Abstracts of Significant Cases Bearing on the Regulation of Insurance 2016

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Supreme Court of the United States

Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936 (U.S. 2016)

In this case, the Supreme Court held that a Vermont law requiring certain insurers and other health care payers to submit health care claims data to an All-Payer Claims Database (APCD) was preempted by federal Employee Retirement Income Security Act (ERISA) law, as applied to self-insured employee benefit plans like the one issued by Liberty Mutual. In its ruling, the Supreme Court affirmed the Second Circuit, holding that "reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA." The Court held that Vermont's reporting regime intrudes upon "a central matter of plan administration" and "interferes with nationally uniform plan administration." Of note, the Court suggested that the Secretary of Labor "may be authorized to require ERISA plans to report data similar to that which Vermont seeks, though that question is not presented here."

The National Association of Insurance Commissioners (NAIC) filed an amicus brief in this case at the request of the Insurance Division of the Vermont Department of Financial Regulation. The NAIC was joined by the National Governors Association, National Conference of State Legislatures, Council of State Governments, and Association of State and Territorial Health Officials, arguing that the Vermont law and the similar APCD laws of 17 other states were not preempted by ERISA. Following this decision, the Department of Labor issued a proposed rulemaking that would require ERISA plans to submit data similar to that required by state APCD laws.

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Zubik v. Burwell, 136 S. Ct. 1557 (2016)

Nonprofit religious employers sued the Secretary of Health and Human Services (HHS) and other government officials, challenging the Affordable Care Act's (ACA) regulatory mandate to provide insurance coverage for contraceptives. Federal regulations require companies to cover certain contraceptives as part of their health plans, unless they submit a form stating that they object on religious grounds to providing contraceptive coverage. The nonprofit religious organizations argued that submitting the notice substantially burdens the exercise of their religion in violation of the Religious Freedom Restoration Act.

Following oral argument, the Court requested supplemental briefing regarding "whether contraceptive coverage could be provided to petitioners' employees, through petitioners' insurance companies, without any such notice from petitioners."

The parties agreed that the Court's suggested remedy would be feasible. The religious employers explained that their religious exercise is not infringed where they "need to do nothing more than contract for a plan that does not include coverage for some or all forms of contraception," even if their employees are still able to receive free contraceptive coverage. Likewise, the Government agreed that the procedures could be modified so they would not infringe on the employers' constitutional rights. The Court vacated the decision below and remanded for further proceedings.

United States Courts of Appeal

Cont'l Cas. Co. v. Symons, 817 F.3d 979 (7th Cir. 2016)

This case involves fraudulent transfers from a subsidiary corporation to its parent, in which the subsidiary was evading debt from its purchase of a crop insurance business. In 1998, IGF purchased a crop insurance business from Continental Casualty Company. In 2002, IGF sold the business to Acceptance Insurance Company for $40 million, while it still owed $24.5 million to Continental from its 1998 purchase. In structuring the 2002 sale, money from Acceptance's purchase price was transferred to IGF's parent company, Symons International and related entities. Symons asserted there was adequate consideration for several of these transfers, including a reinsurance treaty and noncompete agreements.

The Court ruled that Symons was liable as an obligor on IGF's outstanding debt to Continental. The Court also held that the corporate veil could be pierced in this case because the corporations had raided each other and commingled assets. Finally, the judgment held that items of consideration were merely a pretext for fraudulent transfer.

Cent. United Life Ins. Co. v. Burwell, 827 F.3d 70 (D.C. Cir. 2016)

Insurers offering fixed indemnity health care plans filed suit against the Secretary of the HHS, challenging a rule requiring that the plans could be sold only to those who already had minimum essential coverage under the ACA. Fixed indemnity plans pay a predetermined amount to the policyholder for specified medical events and are typically less expensive than comprehensive health care coverage. Prior to the HHS promulgating this rule, fixed indemnity plans could be purchased as stand-alone coverage, as an excepted benefit under the federal Public Health Service Act (PHSA). Once the ACA was adopted, requiring individuals to purchase minimum essential coverage or pay a penalty, many opted to save money by paying the penalty and buying a fixed indemnity plan.

The HHS argued that the PHSA's requirement that fixed indemnity plans be "offered as independent, noncoordinated benefits" meant that they must be independent from *something* and that the HHS simply filled in the blank with "minimum essential coverage." The Court, however, did not agree that the provision was ambiguous. It explained that the requirement regulated providers and not consumers, which meant consumers could purchase additional coverage but were not required to do so. The Court did not afford Chevron deference to the HHS because it was not merely interpreting law but was amending it to govern the actions of a different classification of people than Congress had intended.

United States District Courts

King v. Nat'l Gen. Ins. Co., No. 15-CV-00313-DMR, 2016 WL 2851861 (N.D. Cal. May 16, 2016)

Putative class members filed suit against a number of insurers with whom they contracted to receive private passenger automobile insurance (PPA policies), claiming, among other things, breach of contract, breach of the covenant of good faith and fair dealing, fraud, and violations of the state Unfair Competition Law. Under California law, an insurance company that offers PPA policies must also offer a "good driver" discount of at least 20% below the rate the policyholder would otherwise be charged. Policyholder plaintiffs alleged that the defendant insurers shared common ownership, management or control, and therefore, belong to the same "control group." California law requires agents of an insurer within a control group to offer a policyholder who qualifies as a good driver the lowest rate offered by any of the insurers "for that coverage" in the control group ("cross-offer requirement"). Policyholders alleged that defendant insurers failed to offer good drivers the lowest rates for coverage. Additionally, they alleged that the insurers did not reimburse the overcharges when they were discovered.

Insurers argued that the cross-offer requirement underlies all of the claims and falls within the Department of Insurance's (Department) exclusive jurisdiction, pursuant to the rate, rate-making and rate regulation authority, precluding a private cause of action. The Court held that to the extent a claim does not challenge a rate approved by the Department or Department's ratemaking authority, a private cause of action under the cross-offer requirement can be sustained. The Court found that the action can stand where, as here, plaintiffs argue that insurers wrongly applied the higher rate, rather than the lower rate, both of which the Department approved. Defendants further argued that the term "for that coverage" meant that plaintiffs could be harmed only if lower rates existed for the exact coverage provided to the policyholder. The Court disagreed that the statute should be read so narrowly. The Court granted defendants' motion to dismiss because the law placed the burden on agents, not insurers, to offer the good driver policies, and plaintiffs' claims failed to distinguish these facts. Nevertheless, the Court provided plaintiffs an opportunity to amend their complaint, rejecting defendants' argument that an amendment would be futile.

Burroughs v. PHH Mortgage Corp., No. 15-6122 (NLH/KMW), 2016 WL 1389934 (D.N.J. Apr. 8, 2016)

PHH, a loan servicer, filed a motion to dismiss a class action in this case involving force-placed insurance policies. The plaintiffs alleged that PHH acted together with Assurant Specialty Property to exploit PHH's ability to force-place hazard and wind insurance in order to reap additional, unjustified profits in the form of payments disguised as "expense reimbursements," below-market-rate portfolio tracking, subsidized mortgage servicing and other forms of consideration at the expense of borrowers whose hazard or wind insurance was force-placed.

The Court rejected PHH's argument that any filed rate approved by the governing regulatory agency is per se reasonable and unassailable in judicial proceedings. In denying the motion to dismiss, the Court reasoned that regardless of the rate charged for force-placed insurance, what is being challenged here and in similar cases is not the rate itself, but rather the mortgage servicer's alleged exploitation of its ability to force-place hazard insurance in order to reap additional, unjustified profits in the form of payments disguised as purportedly legitimate fees.

Amtrust N. Am., Inc. v. Safebuilt Ins. Servs., Inc., No. 16-MC-169 (CM) (JLC), 2016 WL 2858898 (S.D.N.Y. May 16, 2016)

The issue before the Court was whether a defendant insurer could assert privilege over an examination report and related documents. Amtrust North America, Inc. et al. filed suit in the U.S. District Court for the Southern District of New York against Safebuilt Insurance Services, Inc., several other insurers and

reinsurers, and the individuals who owned them. The parties had entered reinsurance agreements whereby Amtrust agreed to reinsure policies underwritten by one of the individual defendant's companies. In turn, defendants were to reinsure Amtrust and cover costs, through a captive reinsurance company, Pacific Re, Inc. and its protected cell, Pac Re. Amtrust contended that Pacific Re and Pac Re were unable to fulfill their obligations because they were mismanaged and undercapitalized. Amtrust sought to pierce the corporate veil to recover its losses. Amtrust served Pacific Re's corporate law firm with a subpoena seeking documents and communications with the Office of the Montana State Auditor and Commissioner of Securities and Insurance (CSI) related to the creation of Pacific Re's protected cell, Pac Re. The law firm produced a number of documents, including an examination report and orders of supervision issued to Pacific Re, which it later attempted to claw back as "confidential." Amtrust noticed a deposition of CSI to obtain additional information regarding the creation of Pac Re, CSI's examination of Pacific Re, and the orders of supervision. Defendants moved to quash the subpoena but CSI appeared and answered questions over objections.

The Court held that the examination report and related documents were not privileged for three reasons. First, the Court reviewed the confidentiality provision of Montana's examination law, which states, in part, that the examination reports, working papers and other documents are "confidential, are not subject to subpoena, and may not be made public by the commissioner … without the written consent of the company or upon court order." The Court reasoned that the law protects documents from disclosure by CSI, not the company. Furthermore, the law provides that the documents are "confidential" but not "privileged." Second, the Court found a number of persuasive opinions from other jurisdictions interpreting similar statutes and finding that they did not protect examination documents as privileged. Finally, the Court gave deference to CSI's interpretation of the law based on its cooperation with the deposition despite defendants' objections. While the Court did not find the documents to be privileged, it did allow them to be subject to a stipulated protective order. The Court granted Amtrust's motion to enforce the subpoena and denied defendants' motion to quash.

State Courts

Illinois

Walsh v. Illinois Dep't of Ins., 54 N.E.3d 207, appeal denied, 60 N.E.3d 883 (Ill. 2016)

Joseph Walsh appealed the Illinois Department of Insurance's order revoking his producer license. Walsh argued that the Department abused its discretion by ignoring cases he claimed were comparable to his and by issuing sanctions without accounting for mitigating evidence he presented. He also argued that the sanctions imposed were inconsistent with the law because they "do not protect the public interest."

The Court reviewed the underlying facts before the Department. On various producer license applications in 2007, 2009 and 2011, Walsh had answered "no" in response to a question asking whether he had "an insurance license denied, revoked, suspended or surrendered for disciplinary reasons in any state." But upon investigation, the Department discovered that Walsh's producer license had been revoked by the Ohio Department of Insurance; that the Wisconsin Office of the Insurance Commissioner denied a producer license application he had filed; and that he had entered into a Consent Order and Stipulation with the Michigan Office of Financial and Insurance Regulation. The Department found that Walsh had "obtained a license through misrepresentation" and assessed a $15,000 penalty. Following entry of the Department's revocation order, Walsh requested a hearing on the matter. At the hearing, the investigator revealed that in 2002, Walsh had forged a customer's signature on an insurance policy application and that Walsh had provided false answers to questions on producer license applications in a number of states asking whether he had ever been subject to discipline. In reviewing the agency decision, the Court found that the Department did not abuse its discretion and that the sanctions were appropriate because each instance in which Walsh falsely answered "no" constituted a separate sanctionable episode of misconduct, warranting the penalty assessed.

Maryland

United Ins. Co. of Am. v. Maryland Ins. Admin., 144 A.3d 1230 (2016)

United Insurance Company of America (United) challenged a state law requiring life insurers to use the Social Security Administration's Death Master File as a cross-reference against its list of in-force life insurance policies, annuity contracts, and retained asset accounts to determine whether any policyholders had

died in order to provide beneficiaries with the necessary claim forms and instructions. Prior to enactment of the law, United and many other insurers paid only when a beneficiary submitted "due proof of death," pursuant to contractual language. This practice resulted in many beneficiaries missing timely receipt of settlements owed.

The law did not indicate whether its provisions applied to policies placed prior to the statute's effective date. United met with the insurance commissioner, who advised that she interpreted the law to apply retroactively to those policies. Following the meeting, United filed a civil suit challenging the constitutionality of retroactive application of the law. United argued that retroactive enforcement of the law altered contractual rights and responsibilities, which would result in increased administrative costs. The Supreme Court affirmed the decision to dismiss the lawsuit based on a failure to exhaust administrative remedies. The Court found that United did not overcome the rebuttable presumption that an administrative remedy is intended to be primary. Furthermore, the Court held that the claim did not fit within the constitutional exception to the exhaustion requirement since United did not challenge the constitutionality of the statute as a whole but how it applied in a particular situation.

Pennsylvania

Erie Ins. Exch. ex rel. Sullivan v. Pennsylvania Ins. Dep't, 133 A.3d 102 (Pa. Commw. Ct.), appeal denied, 145 A.3d 728 (Pa. 2016)

Erie Insurance Exchange (Exchange) brought a civil action against its attorney-in-fact, Erie Indemnity Company (Indemnity). Both parties are part of an insurance holding company system, pursuant to the Insurance Holding Companies Act (IHCA). As Exchange's attorney-in-fact, Indemnity issued insurance contracts and collected premiums from subscribers under an agreement entitling Indemnity to a maximum of 25% of all paid premiums. In its action, Exchange contended that Indemnity violated the agreement by collecting additional service charges from subscribers without passing them on to Exchange. Exchange alleged breach of contract, breach of fiduciary duty, and unjust enrichment. The trial court bifurcated the proceedings under the doctrine of primary jurisdiction, which allows a court to refer certain issues within an agency's area of expertise to that department for consideration. In this case, the Court transferred issues falling within the Insurance Department's (Department) expertise to that agency. The Department determined that the sole issue before it was whether Indemnity's retention of added service charges violated the standards contained in the IHCA. After reviewing pleadings and discovery, the Commissioner found that Indemnity did not violate the IHCA standard as the agreement was fair and reasonable.

On appeal, Exchange argued that the Department erred in asserting primary jurisdiction over the common law claims and that even if jurisdiction was appropriate, the Department erred in finding that Indemnity did not breach the

agreement or its fiduciary duties. The Department claimed that it only addressed the issue falling within its expertise: whether the agreement violated the IHCA. The Court determined that the agreement could be found fair and reasonable under the IHCA while also constituting a breach of contract, but that Exchange's pleadings did not allege that the transactions were unfair and unreasonable. Therefore, the Court found that the trial court erred in transferring the matter to the Department. The Court vacated the Department's order and remanded the case back to the Department for transfer to the trial court for further proceedings.

Crosby Valve, LLC v. Dep't of Ins., 131 A.3d 1087 (Pa. Commw. Ct. 2016)

Crosby Valve LLC and other corporate policyholders petitioned to intervene in proceedings with the Insurance Department in which Armour Group Holdings Limited, through its subsidiary Trebuchet U.S. Holdings, Inc., filed a Form A application under the IHCA stating its intent to acquire One Beacon Insurance Company and other entities. The policyholders argued that the acquisition was the insurers' attempt to shed their asbestos, environmental, and other long-tail liabilities, for which they did not have adequate reserves. The Department denied the policyholders' petition to intervene and approved the proposed acquisition.

On appeal to the trial court, policyholders argued that the Department's denial of its petition to intervene was an abuse of discretion and contrary to law, violating their due process rights. Specifically, policyholders argued that the Department should have granted intervention under the General Rules of Administrative Practice and Procedure (GRAPP), which governs practice and procedure before agencies under the Administrative Agency Law. The Court determined that the GRAPP does not apply to the Department's consideration of Form A filings under the IHCA, holding that review of a proposed transaction under the IHCA is a regulatory act, not subject to intervention by non-parties. Furthermore, the Court held that even if the GRAPP applied, the policyholders do not satisfy requirements for intervention under that law because their interest is speculative. The Court affirmed the Department's denial of the petition to intervene and dismissed the petition for review as moot.

Case in Which the NAIC Filed as *Amicus Curiae*

MetLife, Inc. v. Financial Stability Oversight Council, No. 16-5086 (D.C. Cir. 2016)

The NAIC submitted an amicus brief in the United States Court of Appeals for the District of Columbia in the case of *MetLife, Inc. v. Financial Stability Oversight Council* on August 22, 2016. The NAIC filed this brief in support of MetLife, which had prevailed in its arguments at the District Court level. The case involves MetLife's challenge to the Financial Stability Oversight Council (FSOC) in its designation of MetLife as a systemically important financial institution. Pursuant to the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, the FSOC was required to consider the degree to which MetLife is already regulated by one or more primary financial regulatory agencies before making a designation.

The brief asserted that the FSOC largely ignored or discounted the state-based system that regulates MetLife and, therefore, acted in an arbitrary and capricious manner in making the designation. Specifically, the brief described the full range of regulatory tools available to state regulators at the individual entity and group level and the failure of the FSOC to assess the risk of asset liquidation against those tools, which include early warning through risk-based capital requirements and stays on surrender activity. The brief also described the deliberate, incremental process that applies to troubled companies regulated by state insurance commissioners and recounted the FSOC's failure to assess the risk of a hypothetical MetLife liquidation against this process.