the provider that all HIPAA requirements including, but not limited to, the requirement not to disclose PHI for any purpose other than the action, have been met.

Most states include a provision for pre-suit discovery prior to full-scale litigation, which at first glance appears to be the obvious choice. However, this provision typically requires service on all potential parties with notice of the prelitigation subpoena or order. Service of so many parties can be quite an ordeal. More critically, if the records reveal a material representation, then a complaint for rescission would need to be drafted and commenced, and service of all parties will need to be effectuated.

The preferred legal action in most cases is a declaratory judgment action seeking medical records and subsequent rescission if the medical records establish a material misrepresentation. If the records establish a material misrepresentation, a motion to rescind can be made forthwith, after producing the claim and underwriting files to the defendant. Frequently, the documents persuade the beneficiary to accept the return of premiums and rescission of the policy.

Sometimes, even with indicia of a misrepresentation, *e.g.*, cancer or diabetes, in the death certificate, the medical documents establish that the cancer or other medical condition was diagnosed after the policy was issued. In that case, the death benefit is paid and the lawsuit dismissed.

Service issues:

- All parties must be provided with notice of the subpoena and an opportunity to object.
- Try to limit defendants to actual necessary parties to limit service issues.
- Initially name the next of kin as the defendant to obtain the records, as the pleadings can be amended to add the beneficiary if it is determined that a material misrepresentation was made.
- Inability to locate necessary parties. However, Facebook and other social media have proven to be great sources to locate next of kin.

Finally, state court is typically faster and easier than federal court because of stringent federal court rules. For example, Rule 26(f) requires meeting and conferring to plan for discovery, even if the immediate issue is obtaining a court-ordered subpoena, coupled with potential service issues.

Rescission After Two Years

Whether courts will rescind a policy after two years is all over the map. As a general rule, statutes, state common law, and the contestability provision in the policy control.

Typically, rescission is only allowed two years from the date of the policy. Certain state statutes expand the two years to six years if the misrepresentations are intentionally made. *See, e.g.*, N.J. Stat. Ann. 2C:21-4.6 (New Jersey's insurance fraud statute); Tex. Ins. Code Ann. §705.104 (after two years, rescission allowed if a material misrepresentation was intentionally made).

The two-year contestability clause allows the insurer to underwrite and issue policies based on representations made on the application, without the commensurate obligation to investigate the veracity of the representations. Historically, if the insured dies within two years of the policy date (or a material misrepresentation is discovered within two years), the insurer has the right to conduct a broad contestability investigation.

The breadth of the contestability investigation has been limited by the additional requirement of a showing of "any evidence" of a misrepresentation as described in the previous section. On the other hand, if the insured dies after two years, the death benefit is payable (if premiums are up to date) even if the insured made a knowing, intentional and material misrepresentation on the application.

Today, a life insurance policy is no longer as bulletproof after two years as it traditionally was. The two-year deadline has been extended for public policy reasons in certain situations. These situations usually involve a third-party speculator who drives the fraud, and their involvement is contrary to basic public policy against wagering on the life of the insured.

For many years, the common law in most states permitted rescission of a life insurance policy after two years upon a showing of intentional fraud where the owner did not have an insurable interest in the life of the insured. Courts have held that these life insurance policies thwart the public policy underlying the issuance of life insurance. Otherwise, the policy transaction is akin to a speculative investment and the owner could be said to be wagering on the longevity of the insured. The decisions rescinding policies after two years based on the absence of an insurable interest declare the policy void *ab initio*, rendering the incontestability clause inapplicable. *See, e.g.*, *PHL Variable Ins. Co. v. Charter Oak Tr.*, 2012 WL 2044416, at *6 (Conn. Super. Ct. May 4, 2012) (Connecticut); *Crump v. Nw. Nat. Life Ins. Co.,* 236 Cal.App.2d 149, 45 Cal.Rptr. 814 (1965) (California); *Obartuch v. Sec. Mut. Life Ins. Co.,* 114 F.2d 873, 878 (7th Cir. 1940) (Illinois).

More recently, there has been an upswing in schemes involving a group of related speculative policies. In these instances, a broker sells several policies with different insureds but just one premium payor, whose identity is concealed from the insurer. At a minimum, these speculative policies materially misrepresent the identity of the premium payor. The application falsely states that the owner/insured will be making payments, when, in fact, a third-party investor will be making them. These misrepresentations implicate the Patriot Act's "know your customer" requirement that the identity of the premium payor be accurately disclosed. Anti-money laundering requirements regarding the disclosure of the identity of the premium payor are also implicated. *See Johnson v. Metro. Life Ins. Co.,* 24 Misc. 3d 956, 959, (Sup. Ct. N.Y. Cnty. 2009), *aff'd*, 79 A.D.3d 450 (3d Dep't 2010). Speculative policy schemes may also involve imposter situations, where the named insured is not the individual who appears for the paramedical, typically because he or she does not exist. Sometimes these involve foreign death claims. In most jurisdictions, the two-year contestability period is waived if there is evidence that an imposter stood in for the insured.

Another exception to the two-year contestability clause is where the fraud involves an invalid assignment of the policy. The purported "assignee" is not the owner, and thus is a stranger to the policy. This policy can be rescinded for misrepresentations after two years. *American Mayflower Life Ins. Co. of New York v. Moskowitz,* 17 A.D.3d 289 (1st Dep't 2005) (assignment forged; assignee is a stranger to policy and cannot rely on contestability provision). Invalid assignments can also be part of a Stranger Owned Life Insurance ("STOLI") scheme to prevent premium payors from foreclosing on a policy by assigning the encumbered policy to a related entity prior to foreclosure.

Recently, post-two-year rescission litigation has centered on insurers attempting to rescind policies issued as part of STOLI schemes. STOLI schemes are a combination of lack of insurable interests and speculative policies. STOLI transactions involve a more complex fraudulent scheme perpetrated by investors in the policy. Several players are involved, including brokers and representatives of the premium financer. Unlike viatical settlements or sales of properly issued policies on the secondary market, STOLI schemes are concocted before the policies are issued, and require active concealment of the scheme until after the expiration of the two-year contestability period. Thus, insurers are unlikely to discover the fraud within the two years.

Courts across the country have rescinded STOLI policies after two years on several grounds including fraudulent procurement, no insurable interest, misrepresentations as

to premium payor, and/or against public policy prohibiting the wagering on a life. *See, e.g.*, *PHL Variable Ins. Co. v. Charter Oak Tr.*, 2012 WL 2044416, at *6 (Conn. Super. Ct. May 4, 2012) (Connecticut); *Sun Life Assur. Co. of Canada v. Berck,* 770 F. Supp. 2d 728, 733 (D. Del. 2011) (Delaware); *Ohio National Life Assurance Corp. v. Davis,* 803 F.3d 904 (7th Cir. 2015) (Illinois).

In *Sun Life Assur. Co. of Canada v. Wells Fargo Bank, N.A.,* 238 N.J. 157 (2019), the New Jersey Supreme Court recently observed that:

A majority of courts have held that the lack of an insurable interest can be asserted as a defense even after a policy has become incontestable. *See, e.g., PHL Variable Ins. Co. v. Price Dae 2006 Ins. Tr.,* 28 A.3d 1059, 1067–68 (Del. 2011); *Beard v. Am. Agency Life Ins. Co.,* 314 Md. 235, 550 A.2d 677, 691 (1988); *see also* 17 *Couch on Insurance* §240:82 ("The majority of jurisdictions follow the view that an incontestable clause does not prohibit insurers from resisting payment on the ground that the policy was issued to one having no insurable interest -- such a defense may be raised despite the fact that the period of contestability has expired."); 8 *New Appleman on Insurance Law Library Edition* §83.09 (2018) ("Nearly every jurisdiction that has addressed the issue holds that a policy lacking an insurable interest is void and is not rendered valid by an incontestability provision."). *Id.* at 168–69.

In some situations, these transactions are valid, typically where the policy is sold to an investor years after the policy is issued because of a pressing financial need. In *Ohio Nat. Life Assur. Corp. v. Davis*, 803 F.3d 904, 908 (7th Cir. 2015) Judge Posner noted that:

> Despite the fact that purchasers of a life insurance policy as an investment also have a financial stake in the insured's early death (the stake is at its maximum if the insured dies before the investor pays his first premium), the law allows an investor to purchase the beneficial interest in an existing policy on the life of the insured. *Hawley v. Aetna Life Ins. Co.,* 291 Ill. 28, 125 N.E. 707, 708–09 (1919). *There are social benefits, thought to exceed the social costs discussed above, to these transactions. The owner of the policy may have a desperate need for money; the policy may be his only substantial asset; and if he's elderly or in very poor health the present value of that asset may be substantial and he may have a pressing interest in being able to cash it in by selling the beneficial interest).*

Id. (emphasis provided).

In New York, case law still holds that an insurer cannot rescind after two years for lack of insurable interest or a STOLI scheme. The controlling case is the 1989 New York Court of Appeals decision in *New England Mutual Life Ins. Co. v. Caruso*, 73 N.Y.2d 74 (1989). The Court held that the insurer must discover the fraud within two years and is barred from rescinding after this period. However, this case was decided well before the explosion of STOLI schemes, which are carefully crafted so as to not be discovered within two years. This decision may very well be reexamined considering the conclusions of courts across the country. In fact, a New York Supreme Court recently held that the public policy considerations behind insurable interest requirements and the voiding of fraudulent STOLI schemes is relevant to a determination of whether actions by the insurer were reasonable in that context.

In conclusion, an insurer should be on the lookout for *any* of the following red flags while conducting an investigation in connection with possible fraudulent STOLI schemes.

What to review within the two-year contestability period:

- High-dollar policies ($3 million or more).
- The application, in particular representations concerning:
  - The creation of the "family trust."
  - The age and address of the insured.
  - Financial worth.
  - The premium payor.
  - Source of funds.
- Whether the insured/trust has other policies with same broker, and the relationship with the trustee.
- The premium payment history, *i.e.*, who made the payments. In order to conceal the nature of the transaction, the insured/trust or a family member typically makes the first premium payment, and a stranger makes the rest.

What to look for after expiration of the two-year contestability period:

- Changes in identity of trustee—changes may not be filed until after the expiration of the two-year contestability period.
- Assignments of ownership of policy and/or changes of beneficiary made after expiration of contestability period. Are the new owners/beneficiaries companies? Are there successive assignments? Who is the individual signing as the trustee or owner?
- Changes in addresses.

- Whether addresses of assignee and assignor are the same, or if they match the address of the premium payor.
- Requests for information regarding the policy, especially whether premiums are up to date, the policy is in force and the identity of the owner. Illustrations of future premium payments may be requested after the expiration of the contestability clause. If a broker is involved, he or she may make several requests in connection with selling the policy.
- Requests for a duplicate policy since the original policy is necessary to secure the premium payments and to sell the policy.
- Collateral assignments to premium payor, which are typically not recorded until after the expiration of the two-year contestability period.

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A Developing Circuit Split on Diversity in Rule Interpleader

By Moheeb Murray and Mike Steinberger


One of the first lessons that law students learn in Civil Procedure is that complete diversity exists when no party on the left side of the "V" is from the same state as any party on the right side of the "V." Straightforward enough, right? Maybe not, when it comes to interpleader actions in the Sixth Circuit.

There are two vehicles to bring interpleader actions in federal court—"rule interpleader" and "statutory interpleader." While statutory interpleader confers original jurisdiction on the district courts, rule interpleader requires an independent source of jurisdiction (typically either federal question or diversity).

Several trial courts in the Sixth Circuit have chipped away at the avenues to federal court by adopting a narrow view of diversity jurisdiction when it comes to interpleader actions. The first court to adopt such a view was the Western District of Kentucky. There, UBS Financial Services filed an interpleader action against Cornerstone Industries on the one hand and Louis and Debra Kaufman on the other hand. *UBS Fin. Servs., Inc. v. Kaufman*, No. 3:15-CV-00887-CRS, 2016 WL 3199535, at *2 (W.D. Ky. June 8, 2016). UBS was a citizen of Delaware and New Jersey; the Kaufmans and Cornerstone Industries were both citizens of Kentucky. *Id.* at 4. The court framed the critical question as "whether an out-of-state plaintiff may file a federal interpleader complaint against claimants who are all citizens of the forum state" under rule interpleader. *Id.* The court acknowledged that UBS had demonstrated complete diversity under the traditional analysis because UBS did not share citizenship with any defendant. *Id.* Nevertheless, the Court determined that it *lacked* subject-matter jurisdiction because there was not complete diversity between the two defendants, which the Court deemed to be the truly adverse parties. *Id.*

At least one judge in the Eastern District of Michigan has embraced the *Kaufman* decision. *Crestmark Bank v. CIBC Bank USA*, No. 18-11616, 2018 WL 5077165 (E.D. Mich. Oct. 17, 2018). In *Crestmark*, the plaintiff was a citizen of Michigan while all of the defendants held Illinois citizenships. *Id.* The court—following *Kaufman*—held that it lacked

subject-matter jurisdiction because the defendants were not diverse from one another. *Id.* at *4.

The Sixth Circuit has not weighed in on this recent interpretation of diversity jurisdiction in rule interpleader. Other circuits have held that complete diversity exists where the plaintiff is diverse from the defendants, regardless of whether the defendants are diverse from one another. See, *e.g.*, *See, Arnold v. KJD Real Estate, LLC,* 752 F.3d 700, 703 (7th Cir. 2014); *Franceskin v. Credit Suisse,* 214 F.3d 253, 259 (2d Cir. 2000); *Comm'l Union Ins. Co. v. United States,* 999 F.3d 581, 584 (D.C. Cir. 1993); *Leimbach v. Allen,* 976 F.2d 912, 916 (4th Cir. 1992); *CNA Ins. Cos. v. Waters,* 926 F.2d 247, 249 n.5 (3d Cir. 1991); *Aetna Life & Cas. Co. v. Spain,* 556, F.2d 747, 749 (5th Cir. 1977); *Hunter v. Federal Life Ins. Co.,* 111 F.3d 553 (8th Cir. 1940). Those filing interpleaders should monitor the continued development of this potential circuit split.

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