Research Informing Bill Drafting

Case Law Analysis

- Cases that support good health

    - National Life & Accident Ins. Co. v. Lee. The Court stated "issued its policy, and it was in good faith accepted by the applicant, the policy will not be avoided by reason of the fact that the applicant was then afflicted with an incipient and fatal malady, which at that time had not manifested itself or in any way deranged, impaired, or affected the general soundness and healthfulness of the applicant. . . . While the evidence in the present case tended to show that the insured had tuberculosis in an advanced stage about two months after she applied for the policy of insurance, she having stated in her application that she was in sound health, the jury was authorized to find, from the evidence, that she was in apparent good health and did not know that she had this malady at the time of the application for the insurance and acceptance of the policy, and that she made the application and accepted the policy in good faith. In these circumstances, we cannot hold that the evidence conclusively established that the insured had symptoms of this disease, which were known to her to be symptoms thereof, at the time she procured the policy." Likewise, it cannot be "conclusively established that [Jenny] had symptoms of [breast cancer], which were known to her to be symptoms of [breast cancer], at the time she procured the policy.

    - Aetna Life Ins. Co. v. Hub Hosiery Mills (1947). As to the good health issue, the District Court concluded that the insurance company "had failed to sustain the burden of proving by a preponderance of evidence that the [insured] was not in good health when the policy was delivered." The Court's conclusion turned on the absence of any diagnosis or treatment before the policy was delivered, and reflected an appropriate skepticism about the insurance company's efforts to "read history backwards" by sung an expert to make a self-serving retroactive diagnosis.

- Cases denied on conditions other than good health:

    - Krause v. Equitable Life Ins. Co. (1955). Krause case had two-fold condition in the policy: that a beneficiary had to be in good health when the policy was delivered and could not have been treated by or consulted a physician during the interim period since the medical examination. In fact, the jury determined that Krause was in good health but also found that he was treated by and consulted a physician and thus violated the latter requirement.

    - Warren v. Confederation Life Association. The good health provision in this case provided: "The Applicant declares that the above answers are full and true and agrees that: ... any policy issued pursuant to this application has been delivered to the Applicant while the facts concerning the insurability of any person whose life is thereby insured are the same as described in this

application;..." SBLI failed to include such provision in its application or terms of coverage.

- Cases denied based on misrepresentations or concealment of information:

  - *Girouard v. John Hancock Mut. Life Ins. Co.* Similar to Krause, the policy specifically provided that the policy would issue "only if at the time of ... delivery and payment each person proposed for insurance has not consulted, been examined or been treated by a physician or practitioner since the completion of Part B of this application." The Court held in invalidating the policy that there was a "material change for the worse of which the insured had knowledge."

  - Pahigian v. Manufacturers Life Ins. Co. It was argued that an "insured's [f]ailure to give truthful answers deprived the insurer of the opportunity to undertake further investigation which, in all likelihood, would have revealed the diagnosis of" the illness or disease.

  - Pagnotti v. Savings Bank Life Insurance Co. The judge allowed SBLI's summary judgment motion based on clear fraud and misrepresentation in the policy application, and based on undisputed evidence of diagnosis and treatment of the disease before the policy was delivered. The insured stated that she had not consulted a physician or suffered from any illness or disease of the nervous system when in fact she had neurological impairment from 1997-1999 and had consulted her primary care physician and three neurologists for evaluation and treatment in 1998 alone.

  - Lennon v. John Hancock Mutual Life Ins. Co. The insured applied for life insurance two weeks after a biopsy at the hospital showed cancer of the larynx, gave false and misleading answers to the questions in the application about his health, and then was hospitalized and underwent surgery to remove cancer before the policy was delivered.

CASE LAW FOR LIFE INSURANCE

ISSUANCE QUESTIONS

-Golden v Equitable Life 293. Mass 286 (1936).

-Only case law directly on point, merely states that by the terms of the contract in question, the policy was not "issued" until a premium was paid and the policy was delivered. Case law in other states differs somewhat on whether "delivered" means delivered by the company to the insurance agent or delivered to the policy holder herself, with majority position seeming to lean towards delivery to the insurance agent rather than the policy holder.

SERIOUS MEDICAL CONDITION DEFINITIONS

-No case law directly providing an actual definition of what constitutes a serious medical condition. A few cases declare that a pertinent condition is or is not serious, but none go on to provide in depth analysis of any particular differentiations.

-One case discusses the definition of serious medical conditions in light of the 8th amendment prohibition against cruel and unusual punishment, and notes common definitions of "serious medical needs," including "a condition of urgency" that may result in "degeneration" or "extreme pain." In making such a determination, courts consider (1) the existence of an injury that a reasonable doctor would find worthy of comment or treatment, (2) the presence of a medical condition that significantly affects an individual's daily activities, or (3) the existence of chronic and substantial pain.[1] Clearly this focuses more on a known, painful ailment rather than an unknown, potentially dangerous one. A slightly more on point definition from the 2nd circuit specifies that a serious medical condition exists where "the failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain."[2]

Specific Definitions under Mass law

A broken rib where the plaintiff was sent home from the emergency room with only Tylenol is a non-serious medical condition.[3]

Defining several medical conditions as serious - congestive heart failure, anemia, insulin dependent diabetes melitis, reflux, pulmonary hypertension, renal insufficiency, psychotic depression and mild dementia, and, a serious blood infection.[4]

Hypertension can be a serious medical condition in conjunction with atherosclerosis as it can make the latter disease seriously life-threatening. [5]

Breast cancer is a serious medical condition. [6]

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[1] Brady v. Art-Cement Products, co.,11 MDLR 1053, 1989 Mass. Comm. Discrim. LEXIS 18
[2] Harrison v. Barkley, 219 F.3d 132, 136 (2nd Cir. 2000).
[3] Jaroszuk v. City of Worcester, 2006 Mass. Super. LEXIS 197
[4] Guardianship of Mason, 41 Mass. App. Ct. 298, 299 (1996)
[5] Ribas v. Guay, 1998 Mass. Super. LEXIS 356, 4-5
[6] Brady v. Art-Cement Products, co.,11 MDLR 1053, 1989 Mass. Comm. Discrim. LEXIS 18

One Possibility
A long definition (see below) of what constitutes a serious medical condition under the Family and Medical Leave Act may prove useful for our purposes.

29 CFR 825.114

§ 825.114 What is a "serious health condition" entitling an employee to FMLA leave?

(a) For purposes of FMLA, "serious health condition" entitling an employee to FMLA leave means an illness, injury, impairment, or physical or mental condition that involves:

(1) Inpatient care (i.e. , an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity (for purposes of this section, defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom), or any subsequent treatment in connection with such inpatient care; or

(2) Continuing treatment by a health care provider. A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

(i) A period of incapacity (i.e. , inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom) of more than three consecutive calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

(A) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. , physical therapist) under orders of, or on referral by, a health care provider; or

(B) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

(ii) Any period of incapacity due to pregnancy, or for prenatal care.

(iii) Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

(A) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(B) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(C) May cause episodic rather than a continuing period of incapacity (e.g. , asthma, diabetes, epilepsy, etc.).

(iv) A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the *continuing supervision of, but need not be receiving active treatment by,* a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

(v) Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

(b) Treatment for purposes of paragraph (a) of this section includes (but is not limited to) examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. Under paragraph (a)(2)(i)(B), a regimen of continuing treatment includes, for example, a course of prescription medication (e.g. , an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition (e.g. , oxygen). A regimen of continuing treatment that includes the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.

(c) Conditions for which cosmetic treatments are administered (such as most treatments for acne or plastic surgery) are not "serious health conditions" unless inpatient hospital care is required or unless complications develop. Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc. , are examples of conditions that do not meet the definition of a serious health condition and do not qualify for FMLA leave. Restorative dental or plastic surgery after an injury or removal of cancerous growths are serious health conditions provided all the other conditions of this regulation are met. Mental illness resulting from stress or allergies may be serious health conditions, but only if all the conditions of this section are met.

(d) Substance abuse may be a serious health condition if the conditions of this section are met. However, FMLA leave may only be taken for treatment for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. On the other hand, absence because of the employee's use of the substance, rather than for treatment, does not qualify for FMLA leave.

(e) Absences attributable to incapacity under paragraphs (a)(2) (ii) or (iii) qualify for FMLA leave even though the employee or the immediate family member does not

receive treatment from a health care provider during the absence, and even if the absence does not last more than three days. For example, an employee with asthma may be unable to report for work due to the onset of an asthma attack or because the employee's health *care provider has advised the employee to stay home when the pollen count exceeds a* certain level. An employee who is pregnant may be unable to report to work because of severe morning sickness.

October 11, 2007

Jenny's Law:

Shifts of the burden of proof from the insured's party to the insurer. There is perhaps an easy means of passing this.

The path of least resistance:

Insurers do not issue policies until they have satisfied themselves, through the underwriting process, that the insured was in good health as of the application date. The remaining question is whether the insured was still alive and in good health on the date that the policy was approved and paid for. That is meant to be satisfied by the fact that there is no evidence to the contrary, if there is none. Any change in the health condition between the application date and the policy date is to be disclosed, and the failure to disclose such a change would be a misrepresentation. The test of good health is to be made as of the policy date (see Columbia Law Review); evidence post dating the policy date is not admissible. Jenny Crowley did not first have any evidence of cancer until after the policy was already in force; hence, she was in good health on the date that it went into force. It is not about "clinical" good health. Good health is an opinion determined by the insurer on a case-by-case basis (see below, quoted from SBLI's council). Proving that a person is or was in good health is proving that the person is or was in the condition that the insurer determined was good health. All of the answers to the application must be true on the date that the policy went into force, as it was based upon the application attached to the policy that the company determined good health. SBLI had determined Jenny to be in good health on the date that she applied, as evidenced by the issuance of the policy. Her burden of proof is satisfied by the fact that SBLI acknowledged her good health as of the application date by issuing the policy, and was unable to find any evidence to the contrary pre-dating the policy date.

Jenny's Law would fit in well with existing law and would not violate the established rules regarding conditions precedent. Importantly, it would clarify the means by which a person satisfies the burden of proof. First, the issuance of the policy is evidence that the insurer acknowledged the good health as of the application date. Secondly, under Jenny's Law, the insurer would be required to show evidence to the contrary in order to claim that the insured was no longer in good health on the policy date. The insurer, having issued the policy, would be required to show evidence, pre-dating the policy date, of a change in the health condition that left the insured no longer in good health as of the policy date.

Passing Jenny's Law would not only assist in preventing bad faith and breach of contract on the part of an insurer, but would assist the plaintiff in understanding how to satisfy the burden of proof. What has happened all too often is that beneficiaries to not understand the law enough to see through the attempt of an insurer who pretends that the good health clause allows it to vacate its previous determination of good health and cancel a policy in absence of any misrepresentation. Jenny was in good health, not because her doctor said

she was in good health. She was in good health not because all of her blood tests were normal. Jenny was in good health because SBLI determined that she was in good health, on a case-by-case basis within its own underwriting standards before SBLI issued her policy.

SBLI's council quotes Couch On Insurance as follows:

As explained in Couch on Insurance, "good health" is a determination made on a case-by-case basis. "A person may be in good health without being in perfect health, and 'good health' is a comparative term, to be determined according to the particular circumstances of each case, rather than by arbitrary rules. The good health provision is breached if the applicant is suffering from a serious illness, which continues and eventually causes his or her death."

Clearly, Jenny Crowley had been determined by SBLI to have been in good health, and as for her "breaching" that by suffering from cancer, she did that well after her policy had been placed in force. She had not suffered from the illness on the date that her policy was placed in force. As SBLI is unable to show any evidence of suffering as of the policy date, Jenny was still in good health on that date. It does not matter that she may have had the cancer at the time, as there is no such thing as perfect health and there are no arbitrary rules for what good health is or is not. While Jenny's Law would not necessarily change any existing law, it would enable plaintiffs to navigate the burden of proof that the condition precedent places on them.

MEMORANDUM

RE Life Insurance Laws
CC Senator Spilka, Mary-Anne Padien

Brief History

Insurance companies can rely on "good health" clauses to deny benefits for the insured's beneficiaries. Life insurance contracts generally require that the insured be in good health at the time a policy is issued, and these contractual provisions are conditions precedent to contract formation under Massachusetts common law.[1] Since the good health condition is the obligation of the insured, the insured has the burden of proving her own good health in court.[2] Effectively, an insured (or more realistically, the insured's beneficiary) must prove by a preponderance of evidence that she was in good health when the insurance company issued the policy, which is a nearly impossible burden for health problems such as tumors which exist for an indeterminate amount of time prior to discovery.

Other States

Other states' case law indicate a dichotomy of opinion as to whether the burden of proving good health rests on the insured or the insurer. Different approaches rest on whether good health is strictly interpreted as a condition precedent to contract formation. Jurisdictions which interpret good health as a condition precedent place the burden of proof on the insured to indicate that she was in good health.[3] Other jurisdictions determined that the good health requirement only refers to the insured's perception of her own health and not the medical reality of an undetected illness.[4] An insured's evidentiary burden in these cases is considerably less taxing, as she need only convince the jury that she was unaware of the health issue rather than that the health issue was not present. At least one jurisdiction also shifts the burden of proof to the insurer.[5]

A middle ground approach also exists, which holds that when the insurer chooses not to medically examine an insured the insurer only adopts liability for the strict definition of good health rather than the insured's subjective awareness of her good health. While dicta in a few cases indicated that some courts find this approach favorable, only one jurisdiction has actually followed it.[6]

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[1] Fondi v Boston Mut. Life Ins. Co., 112 N.E. 612, 612-13 (1916).
[2] Id.
[3] See, e.g., Leach v Miller's Life Ins. Co., 400 F.2d 179 (5th Cir. 1968) (applying Mississippi law); Huffman v State Capital Life Ins. Co., 174 S.E.2d 17 (N.C. Ct. App. 1970); American Nat'l Life Ins. Co. v John R. Corley Co., 73 S.W.2d 598 (Tex. Ct. Civ. App. 1934); Grover v John Hancock Mut. Life Ins. Co., 125 A.2d 571 (Vt. 1956).
[4] See, e.g., Harte v United Benefit Life Ins. Co., 424 P.2d 329 (Cal. 1967); National Life & Accident Ins. Co. v Lee, 166 S.E. 253 (Ga. Ct. App. 1932); National Aid Life Ass'n v Persing, 63 P.2d 35 (Okla. 1935); Lynch v Metropolitan Life Ins. Co., 235 A.2d 406 (Pa. 1967); Madsen v Metropolitan Life Ins. Co., 156 A.2d 203 (R.I. 1959).
[5] National Aid Life Ass'n v Stroup, 65 P.2d 991 (Okla. 1937).
[6] American Nat. Ins. Co. v Herrera, 211 Cal App 2d 793 (1963).

Unfair Practice Concerns

Even when an insurance company wrongly withholds life insurance benefits from a rightful beneficiary, the insurer's unequal power may cause unjust results. By withholding benefits, the insurer can force the beneficiary to either sue, settle with the insurer for less than the policy's worth, or receive nothing. In cases where the beneficiary needs the policy money immediately, pursuing court action may not be an option. The cost of securing legal representation may also prohibit court action, causing the beneficiary to settle for less than the policy's worth. With these limitations in mind, it may be worthwhile to create an incentive for insurers to pay policies rather than withhold payment and rely on their uneven bargaining power.

An Act to Ensure Consumer's Rights in the Purchase of Life Insurance

SECTION 1: Chapter 175 of the General Laws is hereby amended by adding the following 2 sections:

§ 125A: In any court action based on a life insurance policy where the good health of the insured at the time of the policy's issuance is at issue, there shall be a presumption of good health if the insurer issued the policy to the insured. The presumption of good health shall exist whether or not the insurer conducted a medical examination prior to issuing the life insurance policy. An insurer may rebut the presumption of an insured's good health either by clear and convincing evidence of the insured's relevant misrepresentation as defined by MGL c. 175 § 186, or by clear and convincing evidence indicating that the insured should have known he was not in good health based on active symptoms of a serious health condition as defined by the Family and Medical Leave Act, 29 CFR 825.114. The court shall award reasonable attorney's fees and costs to a prevailing insured or insured's beneficiary.

§ 125B: An insurer who learns that an insured or an insurance policy applicant has or is at significant risk for a serious health condition as defined in section § 125A must notify the insured or the insurance policy applicant of said condition or risk. The insurer must provide such notification regardless of whether the insurer intends to issue or re-issue a policy to an insurance policy applicant. The insurer must provide such notification no matter how the insured came by the information, and must notify the insured or insurance policy applicant within 14 days of learning of said serious health condition.