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Committee Leadership

In This Issue

Leadership Notes

Message from the Chair

By Byrne J. Decker

Greetings LHD Committee Members!

The season's first snowflakes are beginning to fly as I write this, which means that 2019 is quickly drawing to a close. 2019 was a great year for our great Committee and 2020 promises to be even better!

On the heels of our hugely successful April Seminar and the July Fly-In meeting, we recently gathered in New Orleans in October for the Annual Meeting. We kicked things off on Wednesday with a timely CLE session on mediation, featuring Adrienne Publicover, Moheeb Murray, and Virginia Roddy. This was simply an excellent, interactive session that everyone very much enjoyed and benefitted from. Following our business meeting and the cocktail reception, we gathered for an outstanding dinner at world famous Brennan's. Thursday's agenda was chock full of fantastic CLE offerings, followed by a historical walking tour/pub crawl featuring several classic New Orleans cocktails. As always, the Annual Meeting offered numerous networking opportunities that are critical for cultivating relationships and building our practices. The overriding sentiment from our Committee members, though, was simply how wonderful it was to be together with old friends in a vibrant city!

November featured our LHD/ERISA litigation "Boot Camp." For the fourth time in eight years, Committee veterans donated their time and came to Chicago to help teach new LHD practitioners the basics. This is a "can't miss" event for anyone looking to get involved in LHD work and this year's event did not disappoint. The presentations were simply excellent. Probably the best evidence of that is the fact that I saw many of the faculty members taking notes!! We also very much enjoyed the chance to network and get to know the boot camp participants at the cocktail reception and dine-arounds. It was really a great event. A huge thank you goes out to Hinshaw & Culbertson for once again hosting us in their Chicago office!

As we move into 2020, the planning continues for our April Seminar which will take place at the Sheraton New Orleans from April 29 through May 1, 2020. Please be on the lookout for the brochure, which will soon be distributed, and please sign up early! Remember that our Seminar also happens to coincide with the New Orleans Jazz Fest (as if you need another reason to come to New Orleans)!

Finally, as I conclude my first year as Chair of this Committee, let me just reiterate how much I enjoy it! All the tireless work of so many dedicated volunteers makes my job that much easier. If you haven't done so yet, I urge you to get involved in our Committee. Doing so truly pays dividends!

Byrne J. Decker is the managing shareholder in the Portland, Maine office of Ogletree, Deakins, Nash, Smoak & Stewart, P.C. Mr. Decker has a nation-wide practice that specializes in the defense of employee benefits/ERISA litigation. He has defended benefits cases in federal courts in every federal judicial circuit. Mr. Decker is the chair of the DRI Life, Health and Disability Committee.

Message from the Editor

By Moheeb H. Murray

Fellow DRI LHDE Committee members, my co-editor Steve Roach and I, are very pleased to present this edition of *Life, Health, and Disability News*. This edition was open to any topic, so you'll find articles on subject ranging from whether misrepresentations about marijuana use are still material for purposes of rescission, a survey of recent accidental-death decisions from across the US, and whether hackers can be ethical. The next edition will also be open to any non-ERISA LHD subject, so I encourage all of you to write an article and share your knowledge with your colleagues in DRI.

Thank you, and I hope you enjoy reading the articles!

Moheeb H. Murray leads the insurance coverage practice team at Bush Seyferth PLLC.. He represents leading national insurers in life, disability, ERISA, and other insurance-coverage matters at all stages of litigation. He also focuses his practice on complex-commercial and construction litigation.

Feature Articles

Marijuana—Is It Material?

Rescission of Life Insurance Policies Based on Material Misrepresentations in the Age of Legalized Marijuana

By Heather D. Erickson

Forty-two states have enacted various marijuana legalization laws ranging from complete legalized adult recreational use, legalized medicinal use, legalized cannabis-infused products or decriminalization of small amounts of marijuana. Today, there are eleven states—Alaska, California, Colorado, Illinois, Maine, Massachusetts, Michigan, Nevada, Oregon, Vermont and Washington—that have adopted the most expansive laws legalizing recreational marijuana.1 Most other states allow for limited use of medical marijuana under certain circumstances depending on the particular state. Then, there are several other states that have decriminalized the possession of small amounts of marijuana. In 2018, marijuana retail sales in Colorado alone reached $1.2 billion.2

The prevalence of legalized marijuana in the United States brings new challenges for insurers considering rescission based on misrepresentations concerning marijuana use. Rescission is a powerful tool that allows insurers to avoid unintended risks and attack insurance fraud when insureds are not completely accurate, or even dishonest, when obtaining life insurance. In other words, rescission allows an insurer to void an insurance policy when the insured has omitted or misrepresented material facts during the application process. In light of the increased legal marijuana sales, will a less than candid representation about cannabis be considered a material misrepresentation to sustain rescission of a life insurance policy?

Rescission – What Does the Insurer Have to Prove in Court?

Whether in a declaratory action or as an affirmative defense to a breach of contract or bad faith claim, the insurer will have to demonstrate its rescission of a policy was proper under the law. Generally, in most states, an insurer may rescind a life insurance policy if it can show the insured misrepresented facts during the application process. The insurer will also likely have to prove one or more of the following elements: (1) the misrepresentation was material to the risk being insured; (2) that the insured intended to deceive the insurer; and/or (3) that the insurer

1 http://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx
2 https://www.colorado.gov/pacific/revenue/colorado-marijuana-tax-data

reasonably relied on the misrepresentation.3 While states vary in which of the elements an insurer must prove to support its rescission of a policy, most require proof of a material misrepresentation.4

The Misrepresentation – Were the Right Questions Asked During the Application Process?

The most fundamental element of a rescission claim in any state is the existence of a misrepresentation, whether it be an incorrect statement, omission or concealment, by the insured during the process of obtaining a life insurance policy. Initially, in determining whether a misrepresentation was made concerning an insured's marijuana use, courts will turn to the questions asked in the insurance application. If a question on the application is ambiguous, this will hinder an insurer's success on a rescission claim based on an insured's misrepresentation of marijuana use.

Materiality – Would the Disclosure of Marijuana Use Have Changed the Risk?

Materiality is an element of rescission law in nearly every state.5 Moreover, materiality is generally based on evidence produced by the insurer, not the insured. *See Principal Life Ins. Co. v. Locker Grp.*, 869 F. Supp. 2d 359, 364 (E.D.N.Y. 2012). Typically, the test of materiality is whether knowledge of the facts would have influenced the insurer in determining to accept the risk or in setting the amount of premiums. *Id.*; *see also Styzinski v. United Sec. Life Ins. Co. of Illinois*, 332 Ill. App. 3d 417 (2002); *Old Line Life Ins. Co. v. Superior Court*, 229 Cal. App. 3d 1600, 1604, 281 Cal. Rptr. 15, 18 (Ct. App. 1991).

Misrepresentations About Marijuana Use – Current Case Trends

In recent decisions, courts have been reluctant to summarily find in favor of the insurer when it comes to misrepresentations of marijuana use during the application process for life insurance policies. Courts have found that the failure to disclose marijuana use did not amount to a misrepresentation at the summary judgment stage because

3 The following states' statutes govern the insurer's right to rescind an insurance policy: Alabama (Ala. Code § 27-14-7); Alaska (Ak. Stat. § 21.42.110); Arizona (Ariz. Rev. Stat. § 20-1109); California (Cal. Ins. Code § 330-61); Colorado (Colo. Rev. Stat. § 10-16-209); Delaware (Del. Code Ann. Tit. 18, § 2711); District of Columbia (D.C. Code § 31-4314); Florida (Fla. Stat. § 627.409); Georgia (Ga. Code § 33-24-7); Hawaii (Haw. Rev. Stat. § 431:10-209); Idaho (Id. Code § 41-1811); Illinois (215 Ill. Comp. Stat. 5/154); Kansas (Kan. Stat. §§ 40-2205, 40-2,118); Kentucky (Ky. Rev. Stat. § 304.14-110); Louisiana (La. Rev. Stat. § 22:619(A)); Maine (Me. Rev. Stat. tit. 24-A, § 2411); Massachusetts (Mass. Gen. Laws ch. 175 § 186); Minnesota (Minn. Stat. § 60A.08); Montana (Mont. Code § 33-15-403); Nebraska (Neb. Rev. Stat. § 44-358); Nevada (Nev. Rev. Stat. § 687B.110); New Hampshire (N.H. Rev. Stat. § 415:9); New Jersey (N.J. Stat. § 17B:24-3); New Mexico (N.M. Stat. § 59A-18-11); New York (N.Y. Ins. Law § 3105); North Carolina (N.C. Gen. Stat. § 58-3-10); North Dakota (N.D. Cent. Code § 26.1-29-13); Oklahoma (Okla. Stat. tit. 36, § 3609); Oregon (Or. Rev. Stat. § 742.013); Rhode Island (R.I. Gen. Laws § 27-18-16); South Carolina (S.C. Code Ann. § 38-71-40); South Dakota (S.D. Codified Laws § 58-11-44); Tennessee (Tenn. Code § 56-7-103); Texas (Tex. Ins. Code § 705.003); Utah (Ut. Code § 31A-21-105); Vermont (Vt. Stat. tit. 8, § 3736); Virginia (Va. Code Ann. §§ 38.2-309); Washington (Wash. Rev. Code § 48.18.090); and Wisconsin (Wis. Stat. § 631.11). However, some of these statutes may only apply to certain types of insurance policies.

4 Only Iowa, Kansas, Louisiana, Nebraska, Pennsylvania, South Carolina, Texas and Washington require an insurer to prove fraud or an intent to deceive. See Rubes v. Mega Life & Health Ins. Co., 642 N.W.2d 263, 269-71 (Iowa 2002); Kan. Stat. §40-2, 118; La. Rev. Stat. 22:619; Lowry v State Farm Mut. Auto. Ins. Co., 421 N.W.2d 775, 778-790 (Neb. 1988); Tudor Ins. Co. v. Twp. Of Stowe, 697 A.2d 1010, 1016-17 (Pa. Super. Ct. 1997); Lanham v. Blue Cross & Blue Shield of S.C., Inc., 563 S.E.2d 331, 334-35 (S.C. 2002); Tex Ins. Code §705.003; Wash. Rev. Code Ann. §48.18.090.

5 The following states require a showing of materiality: Arizona (Ariz. Rev. Stat. § 20-1109); California (Cal. Ins. Code § 334); Colorado (Hollinger v. Mut. Bene. Life Ins. Co., 560 P.2d 824 (Colo. 1977); Indiana (Ind. Code § 27-8-5-5); Illinois (215 ILCS 5/154); Iowa (Rubes, 642 N.W.2d at 269); Kansas (Kan. Stat. Ann. § 40-2205); Louisiana (La. Rev. Stat. § 22:619); Maryland (Essex Ins. Co. v. Hoffman, 168 F. Supp. 2d 547, 552 (D. Md. 2001); Michigan (Mich. Comp. Laws § 500.2218); Minnesota (Transamerican Ins. Co. v. Austin Farm Center, Inc., 354 N.W.2d 503 (Minn. Ct. App. 1985); Mississippi (Miss. Code § 83-9-11); Nebraska – sickness and accident insurance only (Neb. Rev. Stat. § 44-710.14); New Jersey (Moskowitz, 946 F. Supp. at 331); New Mexico (N.M. Rev. Stat. § 59A-18-11(C)); New York (N.Y. Ins. Law § 3105(b)(1)); Ohio (Pers. Serv. Ins. Co. v. Lester, 2006 Ohio App. LEXIS 5089 (Ohio Ct. App. 2006)); Oregon (Or. Rev. Stat. § 742.013); Pennsylvania (A.G. Allebach, Inc. v. Hurley, 540 A.2d 289 (Pa. Super. Ct. 1988)); Rhode Island (R.I. Gen. Laws § 27-18-16); South Carolina (see note 4, supra) (Agape Senior Primary Care, 636 Fed. Appx. at 876 n.5); Texas (Tex. Ins. Code § 705.004(b)); and Virginia (Va. Code § 38.2-309).

it was disputed who made the representation; whether there was a material misrepresentation; the application questions were ambiguous; or the insurer did not ask right questions.

On October 7, 2019, the Eastern District Court in Wisconsin denied the insurer summary judgment and found a genuine question of fact whether the insured was the one who answered the question regarding marijuana use and whether the marijuana use was a material misrepresentation on the application. *Williams v. Farmers New World Life Insurance Company*, 2019 WL 4933405 (E.D. Wis. October 7, 2019). In that case, the question on the application was whether the insured had ever used or been treated for the use of cocaine, marijuana, heroin, or any other addictive or illegal drug. The insured in *Williams* responded in the negative, but it was later discovered after her death that her medical providers noted daily marijuana use. The insurer had argued that had it known of the insured's marijuana use, it would not have offered her coverage because she would have been considered a current and heavy user of marijuana. *Williams*, 2019 WL 4933405, at *8–10.

In August, 2019, a District Court in Pennsylvania permitted a plaintiff to go forward with her bad faith claim against a life insurance company when the policy was rescinded due to an alleged misrepresentation regarding the insured's marijuana use. *See Horvath v. Globe Life and Accident Insurance Company*, 2019 WL 4058999 (W.D. Penn. August 27, 2019). The court in the *Horvath* case concluded that a reasonable jury could determine that the insurer unreasonably believed it had grounds to rescind the life insurance policies and that it knew of or recklessly disregarded its lack of reasonable basis. *Horvath*, 2019 WL 4058999, *10. In that case, the application question was whether within the past three years, the insured had any chronic illness or condition which requires periodic medical care. The insured's mother answered in the negative. After the death of the insured, the insurer obtained medical records which noted marijuana dependency and participation in a drug treatment program. The insurer presented testimony that it considered substance abuse to be a medical condition requiring periodic medical care. It also offered testimony that "as a cause of more mortality risk, the incomplete drug rehabilitation was the primary issue or concern for underwriting." The court noted the insurer never examined the plaintiff under oath prior to rescinding the policy to gain information on whether she knew she made false statements after she explained that she did not believe the insured's drug treatment was periodic medical care because she thought it was a one-time occurrence.

The *Horvath* court found that a reasonable jury could conclude that the insurer lacked a reasonable basis to believe that the insured's mother knew the alleged misrepresentation was false when she made it, especially when the application failed to ask any specific questions regarding the use of alcohol, marijuana, or other drugs, or about dependency on or addition to alcohol or drugs. *Horvath*, 2019 WL 4058999, *10–11.

Compare the application question at issue in the *Horvath* case to the application question found in *Global Energy Efficiency Holdings, Inc. v. William Penn Life Insurance Company*, 108 N.Y.S.3d 687 (2018). In *Global Energy*, the application specifically asked about the insured's use of tobacco, alcohol, marijuana and other illegal drugs to which the insured denied. The court denied the plaintiff's motion for summary judgment on her claim against the life insurance company as there was a genuine issue of material fact as to whether the insured made a material misrepresentation on his application for life insurance. The insured affirmed on his application that he never used restricted or controlled substances, including marijuana. Yet, after his death, which was due to cardiovascular disease and noted mixed drug intoxication as a contributing factor, his wife told police officers that her husband had been using marijuana for about three years on most evenings.

In contrast to *Global Energy*, the District Court of New Jersey found that the insurer could not satisfy its burden of showing that the plaintiff had misrepresented any answers on the life insurance application regarding marijuana use because the insurer had not asked the right questions. *Hawkins v. Globe Life Insurance Co.*, 105 F. Supp. 3d 430 (D.N.J .2015). In *Hawkins*, the insurance application question requested whether the insured "had or been treated for … drug or alcohol abuse" and the insured had answered "no." In that case, after the death of the insured, the insurer discovered that the insured was arrested for possession of marijuana and underwent a few counseling sessions with a general therapist. The insurer proceeded to rescind the life insurance policy because the insured's mother should have answered in the affirmative when she completed the application because she was aware the insured was arrested for drug-related crimes and attended therapy. The court disagreed because the insurer had not asked if the insured was ever arrested or ever used, possessed or distributed drugs. The court found that the insurer had failed to prove that the insured had or treated for drug abuse to establish a material misrepresentation

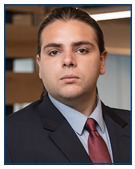
Recommended Practices

While marijuana may be legal in many places now, some insureds may not be inclined to accurately disclose their partaking of it in writing. When deciding to rescind a life insurance policy when an insured is less than candid about their cannabis, an insurer should thoroughly review the underwriting file and confirm there is sufficient evidence to support that the insured made a material misrepresentation of marijuana use during the application process. Whether a material misrepresentation exists will hinge on the following: (1) the specific questions asked of the insured on the application or in subsequent interviews, (2) who completed the application – the insured or a relative, (3) the sufficiency of the evidence regarding the truthfulness of the insured's answers, and (4) the evidence to support that if the insurer had known the true facts, it would not have issued the policy or would have increased premiums to account for the additional risk associated with the particular marijuana use.

Heather D. Erickson is a partner with the law firm of Sanchez Daniels & Hoffman LLP. Her practice primarily focuses on commercial, insurance and employment litigation. She represents insurers in life, health, disability, and ERISA matters from interpleader actions to defense of bad faith claims and everything in between. She has experience in both state and federal courts through trial and appeal. She is admitted to practice in Illinois, the U.S. District Court for the Northern, Central and Southern Districts of Illinois and the 7th Circuit. She counsels clients with an eye towards keeping the legal strategy in alignment with the client's business interests and values.

A Brief Survey of Recent Accidental-Death Insurance Cases

By Moheeb H. Murray and Daniel A. Ruiz

Cases involving accidental-death insurance claims are often ripe for interesting judicial analysis and varied rulings because of the nuanced fact patterns and specific requirements for coverage. This brief survey analyzes a few such cases from across the United States that were decided in the last year.

Does a Fall That Exacerbates Pre-Existing Conditions Constitute an Accidental Death?

In *Davis v. Federal Insurance Company*, 382 F. Supp. 3d 1189 (W.D. Okla. April 08, 2019) and *Vogt v. Minnesota Life Insurance Company*, 383 F. Supp. 3d 996 (E.D. Cal. May 21, 2019), both courts dealt with a life insurance beneficiary suing the insurer for denial of accidental death benefits where a fall precipitated a sharp decline in the decedent's health and culminated in their eventual demise. The court in *Davis* granted summary judgment in favor of the insurer. The court in *Vogt*, on the other hand, denied the insurer's motion for summary judgment. The results in *Davis* and *Vogt* can be most readily distinguished on the basis of which interpretive law applied, and the presence of a medical expert opining directly about causation.

In *Davis*, the decedent who had been suffering from leukemia and was undergoing chemotherapy fell from her wheelchair; nineteen days later she passed away. The medical examiner concluded that the probable cause of death was sepsis, but also indicated subdural hematoma as one of many "contributing causes." The decedent's death certificate further listed "sepsis as the immediate cause of death. The manner of death however was listed on both the death certificate and the examiner's investigative report as "Accident." The policy, however, defined "accident" as an event independent of illness, disease or bodily malfunction.

Both the certificate and the report included space for "significant conditions" that contributed to death but did not result in the underlying cause of death, and in these sections "subdural hematoma" was listed. The investigative report affirmatively linked the hematoma with the fall. Additionally, an affidavit submitted by the daughter of the decedent averred that the decedent was free from any infection prior to her fall, and that—based on her observations and beliefs—her mother's death resulted from her accidental fall.

The insurer argued the investigative report and death certificate did not constitute causal evidence based on the definition of "accident." It also argued that given the plaintiff's lack of any expert witness, no causal evidence

existed linking the bacterial infection to the fall. The court agreed, disregarding the affidavit on the grounds that it was inappropriate lay-witness testimony and further noting that manner-of-death determinations are not dispositive in the context of policies that defined accident.

Thus, given the lack of any qualified expert testimony regarding causation, the court held that the plaintiff lacked evidence to establish a causal nexus between the fall and the bacterial infection that led to the fatal sepsis.

In *Vogt*, the insured suffered from recurrent falls, was on hospice, in poor health, and was likely to pass away naturally. The decedent suffered his last fall in his bedroom, which resulted in a hip contusion. The plaintiff also alleged that the decedent had hit his head and complained of head pain and headaches. Ambulance and emergency-room records documented complaints of head pain. After the final fall, the decedent's functionality noticeably declined, and hospice nurses increased their weekly visits from twice a week to every day. The hospice notes indicated he had significantly declined since his fall. Records indicated the decedent was unable to eat food between the time of his fall and his death one week later and he was bedbound following the fall. 383 F. Supp. 3d at 1001.

Within three days of the fall, the decedent was completely nonverbal and was no longer able to take oral medications. Within five days, he was unable to swallow, was restless, and only taking water by swab. In seven days, he was unresponsive. In eight, he was dead. *Id.* The original death certificate listed Parkinson's Disease as the underlying cause of death, listed cardiopulmonary failure as the immediate cause of death, and included recurrent falls as an additional cause.

The insurer argued that even though the decedent suffered a fall during the last week of his life, the already weak, frail, and terminally ill decedent's death was not caused by an accident and no medical evidence linked the fall to his death. The beneficiary argued overwhelming evidence existed showing the decedent hit his head during his fall and his death was caused by his head injury.

The court held under, California law, policy language referring to "directly and independently of all other causes" is interpreted broadly as permitting recovery if the accident is the "proximate cause" or "initiating cause" of the loss even if a disease may have contributed to the accident. *Vogt*, 383 F. Supp. 3d 996, 1004.

Citing California cases, the court held that it does not matter that an insured's weakened and infirm condition made him less able than a normal person to withstand the effects of injuries. Thus, in the instant case, the Plaintiff had met the burden of presenting evidence that indicated the fall "set in progress the chain of events leading directly to death." *Id.* at 1009. The court primarily relied on evidence that the decedent's functionality decreased noticeably following the fall, the increased the number of visits by the hospice nurses, and a declaration from the Plaintiff's medical expert that the most probable cause of the insured's death was due to a brain injury.

Is Combined Prescription Drug Intoxication Is i.) an Accident, ii.) an Illness or Disease Due to a Reaction to Drug or Medication, or iii.) Medical Treatment?

In *Long v. Aetna Life Insurance Company*, --- F. Supp. 3d ----, 2019 WL 4931352 (N.D.Tex. August 21, 2019), the beneficiary of a life insurance policy sued the insurer for accidental death benefits. The decedent died from complications stemming from accidentally taking several prescription drugs simultaneously and the drug intoxication that subsequently occurred. The medical examiner's autopsy report listed the cause of death as accidental acute combined drug intoxication. The insurer argued against liability on three grounds.

First, the insurer argued that the decedent's death was not an "accident" as defined in the policy. Second, the insurer argued that the policy excluded that cause of death under a provision limiting the scope of coverage for an illness or disease due to a drug or medication. And third, the insurer argued that coverage was excluded under the medical-treatment exclusion. The court granted summary judgment in favor of the insurer on all three issues.

The policy defined accident as a sudden external trauma causing external bodily injury. The court cited the autopsy report, which stated "[t]here is no acute evidence of trauma on the surface of the body," and held the accidentally lethal drug combination was, therefore, not covered as an accident. 2019 WL 4931352, at *4

The policy further provided an "accident" must not be due to, or contributed by, an illness or disease of any kind, including a reaction to a drug or medication. The court held that the policy did not cover combined drug intoxication because it was an illness or disease due to a drug or medication. *Id.* at 5.

Finally, the policy excluded coverage for losses caused by medical treatment. The court held this provision also

precluded recovery because the decedent's death was "undisputedly contributed to by medical treatment." *Id*. at 5.

Does a Crime Exclusion Include Traffic Violations?

In *Boyer v. Schneider Electric Holdings, Inc. Life and Accident Plan,* 350 F. Supp. 3d 854 (W.D. Mo. October 10, 2018), a life-insurance beneficiary sued a plan administrator after denial of accidental death benefits. The insured's death was the result of a single-car accident where the insured had been speeding excessively and had improperly passed several vehicles in a no-passing zone immediately before running off the roadway and striking a tree. The administrator denied benefits under the plan's crime exclusion, because the traffic violations at issue were considered misdemeanors under state law.

The court held that the administrator's interpretation was unreasonable (applying the *Finley* Factors for evaluating reasonableness under ERISA). The policy language excluded coverage for "accidental losses caused by, contributed to by, or resulting from: . . . an attempt to commit or commission of a crime." The court held "the language does not demonstrate an exclusion of coverage for accidents resulting from the insured's traffic violations." Allowing the administrator's construction to stand, the court reasoned, "would allow [the insurer] to deny coverage every time a plaintiff was caught speeding even one mile per hour over the speed limit. To construe the crime exclusion to include such violations is contrary to the plain language." 350 F. Supp. 3d at 864-865.

Does an Intoxication Exclusion Require Causation?

In *Calderon v. Hartford Life and Accident Insurance Company,* 372 F. Supp. 3d 1259 (D. N.M. 2019), a life-insurance beneficiary sued an insurer to recover accidental-death benefits. The insured died from a motorcycle accident while his blood alcohol level was .2, but the collision another driver's inattention and failure to yield the right of way to the decedent caused the accident. Three witnesses at the scene had stated there was no time for the intoxicated driver to avoid the crash. The insurer argued that a provision excluding coverage for injuries sustained while intoxicated barred the beneficiary's recovery.

The insurer also argued that because motorcyclist's blood-alcohol content was .2 percent at the time of the crash, intoxication was a contributing cause of his death and therefore not "an accident independent of all other causes." The court rejected the later argument on the grounds that the insurer conflated the *cause of death* with the *cause of the crash* and cited the death certificate and medical reports, which listed "blunt force injuries" as the cause of death.

The court also rejected the insurer's argument that the intoxication provision barred recovery, holding that there is "an implicit causation requirement that require[s] insurance companies to identify a connection between the injury and the insured's intoxication before denying benefits." 372 F. Supp. 3d at 1268. Citing *Papotto v. Hartford Life & Accident Ins. Co.,* 2011 WL 6939331 (D. N.J. Dec. 30, 2011) (holding that an exclusion that barred recovery for "any loss caused or contributed to by . . . injury sustained while intoxicated" contained a causation requirement), the court said that the insurer's interpretation was unreasonable because an "intoxicated individual fatally struck by lightning while safely relaxing in the comfort of his home would be denied coverage. No reasonable insured party would expect this unusual result." 372 F. Supp. 3d at 1269. (internal citations omitted).

Is Autoerotic Asphyxiation an Excluded Intentionally Self-Inflicted Injury?

In *Tran v. Minnesota Life Insurance Company*, 922 F.3d 380 (7th Cir. April 29, 2019), a life-insurance beneficiary sued an insurer to recover accidental-death payouts, but the insured died while engaging in autoerotic asphyxiation. The insurer argued that the death was not accidental because it fell under a policy exclusion for deaths resulting from "intentionally self-inflicted injury."

The trial court held that the death qualified as an accidental death and did not result from an intentionally self-inflicted injury and it granted judgment for the beneficiary. The Court of Appeals for the Seventh Circuit reversed, holding that a reasonable person would interpret autoerotic asphyxiation to be an intentionally self-inflicted injury, and thus excluded from coverage. The appellate court assumed without deciding that the death was an accident and limited its discussion to whether autoerotic asphyxiation constitutes an injury and then whether the injury is intentionally self-inflicted.

The court disagreed with the Second Circuit's determination in *Critchlow v. First UNUM Life Ins., America,* 378 F.3d 246 (2nd Cir. 2004), which had said death is caused by the total loss of oxygen for sustained period. The Seventh Circuit argued that *Critchlow* improperly parsed the causal

chain of events and that autoerotic asphyxiation is one continuous act and injury. "Strangling oneself to cut off oxygen to one's brain is an injury, full stop." *Tran*, 922 F.3d at 386.

The court then held that autoerotic asphyxiation is necessarily intentionally self-inflicted, disregarding prophylactic measures the decedent took to avoid injury, such as use of a protective towel around the neck to avoid abrasion. In a footnote the court reasoned, "Why, if the person did not think injury was a substantial certainty, would he use prophylactic measures during the act to mitigate injury?" 922 F.3d at 386 n.4.

The court next distinguished *Santaella v. Metropolitan Life Ins. Co.,* 123 F.3d 456 (7th Cir. 1997), which had involved a fatal drug overdose. In that case the trial court found the decedent had undisputedly abused propoxyphene and had suffered a seizure from the drug abuse two months before her death. Acknowledging that there was no evidence that the decedent knew the seizures were a common side effect, the trial court held the injury was self-inflicted, because a reasonable person would have been alerted that the abuse would cause seizures. The Seventh Circuit reversed the trial court on the grounds that the drug abuse victim had a subjective expectation of survival and that such an expectation was objectively reasonable because death was not certain or even highly likely to result from her conduct.

In *Tran*, the court distinguished *Santaella*, because no record evidence existed to indicate the insured had intended to injure herself by taking propoxyphene, whereas the insured in the instant case intentionally strangled himself "regardless of whether it was done with an intent to survive." 922 F.3d at 386.

Conclusion

The jurisprudence on accidental-death insurance yielded interesting results over the past year. As these cases show, the particular facts of each death and the specific policy language often prevent a cookie-cutter analysis. Insurers and their counsel must continue to be careful in analyzing each claim for its particular nuances to make an appropriate coverage decision and, if necessary, defense strategy.

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Daniel A. Ruiz is an associate that focuses his work on litigation. He assists with research, drafting legal documents, and all other aspects of assisting with cases. He also works on product liability and insurance matters.

Can Hackers Be Ethical, Not Evil?

By Alan M. Winchester

We are increasingly seeing situations in which a client's information systems are breached by an ethical hacker. Typically, they take a screen shot or two of data to prove their accomplishment, carefully redact any confidential or protected information and then notify the organization of their security defect, often hoping for a reward or a so-called "Bug Bounty."

In response, the organization fixes the defect, confirms that no information was downloaded by the hacker and that access by others did not occur, and evaluates the event to confirm data subjects did not face any risk nor harm. At this point, the organization reaches the stage of their Incident Response Plan that addresses whether or not to notify the data subjects and their respective states of the event. Does the incident constitute a "breach" that requires notification to the data subjects and relevant state authorities?

Most organizations are tempted to conclude that there is no duty to notify: notifications are costly, embarrassing, and confusing. Moreover, in this situation, notification would arguably cause confusion among the data subjects, who would receive an alarming letter without facing any risk. If someone within the organization had discovered the flaw, and no one else accessed the information, no law anywhere would require a notification. It would be viewed as a "near miss." So why should the outcome be any different when the flaw was discovered by an ethical

hacker who behaved in the same manner as any employee of the organization?

Like any juicy legal issue, there is another side to this analysis. To understand this side's argument context helps. A breach is commonly described as the unauthorized access to protected information. Many breach notification laws require a notification to the data subjects and relevant state authorities only when the information breached is also acquired. In this sense, acquired means that the information was downloaded or viewed by an unauthorized individual in such a way that the content was appreciated and perceived by the unauthorized individual. Other states require notification when the information is merely accessed. For example, New York state's previous breach notification law used to define a breach as: "unauthorized acquisition or acquisition without valid authorization of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by a business." (See 899-aa of the General Business Law.)

The current version of the law defines a breach as the "unauthorized access to or acquisition of, or access to or acquisition without valid authorization, of computerized data that compromises the security, confidentiality, or integrity of private information maintained by a business." Thus, under the old law, an organization would likely conclude they were not breached in the opening example because the ethical hacker did not acquire the information.

Today the organization might not reach the same conclusion. Even though the notification would cause needless worry and aggravation, it could be prudent to conclude the hacker's momentary access to the file constituted a breach under the new language, so arguably a notification should be made—at least until some guidance is given to the contrary—since the fines are $5,000 per violation up to $250,000. There is, after all, no doubt the hacker accessed the file, as screen shots attest. Unfortunately, the law does not directly consider the circumstances of an ethical hacker.

To try to resolve this issue we might consider that New York state has an exception to the definition of "breach" in its notification law. It allows that "Good faith access to, or acquisition of, private information by an employee or agent of the business for the purposes of the business is not a breach of the security of the system, provided that the private information is not used or subject to unauthorized disclosure." 899-aa(1)(c).

The law goes on to help understand the concept of "access" to say:

> In determining whether information has been accessed, or is reasonably believed to have been accessed, by an unauthorized person or a person without valid authorization, such business may consider, among other factors, indications that the information was viewed, communicated with, used, or altered by a person without valid authorization or by an unauthorized person.

Id.

But when the hacker first accessed the system, were they authorized to do what they did? Again, as with any good legal issue, the answer is that it depends. Many organizations have what is called a "bug bounty" program. They have clearly defined rules of engagement, methods for communicating a breach, and a defined reward for hackers (or as many of them prefer to be called, "security researchers") to claim if successful. There are internet sites devoted to the practice.

Consider www.hackerone.com as one example. In the scenario of a published bug bounty, an organization could argue that the actions of the hacker were authorized and even invited. Smaller organizations that cannot afford a full-time security expert may rely on the bounty program as a part of its security program because it gets the benefit of a skilled security expert for a rather trivial sum of money to help fix the systems that are insecure. Large organizations may retain them because no one is perfect, and the efforts of many ethical hackers could find flaws that internal groups might miss. Thus, from a public interest standpoint, ethical hackers address holes for repair and protect the citizens of the state in a manner that is feasible for businesses of every size. This is essentially extreme "penetration testing," where an external agency is contracted to try and breach a system. But in the case of the bounty program you don't know the name of the external entity until after they succeed.

There is also the situation of an organization approached by a "security researcher" that did not have a bounty program in place prior to the researcher gaining access. Assume in this example that the hacker still brings the incident to the attention of the organization and behaves exactly as if there was a bounty program in place. They don't download any content, take only a few redacted screenshots do not demand any payment and help the organization fix the security flaw. Is this a breach? The fact that the organization did not have an official bounty program undercuts the argument that the activity was "authorized." The question then becomes whether one can authorize a hacker after the fact.

The FTC recently settled a case against Uber in which hackers maliciously downloaded a tremendous amount of protected information and demanded a six-figure payout. Uber essentially sought to "launder" the incident as an ethical hack by paying them $100,000 through a bug bounty platform and requiring them to delete the files and execute an NDA. Uber did not notify the data subjects of the breach. Uber also fired their then CISO and chief legal compliance officer. Typical of these sorts of efforts, it was discovered, and Uber settlement resulted in their agreeing to a fine of $148,000,000.

Although Uber is an example of what not to do, the Complaint does allow for a strong argument that were these actually ethical hackers and not extortionists, the failure to notify data subjects would have been appropriate. At paragraph 26 of the amended complaint, the FTC writes:

26. Respondent paid the attackers $100,000 through the third party that administers Uber's "bug bounty" program. Respondent created the bug bounty program to pay financial rewards in exchange for the responsible disclosure of serious security vulnerabilities. However, the attackers in this instance were fundamentally different from legitimate bug bounty recipients. These attackers did not merely identify a vulnerability and disclose it responsibly. Rather, the attackers maliciously exploited the vulnerability and acquired personal information relating to millions of consumers.

One could reasonably conclude that because the FTC acknowledges legitimate bug bounty programs and used the language that "these attackers did not merely identify a vulnerability and disclose it responsibly," it suggests that to the FTC, at least, identification of a defect by a legitimate bug bounty hunter who acts responsibly is not a breach which requires reporting. But Uber did have a formal bug bounty program, so the example is not perfect.

There are no other cases addressing this issue; so whether a state would agree with this or if FTC would still reach the same position for a company without a formal bounty program is an open question. If the data set is relatively small, the least risky and potentially least expensive course of action would be to notify the data subjects of the event explaining how the new laws are unclear about reporting requirements and, out of an abundance of caution, notification is being made even though the incident does not pose any material risk.

For larger datasets it is a harder business decision about whether to notify data subjects of a breach by a genuine ethical hacker or researcher. The elements to consider would be:

- Does the organization have an established bug bounty program and were the rules of that program followed?
- Can the organization conclusively show that the content was not downloaded or otherwise acquired?
- Are the hackers legitimate and reputable?
- Did the hacker act responsibly?
- Is it fair to characterize the payment as a bounty or was it extortion?
  - How much was paid?
  - What were the terms of the payment?
  - Why did the organization decide to pay?
  - Did the individual help remediate the security flaw?
- Does the incident pose any risk to the data subjects?

We don't think the lack of a preexisting bounty program precludes the conclusion that no notification is required. It is just one element to consider. However, if the other five elements fail, it becomes riskier to avoid notifying the data subjects and their respective states because there is likely some event that will precipitate the investigation; and unless the communications are well-crafted, chances are that someone will characterize any bounty payment as extortion that will be seized upon by the investigatory agency.

This alert does not purport to be a substitute for advice of counsel on specific matters

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