

FUNK & BOLTON

A PROFESSIONAL ASSOCIATION

ATTORNEYS AT LAW

100 LIGHT STREET, SUITE 1000
BALTIMORE, MARYLAND 21202-1036
(410) 659-7700
FACSIMILE (410) 659-7773

DAVID M. FUNK
BRYAN D. BOLTON
BRYSON F. POPHAM
LINDSEY A. RADER
GARY C. HARRIGER
DEREK B. YARMIS

MICHAEL R. MCCANN
REN L. TUNDERMANN
JAMES F. TAYLOR
ERIC B. MYERS
CHARLES D. MACLEOD
ARTHUR A. RENKWITZ

OF COUNSEL
JEFFERSON L. BLOMQUIST
J. FRANK NAYDEN
DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Court Holds Plaintiff Must Take Rule 30(b)(6) Deposition Of Defendant Insurer At Its Principal Place of Business

The United States District Court for the District of Maryland recently held that the deposition of the defendant insurer's Federal Rule 30(b)(6) designee must be taken at the defendant's principal place of business in another state, rather than in Maryland.

The plaintiff filed suit seeking an order compelling the issuance of an insurance policy for which he had applied. The plaintiff sought to notice the Rule 30(b)(6) deposition of the defendant insurer in Maryland, but was advised the defendant's designee would only be produced in the state where the defendant's home office was located. The plaintiff filed a motion to compel the deposition in Maryland.

The Court, after denying the motion on unrelated procedural grounds, held the plaintiff had failed to rebut the presumption that the deposition of a corporation by its agents and officers should be taken at its principal place of business, especially when the corporation is the defendant. The Court rejected the plaintiff's argument that, given the insurer's substantial business presence in Maryland and the fact the insurer is better able to pay the costs associated with the deposition, the designee should be required to travel to Maryland.

For further information, please contact **Derek B. Yarmis**, who represented the insurer in this matter.

May 1, 2000
No: 2000-1

35507

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ERIC B. MYERS
CHARLES D. MACLEOD
ARTHUR A. RENKWITZ

OF COUNSEL
JEFFERSON L. BLOMQUIST
J. FRANK NAYDEN
DEBORAH R. RIVKIN
JOHN R. STIERHOFF

INSURANCE LAW BULLETIN

Re: Insured Fails To State Claim Under District Of Columbia's Insurance Code And Consumer Protection Procedures Act

After her claim for disability insurance benefits was terminated, an insured filed suit in the Superior Court for the District of Columbia against her disability insurer. The insured sought to state claims for unfair and unreasonable practices in violation of Section 35-1706(b) of the District of Columbia Insurance Code and unlawful trade practices in violation of the District of Columbia Consumer Protection Procedures Act, D.C. Code Section 28-3904.

After removing the action to Federal Court, the insurer moved to dismiss both claims. The Court granted the motion. First, the Court held the pertinent provision in the District of Columbia Insurance Code concerned insurance rate disputes, not policy benefit claims. Moreover, the Court concluded the Insurance Code does not create a private right of action.

Second, the Court refused to give extraterritorial effect to the District of Columbia Consumer Protection Procedures Act. The insured did not reside in the District of Columbia when she purchased the policy or when she applied for benefits under the policy. Based on these facts, the Court refused to recognize a claim under the District of Columbia Consumer Protection Procedures Act.

If you would like a copy of the Court's opinion or have further questions, please contact **Bryan D. Bolton**, who represented the insurer in this matter.

June 28, 2000
No. 2000-2

45800.003:36976

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ARTHUR A. RENKWITZ
MADELEINE D. STECKEL

OF COUNSEL

JEFFERSON L. BLOMQUIST

J. FRANK NAYDEN

DEBORAH R. RIVKIN

JOHN R. STIERHOFF

INSURANCE LAW BULLETIN

Re: Court Holds Health-Care Provider Cannot Maintain Private Right Of Action Against Health Maintenance Organization Under Maryland Health-General Article

In a case of first impression in Maryland, the United States District Court for the District of Maryland recently held that a health-care provider cannot maintain a private right of action against a health maintenance organization under §§ 19-712 and 19-712.1 of the Maryland Health-General Article (1996).

After an intermediate entity with which plaintiff contracted filed for bankruptcy protection, plaintiff filed this action against the “upstream” HMO seeking reimbursement for health-care services it allegedly provided to members of the HMO. Relying on §§ 19-712 and 19-712.1, plaintiff alleged the HMO was liable for the financial obligations of the bankrupt entity. The HMO moved to dismiss, arguing the applicable statutes did not confer a private right of action. The Court agreed and granted the motion to dismiss.

In the absence of any express indication that the Maryland General Assembly intended to confer a private right of action, the Court concluded several points weighed against such a finding. First, the statutes contain an express administrative remedy that is enforced by the Insurance Commissioner and subject to judicial review. Second, the administrative remedy is adequate to protect the plaintiff’s rights. Third, in view of the express administrative remedy, “it is highly improbable that the legislature ‘absentmindedly forgot to mention an intended private action.’”

If you have any questions or would like a copy of the Court’s opinion, please contact **Bryan D. Bolton**, who represented the health maintenance organization in this matter.

August 15, 2000

No. 2000-3

20021.016:38030v2

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E. ELIZABETH STABER
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OF COUNSEL
J. FRANK NAYDEN
DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

RE: Court Declares Disability Insurance Policy Lapsed Despite Allegations That Disability Predated Lapse And Insurer Failed To Send Premium Notice

The United States District Court for the District of Maryland recently held that a disability income insurance policy lapsed for nonpayment of premium even though the alleged disability commenced before the policy lapsed and the insurer allegedly failed to send the insured a premium notice.

The insured made claim for disability benefits nearly three years after his policy lapsed. The insurer denied the claim and filed a declaratory judgment action. After limited discovery was taken on the lapse issue, the insurer filed a motion for summary judgment.

Granting summary judgment in favor of the insurer, the Court rejected the insured's argument that liability attached when the alleged disability began, ten days before the policy lapsed. The Court reasoned that the claim did not accrue until after the six-month elimination period and, therefore, the policy had long since lapsed. The Court also rejected the insured's argument that the insurer was estopped from asserting the policy had lapsed because a premium notice for the unpaid premium was never sent. The insurer proved, through computer-generated printouts, that it followed its usual and customary business practice of mailing the premium notice to the insured.

If you have any questions or would like a copy of the Court's opinion, please contact **Derek B. Yarmis**, who represented the insurer in this matter, at 410-659-7762 or dyarmis@fblaw.com.

October 5, 2000
No. 2000-4

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J. FRANK NAYDEN
DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Insurer's Termination Of Long-Term Disability Benefits Was Reasonable Despite Inherent Conflict Of Interest

The United States District Court for the District of Maryland recently held that an insurer's termination of long-term disability benefits under an ERISA plan was reasonable, despite an inherent conflict of interest, where the claimant had failed to submit medical evidence supporting his physician's change of opinion.

During administration of a claim, the claimant's physician submitted an attending physician's statement stating that the claimant was capable of performing sedentary work and handling low-stress situations. After the insurer terminated benefits, the same physician opined that the claimant should remain on disability and not reenter the workforce. Neither the claimant nor the physician offered any medical evidence supporting this change of opinion. After the insurer upheld the claim determination, the claimant filed this action.

The Court concluded the insurer had an inherent conflict of interest and therefore applied the "modified abuse of discretion" or "sliding scale" deferential standard of review. The Court held the insurer's termination of benefits was reasonable, however, because the physician's post-claim termination change of opinion was a legal conclusion unsupported by any medical evidence.

If you have any questions or would like a copy of the Court's opinion, please contact **Derek B. Yarmis**, who represented the insurer in this matter, at 410-659-7762 or dyarmis@fblaw.com.

November 1, 2000
No. 2000-5

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JAMES F. TAYLOR
ERIC B. MYERS
CHARLES D. MACLEOD
E. ELIZABETH STABER
MADELEINE D. STECKEL

OF COUNSEL
J. FRANK NAYDEN
DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Court Holds Underwriting Guidelines Should Be Given A Natural And Common Sense Meaning

The Circuit Court for Baltimore City recently held that an insurer properly applied its underwriting guidelines in refusing to provide professional liability insurance to a physician who had been convicted of Medicaid fraud, even though the judgment of conviction had been stricken.

A physician applied for professional liability insurance shortly after his conviction had been stricken. The insurer refused to provide the coverage because its underwriting guidelines made an applicant ineligible if there is evidence indicating "conviction" of a crime involving deceit or falsification. The physician complained to the Insurance Commissioner, who, after a hearing, ruled against the insurer and ordered that the coverage be provided.

The Circuit Court reversed, holding the insurer's refusal to issue a policy was reasonably related to its economic and business purposes. *See* Md. Code Ann., Ins. § 27-501. The Court further held the Commissioner erred by applying a narrow legal and technical meaning to the word "conviction," rather than a natural and common-sense meaning.

If you have any questions, please contact **Jefferson L. Blomquist**, who represented the insurer in this matter, at 410-659-4970 or jblomquist@fblaw.com.

December 1, 2000

No. 2000-6

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KELLY E. PHILLIPS

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JACK A. GULLO, JR.
J. FRANK NAYDEN
DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Court Declares Disability Insurance Policy Null And Void Based On Claim Fraud

The United States District Court for the District of Maryland recently declared a disability income insurance policy null and void because the insured made fraudulent misrepresentations in support of her claim for benefits.

After paying disability benefits for several years, the insurer discovered that the insured's occupational activities were inconsistent with representations made in supplemental statements of claim. The insurer terminated benefits and filed a complaint in federal court seeking a declaration that the policy is null and void and damages for fraud.

After a 44-day bench trial, the district court found that the insured made fraudulent misrepresentations to the insurer for the purpose of inducing the payment of benefits. The court held that the insured breached the implied covenant of good faith and fair dealing, which obligated the parties "to deal fairly and honestly with one another." The court declared the policy null and void and awarded the insurer over \$125,000 in damages.

If you have any questions or would like a copy of the court's opinion, please contact **Bryan D. Bolton**, who represented the insurer in this matter, at 410-659-7754 or bbolton@fblaw.com.

January 12, 2001
No: 2001-1

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A PROFESSIONAL ASSOCIATION

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BRYAN D. BOLTON
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E. ELIZABETH STABER
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KELLY E. PHILLIPS

OF COUNSEL
JACK A. GULLO, JR.
J. FRANK NAYDEN
DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Court Holds Shotgun Homicide Was A Suicide Under Life Insurance Policy Exclusion

The Court of Special Appeals of Maryland recently held that, in determining whether an insured's death was a suicide, the matter should be considered from the perspective of the insured.

The insured, deeply in debt and the target of a criminal investigation, wanted to die. Aware of the suicide exclusion in her life insurance policies, the insured sought help from a close friend. In an effort to disguise her death as a hit, the insured had her friend hold a shotgun while she ran a string around his leg to the trigger. When the insured pulled the string and the gun failed to fire, she pleaded with her friend to pull the trigger. He complied, and the insured died. The friend later pled guilty to voluntary manslaughter.

The trial court entered judgment against the insurer. On appeal, the Court held homicide and suicide are not mutually exclusive, because suicide is determined from the insured's perspective. From this perspective, the insured's death occurred by her own volition and intent. The Court directed the entry of judgment for the insurer.

If you have any questions or would like a copy of the Court's opinion, please contact **Bryan D. Bolton**, who represented the insurer in this matter, at 410-659-7754 or bbolton@fblaw.com.

February 20, 2001

No: 2001-2

42377v2

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KELLY E. PHILLIPS

OF COUNSEL
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J. FRANK NAYDEN
DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Disability Claimant Must Pursue and Exhaust ERISA Plan Remedies Even If The Insurer Concludes The Claimant Is Not Covered By The Plan

The United States District Court for the District of Maryland recently held that pursuit and exhaustion of plan remedies is not futile simply because an insurer denies a claim for disability benefits on the ground that the claimant is not covered under a group insurance contract.

The claimant sought disability benefits under a group insurance contract issued to his employer. The insurer determined the claimant was not eligible for benefits because he was not properly enrolled as a covered employee. Instead of pursuing plan remedies, the claimant filed a complaint in state court. The insurer removed the action to Federal Court and moved to dismiss.

The claimant argued pursuing an ERISA appeal would be futile because an insurer who "does not recognize the insured as holding a policy with the company . . . will not prudently adhere to the policy terms." Granting the motion to dismiss, the Court held the claimant had not made a "clear and positive" showing of futility. There was no evidence the insurer was not fair minded. The Court further observed that, if given a chance, the insurer might be persuaded that the claimant is covered under the group contract.

If you have any questions or would like a copy of the Court's opinion, please contact **Derek B. Yarmis**, who represented the insurer in this matter, at 410-659-7762 or dyarmis@fblaw.com.

March 20, 2001
No: 2001-3

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INSURANCE LAW BULLETIN

Re: Court Sustains ERISA Fiduciary's Resolution Of Conflicting Evidence

The United States District Court for the District of Maryland recently held that an insurer did not abuse its discretion by denying a claim for accidental death benefits based on the insurer's resolution of a conflict between the decedent's medical records and the claimant's affidavits.

The wife of an ERISA plan participant sought accidental death benefits, claiming her husband died from head trauma after falling from a ladder. Although the medical records revealed a recent history of hypertension and headaches, the claimant and her medical expert submitted affidavits claiming the decedent was healthy and did not suffer from headaches.

The insurer asked an independent review physician to assume the medical records were accurate. Based on the medical records, the physician concluded an underlying medical condition likely caused the insured's fall. The insurer then denied the claim because the death was not due solely to an accident. The Court granted the insurer summary judgment, holding the ERISA plan conferred discretion on the insurer, and the insurer was responsible for deciding whether to believe the medical records.

If you have any questions or would like a copy of the Court's opinion, please contact **Bryan D. Bolton**, who represented the insurer in this matter, at 410-659-7754 or bbolton@fblaw.com.

May 25, 2001
No: 2001-4

FUNK & BOLTON

A PROFESSIONAL ASSOCIATION

ATTORNEYS AT LAW

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BALTIMORE, MARYLAND 21202-1036

(410) 659-7700

FACSIMILE (410) 659-7773

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DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Insurance Commissioner Holds Insurer's Decision To Deny Total Disability Benefits Without Conducting An IME Did Not Violate Statute, Regulation, MIA Policy, Or The Insurance Policy

The Maryland Insurance Commissioner recently ruled that an insurer's decision to deny disability benefits, based on the opinion of its in-house physician and without conducting an Independent Medical Examination ("IME"), was not arbitrary or capricious.

An insured physician sought total disability benefits due to a back condition. After the claim was denied, the insured filed a complaint with the Maryland Insurance Administration ("MIA"). The MIA initially found the insurer's refusal to pay the claim was arbitrary or capricious based, in part, on the failure to conduct an IME. The insurer requested a hearing.

At the hearing, the MIA argued the insurer had ignored the opinions of the four treating physicians and relied exclusively on the opinion of the in-house physician. The MIA further argued the in-house physician had not seen the insured and the insurer had failed to conduct an IME. The Administrative Law Judge rejected the MIA's weighing of the number of physician opinions and found no obligation to conduct an IME. "No statute, regulation, policy statement of the MIA, or provision in the policy requires the [insurer] to" perform an IME. The Commissioner adopted the recommended decision as his final decision.

If you have any questions or would like a copy of the decision, please contact **Jefferson L. Blomquist**, who represented the insurer in this matter, at 410-659-4970 or jblomquist@fblaw.com.

June 4, 2001

No. 2001-5

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OF COUNSEL
JACK A. GULLO, JR.
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DEBORAH R. RIVKIN

INSURANCE LAW BULLETIN

Re: Court Holds Insurance Commissioner Has Exclusive Jurisdiction Over Claim To Compel Issuance Of Disability Insurance Policy

The United States District Court for the District of Maryland recently held that a claim for specific performance of an alleged agreement to issue a disability insurance policy must be pursued before the Insurance Commissioner.

After an insurer declined an application for disability insurance based on medical considerations, the applicant filed a complaint in state court, alleging the insurer's managing agent told the applicant's broker that a policy would be issued despite the applicant's medical history. The insurer removed the action to federal court and, after the close of discovery, moved for summary judgment.

Granting the insurer summary judgment, the court held the Maryland Insurance Commissioner has exclusive jurisdiction to enforce an alleged oral agreement to issue an insurance policy. The court also granted the insurer summary judgment on a negligent misrepresentation claim because "promissory or predictive statements" cannot survive in the absence of evidence that the "promisor" or "predictor" made the statement with the present intention not to perform."

If you have any questions or would like a copy of the Court's opinion, please contact **Derek B. Yarmis**, who represented the insurer in this matter, at 410-659-7762 or dyarmis@fblaw.com.

July 27, 2001

No: 2001-6

45923v5

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INSURANCE LAW BULLETIN

Re: Court Holds Estoppel Based On "Explicit Assurances" Is Not Part Of The Federal Common Law Of ERISA

The United States Court of Appeals for the Fourth Circuit recently held that principles of waiver and estoppel are not part of the common law of ERISA and refused to recognize an "explicit assurances" exception.

At the request of the insured, the insurer provided assurances that it would pay 48 months of disability benefits, unaware the insured's birth date was misstated in the application. After learning of the correct birth date, the insurer advised the insured (i) he would receive only 42 months of benefits, and (ii) he would not have to repay the overpayments made as a result of the misstated age. The insured filed a lawsuit in state court seeking the six additional months of benefits, and the insurer removed the action to Federal Court based on the ERISA preemption.

The District Court held the insurer's "explicit assurances" to pay 48 months of benefits created an estoppel. The District Court further held that the insurer waived its right not to pay the additional benefits. The Fourth Circuit rejected both holdings, held the "explicit assurances" exception is not part of the federal common law of ERISA, and directed the entry of judgment in favor of the insurer.

If you have any questions or would like a copy of the decision, please contact **Bryan D. Bolton**, who represented the insurer in this matter, at 410-659-7754 or bbolton@fblaw.com.

August 10, 2001
No. 2001-7

46631

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JOHN R. STIERHOFF
REN L. TUNDERMANN

MICHAEL R. MCCANN
JAMES F. TAYLOR
ERIC B. MYERS
CHARLES D. MACLEOD
ANTONIO A. TROTTA, III*
E. ELIZABETH STABER
CHERYL A. C. BROWN
LEE ANN LEZZER
OF COUNSEL
JACK A. GULLO, JR.
J. FRANK NAYDEN
DEBORAH R. RIVKIN

*ADMITTED IN NY ONLY

INSURANCE LAW BULLETIN

**Re: Court Sustains Removal Of Proceeding To Perpetuate Testimony
Concerning Variable Life Insurance Policy With \$75,057 Death Benefit**

The United States District Court for the District of Maryland recently held that a proceeding to perpetuate testimony filed in State Court was properly removed to Federal Court because the value of the underlying matter in controversy exceeded the sum or value of \$75,000.

Plaintiff applied for a variable life insurance policy on her mother in the face amount of \$75,000. A Temporary Insurance Agreement was issued, and the proposed insured died the next day. Instead of filing a complaint for benefits, plaintiff filed a notice in State Court to perpetuate the insurer's testimony. The insurer removed the notice to Federal Court based on diversity jurisdiction.

Plaintiff filed a motion to remand, stipulating she would not seek damages in excess of \$75,000. The insurer opposed the motion, contending that the death benefits, if due, included the face amount of \$75,000 plus a variable death benefit of \$57. Denying the motion to remand, the Court explained that, in the absence of a complaint setting forth the damages sought, the Court could not determine to a legal certainty that the matter in controversy was \$75,000 or less.

If you have any questions or would like a copy of the decision, please contact **Bryan D. Bolton**, who represented the insurer in this matter, at 410-659-7754 or bbolton@fblaw.com.

September 24, 2001
No. 2001-8

47591v2

Applicability of the legal principles discussed may differ substantially in individual situations.
The information contained herein should not be construed as individual legal advice.

FUNK & BOLTON

A PROFESSIONAL ASSOCIATION

ATTORNEYS AT LAW

100 LIGHT STREET, SUITE 1000

BALTIMORE, MARYLAND 21202-1036

(410) 659-7700

FACSIMILE (410) 659-7773

DAVID M. FUNK
BRYAN D. BOLTON
BRYSON F. POPHAM
LINDSEY A. RADER
GARY C. HARRIGER
DEREK B. YARMIS
JEFFERSON L. BLOMQUIST
REN L. TUNDERMANN
CHARLES D. MACLEOD

JAMES F. TAYLOR
ERIC B. MYERS
ANTONIO A. TROTTA, III*
E. ELIZABETH STABER
CHERYL A. C. BROWN
LEE ANN LEZZER
OF COUNSEL
JACK A. GULLO, JR.
MICHAEL R. MCCANN
J. FRANK NAYDEN
DEBORAH R. RIVKIN
JOHN R. STIERHOFF

*ADMITTED IN NY ONLY

INSURANCE LAW BULLETIN

Re: **Court Holds Part Of Maryland's Appeals And Grievance Law Preempted By ERISA**

On October 12, 2001, the Circuit Court for Baltimore City held that the authority of the Maryland Insurance Commissioner under Maryland's Appeals and Grievance Law to order an insurer to pay a claim denied as medically unnecessary is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").

An insurer of an employee benefit plan denied claims as medically unnecessary. After a quasi-judicial hearing, the Commissioner entered an order under Maryland's Appeals and Grievance Law, Md. Code Ann., Ins. § 15-10A-01 *et seq.*, requiring the insurer to pay the claims and imposing an administrative penalty. The insurer filed a petition for judicial review.

Reversing in part, the Circuit Court held that Section 502(a)(1)(B) of ERISA provides the sole remedy for the recovery of ERISA plan benefits. That portion of the Appeals and Grievance Law authorizing the Commissioner to order an insurer to pay plan benefits conflicts with ERISA's remedial scheme and is preempted by ERISA. The Court held, however, that the Commissioner's authority to regulate the insurer's adjudication of claims through internal and external review procedures is not preempted by ERISA. The Commissioner, therefore, may impose administrative penalties for violations of the Appeals and Grievance Law process. Both the insurer and the Commissioner are expected to appeal.

For further information, please contact **David M. Funk**, who represented the insurer in this matter, at 410-659-7752 or dfunk@fblaw.com.

October 17, 2001

No: 2001-9

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FUNK & BOLTON

A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW
100 LIGHT STREET, SUITE 1000
BALTIMORE, MARYLAND 21202-1036
(410) 659-7700
FACSIMILE (410) 659-7773

DAVID M. FUNK
BRYAN D. BOLTON
BRYSON F. POPHAM
LINDSEY A. RADER
GARY C. HARRIGER
DEREK B. YARMIS
JEFFERSON L. BLOMQUIST
REN L. TUNDERMANN
CHARLES D. MACLEOD

JAMES F. TAYLOR
ERIC B. MYERS
CYNTHIA L. MCCANN MULLIGAN
E. ELIZABETH STABER
CHERYL A. C. BROWN
LEE ANN LEZZER
OF COUNSEL
JACK A. GULLO, JR.
MICHAEL R. MCCANN
J. FRANK NAYDEN
KAY DOUGHTY PHILLIPS*
DEBORAH R. RIVKIN
JOHN R. STIERHOFF

*ADMITTED IN TX ONLY

INSURANCE LAW BULLETIN

Re: Circuit Court Holds Insurance Commissioner Exceeded His Authority In Reviewing Rates Proposed By Nonprofit Health Service Plan

The Circuit Court for Baltimore City recently held that the Maryland Insurance Commissioner exceeded his statutory authority by disapproving a rate filing based on the Commissioner's determination that the rates were not affordable. The Commissioner's inquiry, according to the Court, should have been limited to actuarial considerations.

A nonprofit health service plan submitted rates for approval to the Commissioner. Although the proposed rates were actuarially justified, the Commissioner disapproved the rates claiming the plan should use savings realized from a hospital discount to make the rates more affordable. After a hearing, the Commissioner affirmed his decision and the plan filed a petition for judicial review.

Reversing the Commissioner's decision, the Court held the Commissioner should have limited his rate-review to determining whether the rates were excessive in relation to the benefits based on actuarial principles. Public policy goals, such as making rates more affordable, according to the Court, were not within the Commissioner's administrative purview. The Commissioner, therefore, exceeded his authority by disapproving the rate filing based on affordability considerations.

For further information, please contact **David M. Funk**, who represented the nonprofit health service plan in this matter, at 410-659-7752 or dfunk@fblaw.com.

January 10, 2002
No. 2002-1

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FUNK & BOLTON

A PROFESSIONAL ASSOCIATION

ATTORNEYS AT LAW

100 LIGHT STREET, SUITE 1000
BALTIMORE, MARYLAND 21202-1036
(410) 659-7700
FACSIMILE (410) 659-7773

DAVID M. FUNK
BRYAN D. BOLTON
BRYSON F. POPHAM
LINDSEY A. RADER
GARY C. HARRIGER
DEREK B. YARMIS
JEFFERSON L. BLOMQUIST
REN L. TUNDERMANN
CHARLES D. MACLEOD

JAMES F. TAYLOR
ERIC B. MYERS
CYNTHIA L. MCCANN MULLIGAN
BRADLEY J. NEITZEL
E. ELIZABETH STABER
CHERYL A. C. BROWN
LEE ANN LEZZER
OF COUNSEL
JACK A. GULLO, JR.
MICHAEL R. MCCANN
J. FRANK NAYDEN
KAY DOUGHTY PHILLIPS
DEBORAH R. RIVKIN
JOHN R. STIERHOFF

*ADMITTED IN TX ONLY

INSURANCE LAW BULLETIN

Re: Court Holds Insured Is Not Totally Disabled If He Is Able To Perform Any Of His Substantial Occupational Duties

The United States District Court for the District of Maryland, applying the common law of ERISA, recently held that, because a policy of disability insurance must be read as a whole, the definition of “total disability” must be construed in harmony with the definition of “residual disability.”

After terminating a claim for total disability benefits based on alleged claim fraud, the insurer filed a complaint against its insured, seeking damages for unjust enrichment and a declaration that the policy is null and void or, alternatively, lapsed for nonpayment of premium. The insured filed a counterclaim for benefits and, after the close of discovery, moved for summary judgment.

Denying summary judgment, the Court held that the definition of total disability – the inability “to engage in your occupation” – must be construed in harmony with the definition of residual disability – the inability “to do one or more of your substantial and material daily business duties.” The insured, therefore, is not entitled to total disability benefits if he can perform one or more of the substantial duties of his occupation. The Court also held that the insurer’s claims are cognizable under ERISA and “numerous documents and other evidence presented by [the insurer] clearly establish a genuine dispute whether [the insured] was misrepresenting the extent of his disability”

If you have any questions or would like a copy of the court’s opinion, please contact **Derek B. Yarmis**, who represented the insurer in this matter, at 410-659-7762 or dyarmis@fblaw.com.

April 15, 2002

No: 2002-1

53314v3 Applicability of the legal principles discussed may differ substantially in individual situations.
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FUNK & BOLTON

A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW
100 LIGHT STREET, SUITE 1000
BALTIMORE, MARYLAND 21202-1036
(410) 659-7700
FACSIMILE (410) 659-7773

DAVID M. FUNK
BRYAN D. BOLTON
BRYSON F. POPHAM
REN L. TUNDERMANN
DEREK B. YARMIS
CHARLES D. MACLEOD
JEFFERSON L. BLOMQUIST
LINDSAY A. RADER

JEROME D. BRESLIN*
HUGH M. BERNSTEIN
JAMES F. TAYLOR
PETER C. ISMAX**
CYNTHIA L. MCCANN
CHERYL A. C. BROWN
HISHAM M. AMIN

* ADMITTED IN NE AND DC ONLY
** ADMITTED IN VA ONLY

OF COUNSEL
JOHN A. ANDRYSZAK
GARY C. HARRIGER
MICHAEL R. MCCANN
J. FRANK NAYDEN
DEBORAH R. RIVKIN
JOHN R. STIERHOFF

INSURANCE LAW BULLETIN

Re: Court Holds Maryland's Appeals And Grievance Law Is Not Preempted By ERISA

On November 4, 2002, the Court of Appeals of Maryland held that Maryland's Appeals and Grievance Law is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").

An insurer of an employee benefit plan denied claims as medically unnecessary. After a quasi-judicial hearing, the Commissioner entered an order under Maryland's Appeals and Grievance Law, Md. Code Ann., Ins. § 15-10A-01 *et seq.*, requiring the insurer to pay the claims and imposing an administrative penalty. After the Circuit Court reversed the order in part, the Court of Appeals issued a writ of certiorari to review the judgment of the Circuit Court.

The Court of Appeals held that, although the Appeals and Grievance Law "relates to" ERISA plans, the law falls under ERISA's saving clause, 29 U.S.C. § 1144(b)(2), as a law regulating insurance and, therefore, is not preempted under principles of "field preemption." Relying on the Supreme Court's decision in *Rush Prudential v. Moran*, the Court rejected the insurer's argument that the Appeals and Grievance law is preempted under principles of "conflict preemption." According to the Court, the Appeals and Grievance Law does not "implicate ERISA's enforcement scheme at all, and [is] no different from the types of substantive state regulation of insurance contracts' that the Supreme Court has 'permitted to survive preemption.'"

For further information, please contact **David M. Funk**, who represented the insurer in this matter, at 410-659-7752 or dfunk@fblaw.com.

November 15, 2002
No: 2002-3

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DAVID M. FUNK
BRYAN D. BOLTON
BRYSON F. POPHAM
REN L. TUNDERMANN
DEREK B. YARMIS
CHARLES D. MACLEOD
JEFFERSON L. BLOMQUIST
LINDSEY A. RADER

FUNK & BOLTON
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW
TWELFTH FLOOR
36 SOUTH CHARLES STREET
BALTIMORE, MARYLAND 21201-3020
(410) 659-7700
FACSIMILE (410) 659-7773

JEROME D. BRESLIN†
HUGH M. BERNSTEIN
JAMES F. TAYLOR
PETER C. ISMAY††
CYNTHIA L. MCCANN
CHERYL A. C. BROWN
HISHAM M. AMIN

†ADMITTED IN NE AND DC ONLY
††ADMITTED IN VA ONLY

OF COUNSEL:
JOHN A. ANDRYSZAK
GARY C. HARRIGER
MICHAEL R. MCCANN
J. FRANK NAYDEN
DEBORAH R. RIVKIN
JOHN R. STIERHOFF

INSURANCE LAW BULLETIN

Re: Court Dismisses Statutory Bad-Faith Claim Grounded On Foreign State's Law

The United States District Court for the District of Maryland recently dismissed a statutory claim for bad faith termination of long-term disability benefits because the foreign state's law upon which the claim was based was inapplicable.

After his claim for total disability benefits was terminated, the plaintiff filed a complaint in state court against his insurer for breach of contract and statutory damages for first-party bad faith. The insurer removed the action to federal court and moved to dismiss.

Plaintiff argued that the foreign state's statutory bad faith law applied because, "[u]nder Maryland's choice of law rules, the law of the place of performance governs the issues of performance and/or breach." Although the insurer's principal place of business was in the foreign state, the Court held that the foreign state's law did not apply because the plaintiff is a Maryland resident, his policy was delivered in Maryland, and the premiums were paid in Maryland. The Court also dismissed a claim for breach of contract against the insurer's parent company because the parent company was not a party to the insurance contract.

For further information, please contact **Bryan D. Bolton**, who represented the insurer and parent company in this matter, at 410-659-7754 or bbolton@fblaw.com.

December 6, 2002
No: 2002-4

59273.

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