

Abstracts of Significant Cases Bearing on the Regulation of Insurance 2018

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United States Courts of Appeal

Moda Health Plan, Inc. v. United States, 892 F.3d 1311
(Fed. Cir. 2018)

This case involves the federal Patient Protection and Affordable Care Act's (ACA) three-year risk corridors program, under which insurers that expanded their risk pool would receive payments from the federal government if their costs of providing coverage exceeded the premiums received. The payments were to act as an incentive to insurers unable to estimate the cost of providing care to those seeking coverage under the new exchanges. Conversely, insurers were to pay the federal government a share of their profits when the premiums received exceeded their costs. Citing a lack of payments received from insurers making profit, the federal government had paid only 12.6% of the losses incurred by Moda Health Plan, Inc. (Moda) and other participating insurers under the risk corridors program.

Moda filed suit against the federal government, seeking the remaining payments owed under both statutory and contractual liability theories. The federal government argued that the risk corridors program was intended to be budget neutral; therefore, it owed only the amounts it received as profit from the insurers. The federal government brought this appeal after the U.S. Court of Federal Claims entered judgment for Moda. On appeal, this court reversed the lower court's

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judgment, finding that the federal government did not owe money to Moda or other insurers under either theory of liability.

The court reasoned that, while the plain language of the ACA created an obligation of the federal government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula, the U.S. Congress intended to suspend payments on the risk corridors program beyond the amounts insurers paid in, via riders to the appropriations bills for fiscal years 2015 and 2016. Furthermore, the court found that Moda failed to establish the existence of an implied-in-fact contract based on the ACA, its regulations and the conduct of the U.S. Department of Health and Human Services (HHS). The court applied the presumption that a law is not intended to create a private contractual right and found that the law, regulations and conduct of HHS were all simply part of the incentive program. The NAIC filed an amicus brief in support of Moda's position in this case. Following the adverse ruling, Moda filed a petition for writ of certiorari to the U.S. Supreme Court, and the NAIC filed an amicus brief in support of Moda's petition.

Pharm. Care Mgmt. Ass'n v. Rutledge, 891 F.3d 1109 (8th Cir. 2018)

The Pharmaceutical Care Management Association (PCMA), a trade association representing pharmacy benefit managers (PBMs), filed an action against Arkansas' attorney general seeking a declaration that an Arkansas statute was preempted by the federal Employee Retirement Income Security Act (ERISA). The statute, Act 900, mandates that pharmacies be reimbursed for generic drugs at a price equal to or higher than the pharmacies' cost for the drug based on the invoice from the wholesaler. Act 900 also regulates how PBMs set their reimbursement rates through maximum allowable cost (MAC) lists by requiring them to update the lists within at least seven days from the time there has been a certain increase in acquisition costs. The law also contains administrative appeal procedures and allows the pharmacies to reverse and re-invoice each claim affected by the pharmacies' inability to procure the drug at a cost that is equal to or less than the cost on the relevant MAC list where the drug is not available "below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale." Finally, the law allows pharmacies to "decline-to-dispense" when they will lose money on a transaction.

The district court agreed with the PCMA that the pertinent provisions of the law were preempted by ERISA based on controlling case law in the U.S. Circuit Court of Appeals for the Eighth Circuit. However, the district court found that Medicare Part D did not preempt Act 900, nor was the law unconstitutional on any of the several bases advanced by the PCMA. The PCMA appealed the Medicare Part D ruling, and the state cross-appealed the ERISA ruling.

The Eighth Circuit found that the Arkansas law was preempted by ERISA. While the law did not explicitly reference ERISA, it made an impermissible implicit

reference by regulating PBMs that administered benefits for covered entities necessarily subject to ERISA. The court held that the presumption against preemption did not apply because the law both related to, and had a connection with, employee benefit plans. Lastly, the court found that the state law was preempted by Medicare Part D, as it acted “with respect to” the Negotiated Prices Standard by regulating the price of retail drugs, and it acted with respect to the Pharmacy Access Standard, as it would interfere with convenient access to prescription drug availability.

Ausmus v. Perdue, 908 F.3d 1248 (10th Cir. 2018)

Winter wheat farmers in Colorado filed a challenge to the Federal Crop Insurance Corporation’s (FCIC) implementation of the Farm Crop Insurance Act (FCIA) upon being denied the actual production history (APH) yield exclusion when they purchased crop insurance for the 2015 crop year. The farmers lost their challenge through the administrative appeals process and appealed to the district court, which reversed and remanded the matter. The U.S. Court of Appeals for the Tenth Circuit treated the remand order as final and granted review.

The farmers purchased insurance that provided protection from low crop yields due to “unavoidable, naturally occurring events.” The coverage available to a farmer is calculated by multiplying the projected price, the coverage level percentage (selected by the farmer) and the APH yield. The APH is based on an average of the last four to 10 years of the farmer’s own history, and it is calculated by adding the yearly yields and dividing that sum by the number of yields. The farmer can purchase more insurance with a higher APH. Congress amended the FCIA in 2000 to allow the FCIC to adjust a farmer’s APH when a farmer experienced an especially poor harvest “for any of the 2001 and subsequent crop years.” This provision was amended in 2014 to allow farmers to elect to exclude a yield from the APH calculation when a crop yield was 50% below the average yield of that crop in the county during the previous 10 consecutive crop years. Shortly after the 2014 amendment was made, the FCIC published an interim rule that phased in farmers’ eligibility for the APH yield exclusion as the FCIC updated its actuarial documents to add newly eligible crops.

In this case, the farmers elected the APH yield exclusion, but the U.S. Department of Agriculture (USDA) notified insurance providers that the exclusion would not be available for winter wheat for the 2015 crop year. The farmers challenged this ruling, arguing that the FCIA, as amended, was written to apply to “2001 and subsequent crop years,” which would include the 2015 crop year, because the 2014 amendment at issue did not contain new implementation deadlines. The Tenth Circuit found that the FCIA, including the 2014 amendment, unambiguously applied to “2001 and subsequent crop years.” Because the statute was unambiguous, the court afforded no deference to the FCIC’s interpretation and did not need to resort to legislative history.

United States District Courts

Amica Life Ins. Co. v. Wertz, 350 F. Supp. 3d 978 (D. Colo. 2018)

Amica Life Insurance Company (Amica) filed a declaratory judgment action against the beneficiary of a life insurance policy, Michael Wertz, arguing that it had properly denied payment of benefits. The policy at issue contained a two-year suicide exclusion that had been implemented by the Interstate Insurance Product Regulation Commission (Compact). Colorado, as a member of the Compact, implemented the two-year suicide exclusion for the policy at issue even though another Colorado statute limited suicide exclusions to one year for policies not filed with the Compact.

The question before the court was whether the Colorado Legislature, in enacting the Compact, could delegate to a Colorado administrative agency, the discretion to promulgate regulations that substantively modify state statutes. In answering this question in the affirmative, the court held that by enacting the Compact, the Colorado gave express authority to the Compact to adopt uniform standards that control over conflicting state laws as to the content of the Compact-approved policies. The NAIC filed an amicus brief in support of Amica's position in the district court. Mr. Wertz has appealed to the U.S. Court of Appeals for the Tenth Circuit, and the NAIC filed a joint amicus brief with the Compact in further support of Amica.

Progressive Northwestern Insurance Company v. Gant, No. 15-9267-JAR-KGG, 2018 WL 4600716 (D. Kan. Sept. 24, 2018)

This case involved the question of whether the court should apply the unpublished nonbinding rule from the *Restatement of the Law, Liability Insurance* (Restatement) that an insurer can be held directly liable for the conduct of defense counsel retained for the policyholder. Progressive Northwestern Insurance Company (Progressive) filed a declaratory judgment action seeking a declaration that it fulfilled its contractual obligations in good faith and without negligence under an insurance policy issued to Edward and Linda Birk, whose son, Justin Birk, was involved in a vehicular homicide that killed Kathryn Gant. Defendant Gabriel Gant, as assignee of the Birks' rights against Progressive, counterclaimed for breach of contract and bad faith.

Among the Defendant's claims was that Progressive violated its obligation to defend the Birk defendants by breaching the duty to hire competent counsel. Specifically, Mr. Gant argued that defense counsel hired by the insurer was incompetent because Progressive had prior knowledge of the attorney's alleged reputation for "thwarting" settlement. Applying Kansas law, the court predicted that

the Kansas Supreme Court would have agreed that it was immaterial to the case at hand as to whether Progressive had prior knowledge that counsel in prior cases had found retained counsel aggressive or difficult to work with. Citing the Restatement Mr. Gant asserted that “where an insurer hires an attorney despite a known problem, and then that same problem surfaces in the case for which the attorney was hired, the insurance company that hired the attorney is liable for the loss to the insured by the hiring of that attorney.”

The court held that Mr. Gant’s reliance on the Restatement was premature because, as of the date of the court’s order, the official text of the Restatement had not been published. The court also stated that Kansas courts have neither directly addressed the issue of when an insurer may be directly liable for the conduct of defense counsel retained for the insured, nor relied upon or adopted the new Restatement’s rule. Therefore, the court was not inclined to use a nonbinding Restatement as a means to overturn or expand Kansas law.

Additionally, even if the court were persuaded to follow the Restatement, Progressive would only be liable for acts or omissions of retained counsel “within the scope of the risk that made his selection unreasonable.” Mr. Gant argued that retained counsel failed to properly provide notice to another insurer due to the fatal collision, but the Court stated that any such failure was due to the misinterpretation of the policy, not that retained counsel obstructed the settlement or committed legal malpractice. As such, any alleged deficiency in retained counsel’s performance with respect to his settlement skill set, or lack thereof, was beyond the scope of risk that made the selections of counsel unreasonable.

PHI Air Med., LLC v. New Mexico Office of Superintendent of Ins., No. 18 CV 382 JAP/SCY, 2018 WL 6478626 (D.N.M. Dec. 10, 2018)

PHI Air Medical (PHI) filed an action against the New Mexico Office of Superintendent of Insurance (OSI) and Superintendent John G. Franchini seeking a declaratory judgment that the New Mexico insurance laws prohibiting the balance billing of air ambulance patients are preempted by the federal Airline Deregulation Act (ADA). PHI also sought an injunction against the OSI defendants from enforcing New Mexico insurance laws against PHI and other air ambulance providers. The OSI defendants claim that the state laws were enacted for the purpose of regulating the “business of insurance” and are valid under the federal McCarran-Ferguson Act.

PHI is an air carrier licensed by the New Mexico Department of Health to provide air ambulance services to New Mexico residents. In June 2016, PHI provided medically necessary emergency transport for a stroke patient. The patient was covered by a policy issued by New Mexico Health Connections (NMHC). PHI, which was an out-of-network provider, submitted an invoice to NMHC but did not receive full reimbursement. The plan promised to cover emergency services from an out-of-network provider at the in-network benefit level up to the “usual,

customary, and reasonable amount” as determined by NMHC. The patient was required to pay a \$100 copay, which he did. PHI used NMHC’s internal review process to appeal the reimbursement decision, seeking the unpaid balance of \$30,961.14. Upon denial of its appeal, PHI sent an invoice for the remaining amount to the patient.

The patient filed an external review request with the OSI pursuant to the state law prohibiting balance billing. The OSI issued an opinion and order finding that the patient was not responsible for the invoice because he had paid the copay and the state law required managed health care plans to ensure “emergency care is immediately available without prior authorization requirements, and appropriate out-of-network care is not subject to additional costs.” Additionally, the OSI noted that it “does not have jurisdiction over contractual matters between carriers and providers”; therefore, it could make “no determination about whether NMHC was responsible for the balance due.”

PHI then filed this claim in district court. The court dismissed all claims without prejudice, finding that it did not have subject-matter jurisdiction and that PHI lacked standing to sue the OSI defendants. The Court held that PHI could seek redress only from NMHC, not the OSI, as the state law at issue provided the OSI with authority over insurers but not providers.

NRA of Am. v. Cuomo, 350 F. Supp. 3d 94 (N.D.N.Y. 2018)

The National Rifle Association of America (NRA) filed an action against defendants Andrew Cuomo, New York Governor; Maria T. Vullo, Superintendent of the New York State Department of Financial Services; and the New York State Department of Financial Services (DFS). In October 2017, the DFS initiated an investigation of the NRA’s Carry Guard insurance program, focusing on two insurance companies: Chubb Ltd., which acted as underwriter of the policies; and Lockton Affinity, LLC, which acted as administrator of the program. The Carry Guard program provided, among other policy coverages: 1) liability insurance to gun owners for acts of intentional wrongdoing; and 2) legal services insurance for any costs and expenses incurred in connection with a criminal proceeding resulting from acts of self-defense with a legally possessed firearm, in violation of New York insurance law. Shortly after the DFS initiated the investigation, Lockton Affinity suspended the Carry Guard program and no longer provided Carry Guard policies to New York residents. The DFS’ investigation revealed that Lockton Affinity and Chubb violated numerous provisions of the New York insurance law in connection with the Carry Guard program and additional NRA programs.

The suit, which asserted claims under the U.S. and New York constitutions for alleged violations of free speech, due process and equal protection, among other claims, came after Gov. Cuomo directed the DFS to issue guidance letters to the banks and insurers regulated by the state, urging them to consider their reputational risks by doing business with the NRA and similar groups. The NRA cited the DFS

guidance letters, as well as public comments from Superintendent Vullo and Governor Cuomo, and the regulatory actions, to argue that the state agency exceeded its regulatory authority and pursued the NRA for political reasons.

The DFS filed a motion to dismiss the NRA's claims. The court dismissed most of the NRA's causes of action, including its First Amendment freedom-of-association claims; equal protection claims for selective enforcement against the NRA; due process claims; claims of a conspiracy between Gov. Cuomo and Superintendent Vullo to threaten banks and insurance companies with regulatory scrutiny if they did business with the NRA; and claims that Gov. Cuomo and Superintendent Vullo tortiously interfered with its business interests.

The court also dismissed the NRA's equal protection claims for selective enforcement to the extent that the NRA sought an order enjoining defendants from selectively enforcing the New York insurance laws against Chubb and Lockton Affinity; however, it allowed the associated claim for monetary damages to go forward. The court also allowed the NRA's First Amendment freedom-of-speech claims that Gov. Cuomo, Superintendent Vullo and the DFS interfered with the NRA's right to advance its agenda by making public statements threatening to use the power of their offices against businesses that work with the NRA.

Texas v. United States, 340 F. Supp.3d 579 (N.D. Tex. 2018)

Various states and individuals brought an action against the U.S., the HHS, the secretary of the HHS, the Internal Revenue Service (IRS) and the Acting Commissioner of the IRS, seeking a declaration that the ACA individual mandate, which imposed minimum essential coverage requirements under which certain individuals were obligated to purchase and maintain health insurance coverage, as amended by the federal Tax Cuts and Jobs Act of 2017 (TCJA), was unconstitutional and that the remainder of the ACA was not severable.

The ACA had previously been upheld by the U.S. Supreme Court in 2012, as a legitimate exercise of the congressional taxing power, but the plaintiffs argued that because the TCJA eliminated the penalty and no longer raised revenue for the federal government, the individual mandate no longer operated as a tax and was, therefore, unconstitutional. The plaintiffs further argued that the entirety of the ACA relies on the continued existence of the individual mandate, making the individual mandate inseparable from the rest of the ACA. Thus, the plaintiffs alleged, because the individual mandate was unconstitutional, that the ACA as a whole was unconstitutional, as well.

In a December 2018 opinion, the U.S. District Court of the Northern District of Texas found that the ACA was unconstitutional. In doing so, the court held that because the TCJA reduced the ACA's shared responsibility payment to zero, the mandate to purchase insurance could no longer be saved as a constitutional fundraising tax. Because the court found that the remainder of the ACA could not stand without the "essential" mandate, the entire law was set aside.

State Courts

Illinois

Thrivent Inv. Mgmt. Inc. v. Ill. Sec. Dep't, No. 1-17-1913, 2018 WL 4198879 (Ill. App. Aug. 28, 2018)

In October 2015, the Securities Department of the Office of the Illinois Secretary of State sent a Statement of Evidence to Thrivent Investment Management, Inc. (Thrivent), alleging Thrivent committed acts that could subject Thrivent to suspension of its registrations as an investment adviser and securities dealer. Thrivent filed a complaint in which it asked the court to enjoin the Securities Department's investigation, alleging that the investigation centered on Thrivent's sales of variable annuities and that the Illinois Department of Insurance had exclusive jurisdiction over such sales. Thrivent later amended its complaint, claiming that the document requests the Securities Department sent to Thrivent in the course of its investigation violated Thrivent's right to due process and its right to be free from unreasonable searches, seizures and invasions of privacy.

While the case was pending, the Securities Department sent Thrivent a notice of hearing informing Thrivent that an officer of the Secretary of State would hear evidence concerning Thrivent's alleged misconduct. Thrivent responded by arguing that only the Attorney General had authority to initiate proceedings against Thrivent and that the attorney who sent the notice worked for the Securities Department, not the Attorney General. In response, the Attorney General appointed two attorneys from the Securities Department to act as special assistant attorneys general for pursuing the charges against Thrivent. The circuit court found that the Securities Department had authority to investigate the alleged misconduct and dismissed Thrivent's complaint. Thrivent moved to vacate the dismissal and sought leave to amend its complaint again, but both requests were denied. Thrivent then appealed.

The appellate court found that by appointing the special assistant attorneys general, the Attorney General authorized the proceedings on the fraud charges, and, as a result, the circuit court did not abuse its discretion by denying Thrivent leave to amend its complaint as a claim regarding the authorization of special assistant attorneys general would have been a frivolous claim. The appellate court also found that Thrivent had not alleged facts showing that judicial proceedings on the Securities Department's requests would fail to protect Thrivent's constitutional rights. Finally, the appellate court held that while state law bars the Securities Department from regulating the issuance and sale of variable annuities, it did not bar the Securities Department from investigating allegations of fraud.

Washington

Keodalah vs. Allstate, 413 P.3d 1059 (Wash. Ct. App. 2018), review granted, 424 P.3d 1214 (2018)

Moun Keodalah was involved in an automobile accident in which the motorcyclist he collided with was killed. The motorcyclist was uninsured, and Mr. Keodalah sought underinsured motorist coverage from Allstate under his policy. Investigations were done by both the Seattle Police Department and an accident reconstruction firm hired by Allstate. Both investigations determined that the motorcyclist was speeding and that Mr. Keodalah was stopped at the stop sign. The police report further showed that Mr. Keodalah was not using his cell phone at the time of the accident. Despite these reports, Allstate claimed that Mr. Keodalah was 70% at fault and offered only a fraction of the \$25,000 policy limits. Mr. Keodalah filed a lawsuit against Allstate, asserting an underinsured motorist (UIM) claim. Allstate designated insurance adjuster Tracey Smith as its representative to testify on behalf of the company. Following a jury trial, Mr. Keodalah was awarded more than \$100,000. Mr. Keodalah then filed a second suit against Allstate and Ms. Smith, alleging claims of insurance bad faith and violations of the Insurance Fair Conduct Act (IFCA) and the Consumer Protection Act (CPA). The trial court granted, in part, Allstate and Ms. Smith's motions to dismiss, dismissing all of Mr. Keodalah's claims against Ms. Smith and certifying the case for discretionary review.

The Washington Court of Appeals granted discretionary review of the three issues: 1) whether the IFCA creates a private cause of action for violation of a regulation; 2) whether an individual insurance adjuster may be liable for bad faith; and 3) whether an individual insurance adjuster may be liable for violation of the CPA. An intervening Washington Supreme Court decision held that the IFCA did not allow a private right of action, so the court limited its review to the remaining two issues. The court reversed the trial court's determination and held that the claims could move forward. It found that the duty of good faith applies equally to individuals and corporations acting as insurance adjusters, as the insurance code of Washington applies to "all insurance transactions...and all persons having to do therewith..." It further held that individual adjusters can be liable for a CPA violation even without the existence of a contractual relationship with the consumer.