Abstracts of Significant Cases Bearing on the Regulation of Insurance 2014

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United States Courts of Appeal

Feingold v. John Hancock Life Ins. Co., 753 F.3d 55 (1st Cir. May 27, 2014)

This case examines the effect of a regulatory settlement on individual life insurance disputes. The plaintiff sued in a putative class action, alleging that John Hancock had an obligation to proactively confirm deaths of insureds rather than wait for notice. The plaintiff's mother purchased a life insurance policy in 1945, which was not discovered by the plaintiff until he searched the Illinois unclaimed property website and found proceeds of a dividend. The plaintiff informed John Hancock of his mother's death and received $1,349 for death benefits; however, the requested copy of the life insurance policy was not provided. In filing a putative class action, the plaintiff relied on a Global Resolution Agreement (GRA) with Illinois and several other states which required John Hancock to search the Death Master File (DMF) of the Social Security Administration (SSA) in its prospective course of business.

The United States Court of Appeals for the First Circuit rejected the plaintiff's argument that the GRA imposed obligations that created a common law claim for damages. The Court noted that John Hancock had used its best efforts to identify the applicable policy form in 1945, and that such form required a beneficiary to provide proof of the policyholder's death. This practice is consistent with Illinois law. The Court also held that the plaintiff is not a third-party beneficiary to the GRA and found no evidence that the GRA was intended directly to benefit anyone other than the signatory states.

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Merrimon v. Unum Life Ins. Co. of America, 758 F.3d 46 (1st Cir. July 2, 2014)

The plaintiffs in this case are a class of beneficiaries of Employee Retirement Income Security Act (ERISA)-regulated employee welfare benefit plans funded by guaranteed-benefit group life insurance policies that the defendant issued. In 2007, each plaintiff submitted a claim for life insurance benefits. After reviewing the submissions, the insurer approved the claims. The insurer redeemed the claims by establishing retained assets accounts (RAAs) for the plaintiffs and credited to each plaintiff's account the full amount of the benefits owed. At the same time, the insurer mailed books of drafts to the plaintiffs, along with informational materials regarding the accounts. The drafts empowered the plaintiffs to withdraw all or any part of the corpus of RAAs, provided, however, that each withdrawal was in an amount not less than $250.

The plaintiffs fully liquidated their RAAs, and the accounts were closed. During the time that funds remained in their RAAs, however, the insurer retained the credited funds in its general account and paid the plaintiffs interest at a rate of 1%, which the plaintiffs claim was substantially less than the return the insurer earned on its portfolio. The United States Court of Appeals for the First Circuit held that it is not self-dealing in plan assets—in violation of ERISA—to pay death benefits in the form of RAAs. Further, the Court held that such a redemption method did not offend the insurer's duty of loyalty toward the class of beneficiaries in violation of ERISA.

United States District Courts

St. Louis Effort for AIDS v. Huff, Case No. 13-42456 (W.D. Mo. Jan. 23, 2014)

In this case involving implementation of the federal Affordable Care Act (ACA), plaintiffs seeking to act as federal counselors for the federally facilitated health care exchange challenged provisions of Missouri's Health Insurance Marketplace Innovation Act (HIMIA). The plaintiffs alleged that HIMIA's additional licensing requirements and restrictions on providing advice concerning benefits, terms and features of a particular health plan created a risk that the counselors will be punished for performing their duties required under the ACA.

The United States District Court for the Western District of Missouri granted the motion for preliminary injunction to prevent enforcement of the HIMIA, but only as to those plaintiffs qualifying as certified application counselors (CACs). The Court held that Missouri's attempt to regulate the conduct of CACs is preempted by the ACA and that "having made the choice to leave the operation of the exchange to the federal government, Missouri cannot choose to impose additional requirements or limitations on the exchange."

SEC Comm'n v. Life Partners Holdings, Inc. 2014 WL 1364501 (W.D. Tex. March 12, 2014)

The U.S. Securities and Exchange Commission (SEC) alleged financial disclosure and accounting fraud relating to misleading marketing practices in selling life insurance investments to individual investors. In a jury trial before the United States District Court for the Western District of Texas, the jurors were not persuaded by the primary fraud and insider trading allegations, finding in favor of defendants on eight of 12 counts. The defendants moved for judgment as a matter of law on the remaining four counts.

The Court upheld two of the four jury verdicts, question 6 and question 12 concerning securities fraud, rejecting the defendants' argument that the jury lacked sufficient evidence to reach its conclusions. Two other jury verdicts, question 4 and question 5, assigned liability for misrepresentations regarding the company's revenue recognition policies. The defendants asserted the SEC had withdrawn these claims in the course of the trial and pointed to various statements in the transcript. The Court disagreed, holding the SEC was not required to discuss revenue recognition directly if the jury could glean whatever information it needed to address the claims from other evidence and testimony. However, as to one element of question 4, the Court agreed with defendants that the jury would have to find the unlawful conduct occurred in a narrow two-month period in order to satisfy the phrasing of the jury question. The Court found no evidence to support the jury's conclusion that the violations occurred during this window, as opposed to the four-year timespan that had been reflected in the SEC's case.

Arkansas

Nationwide Mut. Fire Ins. Co. v. Citizens Bank & Trust Co., 431 S.W.3d 292 (Ark. Jan. 23, 2014)

The parties filed cross-motions for summary judgment in this dispute over a homeowner's insurance policy claim. Citizens Bank & Trust was the first mortgagee on a dwelling purchased by the Ludwicks. The dwelling was destroyed by fire in 2009, and during the investigation of the subsequent claim, Nationwide discovered two previous fire losses sustained by the Ludwicks that were not disclosed on their application. Nationwide voided the policy back to its inception and refunded premiums paid. The claim was also denied as to Citizens.

The Supreme Court of Arkansas acknowledged that the rescission was proper on the basis of material misrepresentation or omission of prior fire losses. However, the mortgagee on the property has a separate and independent contract and a valid claim on the loss under Arkansas law. The Court cited precedent holding that the rights of a named mortgagee in an insurance policy are not affected by any act of the insured, including improper and negligent acts.

California

Marissa Rea v. Blue Shield of CA, Case No. B244314 (Cal. Ct. App. June 10, 2014)

In its 2012 edition, the Journal of Insurance Regulation reported on *Harlick v. Blue Shield of CA, 686 F.3d 699 (9th Cir. June 4, 2012)*. In that case, the United States Court of Appeals for the Ninth Circuit ruled that insurers must provide residential treatment when medically necessary to treat severe mental illness, specifically anorexia and bulimia, pursuant to the California Mental Health Parity Act (Parity Act), even if residential treatment is not offered for a medical condition under the relevant insurance policy. Blue Shield mounted another challenge to the Parity Act in the Marissa Rea case, in which the California Court of Appeal conducted a lengthy analysis of the Parity Act and its predecessor, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). The Parity Act provides a list of mandated benefits, introducing the list as "including." Blue Shield asserted this list, which does not include residential treatment, should be considered exhaustive because the Legislature did not use the phrase "including, but not limited to" in the benefits subsection. "Including, but not limited to" appears later in the same statute preceding another list of mandated terms and conditions. Blue Shield also argued that the Parity Act references and must be construed alongside the more limited Knox-Keene Act. The trial Court found in favor of Blue Shield.

In reversing that decision, the Court noted the different approaches of the two Acts in limiting the exposure of insurers. The Knox-Keene Act provided a more limited list of required benefits, but the requirements applied to all physical illnesses, while the Parity Act expanded the benefits available, but only for "severe" mental illness. The Court also referenced a competing Parity bill the Legislature had initially considered that specifically exempted residential treatment. No such exemption appears in the adopted Act. The Court found that the Legislature sought flexibility in fashioning care for mental illness and declined to expressly exclude one of the most effective treatments for eating disorders.

Consumer Watchdog v. Dep't of Managed Health Care, 225 Cal. App. 4th 862 (Cal. Ct. App. 2014)

The plaintiffs in this case, Consumer Watchdog, are supporters of individuals certified by the private Behavior Analyst Certification Board (BACB) who perform or supervise the use of applied behavior analysis (ABA) as a treatment for autism. Under the Knox-Keene Act, the defendants, the Department of Managed Health Care (DMHC), have the charge of ensuring that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees. Knox-Keene requires the use of licensed individuals when a license is required by law. In 1999, the California Legislature passed the Parity Act, which requires coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, including the medically necessary treatment of autism. DMCH upheld the denial of coverage for ABA when provided, or supervised by BACB-certified therapists who were not otherwise licensed. DMCH contends that it may require plans to cover ABA therapy only when it is provided by someone licensed to practice medicine or psychology.

Plaintiffs brought a petition against the DMCH, alleging that it is a violation of the Parity Act for a health plan to refuse to cover any treatment for autism that is deemed medically necessary. Plaintiffs further alleged that the law requires coverage for any medically necessary treatment for autism "when it is provided by a licensed provider, a provider that is certified by a professional organization or individuals who are supervised by a licensed or certified provider." The California Court of Appeal for the Second District held that a 2011 statute authorizes BACB-certified providers to provide ABA therapy under state licensing laws and, therefore, the DMCH can no longer uphold a plan's denial of coverage on the basis that a BACB-certified provider is not licensed.

Mercury Cas. Co. v. Jones, Case No. 34-2013-80001426 (Cal. Super. Ct. June 11, 2014)

The petitioner, Mercury Casualty Company (Mercury) challenged the insurance commissioner's order that its proposed homeowners insurance rates were excessive. This case involves application of Proposition 103, which was enacted by California voters in 1988 and required insurers to roll back insurance rates 20%. Insurers can request a variance from this percentage if the resulting rate would be "confiscatory," which the commissioner contends would require a prima facie showing that applying the formula would cause the insurer to suffer deep financial hardship to its enterprise as a whole. Mercury claimed the commissioner prohibited the use of Mercury's own data to demonstrate the financial hardship.

The Superior Court of California, Sacramento County, cited precedent indicating that confiscation does not arise "whenever a rate simply does not produce a profit which an investor could reasonably expect to earn in other

business with comparable investment risks." The Court found that Mercury's request to substitute its own expense data into the ratemaking formula would effectively relitigate a matter that was already decided by the administrative law judge. The Court also affirmed the commissioner's removal of institutional advertising expenses from the ratemaking formula, as such expenses are expressly excluded under state regulations.

Connecticut

Lageux v. Leonardi, 85 A.3d 13 (Conn. App. Ct. Feb. 18, 2014)

In this case involving license requirements, the plaintiff appealed the denial of his application for a producer license. As required in the application, the plaintiff described the circumstances of his criminal convictions, which included seven counts of harassment in the second degree and one count of criminal trespass in the second degree between 1996 and 1999. The narrative indicated hostility toward court-ordered therapy and mentioned the "women who would rather send me to prison than to go out on a date with me or give me the time of day … ." The Department of Insurance (DOI) denied the plaintiff's request for a license, relying on the general licensing statute that allows the commissioner to consider the applicant's moral character.

On appeal, the plaintiff argued the general licensing statute had been amended to specifically exclude producers when the Legislature enacted separate provisions for producer licensing. The new sections did not include a moral character element. The Appellate Court agreed that the commissioner could not rely on the general licensing statute; however, the discriminatory practices provision of the human rights statute allows for denial of a license or certificate after considering the nature of the crime and its relationship to the job for which the person has applied. The Court also noted the Legislature's adoption of the NAIC's uniform producer application and State Licensing Handbook, both of which require criminal convictions to be disclosed. The Court concluded the commissioner has additional discretion beyond the producer licensing statutes.

Delaware

Cohen v. Stewart, 89 A.3d 65 (Del. April 9, 2014)

Indemnity Insurance Corporation, which underwent a routine regulatory examination in 2012, is a Delaware risk retention group (RRG) that sells liability policies to restaurants and nightclubs. Appellant Jeffrey Cohen was the chief executive officer (CEO) and owned and controlled at least 17 different companies, including IDG, which was Indemnity's managing general agent. Over a three-year period, IDG collected premiums on Indemnity's behalf but did not remit those premiums to Indemnity. The commissioner ultimately concluded that IDG was

insolvent because its total assets were $3 million, while its total liabilities exceeded $24 million. Following the liquidation order in spring of 2013, Cohen resigned as CEO and allegedly engaged in the following actions:

- Falsified a bank statement showing a fictional $5.1 million account held by Indemnity.
- Accessed Indemnity's computer servers, monitored company email and disconnected the telephone service for the office.
- Sent threatening text messages to members of management.
- Disclosed confidential documents to the ratings agency A.M. Best, which resulted in a ratings downgrade for Indemnity.
- Refused to turn over three luxury company cars until a court order was issued, at which time Cohen parked the cars directly in front of Indemnity's building, blocking the entrances, and left with the keys.

Indemnity's board of directors sought sanctions against Cohen and laid out these allegations in a motion on Sept. 9, 2013. The Court of Chancery held an ex parte office conference on the motion on Sept. 10, 2013. Cohen was never sent a transcript of the conference, despite the Court's instructions. Cohen appealed multiple orders of the Chancery Court, claiming this oversight violated his constitutional due process rights. On appeal, the Supreme Court of Delaware found the oversight to be regrettable but not prejudicial. The Court found that Cohen received sufficient notice of the substance of the allegations against him when he was served with the motion for sanctions and proposed order imposing criminal sanctions for future violations. The Court further noted the ex parte session resulted in an order more favorable to Cohen, allowing for the imposition of either a civil or criminal contempt order upon a violation.

Indiana

Commonwealth Land Title Ins. Co. v. Robertson, 5 N.E.3d 394 (Ind. Ct. App. March 4, 2014)

Commonwealth petitioned for judicial review of an Indiana Department of Insurance (IDOI) order finding several violations of the Rate Statute and the Unsafe Business Practices Statute and ordering certain actions to cure the violations. The IDOI engaged a consultant to conduct a targeted market conduct examination of Commonwealth's title insurance transactions from 2005–2010. Commonwealth produced a memo describing their Cents per Thousands (CPT) program, under which an agent will pay remittance rate dollars to the underwriter based on a special rate chart rather than calculating premium for title insurance. A vice president and state agency manager at Commonwealth informed the consultant examiner that "the premium charged to the consumer during the CPT program was not specifically tied to risk." The examiner calculated that

Commonwealth underpaid an estimated $62,000 in premium taxes during the examination period.

The IDOI concluded that the CPT program was intended to allow agents to charge varying premiums to consumers based on factors such as the consumer's sophistication, property location and negotiations, rather than the risk of writing the title insurance. The Court found that the order included substantial evidence that Commonwealth violated the Rate Statute, which prohibits title insurers from excessive or inadequate charges and prohibits unfair discrimination between persons of the same class involving essentially the same hazards. The Court also rejected Commonwealth's argument that the Unsafe Business Practices Statute was inapplicable, holding that the IDOI is not required to show Commonwealth's solvency was threatened by the violations.

Washington

Kreidler v. Cascade Nat'l Ins. Co., 329 P.3d 928 (Wash. Ct. App. July 22, 2014)

In this case involving liquidation of the Cascade National Insurance Company (Cascade), prior disputes between the insurer and its general agent for auto insurance policies in California continued into the insolvency phase. The general agent, Statewide General Insurance Agency (Statewide), had an agreement to collect premiums on the Cascade policies it sold, deduct a provisional commission and deposit the balance into a trust account. Statewide signed a settlement agreement in 2003 acknowledging that it owed Cascade $230,000 in unpaid earned premiums, but Statewide later alleged that Cascade withdrew $478,656 from the trust account without crediting the amount against Statewide's debt. Cascade allegedly continued collecting the debt from prearranged installment payments. In 2007, with Cascade now in insolvency, the insurance commissioner filed a claim against Statewide to recover $941,879 in improperly withheld premiums. Statewide sought to set off the $478,656 amount plus the $230,000 collected through installments pursuant to the settlement agreement Statewide claims is unenforceable.

In affirming the lower court's order of summary judgment in favor of the commissioner, the Court of Appeals analyzed the role of Statewide as "a curator of the money that already belongs to the insurer." The Court ruled that Statewide always held the premiums it collected in a fiduciary capacity for the benefit of Cascade. Statewide was not at liberty to use the premiums for its own benefit, not even to credit itself for Cascade's alleged duplicative debt collection. The Court held that an insurance agent may not set off amounts owing to its parent insurer against premiums that it holds for the insurer in a fiduciary capacity.

West Virginia

Lightner v. Riley, 760 S.E.2d 142 (W.Va. June 4, 2014)

The plaintiff, a borrower in default of a $6,500 loan from CitiFinancial, filed a consumer complaint challenging the rates for credit property insurance and credit involuntary unemployment insurance set by Triton in connection with the CitiFinancial loan. The plaintiff alleged that historically low loss ratios incurred (as opposed to projections and filings) were indicative of excessive rates. The insurance commissioner commenced an investigation and analysis of all rate filings by Triton in West Virginia, resulting in the production of thousands of documents from Triton, as well as the opportunity for the plaintiff to supply further information. The commissioner then filed an order denying the plaintiff's request for a hearing, finding that no rule was in effect concerning benchmark minimum loss ratio standards for the products in West Virginia and that rates filed in other states are not dispositive of whether the rates were appropriate.

The Supreme Court of Appeal upheld the commissioner's order and the lower court's ruling that the commissioner was not required to grant a hearing on demand. The state's legislative rules provide the commissioner shall refuse a hearing if the hearing would serve no useful purpose. The Court noted the investigation was thorough and included an independent actuarial opinion concluding the rates were reasonable. In addition, the plaintiff failed to identify any evidence that he was prevented from presenting to the commissioner during the course of the investigation.

Wisconsin

Dermody v. Commissioner of Ins., 843 N.W.2d 711 (Wis. Ct. App. Jan. 30, 2014)

The plaintiff appealed the order of the insurance commissioner, and subsequent decision of the administrative law judge (ALJ), that he had violated statutes relating to insurance intermediaries. The plaintiff's license was initially revoked in 2009 for failure to pay taxes. The ALJ's findings of fact, issued in January 2012, indicated the plaintiff had sold insurance policies to two couples after his insurance license had been revoked and that he misinformed another policyholder by assuring she would incur no penalties on withdrawals. The 2012 decision ordered the plaintiff to pay restitution, ordered a $15,000 forfeiture and prohibited the plaintiff from applying for an insurance license for five years.

On appeal, the plaintiff contended the ALJ decision was not supported by substantial evidence. The decision was supported in part by the testimony of Lyle and Elayne Bolender, who signed an insurance policy in the plaintiff's presence. The plaintiff contended that his wife, Kathleen, sold the Bolenders their policy, and he was only present as a caretaker for his wheelchair-bound wife. The

Bolenders testified that Kathleen was not present, and the plaintiff later pressured them to sign false affidavits. On appeal, the Court of Appeals of Wisconsin declined to pass judgment upon the credibility of the witnesses and noted the ALJ was uniquely positioned to weigh the credibility of witness testimony. The Court also found substantial evidence in the record to establish that another policyholder paid $3,700 in annuity withdrawal penalties, despite the plaintiff's initial promise and continuing claims that the withdrawals were penalty-free. This coverage dispute arose from a $350 million settlement involving claims that UnitedHealth Group (United) did not properly reimburse medical providers for covered services under health insurance policies. Following the settlement, United brought suit against its primary insurer and nine excess insurers. In the process of mediation, the primary insurer agreed to pay out through the policy limits, and United settled with five of its excess insurers, leaving four insurers as defendants in this action filed in the United States District Court for the District of Minnesota.

The primary issue at this stage of litigation was United's failure to allocate the $350 million between covered and uncovered claims. The defendants asserted that this failure precluded United from seeking coverage for any part of the settlement. The Court rejected this argument, finding no precedent to show that an insured must contemporaneously allocate a settlement or forfeit insurance coverage. However, the Court agreed with the defendants that it is now United's responsibility to allocate the coverage between claims that fall within exclusions and claims that do not. The Court noted that United controlled the litigation, negotiated the settlement, and was in a better position to know how the settling parties valued the claims.

Cases in Which the NAIC Filed as Amicus Curiae

City of Sterling Heights General Employees' Retirement System v. Prudential Financial, Inc., No. 2:12-cv-05275-SDW-MCA (D. NJ July 23, 2014)

On July 23, the NAIC filed a motion for leave to file an amicus brief (and the accompanying brief) in support of Commissioner Michael F. Consedine (PA) in the case *City of Sterling Heights General Employees' Retirement System, et al. v. Prudential Financial, Inc., et al.* in the United States District Court for the District of New Jersey addressing whether records and reports from a market conduct examination contractor are subject to discovery in a class action lawsuit in federal court.

The case is a putative shareholder class action asserting securities law claims. In 2009, Pennsylvania conducted a market conduct examination of Prudential Financial that was expanded into a multi-state exam in 2011. Pennsylvania was one of the lead states. Verus Financial, LLC, was a contract examiner, and its

records were subpoenaed. Verus asserted that state examination laws protected state contractor examination-related information from discovery, which is consistent with provisions in the *Model Law on Examinations* (#390). The brief focused upon issues pertaining to the confidentiality of information under Model #390 and state laws based thereon.

Mary C. Fontaine v. Metropolitan Life Insurance Company, No. 1:12-CV-08738 (7th Cir. Oct. 14, 2014)

On Oct. 14, the NAIC filed an amicus brief in support of plaintiff-appellee Mary Fontaine at the request of the Illinois Department of Insurance in the case *Mary C. Fontaine v. Metropolitan Life Insurance Company* in the United States Court of Appeals for the Seventh Circuit.

At issue was Illinois' regulation prohibiting discretionary clauses in insurance policies, which was modeled after the *Prohibition on the Use of Discretionary Clauses Model Act* (#42). MetLife appealed the District Court's reversal of MetLife's denial of Fontaine's benefits claim. The District Court applied a de novo standard of review after finding that the Illinois regulation applied to the plan at issue and was not preempted by ERISA. MetLife appealed, arguing that the Court should have applied the arbitrary and capricious standard of review because Illinois' regulation was not applicable to the plan at issue and was preempted by ERISA. The NAIC brief discussed the background and importance of Model #42 and state laws based thereon. The brief also addressed the issues of applicability and preemption.