

## HEALTH AND DISABILITY INSURANCE LAW COMMITTEE

### DIFFICULT REMOVALS: REVEALING THE DISGUISE

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#### INTRODUCTION

An occasional challenge for defendants is the federal diversity claim that masquerades in state court. It may be cloaked by fraudulent joinder, disguised amounts in controversy, or just artfully drafted to seem unthreatening. When the clock strikes twelve (months) the disguise falls away and the defendant suddenly is staring at a claim for big damages and total diversity among the parties.

The reason Congress created federal diversity jurisdiction was to prevent undue favoritism among citizens of different states. Federal judges, however, guard their docket carefully. Some remand cases on their own, while others are very demanding. District judges are not answerable on appeal for remand orders and thus, there is only one chance to get it right.

This article discusses how some plaintiffs have tried to avoid federal jurisdiction, and how defendants and courts have responded. These cases and authorities are mostly from recent briefs and memos, so

this article is only a starting point for research and not an authoritative statement. The law is constantly evolving in this field.

#### Basics Of Diversity Jurisdiction

Removal is governed by 28 U.S.C. §§1441 through 1452. A defendant can remove a civil case if the plaintiff could have filed it in federal court originally. 28 U.S.C. §1441. The removal notice need only contain a short and plain statement of the grounds for removal and be filed with a copy of the "all process, pleadings and orders" received by the moving defendant. §1446(a). Once a removal is filed, the state court "shall proceed no further" unless the case is remanded. 28 U.S.C. 1446(e).

There are two main requirements for diversity jurisdiction. The stakes must exceed \$75,000 (exclusive of interest and costs) and no plaintiff and defendant may be of the same citizenship. See 28 U.S.C. §1332. Punitive damages do count toward the amount in controversy. *Bell v. Preferred Life Assurance Soc. of Montgomery*, 320 U.S. 238, 240 (1943).

A corporation is a citizen of the state of both its place of incorporation and its principal place of business. 28 U.S.C. §1332(c). Other entities like partnerships and limited liability companies are deemed citizens of every state where a partner or member resides. This is important because the right of

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*... bringing together plaintiffs' attorneys, defense attorneys and insurance and corporate counsel for the exchange of information and ideas.*

history.” *Id.* at 670. Even with a group policy, insurance companies may use underwriting procedures in determining a person’s eligibility for coverage. *Id.* After “assessing the individual’s risk, the insurer may charge the applicant a higher

premium, exclude coverage for a specified condition or decline to provide coverage.” *Id.*

In conclusion, the court answered the certified question as follows: “New York Insurance Law Section 3234(a) means that a policy

may impose a 12-month waiting period during which no benefits will be paid for a disability stemming from a preexisting condition and arising in the first 12 months of coverage.” *Id.* 

## BREACH OF HEALTH-INSURANCE CONTRACT CASE OVERRULES *COLQUITT*

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The Alabama Court of Civil Appeals recently overruled *Blue Cross-Blue Shield of Alabama v. Colquitt*, 168 So. 2d 251 (Ala. Ct. App. 1964) in *Legg v. Fortis Insurance Company*, No. 2060550, 2007 WL 1866764 (Ala. Civ. App. June 29, 2007), *cert. denied*, No., 1061495, 2007 WL 2460076 (Ala. Aug. 31, 2007). *Colquitt* stood for the rule that when a loss occurs within the grace period of a health-insurance contract after a premium has not been paid, an obligation on the part of the underwriter to the insured arises for an unencumbered sum at least equal to the unpaid premium, and the premium is deemed to have been paid and the term of the policy is appropriately extended. *Colquitt*, 168 So. 2d at 254.

The court in *Legg* dispensed with this rule, finding that if the insurance company does not receive the premium within the grace period, the policy lapses as of the date the premium was due or the policy expired, and the insurer may refuse to provide retroactive coverage. *Legg*, 2007 WL 1866764, at \*6. The *Legg* opinion significantly alleviates insurance companies’ concerns that they may be required to pay health-insurance claims arising during grace periods

when the premium payment was never paid.

At its inception, *Legg* involved a state-court claim by Legg against defendants John Alden Life Insurance Company and Fortis Insurance Company for breach of contract and bad-faith refusal to pay an allegedly valid insurance claim. *Id.* at \*2. In June 2003, Legg sought and obtained short term medical insurance coverage from John Alden, with such insurance to be administered by Fortis. *Id.* at \*1. The insurance certificate contained a provision for a grace period of ten days which provided for delinquent premium payments. *Id.* at \*1-2. In particular, the provision stated, “If the premium is not received at Our Home Office by the end of the grace period, this policy or certificate will lapse.” *Id.* at \*2.

Legg made monthly premium payments in a timely manner so as to extend his coverage through at least October 28, 2003, but he failed to make a monthly premium payment due on October 29, 2003, triggering the ten-day grace period which extended the time to pay until November 8, 2003. *Id.* On October 31, 2003, during the grace period, Legg underwent hernia surgery and incurred medical expenses incident thereto. *Id.* Legg testified

that on November 7, 2003, he sent a premium check via regular mail. *Id.* However, the check was not received until November 17, 2003, after the ten-day grace period had expired. *Id.* Fortis refunded the premium payment to Legg on December 15, 2003, noting in its letter to Legg that the last date of coverage had been October 28, 2003, and that no premium payments had been received within ten days of October 29, 2003. *Id.* Further, Legg’s claim for medical benefits with respect to the October 31, 2003 surgery was denied on the basis that the insurance certificate had lapsed. *Id.*

Legg alleged that John Alden and Fortis had breached the insurance certificate by failing to pay a claim for benefits arising out of the October 31, 2003, surgery and that the defendants had acted in bad faith in allegedly failing to investigate and pay that claim. *Id.* After a hearing, the trial court granted summary judgment in favor of the defendants. *Id.* On appeal, the question arose as to whether Legg’s claim for benefits as to his October 31, 2003, surgery was properly denied. *Id.*

The Alabama Court of Civil Appeals found that summary judgment in the defendants’ favor was

proper, noting that a grace period was provided to give a certificate-holder currently in arrears the opportunity to make a belated payment, and not to bestow a free bonus month of insurance coverage added to every contract. *Id.* at \*3-6 (citing *Zaitschek v. Empire Blue Cross and Blue Shield*, 632 N.Y.S.2d 434 (Civ. Ct. 1995) (finding that New York's grace period statute, like Alabama's, was interpreted so as not to require an insurer to pay a health-insurance claim arising during a grace period when a premium payment was never paid)).

Importantly, the court also overruled *Colquitt* to the extent that it was inconsistent with the opinion in *Legg*. *Id.* at \*5. *Legg* relied on *Colquitt* for the first time on appeal

to support his contention that his claim was valid and should have been paid despite his failure to pay the premium due on October 29, 2003. *Id.* at \*4. The court, however, rejected the assumption in *Colquitt* that a loss occurring during a grace period set forth in a disability insurance policy gave rise to an obligation of the underwriter to pay the claim to the insured, thereby creating a sort of credit from which the delinquent premium could be retroactively paid (via a setoff). *Id.* at \*5. The court noted that *Colquitt* has never been cited by the Alabama Supreme Court and also that subsequent to *Colquitt*, the same court held in *Blue Cross-Blue Shield of Alabama v. Craig* that "the mere occurrence of a loss during a grace period that might have

been payable under a particular policy of disability insurance does not thereby excuse the insured's failure to make the tardy premium payment." *Id.* (citing *Craig*, 242 So. 2d 398 (Ala. Civ. App. 1970)). Thus the court found that *Craig* had effectively rejected the holding in *Colquitt* more than 35 years ago. *Id.*

The court concluded that "[a]lthough we have a healthy respect for the principle of stare decisis, we should not blindly continue to apply a rule of law that does not accord with what is right and just, and it is not 'right and just' that an insured receive an extra period of coverage at no cost." *Id.* (citing *Ex parte State Farm Fire & Cas. Co.*, 764 So. 2d 543, 545 (Ala. 2000)).

## TRIBAL COURT RULES NO JURISDICTION OVER HEALTH INSURER BASED UPON TRIBAL ERISA

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Rhonda Meeks, a former employee of the Foxwoods Resort and Casino in Ledyard, Connecticut, sought approval from Health Net, the health insurance carrier for casino employees, for a surgical procedure known as a "pro disc" replacement. Health Net denied this procedure and Meeks appealed. Health Net, after additional review, denied her appeal. Meeks then sued Health Net in court seeking to overturn the denial. In essence, Meeks was suing for a benefit she claimed should have been provided to her under the terms of an employee health benefit plan – a scenario that the courts have seen, and adjudicated, under the auspices of ERISA on countless occasions.

But this particular scenario was unique because the employer was the Mashantucket Pequot Tribal Nation, a federally recognized tribe entitled to sovereign immunity, the Casino was located on tribal lands and the court Meeks filed her complaint in was tribal court. The Mashantucket Tribal Nation and its judiciary had developed its own procedures for civil actions, its own rules of evidence and its own rules of law including, but not limited to, enactment of Title XV M.P.T.L. ch. 1, § 5, "Administration and Claims Review of Tribally Sponsored Employee Benefit Plans under ERISA" which was referred to as "TERISA."

The primary issue in the case of *Rhonda Meeks v. Health Net*, No. CV-GC-2007-36 (MPTN, July 5, 2007), concerned the scope of the tribal court's civil jurisdiction over claims filed in tribal court by a non-tribal, non-resident individual against a non-tribal, extra-territorial corporation over something (a denial of a surgical procedure) that did not happen or occur on tribal lands. action to enforce rights she asserts under the Tribe's employee insurance plan and because the action involved the federal ERISA statute, the first question was one of jurisdiction. The simple approach was to assume that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. 1001, et seq., governed the action and thus the

<sup>1</sup> The events noted herein occurred before the author joined the Division as legal counsel.