# Abstracts of Significant Cases Bearing on the Regulation of Insurance 2017

Jennifer M. McAdam*
Kara D. Binderup**

## United States District Courts

*Pharm. Care Mgmt. Ass'n v. Gerhart, 852 F. 3d 722 (8th Cir. 2017)*

Pharmaceutical Care Management Association, a trade association representing pharmacy benefits managers (PBMs), filed an action against Iowa's insurance commissioner and attorney general seeking a declaration that an Iowa statute was preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA) and violated the dormant Commerce Clause of the U.S. Constitution. The Iowa statute at issue regulates how PBMs, which act as third-party plan administrators, establish generic drug pricing and requires certain disclosures on pricing methodology be made to the network pharmacies and to the insurance commissioner.

The district court dismissed the claim, holding that the statute did not have an impermissible "connection with" ERISA, as it does not unduly restrict the administration of any ERISA plan, does not mandate the provision of any benefits or require a particular pricing methodology. It also found that the statute did not impermissibly reference ERISA, as it did not act "immediately and exclusively" on ERISA plans. On appeal, the Eighth Circuit reversed the dismissal, finding that the statute was preempted by ERISA. The court held that the statute referenced ERISA because it applied to PBMs that administer prescription drug benefits for ERISA plans and explicitly exempted certain ERISA plans. It also found that, by requiring disclosures regarding pricing methodology, the statute had a "connection with" ERISA plans because "reporting, disclosure, and recordkeeping … are

* Jennifer M. McAdam is Legal Counsel with the NAIC.
** Kara D. Binderup is Senior Counsel with the NAIC.

integral aspects of ERISA" and, therefore, interfered with the national scheme of plan administration.

### *Onyx Ins. Co. v. N.J. Dep't of Banking and Ins., No. 16–2153, 2017 WL 3393833 (3d Cir. Aug. 8, 2017)*

In this case involving New Jersey's Unsatisfied Claim and Judgment Fund, the U.S. Court of Appeals for the Third Circuit upheld a lower court ruling dismissing the claim of a risk retention group (RRG). Onyx, an RRG, had argued the federal Liability Risk Retention Act of 1986 (LRRA) preempted New Jersey's statutory scheme, which excluded RRGs from participating in the fund that assesses member insurers and makes personal injury payments to cover uninsured pedestrians. The court ruled that LRRA's express language indicates a state "may" require an RRG to participate in state-established mechanisms for equitable apportionment among insurers of losses and expenses. The state has discretion whether to include RRGs in the fund and, furthermore, the state's actions are not discriminatory absent an express LRRA violation.

### *U.S. v. Anthem, Inc., 855 F.3d 345 (D.C. Cir. 2017)*

In this antitrust case, the U.S. Court of Appeals for the D.C. Circuit upheld a lower court's ruling that the proposed merger between Anthem and Cigna, the second- and third-largest sellers of health insurance to large companies in the U.S., would violate the federal Clayton Antitrust Act. The court agreed with the federal government that Anthem failed to show the kind of extraordinary efficiencies that would counterbalance likely price increases in a highly concentrated market following the merger.

The court rejected Anthem's argument that a merged entity would allow for product innovation by incorporating Cigna's customer-facing programs and Anthem's low rates. The court found this benefit to be uncertain in timeliness or effectiveness, while the upward pricing pressure due to the loss of a competitor would be immediate. Furthermore, the court affirmed the lower court's ruling that Anthem had failed to provide sufficient evidence that it could not improve product offerings on its own.

### *Blue Cross and Blue Shield of N.C. v. U.S., 131 Fed. Cl. 457 (2017)*

In this suit to collect full Risk Corridors Program payments from the federal government, Blue Cross and Blue Shield of North Carolina (Blue Cross) alleged a violation of Section 1342 of the federal Affordable Care Act (ACA), as well as breach of Blue Cross's qualified health plan (QHP) agreement with the federal government, breach of implied-in-fact contracts, breach of the covenant of good faith and fair dealing, and violation of the Takings Clause of the U.S. Constitution. ACA Section 1342 established the Risk Corridors Program to cap the profits and

losses of insurers offering QHPs. The federal government had made only partial payments to Blue Cross.

The U.S. Court of Federal Claims found in favor of the federal government, holding that ACA Section 1342 does not establish a deadline for full payments. The court also found no reasonable reading of the QHP agreement that would create an obligation to make full, annual risk corridors payments. Furthermore, it found the U.S. Congress did not intend for statutory obligations in the ACA to contractually bind the federal government. The court also ruled that an implied covenant of good faith and fair dealing cannot expand contractual duties.

## *State of Cal. v. Trump, No. 17–cv–05895–VC, 2017 WL 4805588 (N.D. Cal. Oct. 25, 2017)*

The District Court for Northern District of California denied preliminary injunction to 17 states challenging the executive order terminating payments under the ACA cost-sharing reduction (CSR) provision. The injunction was intended to continue CSR payments to low-income participants on the federal exchanges (lowering their out-of-pocket expenses) pending the outcome of a lawsuit challenging the validity of CSR program funding. That lawsuit was initiated by the U.S. House of Representatives against the Obama administration, and several states intervened in the suit to advocate for the validity of the CSR program following the 2016 presidential election. A decision is expected in 2018.

The court agreed with the Trump administration that a preliminary injunction was not warranted, holding that individual states had taken sufficient measures to shield lower-income people from the impact of the executive order. The court noted that California and other states had worked with insurers to compensate for lost CSR payments by concentrating premium increases in subsidized "Silver" plans, resulting in increased tax credits for insureds between 100% and 400% of the federal poverty level. The court further ruled that 38 states accounted for the termination of CSR payments when setting 2018 rates. While giving some credence to the states' argument that termination of CSR payments creates confusion and may deter consumers from obtaining coverage, the court ultimately concluded that a preliminary injunction order would not alleviate confusion.

## *King v. Nat'l Gen. Ins. Co., No. 15-CV-00313-DMR, 2017 WL 588291 (N.D. Cal. Feb. 14, 2017)*

Putative class members filed suit against a number of insurers with whom they contracted to receive private passenger automobile insurance. Policyholder plaintiffs are all "good drivers" entitled to a discount on the rate the policyholder would otherwise be charged. Policyholders allege that the agents of the defendant insurers within the same control group failed to cross-offer a policy with the lowest rates for coverage because defendant insurers concealed this requirement from the agents. Defendants claim that two of the insurers are entitled to "super

group" exemptions from the cross-offer requirement and that three of the insurers are restricted from making cross-offers to consumers who are not members of certain affinity groups (e.g., AAA, AARP, etc.).

This is the third round of motions to dismiss the action. Defendant insurers argue that the determination of "super group" status is within the exclusive jurisdiction of the California Department of Insurance (CDI). Policyholders argue that because they are not asking for a determination as to the reasonableness of rates, a court can decide the matter. The court held that, while it could make the "super group" determination, it would exercise discretion to invoke the primary jurisdiction doctrine to take advantage of the CDI's administrative expertise.

## *Gerhart v. U.S. Dept. of Health & Human Servs., 242 F.Supp.3d 806 (S.D. Iowa 2017)*

The U.S. District Court for the District of Iowa granted a motion to dismiss in this action involving Risk Corridors Program payments. The U.S. Department of Health and Human Services (HHS) withheld partial risk corridors payments for an insolvent insurer and used the amounts to offset an alleged debt arising from a startup loan. The Iowa insurance commissioner, in his capacity as liquidator of CoOportunity Health, Inc., requested declaratory relief applying Iowa law to all claims against the insurer, rejecting HHS' claim of "super priority," and prohibiting HHS from setting off or netting any payments owed to CoOportunity against claimed debts.

The court agreed with HHS that jurisdiction was appropriately placed in the U.S. Court of Federal Claims because the requested damages can be addressed monetarily under the federal Tucker Act. Reversing the holding of funds or prohibiting the offset would both result in the payment of money from HHS; as such, the Court held that money would adequately address the alleged harm. The court also ruled that opining on the choice of law would be tantamount to an advisory opinion and, therefore, would be outside the court's jurisdiction.

## *Jacob v. UNUM Life Ins. Co. of Am., No. 16-cv-17666, 2017 WL 4764357 (E.D. La. Oct. 20, 2017)*

Policyholder, Jacob, appeals the denial of disability benefits, arguing that the court should review her claim *de novo*, as the policy's discretionary clause is void under Texas law. The plan's discretionary clause provides that the policy administrator's determinations are reviewed by the courts only for an abuse of discretion. Texas has a relevant statute and regulation, both of which prohibit the use of discretionary clauses in insurance policies. At issue is whether either of these apply based on their effective dates and on the facts surrounding the issuance of an amendment to the plan. The regulation applies "on or after any . . . amendment of the form occurring on or after June 1, 2011." The statute took effect

June 17, 2011. UNUM issued the plan in 1997 and issued an amendment to the plan in 2014.

The court determined that Texas law prohibits the plan's discretionary clause, reasoning that, if the amendment constituted a new policy, the statute would apply and if the amendment amended the existing policy, the regulation would apply. The court also rejected UNUM's argument that the agency's regulation was invalid, holding that the agency has broad authority to adopt necessary and appropriate rules "to implement the powers and duties of the department under [the insurance] code," as well as specific authority to adopt rules prohibiting companies from engaging in unfair or deceptive practices.

# State Courts

## California

*Assoc. of Cal. Ins. Cos. v. Jones, 386 P.3d 1188 (Cal. 2017)*

This case involves a challenge to rules promulgated under the insurance commissioner's authority granted by California's Unfair Insurance Practices Act (UIPA). In the wake of California wildfires, homeowners found that they were substantially underinsured when it came to replacing their homes. To address this problem, the insurance commissioner issued rules to standardize insurers' replacement cost calculations and clarified that estimates given by insurers that did not comport with the new rule could be considered misleading under UIPA. The rule required that an estimate include all expenses necessary to rebuild the insured structure and that the insurer verify its estimate methods annually.

Plaintiffs, the Association of California Insurance Companies and the Personal Insurance Federation of California (collectively, Association), filed a declaratory judgment action challenging the validity of the rules, claiming that they exceeded the commissioner's authority, improperly restricted insurance underwriting and violated insurers' right to free speech. The trial court found that the regulation exceeded the commissioner's authority by attempting to define additional practices under UIPA by rule. The appellate court affirmed, finding that UIPA did not define "incomplete replacement cost estimates," noting that the omission "was a deliberate choice." The California Supreme Court reversed, holding that the commissioner had broad authority under UIPA to bring enforcement actions and to promulgate rules. The court did not believe that the legislature's failure to define "incomplete replacement cost estimates" meant that the commissioner could not do so. The court held that the Association did not meet its burden to show that a noncompliant estimate would not be misleading in most cases.

## Illinois

*Catledge v. Dowling, 82 N.E.3d 781 (Ill. App. Ct. 2017)*

Policyholder Catledge filed a suit seeking review of the Illinois Department of Insurance's (IDI) order upholding the cancellation of his homeowners policy. Nationwide Mutual Fire Insurance company notified Catledge that his policy had been cancelled due to a "substantial change in risk" when the home went into foreclosure. The IDI granted Catledge's request for a hearing on the matter and the hearing officer found the cancellation was allowed under Illinois law. The IDI acting director entered a final order adopting the recommendations of the hearing officer. Catledge then filed a complaint in state court seeking judicial review.

The trial court granted the IDI's motion to dismiss based on a finding that Catledge had failed to exhaust his administrative remedies. The appellate court affirmed this decision because Catledge did not seek rehearing of the acting director's order before seeking judicial review. The court did not find that Catledge had met any of the exceptions to the exhaustion doctrine, as he asserted that a rehearing would be done by the same hearing officer without providing any evidence for that claim.

## Indiana

*First Am. Title Ins. Co. v. Robertson, 65 N.E. 3d 1045 (Ind. Ct. App. 2016), reh'g denied (Jan. 31, 2017)*

This case, on remand from the Indiana Supreme Court, involves the Indiana Department of Insurance's (IDOI) market conduct order in the examination of First American Title Insurance Company. First American had originally filed a petition for review in state court claiming that the IDOI failed to timely file its order in the matter. The case went up to the Indiana Supreme Court, which held that the trial court erred in failing to grant the IDOI's motion to dismiss for First American's failure to file the agency record.

On remand to the trial court, First American filed a writ of prohibition and mandate, a request for declaratory relief and an amended petition for judicial review. The request for declaratory relief included a claim that an administrative agency's void action is subject to collateral attack at any time. The IDOI filed a motion to dismiss, arguing that the Indiana Supreme Court already determined that First American's administrative procedure claim failed and, because the declaratory judgment action was based on the same claim, both were barred by res judicata and law of the case doctrines. The trial court granted the motion to dismiss. The Court of Appeals affirmed the order, finding that the claims were barred by res judicata. The court reasoned that First American's claims concerned whether the order was timely filed and that such fact-sensitive issues should be resolved by the administrative agency.

## *Discovery Ins. Co. v. N.C. Dept. of Ins., No. COA17-285, 2017 WL 4364481 (N.C. Ct. App. Oct. 3, 2017)*

In this case involving fraudulent claims against the North Carolina Reinsurance Facility (NCRF), a statutorily created entity reinsuring all motor vehicle liability insurers in the state, the Court of Appeals of North Carolina upheld the insurance commissioner's order of restitution. The petitioner, Discovery Insurance Company, learned that one of its claims executives had issued checks for fraudulent payments totaling $5.3 million, with $1.3 million of that amount reimbursed by the NCRF as auto liability claims payments. The NCRF sought reimbursement of $1.3 million from Discovery and ultimately obtained a favorable order from the insurance commissioner. Discovery appealed.

The court held the NCRF was properly authorized to recoup fraudulent funds under a statutory catch-all provision empowering the entity to take any action necessary to accomplish the purpose of the NCRF. This provision allows the NCRF to order reimbursement without the necessity of commencing a civil lawsuit. The court also rejected Discovery's argument that the NCRF was estopped from seeking repayment because the NCRF allegedly did not follow its own claims audit process. The court found Discovery violated its own duty to obtain claimant confirmation on a reasonably representative number of claim payments; therefore, Discovery had unclean hands and could not assert an estoppel claim.

## *Progressive Am. Ins. Co. v. Garrido, 211 So.3d 1086 (Fla. Dist. Ct. App. 2017)*

The Florida Third District Court of Appeal overturned a lower court's ruling that Florida's exclusion of chiropractors from its statutory list of "medical professionals qualified to diagnose an emergency medical condition" was unconstitutional. The court ruled that separate treatment of chiropractors under the personal injury protection statute had a rational basis and should survive an equal protection claim. The court acknowledged that chiropractors may be as qualified as other medical professionals to diagnose patients with an emergency condition, but declined to substitute judicial fact-finding for legislative fact-finding. The statutory exclusion bears a reasonable relationship to a legitimate governmental objective.

# Cases in Which the NAIC Filed as *Amicus Curiae*

## *Moda Health Plan, Inc. v. United States, No. 17-1994 (NAIC brief filed Aug. 28, 2017)*

The NAIC submitted an amicus brief in the U.S. Court of Appeals for the Federal Circuit in the case of *Moda Health Plan v. United States* on Aug. 28, 2017. The NAIC filed this brief in support of Moda Health Plan, which had prevailed in its arguments in the U.S. Court of Federal Claims. The case involves the ACA Risk Corridors Program, under which insurers operating on state exchanges were subject to caps on their profits or losses beyond a certain threshold. The federal government has paid 12.6% of what it owes Moda and other insurers for losses under the Risk Corridors Program. The NAIC's brief asserted that nonpayment of risk corridors amounts on a national scale has negatively impacted state insurance regulators' ability to oversee rates, licensing, capital adequacy and liquidation of companies. Nonpayment has also suppressed competition, ultimately hurting consumer choice and affordability.

## *Amica Life Ins. Co.v. Wertz, No. 1:15-cv-01161-WJM-CBS, D. Colo. (NAIC brief filed Oct. 27, 2017)*

The NAIC submitted an amicus brief in support of plaintiff Amica Life Insurance Company's motion for summary judgment on Oct. 27, 2017. The underlying declaratory judgment action filed by Amica against a life insurance policy beneficiary centered on the enforceability of a two-year suicide exclusion contained in a policy issued pursuant to the uniform standards approved by the Interstate Insurance Product Regulation Commission (IIPRC). While Amica argued the two-year suicide exclusion should apply, defendant Wertz argued that Colorado's one-year suicide exclusion statute was applicable, as adoption of the IIPRC uniform standards represented an unconstitutional delegation of authority to an interstate agency. In light of the perceived conflict between the IIPRC uniform standards and Colorado law, the U.S. District Court for the District of Colorado certified a question to the Colorado Supreme Court asking for it to rule on the matter. The Colorado Supreme Court rejected the opportunity to address the question, leaving the issue to the federal court for its consideration. The NAIC's brief detailed the development of the NAIC *Interstate Insurance Product Regulation Compact* (#692), while also addressing the constitutional issues considered during its development. The NAIC's brief also argued that Colorado's adoption of Model #692, as well as its adherence to the IIPRC uniform standards, was an appropriate delegation of authority to the IIPRC.