From the Bench

by Thomas A. Croft, Esq.

There are two cases of note this month, one which addresses the novel issue of whether an insured group must continually pay claims in respect of a claimant during the policy period after a disclosure-based denial to preserve its rights, and another reiterating some fundamentally important principles regarding the effect of stop loss insurance in general, and advance funding in particular, on the self-insured character of a Plan.

1. Ohio Federal Court Holds Payment Outside the Policy Period Does Not Necessarily Relieve Stop Loss Carrier from Liability Where There was a Previous Disclosure-Based Denial (*Florida Keys Electrical Cooperative Association v. Nationwide Life ins. Co., et al.,* No. 2:14-cv-372, S.D. Ohio, October 16, 2014).

This case decides an issue of first impression in the stop loss arena, and is significant for carriers, MGUs, TPAs and self-insured groups. Essentially, it holds that, once a carrier denies a claim on disclosure grounds, it is no longer necessary for the group to pay future claims for the claimant at issue in order to preserve its rights to sue the carrier for claims incurred but not paid during the coverage period set forth in the stop loss policy. This general statement is subject to various qualifications, as the discussion below shows.

Facts (as set forth in the Court's opinion and as taken from the allegations of the Group's Complaint)[1]:

The group, Florida Keys Electrical Cooperative Association ("Florida Co-op"), was insured under a Nationwide Life Insurance Company ("Nationwide") stop loss policy issued through its MGU, RMTS, LLC ("RMTS"). This was 24/12 policy, providing coverage above the specific deductible for claims incurred between January 1, 2009 – December 31, 2010, and paid by the group between January 1, 2010 – December 31, 2010.

The group's Complaint alleged that it sought reimbursement for claims of $534,394.67, apparently incurred and paid by the group during the policy periods set forth in the stop loss policy, for claimant "TC," a dependent spouse, which were denied for disclosure reasons by RMTS on September 23, 2010 on behalf of Nationwide. Florida Co-op appealed the denial. The Court's opinion is silent on what response RMTS made to the appeal, although Florida Co-op's Complaint alleged neither RMTS nor Nationwide ever "formally" denied it, though they did not pay the claims.

In any event, Florida Co-op's Complaint also alleged that additional amounts were incurred with respect to "TC" during the policy period, including a claim from a provider for more than $715,000, but that Florida-Co-op was able to negotiate a reduction of this amount to approximately $501,000.[2]

The problem: Florida Co-op did not actually pay the reduced hospital bill of $501,000 until sometime in 2012 – well outside the policy benefit period.

Florida Co-op filed suit against Nationwide and RMTS in April 2014, alleging, among other things, that Nationwide breached its stop loss contract, not only as to the original $534,394.97 which it had paid during the policy period, but also as to the additional amounts that were not paid until 2012, after the policy period expired (hereinafter the "Late-Paid Claims"). Florida Co-op sought damages from Nationwide for breach of contract and under other theories. The claim against RMTS was based on alleged tortious interference with Florida-Co-op's rights under the stop loss policy.[3]

The Motion and the Court's Analysis:

Both Nationwide and RMTS filed a motion for judgment on the pleadings as to the "Late-Paid Claims" – the claims paid in 2012. It is important to understand that this motion was not addressed to merits, *vel non*, of the disclosure issue itself, but was simply based on the fact that the approximately half a million dollars of the total of claims at issue were not paid within the policy window. In other words, Nationwide/RMTS wanted these amounts excluded from the lawsuit up front, based on the express terms of the stop loss policy, which required payment before December 31, 2010 for coverage to apply.

Florida-Co-op responded to Defendants' motion by arguing that the previous denial of the claims relating to "TC" on disclosure grounds excused it from complying with the policy terms as to the "Late-Paid Claims." Indeed, Florida Co-op's Complaint alleges that it did not even file a claim for reimbursement with Nationwide/RMTS for the "Late-Paid Claims," but nevertheless is entitled to reimbursement of them.

This brings us to the doctrine of *anticipatory repudiation*, or *anticipatory breach of contract*, which was determinative of the outcome of Nationwide/RMTS's motion. Under Florida law as interpreted by the Court (there was likely a Florida choice of law provision in the stop loss policy), "[a]n anticipatory breach of contract is one committed before the time when there is a present duty of performance, and is the outcome of words or acts evincing an intention to refuse performance in the future." The Court observed that "disavowing a contractual duty before the time specified in a contract for performing that duty has arrived is the very definition of an anticipatory breach." The Court interpreted Florida Co-op's Complaint to allege that the denial of the first claims for "TC" on disclosure grounds constituted an advance notice that all claims relating to "TC" in the future would be denied on these same grounds. As a practical matter, that seems sensible – once a stop loss claim has been denied on disclosure grounds, it is highly unlikely that future claims would be honored, as the disclosure issue that lead to the initial denial cannot be "cured" by subsequent action on the part of the insured.

The Court reviewed the options of a party to a contract upon an anticipatory repudiation by the opposite party, and concluded that one of them is for that party "to treat the repudiation as a breach by making some change in position." Here, the Court concluded that Florid-Co-op's decision to treat the denial of the first claims as a breach of Nationwide's obligations to reimburse for all claims related to "TC" and its decision not to pay within the policy period and pursue negotiations with the provider was a legitimate response: "[Florida Co-op] did not have to engage in futile pursuit of reimbursement, including meeting its contractual obligation to pay under the policy. Rather, when an anticipatory breach occurs, the nondefaulting party is relieved of its obligations under the contract."

The Court went on to add an important qualification to Florida Co-op's rights in this situation. Essentially, the Court held that Florida Co-op must be able to prove that it could have performed – that is, pay the Late-Paid Claims within the policy period--but simply elected not to do so in light of the anticipatory repudiation by Nationwide. While the Complaint did not expressly allege that Florida Co-op was ready, willing, and able to pay the Late-Paid Claims within the policy period, the Court concluded that such allegations could be inferred from the allegations of the Complaint, based on what the Court termed "judicial experience and common sense."

In summary, then, the Court decided that the fact that the Late-Paid Claims were not paid within the policy period was not alone fatal to Florida-Co-op's rights to reimbursement under the stop loss contract. The Court stated: "Whether this inference…that [Florida-Co-op] was ready, willing and able to pay remain[s] correct in light of the actual development of facts in this case remains just as open as the issue of whether Defendants indeed breached the contract [by denying the initial claims on disclosure grounds] does." In short, Florida-Co-op was not tossed out on its ear just because the claims at issue were paid late. The

propriety of the denial of all the claims on disclosure grounds remains an issue for trial, as does Florida Co-op's ability to have paid the Late-Paid Claims within the policy period.

Author's note: The "change of position" requirement appears to have been satisfied in this case by the group's choice not to pay the Late-Paid Claims within the policy period and its pursuit of a discount with the provider instead. One wonders whether the result might have been different if Florida Co-op had simply waited until 2012 and not pursued negotiations with the provider. As a practical matter, a stop loss carrier's denial of a claim on disclosure grounds should not automatically give an indefinite extension to a group to pay subsequent claims, or excuse even filing a stop loss claim for them.

The safest course in these kinds of situations for the group, obviously, is to pay all potentially eligible claims within the policy period, file timely claims for them in spite of the earlier disclosure-based denial, and eliminate the need for an "anticipatory breach" type argument. Note also that this case applied Florida law. The law on anticipatory repudiation can vary significantly from state to state.

2. Wisconsin Federal Court Reiterates Principle That Plan Established By Employer With Stop Loss Coverage Still Retains Self-Insured Status Under ERISA Despite Advance Funding Feature (*Wausau Supply Co. v. Murphy,* No. 13-cv-698-wmc, W.D. Wis., September 22, 2014).

This recurring issue came up again recently in a subrogation case. In Wisconsin, the "make whole doctrine" generally applies to subrogation recoveries, essentially meaning that before an insurer is entitled to any subrogation recovery, the injured party is entitled to be compensated, i.e., "made whole," for all his injuries. That doctrine, however, does not apply if ERISA pre-empts it, as in the case of a self-insured Plan.

In the above-cited case, the employer/Plan Administrator maintained medical stop loss coverage from American National Insurance Company ("ANIC"). A minor Plan beneficiary was seriously injured while at a child care center. The employer paid out a total of more than $525,000 in medical benefits for the child. Through the parents, the child filed a personal injury action against the owners of the child care center, and entered into a substantial settlement. The Plan contained a subrogation provision giving it a right to first reimbursement and an automatic lien if the beneficiary recovered, by settlement or judgment, for his injuries from a third party.

Following the settlement with the child care center, the parents refused to honor

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the Plan's subrogation rights, advancing two arguments of relevance here: first, that the stop loss coverage maintained by the employer stripped the Plan of its self-insured status so that the "make whole" doctrine applied; and, second, that if the mere existence of stop loss coverage did not have this effect, then the advance funding feature of that policy did.

The advanced funding mechanism, apparently termed "simultaneous reimbursement" in the ANIC policy, provided for an expedited claims review and reimbursement procedure whereby the stop loss carrier would forward specific claim reimbursement to the group's TPA, and the TPA would simultaneously release payment to the providers.

The federal court disposed of parents' argument that the mere existence of stop loss coverage rendered the Plan subject to the "make whole" state law doctrine, citing a previous Wisconsin state court case and a long line of federal cases holding that the existence of stop loss insurance does not deprive an otherwise self-insured Plan of status as such. I quote the Court's review of these cases at length, inasmuch as they are the anchors for this extremely important article of faith in the self-insured arena:

"While the Seventh Circuit has not considered this issue, as far as the court can discern, all circuit courts considering it have held that stop-loss insurance does not strip a self-funded, employee benefit plan of its uninsured status. *See Bill Gray Enters., Inc. Emp. Health & Welfare Plan v. Gourley*, 248 F.3d 206, 209 (3rd Cir. 2001) ("We join our sister circuits in holding a self-funded employee benefit plan with stop-loss insurance is not deemed an insurance provider under the Employee Retirement Income Security Act."), *abrogation recognized on other ground, U.S. Airways, Inc. v. McCutchen*, 663 F.3d 671 (3rd Cir. 2011), rev'd, 133 S. Ct. 1537 (2013); *see also Thompson v. Talquin Bldg. Prods. Co.*, 928 F.2d 649, 653 (4th Cir. 1991) (holding that "stop-loss insurance does not convert Talquin's self-funded employee benefit plan into an insured plan"); *Brown v. Granatelli,* 897 F.2d 1351, 1354 (5th Cir. 1990) (holding that "under Texas law stop-loss insurance is not accident and sickness insurance"); *United Food & Commercial Workers & Emp'rs Ariz. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986) ("The stop-loss insurance does not pay benefits directly to participants, nor does the insurance company take over administration of the Plan at the point when the aggregate amount is reached. Thus, no insurance is provided to the participants, and the Plan should

properly be termed a non-insured plan, protected by the redeemer [sic] clause and preemptive of the Arizona anti-subrogation law.")."

Also rejecting the parents' argument that the "simultaneous reimbursement" feature of the stop loss policy affected the analysis of the Plan's self-funded status, the Court noted that the payment from the carrier still went through the employer/Plan Administrator for reimbursement to the medical providers and did not go directly to any Plan Participants or their medical providers.

Thus, this case stands as comforting reassurance that fundamental principles on which our industry daily relies – totally outside the narrow subrogation context – remain good law. ■

Tom Croft is a magna cum laude graduate of Duke University (1976) and an honors graduate of Duke University School of Law (1979), where he earned membership in the Order of the Coif, reserved for graduates in the top 10% of their class. He returned to Duke Law in 1980 as Lecturer and Assistant Dean (1980-1982) and as Senior Lecturer and Associate Dean for Administration (1982-1984). He also taught at the University of Arkansas-Little Rock law school, where he was an Associate Professor of Law (1990-91), earning teacher of the year honors.

Tom currently consults extensively on medical stop loss claims and related issues, as well as with respect to HMO Excess Reinsurance, Medical Excess of Loss Reinsurance, and Provider Excess Loss Insurance. He maintains an extensive website analyzing more than one hundred cases and containing more than fifty articles published in the Self-Insurer Magazine over many years. See www.stoplosslaw.com. He regularly represents and negotiates on behalf of stop loss carriers, MGUs, Brokers, TPAs, and Employer Groups informally, as well as in litigated and arbitrated proceedings, and has mediated as an advocate in many stop-loss related mediations. Tom can be reached at tac@xsloss.com.

Resources

[1]*Because of the procedural posture of the motion at issue, the Court was required to assume that the plausible allegations of the Complaint were true. See Fed.R.Civ.P. 12(c); 12(b)(6); Bell Atlantic Corp. v. Twombly, 550 U.S. 554, 570 (2007).*

[2]*It is unclear from the Complaint or the Court's opinion whether an additional $47,000 in claims relating to "TC" were paid during the policy's benefit period or not.*

[3]*The author questions the viability of this theory under the general proposition that an agent, an MGU such as RMTS, cannot tortiously interfere with its principal's contract under the law of many states. Typically, while not a party to the stop loss contract, the MGU is not a "stranger to the contract" legally capable of tortiously interfering with it. Florida law may or may not have different features.*