For The Defense™

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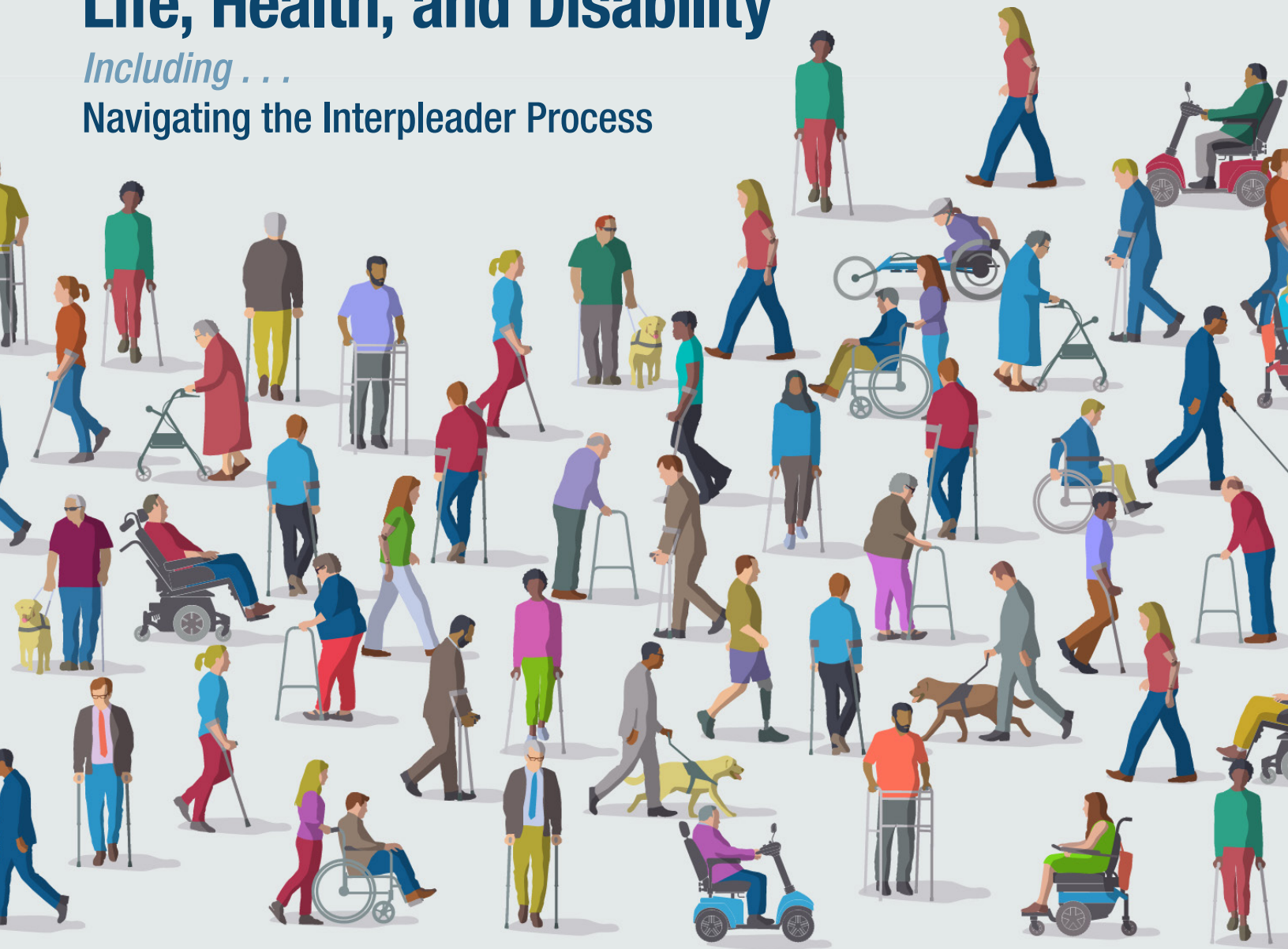
The magazine for defense, insurance and corporate counsel

March 2023

Life, Health, and Disability

Including . . .

Navigating the Interpleader Process



Also in This Issue . . .

The No Surprises Act: Overview of Key Provisions, Implementation, and Enforcement

Reading the Tea Leaves: Determining a Former Spouse's Entitlement to Life Insurance Proceeds

And More!

A New Era in Partnerships

For over 60 years DRI has been the leader in providing resources and thought leadership to the civil defense community.

Today, we look to further advance the profession by creating Partnerships with organizations that are ready to work in concert to shape the future.

DRI welcomes LawyerGuard as our inaugural Premier Corporate Partner—we look forward to collaborating on a number of exciting new initiatives in support of the interests of business and individuals in civil litigation.

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Learn more about DRI and our Premier Corporate Partners at dri.org/partners.

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Celebrating Strength and Pushing for Progress at DRI

Dean Martinez, Chief Executive Officer

As we celebrated Black History Month in February and are now in the middle of Women's History Month this March, DRI is proud to acknowledge the incredible contributions women and minority groups have made to the legal profession. Last year, ***we highlighted the*** nomination of Ketanji Brown Jackson to the United States Supreme Court. Now, Justice Jackson is officially the first female African American Justice on the Court, having taken her oath of office on June 30, 2022.

We also saw strong gains for women and minorities throughout 2022. In fact, Law.com's ***2022 Diversity Scorecard*** indicated that the overall percentage of minority attorneys across Big Law increased from 18.5% to 20.2%, the largest year-over-year shift on record.

These are all promising signs of progress in the legal space, and we'd like to share some updates specific to our organization, as well. In October 2022, Lana Olson became the fifth woman to serve as president of DRI. ***In an interview with Birmingham Business Journal***, President Olson shared her plans for the organization, the impact of her presidency on her firm, and how her membership in the organization has benefited her legal career. She shared how her involvement with DRI was "the best professional thing that I've done other than join my firm," she told the outlet.

DRI is committed to ensuring that our board, committees, and staff reflect the makeup of our profession. We encourage all of our members to get involved this year.

Through our programming and publications, we continue to confront important topics that impact our profession, including, but not limited to, equality. Our ***February*** and ***March 2023*** issues of The Voice featured powerful pieces dedicated to Black History Month and Women's History Month. We plan to continue to feature DRI members throughout the year, we'd love to feature you in our publications, too. Learn more and get in touch with us by visiting DRI's ***publications page***.

Plus, check out our 2023 seminars for programming designed to allow you to continue to build your business and keep you informed of emerging legal trends. We have an incredible lineup of programs for 2023. Whether it is a seminar focused on a specific area of law such as ***Toxic Torts and Environmental Law***, ***Business and Intellectual Property***, or ***Trucking Litigation***, or broader topics such as ***Women in the Law*** or ***Young Lawyers***, DRI has a program for you. Visit ***our events page*** to see the entire lineup of virtual and in-person programs for 2023.

Thank you for giving me the chance to share these exciting achievements and opportunities with you. Our community is our biggest asset, and its power is boundless.

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ON THE RECORD

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2023: Welcome Back to the New LHD Committee

Michelle Thurber Czapski is the Chair of DRI's Life, Health and Disability Committee. She hails from Detroit, Michigan, where she practices in the areas of life, health, disability and ERISA defense, financial services, and commercial litigation. Michelle chairs Bodman's Litigation and Alternative Dispute Resolution Practice Group and is also Chair of its Insurance Industry Team. Michelle is the former Chair of DRI's Commercial Litigation Committee, has served on the Membership Committee and Class Action Task Force, and has the distinction of having chaired two seminars in less than a year. She and her husband Chris have two high schoolers and a silver lab.

As I write this, 2023 has just begun, and Sarah Delaney and I are three months into our tenure as Chair and Vice Chair of the ***Life, Health and Disability Committee***. A new year and a new leadership position bring a fresh excitement to be sure, but in a sense, I feel that we are on the cusp of a new era; as if the entire committee has reinvented itself. The past few years have been quite a ride. We have bobbed and weaved, "pivoted" repeatedly, and taught ourselves new ways of working, connecting, and thriving. Now, we conduct our business remotely via Zoom or Teams (so much better than a traditional conference call), in person, and in a hybrid format, with some people on a screen and some people in the room. This way, everyone can be involved, whether they can come to our live meeting or not, and for a group that is scattered across the country, this freedom is key. We have revamped our meeting timing and formats, sharing screens, conducting live online game nights, and all manner of other creative stuff. And, while we have been "apart," a funny thing happened: we came together.

So now, as we begin the first year since 2019 that will feature all of our "normal" live events, I am thrilled to see how the new, more nimble, creative, and connected LHD will fare. With so many new ways to participate on top of how we always did, I couldn't help but think that this year would be something special. And so, we have dubbed 2023 the "LHD Year of Engagement." Involvement in the LHD has never been more rewarding, fun, or easy, so there is no reason for anyone to stand on the sidelines. Here is what some of our subcommittees and SLGs are up to.

Programming

Of course, our premier event of the year is our ***Life, Health, Disability, and ERISA Seminar***, and it is first up on our programming itinerary. We will be in New Orleans at the Hilton New Orleans Riverside on April 24–26, and Elizabeth Doolin and her team have done a bang-up job of creating a memorable three days for us all. The conference will feature the usual lineup of unmatched excellence in LHDE content, as well as more small group networking than ever before, a Premier Networking Reception on the Creole Queen riverboat, an enlarged Diversity and Inclusion Luncheon, presentation of the Linda Lawson Mentoring Award, and much, much more.

In the summer, we typically have our fly-in meeting for committee leadership in Chicago. While the date for this year's meeting has not yet been set, we are definitely planning to have a live meeting with a remote option, as we have done for the past two years. It is great to be able to offer people the opportunity to participate even if they cannot travel. Registration for the meeting is free, and everyone who wants to participate is welcome—all who are engaged in LHD are "leaders." If you don't already have a title and want one, we will get one for you!

The fall will bring the ***DRI Annual Meeting*** in San Antonio on October 24-27. We in the LHD love the Annual Meeting and the opportunities it brings to hang out with each other, network with other committees, and sightsee in the host city without the activity generated by putting on a seminar. We always have a great time at our LHD Committee meeting/CLE and social events, and I am sure this year will be no exception.

Finally, in November, we will host our biannual New Lawyers Boot Camp in Chicago. While dates and details are still in the works, this small, classroom style setting offers attendees the chance to learn the basics of our practice from the leaders in the field, including industry greats Mark Schmidtke and Brooks Magratten, our program Chair and Vice Chair. Attendees will also have the opportunity to network with each other and the seminar faculty at dinner the evening prior to the seminar.

Publications

Our Publications Subcommittee has always been a shining light in LHD, and 2023 is no exception. This issue of ***For the Defense*** is just one example of the content generated by this well-oiled machine. And, while the newsletters published by the LHD's Publications Subcommittee for many years have now morphed into submissions to The Brief Case, the pubs people have rolled with the changes and developed a schedule to make sure that we are contributing regularly and producing as much content as before.

Kent Coppage and his crew also see that we regularly contribute to The Voice and In-House Defense Quarterly, as well. Meanwhile, new ideas for compendia surface from time-to-time, and the Publications Subcommittee oversees those efforts. Our Life Insurance book and Rescission online survey are invaluable resources to many practitioners, and we look forward to our next contribution to the state of knowledge in our field.

Diversity and Inclusion

Our Diversity and Inclusion Subcommittee is busy with several seminar-related projects right now: the Diversity and Inclusion Luncheon, a highlight of our seminar that is now open to all attendees; and our law student initiative. Our Diversity and Inclusion Subcommittee is also instrumental in assisting with our membership and programming efforts, as well, as they help us to keep Diversity and Inclusion in mind with all that we do.

SLGs

As the name implies, the LHD Committee specializes in Life, Health and Disability Insurance law, and we have the Specialized Litigation Groups ("SLGs") to prove it! We also have ERISA and Regulatory SLGs to cover our favorite statute that governs so many of these types of claims, as well as the regulations enacted by the DOL and other agencies who oversee them. Our SLGs are our specialty think-tanks who provide ideas, content, and direction for everything we do.

Marketing/Networking/DRI For Life/Dine-Arounds/Fly-In

The fine folks on these subcommittees are in charge of researching, planning, organizing, and getting the word out about all of our fun committee activities—both live and virtual. I could fill this entire article with descriptions of all of the wonderful events, large and small, that they have put together and the coordinated marketing campaigns that they have successfully pulled off to make sure that everyone is informed and appropriately excited about our upcoming events. Thanks to these folks, we have had record numbers of fantastic meals at restaurants across the country, learned line dancing, gone for runs at dawn, pretended to be Kate Winslet on the sterns of model boats (don't ask), tried custom drinks named after ERISA decisions and more. If the top-notch content brings folks into the committee, I firmly believe that the camaraderie developed at these types of events is what keeps folks coming back.

Young Lawyers

Young Lawyers are an integral and important part of our committee. We love them because they plan an awesome after-dinner party on the Thursday evenings of our seminars, but they do so much more than that. Our Young Lawyers are involved in every aspect of our committee and provide valuable input as to what we should be doing now, and what we should be thinking about doing in the future. Our active Young Lawyers move "up the ranks" and are our best source of future committee leaders.

Come Join Us

So, as you can see, there are many facets to the LHD Committee, and all are functioning in a slightly different, more agile, more creative, simply better way than ever before. No longer is distance or time any barrier to the involvement of any practitioner who has in interest in life, health, disability, or ERISA law. I personally invite any and everyone who meets that description to come join us and see what the LHD is all about.

Michelle Czapski

The No Surprises Act

By Milanna Datlo

The NSA provides federal protections against surprise (or balance) billing for three categories of services, all of which have in common the patient's inability to choose a provider.

Overview of Key Provisions, Implementation, and Enforcement

The federal No Surprises Act ("NSA") was enacted as part of the Consolidated Appropriations Act, 2021 on December 27, 2020. It applies to group health plans (including grandfathered plans), health insurance issuers of group or individual health coverage for plans/policies, and Federal Employees Health Benefits (FEHB) Program carriers.

The NSA provides federal protections against surprise (or balance) billing for three categories of services, all of which have in common the patient's inability to choose a provider. Specifically, the NSA applies to:

- out-of-network emergency services;
- non-emergency services furnished at in-network facility by an out-of-network provider without the patient knowingly electing that provider or giving consent to be billed; and
- out-of-network air ambulance services.

Balance billing refers to the practice of out-of-network providers billing patients for the difference between: (1) the provider's billed charges, and (2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost-sharing (such as a copayment, coinsurance, or amounts paid toward a deductible).

The Departments of the Treasury, Labor, and Health and Human Services (the "Departments") and the Office of Personnel Management (the "OPM") issued implementing regulations for the NSA's provisions: two parts of Interim Final Rules ("IFR") in July 2021 (July 2021 IFR) and in October 2021 (October 2021 IFR), and Final Rules ("FR") in August 2022, which became effective on October 25, 2022.

Summary of the Interim Final Rules Implementing the NSA

July 2021 IFR

A patient's cost-sharing amounts for the non-air ambulance services subject to the NSA is limited to the "recognized amount," which is:

- if the state has an All-Payer Model (APM) Agreement, the amount under such agreement; or
- if there is no such applicable APM Agreement, an amount determined by state law; or
- if neither of the above apply, the lesser of the billed charge or the plan's or issuer's median contracted (in-network) rate, referred to as the qualifying payment amount (QPA), for the service in the geographic region.

An APM Agreement is an agreement between the Centers for Medicare & Medicaid Services and a state to test and operate systems of all-payer payment reform for the medical care of residents of the state. With respect to the QPA, the Departments (or applicable state authorities) are responsible for conducting audits of the plan's or issuer's QPA calculation methodology to ensure its accuracy.

The NSA's cost-sharing protections also apply to air ambulances but there is no "recognized amount" because states are preempted from regulating these providers under the Airline Deregulation Act. Under the NSA, cost-sharing amounts for their services must be based on the lesser of the billed charge or the QPA.

When the QPA serves as the cost-sharing amount, plans and issuers are required to make disclosures about the

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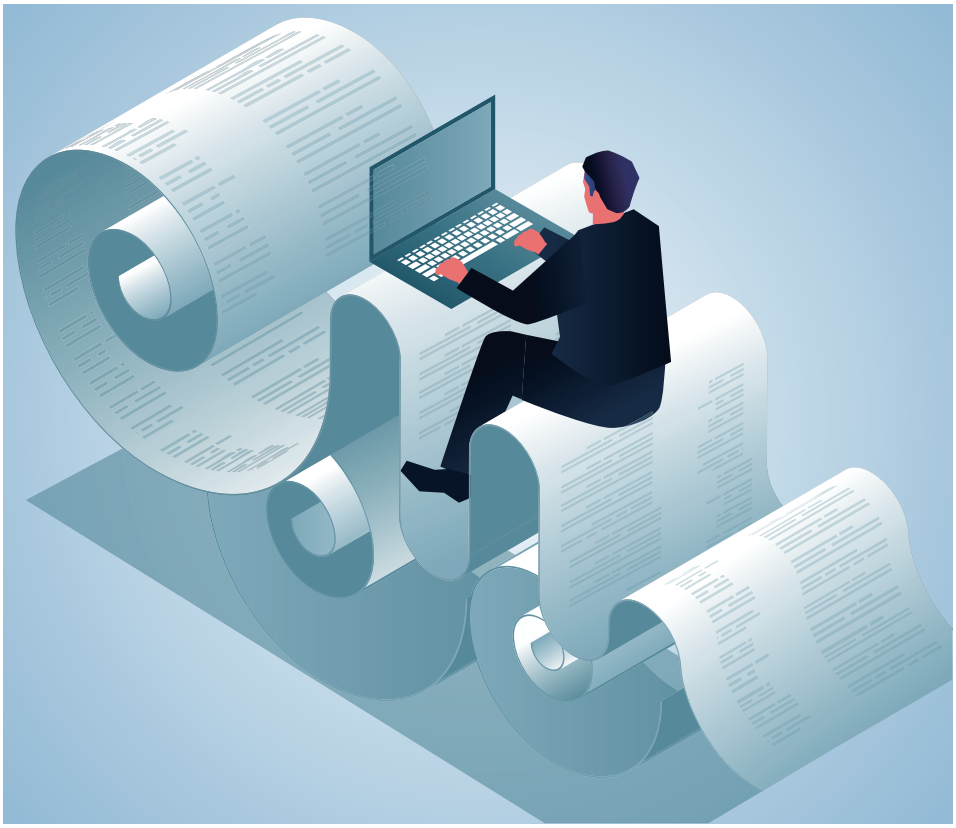

QPA with each initial payment or notice of denial of payment and provide additional information upon request of the provider or facility. Providers are banned from sending patients balance bills for any amounts beyond the cost-sharing.

The total amount paid by a plan or issuer for the services subject to the NSA, referred to as the "out-of-network rate," must be equal to one of the following amounts, less any cost-sharing payments:

- an amount determined by an applicable APM Agreement; or
- if there is no such applicable APM Agreement, an amount determined by state law; or
- if there is no state law determined rate, an agreed upon rate; or
- if no agreement is reached, an amount determined by the newly created federal independent dispute resolution ("IDR") process.

For example, if the out-of-network rate for a non-air ambulance service is determined to be $1,500 and the "recognized amount" for the service is determined to be $1,000, the plan is required to pay $500 (the difference between the out-of-network rate and the cost-sharing amount) and the patient is required to pay $1,000, even if the patient has not yet paid any of the plan's deductible which is higher than $1,000, because the patient's out-of-pocket costs are limited to the cost-sharing amount calculated using the recognized amount.

October 2021 IFR

If the provider or the facility disagrees with the payment for the service subject to the NSA, there is a mandatory 30-day negotiation period. If negotiations do not result in an agreement by the end of the negotiation period, the parties have four (4) days to request that the IDR process determine the rate. Each party submits their best offer to the independent arbitrator, who must choose one or the other (arbitrator cannot split the difference).

The NSA recognizes that lack of standards for payment determinations may result in large awards to facilities and providers and, consequently, increased premiums. Therefore, it limits the factors arbitrators may consider in making decisions.

The IDR entity may not consider any information submitted by the parties concerning the following *prohibited factors:*

- usual and customary charges, also known as the UCR amount, referring to the amount providers in a geographic area usually charge for the same or similar medical service;
- the amount that would have been billed if the services were not subject to the NSA; and
- rates payable in public sector programs, such as Medicare and Medicaid.

The IDR may consider a*llowed factors*, which include:

- training, education, and experience of the provider;
- market share in the geographic region where the service was provided held by the out-of-network provider, facility, the plan, or the issuer;
- patient acuity or complexity of the service;
- teaching status and scope of services of the out-of-network facility;
- good faith efforts made by the out-of-network facility or provider to join the network; and
- prior contracted rates between the provider or facility and the plan or issuer, if applicable, during the previous four (4) plan years.

The October 2021 IFR required that IDR entities apply a "rebuttable presumption" in favor of the QPA, *i.e.*, select the offer closest to the QPA, unless the additional information submitted by either party on the allowed factors "clearly demonstrated" that the QPA was "materially different" from the appropriate out-of-network rate. Such mandatory deference to the QPA in the out-of-network rate determination process has been aggressively challenged by providers in court.

In particular, on October 28, 2021, the Texas Medical Association, a trade association representing physicians, and a Texas physician filed a lawsuit against the Departments and the OPM, asserting that the October 2021 IFR ignored Congress's intent that IDR entities should not favor any single allowed factor in determining the out-of-network rate related to non-air ambulance services. Plaintiffs argued that the NSA requires that the IDR entity always consider the QPA without the parties

specifically bringing it to its attention *and* consider "additional information" or "additional circumstances" if the parties choose to submit that as part of their offer. On February 23, 2022, the United States District Court for the Eastern District of Texas (the "District Court") vacated applicable portions of the October 2021 IFR. *Tex. Med. Ass'n v. U.S. Dept. of Health and Human Servs.,* Case No. 6:21-cv-425 (E.D. Tex. 2022).

In addition, on April 27, 2022, LifeNet, Inc., a provider of air ambulance services, filed a lawsuit against the Departments and the OPM seeking vacatur of the requirement in the October 2021 IFR that the IDR entity may consider information submitted by a party only if the information "clearly demonstrate[s] that the qualifying payment amount is materially different from the appropriate out-of-network rate." On July 26, 2022, the District Court issued an order vacating this language. *LifeNet, Inc. v. U.S. Dep't of Health and Human Servs., et al.*, Case No. 6:22-cv-162 (E.D. Tex.).

Summary of the Final Rules Implementing the NSA

The FR removes the language vacated by the District Court and finalizes parts of the July 2021 and October 2021 IFR related to (1) the information that must be disclosed about the QPA to address downcoding, (2) the certified IDR entity's consideration of the statutory factors when making a payment determination, and (3) the IDR entity's written decision explaining the rationale for its out-of-network rate determination in *all* cases.

"Downcoding" means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed. If a QPA is based on a downcoded service code or modifier, in addition to the information already required to be provided with an initial payment or notice of denial of payment, a plan or issuer must provide (1) a statement that the billed service code or modifier was downcoded, (2) an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any, and (3) the amount that would have been the QPA had the service code or modifier not been downcoded.

The IDR entity is required to consider the QPA and the permissible additional information when determining the out-of-network rate, without defaulting to the offer closest to the QPA or applying a presumption in favor of that offer. Rather, the IDR entities must select the offer that best represents the value of the service under dispute after considering the QPA and all permissible information submitted by the parties. The FR explain that the QPA is a quantitative figure that often represents an appropriate out-of-network rate, as the QPA calculation methodology already incorporates the qualitative factors that affect costs, including medical specialty, geographic region, and patient acuity and case severity, and considering the same factors twice would be redundant. Nonetheless, the FR acknowledge that there are instances where certain factors affecting the value of a particular service may not be adequately reflected in the QPA, but are relevant in determining the appropriate out-of-network rate.

The FR provide the following examples illustrating the IDR entity's payment determination process:

Example 1. (i) Facts: A level 1 trauma center that is an out-of-network emergency facility and an issuer are parties to a payment determination. The facility submits an offer that is higher than the QPA and additional information showing that the scope of services available at the facility was critical to the delivery of the provided service, given the particular patient's acuity. The facility also submits additional information showing the contracted rates used to calculate the QPA for the service were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the facility, which relates to the service that is the subject of the payment determination. If the IDR entity determines that the additional information about the scope of services submitted by the facility demonstrates that the facility's offer best represents the value of the service, the certified IDR entity should select the facility's offer as the appropriate rate.

The NSA recognizes that lack of standards for payment determinations may result in large awards to facilities and providers and, consequently, increased premiums.

Example 2. (i) Facts: An out-of-network provider and an issuer are parties to a payment determination. The provider submits an offer that is higher than the QPA and additional information regarding the provider's level of training and experience.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the out-of-network provider. However, if the IDR entity determines that the provider's level of training and experience does not relate to the service that is the subject of the payment determination (for example, the information does not show that the provider's level of training and experience was necessary for providing the service to the particular patient, or that the training or experience made an impact on the care that was provided), the IDR entity should select the QPA, which best represents the value of the service.

Example 3. (i) Facts: An out-of-network provider and an issuer are parties to a payment determination involving an

emergency department visit for the evaluation and management of a patient. The provider submits an offer that is higher than the QPA and additional information showing that the acuity of the patient's condition and complexity of the service required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer submits an offer equal to the QPA for CPT code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity, and additional information showing that this CPT code accounts for the acuity of the patient's condition. The IDR entity determines that the information provided by the provider and issuer relates to the service that is the subject of the payment determination.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the parties. However, it should not give weight to the additional information on the acuity of the patient and complexity of the service provided by the provider if that information is already accounted for in the calculation of the QPA, and should select the QPA that best represents the value of the service

Example 4. (i) Facts: An out-of-network emergency facility and an issuer are parties to a payment determination. Although the facility is out-of-network during the relevant plan year, it was in-network in the previous four (4) plan years. The issuer submits an offer that is higher than the QPA and additional information showing that the offer is equal to the facility's contracted rate for the previous year with the issuer for the service and that the prior contracted rate took into account the case mix and scope of services typically furnished at the facility. The facility submits an offer that is higher than both the QPA and the prior contracted rate and also submits additional information showing that the case mix and scope of available services were integral to the service provided.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the parties, but should not give weight to information to the extent it is already accounted for by the QPA. If the IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information that the issuer submitted regarding prior contracted rates, then the IDR entity should give weight to that information only once. If the IDR entity determines that the issuer's offer (prior contracted rate) best represents the value of the disputed service, the IDR entity should select the issuer's offer.

Example 5. (i) Facts: An out-of-network provider and an issuer are parties to a payment determination regarding a service for which the issuer downcoded the service code that the provider billed. The issuer submits an offer equal to the QPA (calculated using the downcoded service code) and additional information including the documentation disclosed to the out-of-network provider at the time of the initial payment (which describes why the service code was downcoded). The out-of-network provider submits an offer equal to the amount that would have been the QPA had the service code not been downcoded and additional information that explains that the billed service code was more appropriate than the downcoded service code due to the complexity of the service, as evidence that the QPA for the service code that the provider billed best represents the value of the service.

(ii) Conclusion: The IDR entity must consider the QPA, which is based on the downcoded service code, and then must consider whether to give weight to additional information submitted by the parties. If the IDR entity determines that the additional information submitted by the provider demonstrates that the provider's offer best represents the value of the service, the IDR entity should select the provider's offer.

After the IDR entity has selected an offer, it must explain its determination in a written decision and submit it to the parties and the Departments. The written decision must explain what information the IDR entity determined demonstrated that the offer selected is the out-of-network rate that best represents the value of the service. This explanation must include the weight given to the QPA and any additional non-prohibited, credible information submitted. If the IDR entity relies on any additional information in selecting an offer, the written decision must explain the conclusion that this information was not already reflected in the QPA.

For calendar year 2023, certified IDR entities may charge $200 to $700 for single determinations and $268 to $938 for batched determinations. See ***https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf***. Loser pays the cost of the arbitration.

Implementation and Enforcement of the NSA

Currently, there are 33 states with existing laws protecting consumers against surprise medical bills. Jack Hoadley, et al., *No Surprises Act: A Federal-State Partnership to Protect Consumers from Medical Bills*, The Commonwealth Fund (Oct. 20, 2022). Where state laws have a narrower scope than the NSA, the NSA expands consumer protections. However, some state laws have a broader scope than the NSA, *e.g.*, include protections for additional services such as ground ambulance services. *Id.* As long as state balance billing laws do not prevent the application of the NSA's protections, the NSA does not preempt them.

The NSA fills in gaps left by existing state law protections, including where federal laws preempt state action. Specifically, if the state has no applicable APM Agreement, state balance billing laws, if they exist, apply to the determination of the recognized amount and the out-of-network rate only when the insurer/plan, the provider and the facility are within the state jurisdiction. Typically, this includes fully insured plans but not employer-sponsored self-funded plans because ERISA preempts state laws with respect to self-funded group health plans and prohibits states from regulating a self-funded plan as insurance. Similarly, the Airline Deregulation Act preempts state laws with respect to air ambulances. The NSA provides

nationwide protections in both of these circumstances.

The following examples in the July 2021 IFR illustrate how state laws may or may not apply. Each example assumes there is no applicable APM Agreement that would determine the recognized amount or out-of-network rate.

Example 1. (i) Facts. A health insurance issuer licensed in State A covers a specific non-emergency service that is provided to an enrollee by an out-of-network provider in an in-network health care facility, both of which are also licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by out-of-network providers in an in-network health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The state law applies to health insurance issuers and providers licensed in State A. The state law also applies to the type of service provided.

(ii) Conclusion. State A's law would apply to determine the recognized amount and the out-of-network rate.

Example 2. (i) Facts. Same facts as Example 1, except that the out-of-network provider and in-network health care facility are located and licensed in State B. State A's law does not apply to the provider, because the provider is licensed and located in State B.

(ii) Conclusion. State A's law would not apply to determine the recognized amount and out-of-network rate. Instead, the lesser of the billed amount or QPA would apply to determine the recognized amount, and either an amount determined through agreement between the provider and issuer or an amount determined by an IDR entity would apply to determine the out-of-network rate.

Example 3. (i) Facts. An individual receives emergency services at an out-of-network hospital located in State A. The emergency services furnished include post-stabilization services that are within the scope of the NSA. The individual's coverage is through a health insurance issuer licensed in State A, and the coverage includes benefits with respect to services in an emergency department of a hospital. State A has a law that prohibits balance billing for emergency services provided to an individual at an out-of-network hospital located in State A and provides a method for determining the cost-sharing amount and total amount payable in such cases. The law applies to issuers licensed in State A. However, State A's law has a definition of emergency services that does not include post-stabilization services.

(ii) Conclusion. State A's law would apply to determine the cost-sharing amount and out-of-network rate for the emergency services, as defined under State A's law. State A's law would not apply for purposes of determining the cost-sharing amount and out-of-network rate for the post-stabilization services. Instead, the lesser of the QPA or billed amount would apply to determine the recognized amount, and either an amount determined through agreement between the hospital and issuer or an amount determined by an IDR entity would apply to determine the out-of-network rate, with respect to post-stabilization services.

Example 4. (i) Facts. A self-insured plan, subject to ERISA, covers a specific non-emergency service that is provided to a participant by an out-of-network provider in an in-network health care facility, both of which are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by out-of-network providers in an in-network health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The law applies to health insurance issuers and providers licensed in State A, and provides that plans that are not otherwise subject to the law may opt in. The law also applies to the type of service provided. The self-insured plan has opted in.

(ii) Conclusion. State A's law would apply to determine the recognized amount and the out-of-network rate.

The NSA anticipates that states have the primary enforcement role, to ensure that the plan or issuer actually pays the provider the correct amount determined either by state law or by the IDR entity. But initially most states will partner with federal agencies or rely entirely on federal enforcement. Hoadley, *supra*.

Conclusion

The main goal of the NSA is to protect consumers against balance billing when treated without their knowledge or consent by out-of-network providers or at out-of-network health care facilities. Significantly, however, the scope of the NSA's application is limited to only three distinct categories of out-of-network health care services. Accordingly, as the first step, it is necessary to determine whether the NSA's protections apply to the service at issue.

Another important goal of the NSA is to shield consumers from ever-higher health insurance premiums and to limit cost-sharing costs. To bring certainty to the out-of-network provider rate and cost-sharing determination with respect to the services it governs, the NSA establishes a methodology that defers to the applicable APM Agreement or, if does not exist, to the state law. However, not all states have laws protecting consumers against surprise medical bills. Furthermore, existing state laws do not apply to self-funded plans, out-of-state facilities and providers who are not licensed in the state.

If state law does not exist or apply, the NSA creates a mechanism – a federal IDR process - for resolution of out-of-network provider rate disputes with respect to the services subject to its provisions. The IDR entity must consider the QPA and the permissible additional information, if the parties choose to submit it as part of their offer, and select the offer that best represents the value of the disputed service.

Deference to the QPA, which often incorporates the qualitative factors affecting the value of a particular service, is the most straightforward way to determine the appropriate out-of-network rate. Nonetheless, providers have been challenging in court the rules as to how the QPA should be considered in IDR determinations. *See* Katie Keith, *The Six Provider Lawsuits over the No Surprises Act: Latest Developments,* Health Affairs Forefront (Feb. 16, 2022); Katie Keith, *Health Care Providers Fight Arbitration Rule in No Surprises Act,* To the Point, The Commonwealth Fund (Mar. 17, 2022); and Katie Keith, *Providers Sue (Again) Over No Surprises Act*, Health Affairs Forefront (Sept. 27, 2022). While the FR addressed issues raised in the litigation, some litigation remains active, and further changes could curtail the cost-containment goals of the NSA. Accordingly, until the final resolution of pending lawsuits, providers and payors should maintain records of all permissible additional information relating to the services subject to the NSA.

What Qualifies As An "Other Person Having Interest" Under California Insurance Code 10113.71?

By Michael A.S. Newman

Crucial questions arise that the law fails to address. It is the work of lawyers and judges to answer these questions.

There is an old saying that no military plan survives contact with the enemy. It can likewise be said that no piece of legislation wholly survives contact with its own implementation. Inevitably, crucial questions arise that the law fails to address. It is the work of lawyers and judges to answer these questions.

Thus, in 2012, the California Legislature enacted what must at the time have seemed like a simple set of changes to the California Insurance Code pertaining to life insurance. Sections 10113.71 and 10113.72 of the Insurance Code address the procedures for lapsing a life insurance policy when the policy owner fails to pay premium. The statues together provide that (a) applicants and policy owners must have an opportunity to designate additional people to receive notice of pending termination (section 10113.72); (b) policy owners and designees must receive notice within 30 days of a missed premium, and at least 30 days prior to termination (section 10113.71(b)); and (c) each policy is to have a 60-day grace period (section 10113.71(a)).

The question immediately arose – do these statutes apply to policies issued ***prior*** to January 1, 2013, the effective date of the statutes? The statutes were silent as to this. Consistent with opinion letters from the California Department of Insurance, many life insurance companies maintained that the statutes did not apply to policies issued prior to 2013. This seemed in line with the general principle that statues do not operate retroactively. Nevertheless, in *McHugh v. Protective Life Ins. Co.*, 12 Cal. 5th 213 (2021), the California Supreme Court, reversing the ruling of the Court of Appeal, held that the statutes ***do indeed*** apply to policies issued prior to 2013. The dockets of California courts witness the raft of lawsuits that have resulted from this ruling, as the insurance industry (and the plaintiff's bar) struggle with its implications.

But *McHugh* did not answer every question arising under the statutes, and there are others that will no doubt need to be the subject of further clarification by the courts. One such issue, hitherto not addressed by any published California state court decision, has to do with the meaning of the words "other person having an interest" as it appears in Section 10113.71(b). That section reads as follows (emphasis added):

> (1) A notice of pending lapse and termination of a life insurance policy shall not be effective unless mailed by the insurer to the named policy owner, a designee named pursuant to Section 10113.72 for an individual life insurance policy, and a known assignee ***or other person having an interest in the individual life insurance policy***, at least 30 days prior to the effective date of termination if termination is for nonpayment of premium.
> (2) This subdivision shall not apply to nonrenewal.
> (3) Notice shall be given to the policy owner and to the designee by first class United States mail within 30 days after a premium is due and unpaid. However, notices made to assignees pursuant to this section may be done electronically with the consent of the assignee.

What does "person having an interest" mean in this context? The statute does not say. "Interest" can have many meanings, some narrow and some broad. Not surprisingly, some plaintiffs have

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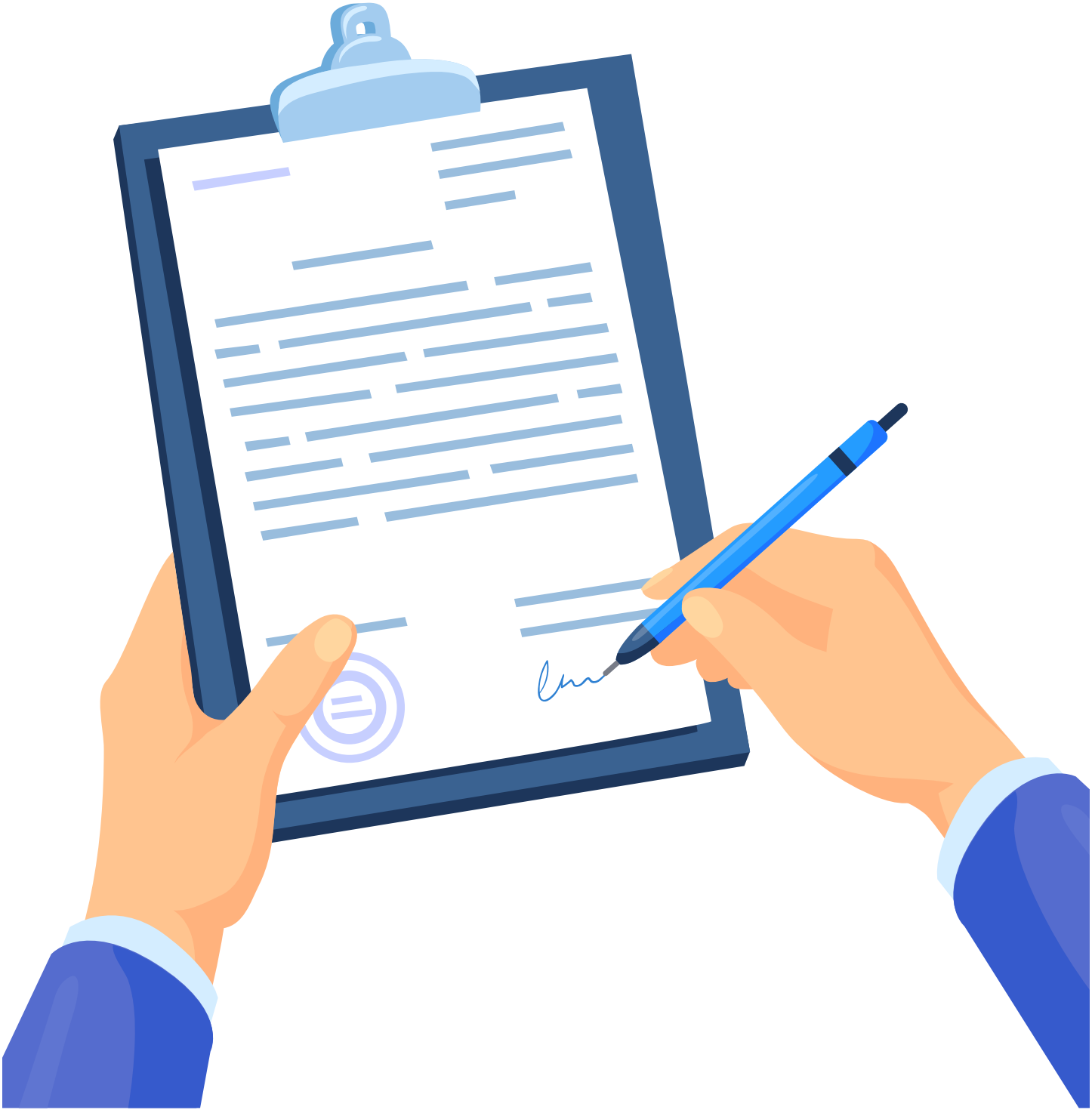

attempted to argue that the term "interest" should be read broadly – for instance, that it applies to beneficiaries under the policy.

Is "interest" to be read in its broadest sense, or more narrowly? It is the argument of this article that the term "interest" must be read narrowly. In particular, such an "interest" must be similar in type to that of an assignee.

A Broad or Overinclusive Reading of "Interest" Would Render Much of Section 10113.71 Surplusage

While the term "interest" can, in some circumstances, be susceptible to a broad interpretation, section 10113.71 makes clear that "interest" must indeed be read narrowly, since a broad reading would render much of the statute surplusage, contrary to basic principles of statutory interpretation. Section 10113.71(b)(1) provides a list of three groups who must receive notice of pending lapse. First, **owners**; second, **designees**; and third, **assignees** or "other persons having an interest." And yet, if "person having an interest" is to be read as meaning any person with any kind of right pertaining

to the policy, then that would absorb all of the other categories in this list – since owner, designee, and assignee would all fall into this category as well. Such a reading would render much of section 10113.71(b)(1) superfluous, militating against the directive that courts must "assume each term has meaning and appears for a reason." *Kulshrestha v. First Union Commercial Corp.*, 33 Cal. 4th 601, 611 (2004); *Delaney v. Superior Court*, 50 Cal. 3d 785, 799 (1990) (A "construction that renders a word surplusage should be avoided.").

Furthermore, the placement of "person having an interest" at the very end of the list, and attached to assignee, suggests the "interest" must be of the same nature as that of an assignee. If "person having an interest" was broad enough to entail any person with some kind of a right associated with the policy, it would make no sense to place the term as a seeming afterthought at the end of the third item of a list, as it is in section 10113.71. The very breadth and inclusiveness of the term would make such placement incongruous.

The Omission of "Person Having an Interest" From Section 10113.71(b)(3) Makes the Most Sense if the "Interest" is Very Closely Related to the Concept of Assignee

Section 10113.71(b)(3) (quoted above) describes how notice is to be conveyed. First, this subsection sets out how policy ***owners*** and ***designees*** are to be sent the notice (*i.e.*, by first class U.S. Mail), and then provides that "notices made to ***assignees*** pursuant to this section may be done electronically with the consent of the assignee." (Emphasis added). So how are persons "having an interest" to be provided notice? The statute does not say. If "person having an interest" was to be read broadly, it would be incongruous not to indicate how notice to this category was to be provided. However, if person "having an interest" is merely a subcategory of, or is similar in type to, assignee, then this omission makes sense. *See The Internat. Brotherhood of Boilermakers, etc. v. NASSCO Holdings Inc.*, 17 Cal. App. 5th 1105, 1122 (2017) (when a legislature omits language from a statute, that omission also has meaning.)

This reading is further supported by the California Supreme Court in *McHugh*, which describes 10113.71(b)(1) as providing "that notice of pending lapse and termination 'shall not be effective unless mailed by the insurer' to the policy owner, a designee, and a known assignee 'at least 30 days prior to the effective date of termination.'" *McHugh, supra*, 12 Cal. 5th at 237-238. The Court's total omission of "a person having an interest" again supports the notion that such an interest must be read to be very similar in type to that of an assignee.

The Structure of the Statute Supports the Notion That the "Interest" Must Be Similar in Type to an Assignee

The structure and punctuation of the statute likewise suggest that "person having an interest" must be read narrowly, and that it be interpreted as similar in type to an assignee. *United States Nat'l Bank v. Independent Ins. Agents of Am.*, 508 U.S. 439, 455 (1993) (eschewing isolated words or sentences in favor of "a statute's full text, language as well as punctuation, structure, and subject matter"). In particular, the use of the comma, setting assignee and "persons having an interest" together conjoined by the word "or" suggests that the "interest" must be similar in type to assignee. *People ex rel. Gwinn v. Kothari,* 83 Cal. App. 4th 759, 768 (2000) ("Commas are used to separate items in a list. [citation omitted]. Their presence or absence in a statute is a factor to be considered in its interpretation.")

The legislative history supports this interpretation, since the California Legislature specifically eliminated the comma that ***originally*** stood between "assignee" and "person having an interest." After having initially designating "assignee" and "person having an interest" as separate categories in a list (in the April 26, 2012 version), the Legislature joined them as a single category (in the May 9, 2012 version). *Berry v. American Express Publishing, Inc.*, 147 Cal. App. 4th 224, 230 (2007)("The evolution of a proposed statute after its original introduction in the Senate or Assembly can offer considerable enlightenment as to legislative intent.... [C]ourts must not interpret a statute to include terms the Legislature deleted from earlier drafts."); *Jimeno v. Mobil Oil Co.,* 66 F.3d 1514, 1530 (9th Cir. 1995)(giving "substantial weight to" deletions "during the drafting stage" of legislation, since "the fact that the Legislature specifically considered and rejected a provision 'is most persuasive to the conclusion that the act should not be construed to include the omitted provision.'")

All of this supports the idea that the "interest" of a "person having an interest" under section 10113.71 must be narrow, and similar in type to that of an assignee.

Purposes Behind Sections 10113.71 and 10113.72 Support this Reading

All of this supports the idea that the "interest" of a "person having an interest" under section 10113.71 must be narrow, and similar in type to that of an assignee. An "assignment" is "[a] transfer or making over to another of the whole of any property, real or personal, in possession or in action, or of any estate or right therein. It includes transfers of all kinds of property, including negotiable instruments." Black's Law Dictionary, 6th Ed. "[B]y an assignment the assignor parts with the whole property and the assignee stands, to all intents and purposes, in the place of the assignor." *Higgins v. Monckton*, 28 Cal. App. 2d 723, 728 (1938). The assignment of a life policy is defined as "[t]he formal transfer of a life insurance policy from the assured to another person." *Equitable Life Assurance Soc. v. Arnold*, 27 F. Supp. 360, 363 (D. Mass. 1939). "[U]nderscoring the 'absolute and complete nature' of an assignment,... upon assignment, the rights of the assignor become vested in the assignee and the debtor is justified in paying the assignee, not the assignor, on the assigned claim." *In re Lewis*, 157 B.R. 555, 562-563 (Bankr. E.D.

Pa. 1993); *see also, Holywell Corp. v. Smith*, 503 U.S. 47, 54 (1992).

Sections 10113.71 and 10113.72 were enacted to protect and further the rights of policy owners – that is, those with an interest in the policy itself, not merely in the policy benefits. Section 10113.71(b) provides that owners, those designated by owners, and assignees (i.e., those assigned the rights of a policyholder) receive notice. Section 10113.72 requires insurers to annually notify "policy owner[s]" of their right to update and change their third-party notice designation. Indeed, in earlier versions of the bill, the term "insured" stood in the wherever "policy owner" appears now. However, the fifth (June 19, 2012) version of the bill specifically eliminated the term "insured," replacing it with the term "policy owner." Additionally, the analysis prepared for the Senate Committee on Insurance, dated June 13, 2012, described the purpose of the bill as follows (emphasis added):

> To provide consumer safeguards from which ***people who have purchased life*** insurance coverage, especially seniors, would benefit....The protections provided by AB 1747 are intended to make sure that ***policy owners*** have sufficient warning that their premium may lapse due to nonpayment.

In its Background Information Sheet, the Assembly Committee on Insurance gave background on the bill (emphasis added):

> This bill provides consumer safeguards from which ***people who have purchased life insurance coverage***, especially seniors, would benefit....

Again, the primary purpose of this statute is not to extensively expand the scope of those who receive notice of pending lapse, but to provide protections to "policyholders" or those "who have purchased life insurance coverage."

> Likewise, as explained in *McHugh, supra* at 224, the benefit of a notice provision is that it "protects ***policy owners*** from losing coverage due to their neglect." *Id*. at 224(emphasis added). "A grace period offers an obvious benefit to ***policy owners***: time to pay a missed premium without an interruption in coverage." *Id*. at 224 (emphasis added). "Section 10113.72 requires life insurance policies to ***grant policy owners*** the right to designate at least one other person to receive a notice of an overdue premium and impending lapse or termination of the policy." *Id*. at 226 (emphasis added). In short, it is clear from the statute, the legislative history, and the case law, that the primary purpose of sections 10113.71 and 10113.72 was to provide additional protection and rights to policy holders. Such rights were ensured by giving them the right to designate a person to receive notice, and by similarly protecting the rights of assignees (i.e., persons assigned ownership interest in the policy).

It therefore follows, for all of the above reasons, that the "interest" of a "person having an interest" must be similar in type to that of an assignee's – i.e., some type of transferee of the ownership interest in the policy. Indeed, there are multiple ways in which such an interest can pass other than by assignment. Under California law, "life or disability policy may pass by transfer, will or succession to any person, whether or not the transferee has an insurable interest." Cal. Ins. Code § 10130. "An insurance policy in legal contemplation is property, which can be sold, assigned or bequeathed by the owner thereof." *Estate of Sears*, 182 Cal. App. 2d 525, 530 (1960). Section 10130 gives an "assignee rights to any proceeds of the insurance policy superior to the rights of the named beneficiary, during the life of the assignment." *Esswein v. Rogers*, 216 Cal. App. 2d 91, 92 (1963). In this manner, there are multiple ways a person can obtain an interest similar in type to an assignee. The clearest reading of section 10113.71(b) is that a "a known assignee or other person having an interest in the individual life insurance policy" must fall within this category. Examples of such persons "having an interest" would thus be those who were bequeathed the policy in a will, those to whom the policy passed by succession, and those who received the policy by some other form of transfer -- as well as those who were assigned the policy.

In an Unpublished Ruling, California Court of Appeal has Determined Person with an "Interest" Must Be Similar to an Assignee

The California Court of Appeal adopted reasoning similar to that proposed above in the unpublished decision *Rosen v. Pac. Life Ins. Co*., 2017 Cal. App. Unpub. LEXIS 6770 (2017), when it addressed the question of whether a beneficiary was deemed an "other person having an interest" within the meaning of section 10113.71(b). As the Court explained:

> In construing the phrase "other person having an interest in the individual life insurance policy," we begin with context. The phrase appears in the following list: "the named policy owner, a designee named pursuant to Section 10113.72 for an individual life insurance policy, and a known assignee or other person having an interest in the individual life insurance policy."

As the Court observed, each item on the list

> is conjoined by "and," with the interested-person phrase being linked to "assignee" by "or." This suggests the "interest" in question is similar in nature to an assignee. That reading is confirmed by section 10113.71, subdivision (b)(3), which provides that owners and designees are to receive notices by first class mail, but "notices made to assignees pursuant to this section may be done electronically with the consent of the assignee," with no mention of interested persons.

Indeed, "[t]he fact that the Legislature did not feel the need to repeat the interested-person phrase suggests it is close enough in nature to an assignee to not require repetition." *Id*.

Based on this, the Court determined that beneficiaries are not entitled to notice under section 10113.71. As the *Rosen* court noted, "'[a] life or disability policy may pass by transfer, will or succession to any person, whether or not the transferee has an insurable interest. Such transferee may recover upon it whatever the insured might have recovered.' (§ 10130.) 'An insurance

policy in legal contemplation is property, which can be sold, assigned or bequeathed by the owner thereof.' (*Chase v. Leiter* (1950) 96 Cal. App. 2d 439, 456, 215 P.2d 756.)" In other words, the *Rosen* court concluded, "[g]iven the variety of ways rights to a life insurance contract may be transferred, the interested-person phrase provides meaning ***by covering transfers akin to an assignment.***" *Id.* at *8 (emphasis added).

Conclusion

Doubtless, contention and litigation will continue to arise in the interpretation of sections 10113.71 and 10113.72 of the California Insurance Code. The *McHugh* litigation itself, now on remand, is still hotly contested, and ancillary questions are working their way through the courts. The question of what constitutes an "interest" under section 10113.71(b) will likewise continue to find its way back to the courts. When that happens, the courts should adopt the narrow interpretation espoused in *Rosen* and described above. Anything more inclusive threatens to upend the statutory framework, render much of the statute surplusage, and negate the clear intent of the legislature in passing these statutes. Sections 10113.71 and 10113.72 were primarily meant to protect those with an interest in the policy itself, not merely in the proceeds of the policy. This is why the statute limits the notice requirements to owners, designees, and assignees. It is evident that the addition of the term "person having an interest" was included only to make sure that those with interests similar to those of an assignee are protected. It was not meant to impose on insurers an open-ended obligation to provide notice to any person who could claim some inchoate "interest" in the policy proceeds.

Navigating The Interpleader Process

By Heather J. Austin

Practices and procedures will vary from court to court. However, there are certain "best practices" that should be employed regardless of the jurisdiction.

It is difficult to conceive of a form of litigation that was intended to be less contentious (for the plaintiff, at least) than an Interpleader. Defined in the simplest terms by the Merriam-Webster Dictionary, "interpleader" is "a proceeding to enable a person to compel parties making the same claim against him to litigate the matter between themselves." The process "emerged in the fourteenth century" and has "evolved to become 'an affirmative remedy to be used against multiple claimants seeking relief upon a single obligation.'" *Wells Fargo Bank, N.A. v. Mesh Suture, Inc.*, 31 F.4th 1300, 1308 (10th Cir. 2022) (internal citations omitted).

Ideally, interpleader allows "the stakeholder to avoid 'the expense and risk of defending two actions.'" *Mesh Suture, Inc.*, 31 F.4th at 1309 (internal citations omitted). Historically, "the stakeholder avoided almost all expense because it was entitled to recover its attorney fees and costs." *Mesh Suture, Inc.*, 31 F.4th at 309 (citing *Mutual Life Ins. Co. of N.Y. v. Bondurant*, 27 F.2d 464, 465 (6th Cir. 1928)). In addition to a myriad of state laws that allow for interpleader relief, "[t]oday, the interpleader procedure can be pursued in federal court under two different provisions," specifically rule interpleader and statutory interpleader, "which differ somewhat in practice and benefit." *See AmGuard Ins. Co. v. SG Patel & Sons II LLC*, 999 F.3d 238, 244 (4th Cir. 2021). Both provisions "recognize and incorporate the history of equitable interpleader, including the fundamental distinction between strict interpleader ("in which the 'plaintiff' is neutral and therefore a stakeholder with no interest in the corpus at issue") and actions in the nature of interpleader ("in which the 'plaintiff' claims an interest in all or part of the corpus"). *See AmGuard*, 999 F.3d at 245.

Rule Interpleader v. Statutory Interpleader

Rule Interpleader

Federal Rule of Civil Procedure 22 authorizes an action in Interpleader, stating:

> (a) Grounds.
>
> (1) By a Plaintiff. Persons with claims that may expose a plaintiff to double or multiple liability may be joined as defendants and required to interplead. Joinder for interpleader is proper even though:
>
> (A) the claims of the several claimants, or the titles on which their claims depend, lack a common origin or are adverse and independent rather than identical; or
>
> (B) the plaintiff denies liability in whole or in part to any or all of the claimants.
>
> (2) By a Defendant. A defendant exposed to similar liability may seek interpleader through a crossclaim or counterclaim.
>
> (b) Relation to Other Rules and Statutes. This rule supplements—and does not limit—the joinder of parties allowed by Rule 20. The remedy this rule provides is in addition to—and does not supersede or limit—the remedy provided by 28 U.S.C. §§ 1335, 1397, and 2361. An action under those statutes must be conducted under these rules.

Rule Interpleader is only available when federal jurisdiction is otherwise established. *See, e.g., AmGuard*, 999 F.3d 238, 244; *Guardian Life Ins. Co. of Am. v. Gonnella*, 806 F. App'x 79, 81 (3d Cir. 2020). For example, Rule 22 interpleader of competing claims for benefits owed under an ERISA-governed plan is appropriate

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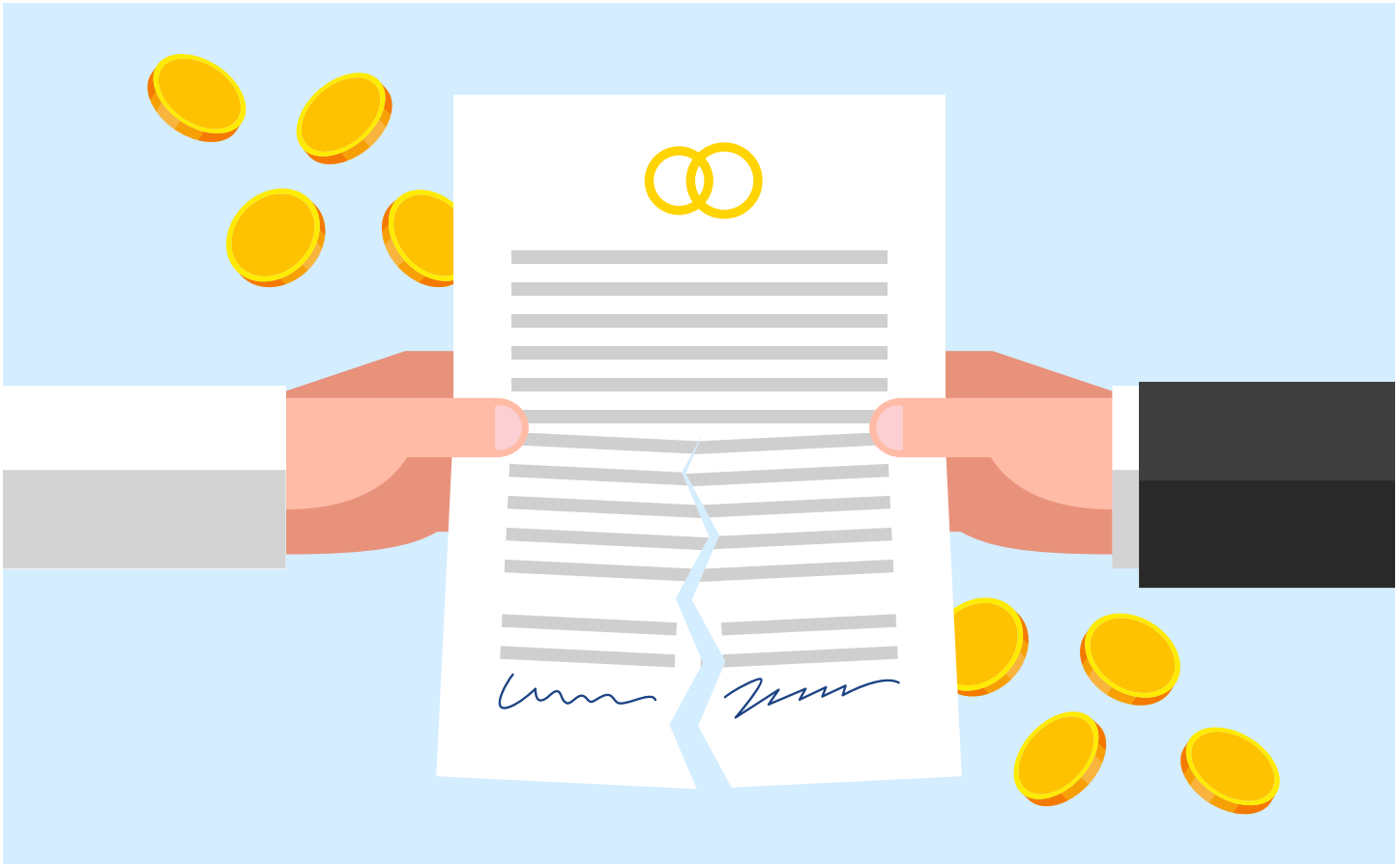

based on the presence of a federal question. *See* 29 U.S.C. §1132(d). *See also Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000) ("[W]e hold that interpleader is a cognizable action under ERISA section 1132(a)(3)(B)(ii)). An interpleader plaintiff may also "invoke rule interpleader under a court's diversity jurisdiction, which requires complete diversity of citizenship between all plaintiffs and defendants and an amount in controversy exceeding $75,000." *AmGuard*, 999 F.3d 238, 244 (citing 28 U.S.C. § 1332). A prudent practitioner will plead both federal question and diversity jurisdiction, if applicable, and when proceeding under Rule 22.

Statutory Interpleader

Statutory Interpleader provides a less onerous path to federal court. Pursuant to 28 USC §1335:

> (a) The district courts shall have original jurisdiction of any civil action of interpleader or in the nature of interpleader filed by any person, firm, or corporation, association, or society having in his or its custody or possession money or property of the value of $500 or more, or having issued a note, bond, certificate, policy of insurance, or other instrument of value or amount of $500 or more, or providing for the delivery or payment or the loan of money or property of such amount or value, or being under any obligation written or unwritten to the amount of $500 or more, if
>
> (1) Two or more adverse claimants, of diverse citizenship as defined in subsection (a) or (d) of section 1332 of this title [28 USCS § 1332], are claiming or may claim to be entitled to such money or property, or to any one or more of the benefits arising by virtue of any note, bond, certificate, policy or other instrument, or arising by virtue of any such obligation; and if
>
> (2) the plaintiff has deposited such money or property or has paid the amount of or the loan or other value of such instrument or the amount due under such obligation into the registry of the court, there to abide the judgment of the court, or has given bond payable to the clerk of the court in such amount and with such surety as the court or judge may deem proper, conditioned upon the compliance by the plaintiff with the future order or judgment of the court with respect to the subject matter of the controversy.
>
> (b) Such an action may be entertained although the titles or claims of the conflicting claimants do not have a common origin, or are not identical, but are adverse to and independent of one another.

Unlike §1332 diversity jurisdiction, which again requires completely diverse citizenship of the *plaintiffs and defendants*, diversity is established for purposes of §1335, in relevant part, if there exists two or more *adverse claimants* of diverse citizenship. *Compare* 28 U.S.C. § 1332, *with* §1335. In a strict interpleader action, this will require a showing that the defendants are of diverse citizenship because the stakeholder's neutrality makes its

citizenship a non-factor. But in an action *in the nature of* interpleader, §1335 diversity may be established by showing that the plaintiff and the defendants are of diverse citizenship.

When, in addition to facing competing claims to a common fund from multiple claimants, a stakeholder denies that all or part of the fund is payable to anyone, the stakeholder may file an action in the nature of interpleader. Rule 22(a)(1)(B) specifically allows for interpleader where "the plaintiff denies liability in whole or in part to any or all of the claimants." Similarly, 28 USC §1335 allows both an action in interpleader and an action in the nature of interpleader. In the latter, "the plaintiff is not merely a stakeholder but also has an interest in the money or property, and it may initially deny whether some or all of the property is owed to any or all claimants." *AmGuard*, 999 F.3d 238, 244.

In *Charles Schwab & Co. v. Gomez*, Nos. 21-1344, 21-2531, 2022 U.S. App. LEXIS 4698, at *4 (7th Cir. Feb. 22, 2022), Felipe Gomez "principally argue[d] that the district court lacked authority to proceed under 28 U.S.C. § 1335, the interpleader statute… because in his view…the two defendants are not 'adverse' in the way that §1335 requires. But Felipe did not argue that he and his son, the other defendant, were not diverse from Schwab, just as §1332 (rather than §1335) requires" and "the amount in controversy—$300,000—is well above the statutory minimum". *Id.* at *4. Therefore, the court had diversity jurisdiction pursuant to §1332 and a Rule 22 action was appropriate.

But, in *AmGuard*, the court considered whether §1335 "statutory interpleader's requirement of minimal diversity among adverse claimants can be satisfied when the defendants named in the interpleader are citizens of the same State but the plaintiff that commenced the action is a citizen of a different State and alleges an interest in the property". *AmGuard*, 999 F.3d 238, 245. Rejecting the analysis of several district courts that "answered in the negative," the court in *AmGuard* concluded "that the better reasoned position is that an interpleader plaintiff's citizenship may be considered to satisfy §1335's minimal diversity requirement when the action is in the nature of interpleader." *AmGuard*, 999 F.3d 238, 245-246 (rejecting *Am. Fam. Mut. Ins. Co. v. Roche*, 830 F. Supp. 1241, 1246-49 (E.D. Wis. 1993); *Travelers Ins. Co. v. Harville*, 622 F. Supp. 68, 69 (S.D. Ala. 1985)) (additional citations omitted).

Because §1335 uses the term "plaintiff" rather than "stakeholder," the court in *AmGuard* concluded that distinct roles were anticipated. *See AmGuard*, 999 F.3d 238, 246. "[W]hen an interpleader plaintiff claims no interest in the corpus, it functions in the traditional role of stakeholder." *AmGuard*, 999 F.3d at 246. However, "when the plaintiff claims an interest in all or part of the corpus — as is the case in an action in the nature of interpleader — it stands in conflict or 'controversy' with the other claimants to the corpus such that the plaintiff and the defendant-claimants are adverse." *AmGuard*, 999 F.3d at 246. "Thus, when § 1335 confers jurisdiction on federal courts for controversies among 'adverse claimants, of diverse citizenship,' the term 'adverse claimants' includes a plaintiff who has an interest in the corpus, making its interest adverse to the other claimants." *AmGuard*, 999 F.3d at 246.

To support its holding, the court in *AmGuard* relied on *Treinies v. Sunshine Mining Co.*, 308 U.S. 66 (1939). In *Treinies*, the Supreme Court held that the plaintiff's citizenship is irrelevant in a strict interpleader action because the "deposit and discharge effectually demonstrates the applicant's disinterestedness as between the claimants and as to the property in dispute." *Id.* at 72. However, the corollary, according to *AmGuard*, is also suggested: "that an *interested* plaintiff's citizenship is relevant, as the plaintiff is not disinterested in the money or property deposited with the court." *AmGuard*, 999 F.3d 245, 246-247.

Good Faith Fear of Colorable Adverse Claims

Although interpleader actions are designed to relieve a stakeholder of the burden of protracted litigation, disputes still arise, and they can begin with early challenges to the plaintiff's right to interplead. In *New York Life Insurance Co. v. Lee*, 232 F.2d 811 (9th Cir. 1956), the court stated "[t]here is no doubt... that an asserted adverse claim may be so wanting in substance that interpleader under the statute may not be justified." *Id*, at 813 (citing *John Hancock Mut. Life Ins. Co. v. Beardslee*, 216 F.2d 457, 460 (7th Cir. 1954)).

In *Michelman v. Lincoln National Life Insurance Co.*, 685 F.3d 887, 894 (9th Cir. 2012), the court "expressly h[e]ld that in order to avail itself of the interpleader remedy, a stakeholder must have a good faith belief that there are or may be colorable competing claims to the stake" and stated that "[t]his is not an onerous requirement." (Internal citations omitted). According to *Michelman*, "[t]he threshold to establish good faith is necessarily low so as not to conflict with interpleader's pragmatic purpose, which is 'for the stakeholder to 'protect itself against the problems posed by multiple claimants to a single fund.'" *Id.* at 894 (internal citations omitted).

The stakeholder need not make a determination regarding the underlying merits of the claim. To the contrary, "[i]n an interpleader action, the stakeholder is often neutral as to the outcome". *Philippines v. Pimentel*, 553 U.S. 851, 854, 128 S. Ct. 2180, 2184, 171 L.Ed.2d 131, 131 (2008). "[G]ood faith requires a real and reasonable fear of exposure to double liability or the vexation of conflicting claims." *Michelman*, 685 F.3d 887, 894 (citing *Union Cent. Life Ins. Co. v. Hamilton Steel Prods., Inc.*, 448 F.2d 501, 504 (7th Cir. 1971); *Wash. Elec. Co-op., Inc. v. Paterson, Walke & Pratt, P.C.*, 985 F.2d 677, 679 (2d Cir. 1993)).

Although interpleader actions are designed to relieve a stakeholder of the burden of protracted litigation, disputes still arise

"[T]o support an interpleader action, the adverse claims need attain only 'a minimal threshold level of substantiality.'" *Equitable Life Assurance Soc'y of the U.S. v. Porter-Englehart*, 867 F.2d 79, 84 (1st Cir. 1989). "It is not necessarily the 'likelihood of duplicative liability,' but rather the 'threat

of possible multiple litigation,' that justifies resort to interpleader." *Sevelitte v. Guardian Life Ins. Co. of Am.*, 55 F.4th 71, 80 (1st Cir. 2022) (internal citations omitted). From a commonsense perspective, the court in *Michelman*, explained that "[o]f course, the claims of some interpleaded parties will ultimately be determined to be without merit" and "it would make little sense in terms either of protecting the stakeholder or of doing justice expeditiously to dismiss one possible claimant because another possible claimant asserts the claim of the first is without merit." *Michelman*, 685 F.3d at 894-95. However, "[t]he adverse claim—whether actual or potential—must be at least colorable." *Michelman*, 685 F.3d at 895 (citing *Fonseca v. Regan*, 734 F.2d 944, 948-50 (2d Cir. 1984); *Dunbar v. U.S.*, 502 F.2d 506, 511 (5th Cir. 1974); *Bauer v. Uniroyal Tire Co.*, 630 F.2d 1287, 1292 (8th Cir. 1980)). *See also Minnesota Mutual Life Ins. Co. v. Ensley* 174 F.3d 977 (9th Cir. 1999); *Mack v. Kuckenmeister*, 619 F.3d 1010 (9th Cir. 2010) (citing *John Hancock Mut. Life Ins. Co. v. Kraft*, 200 F.2d 952, 954 (2d Cir. 1953)). "[T]he threshold showing is not exacting." *Michelman*, 685 F.3d at 896.

While, as discussed below, there are circumstances under which interpleader has been deemed inappropriate, a stakeholder is well advised to interplead as soon as it has knowledge of competing claims. Waiting until after a claimant initiates litigation is neither necessary nor advised, as both rule and statutory interpleader "may be invoked not only when claimants have already made a claim to the stakeholder's property but also when the claimants may make such a claim in the future." *AmGuard*, 999 F.3d at 245 and 248 (citing *California v. Texas*, 457 U.S. 164, 166 n.1, 102 S. Ct. 2335, 72 L. Ed. 2d 755 (1982) (per curiam) (emphasis added) (cleaned up) (quoting *Texas*, 306 U.S. at 406)) ("the Supreme Court has consistently held that 'to bring an interpleader suit, "a plaintiff *need not await institution of independent suits*"'"). *See also Lexington Ins. Co. v. Jacob Indus. Maint. Co.*, 435 F. App'x 144 (3d Cir. 2011).

Although the plaintiff's burden of proving colorable adverse claims is not significant, it was long ago established that the burden should not be ignored. The insured in *Beardslee* changed the beneficiary designation on several occasions, alternating between his children and his wife. When, the insured sought again, to change the designation to his daughters, they were told by the insurer that the designation could not be changed. The representation was inaccurate, and as a result, the insured's wife remained the named beneficiary when he died. The insured's daughter asked that the insurer cover the cost of the medical and burial expenses that had been incurred – an amount that was approximately the same as the value of the policy. She referred to the insurer's inaccurate representation as justification for the request. The insurer responded by initiating an interpleader action. *Beardslee*, 216 F.2d 457.

The insured's daughter never appeared in the interpleader and default judgment was entered against her at the request of the insured's surviving wife. The insurer appealed to the Seventh Circuit Court of Appeals after the district court not only entered judgment in favor of the wife but also assessed fees against the insurer due to the delay caused in paying the proceeds. The Seventh Circuit affirmed the judgment of the district court in relevant part, concluding that the insured's daughter had no viable claim to the policy proceeds. Rather, the daughter's only potential claim was against the insurer in relation to the misinformation provided prior to her father's death. Even if the insured's daughter prevailed on a tort claim against the insurer, the insured's daughter would not be entitled to the policy proceeds. The insurer had no reasonable fear of multiple and competing claims to the policy proceeds and interpleader was therefore inappropriate. *Id.*

Relative to the insured's wife's fee claim, however, the Seventh Circuit held that "[s]ince [the insured's daughter] was not a claimant within the meaning of the Interpleader Act, the District Court properly found that the delay by the company in paying the proceeds of the policy to [the insured's wife] was vexatious and unreasonable, and that she was, therefore, entitled to recover reasonable attorney's fees as part of the costs of the action" as well as interest. *Id.* at 461. Other courts have also determined that fees may be assessed against a stakeholder that acts in bad faith when initiating an interpleader action. *See Michelman v. Lincoln Nat'l Life Ins. Co.*, 685 F.3d 887, 893-96 (9th Cir. 2012) (citing *Gelfgren v. Republic Nat'l Life Ins. Co.*, 680 F.2d 79, 81 (9th Cir. 1982) (citing *Murphy v. Travelers Ins. Co.*, 534 F.2d 1155, 1164 (5th Cir. 1976))).

Interpleader Will Not Alter Substantive Rights

"Interpleader is a procedural device not intended to alter substantive rights. It is not the function of an interpleader rule to bestow upon the stakeholder immunity from liability for damages that are unrelated to the act of interpleading, such as negligence in preserving the fund." 44B Am Jur 2d Interpleader § 4. The Supreme Court addressed this issue in *State Farm Fire & Casualty Co. v. Tashire*, 386 U.S. 523, 87 S. Ct. 1199, 18 L. Ed. 2d 270 (1967), where the insurer of a truck driver (who was a citizen of Oregon) initiated an interpleader action in federal court in Oregon when its insured was involved in a motor vehicle accident in California with a bus carrying passengers (including citizens of five states and Canada).

The insurer anticipated that pending tort claims, if successful, would result in damage assessments that would exceed the limits of its liability under the policy. The insurer, therefore, deposited the funds into the court's registry and sought an order relieving it of any further liability. The insurer specifically asked that the court require all claimants to proceed against the driver and the carrier in a single proceeding and that it be discharged from any further obligations under the policy, including the defense of the driver in any other lawsuits. The district court granted the relief requested. On appeal, the Ninth Circuit held that the insurer was not entitled to interpleader relief unless and until a judgment was entered against the tortfeasor; however, the Supreme Court disagreed, in part, reasoning instead that: "[w]ere an insurance company required to await reduction of claims to judgment, the first claimant to obtain such a judgment or to negotiate a settlement might appropriate all or a disproportionate slice of the fund before his fellow claimants were able to establish their claims" and that "[t]he difficulties such a race to judgment pose

for the insurer, and the unfairness which may result to some claimants, were among the principal evils the interpleader device was intended to remedy. *Id*. at 533, 87 S. Ct. at 1205, 18 L.Ed.2d at 277.

While State Farm "properly invoked the interpleader jurisdiction under §1335," the Supreme Court concluded that the statute did not "entitle it to an order both enjoining prosecution of suits against it outside the confines of the interpleader proceeding and also extending such protection to its insured, the alleged tortfeasor." *Id*. at 533, 87 S. Ct. at 1205, 18 L.Ed.2d at 277. The court "h[e]ld that the interpleader statute did not authorize the injunction entered in the present case." *Id*. at 537, 87 S. Ct. at 1207, 18 L.Ed. at 279. The court reasoned that "[t]hirty-five passengers or their representatives have claims which they wish to press against a variety of defendants" and "[t]he circumstance that one of the prospective defendants happens to have an insurance policy is a fortuitous event which should not of itself shape the nature of the ensuing litigation." *Id*. at 534-35, 87 S. Ct. at 1205-06, 18 L.Ed. at 277-78. There was nothing, for example, in the interpleader statute that could compel a California resident who was injured aboard a bus in California to file suit anywhere other than California. *Id*. at 534-35, 87 S. Ct. at 1205-06, 18 L.Ed. at 277-78.

The Risk of Delaying Interpleader of Colorable Claims

The need to ensure that there exists colorable competing claims should be weighed against the risk of delay or failure to file an interpleader. The stakeholder will want to win any race to the courthouse to avoid, for example, having to defend against baseless claims that (i) it seeks to delay payment of benefits otherwise payable or (ii) that it is not entitled to fees and costs that it could have sought if it had filed an action in interpleader.

In *Sevelitte v. Guardian Life Insurance Co. of America*, 55 F.4th 71, 81-82 (1st Cir. 2022), the plaintiff sued Guardian for an amount in excess of the death benefit at issue, arguing that Guardian "wrongfully instigated the dispute by '[seeking] and encourag[ing] the application for the beneficial interest by' the competing claimant. She alleged breach of contract and argued against the discharge of Guardian from the proceedings. As one might expect, a "stakeholder who has 'acted in bad faith to create a controversy over the stake may not claim the protection of interpleader.'" *Id*. at 81. However, in this case, the plaintiff "failed to plausibly allege any bad faith by Guardian," as the court concluded that Guardian never denied liability but merely sought to resolve an ambiguity created by a divorce agreement at issue by making the insured's estate aware of its potential claim and ultimately seeking interpleader." *Id*. at 81.

The court in *Sevelitte* acknowledged that "where the stakeholder may be independently liable to one or more claimants, interpleader does not shield the stakeholder from…liability in excess of the stake." *Id*. at 81 (internal citations omitted). However, "such liability must be 'truly independent' to prevent dismissal of the stakeholder." Id. at 81 (citing *Lexington*, 435 F. App'x 144, 148; *Berry v. Banner Life Ins. Co*., 718 F. App'x 259, 262 (5th Cir. 2018)). Such was not the case in *Sevelitte*, as there was no evidence that the defendant engaged in an unfair claim practice. *Id*. at 81. Similarly, in *Primerica Life Insurance Co. v. Woodall*, 38 F.4th 724, 725-27 (8th Cir. 2022), the district court granted summary judgment in favor of the plaintiff on a counterclaim filed by the claimants, finding that Primerica was not liable for initiating an interpleader. "The district court recognized that while Primerica's 'missteps' contributed to causing competing claims, there was no evidence Primerica acted in 'bad faith' or otherwise 'transgress[ed] equitable standards of conduct.'" *Id*. at 727. "The district court did not abuse its discretion when making this decision." *Id*. at 727.

When, as was the case in *Berry*, a claimant files suit first, the stakeholder may (if grounds exist) remove the matter to federal court. Recall, however, that most states have their own interpleader rules or statutes under which a stakeholder may proceed if there is no basis for removal. Additionally, "[t]he Federal Rules of Civil Procedure, including their joinder provisions, apply in interpleader cases just as they would in any other civil action in federal court." *N.Y. Life Ins. Co. v. Deshotel*, 142 F.3d 873, 881 (5th Cir. 1998) (internal citations omitted). Therefore, "[a] defendant exposed to similar liability may [also] seek interpleader through a crossclaim or counterclaim." Fed. R. Civ. P. 22(a)(2). Whether defending against a claim in state or federal court, the stakeholder should proceed by filing a counterclaim in interpleader and by joining (if necessary) and filing interpleader cross-claims against any and all other existing or potential claimants.

Procedural Considerations When Filing an Interpleader

Filing and Service of Process

Again, rule interpleader "can be invoked only when federal jurisdiction is otherwise established" by the existence of a federal question or diversity of citizenship. *AmGuard*, 999 F.3d 238, 244 (internal citation omitted). However, relative to statutory interpleader actions, 28 U.S.C. §1397 provides that "[a]ny civil action of interpleader or in the nature of interpleader under section 1335 of this title may be brought in the judicial district in which one or more of the claimants reside."

Once suit is filed, the interpleader plaintiff must satisfy certain requirements and consideration should be given to these obligations before the complaint is filed. The first is service of process. Federal Rule of Civil Procedure 4(m) imposes a "time limit for service" and states that "[i] f a defendant is not served within 90 days after the complaint is filed, the court – on motion or on its own after notice to the plaintiff – must dismiss the action without prejudice against that defendant or order that service be made within a specified time" and the court is only required to extend the time to perfect service upon a showing of good cause.

As explained above, it is not necessary to delay an interpleader until the claimants have already made a claim. *Lexington*, 435 F. Appx 144; *AmGuard*, 999 F.3d 238. Because interpleader is appropriate when the claimants *may* make such a claim in the future, it is possible that the plaintiff may not know the whereabouts of the potential claimants. This, for example, may occur when a child challenges a former spouse for life insurance benefits payable upon the death of the insured. If the child prevails, a portion of the benefit

may be subject to distribution to other surviving children who may not have asserted a claim. Their whereabouts may not be known. They may be located in a country subject to Hague Convention requirements. Language barriers may hinder communication efforts. Because these individuals will nonetheless need to be served within the 90-day deadline, pre-litigation investigation may be appropriate in order to ensure that the plaintiff can perfect service as required, move to extend the deadline or lay the groundwork for a due diligence argument that may be necessary for any motion for leave to perfect service by publication.

Obligation to Deposit of Funds

28 U.S.C. §1335, unlike Rule 22, imposes an affirmative obligation to deposit the interpleader funds with the Court or post bond. Statutory interpleader is permissible "if (2) the plaintiff has deposited such money or property or has paid the amount of or the loan or other value of such instrument or the amount due under such obligation into the registry of the court…, or has given bond payable to the clerk of the court." However, even when proceeding solely pursuant to Rule 22, a prudent practitioner will nonetheless deposit the interpleader funds with the court as soon as possible.

Failure to deposit the funds can create another point of contention in an otherwise simple interpleader action. In *United States Life Insurance Co. v. Holtzman*, 723 F. App'x 141 (3d Cir. 2018), Holtzman argued that the plaintiff was required to deposit the funds with the court *when the complaint was filed* in order to satisfy the requirements of 28 U.S.C. §1335. The district court allowed the plaintiff to cure the defect and perfect jurisdiction by depositing the funds, and on appeal, Holtzman argued that this delayed deposit was impermissible. The argument ignored the fact that, as a practical matter, the plaintiff was not procedurally able to deposit the funds when the complaint was filed. The Third Circuit Court of Appeals noted that "[u]nder the local rules, U.S. Life could not have deposited the funds absent a court order to do so." *Id*. at 145. Only "[o]nce U.S. Life responded to the Court's directive to deposit, the District Court had subject matter jurisdiction: its order discharging U.S. Life took effect, and it properly considered the merits of the adverse claims to the funds." *Id*. at 145.

The defendant in *Wells Fargo Bank, N.A. v. Mesh Suture, Inc.,* 31 F.4th 1300, 1308-11 (10th Cir. 2022) made a similar argument. However, the court "reject[ed] this challenge of Mr. Schwartz to the district court's jurisdiction. As we proceed to explain, it was sufficient for statutory-interpleader purposes that the district court appointed a receiver who, as ordered by the court, took possession of and managed the account." *Id*. at 1309. "Court-appointed receivers are officers of the court and may be empowered to assume the control, custody, and management of property involved in litigation." *Id*. at 1311 (internal citations omitted). "Here the district court secured possession of, and exclusive control over, the Wells Fargo account through its receiver. The disputed property was thereby deposited with the court, at its disposal, and ready to be distributed to the prevailing claimant. This was a sufficient deposit for the purposes of establishing statutory-interpleader jurisdiction." *Id*. at 1311.

Interpleader Relief: Discharge and Fees

An Action in Interpleader Will Proceed in Two Stages

Once the court accepts that the requirements for rule or statutory interpleader have been satisfied, the litigation will proceed to a second stage, during which the court will determine the respective rights of the claimants. *See Auto Parts Mfg. Miss., Inc. v. King Constr. of Houston, L.L.C.*, 782 F.3d 186, 193 (5th Cir. 2015) (citing *Rhoades v. Casey,* 196 F.3d 592, 600 (5th Cir. 1999)). *See also Guardian Life Ins. Co. of Am. v. Gonnella*, 806 F. App'x 79, 81 (3d Cir. 2020) (citing *Prudential Ins. Co. of Am. v. Hovis*, 553 F.3d 258, 262 (3d Cir. 2009)). "After entering a judgment in the interpleader action the district court also has the power to make all appropriate orders to enforce its judgment. 28 U.S.C. § 2361. The two-stage process applies to both rule and statutory interpleader proceedings. *See Metro. Life Ins. Co. v. Little*, No. 13 cv 1059 (BMC), 2013 U.S. Dist. LEXIS 116817, at *2 (E.D.N.Y. Aug. 17, 2013) (citing *New York Life Ins. Co. v. Connecticut Development Authority*, 700 F.2d 91 (2d Cir. 1983)).

Discharge

In an interpleader action the district court may also enter an order restraining the claimants from instituting any proceeding affecting the property until further order of the court." *Rhoades*, 196 F.3d 592, 600-01. However, statutory interpleader offers more expansive protections than Rule 22. Specifically, pursuant to 28 U.S.C. §2361, "[i]n any civil action of interpleader or in the nature of interpleader under section 1335…a district court may issue its process for all claimants and enter its order restraining them from instituting or prosecuting any proceeding in any State or United States court affecting the property, instrument or obligation involved in the interpleader action until further order of the court." The district court is further authorized, pursuant to 28 U.S.C. §2361, to "discharge the plaintiff from further liability, make the injunction permanent, and make all appropriate orders to enforce its judgment."

While such expansive relief is not provided for in Rule 22, some courts will nonetheless grant injunctive relief in a rule interpleader action. In *Unum Life Ins. Co. of Am. v. Smith*, No. 2:17-cv-489-WKW, 2018 U.S. Dist. LEXIS 53245, at *9-10 (M.D. Ala. Mar. 28, 2018), the court was "satisfied that, even in a rule interpleader case, it can afford the injunctive relief sought." Critical of courts that have ruled otherwise, the court in *Smith* wrote "these cases solely view the injunction through the lens of injunctions issued under 28 U.S.C. §2361 or even a Rule 65 restraining order. Re-litigation 'would be judicially wasteful and raise the possibility of inconsistent results' and 'would also defeat the purpose of the [plaintiff's] interpleader action.'" *Id*, at *11.

Fee Claims

"Although not required under the interpleader statute or the Federal Rules of Civil Procedure, '[i]t is well settled that a district court has the authority to award costs, including reasonable attorney's fees, in interpleader actions.'" *John Hancock Life Ins. Co. (U.S.A.) v. Estate of Wheatley*, No. 21-20508, 2022 U.S. App. LEXIS 25102, at *9 (5th Cir. Sep. 7, 2022). As noted above, interpleader cannot be used as a shield from liability for the stakeholder's own

misdeeds. "A district court can abuse its discretion by awarding attorneys' fees to an interpleader-plaintiff who is in 'substantial controversy with one of the claimants.'" *Id*. at *10. (citing *Rhoades v. Casey*, 196 F.3d 592, 603 (5th Cir. 1999)). Further, "where an interpleader-plaintiff is 'in part responsible for causing [the] litigation' and 'in part responsible for protracting [the] litigation,' a district court's award of fees is an abuse of discretion." *Id*. at *10 (citing *Royal Indem. Co*., 307 F. App'x at 806).

Absent any impropriety, relief in the form of fees "is generally available…, whether [interpleader] is statutory under 28 U.S.C. §1335 or a Rule 22 interpleader with other jurisdictional grounds." *See Metro. Life Ins. Co. v. Little*, No. 13 cv 1059 (BMC), 2013 U.S. Dist. LEXIS 116817, at *9 (E.D.N.Y. Aug. 17, 2013) (citing *Septembertide Pub., B.V. v. Stein and Day, Inc*., 884 F.2d 675 (2d Cir. 1989)). The factors used to assess a fee claim, however, vary by jurisdiction. *Compare Royal Indem. Co. v. Bates*, 307 F. App'x 801, 806 (5th Cir. 2009) (considering: "(1) whether the case is simple; (2) whether the interpleader-plaintiff performed any unique services for the claimants or the court; (3) whether the interpleader-plaintiff acted in good faith and with diligence; (4) whether the services rendered benefited the interpleader-plaintiff; and (5) whether the claimants improperly protracted the proceedings"), *with Septembertide*, 884 F.2d 675, 683 (considering if: the plaintiff is "(1) a disinterested stakeholder, (2) who had conceded liability, (3) has deposited the disputed funds into court, and (4) has sought a discharge from liability").

Successful fee claims are not generally assessed against any individual claimant but are instead recovered from the fund. *See Septembertide*, 884 F.2d 675, 683. Where all of the factors weigh in favor of the plaintiff, the court may still deny an otherwise reasonable fee request if it will deplete the fund. *See, e.g., Travelers Indemnity Company v. Israel*, 354 F.2d 488, 490 (2d Cir. 1965) ("We are not impressed with the notion that whenever a minor problem arises in the payment of insurance policies, insurers may, as a matter of course, transfer a part of their ordinary cost of doing business to their insureds by bringing an action for interpleader"). *See also Unum Life Ins. Co. of Am. v. Scott*, No. 3:10CV00538 (DJS), 2012 U.S. Dist. LEXIS 8869, at *7-8 (D. Conn. Jan. 24, 2012) ("Such is a cost of doing business which should not be transferred by invoking interpleader. Conflicting claims to the proceeds of a policy are inevitable and normal risks of the insurance business. Interpleader relieves the insurance company of multiple suits and eventuates in its discharge. Accordingly, the action is brought primarily in the company's own self-interest"). *But see Locals 40, 361 & 417 Pension Fund & v. McInerney*, 2007 U.S. Dist. LEXIS 1974, at *17 (S.D.N.Y. Jan. 9, 2007) (awarding reasonable fees to the plaintiff); *Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000); *Principal Life Ins. Co. v. Brooks*, No. 1:19-CV-00450, 2020 U.S. Dist. LEXIS 111435, at *8 (M.D. Pa. June 25, 2020) ("Fees and costs are appropriate because Principal is a disinterested stakeholder that has conceded liability under the policy and has sought discharge from further liability").

The amount of fees is also within the discretion of the court. In *Crew Inc. v. Walker*, No. 5:20-cv-01946-SVW-SP, 2022 U.S. Dist. LEXIS 25463, at *33 (C.D. Cal. Jan. 6, 2022), the plaintiff requested $205,000 in fees. The court awarded fees but substantially reduced the amount to $15,000, writing that even this amount is "generous to Crew." *Id*. at *32. "Crew's complaint was a relatively-short ten page complaint, which was unlikely to have required extensive research or analysis for an experienced ERISA firm". *Id*. at *32. Additionally, "Crew did not face any difficulties in service of process." *Id*. at *32. Crew also, "at no point filed an order seeking to discharge it from liability and dismiss it from the action; rather, Crew waited to do so until filing the instant motion, months after the case itself had been resolved." *Id*. at *32-33. Crew also cited "no persuasive authority for the proposition that its requested fee award of nearly $205,000 is reasonable on this record." *Id*. at 833 (stating that the decision was "consistent with relevant authorities' treatment of fees awarded to plaintiffs-in-interpleader" and citing *Schirmer Stevedoring Co. v. Seaboard Stevedoring Corp*., 306 F.2d 188, 190 (9th Cir. 1962) (remand with instruction to reduce a $48,000 fee award to $5,000); *Prudential Ins. Co. v. Boyd*, 781 F.2d 1494 (11th Cir. 1986 (awarding $1,300 from a $63,000 fund at issue); *In re Technical Equities Corp*., 163 B.R. 350, 360-361 (Bkrtcy. N.D. Cal. 1993 (collecting cases)).

The need to ensure that there exists colorable competing claims should be weighed against the risk of delay or failure to file an interpleader.

Conclusion

As noted above, in addition to the federal rule and statutory interpleader authority, many states have their own interpleader rules and statutes. Practices and procedures will vary from court to court. However, there are certain "best practices" that should be employed regardless of the jurisdiction. First, when presented with competing claims or when made aware of the potential for colorable competing claims, interplead and do so without delay. Simultaneously move to deposit the funds with the court – especially when pursuing statutory interpleader relief, as an order granting leave to deposit will likely be required. A reasonable fee claim may also be presented; however, before proceeding, consider whether such a motion would be futile (*i.e*., if the courts in your jurisdiction deem interpleader to be a cost of doing business). As some courts will not allow for any fee recovery and other courts will substantially reduce fee award requests, it is prudent to limit the fees incurred by seeking discharge as early as practicably possible.

Reading the Tea Leaves

Determining a Former Spouse's Entitlement to Life Insurance Proceeds

By Charan M. Higbee and Jodi K. Swick

Everyone desires to have their financial affairs in order when they die. Yet, this often is not the case.

Everyone desires to have their financial affairs in order when they die. Yet, this often is not the case. A prime example is a deceased insured's life insurance beneficiary. People frequently fail to change their insurance beneficiary designation after divorce. This single issue has caused much litigation and forced courts to examine whether the insured intended a former spouse to receive their life insurance proceeds.

In the last 25 years, state legislatures have stepped in to declare the insured's presumed intent was to remove the former spouse as their beneficiary. More than half the states have enacted "revocation-on-divorce" statutes. Consistent with the name, these statutes automatically remove the former spouse as an insured's life beneficiary and require no action by the newly divorced insured. The remaining states look to common law to resolve this thorny issue with many courts deeming the insured's failure to change the beneficiary as evidencing an intent to keep the former spouse as the policy beneficiary.

With or without a revocation-on-divorce statute, a myriad of legal issues arise when an insured dies and the ex-spouse remains the designated beneficiary. Courts are called to review and interpret the terms of marital property agreements and decide whether the former spouse's future interest in a life insurance benefit was expressly released. Courts also have been asked to determine whether a particular revocation-on-divorce statute has retroactive application to policies issued or divorces entered prior to enactment of the law. Choice of law problems additionally may emerge when a divorce is entered in one state and the insured dies in another.

There often is no easy answer when a former spouse remains the designated policy beneficiary and the deceased insured's new spouse, children, or estate make a claim to policy benefits. Applicable state laws and cases must be considered along with any specific divorce decree or property settlement agreement. Each spouse's state of domicile, before and after divorce, also can come into play. Claims and legal personnel should work together before paying any benefit. In the end, an interpleader may be the safest course of action.

State courts and legislatures seek to uphold the insured's presumed intent.

In the United States, common law rules have long existed to resolve estate litigation in a way that conforms to a decedent's presumed intent, including as to a testamentary bequest to a former spouse. *See Sveen v. Melin*, 138 S.Ct. 1815, 1819 (2018). Yet, traditionally "[a]t common law, divorce did not alter the beneficiary designation of an ex-spouse" as to life insurance. *See Sevelitte v. Guardian Life Ins. Co. of America*, 55 F.4th 71, 75 (1st Cir. 2022). Over time, and with divorce becoming more widespread, states began enacting statutes to codify the presumed intent of a decedent who dies without changing a will or life insurance beneficiary designation after divorce. "So-called revocation-on-divorce statutes treat an individual's

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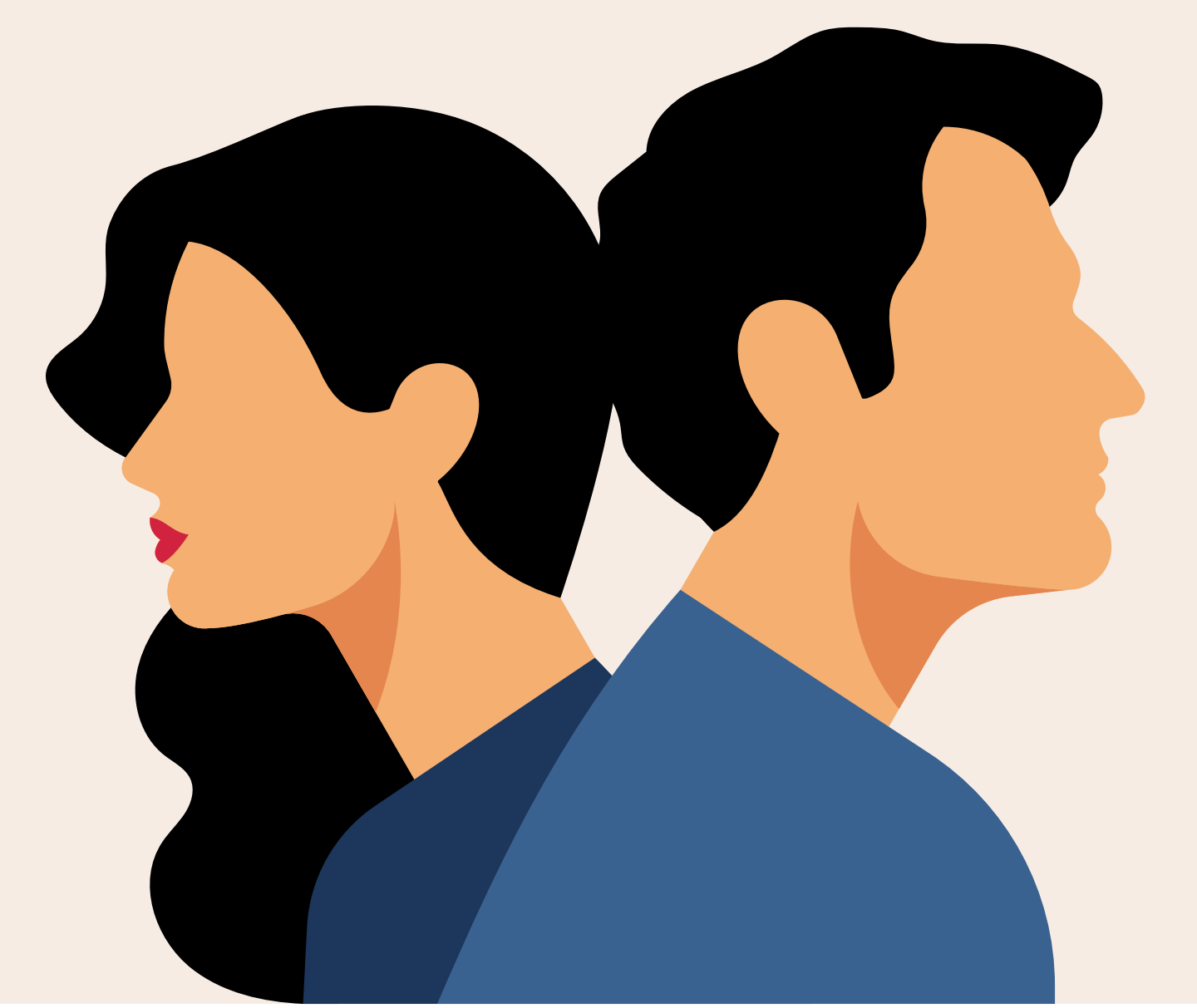

divorce as voiding a testamentary bequest to a former spouse. Like the common-law rule, those laws rest on a 'judgment about the typical testator's probable intent.' They presume, in other words, that the average Joe does not want his ex inheriting what he leaves behind." *Sveen*, 138 S.Ct. 1815, 1819 (citation omitted).

Many states follow the lead of the Uniform Probate Code model statute, which was amended in 1990 to include a provision revoking upon divorce a life insurance beneficiary designation made to a former spouse. See Uniform Probate Code § 2-804(a)(1) and (b)(1). The "underlying idea" was that the typical decedent also would not want a former spouse to benefit from their life insurance. See Sveen, 138 S.Ct. 1815, 1819. The presumption behind the enactment of a revocation-on-divorce statute is that "a decedent's failure to change his beneficiary probably resulted from 'inattention,' not 'intention.'" *Id.* (citation omitted).

Revocation-on-divorce statutes typically contain specified exceptions to the automatic revocation such as express deference to the terms of the insurance contract (often referenced as the "governing instrument"), a court order, or a marital settlement agreement that requires the former spouse remain the designated policy beneficiary. *See, e.g.*, Uniform Probate Code § 2-804; N.J.Stat.Ann. 3B:3-14; and 15 Okla.Stat.Ann. § 178. Frequently, the statutes allow for revival of a beneficiary designation upon the insured's remarriage to the former spouse. *See id.*

However, a significant number of states have not enacted revocation-on-divorce statutes applicable to life insurance. In 2018, the Supreme Court noted that 26 states had adopted revocation-on-divorce laws, meaning that nearly half the states lacked such a statute. *See Sveen*, 138 S.Ct. 1815, 1819. States which have not adopted a statute have followed a contrary reasoning: failure of a spouse to exercise the power to change a beneficiary designation after divorce is deemed an indication they do not wish to effect such a change. *See*

Thorp v. Randazzo, 41 Cal.2d 770, 774 (1953). An appellate court in Louisiana, a state also without a statute, noted "[w]e perceive nothing inherently absurd about leaving a former spouse on an insurance policy" and the fact the ex-husband went 14 years without changing the beneficiary could equally prove that he intended to leave his former spouse as the beneficiary. *See Southern Farm Bureau Life Ins. Co. v. Cox*, 247 So.3d 999, 1004 (La. Ct. App. 2d Cir. 2018); *see also Western-Southern Life Assurance Co. v. Cropenbaker*, 2016 WL 5030108, *4 (S.D. Ohio Sept. 19, 2016) (applying Kentucky law which does not have a revocation-on-divorce statute, the district court stated the fact the ex-husband chose to leave his former wife as the policy beneficiary for eight years after their divorce alone evidenced an intent for the ex-wife to receive the policy proceeds).

As a caveat, state revocation-on-divorce statutes may not apply where the policy is governed by federal law. *See, e.g., Hillman v. Maretta*, 569 U.S. 483 (2013)(holding The Federal Employees' Group Life Insurance Act of 1954 (FEGLIA) preempted Virginia's statute and that insurance proceeds owed to a designated beneficiary under FEGLIA cannot be allocated to another person by operation of state law) and *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001)(Washington's revocation-on divorce statute was preempted as it applied to ERISA benefit plans). *Egelhoff* noted ERISA's objective of implementing nationally uniform plan administration and explained that "[r]equiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Id*. at 149-150 (citation omitted). Moreover, certain state statutes expressly carve out application to life insurance policies subject to federal law. *See, e.g.*, 750 Ill. Comp.Stat.Ann. 5/503(b)(5).

Absent a statute, courts look to common law principles of contract interpretation.

In many states without a revocation-on-divorce statute, courts must look to the specific language contained in the marital settlement agreement to determine whether an intent existed to release the beneficiary spouse's right to receive a policy death benefit. As articulated by North Carolina courts, a divorce does not revoke the beneficiary designation in a life insurance policy and a separation agreement must clearly indicate an intent to deprive either spouse of the right to take under the insurance contract of the other. *See Daughtry v McLamb*, 132 N.C.App. 380, 382 (1999), citing to *Tobacco Group Ltd. v. Trust Co.*, 7 N.C.App. 202, 206 (1970). Further, the West Virginia Supreme Court of Appeals "has long recognized that settlement agreements are contracts and subject to enforcement like any other contract" and therefore analyzed pursuant to West Virginia contract law to determine if a former spouse waived a beneficiary interest in life insurance proceeds. *Baker v. Baker*, 793 F.App'x 181, 185 (4th Cir. 2019) (citation omitted).

Not surprisingly, the absence of a revocation statute in California has spawned much litigation. In California, a person may have a community property interest in a life insurance policy insuring their spouse which is different and separate from the rights which accrue if a spouse is named as an insurance policy beneficiary. *See Life Ins. Co. of North America v. Cassidy*, 35 Cal.3d, 599, 606 (1984). The spouse's "expectancy interest" as a designated beneficiary "may be assigned or renounced by contract of the beneficiary, but only if the contract expressly or by necessary implication so provides." *Id*. The release of a community property interest in a life insurance policy does not nullify a beneficiary designation of the former spouse. Thus, "general language in a marital settlement agreement will not be construed to include an assignment or renunciation of the expectancy interest conferred on the named beneficiary of an insurance policy or a will unless it clearly appears that the agreement was intended to deprive either spouse of such a right." *Id*. at 605; *see also Thorp*, 41 Cal.2d 770, 776 ("Expectancies under a will or an insurance policy may be regarded as waived only when it appears that the attention of the parties was directed to such expectancies and their intention to disclaim future rights which might develop from such expectancies is made clear in their property settlement agreement.")

In *Cassidy*, a provision in the marital settlement agreement released, relinquished, quitclaimed, and surrendered "all and every right as the spouse of the other *and any and all present or future claims or demands of every nature* on or against the other, or... the property of the other..." and waived "the right to inherit from the other or rights to or in connection with any family allowance, *and the right to receive in any manner any property of the other upon the death of the other* except as a devisee, legatee or beneficiary under any last will and testament hereafter executed.... " See 35 Cal.3d 599, 608 (emphasis original). This language was held "sweeping in nature" and showed an intent to waive and relinquish any expectancy that was not thereafter reaffirmed, as well as to settle their community property rights.

More recently, a marital settlement agreement governed by California law and stating the ex-husband agreed to sell, assign, transfer, and convey to the ex-wife as her sole and separate property all of his right, title, and interest in the ex-wife's "life insurance policy insuring her life" was held sufficient to extinguish the ex-husband's interest as a beneficiary even though his ex-wife never changed the beneficiary designation. *See New York Life Ins. and Annuity Corp. v. Alvarez*, 2021 WL 6882374, *4 (C.D. Cal. Dec. 28, 2021). The *Alvarez* court pointed to additional release provisions in the contract and the ex-husband's agreement to "waive and relinquish any rights that he... may have as surviving spouse or heir at law or otherwise, to whatsoever in the estate of" the ex-wife. *Id*.

Lacking a revocation-on-divorce statute, the Kentucky Supreme Court expressly stated, "[u]nless and until the Kentucky General Assembly legislates a different result, we hold that the rights of an insurance policy beneficiary, including the right to receive the policy's proceeds upon the insured's death, are not affected by the mere fact of a divorce between the beneficiary and the insured." *Hughes v. Scholl*, 900 S.W.2d 606, 608 (Ky.1995). Like California, Kentucky law views the ownership interest in a life insurance policy to be distinct from the expectancy

interest held by a designated beneficiary. Thus, a separation agreement that only addresses the insured spouse's ownership interest in a life insurance policy does not specifically divest a former spouse's beneficiary expectancy to the life insurance proceeds and this right remains intact after a divorce. *See Cropenbaker*, 2016 WL 5030108 (Ohio federal court applying Kentucky common law).

Where applicable, community property rights also must be considered. For example, in *Life Insurance Co. of North America v. Ortiz*, 535 F.3d 990 (9th Cir. 2008), the Ninth Circuit held that a California divorce judgment did not clearly encompass a release of the prior wife's beneficiary status under a life insurance policy, *i.e.*, her expectancy interest. The beneficiary designation made prior to divorce was held valid after the insured's death. However, the insured's second wife was entitled to a community property interest in a portion of the life insurance proceeds based on the marital earnings that funded the term life insurance during the insured's second marriage.

In Oregon, another state without a statute, courts make a case-by-case inquiry that turns on the degree of specificity of the language employed in the marital property settlement agreement or divorce judgment and whether the language supports the parties' intent to terminate a beneficiary interest in life insurance. *See In re Marriage of Keller*, 232 Or.App. 341, 350-351 (2009); *see also Midland Nat. Life Ins. Co. v. Lacheln*, 2012 WL 6851533, *6 (D. Or. Oct. 3, 2012)("Under Oregon law, it is the degree of specificity of the relevant terms that determines whether a named beneficiary can recover under an insurance policy after entry of a divorce judgment.") The agreement of the spouses upon divorce governs even though the insured does not thereafter remove the former spouse as the policy beneficiary. *See Lacheln*, at *6.

West Virginia similarly has no revocation-on-divorce statute and deems "spousal forfeiture" purely a creature of statute. *See Baker*, 793 F.App'x 181, 184 n. 4. A former spouse retains the beneficiary interest unless it is waived by the terms of a property settlement agreement. *See id*. at 184. Property settlement agreements are contracts and subject to enforcement like any other contract. *Id*. at 185.

Even with a statute, possible retroactive application muddies the waters.

A revocation-on-divorce statute seeks to provide a bright light rule for universal application. Yet, implementation is less clear when a beneficiary designation or divorce judgment is entered prior to the statute's effective date. Further complicating the matter, court holdings on this subject may differ by state and are dependent on the express terms of the statute as well as the court's interpretation of the legislature's intent.

In *Sveen*, the Supreme Court addressed whether applying Minnesota's revocation-on-divorce statute to a beneficiary designation made prior to the statute's enactment violates the U.S. Constitution's Contracts Clause. 138 S.Ct. 1815. In 2002, Minnesota enacted a statute similar to the Uniform Probate Code model. *See* Minn.Stat.Ann. § 524.2-804, subd. 1. Mr. Sveen purchased a life insurance policy in 1998 and, at that time, named his wife as the primary beneficiary. The couple divorced in 2007 but the divorce decree made no mention of the insurance policy and Mr. Sveen never changed the beneficiary designation before his 2011 death. Competing claims were made to the death benefit. Mr. Sveen's ex-wife noted the Minnesota statute did not exist when the policy was purchased, and she was designated the primary beneficiary. She asserted that applying the later-enacted law to the policy would violate the Constitution's Contracts Clause (Art. 1, § 10, cl.1). The Eighth Circuit agreed with her argument.

Reversing the Eighth Circuit and holding application of Minnesota's revocation-on-divorce statute would not violate the Contracts Clause, the Supreme Court stated that not all laws affecting pre-existing contracts violate this constitutional clause. The Court applied its well-established two-step test to determine whether Minnesota's statute crossed the constitutional line. *See* 138 S.Ct. 1815, 1821. The Supreme Court's analysis stopped after the first step: whether the state law has operated as a substantial impairment of a contractual relationship. In answering this initial question, the Court "considered the extent to which the law undermines the contractual bargain, interferes with a party's reasonable expectations, and prevents the party from safeguarding or reinstating his rights." *Id*. at 1822. The Court explained the Minnesota statute did not substantially impair pre-existing contractual arrangements because: (1) the statute was designed to reflect a policyholder's intent so as to support, rather than impair, the contractual scheme; (2) the law is unlikely to disturb any policyholder's expectations because it does no more than a divorce court could always have done; and (3) the statute supplies a mere default rule which the policyholder can undo in a moment by completing a change of beneficiary form after the divorce or agreeing in the divorce settlement to continue the ex-spouse's beneficiary status.

In *American Family Life Assurance Co. of Columbus v. Parker*, 488 Mass. 801 (2022), the court similarly held Massachusetts' revocation-on-divorce statute had retroactive application to a beneficiary designation made prior to the statute's effective date. The Massachusetts statute tracked the language of Minnesota's statute (examined in *Sveen*) and contained its own retroactivity provision. *See id*. at 807. Thus, the *Parker* court found the subject statute constitutional and that its two retroactivity provisions were consistent with the intention of the Massachusetts legislature that the statute operate retroactively.

Not surprisingly, the absence of a revocation statute in California has spawned much litigation.

In both *Sveen* and *Parker*, the divorce decrees were entered after enactment of the subject statutes. The issue presented in those cases was retroactive application of the revocation-on-divorce statutes to

beneficiary designations made prior to the statutes' effective dates.

In contrast, an Illinois appellate court recently ruled that the state's revocation-on-divorce statute does not apply to divorce judgments entered prior to the statute's effective date. *See Shaw v. U.S. Financial Life Ins. Co.*, 2022 IL App. (1st) 211533 (2022). In *Shaw*, the spouses' marital dissolution judgment was entered in 2016 but did not address life insurance; the Illinois revocation-on-divorce statute applicable to life insurance became effective January 1, 2019; and the insured ex-husband died in 2020. The ex-wife claimed an entitlement to a life insurance benefit under the insured's policy because she remained the designated beneficiary and the divorce was entered prior to the statute's effective date. The insured's son disputed this claim and relied on the statute to assert the beneficiary designation had been revoked. Examining the language of the statute (which differed from the Uniform Probate Code) and existing case law, the *Shaw* court held the operative act triggering application of the statute is the date of the dissolution judgment and not the date of the insured's death. *Id.* at 9. Thus, where "the date of the dissolution judgment preceded the effective date of the statute, the statute does not apply" and the ex-wife was entitled to the death benefit. *Id.*

Similarly, *Ohio National Life Ins. Co. v. Anderson*, 500 F.Supp.3d 881 (D. Neb. 2020) addressed the retroactive application of Nebraska's revocation-on-divorce statute to a divorce decree which pre-dated the statute's enactment. In *Anderson*, Roger Anderson designated his then wife, Debra, as a life insurance policy beneficiary in 1979. The couple divorced in 1988. The divorce decree and property settlement agreement provided the subject policy was to be Roger's sole and separate property free and clear of any claim by Debra. However, Roger died in 2018 without ever changing the beneficiary designation. Debra and the policy's contingent beneficiary made competing claims to the policy's death benefit. Nebraska's statute (Neb.Rev.Stat. § 30-2333) took effect in 2017. The *Anderson* court found "nothing in the language of section 30-2333 to suggest the Legislature meant for it [to] apply retroactively" and "[a]bsent language evidencing such intent, the Nebraska Supreme Court would not give the statute retroactive effect." 500 F.Supp.3d at 886 (citation omitted). Noting the Andersons' divorce decree was entered in 1988 and that the language of the statute did not contain language indicating it was intended to operate on divorces that were already finalized, the Court ruled the beneficiary designation to Debra was not statutorily revoked. *See id.*

Occasionally, a state's legislature has addressed the question of retroactivity. Thus, some statutes expressly state when the statute applies, which may or may not be the date of its enactment. *See, e.g.*, Nev. Rev.Stat. § 111.781(10)("This section applies only to nonprobate transfers which become effective because of the death of a person on or after October 1, 2011, regardless of when the divorce or annulment occurred); 15 Okla.Stat.Ann. § 178(D)("This section shall apply to any contract of a decedent made and entered into on or after November 1, 1987...").

Marital settlement agreements further complicate application of a revocation statute.

The obvious take-away from existing case law is that, even where a state has enacted a revocation-on-divorce statute, legal disputes frequently remain. Often, these disputes require courts to again apply the rules of contract interpretation to a marital settlement agreement, but other wrinkles can develop.

Massachusetts' statute (modeled after the Uniform Probate Code) provides for automatic revocation of a life insurance beneficiary designation upon divorce "[e]xcept as provided by the terms of a governing instrument, a court order, or a contract relating to the division of the marital estate made between the divorced individuals..." Mass.Gen.Laws ch. 190B, § 2-804(b). Thus, in *Sevelitte*, the First Circuit was forced to examine the terms of a divorce agreement to determine whether the parties intended the former wife to remain the designated beneficiary under the ex-husband's whole life policy. 55 F.4th 71, 83. The relevant paragraph of the agreement stated, "The Parties acknowledge that the current Whole Life Insurance Policy shall remain in full force and effect and ownership of said policy is with the Husband. The Parties acknowledge that should the Husband elect to cash in said policy that the Wife shall be entitled to one half of the value of said policy at the time of the cashing in of said policy." *Id.* at 77. After the insured's death, the former wife (who remained the designated policy beneficiary) submitted a claim for the death benefit that was challenged by the insured's estate. The ex-wife contended the divorce agreement evidenced an intent that she remain the primary beneficiary of the policy after divorce. The First Circuit, applying ordinary principles of contract interpretation, found the language in the divorce agreement ambiguous as to whether it was intended to prevent revocation of the beneficiary designation upon divorce or, instead, aimed to maintain the asset value of the policy and provide the ex-wife with half upon sale of the policy. See id. at 83. The First Circuit vacated the district court's entry of judgment on the pleadings in favor of the estate with respect to the policy proceeds and remanded for resolution of the interpleader action.

Although Nevada has a revocation-on-divorce statute applicable to life insurance beneficiary designations, litigation arose over the entitlement to life insurance proceeds in *Primerica Life Ins. Co. v. Aguilar*, 2021 WL 2371228 (D. Nev. June 9, 2021). The Nevada statute (Nev.Rev.Stat. § 111.781) was held to have automatically revoked the beneficiary designation of the former wife upon divorce. However, a factual dispute existed as to whether the insured subsequently redesignated his former wife as the policy beneficiary by sending a letter to the insurer after the divorce. Cross-motions for summary judgment seeking the policy benefit therefore were denied.

The Second Circuit held a former wife was entitled to life insurance proceeds because New York's revocation-on-divorce statute does not apply where the former wife was the owner of the policies insuring the life of her ex-husband and she alone was authorized to designate the beneficiaries. *See New York Life Ins. Co. v. Sahani*, 730 F. App'x 45 (2nd Cir. 2018).

The Oklahoma Supreme Court recently addressed the applicability of Oklahoma's revocation-on-divorce statute (15 Okla. Stat.Ann. § 178(A)) to the situation where the husband died following an order

granting divorce but prior to a final judgment on property and debt issues. *See Ghoussoub v. Yammine*, 518 P.3d 110 (Okla.2022). The *Ghoussoub* Court read the revocation-on-divorce statute in conjunction with the statutes governing dissolution of marriage to conclude the "after being divorced" language in § 178(A) limits automatic revocation of an existing beneficiary designation to a divorce where final judgment on all issues has been rendered. Id. at 116. Thus, § 178(A) did not operate under the circumstances presented in *Ghoussoub*.

Choice of law issues create more uncertainty and confusion.

Choosing the jurisdiction that governs a beneficiary designation to a former spouse is a recurring issue as individuals often relocate such that a policy is issued in one state, the divorce occurs in a second, and the insured dies in a third. Under these circumstances, many factors and public policy concerns are considered to determine which state law applies. The answer in any given situation is far from clear.

In *Matter of Estate of Sullivan*, the insured and her husband, residents of Delaware, divorced in Delaware in 2018. See 2021 WL 4203216, **1 and 2 (Del. Ch. Sept. 16, 2021). The wife thereafter moved to Pennsylvania where she lived until her death. The former husband, a Delaware resident, remained the ex-wife's designated beneficiary on two individual life insurance policies and one group policy issued to her former Delaware employer. Delaware does not have a revocation-on-divorce statute applicable to life insurance, but such a law exists in Pennsylvania. Moreover, the policies did not contain a choice of law provision. The issue presented was whether Delaware or Pennsylvania law governed the ex-husband's entitlement to the life insurance death benefits. Applying the "most significant relationship test" set forth in the Restatement (Second) of Conflict of Laws, the *Sullivan* court first noted the life insurance proceeds were not marital assets and the case did not involve interpretation of the Delaware divorce decree. *See id*. at 5. The court next determined that the insured's domicile at the time of her death, Pennsylvania, had the most significant relationship to the issue. Even though Delaware was the place of contracting and negotiating the individual policies, the court found, "Delaware has no particular public policy concern involving Pennsylvania domiciliaries." *Id*. at 6. Thus, Pennsylvania law was held to govern the disposition of the individual life insurance proceeds which divested the former husband of his beneficiary status. The court reached a different conclusion as to the group policy, noting the applicable law usually is that governing the master policy and will usually be the state where the employer has its principal place of business. *Id*. at *7. In this case, the group policyholder was the University of Delaware and located in Delaware. Delaware law therefore governed the beneficiary determination under the group policy and the ex-husband was entitled to those life insurance proceeds.

In *Maddux v. Philadelphia Life Ins. Co.*, 77 F.Supp.2d 1123 (S.D. Cal. 1999), the couple were married in California; moved to Kansas where the husband obtained life insurance and designated the wife as the primary beneficiary; separated while in Kansas; the wife moved to California; the husband moved to Oklahoma where the divorce decree was entered; and the husband died in California in 1997 where he had relocated. The ex-wife remained the policy beneficiary at the time of the insured's death. Pursuant to the existing Oklahoma statute, the divorce extinguished the ex-wife's entitlement to the life insurance proceeds. However, the life insurance application expressly stated "[a]ny policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application is signed," which was Kansas. *Id*. at 1128. Under Kansas law at the time, the rights of the beneficiary under a life insurance policy were not affected by divorce unless the terms of the insurance contract provided otherwise. *See id*. The district court found the insurer acted reasonably in bringing an interpleader action when faced with competing claims to the policy proceeds, including because "either group of claimants could have been legitimately entitled to the proceeds. As noted above, there appears to be a direct conflict between Oklahoma and Kansas law (not to mention California law) on the issue of whether a former spouse, even when named as an express beneficiary, is entitled to insurance proceeds after divorce from the insured. If Oklahoma law applies, Caine [the ex-wife] would surely not recover any proceeds—but rather, the contingent beneficiary or Manley's Estate... would gain access to the proceeds. On the other hand, if Kansas law applies, Caine may in fact be entitled to all insurance proceeds. However, as noted above, the Court has concerns as to whether Kansas law is even applicable in light of the uncontested Oklahoma divorce decree, a final judgment entitled to Full Faith and Credit." 77 F.Supp.2d 1123, 1129. Accordingly, summary judgment was entered in favor of the interpleading insurer as to the contract and tort claims alleged against it.

Where a former spouse remains the designated beneficiary, insurers should proceed with caution and consider an interpleader.

Contrary to the famous words of Sherlock Holmes, resolution of a divorced spouse's right to receive policy benefits is far from "elementary" even where the governing state has enacted a revocation-on-divorce statute.

In this situation, claims personnel should be trained to request the spouses' divorce judgment or marital settlement agreement, consider whether a community property state is involved, review the policy for a choice of law provision, and be wary before issuing payment when a competing claim is made by the insured's family or estate. A revocation-on-divorce statute, even if applicable, may not end the inquiry. Review by in-house or outside counsel also should be considered before paying such a claim. As shown by the cases discussed above, many pitfalls exist in resolving these claims and the obvious goal is to only pay the policy benefit once. Not surprisingly, insurers often interplead when facing competing claims involving a former spouse, and courts consistently find such interpleaders reasonable.

Chasing The Money

Navigating The Complexities Of Equitable Relief Under Erisa § 502(A)(3)

By Wm. Jere Tolton, III

This article examines the use of ERISA enforcement mechanisms when there has been a third-party recovery against which a constructive trust or equitable lien by agreement may lie.

The Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. §§ 1001 *et seq.*, regulates the administration and enforcement of employee welfare benefit plans, including most private employer health and disability insurance plans. These types of plans frequently contain language allowing the plan, through its plan administrator or insurer, to seek reimbursement when the plan pays benefits or medical expenses to or for the benefit of a participating employee ("plan participant") or their covered dependents.

A typical fact pattern involves a plan participant or beneficiary who sustains accident-related injuries caused by a third party, thereby incurring medical expenses that are paid by an ERISA-regulated health plan. If the participant or beneficiary then sues the third-party responsible for the injuries and achieves a recovery, whether by settlement, judgment, or otherwise, most health plans require the participant to reimburse the plan for the expenditures it made, and impose a lien against the third party recovery in the amount paid by the plan. Essentially, a condition of plan benefits is the promise to reimburse. Benefit plans can reasonably expect that participants and beneficiaries will honor their reimbursement obligations to the plan voluntarily. Most do. But when the participant or beneficiary refuses to cooperate after securing a tort settlement or disputes the reimbursement amount, a plan fiduciary may have few options other than a lawsuit to enforce the plan's reimbursement provision to try to recover at least a portion of what was paid.

This article examines the use of ERISA enforcement mechanisms when there has been a third-party recovery against which a constructive trust or equitable lien by agreement may lie. After a brief overview of the Supreme Court decisions in this area, the article addresses recent cases applying the remedial reach of § 502(a)(3) and offers practical tips and strategies for recovery of plan assets.

Appropriate Equitable Relief Under Section 502(a)(3)

Equitable relief to enforce a reimbursement provision in a welfare benefit plan is permissible under ERISA § 502(a)(3). A plan fiduciary may bring a civil action under this section "to obtain other appropriate equitable relief to redress … [or] to enforce … any act or practice which violates … the terms of the plan." 29 U.S.C. § 1132(a)(3). Reimbursement provisions in ERISA plans create an equitable lien by agreement in favor of the plan against any future recovery by the plan participant. "An ERISA plan creates an equitable lien by agreement when, under the terms of the plan, one party agrees to convey a particular fund to another party." *Arrington v. Sun Life Assur. Co. of Canada*, No. TDC-18-0563, 2019 WL 2571160, at *14 (D. Md. June 21, 2019) (internal quotation marks and citation omitted). The enforcement of reimbursement provisions helps to ensure the financial security of health and disability plans, honors the terms of ERISA plans as written, and controls the cost of maintaining such plans for employers and their employees.

Supreme Court Decisions Addressing the Scope of § 502(a)(3) Relief

In 1993, the Supreme Court in *Mertens v. Hewitt Associates,* 508 U.S. 248 (1993), held that equitable relief under § 502(a)

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(3) is limited to the categories of relief that were typically available in courts of equity (namely, injunction, mandamus, and restitution). The Court held that plans cannot use § 502(a)(3) to impose personal liability on non-fiduciaries to recover compensatory damages for monetary losses to the plan. *Id*. at 256, 113 S.Ct. 2063.

The Court elaborated on this construction in *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002), in which it held that an action by a health plan's stop-loss insurer for equitable restitution under § 502(a)(3) was, in reality, an impermissible attempt to impose personal liability on a plan beneficiary, on whose behalf the health plan had paid medical expenses arising from injuries sustained in a car accident. Even though the health plan included a reimbursement provision that required the beneficiary to repay the plan after a third-party recovery, the Court held that the insurer's claims were not authorized because the "nature of the underlying remedies" was money damages – the classic form of legal relief. *Id*. at 213, 122 S.Ct. 708. The Court reasoned that a key feature of equitable restitution in the days of the divided bench (that is, before 1938 when courts of law and equity were separate) was that it imposed a constructive trust or equitable lien on "particular funds or property in the defendant's possession." *Id*. at 214, 122 S.Ct. 708. This possession requirement was not satisfied in Knudson because the settlement funds from which the insurer sought reimbursement were not in the beneficiary's possession. *Id*. Accordingly, the Court determined that the insurer's claim for equitable restitution could not proceed under § 502(a)(3) as the relief sought was "not equitable – the imposition of a constructive trust or equitable lien on particular property – but legal – the imposition of personal liability for the benefits that [the insurer] conferred upon [the beneficiary]." *Id*.

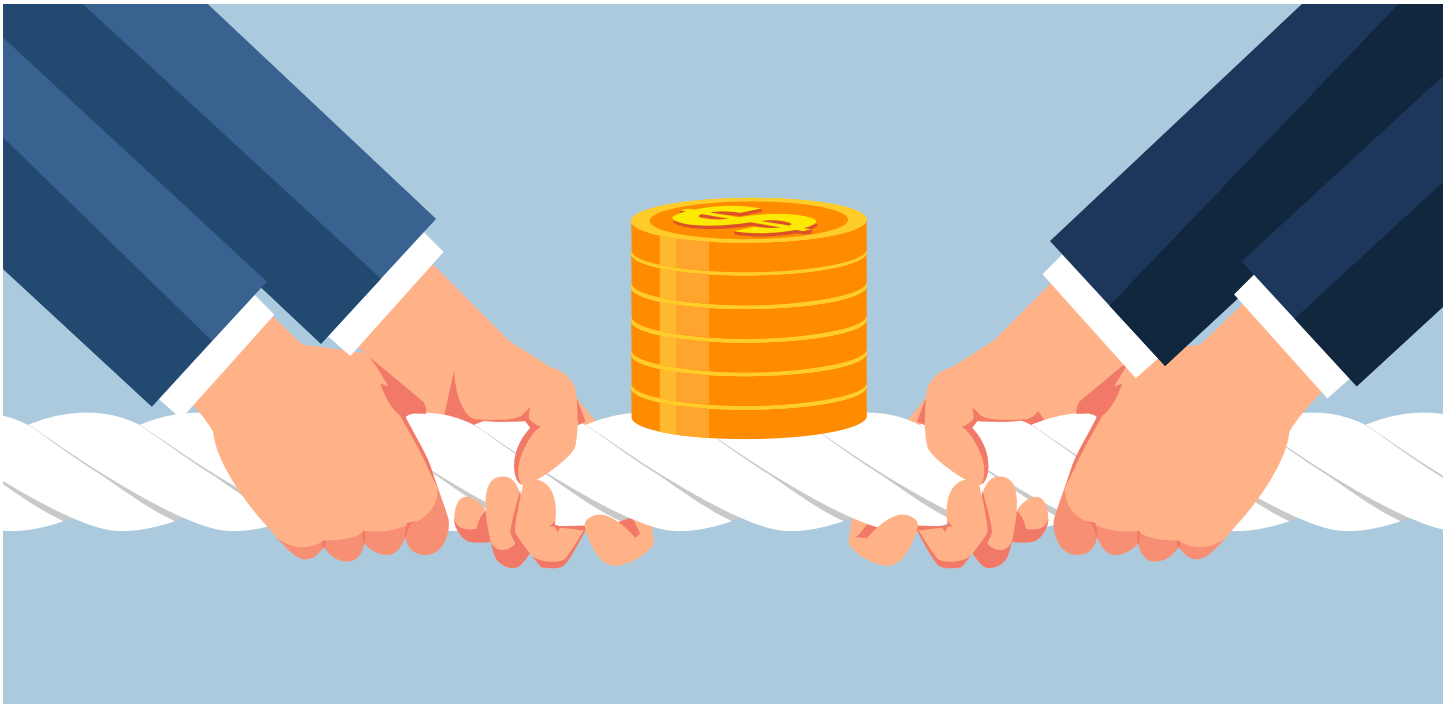
Knudson instructed that an ERISA plan's equitable lien rights attach only to an "identifiable fund" in the control or possession of the plan participant or beneficiary, meaning that the recovery must be derived from the third-party recovery, rather than the obligor's general funds. This principle was reinforced in *Sereboff v. Mid Atlantic Medical Services, Inc*., 547 U.S. 356 (2006), another instance in which an ERISA health plan sued to recover expenditures under § 502(a)(3). The fact pattern was by now familiar. The plan had paid medical expenses incurred by plan participants who suffered injuries in an auto accident. After the participants negotiated a settlement in their personal injury lawsuit against the at-fault driver, the plan claimed part of the proceeds, citing the plan's reimbursement provision. The participants refused to repay despite several letters to their attorney about the plan's lien. The plan then sued the participants in federal court under § 502(a)(3) and won.

Sereboff held that both the nature of the claim and the remedy sought by the plan were equitable and thus permissible. The plan was seeking reimbursement from specifically identifiable funds within the participants' control (a portion of their settlement recovery). In suing the participants for reimbursement of medical expenses paid by the ERISA plan, the Court recognized that the plan appropriately relied on constructive trust principles espousing, "that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." *Id*. at 363-64, 126 S.Ct. 1869 (quoting from *Barnes v. Alexander*, 232 U.S. 117, 121, 34 S.Ct. 276, 58 L.Ed 530 (1914)). In other words, a person who agrees to convey specific funds not yet acquired becomes a trustee upon securing possession of those funds. *Sereboff* concluded that the plan's claim for reimbursement was the modern equivalent of an action in equity to enforce a contract-based lien — that is, an equitable lien by agreement *over* funds that the participants had promised to repay. *Id*. at 360-63, 126 S.Ct. 1869 (holding that the plan fiduciary could seek reimbursement where settlement proceeds were held in an investment account); *see also, U.S. Airways, Inc. v. McCutchen,* 569 U.S. 88, 93-95, 133 S.Ct. 1537 (2013) (plan fiduciary could seek equitable relief from plan participant where a portion of the settlement funds were held in escrow and the remainder was identifiable and within his possession).

A plan is no longer pursuing "equitable relief" under § 502(a)(3), however, when it seeks to enforce its lien against the obligor's general assets. The Court in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, 577 U.S. 136 (2016), held that the plan insurer could not obtain a lien under § 502(a)(3) against a beneficiary's assets generally when the third-party settlement had already been dissipated on nontraceable items. Once the beneficiary has "dissipated" settlement proceeds on nontraceable items, the action loses the mantle of "appropriate equitable relief." 577 U.S. 136, 136 S.Ct. 651. The Court observed that the premise of an equitable lien by agreement is the constructive possession of a fund held by the defendant to which the plaintiff is entitled. Equitable liens are enforceable only against a specifically identified fund because an equitable lien "is simply a right of a special nature *over* the thing … so that the very thing itself may be proceeded against in an equitable action." *Id*. at 145 (citing 4 S. Symons, Pomeroy's Equity Jurisprudence § 1233, at 692).

A plan is no longer pursuing "equitable relief" under § 502(a)(3), however, when it seeks to enforce its lien against the obligor's general assets.

Montanile serves as a cautionary tale for plan fiduciaries not to dawdle. Injured by a drunk driver, the plan participant signed a reimbursement agreement reaffirming his obligation to reimburse his employer's health plan from any tort recovery he obtained. The participant sued and obtained a $500,000 settlement, more than enough to reimburse the medical expenses the health plan paid on his behalf. The attorney for the participant held a portion of the tort recovery in escrow while trying to negotiate with the plan to compromise



its lien. After negotiations failed, the participant's attorney warned the plan fiduciary that the reserved funds would be delivered to the client within 14 days. The fiduciary failed to take immediate steps to protect its interests, waiting six months to file suit, by which time the escrowed funds had been released to the client and spent on nontraceable items. The Court ruled that once the plan participant had spent all of the settlement money on nontraceable items, the plan's equitable lien was eliminated and the fiduciary could not rely on § 502(a)(3) to attach a lien to general assets. *Id*. at 145 146, 136 S.Ct. 651.

Recent Efforts by Plans to Obtain "Appropriate Equitable Relief" Under § 502(a)(3)

In recent years, federal courts have generally been receptive to efforts by plan fiduciaries to enforce reimbursement provisions in benefit plans, adhering to ERISA's objective of having the terms of the plan enforced as written. *E.g., Vercellino v. Optum Insight, Inc*., 26 F.4th 464 (8th Cir. 2022) (health plan, which paid medical expenses of plan beneficiary injured in an accident, was entitled to reimbursement from proceeds recovered in personal injury lawsuit); *Publix Super Markets, Inc. v. Figareau*, 857 F. App'x 545 (11th Cir. 2021) (enforcing an equitable lien under a self-funded health plan where the covered participants later secured a medical malpractice settlement; declining to limit the amount of reimbursement under the lien); *Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Haynes*, 966 F.3d 655, 657 (7th Cir. 2020) (concluding that an equitable lien by agreement acts to carry out a contract's provisions — in this case, a health plan's subrogation and reimbursement provisions; enforcing subrogation provisions against a health plan beneficiary); *but see, GC America Inc. v. Hood*, No. 20 cv 03045, 2022 WL 910556 (N.D. Ill. Mar. 29, 2022) (dismissing a health plan's § 502(a)(3) claim for reimbursement of plan-covered medical expenses for failure to plead that the defendant had possession of the settlement funds from which the reimbursement would be paid); *Dean v. Aetna Life Ins. Co.*, No. 21 cv-363, 2022 WL 847249 (S.D. Ohio Mar. 22, 2022) (dismissing plan insurer's counterclaim for overpayment of long-term disability benefits where action was premised on state contract law and sought to recover legal damages).

Some courts recognize that the plan participant cannot defeat the plan's recovery efforts simply by combining entrusted funds with personal funds. Any commingling of wrongfully possessed funds and personal funds permits a lien on the commingled account. *See, e.g., Zirbel v. Ford Motor Co., 980 F.3d* 520, 524 (6th Cir. 2020) (citing *Montanile*, 577 U.S. at 144-45); *see also, Sheet Metal Workers' Health and Welfare Fund of North Carolina v. Law Office of Michael A. DeMayo, LLP,* 21 F.4th 350, 354 (6th Cir. 2021) ("[I]f a defendant only commingles the plaintiff's claimed funds with its other assets, the defendant still possesses the claimed funds, making the plaintiff's remedy an equitable one.") (citing *Knudson*, 534 U.S. at 213-14, 122 S.Ct. 708)). Nonetheless, plan fiduciaries seeking equitable relief under a § 502(a)(3) action must act diligently to follow the money to the "specifically identified fund" or to traceable items such as a car, house, or an investment fund. *Id*. at 524 (citing *Montanile*, 577 U.S. at 149) (noting that when funds can be traced to such hard assets, the lien attaches to the asset, preserving the fiduciary's ability to recover in equity).

To hedge against the risk of funds dissipation, ERISA plans may opt to include recoupment provisions that can be utilized when the participant fails to comply with reimbursement obligations but continues to submit claims under the plan. Under this type of provision, the unreimbursed benefits are offset against future liability for covered expenses until the past obligation is resolved. As the

Ninth Circuit recognized in *Mull v. Motion Picture Industry Health Plan*, 41 F.4th 1120 (9th Cir. 2022), "self help remedies" such as these "do not require a civil action under § 502(a)(3) to enforce." *Id*. at 1130. In *Mull*, the health plan paid medical expenses to a dependent beneficiary after she was injured in an accident. Although the plan included an enforceable reimbursement provision to recover paid medical expenses out of third party settlement funds, the beneficiary spent those funds instead of reimbursing the plan. The plan, invoking its recoupment provision, continued processing medical claims submitted by the participant and his dependents in the usual course. But instead of making payments to the service providers, the plan applied its share of the covered expense as a credit against the unreimbursed benefits stemming from the dependent beneficiary's accident.

The participant and his covered dependents, distressed by this turn of events, sued under ERISA's civil enforcement provision, § 502(a)(1)(B), and "catch-all" provision, § 502(a)(3), to recover benefits withheld and compel the plan to honor future claims for covered services. Citing *Knudson* and its progeny, the plaintiffs argued that the plan's only remedy was an equitable action for relief under § 502(a)(3), relief that was futile since the settlement funds targeted for reimbursement had already been spent on nontraceable items. Finding that the plan's recoupment provision did not violate ERISA's exclusive remedial scheme, the Ninth Circuit aligned itself with the "numerous" courts that have enforced similar self-help remedies without resort to judicial action under § 502(a)(3). *Id*. at 1137-38 (collecting cases). Because the plan's terms authorized the recoupment procedure by crediting future covered expenses against the standing obligation, the "identifiable fund" requirement was not implicated. "As our court and others have recognized, plan fiduciaries may bargain for and implement self-help remedies that do not require judicial enforcement." *Id*. at 1138.

Practice Tips

The following are tips and strategies for the practitioner seeking to assist a plan fiduciary recover funds from a participant or beneficiary who has received funds from a third-party settlement:

1. *Review the plan document.* Before taking any action to enforce the lien, review the plan document to ensure that it includes a provision for an equitable lien by agreement and that the lien is valid and enforceable. Anticipate that the plan participant or beneficiary may argue that the lien is not valid because it is not included in the plan document or that it was not properly established through a written agreement between the parties. *E.g., Messing v. Provident Life & Accident Ins. Co*., 48 F.4th 670 (6th Cir. 2022) (declining to allow an equitable lien by agreement for repayment of plan benefits where no plan provision identified a particular fund to be the source of the disputed repayment obligation).
2. *Identify the lien amount.* Determine the amount of the lien and the specific funds that are subject to the lien. Be prepared to document that the lien amount is correct. Plans may include language requiring that any third-party recovery be kept separate from other funds and be held in trust until conveyed to the plan.
3. *Send formal notice of lien rights.* Make sure to secure the participant's written acknowledgement of responsibility for reimbursing the plan in the event there is a third-party recovery. Have the participant sign a reimbursement agreement once a claim under the plan is made, when the incentive to cooperate with the plan is arguably at its peak. Send written notice to the participant informing them of the plan provisions on potential third-party recoveries. The notice should include deadlines by which the plan is to be notified of any legal action against third parties and a separate deadline by which the plan is to receive reimbursed funds following the third-party settlement or recovery.
4. *Communicate, again and again.* Establish regular communication with the participant and their attorneys. This will demonstrate due diligence on the part of the plan fiduciary that can be persuasive if legal action is required. Moreover, persistent communication about the reimbursement right may produce a negotiated repayment plan or satisfactory recovery without the expense and risks of legal action.
5. *File suit under § 502(a)(3).* If negotiation is not successful and the participant or beneficiary is not willing to repay the funds voluntarily, consider legal action under ERISA § 502(a)(3). This may include joining the personal injury attorney as a co-defendant in the § 502(a)(3) lawsuit. An individual attorney or law firm that holds disputed settlement funds on behalf of a plan participant or beneficiary need not be a party to the plan to be subject to suit under ERISA. ERISA recognizes that nonplan defendants can be subject to liability. *See Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.,* 530 U.S. 238, 246 (2000) ("§ 502(a)(3) admits of no limit … on the universe of possible defendants."). "[T]here is no statutory barrier that prevents [the plan participant's attorney] from being a defendant in a suit brought pursuant to § 502(a)(3) of ERISA, provided that the relief sought lies in equity." *Central States, Southeast and Southwest Areas Health and Welfare Fund. v. Haynes*, 397 F.Supp.3d 1149, 1161 (N.D. Ill. 2019), *aff'd*. 966 F.3d 655 (7th Cir. 2020) (quoting *Longaberger Co. v. Kolt*, 586 F.3d 459, 468 (6th Cir. 2009) (abrogated on other grounds by *Montanile*)); s*ee also, Synchrony Financial Welfare Benefits Committee v. DeMayo Law Offices, LLP*, No. 3:21-cv-00376, 2022 WL 2600165 (W.D. N.C. July 8, 2022) (noting attorneys and law firms are subject to suit under ERISA § 502(a)(3)). Joining the participant or beneficiary, their lawyer, and the lawyer's firm helps to avoid ambiguity about who possesses the money. A motion can be made compelling the attorney to deposit the disputed amount with the court pending the outcome of the § 502(a)(3) litigation.
6. *Trace the funds.* This can be achieved through the use of interrogatories and other discovery, or through a records subpoena of bank records. Once you have traced the funds, seek a preliminary injunction or temporary restraining order to enjoin defendants from disposing of or dissipating the funds in possession, being careful to identify the

specific funds subject to the equitable lien. Circumstances depending, try to negotiate the terms of a proposed order in which the settlement funds are preserved. Notably, in *Sereboff*, the defendants agreed to preserve $74,869.37 of the disputed settlement funds in an investment account until the Court ruled on the merits of the § 502(a)(3) claim. 547 U.S. at 360, 126 S.Ct. 1869. If a law firm is holding settlement funds in an IOLTA while the lien issue is litigated, it may be possible to negotiate an agreement, reduced to a stipulated order, to maintain those funds at issue in trust until further order or resolution of the litigation. But be sure to ask the court to specify the settlement funds or the funds belonging to the plan in its order requiring a defendant to retain the funds, as an order restraining the dispersing of general assets held by the defendant may be deficient.

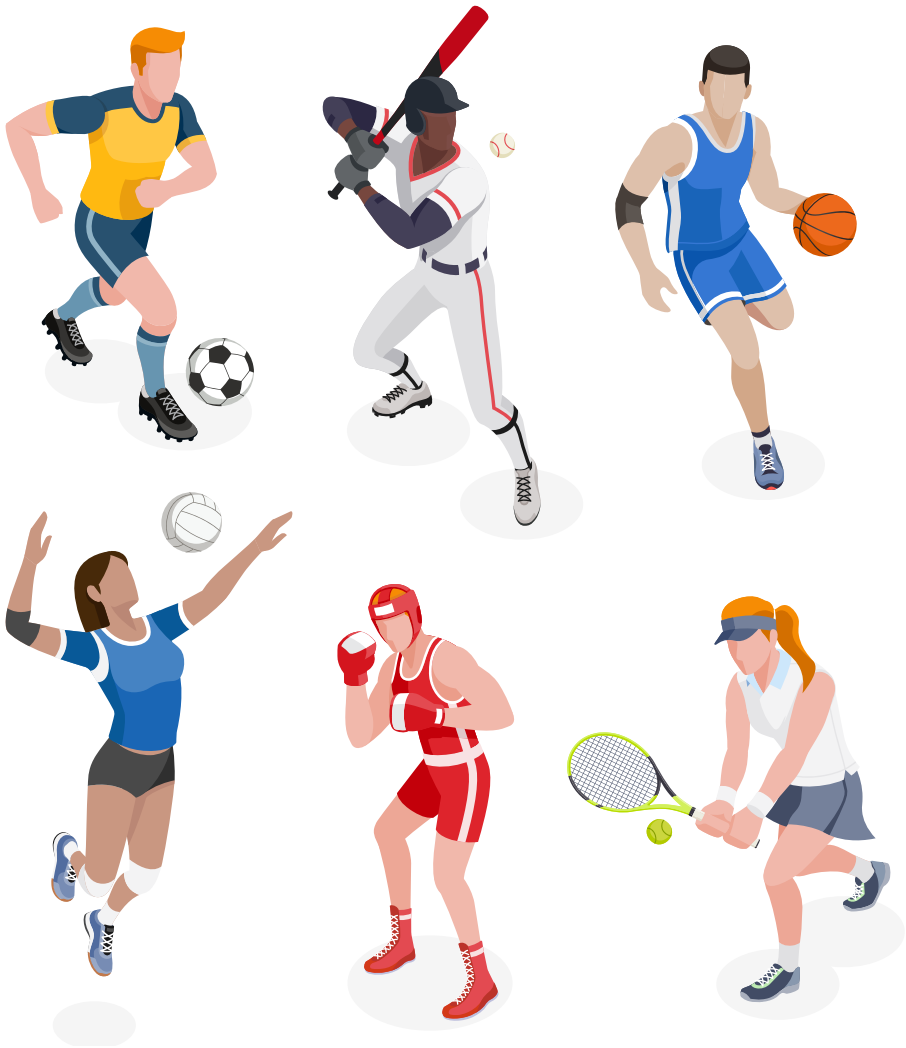
In the end, the most important strategy is vigilance. The plan fiduciary must closely monitor the plan participant's efforts to recover reimbursable funds from third-parties. Requesting regular status updates about a workers' compensation claim or an application for social security benefits, or tracking the progress of a negligence action against the tortfeasor that the participant seeks to hold accountable, provides the diligent fiduciary its best chance to recover reimbursement, and best opportunity to avoid litigation.

Don't Hate the Player, Hate the Game:

Unionization of College Athletes

By Princeton Carter

This is not a player issue. This is not a sports issue. This is a labor issue.



There has been an evolutionary wave toward creating employment relationships between colleges and student-athletes. Teenagers and million-dollar contracts have historically sparked controversy, speculation, and financial skepticism. Collegiate athletes of any sport attract significant revenue to the schools they attend. Until recently, athletes sacrificed their bodies for exposure and experience in hopes of reaching the next level. A college athlete rarely makes it to the next level. However, it is almost guaranteed that these colleges will receive a significant amount of revenue from adding a star player, gaining alumni support, and improving the quality of their programs. In light of the U.S. Supreme Court's ruling implementing name, image, and likeness ("NIL") in the case of *Alston* opening pandora's box to education-related compensation, now institutions must decide to offer athletes big dollars in salaries to pay them for their talents. Under the Court's ruling, this is no longer a student issue. (Alston v. National Collegiate Athletic Association, no. 19-15566, 9th cir. 2020). This is not a player issue. This is not a sports issue. This is a labor issue.

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Although collegiate athletes profit from NIL deals based on their likeness, popularity, and overall social influence, players gain each characteristic through their athletic ability. Under the *Alston* ruling, the NCAA itself can't bar schools from adding dollars to prominent athletes looking to land as a Division I basketball or football player. Thus, athletes who start for a Division I Athletic team are likely to receive and earn greater compensation from their NIL contracts than starters of DIII athletic teams. (Alston v. National Collegiate Athletic Association, no. 19-15566, 9th cir. 2020). Thus, a collegiate athlete's likelihood of receiving greater compensation from a NIL deal is based on their ability to start and the popularity of their sport. Once, signed, players gain money through their NIL contracts by: "1) Accepting direct payments for promotional activities; 2) Receiving free or sponsored products in exchange for promotion; 3) Receiving free or sponsored services in exchange for promotion; 4) Earning affiliate money from social media promotion; 5) Becoming an ambassador for a brand or business; 6) Appearing in commercials, ad, and digital advertising." (Paul Rudder, How Much Money Can College Athletes Make With NIL Marketing Endorsement Deals? Diario AS, 2022).

The Profit & The Problem

Due to the increased popularity of NIL deals, schools with greater name recognition have become big players in the NIL scene. These schools indirectly impact players' ability to rely on a single NIL contract to support them financially and set them up for life after college, regardless of their chances of becoming professional athletes. Nonetheless, the financial factor behind the NIL is often only seen as a luxury or prerequisite for top recruits ascending to the next level. However, this is not always the case, especially for those who do not attend programs that receive primetime coverage on ESPN. For example, the decathlete and football athlete, Rayquan Smith, is known as the "King of NIL." The Norfolk Smith has earned 70 NIL deals to support himself financially. He is one of many student-athletes who use NIL deals for financial stability and postgrad plans. (Brett Knight, College Sports' 'King of NIL' Is Racking Up Endorsement Deals at a Small HBCU Forbes (2022)).

Smith earned the "Hustle Award" from the NIL Summit in June 2022. Many have commented on Smith's success and described it as "an extraordinary feat, to thrive as a student, athlete, and brand is nothing short of amazing." (Brett Knight, College Sports' 'King of NIL' Is Racking Up Endorsement Deals at a Small HBCU Forbes, 2022).

However, his need to sign 70 NIL deals over the span of three years for his financial wellness highlights a greater issue. (Brett Knight, College Sports' 'King of NIL' Is Racking Up Endorsement Deals at a Small HBCU Forbes (2022)).The problem is the insufficient financial compensation for their labor, the impact of student-athletes on the yearly revenue, and overall financial positioning. In addition, this issue not only impacts male athletes outside the top-ranked athlete programs, but directly impacts female athletes. Specifically those who have been historically underpaid, under-advertised, and dismissed for their claims of the same treatment as their male counterparts. Today, there are some NIL male collegiate athletes whose contracts are bigger than those of championship women's basketball players. For example, in June 2022, 4-star prospect Jaden Rashada turned down an $11 million NIL contract offer from the University of Florida and signed a $9.5 million NIL deal with a University of Miami booster. (Max Escarpio, College Football's Most Unique NIL Deals in 2022 Bleacher Report, 2023).

Later in 2022, Olivia Dunne, a star gymnast at Louisiana State University, was the female athlete with the biggest NIL contract with an estimated worth of $2.6 million. (SI Staff, The Biggest NIL Earners In Women's Sports From 2022 Sports Illustrated, 2022). This gender pay gap only expands when comparing male collegiate NIL contracts to professional women's sports contracts. In the same year, the highest-paid WNBA players were Breanna Stewart, DeWanna Bonner, Jewell Loyd, Elena Dell Donne, Skylar Diggins-Smith, Brittney Griner, and Diana Taurasi. (Angela Bucalo, Who Is the Highest Paid WNBA Player? ONE37pm (2022)). These seven players each had a base supermax salary of $221,450 for the 2021 WNBA season. Meanwhile, the league minimum salary is now $58,710. (Angela Bucalo, Who Is the Highest Paid WNBA Player? ONE37pm, 2022)). The salary cap, which is regarded as a hard cap, stands at $1,339,000; this amount of money is distributed among 11 or 12 players on each of the 12 rosters. (Angela Bucalo, Who Is the Highest Paid WNBA Player? ONE37pm, 2022)). The differences in pay between female and male athletes are likely to cause issues with Title IX.

These strikingly different financial compensation contracts between female and male athletes impact the differences and speak to the need for unionization. Through the unionization of collegiate athletes, more student-athletes will be able to be compensated for the revenue they bring to their athletic program, conference, and overall university.

The exploitation of collegiate athletes seems much more evident when looking at the collegiate sports program from a profit-based business perspective. When looking at collegiate sports and NIL contracts wholistically, those who risk their education, health, and careers at the risk of injury, financial shortfalls, and academic challenges are paid the least. Coaches, athletic directors, and board members all have a stake in this race as employers of student-athletes. Coaches of top-tier programs, such as Nick Saban, "earn $7 million annually without ever playing a single down. Moreover, Alabama Athletic generated a surplus of more than $33 million for the 2013-14 fiscal year. That number is nearly $6 million more than $27 million surplus from the 2012-13 fiscal year." (Ben Kercheval, Alabama's Insane $33 million Profit From Football Proves Nick Saban's Value Bleacher Report (2017)). "Saban's football program had a $53 million surplus with revenues of $95.3 million. The expenses rose by less than a million from 2012-13 but the revenue jumped by nearly $7 million. The biggest football gains came from royalties ($4.5 million from $1.3 million), broadcast television, radio, and Internet rights ($9.1 million from $7.2 million) and contributions ($20.7 million from $18.9 million)." (Ben Kercheval, Alabama's Insane $33 million Profit From Football Proves Nick Saban's Value Bleacher Report (2017)).

Attorneys, Advocates, Athletes

When collegiate athletes have sought financial compensation for their labor's contribution to the profit and revenue of the university, their claims are regarding: 1) antitrust violations regarding the NCAA's restriction on competition and enabling low pay for college athletes, 2) minimum wage law violations, the argument that college athletes should be paid at least the minimum wage, and 3) discrimination claims arguing that NCAA's rules discriminate against collegiate athletes, treating them differently from other university employees. When players, as plaintiffs, have presented these issues in court, the court has ruled in favor of the NCAA, the defendant.

These strikingly different financial compensation contracts between female and male athletes impact the differences and speak to the need for unionization.

Two main court cases have directly impacted the unionization and labor practices of collegiate athletes. The first case is the case of *Northwestern v. College Athletes Players Association* (CAPA). In Northwestern, the scholarship football players of Northwestern University sought to form a union (CAPA) to negotiate for better pay, benefits, and working conditions. Northwestern v. CAPA, Case 13 - RC- 121359 (2015).In 2014, the National Labor Relations Board (NLRB) initially ruled that the players had the right to form a union because they were employees under federal law. In its appeal of the NLRB's decision, the university argued that the players were student-athletes who were receiving an education, not employees. As a result of the case, the United States Court of Appeals for the Seventh Circuit overturned the NLRB's decision stating that: 1) the NLRB did not have the authority to determine whether or not the players were employees; 2) the players could not form a union because they were not employees. (Northwestern v. CAPA).

The second case is the case of *Alston v. NCAA*. In Alston, a group of current and former college athletes filed a class-action lawsuit in the U.S. District Court for the Northern District of California, challenging the NCAA's rules that prohibit athletes from receiving compensation or benefits beyond scholarships and related expenses. (Alston v. National Collegiate Athletic Association, no. 19-15566 (9th Cir. 2020)). As a result of the restrictions on competition and artificially low pay for college athletes, the plaintiffs argued that these rules violated antitrust law; 2) they discriminated against athletes by treating them differently than employees; 3) athletes should receive compensation for their likeness and image. Id. The NCAA, the defendant, argued that: 1) its rules were necessary to maintain the amateur status of college sports and to promote consumer demand for college sports, and 2) student-athletes are not employees, but rather students who are receiving an education. The court issued a summary judgment in favor of the NCAA, agreeing with the NCAA's points while highlighting that the decision to pay college athletes is a policy decision up to the NCAA. Id.

Unionize, Organize, Execute

Today, universities nationwide have allowed athletes to profit off their names, image, and likeness, thus collegiate athletes have crossed over into the business world as a valuable part of the collegiate workforce. With power in the hands of student-athletes, athletic departments will feel pressure to compensate students and student-athletes. NIL Contracts' impact on college campuses will likely continue to trigger issues under Title IX, the federal law banning discrimination based on sex in educational settings.

Thus, university student-athletes should unionize to ensure they are properly advocated for, compensated, and protected. The NCAAPA, National Collegiate Athletic Association Players Association, could act as a labor union that represents all collegiate athletes under the NCAA. It would serve as the exclusive collective bargaining representative for NCAA athletes by negotiating and enforcing collective bargaining agreements (CBAs) with the NCAA. The NCAAPA will also provide support and assistance to its members, including advice on financial and legal matters, while promoting and protecting the interests of all collegiate athletes. The NCAAPA will also provide support and resources to those who have graduated and have not transitioned to the professional level.

The implementation of a union would change the cost-benefit analysis since workers' compensation, at least going forward, would provide a far more definitive and predictable cost analysis. It would also help schools make smart decisions about the future of college sports. Injury, coach preferences, recruiting packages, and other recruiting incentives will provide a new level of clarity for prospective players, starters, and future professional athletes.

> "From a legal standpoint, I'm aware of no union activities among college sports. As an athlete, it's made clear to you early on that when you participate on a team, you are part of a dictatorship, not a democracy."
>
> -Mike Ingersoll, Attorney at Womble Bond Dickinson LLP

However, this decision to unionize collegiate athletes will spark some discussion about losing the amateurism of collegiate sports. Now, college sports will be a semi-professional sphere for those with less experience and social influence than those on the professional scale. This argument is often misplaced in understanding how the dynamic of collegiate sports initially functioned. This perception that an increase in quality will remove the fun from the game is rooted in the misconception that college athletes have not earned the right to be paid for their labor. The regulations around college athletes have provided a hollow limitation around this perception with the prohibition of high school athletes skipping the college level and entering the professional sphere.

This policy change further strengthens the belief that the labor of college athletes is less than professional athletes. However, this is not the case. Professional athletes have more time, money, and resources to train while collegiate athletes do not. In addition, for each collegiate team, the athletes' labor directly contributes to the profit of the team, program, and overall organization; thus, they deserve sufficient financial compensation. This is where a union steps in to ensure that a four-star 17-year-old Center looking to win her first NCAA Division I Basketball Championship is compensated for the revenue she brings to her team, athletic program, and overall university.

The Closer

The unionization of college athletes is an opportunity for college athletes to be financially compensated for their labor contributions to the university. However, this is more than an opportunity for financial compensation. The creation of an NCAAPA would allow male athletes to leverage their influence, popularity, and privilege for the equal treatment and pay of female athletes. This creation could cause a ripple effect of repercussions for all women's professional athletes. If collegiate female athletes receive equal pay, the pay of professional female athletes is likely to follow. This change represents an opportunity for a coed unionization of athletes that could leverage their influence, athletic prowess, and future careers to mend the gender pay gap.