Abstracts of Significant Cases Bearing on the Regulation of Insurance 2015

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Supreme Court of the United States

King v. Burwell, 135 S. Ct. 2480 (2015)

This case reviewed language of the federal Affordable Care Act (ACA) to determine whether Congress intended refundable tax credits to be available to qualified individuals in states with a federal exchange, rather than a state exchange. The ACA allows refundable tax credits to individuals who enroll in a health insurance plan through "an Exchange established by the State." The IRS promulgated a rule making the tax credits available to all qualified individuals, regardless of which type of exchange was established in their state. Petitioners are Virginia residents who did not want to be required to purchase health insurance. If the tax credit was unavailable to them, because Virginia has a federal exchange, their income level would exempt them from the requirement. Petitioners argued that a federal exchange is not "an Exchange *established by the State*" and, therefore, they were not qualified for the tax refund and not required to purchase insurance.

The Court did not afford *Chevron* deference to the IRS' interpretation due to the fact that Congress had not expressly delegated its power and because the agency has no expertise in health care policy. Nonetheless, the Court found that the provision allowing tax credits applies to residents of states with either type of exchange. The Court found that the phrase "an Exchange established by the State" was ambiguous when viewed in context of the statute as a whole, the goal of which was to improve health insurance markets by ensuring affordable coverage to a large number of individuals. The dissent argues that because the phrase "an

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Exchange established by the State" is not ambiguous when read alone, there is no need to review the statute as a whole.

United States Courts of Appeal

Fontaine v. Metropolitan Life Ins. Co., 800 F.3d 883 (7th Cir. 2015)

This case revolves around the question of which standard of review should be applied to an appeal of the denial of benefits under a plan governed by ERISA. Beneficiary Mary Fontaine filed a claim for disability benefits with MetLife when her vision problems prevented her from working at the high level and pace her law firm required. MetLife denied her claim, finding that she did not meet the definition of disabled under the terms of her policy. After MetLife affirmed its initial denial, Fontaine filed a suit for wrongful denial of benefits. The ERISA plan at issue contained a clause providing that MetLife's benefit determinations "shall be given full force and effect" unless they are shown to be "arbitrary and capricious." But the Illinois Department of Insurance (DOI) had issued a regulation prohibiting such clauses. The Illinois regulation was modeled after the NAIC's *Prohibition on the Use of Discretionary Clauses Model Act* (#42). The District Court found that the Illinois regulation applied, requiring *de novo* review of MetLife's benefit determination. Upon review of the evidence, the court found that Fontaine was entitled to disability benefits.

On appeal to the Seventh Circuit, MetLife argued that the Illinois regulation was not applicable to the policy at issue and was preempted by ERISA. The Court affirmed the district court's judgment, finding that the regulation did apply and was not preempted. Specifically, the Court found that the Illinois regulation at issue fell within ERISA's savings clause because it "regulates insurance" as a law "directed towards entities engaged in insurance" and "substantially affect[s] the risk pooling arrangement between the insurer and the insured." Furthermore, the Court found that it did not conflict with ERISA's civil enforcement scheme. Finally, the Court dismissed MetLife's arguments that the Illinois regulation did not apply to its policy. The NAIC filed an *amicus* brief in this case supporting Plaintiff-Appellee Mary Fontaine at the request of the Illinois DOI.

St. Louis Effort for AIDS v. Huff, 782 F.3d 1016 (8th Cir. 2015)

The director of the Missouri DOI appeals the District Court's preliminary injunction enjoining enforcement of Missouri's Health Insurance Marketplace Innovation Act (HIMIA). HIMIA regulates individuals who "provide[] information or services in connection with eligibility, enrollment, or program specifications of any health benefit exchange operating in [Missouri]." The District Court found that the law was preempted by the ACA. On appeal, the Eight Circuit affirmed in part and reversed in part, finding that the ACA's preemption

clause was more limited than the district court had acknowledged. The case was remanded to the District Court.

The Court found that appellees would likely prevail on preemption arguments for three substantive provision of HIMIA as they applied to certified application counselors (CACs). The provision prohibiting CACs from providing advice regarding health plans could conflict with the federal duty to provide information and clarify distinctions among plans. Likewise, the provision preventing CACs from providing information about plans not offered on the exchange could conflict with the federal duty to clarify distinctions among plans. Finally, the provision requiring navigators to advise clients to consult with an insurance producer may interfere with the federal rule that CACs provide impartial information since, in Missouri, insurance producers include agents compensated by companies and brokers who are not required to provide complete and impartial information. The Court dismissed the due process claim that HIMIA was impermissibly vague.

Allen v. USAA Cas. Ins. Co., 790 F.3d 1274 (11th Cir. 2015)

Policyholders appeal the District Court's dismissal of their proposed class action seeking recovery of premium payments for building ordinance and law (BOL) insurance. BOL coverage is included with homeowners insurance to provide protection up to a percentage of the home's value, in the event repairs or replacements require compliance with building ordinances adopted after the home was originally built. Policyholders argue that a Florida statute requires an insurer to obtain consent on a form approved by the Florida Office of Insurance Regulation (Regulation Office) if it raises BOL coverage above the 25% default coverage amount. Policyholders claim that their insurance provider raised BOL coverage from 25% to 50% without obtaining their consent on a Regulation Office form.

The Eleventh Circuit affirmed the District Court's dismissal of the action. The Court found that the statute at issue requiring a 25% amount of BOL coverage was intended to ensure homeowners had minimum protection. In reading the statute as a whole, the Court found that an insurer would need to obtain consent on a Regulation Office form if a policyholder elected for less than 25% coverage but not if they elected for more. The Court further explained that even if the insurance company had violated the law, the only recovery available was enforcement of the contract, not recovery of premium payments.

United States District Courts

Mountain States Health Alliance v. Burwell, Case No. 13-641 (RDM), 2015 WL 5297498 (D. D.C. Sept. 10, 2015)

Medicare providers filed this action challenging the decision of the Secretary of the U.S. Department of Health and Human Services (Secretary) to deny reimbursement of Medicare bad debt (unpaid deductibles and copayments) based on her interpretation of the rules governing reasonable collection efforts. The *Provider Reimbursement Manual* (Manual) states that a provider must use similar collection efforts with its Medicare patients as it does with its non-Medicare patients. The Manual further provides that if collection agencies are used for non-Medicare debt, they must also be used for Medicare debt of like amounts. Providers used the same collection efforts for a one-year period but after that time, if any debts remained uncollected, they pursued only those of non-Medicare patients, seeking reimbursement from the Medicare program for the Medicare bad debt.

The Court found that the Secretary's rule prohibiting differential treatment of Medicare and non-Medicare debt violated the Bad Debt Moratorium. The Moratorium was put into place by Congress in 1987 and froze the Secretary's attempts to more closely scrutinize bad debt reimbursement requests. While the rule had been in place prior to the Moratorium, the Secretary's interpretation of the rule had become inflexible. The Court acknowledged that the Secretary is typically afforded deference but found the denial of reimbursement to be unreasonable because it was based on mischaracterized pre-Moratorium decisions. The Court remanded the case for application of the more flexible approach to determining whether reasonable collection efforts were made.

City of Westland Police and Fire Retirement Sys. v. Metlife, Inc., Case No. 12-cv-0256 (LAK) 2015 WL 5311196 (S.D.N.Y. Sept. 11, 2015)

This case involves MetLife's motion to dismiss a putative shareholder class action alleging that it had violated securities laws and misled investors by failing to maintain sufficient reserves for incurred but not reported (IBNR) death benefit claims on its group life insurance policies and by overstating its earnings and financial strength in light of the insufficient reserves. Shareholders also allege that MetLife falsely misrepresented its mortality ratios. Shareholders claim that beginning in the 1980s, MetLife had been using the Social Security Administration's Death Master File (SSA-DMF) to discontinue annuity payments to those who had deceased but not to locate individuals owed life insurance benefits. In 2007, MetLife allegedly began using the SSA-DMF to locate and pay beneficiaries of individual (but not group) life insurance policies. Beginning in

2009, MetLife's accounting practices were investigated by a number of states through a market conduct examination and by the New York Attorney General. MetLife waited until 2011 to begin using the SSA-DMF to locate and pay its group life insurance beneficiaries. Shareholders further contend that MetLife waited two years to disclose the state investigations and that once it did so, its stock prices dropped, causing them economic damages.

Before issuing an opinion on the motion to dismiss, the Court waited for the Supreme Court to decide a case with similar facts, *Omnicare, Inc. v. Laborers District Council Construction Industry Pension Fund*. Relying on *Omnicare*, the Court found that while MetLife's IBNR reserves were insufficient to meet its life insurance obligations, this fact was not determinative. Instead, the Court held that to survive a motion to dismiss the U.S. Securities and Exchange Commission (SEC) Rule 10b-5 claims regarding the allegedly inadequate IBNR reserves, plaintiffs needed to allege that MetLife knew its reserves were inadequate but told investors that they were adequate. Alternatively, plaintiffs needed to allege that MetLife did not perform an adequate inquiry into whether its reserves were adequate, rendering misleading its representation that they were adequate. Because shareholders did neither, these claims were dismissed. Likewise, the remaining Rule 10b-5 claims were dismissed for failure to allege untrue statements of material fact or omission of a material fact. The Court also dismissed a number of related claims, including failure to disclose the state investigations. Ultimately, the only claims that survived included allegations under Section 11 of the Securities Act that MetLife misrepresented its mortality ratios and the accompanying claim for joint and several liability.

State Courts

California

Myers v. State Board of Equalization, 240 Cal. App. 4th 722 (Cal. Ct. App. 2d 2015)

This case addresses the issue of whether entities issuing health care service plans (HCSPs) can be taxed as insurers under the California constitution. The plaintiff, a taxpayer, filed a writ of mandamus and a declaratory judgment action to compel state officials to collect a gross premium tax from two entities, Blue Shield and Blue Cross (collectively, the Blues) as insurers, rather than the corporate franchise tax imposed on all other businesses. The taxpayer argues that the PPO products sold by the Blues, which constitute a majority of their business, are indemnity health insurance contracts, making them insurers. The Blues filed a demurrer seeking to dismiss the case, arguing that they were HCSPs under

California's Knox-Keene Act and not insurers. The trial court agreed, relying on the fact that, as HCSPs, the Blues were not subject to regulation by the DOI.

On appeal, the Court of Appeal reversed that decision, finding that the taxpayer's complaint contained sufficient facts to support that the Blues were insurers subject to the gross premium tax. Relying on two California Supreme Court cases, the Court held that the trial court should have looked beyond regulatory labels to determine whether a significant proportion of the Blues' business was based on indemnification.

Indiana

First American Title Ins. Co. v. Robertson, 19 N.E.3d 757 (Ind. 2014), amended on rehearing at 27 N.E.3d 768 (Mem) (March 26, 2015)

Following a market conduct examination of First American Title Insurance Company, the commissioner of the Indiana DOI forwarded the report to the insurance company. First American submitted a rebuttal to the report's findings. Under the examination statute, the commissioner had 30 days to enter an order, but instead of issuing an order, the commissioner sought several extensions so that the parties could resolve the issues raised by the report. When First American refused a further request for extension, the commissioner issued an order calling for a hearing before an administrative law judge. Before the hearing date, First American filed an action in the state trial court seeking judicial review of the commissioner's order, arguing it was void because it had been issued after the 30-day statutory deadline. The commissioner moved to dismiss the suit for failure to submit the agency record as required by the state Administrative Orders and Procedures Act.

The trial court denied the commissioner's motion to dismiss, but it also denied First American's petition for judicial review for failure to show prejudice by the untimely order. On appeal, the commissioner asserted for the first time that the petition should be denied for First American's failure to exhaust administrative remedies. The Court of Appeals held that: 1) the commissioner's order was void for being untimely and that First American did not need to show it was prejudiced; 2) failure to exhaust administrative remedies is a procedural error that does not rob the court of subject matter jurisdiction and that the commissioner waived this argument by raising it for the first time on appeal; and 3) First American did not need to submit a formal agency record since the documents attached to its petition were sufficient for review. On transfer, the Supreme Court agreed with the Court of Appeals that failure to exhaust administrative remedies does not implicate the trial court's subject matter jurisdiction and that the commissioner had nonetheless waived this argument. The Court explained that the commissioner could have argued that a finding of waiver was inappropriate, but he had not done so. Ultimately, the Supreme Court dismissed First American's petition by declaring a

"bright line" rule holding that courts may not review an administrative order when the agency record has not been filed.

New Jersey

Allstate New Jersey Ins. Co. v. Lajara, No. A-4188-14T3, 2015 WL 5009084 (N.J. Super. Ct. App. Div. Aug. 19, 2015)

This case addresses the issue of whether a statement taken by prosecutors during an insurance fraud investigation is discoverable by an insurance company in a civil suit against the affiant and others allegedly involved in the scheme. Allstate filed a civil suit against several defendants for insurance fraud. Defendants were health care providers, including medical doctors and chiropractors, some of whom were unlicensed. Defendants allegedly paid individuals to stage automobile accidents and would then provide unnecessary care, prescribe unnecessary medical equipment, unlawfully split fees and conceal self-referrals. One of the defendants, a chiropractor, entered into an agreement with the New Jersey Office of the Insurance Fraud Prosecutor (OIFP), where he provided a proffer statement describing his participation in the fraud scheme. He later pled guilty to several charges and was sentenced to six years in prison and ordered to pay restitution of more than $600,000.

During discovery in the civil lawsuit, Allstate asked one of the prosecutors for the chiropractor's proffer statement. The prosecutor sent it to Allstate's lawyer. Allstate later deposed the chiropractor, who claimed that he had no recollection of the fraud scheme. When Allstate attempted to enter the proffer statement as an exhibit, the chiropractor objected and moved for a protective order. The trial court found that the proffer statement was not confidential. The Appellate Division affirmed the trial court's decision, finding that the parties placed restrictions on the statement's use in criminal matters but not in civil litigation. The Court also found that, as part of his plea agreement, the chiropractor agreed to testify truthfully in all proceedings concerning the fraud scheme. Furthermore, the Court held that the chiropractor's claim of privilege failed because a regulation allows the OIFP to share confidential information with "referring entities on pending cases," and insurance companies are considered "referring entities."

Pennsylvania

In Re Penn Treaty Network America Ins. Co., 119 A.3d 313 (Pa. 2015)

This case addresses the issue of when a Court should defer to an insurance commissioner's determination to convert the rehabilitation of a troubled insurance company into liquidation proceedings. Penn Treaty Network America Insurance

Company (PTNA) and its subsidiary are life insurers specializing in long-term care (LTC) insurance. PTNA's financial troubles began in the 1990s, when it sold a large number of underpriced and poorly underwritten policies providing generous benefits. The companies never fully recovered financially and, in 2009, a former Pennsylvania insurance commissioner began rehabilitation proceedings.

Several months after initiating an uncontested rehabilitation, the commissioner filed petitions to convert to liquidation proceedings, citing the companies' insolvency. The Court below denied the petition, explaining that no deference was owed to the commissioner when there are specific statutory standards governing termination of rehabilitation. In its decision, the Supreme Court cited a number of cases from Pennsylvania and other jurisdictions holding that the commissioner is owed deference in making the determination to convert rehabilitation proceedings to liquidation, reviewable by a court under an abuse-of-discretion standard. Despite this, the Supreme Court found that, in this instance, continued rehabilitation was proper because the former commissioner who had initiated the rehabilitation proceedings had improperly treated the rehabilitation as a conservatorship to give him time to prepare for liquidation.

Tighe v. Consedine, 121 A.3d 569 (Pa. Commw. Ct. 2015)

In this case, policyholders challenged cancellation of their homeowners insurance policy under Pennsylvania's Unfair Insurance Practices Act (Act). The insurance company issued the policy before inspecting the premises. Upon inspection and after consulting with its underwriter, the company determined that the deck, which was 14 feet above ground, would need a railing. A month later, policyholders were notified that they would need to install a railing within 30 days to avoid cancellation of the policy. Policyholders requested a 30-day extension, which the company granted. After the time lapsed and the rail had not been installed, the company cancelled the policy. When policyholders sought review of the cancellation, the company offered another four-month period to install the railing. But policyholders still never installed the railing.

This appeal follows the insurance commissioner's finding that the insurer's cancellation of the policy did not violate the Act. The Act allows an insurer to cancel a policy within 60 days or at any time when "there is a substantial increase in hazards insured against by reason of willful or negligent acts or omissions by the insured." The Court affirmed the commissioner's decision because policyholders were notified within 60 days that the railing needed to be installed, and their willful failure to do so constituted a "substantial increase in hazards."

Tennessee

Chartis Cas. Co. v. State of Tennessee, 2015 WL 5766279 (Tenn. Oct. 2, 2015)

This case is a consolidated review of claims brought by five workers' compensation insurers domiciled in Pennsylvania. The insurers argue that they were incorrectly assessed retaliatory taxes by the state of Tennessee due to a misinterpretation of Pennsylvania statutes and regulations. Tennessee law imposes retaliatory taxes upon insurers domiciled in a state with laws imposing higher taxes or other obligations on Tennessee insurers doing business there than those imposed under Tennessee law on the other state's domiciliaries doing business in Tennessee. The issue addressed on appeal is whether Pennsylvania law imposes taxes or other obligations that exceed those imposed by Tennessee.

The Tennessee Supreme Court determined that the Pennsylvania workers' compensation fund statutes—interpreted by the state of Tennessee as imposing excess obligations, and, thereby, requiring payment of retaliatory taxes by the insurers—had been repealed by a more recently adopted statute. The new statute, Section 578, specifically reads that the assessments "shall no longer be imposed *on* insurers, but shall be imposed, collected and remitted *through* insurers[.]" The Court concluded that the previous statutes had been repealed by this law and that collecting the assessments *through* insurers placed the burden on insured employers, rather than the insurers themselves. Therefore, the state of Tennessee had no authority to collect the retaliatory taxes.

Texas

De La Garza v. Texas Dep't of Ins., No. 03-11-00869-CV, 2015 WL 1285702 (Tex. App. March 19, 2015)

An insurance agent, Elias De La Garza, appeals the trial court's affirmance of a default order entered by the commissioner of the Texas DOI, revoking his occupational licenses. The DOI had sent multiple notices to the agent regarding client complaints and seeking a response. When he never replied, the DOI sent notice of a hearing before an administrative law judge. The insurance agent's assistant signed the notice and returned the receipt, but the agent never appeared at the hearing, resulting in a default order. The DOI sent the order to the agent's office. More than a month later, the agent filed several motions with the DOI, including a motion for rehearing, a motion for extension of time and a motion to set aside the order. In an affidavit supporting his motions, the agent claimed that he was unaware of any of the notices sent by the DOI and that he later learned that one of his employees had shredded them without his knowledge. The DOI granted his extension of time, and he filed his motion for rehearing. Before an

administrative decision was made, he filed an action with the trial court, seeking a declaration that the default order was void. The DOI then entered an order denying the agent's motions. The agent amended his petition to seek judicial review of the default order.

On appeal, the Court found that the insurance agent had exhausted his remedies by filing the motion for rehearing within the extended period of time and by amending his suit to include a petition for judicial review of the default order. The agent raises several arguments that his substantial rights were prejudiced by entry of the order. The Court dismissed the agent's argument that the order was "made through unlawful procedure" because while the DOI failed to comply with technical language requirements for the notice and affidavit, the agent failed to show he was prejudiced by this. The Court dismissed the argument that the default order was "affected by other error of law" because while his failure to file a written response to the DOI's notice of hearing may not have been intentional on his part or a result of his own "conscious indifference," he was ultimately responsible for his employee's actions. Finally, the Court dismissed his argument that the order violated his right to due process because the DOI afforded him "all of the notice and opportunity to be heard that he was entitled to receive." The Court of Appeals affirmed the trial court's judgment affirming the DOI's default order.

Cases in Which the NAIC Filed as *Amicus Curiae*

MetLife, Inc. v. Financial Stability Oversight Council, No. 1:15-cv-45 (D. D.C. NAIC brief filed June 26, 2015)

The NAIC submitted an amicus brief in the U.S. District Court for the District of Columbia in the case of *MetLife, Inc. v. Financial Stability Oversight Council*. The NAIC filed this brief at the request of the California DOI and in support of MetLife's motion for summary judgment. 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 (Dodd-Frank), 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.

Gobeille v. Liberty Mut. Ins. Co., No. 14-181 (U.S. NAIC brief filed Sept. 3, 2015), appealed from Liberty Mut. Ins. Co. v. Donegan, 746 F.3d 497(2d Cir. 2014)

At the request of the Insurance Division of the Vermont Department of Financial Regulation, the NAIC filed an amicus brief on the merits with the U.S. Supreme Court, in support of Alfred Gobeille, chair of the Vermont Green Mountain Care Board, appealing the Second Circuit's opinion in favor of Liberty Mutual Insurance Company. The Second Circuit determined that ERISA preempted a Vermont state statute and regulation requiring certain insurers and other health care payers to submit health care claims data to an All-Payer Claims Database (APCD), as applied to Liberty Mutual's self-insured employee benefit plan. The collected data is used to analyze health care utilization, cost, quality and population health, as well as to support health care reform initiatives. The Second Circuit found that the law had an impermissible "connection with" ERISA's federal reporting requirements.

The NAIC, joined by the National Governors Association (NGA), National Conference of State Legislatures (NCSL), Council of State Governments (CSG), and Association of State and Territorial Health Officials (ASTHO), argued that the Vermont law and the similar APCD laws of 17 other states were not preempted by ERISA. Specifically, *amici* argued that: 1) APCD laws fill critical information gaps for states; 2) the presumption against ERISA preemption applies because in enacting APCD laws, states are exercising their traditional police powers; 3) the APCD laws do not "relate to" ERISA in an impermissible manner; and 4) finally, APCD laws do not interfere or conflict with requirements imposed by ERISA.

New York Life Ins. Co. v. Ortiz, Case No. 14-74 (D. R.I. NAIC brief filed Dec. 22, 2014)

The NAIC filed an amicus brief in support of plaintiff New York Life Insurance Company at the request of the Rhode Island DOI. At issue was the application of the "interest on death benefit proceeds" provision of the uniform standards adopted by the Interstate Insurance Product Regulation Commission (IIPRC), as opposed to Rhode Island's statutory interest rate, to the proceeds of an individual term life insurance policy approved by the IIPRC for issue in Rhode Island. The issuer of the policy, New York Life Insurance Company, filed an interpleader action in federal district court seeking to apply the rate of interest calculated in accordance with the IIPRC-approved policy provision. Defendant

Massiel Ortiz countered with bad faith claims and prayed for the statutory rate of interest. The Magistrate Judge issued a Report and Recommendation declining to apply the interest provision in the policy, in contravention of the statutory Compact provision stating that the uniform standards requirements shall be the exclusive provisions applicable to the content of policies filed with the IIPRC. Following the IIPRC's appearance via affidavit supporting the plaintiff's objections to the Report and Recommendation, the NAIC filed as amicus curiae recommending that the district court reject the Report and Recommendation on the interest payable. The NAIC brief discussed the background of the IIPRC and compacts in general and addressed several related deficiencies in the Report and Recommendation.

In an order dated Sept. 30, 2015, the Court directed New York Life Insurance Company to deposit the principal amount of policy proceeds into the Court's registry to stop the accrual of interest. The Court then gave the parties and any *amici* 90 days to provide supplemental briefing on the issue of which interest rate applied.