

Abstracts of Significant Cases Bearing on the Regulation of Insurance

2021

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United States Supreme Court

California v. Texas, 141 S.Ct. 2104 (2021)

In its 2019 edition, the *Journal of Insurance Regulation* reported on *Texas v. United States*, 945 F3d 355 (5th Cir. 2019), where a group of states led by Texas sued the federal government challenging the constitutionality of the Patient Protection and Affordable Care Act (“ACA”). Plaintiffs argued that the individual mandate requiring all citizens to have health insurance is unconstitutional and is not severable from the entire Act, therefore, the entire law should be invalidated. The issues raised were: 1) did Plaintiffs’ have standing to challenge the individual mandate; 2) did the House of Representatives have standing to intervene; 3) is the individual mandate constitutional; and 4) even if the court finds that the individual mandate is unconstitutional, is it severable and whether the remaining provisions of the ACA should remain in effect.

The Fifth Circuit held that both the House of Representatives and Plaintiffs had standing, as there is a live case and controversy, and the individual mandate is unconstitutional. The Fifth Circuit remanded the case to the district court to “explain with more precision what provisions of the post-2017 ACA are indeed inseparable from the individual mandate.” In January 2020, the General Counsel of the House of Representatives filed a petition for a writ of certiorari in the United States Supreme Court and a motion to expedite consideration of the certiorari petition. The Supreme Court ordered the Plaintiffs to file a response to this motion. On January 21, 2020, the Supreme Court denied the motion to expedite consideration of the certiorari petition. On March 2, 2020, the Court agreed to hear the case during the 2020-2021 term reviewing both the severability and standing issues raised by the Fifth Circuit. Both California and Texas petitioned review of the Fifth Circuit’s decision and the Supreme Court consolidated both cases in the present case. In a 7-2 decision, the Court reversed the Fifth Circuit ruling holding that Texas and other states did not have standing to bring a challenge to the individual mandate because the states cannot show a past or future injury. The Court did not rule on the constitutionality of the individual mandate.

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United States District Courts

Maine

*Martin v. Nat'l Gen. Ins. Co., No. 2:21-cv-00102-GZS, 2021 WL 5225622, at *1 (D. Me. Nov. 9, 2021)*

Defendant, National General Insurance Company, issued a homeowner's insurance policy to Plaintiff. The policy's coverage extended from January 6, 2017, through January 6, 2018. The policy included a condition that no action can be brought against Defendant unless there has been full compliance with all the terms with the policy and the action is started within two years after the date of loss.

On March 4, 2017, a water pipe froze and burst in Plaintiff's home causing damage to the home and its contents. Plaintiff filed a claim with Defendant the same day. Defendant provided Plaintiff with two proofs of loss, one for the contents of Plaintiff's home and one for the home itself. The proofs of loss stated that Defendant would compensate Plaintiff \$13,070.97 for the contents damage and \$225,840.01 for the home damage. Defendant paid for these losses. The policy also allowed Plaintiff to claim another \$8,099.82 for contents and \$36,393.02 for the home as "Recoverable Depreciation" upon providing proof that he replaced the contents and completed repairs to the property. Defendant also paid Plaintiff \$5,000 for mold damage which represents the policy's coverage limit for mold damage.

Plaintiff's attorney sent Defendant a Supplemental Demand for Coverage asking for an additional \$153,255.37 which included recoverable depreciation amounts plus and additional \$42,512.40 for contents damages, \$10,717.41 for home damages, and \$55,532.72 for mold damage. Defendant denied Plaintiff's additional claim for mold damage but agreed to consider certain contents damage claims. Defendant sent a final loss summary that showed that Defendant made an additional payment in response to Plaintiff's supplemental demand. The \$40,712.92 additional payment consisted of \$36,393.02 in recoverable depreciation for the home damage and \$4,319.90 for Plaintiff's pinball machine and pool table.

Plaintiff filed suit alleging claims of breach of contract, negligence, and unfair claims settlement practices under Maine law. Defendant then removed the action from state court to the District Court of Maine. In April 2021, Defendant moved for summary judgment on "whether 23-M.R.S.A. § 2433 violated the Dormant Commerce Clause given its disparate treatment of foreign insurers such as Defendant." *Id.* at *2. 23-M.R.S.A. § 2433 provides:

No conditions, stipulations or agreements in a contract of insurance shall deprive the courts of this State of jurisdiction of actions against foreign insurers, or limit the time for commencing actions against such insurers to a period of less than 2 years from the time when the cause of action accrues.

Id. Defendant also asked the court to declare that § 2433 is unconstitutional based on the Dormant Commerce and the Equal Protection Clause. The court held that

Defendant's Dormant Commerce Clause claim failed because "Maine's foreign-insurer statute of limitations falls within the ambit of the McCarran-Ferguson Act's protection, and so Defendant's challenge to it as a violation of the Dormant Commerce Clause fails "because § 2433 is directly related to the regulation of insurance." *Id.* at *4. The court held that Defendant's Equal Protection Clause argument should be reserved for a later time when there is a more developed factual record.

State Courts

California

State Farm Gen. Ins. Co. v. Lara, 286 Cal. Rptr.3d 146 (Cal. Ct. App. Oct. 29, 2021)

Plaintiff filed an application to increase its homeowners' insurance rates under the prior approval system created by Proposition 103. Consumer Watchdog, a nonprofit organization intervened and challenged Plaintiff's proposed rates. Defendant "relied on section 2644.20, addressing projected yield, to use the combined annual statement of [Plaintiff's] parent company, State Farm Mutual Automobile Insurance Company. . . and its property-casualty affiliates." *Id.* at 153. Defendant ordered Plaintiff to decrease its rate retroactively and issue refunds to policyholders. Plaintiff then filed a petition for writ of mandate in superior court and the court determined that the insurance code required the rate to mathematically reflect the applicant insurer's income, and Defendant's interpretation and application of regulation pursuant to the insurance code to use the income of Plaintiff's affiliated conflicted with the statute. *Id.* The superior court found in favor of Plaintiff, required that Defendant's order be set aside, and remanded the remaining issues to the Defendant, including the retroactive rate and refund. Defendant appealed arguing that they properly interpreted the statute and regulation and had the authority to impose a retroactive rate and require refunds. The Court of Appeal concluded that the superior court correctly determined that the insurance code required use of the applicant insurer's income in applying Section 2644.20. The court also held that the retroactive rate and refund were impermissible. Defendant initiated an appeal in the California Supreme Court on December 7, 2021.

Maine

Corinth Pellets, LLC v. Arch Specialty Ins. Co., 246 A.3d 586 (Me. Feb. 23, 2021)

In its 2020 edition, the *Journal of Insurance Regulation* reported on *Corinth Pellets, LLC v. Arch Specialty Ins. Co.*, No. BCD-CV-19-37, 2020 WL 1990826, at *1 (Bus. & Consumer Ct. Jan. 23, 2020), where Plaintiff, Corinth Pellets, operated a wood pellet mill that suffered a fire the day after their property policy expired. The issue was whether Section 2009-A, the statute that governs cancellation and renewal of surplus lines policies requires an insurer to give written notice of its intent to cancel or renew the policy. The trial court granted Defendant's motion to dismiss. The court reasoned that the plain reading of Section 2009-A's notice requirement did not apply to Defendant's

nonrenewal of Plaintiff's policy, and that Plaintiff's damages were not covered by the policy.

In the present case, Plaintiff appealed the trial court's decision arguing that the fire loss is covered because Defendant failed to notify Plaintiff of its intention not to renew the policy as required by Section 2009-A. Defendant argues that the fire loss is not covered because it occurred after they policy term expired. The court held that "Section 2009-A(1) requires a surplus lines insurer to give written notice of its intent either to cancel a policy or not to renew a policy at least fourteen days before the effective date of the cancellation or nonrenewal" and the court remanded the case back to the trial court. *Id.* at 596.

Nebraska

***Hauptman, O'Brien, Wolf, & Lathrop, P.C. v. Auto-Owners Ins. Co.,* 964 N.W.2d 264 (Neb. 2021)**

Defendant issued an automobile insurance policy to Plaintiff's client, Charlyn Imes. The policy and the endorsement contained a section that preserved the insurer's right to recover payments. The endorsement provided that if the insurer makes a payment and the person for whom payment is made has a right to recover damages from another, the insurer will be entitled to that right, and that right must be transferred to the insurer. Imes suffered injuries in a motor vehicle accident and retained Plaintiff. Defendant made medical payments of \$1,000 on Imes' behalf. Defendant represented Imes in her lawsuit against the negligent third party and the parties settled for \$48,200. Plaintiff asked Defendant to take a one-third reduction of its \$1,000 and Defendant refused to accept less than \$1,000. Plaintiff sued Defendant and argued that in its defense of Imes, Plaintiff was reasonable in asking for its customary attorney fee which is one-third the amount recovered. This request was made pursuant to the Nebraska common law known as the common fund doctrine. The doctrine provides, "an attorney who renders services in recovering or preserving a fund in which a number of persons are interested, may in equity be allowed his or her compensation out of the whole fund, only where the attorney's services are rendered." *Id.* at 149-150. Defendant answered Plaintiff's lawsuit with multiple affirmative defenses and asked the trial court to declare that it was entitled to the full \$1,000 under Neb. Rev. Stat. § 44-3,128.01 which provides the right of subrogation of medical payments, and the terms of the insurance policy. The trial court held that Neb. Rev. Stat. § 44-3,128.01 "in no way limits or affects the Common Fund doctrine and the Common Fund doctrine in no way affects section 44-3,128.01." *Id.* at 268.

Defendant appealed the trial court's decision, and the Nebraska Court of Appeals affirmed the trial court's order, holding that the issue in the case was Plaintiff's entitlement to recover a reasonable attorney fee for its efforts in securing Plaintiff's subrogated medical payment. The trial court "recognized that the statute was silent as to attorney fees and stated that there was nothing in case law to indicate that the statute preempted the common fund doctrine." *Id.* at 269. Defendant appealed this decision to the Nebraska Supreme Court. The court affirmed the court of appeals' decision holding that Neb. Rev. Stat. § 44-3,128.01 did not intend to preempt the

common fund doctrine. The court held that Neb. Rev. Stat. § 44-3,128.01 only provides that an insurer is entitled to “subrogation for medical payments coverage under an automobile liability policy, but it is silent as to attorney fees.” *Id.* at 271.

Nebraska Dental Ass’n v. Eric Dunning, No. CI 19-3072, at *1 (Dec. 29, 2021)

Plaintiff, a group of Nebraska dentists, filed a lawsuit in the District Court of Lancaster County against the Nebraska Department of Insurance (“Department”) for the court to determine when dental services are “covered” under group dental plans or contracts. Neb. Rev. Stat. § 44-3805 and Neb. Rev. Stat. § 44-7,105 prohibit dentists and insurers from negotiating prices for services that are not “covered” by their contract. After the state legislature passed these statutes, dentists and insurers disagreed about when certain procedures are “covered” by the contract. In response, the Department issued a notice providing two interpretations of “covered service,” and allowed dental plans to use either interpretation until “a definition is supplied by the Legislature or the courts.” *Id.* at *4. Plaintiff was dissatisfied with the Department’s notice and requested this court to declare that the Department’s Director does not have the authority to approve contracts that include provisions that violate Neb. Rev. Stat. § 44-3805 and Neb. Rev. Stat. § 44-7,105. Plaintiff also asked the court to declare that the Department’s notice was invalid and that the court should enjoin the Director from implementing or enforcing the notice. The court held that Neb. Rev. Stat. § 44-3805 and Neb. Rev. Stat. § 44-7,105 are ambiguous and that it agreed with the Department’s definition of “covered services” holding that “covered” “does not mean, as the Plaintiffs argue ‘any dental service for which the insurer or plan pays no money to the dental provider for the service actually provided and identified by the dental provider. . . .’” *Id.* at *23. Rather, the court held that “a service may be covered by a plan even if a dentist’s reimbursement is precluded by contractual provision like annual limits.” *Id.*

New Hampshire

Genworth Life Ins. Co. v. New Hampshire Dept. of Ins., 260 A.3d 838 (N.H. Feb. 17, 2021)

The Long-Term Care Insurance (“LTCI”) Act requires the insurance commissioner to “issue reasonable rules to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices.” *Id.* at 840. In 2004, Defendant issued regulations allowing insurers to increase premium rates, “provided that the increases did not cause the policies to fall below the loss-ratio standard.” *Id.* In 2014, Defendant proposed several amendments to the rate-increase regulations, which allow “insurers to increase rates once every three years, subject to the commissioner’s approval.” *Id.* The amended regulations provided that the commissioner “shall not approve’ any requested increase that exceeds the caps.” *Id.* (citing N.H. Admin. R., Ins. 3601.19(f) (2015)). The amended regulations also included rate increases that were issued before the amendments. Plaintiff challenged amended regulations promulgated by Defendant that retroactively limited rate increase for LTCI policies. Plaintiff sought declaratory and injunctive relief against Defendant

challenging the rate-increase caps. Plaintiff argues that the caps were *ultra vires* and exceeded Defendant's statutory authority. The trial court dismissed Plaintiff's claim and this appeal followed.

On appeal, Plaintiff argues that the amended regulations impair its contractual rights in violation of the contract and takings clauses of the State and Federal Constitutions and exceed Defendant's statutory authority "to issue reasonable regulations to promote premium adequacy and to protect policyholders in the event of substantial rate increases." *Id.* at 841. The court reversed the trial court's decision, holding that the amended regulations were *ultra vires* because "they are not reasonable rules that either promote premium adequacy or protect policyholders in the event of substantial rate increases." *Id.* at 846. The court also stated that due to its ruling that the amended regulations exceeded Defendant's authority, it did not address Plaintiff's remaining claims.

Pennsylvania

In Re: Penn Treaty Network Am. Ins. Co., 259 A.3d 1028 (Pa. Commw. Ct. July 9, 2021)

Pennsylvania Insurance Commissioner in her capacity as Statutory Liquidator of Penn Treaty Network America Insurance Company ("Penn Treaty") and American Network Insurance Company ("ANIC") filed a declaratory judgment action to have the court declare "that she is authorized under Article V of [t]he Insurance Department Act of 1921 (Article V) to allocate assets from [both Penn Treaty and ANIC's] estates to pay policyholder claims for benefits that exceed applicable statutory guaranty association limits." *Id.* at 1029. The court denied the commissioner's motion stating that there is "simply no statutory authority for this well-intentioned proposal." *Id.* at 1050. The court also held that pursuant to Article V and the Pennsylvania Life and Health Insurance Guaranty Association Act the current systems function well and that "policyholders who experience a benefit-triggered event. . . are protected." *Id.* The court further stated that policyholders must look to their guaranty associations for payment order of their claims, not the estate of the liquidated insurer. *Id.*

Utah

Drew v. Pac. Life Ins. Co., 496 P.3d 201 (Utah Sept. 2, 2021)

Plaintiff brought action against Defendant, a life insurer, alleging that Defendant was vicariously liable for injuries they suffered by relying on misrepresentations made by employees of Defendant's appointed insurance producer, who advised Plaintiffs to obtain reverse mortgage in order to purchase and resell two \$1.5 million life insurance policies, which resulted in Plaintiff losing the majority of their life savings. The trial court granted Defendant's motion for summary judgement and Plaintiff appealed. The Court of Appeals held that under the terms of the Utah Insurance Code, producers soliciting life insurance policies for Defendant were acting as its agents and therefore Defendant was vicariously liable for torts committed during the solicitation process. Defendant filed petition for certiorari in the Utah Supreme Court and the petition was

granted. The Supreme Court vacated the Court of Appeals' determination that the producers working for Defendant were not agents of Defendant. The court granted partial summary judgment to Plaintiff on the "appointed licensee" issue and held that under Utah Code § 31A-23a-405(2), the producers working for Defendant were Defendant's "appointed licensee." *Id.* at 227. The court explained further that even though the producers lacked express or implied actual authority, the producers acted with apparent authority when it made representations about Defendant's products to sell policies to Plaintiff. *Id.*

West Virginia

*Steele v. West Virginia Off. of Ins. Comm'r, No. 19-1167, 2021 WL 195290, at *1 (W. Va. Jan. 20, 2021)*

On September 19, 2018, a claims administrator denied Plaintiff's request to reopen his claim for a permanent partial disability evaluation. The Workers' Compensation Office of Judges affirmed the claim administrator's order on July 3, 2019. The Board of Review affirmed this decision on November 22, 2019, and this appeal followed.

Plaintiff sustained an injury to his back while working as a coal truck driver in 1998. In 1999, the claims administrator found the claim compensable for contusion of the chest wall, neck sprain, and lumbosacral sprain. Plaintiff was awarded temporary total disability from December 8, 1998, through June 20, 1999. The Office of Judges affirmed the claims administrator's order and the decision noted that the claim was compensable only for the contusion of the chest wall, neck sprain, and lumbosacral sprain. On September 18, 2001, Plaintiff's doctor sought authorization for a cystoscopy test regarding urological conditions related to the compensable injury. Plaintiff requested that his claim be reopened for a permanent partial disability evaluation. The request included issues stemming from a urological condition. Plaintiff argued that the claims administrator had an obligation to refer him for a permanent partial disability examination pursuant to West Virginia Code § 23-4-2. West Virginia Code § 23-4-2 provides that in every closed claim, the "commission shall give notice to the parties of the claimant's right to a permanent partial disability evaluation." *Id.* at *3. The Office of Judges found that West Virginia Code § 23-4-2 did not apply in Plaintiff's case because his "compensable conditions were properly evaluated for permanent disability, and he was granted a 15% permanent partial disability award for his compensable conditions." *Id.* Plaintiff's claim was denied. The Supreme Court of Appeals of West Virginia affirmed the Office of Judges' decision, and held that the claim is compensable only for the injuries specified in the initial Board of Review order and there was no clear violation of any constitutional or statutory provision.

Cases in Which the NAIC Filed as Amicus Curiae

Data Mktg. P'ship v. Dep't of Labor, No. 20-11179, (5th Cir. 2021) (NAIC brief filed April 7, 2021) In its 2020 edition, the *Journal of Insurance Regulation* reported on *Data Mktg. P'ship v. Dep't of Labor*, 490 F.Supp.3d 1048 (N.D. Tex. Sept. 28, 2020) where the district court held in favor of Plaintiff and that the Department of Labor ("DOL") filed an appeal in the Fifth Circuit. The NAIC submitted an amicus brief to the Fifth Circuit Court of Appeals on April 7, 2021, supporting the United States Department of Labor in seeking a reversal of the district court's order. At issue is whether the health plan sponsored and administered by Data Marketing Partnership ("DMP") and offered to its limited partners is an "employee benefit plan" within the meaning of ERISA or whether state insurance laws govern the plan. DMP states that its business consists of limited partners installing a track app of their smart phones so that they can sell the data to third-party marketing firms. DMP calls its limited partners "working owners" of the company, arguing that it is providing a single-employer health plan pursuant to ERISA. The DOL issued an advisory opinion stating that, based on the presented facts, DMP was not an employer and the "limited partners" were not employees or "working owners." The NAIC filed a brief agreeing with the DOL that DMP's health plan appears to be a scheme to avoid regulatory oversight of the commercial sale of insurance outside the context of employment-based relationships. The brief explained that ever since ERISA was enacted, there have been a number of such schemes to evade state insurance law, putting consumers at serious risk of losing health coverage to insurer insolvency.

Gunn v. Cont'l Cas. Co., No. 1:18-cv-03314 (N.D. Ill. 2021) (NAIC brief filed Sept. 16, 2021) The NAIC submitted an amicus brief on September 16, 2021, at the suggestion of the Seventh Circuit Court of Appeals, to the United States District Court for the Northern District of Illinois to "educate generalist federal courts about the broader implications of choice-of law rules as applied to group insurance policies." *Gunn v. Cont'l; Cas. Co.*, 968 F.3d 802, 813 (7th Cir. 2020). The NAIC's brief supports CNA's position that the Washington Office of the Insurance Commissioner (OIC) properly exercised its authority in approving the rates for the CNA certificate of insurance issued to plaintiff Carlton Gunn. Gunn argues that because the policy was issued to his employer in Washington, D.C., it was the D.C. Department of Insurance, Securities and Banking's approved rates that applied to his certificate. Gunn is a resident of Washington state and his certificate was issued to him in Washington. Washington law contains several provisions providing the OIC with authority to approve rates for certificates issued to residents in the state. The NAIC takes the position that the filed-rate doctrine recognizes the authority of the Washington OIC to approve premium rates that are actuarially justified pursuant to legal requirements, making a choice of law analysis inapplicable.