Paper Title: “Conversion, Portability and Evidence of Insurability: Mistakes Will Be Made”

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Conversion, Portability and Evidence of Insurability: Mistakes Will Be Made

I. Introduction

Conversion and portability are terms frequently used to describe options offered under an employer's group insurance coverage that allow an employee to retain coverage – without providing evidence of insurability – if the employee's coverage is ending or reducing. Generally, conversion is used to describe "converting" group coverage to an individual policy, whereas portability is used to describe "porting" or moving coverage from the employer group policy to another group policy.

But on closer examination, conversion, portability and evidence of insurability are linked in another way. Each is rife with opportunities for mistakes that will give rise to a variety of claims, against both insurers and plan sponsors. This paper examines some recent cases involving such claims, considers the impact of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* ("ERISA"), on them, and provides practical advice for the defense of such claims.

II. Evidence of Insurability

Evidence of insurability, or proof of good health, is required by group insurers for certain optional coverages and also when an employee enrolls for coverage outside an initial eligibility period or open enrollment period (and without a qualifying life event). Many group insurance plans are "self-administered" by the employer, meaning that it is the employer's responsibility to let its employees know if evidence of insurability is required before withholding premiums from an employee's paycheck. *See Gordon v. CIGNA Corp.*, 890 F.3d 463, 467 (4th Cir. 2018) (describing duties of employer and insurer in one such self-administered plan). More often than not, such premiums are submitted to the insurer in a "lump sum" group premium, and the insurer is not aware of the persons the employer believes are covered until a claim is made. *Id.*

A self-administered plan was at issue in *Salyers v. Metropolitan Life Insurance Co.*, 871 F.3d 934, 938 (9th Cir. 2017), and the court was critical of what it called a "compartmentalized system" where the employer was responsible for interacting with plan participants yet the insurer was largely unaware of plan participants' coverage elections. The plaintiff in *Salyers* initially applied in 2013 for $20,000 in dependent life insurance coverage for her husband, for which the plan did not require evidence of insurability. But, the employer mistakenly entered $500,000 as the amount of coverage and began deducting premiums for this amount, but did not request evidence of insurability. During the open enrollment period for 2014, the plaintiff elected $250,000 in coverage for her husband, and because this was smaller than the mistakenly-entered $500,000 amount from the year before, the employer's system did not flag the request for coverage above the amount requiring evidence of insurability. Premiums for the $250,000 in coverage were deducted from plaintiff's pay. In early 2014, plaintiff's husband died, and the employer advised plaintiff that her husband had $250,000 in coverage. *Id.* at 936-37. The plaintiff brought suit after MetLife paid the amount of

guaranteed issue coverage, but declined to pay the full $250,000 for lack of evidence of insurability. (The employer refunded the erroneously-withheld premiums.) The plaintiff contended that MetLife had waived the evidence of insurability requirement because the employer's knowledge and conduct could be imputed to MetLife under agency law. The district court considered the plaintiff's benefits claim under the *de novo* standard of review, but rejected application of the waiver doctrine. *Salyers v. Metro. Life Ins. Co.*, Case No. CV 14-7490 PA, 2015 U.S. Dist. LEXIS 107497, 2015 WL 4779243 (C.D. Cal. Aug. 14, 2015), *rev'd*, 871 F.3d 934 (9th Cir. 2017).

The Ninth Circuit, however, reversed. 871 F.3d at 938-41. The court first acknowledged that ERISA preempts state laws that deem a policyholder-employer to be the agent of an insurer in administering group policies. *Id.* at 939 (citing *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 379 (1999)). However, the court then adopted principles from the Restatement (Third) of Agency as federal common law and found that the employer in *Salyers* had at least apparent authority to act on MetLife's behalf with respect to evidence of insurability. *Id.* at 941 (employer's "direct interaction with plan participants, coupled with MetLife's failure to engage with [plaintiff] about evidence of insurability, suggested that [employer] had apparent authority on the collection of evidence of insurability"). The court stated that this was not an "automatic agency rule" but rather a determination that should be made on a case-by-case basis. Having found that the employer's knowledge and conduct could be attributed to MetLife, the Ninth Circuit concluded that the deduction of premiums, the failure to ask for evidence of insurability for several months, and the representation to the plaintiff that she had $250,000 in coverage were "collectively 'so inconsistent with an intent to enforce' the evidence of insurability requirement as to 'induce a reasonable belief that [it] ha[d] been relinquished.'" *Id.* (citation omitted). As a result, the court ruled that MetLife could not contest coverage for the failure to provide evidence of insurability.

In the more recent *Gordon* case, the court was presented with plan documents which clearly allocated duties between the employer and the insurer. 890 F.3d at 467. The decedent-insured had enrolled in his employer's plan and attempted to obtain $250,000 in supplemental insurance coverage. The employer deducted premiums for that amount of coverage, and the decedent-insured died less than a year after he enrolled in the plan. As in *Salyers*, the insurer paid $150,000 in guaranteed issue coverage but denied coverage as to the remaining $100,000 for which evidence of insurability was never received. (The employer refunded the erroneously-withheld premiums.) The plaintiff, who was the widow and beneficiary, brought suit against LINA and the employer for breach of fiduciary duty. (The district court placed blame for the decedent-insured's lack of supplemental coverage on the employer and denied the employer's motion to quash class certification, resulting in the employer settling.) LINA successfully defended against the breach of fiduciary duty claim by contending that, under the plan documents, LINA owed no fiduciary duty with regard to soliciting evidence for coverage beyond the guaranteed issue amount or notifying the decedent-insured that he had not completed the evidence of insurability requirement. The Fourth Circuit upheld the entry of summary judgment for LINA for these reasons. *Id.* at 473-76. The court also rejected the plaintiff's argument that LINA was a fiduciary because it exercised control over the bulk premiums received from the employer, finding that the plan at issue fell within ERISA's "guaranteed benefit

policy exclusion" which meant that only the policy was a plan asset. *Id.* at 470-73 (citing 29 U.S.C. § 1101(b)(2)).

While the employer in *Salyers* was not sued, and the employer in *Gordon* settled, the employer in *Schwartz v. Keolis Commuter Services*, Case No. 16-cv-11506-LTS, 2018 U.S. Dist. LEXIS 46091, 2018 WL 1411202 (D. Mass. Mar. 20, 2018), managed to escape a breach of fiduciary duty claim. In *Schwartz*, the decedent-insured enrolled in her employer's plan in 2005. She later sought increased life insurance coverage in 2008 and submitted evidence of insurability, which was rejected by the plan's insurer (UNUM). In 2014, her employer (which operated commuter rail lines for the Massachusetts Bay Transportation Authority) lost the contract for that work to Keolis Commuter Services, which hired the employees of the prior operator. The former employer, UNUM, and Keolis entered into an assignment of the group insurance policies, but the plan's original effective date was unchanged. At the open enrollment period for 2015, Keolis provided a benefits enrollment and change form which did not mention evidence of insurability, but did include a statement that each employee was required to sign indicating that they were responsible for reading the summary plan description to understand benefits and any restrictions. The decedent-insured sought increased life insurance coverage on that form which she provided to Keolis, and Keolis began deducting premiums for that increased amount. (Although the premiums were forwarded to UNUM, the decedent-insured was not individually identified.) The decedent-insured died later in 2015, and UNUM paid the guaranteed issue amount but denied the plaintiff-beneficiary's claim for further benefits due to the failure to provide evidence of insurability which was required because she enrolled more than 31 days after her eligibility date. UNUM rejected plaintiff's claim that the decedent-insured had applied for coverage with Keolis, a new employer, at the earliest offering because the only change had been the name of the employer-policyholder. 2018 U.S. Dist. LEXIS 46091 at *2-9.

The *Keolis* court summarily rejected the plaintiff's claims against UNUM for benefits pursuant to 29 U.S.C. § 1132(a)(1)(B) and for breach of fiduciary duty. *Id.* at *18-20. However, the district court easily found that Keolis was a fiduciary with respect to its self-administration of the plan and that it failed to satisfy its fiduciary duties with due care. *Id.* at *24-25. Nonetheless, the district court essentially found that any breach had not caused the decedent-insured to believe she had the increased coverage as any such understanding on her part would not have been reasonable under the specific facts. *Id.* at *25-27. Further, the district court agreed that the remedy of equitable surcharge (i.e., relief afforded by courts in equity to provide monetary compensation as relief for loss resulting from a trustee's breach of duty) sought by the plaintiff under 29 U.S.C. § 1132(a)(3) was not available because the plaintiff had not shown actual harm. *Id.* at *27-29. Specifically, the plaintiff did not offer anything more than speculation that the decedent-insured would have or could have obtained alternate life insurance coverage had it not been for Keolis's breach of fiduciary duty; in contrast, Keolis offered evidence that the decedent-insured (who at the time was undergoing cancer treatment) would not have been able to obtain insurance coverage on the open market during the relevant time period. *Id.*

III. Conversion and Portability

The cases discussed in this section involve the so-called "right to conversion" or "portability right" in ERISA-governed plans, as these rights arise under the employer-provided group insurance coverage. The issue of whether a converted or ported policy is governed by ERISA is beyond the scope of this paper, but for a general discussion of this topic, *see Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872 (9th Cir. 2001) and *Demars v. Cigna Corp.*, 173 F.3d 443 (1st Cir. 1999).

The issue of proper notice of a right to convert was addressed in the recent case of *Vest v. Resolute FP US Inc.*, 905 F.3d 985 (6th Cir. 2018). There, the Sixth Circuit rejected the plaintiff-beneficiary's claim that her late husband's employer had breached its fiduciary duties in failing to notify him of his right to convert a group life insurance policy to an individual policy when his employment terminated due to disability. The court noted that a fiduciary could not be held liable for failure to disclose information that it was not required to disclose by ERISA's detailed disclosure requirements. *Id.* at 987. However, the court acknowledged that a fiduciary could breach its duty of disclosure by providing misleading or inaccurate information in response to a participant's question or by providing misleading or inaccurate information on its own initiative. Nonetheless, the plaintiff never alleged that the decedent-insured had asked his employer any question about conversion coverage, or that the employer knew such an issue would be important to him. Further, the plaintiff conceded that the employer was not required to provide information about conversion rights beyond what was in the summary plan description, and the plaintiff did not contend that the employer failed to provide the summary plan description to her late husband. *Id.* at 987-89.

In contrast to the *Vest* case, the plaintiff in *Estate of Foster v. American Marine SVS Group Benefit Plan*, Case No. CV 17-165-M-DLC, 2018 U.S. Dist. LEXIS 189846, 2018 WL 5810506 (D. Mont. Nov. 16, 2018), contended that her late husband's employer was required by Hawaii statute to provide notice of his right to convert his group life coverage to an individual policy. *See* Hawaii Rev. Stat. Ann. § 431:10D-214 (providing that where an insured is entitled to a conversion right and does not receive notice of that right, an insurer must provide an additional period of time within which to exercise the right). While the employer contended that it had provided notice, the plaintiff disputed that notice had been provided. At the motion to dismiss stage, the district court only considered the issue of whether ERISA preempted the Hawaii statute. The district court held that Hawaii's statute was saved from preemption under ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A), because the statute (1) is directed specifically toward entities engaged in insurance (even though it obligated the employer, a non-insurance entity), and (2) substantially affects the risk pooling relationship. 2018 U.S. Dist. LEXIS at *13-24. The court rejected a line of authority finding ERISA preemption of similar statutes as having been decided under an outdated test, and instead was persuaded by another district court which held that a Pennsylvania statute requiring notice of conversion rights was saved from ERISA preemption. *Id.* at *19-20 (citing *Meyers v. Metro. Life Ins. Co.*, Case No. 12-3699, 2013 U.S. Dist. LEXIS 30554, 2013 WL 820591 (E.D. Pa. Mar. 6, 2013) (discussing 40 Pa. Stat. Ann. § 532.7)).

Another case, *Colander v. Metropolitan Life Insurance Co.*, Case No. 17 C 2601, 2017 U.S. Dist. LEXIS 141616, 2017 WL 3816100 (N.D. Ill. Aug. 31, 2017), involved the

mistaken issuance of coverage under a portability option, and turned on the court's analysis of the carefully worded policies. In *Colander*, the decedent-insured had both basic and optional group life insurance coverage through his employment with Deloitte LLP; the basic coverage was continued without payment of premium when the decedent-insured went out on disability. For the $316,000 in optional coverage, the Deloitte plan offered a portability option to continue the coverage through payment of premium after employment ended. While on disability but before Deloitte officially terminated him, the decedent-insured elected to accelerate payment on the Deloitte optional coverage and received over $250,000. He then had $63,200 in optional coverage remaining under the Deloitte optional life insurance plan. However, upon termination, MetLife provided the decedent-insured with an application for $324,000 in coverage under the portability option, and the decedent-insured enrolled for coverage under the portable plan. The portable plan clearly stated that he was only eligible for coverage if his coverage under the Deloitte plan had ended, and further that if the decedent-insured became entitled to a death benefit under the Deloitte plan, coverage under the portable plan would end. The Deloitte plan also stated that MetLife would not pay under both the Deloitte plan and the portable plan, and that to receive payment under the Deloitte plan, any portable plan certificate of insurance would have to be surrendered. 2017 U.S. Dist. LEXIS 141616 at *1-5.

Shortly after paying his first premium, the decedent-insured in *Colander* passed away. After being notified, MetLife paid the remaining $63,200 in coverage under the Deloitte plan, and denied the plaintiff-beneficiary's claim to the portable coverage. (MetLife stated that it refunded the portable coverage premiums.) *Id.* The plaintiff brought a state law claim for breach of contract under the portable plan, and MetLife contended that the plaintiff either failed to state a claim or that the claims were preempted by ERISA. The court found it unnecessary to decide the preemption issue, as the result was the same for the breach of contract claim under state law as it was if the plaintiff had stated an ERISA claim for benefits. Although the court found that a mistake had been made in offering $324,000 in portable coverage to the decedent-insured, the court held that the explicit terms of both plans foreclosed any claim under the portable plan. *Id.* at *12-18.

IV. Conclusion

With the different roles of employers and insurers in the evidence of insurability and right of conversion/portability processes, it is easy to see how the occasional mistake can be made. In defending cases arises from these mistakes, careful review of the relevant plan documents, analysis of the specific ERISA cause of action and available remedies, and consideration of any statutory requirements (and the impact of ERISA preemption) is essential. But beyond these initial considerations, any premiums for unavailable coverage should be refunded. To the extent another entity is responsible for the mistake giving rise to the litigation, the defense practitioner should consider any available contractual or common law indemnification rights against the responsible entity. And if the defense practitioner is representing the responsible party, that party should investigate whether any errors and omissions coverage is available and, if so, provide appropriate notice to the liability carrier.