

State Court Decisions

In General

Because of ERISA's preemption rule, the claim examiner's interest in state court decisions has become rather academic. This is so because federal courts under ERISA direction will apply the arbitrary and capricious guidelines – and not rely on a jury to settle on the facts.

Nevertheless, it is useful to give a brief review on how state courts have adjudicated many issues which have arisen in the past. By reviewing these cases the reader can discern the courts logic which should be helpful in guiding by the arbitrary and capricious guides – i.e., to follow the state court's logic will most likely be acceptable when such is measured against an arbitrary and capricious standard.

The state cases are discussed under these topic headings:

- Eligibility and Administration
- Benefits and Covered Expenses
- Nonoccupational and Workers Compensation Exclusion
- Subrogation and Coordination of Benefits
- Preexisting Conditions.

Only the pattern-type decisions are discussed herein.

Eligibility and Administration

Courts will permit a close adherence to dates: when claims are incurred, when persons become eligible or are terminated, e.g.

Actions by plan employer plan supervisor, insurer (not mere ministerial) which are in error and which lead the participant to believe there is coverage will be held against the miscreant. Courts will honor language clearly and unambiguously stated; courts will not honor the other type and will take pains to construe same against the drafter.

While participants do not have a vested interest in plan benefits, no action can be taken to diminish the right of a participant once a claim has begun.

When doubtful circumstances arise, courts will try to determine the intentions of the parties and be guided accordingly.

Notice to participant by means of the booklet was good and sufficient notice of plan eligibility.

Courts hold it repugnant to terminate any coverage without adequate (at least 30 days) notice. Never let participants believe they have coverage when they don't have.

Ministerial errors (giving a booklet before coverage or deducting employee contributions after termination) will not result in ill-gotten coverage. Clerical errors are not arbitrary and capricious actions.

Actively-at-work provision will be construed so as to *give* coverage and *not deny* coverage. Actions and loyalties of broker will determine whether such broker is an agent for the employer or of the insurer.

More difficulties arise by not notifying participant of *action X* than *action X* itself. Agent's misrepresentations can cause coverage to attach - payment will be the insurer's or the employer's depending on whose agent such agent was.

Expect court to be lenient on participant as regards claims submission dates.

Double payment may result when claim checks are made payable to wrong people.

Misrepresentation of late applicants on health questions will result in there being no coverage.

Benefits and Covered Expenses

Courts will honor language clearly and unambiguously written.

- Regular nursing home is not a skilled nursing home.
- Sterilization is neither an accident nor an illness.
- Acupuncture is not medical treatment.
- TMJ, not otherwise excludable, is payable as a medical claim.
- RN does not include other nurses.
- Tumor of gum is a medical, not dental, condition.
- Child-caring institution is not a hospital.
- Mental health and behavior problems are different.

Danger of actions being deemed arbitrary and capricious will exist when these conditions are found.

- Insurer took extra pains to deny.
- Claim was not thoroughly investigated.
- No supportive medical opinion was obtained.
- Denial was made when benefits clearly payable.
- Insurer followed a guide and not a document.

Where there are conflicting medical opinions, insurer will usually be required to pay - but will not be guilty of arbitrary and capricious action - i.e., punitive damages; also an honest misreading is not arbitrary and capricious.

Amendment to cut back a benefit of a particular person will likely be held to be arbitrary and capricious.

Issues of preexisting and medical necessity, if at trial, will usually go against the insurer.

Medical care to relieve pain and suffering is necessary care.

Confusion often results with mandated benefits where state requirements and contract issues differ; also where mandated benefits are enacted to group policies between renewals.

Where not specifically defined, alcoholism is a disease.

Medical opinion is assailable but only by another or contrary medical opinion.

Unless facilities are closely defined, court will construe the document to allow coverage.

Maintenance care for Alzheimer's patient was held to be medical care and to be covered.

The physician, retained to give the employer an opinion, is still an independent contractor and not an employee of the employer.

Medical necessity must be well defined or it will be ineffective if court-reviewed.

Non-Occupational and Workers Compensation Exclusion

Courts have agreed that it is not acceptable for a participant to collect from the plan *and* Workers' Compensation.

Courts will recognize the nonoccupational v. Workers' Compensation excluded distinction.

Subrogation and Coordination of Benefits

To be effective, subrogation must be in the plan document and booklet; a retroactive amendment is not acceptable.

Where court makes no award for medical benefits in its adjudication, insurer may be left empty.

Subrogation rights extend to dependents of the participant.

Plan may coordinate with *what plan would have paid* where insurer has gone bankrupt.

Payer for plan may hold back money pending the compliance of the participant.

For COB purposes a group accident policy does not count.

Insurer is *out-of-luck* if payment is made before subrogation release is obtained.

Coordination with no-fault is acceptable.

Special agreements between participant, plan insurer, etc., should be avoided and straight subrogation practices followed; reason is there are many states with laws against the assignment of personal injury claims.

Preexisting Conditions

Courts will strictly construe preexisting conditions against the insurer.

Where condition exists (sinus block, e.g.) prior to policy issue but problem (infection, e.g.) comes after issue the court will hold the infection is not preexisting.

Courts hold a strict connection between pre and post conditions must be proven. Treatment, however, may be as little as a casual note in the physician's files. It is not necessary that participant fully understand the meaning of the treatment or the condition.

Court held no such things as a congenital preexisting condition.

Where accident exacerbates a preexisting condition, the claim is not deniable.