Abstracts of Significant Cases Bearing on the Regulation of Insurance 2019

Olivea Myers*

United States Court of Appeals

Fifth Circuit

Texas v. United States, 945 F.3d 355 (5th Cir. 2019)

A group of states led by Texas ("Plaintiffs") sued the federal government challenging the constitutionality of the Patient Protection and Affordable Care Act ("ACA") in the United States District Court for the Northern District of Texas. Plaintiffs argued that the individual mandate requiring all citizens to have health insurance is unconstitutional and that it is not severable from the entire Act; therefore, the entire law should be invalidated. The district court agreed with Plaintiffs and held that the individual mandate was unconstitutional, inseverable, and therefore, struck down the ACA in its entirety. California and other intervening states appealed the district court's decision to the United States Court of Appeals for the Fifth Circuit. The United States House of Representatives motioned the Fifth Circuit to intervene as a defendant, and the Fifth Circuit granted the motion. The issues raised in this case 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 should the remaining provisions of the ACA should remain in effect.

The Fifth Circuit held that both the House of Representatives and Plaintiffs have standing, as there is a live case and controversy, and that 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

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inseverable 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.

United States District Courts

District of Columbia

New York v. United States Dep't of Labor, 363 F.Supp.3d 109, (D.D.C. 2019)

In this case, eleven states and the District of Columbia ("States") sued the United States Department of Labor ("DOL") alleging that the DOL's Final Rule interpreting the definition of "employer" under the Employee Retirement Income Security Act of 1974 ("ERISA"), is unlawful under the Administrative Procedure Act ("APA"). The States further argued that the DOL's Final Rule violates the Patient Protection and Affordable Care Act ("ACA") that "establishes standards that apply differently to individual, small-group, and large-group health insurance markets" by intentionally trying to bypass the ACA's distinct standards.

In June 2018, the DOL promulgated the Final Rule, that relaxed two of the three key criteria for qualifying as a "bona fide association" to establish an association health plan ("AHP") under ERISA. The three criteria are purpose, commonality of interest, and control. The Final Rule relaxed the commonality of interest and purpose requirements. AHPs can now satisfy the new "commonality of interest" test if their members are either in the same trade or business or in the same geographic area. Before the Final Rule, "geography, alone, was not sufficient to establish commonality." AHPs can now be recognized as "bona fide associations" even if its primary purpose is "to offer and provide health coverage to its employer members and their employees" as long as it has "at least one substantial business purpose" unrelated to the provision of health care. Prior DOL guidance "required that associations be viable organizations even without providing an AHP." The Final Rule adds an entirely new provision that allows working owners, or sole proprietors, without any employees, to "qualify as both an employer and employee" for two ERISA purposes. First, working owners may join bona fide associations of employers. Second, working owners may qualify as both employer and employee for the "purposes of satisfying the requirement that AHPs—as ERISA health benefit plans—may only offer health coverage 'to employer members through the association'" for qualifying employees and beneficiaries. Prior DOL guidance held that "working owners without common law employees were not permitted to participate" in an AHP.

The district court held in favor of the States, holding that the Final Rule is unlawful because the bona fide association and working owner provisions conflict with the text and purpose of both the ACA and ERISA. The DOL appealed this decision believing that they should be given deference in their decision to expand the term "employer" under ERISA in the United States Court of Appeals for the District of Columbia Circuit, but a decision has not been reached.

Maine

Nat'l Fire Adjustment Co., Inc. v. Cioppa, 357 F.Supp.3d 38 (D. Me. 2019)

In this case, the National Fire Adjustment Company, Inc. ("NFA") challenged the Maine Bureau of Insurance's ("Bureau") enforcement of 24-A M.R.S. § 1476, that prohibits public adjusters from soliciting business from or offering a contract for public adjustment services to Maine citizens within the first 36 hours after property damage has occurred. NFA argued that the enforcement of this provision violates its First Amendment right to free speech. The Bureau argued that enforcing the 36-hour rule advances "a substantial governmental interest and is no more burdensome than is necessary to serve that interest."

The district court upheld the 36-hour rule as it relates to offering a contract for public adjustment but struck the anti-solicitation ban. The court held that as it relates to the 36-hour rule "prohibit[ing] the actual offer of a public adjustment contract" before 36 hours "serves a substantial consumer protection interest." However, the court held that the 36-hour rule's ban on all solicitation is unconstitutionally broad.

Florida

Phillips v. NCL Corp., No. 18-23912-Civ-Scola, 2019 WL2288987 (S.D. Fla. May 29, 2019)

Cruise ship passengers ("Plaintiffs") filed a lawsuit against Norwegian Cruise Lines ("NCL") alleging violations of the Florida Deceptive Unfair Trade Practices Act ("FDUTPA") and unjust enrichment. Plaintiffs' claims arise out of their purchase of the Booksafe Travel Protection Program ("BTPP"). The BTPP includes a travel insurance policy, as well as access to both a cancellation fee waiver program and an emergency assistance program. Plaintiffs purchased their cruise ticket, and they agreed to the terms and conditions of the Guest Ticket Contract. The Guest Ticket Contract has a broad arbitration clause that requires that any claims that are related to the guest's cruise shall be resolved by binding arbitration. The Guest Ticket Contract also includes a class action waver. Plaintiffs allege that NCL violated FDUTPA and was unjustly enriched by receiving unearned and undisclosed commissions related to the their purchase of the BTPP, bundling the BTPP together

to conceal the true cost of the program, and presenting the BTPP to create an impression that the price for the BTPP was comprised of pass-through charges even though NCL received an unearned and undisclosed commission. The sole issue before the district court was whether Plaintiffs' claims related to the purchase of the BTPP, fall within the scope of the arbitration clause.

The district court held that the Plaintiffs' claims fall under the scope of the arbitration clause in the Guest Ticket Contract. "The whole purpose of [BTPP] is to protect Plaintiffs' stay on the cruise, which is the core of the Contract. . . Indeed, without the stay on the cruise, which is the core of the Contract there is no [BTPP] and therefore no claims for the Plaintiffs to advance." The district court applied the same analysis to the class action waver, holding that the waiver applies to the Plaintiffs' claims and should be enforced. The district court granted NCL's motion to compel arbitration and dismissed the case.

State Courts

California

Mercury Cas. Co. v. Lara, 35 Cal. App. 5th 82 (Cal. Ct. App. 2019)

In its 2014 edition, the *Journal of Insurance Regulation* reported on *Mercury Cas. Co. v. Jones*, Case No. 34-2013-80001426 (Cal. Super. Ct. June 11, 2014), where the Petitioner, Mercury Casualty Company ("Mercury") challenged the insurance commissioner's order that its proposed homeowners insurance rates were excessive. Mercury challenged the application of Proposition 103, which was enacted by California voters in 1988 and required insurers to roll back insurance rates 20%. Insurers are able to request a variance from this percentage if the resulting rate would be "confiscatory." Insurers would have to prove to the commissioner that the decrease in insurance rates 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 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.

In 2015, the Commissioner fined Mercury 27.6 million dollars for charging consumers unapproved and unfairly discriminatory rates. In the present case, Mercury appealed the Commissioner's fine and the California Court of Appeals affirmed the Commissioner's decision. On August 14, 2019, the California Supreme Court denied Mercury's petition for review, thereby upholding the Commissioner's order fining Mercury.

Illinois

Corbin v. Allstate Ins. Co., No. 5-17-0296, 2019 WL 362480 (Ill. App. Ct. 5th Jan. 29, 2019)

Plaintiffs filed a class action lawsuit against Allstate. Plaintiffs alleged three claims: 1) Allstate violated the Consumer Fraud Act by engaging in unfair and deceptive practices in developing their rating methodologies; 2) Allstate's alleged failure to disclose its use of price optimization (charging longtime policyholders higher premiums rather than new customers who bear the same amount of risk, but were unwilling to pay the higher price) also violated the Consumer Fraud Act; and 3) Allstate has unjustly enriched itself by employing hidden price optimization practices. Allstate argues that Plaintiffs' claims are barred by the filed rate doctrine that provides protection to public utilities and other public entities from civil suits "if the entity is required to file its rates with the governing regulatory agency and the agency has the authority to set, approve, or disapprove the rates."

The appellate court was charged with answering two certified questions from the circuit court. The first question asks whether the Plaintiffs' claims regarding Allstate's rate filings are barred by the filed rate doctrine. The second question asks whether the Department of Insurance ("Department") has primary jurisdiction—a doctrine that allows an administrative agency to decide an issue even though the circuit court has jurisdiction over the issue—"to determine if the complained-of conduct by a regulated automobile insurance company constitutes an unfair or deceptive trade practice."

The appellate court held that the filed rate doctrine did not apply because the Department's Director does not have any administrative authority to set, approve, or disapprove of filed rates. The court held that rates filed by Allstate are not subject to approval by the Department, therefore the filed rate doctrine does not apply in this case. The appellate court also held that the Department did not have primary jurisdiction over Plaintiff's claims holding that the violations alleged in Plaintiffs' claims are not prohibited in the unfair methods of competition section in the insurance code; therefore, the Department does not have any "specialized knowledge or technical expertise with regard to the deceptive practices alleged." Having answered the questions before the court, the appellate court remanded the case to the circuit court for adjudication of Plaintiffs' claims.

Missouri

Holden v. Dep't of Commerce and Ins., No. WD82506, 2019 WL 6703849 (Mo. Ct. App. Dec. 10, 2019)

In this case, Petitioner Michael Holden submitted a non-resident title insurance producer's license application in 2009 with the Missouri Department of Commerce

and Insurance ("Department"). The Director of the Department issued an order refusing Holden a license. The Department found that Holden's application failed to disclose that he used to be President of Guaranty Land Title Insurance, Inc. ("Guaranty"). Holden's application also failed to disclose three voluntary forfeiture agreements Guaranty entered into when Holden was President of the Company. The Department also held that Holden violated state law by transacting business as an insurance producer without a license in 2008 and 2009. Holden appealed the Department's order to the Administrative Hearing Commission ("AHC"). The AHC upheld the Department's order. Holden then appealed the AHC's decision in the Cole County Circuit Court. While Holden's appeal was pending, he filed another application for the same non-resident title insurance producer license in October 2014. In that application, he disclosed the information he omitted in his previous 2009 application. The Department again refused to issue Holden a non-resident title insurance producer's license relying on the same grounds used in the 2009 application. Holden sought relief from the AHC again, and the Department's order was again upheld as the AHC found that the Department had cause to deny Holden's application and that his arguments were barred by collateral estoppel because the same issues were raised in his 2009 appeal. Holden filed another petition in the Cole County Circuit Court where the circuit court agreed with Holden. The Circuit Court found that the Department violated Holden's constitutional rights to due process for denying his 2014 application based on the same reasons as the 2009 application. The Department appealed to the Missouri Court of Appeals. The Department argued that the Circuit Court's decision should be reversed because the Circuit Court lacked statutory authority to review the administrative decision as a contested case.

The Missouri Court of Appeals held that, "for purposes of judicial review, the Missouri Administrative Procedure Act classifies administrative proceedings as either 'contested' or 'non-contested cases.'" "Contested cases provide the parties with an opportunity for a formal hearing with the presentation of evidence, including sworn testimony of witnesses and cross-examination of witnesses, and require written findings of fact and conclusions of law." "Non-contested cases do not require formal proceedings or hearing before the administrative body." In a non-contested case, the circuit court hears evidence, determines facts, and determines the validity of the agency's decision. The court of appeals held that based on a Missouri Supreme Court ruling, the Department's decisions are non-contested cases. The court of appeals reversed and remanded the circuit court's ruling and ordered that the circuit court lacked the statutory authority to review this case as a contested case. The court also held that Holden could amend his petition so that it can be reviewed as a non-contested case in the circuit court.

Nebraska

Diamond v. Dep't of Ins., 302 Neb. 892, (Neb. 2019)

The Nebraska Department of Insurance ("Department") issued an order against Petitioner Mark Diamond, a licensed insurance producer in Nebraska, holding that he violated three provisions of the Insurance Producers Licensing Act ("Act") and assessed him a $2,500 fine. Diamond appealed the Department's decision. Diamond was the chief executive officer and President of Bella Homes, LLC. Bella Homes "intended to buy homes from individuals who were struggling to make their mortgage payments and provide a 3-to 7-year repayment plan." Bella Homes "was expected to purchase the homeowner's mortgage from the existing lender and enter into a lease with the homeowner. . . ." Diamond formed this company at the request of a friend who had twice been convicted of fraud and could no longer handle another's finances. Bella Homes never purchased the home loans of its customers and did not protect the customer's homes from going into foreclosure. In 2012, the United States of America and the State of Colorado filed a civil action against Bella Homes, LLC and the individuals within the company, which included Diamond. The complaint alleged several violations of Mortgage Assistance Relief Services ("MARS") rules. In March 2012, Diamond confessed liability in defrauding distressed homeowners nationwide and a consent judgment was entered against him in the federal case. In December 2016, the Department filed an action against Diamond for violating §§ 44-4065(1) and 44-4509(1)(g) and (h) of the Act. The Director of the Department found that Diamond had a duty to report the federal consent judgment thirty days after the final disposition of the case pursuant to § 44-4065(1). The Director also found that, "although Diamond may not have been complicit in the fraudulent scheme, lending his reputation and partnering with someone convicted of fraud showed irresponsibility in business and violated § 44-4059(1)(h)." The director also found that because Diamond admitted to violating a MARS rule that included fraud, he violated § 44-4065(1)(g). The Department further held that because no Nebraska insurance consumers had been harmed and due to the length of time that had passed, that it would not revoke Diamond's license and assess him a $2,500 fine. Diamond appealed this decision to the district court. The district court affirmed the Department's decision stating that Diamond clearly violated §§ 44-4065(1) and 44-4509(1)(g) and (h). Diamond appealed this decision arguing that the district court erred in finding that in the federal consent judgment, Diamond admitted to fraud within the meaning of § 44-4059(1)(g), and the Nebraska Supreme Court moved the case to its docket.

The Nebraska Supreme Court held that, "under § 44-4059(1)(g), 'fraud' of an insurance producer means any act, omission, or concealment which involves a breach of legal or equitable duty, trust, or confidence justly reposed, and injurious to another or by which an undue and unconscientious advantage is taken of another." The Nebraska Supreme Court further held that Diamond's confession of violating

the MARS Rule fell into the definition of "fraud" under the Act; therefore, the district court's decision upholding the Department's order was affirmed.

New York

New York State Land Title Ass'n, Inc. v. New York State Dep't of Fin. Servs., 178 A.D.3d 611 (1st Dep't 2019)

In this case, Petitioner is challenging Insurance Law § 6409(d) and the New York State Department of Financial Services' ("DFS") Insurance Regulation 208 by stating that Insurance Law § 6409(d) is ambiguous as to the term "other consideration or valuable thing," and that certain provisions of Insurance Regulation 208 have a rational basis. DFS investigated licensed title insurers to assess how title insurers were calculating their premiums. As a result of the investigation, DFS uncovered that the title insurers were engaging in practices that ultimately resulted in higher premiums and closing costs for consumers, which violated Insurance Law § 6409(d). DFS found that insurers were reporting meals and entertainment expenses in "advertising, marketing and promotion, and travel, and 'other.'" DFS found that approximately 5.3% of premiums charged statewide violated Insurance Law § 6409(d). As a response, DFS promulgated Insurance Regulation 208, which delineates permissible and impermissible practices and prohibits offering inducements, such as meals, entertainment, gifts, and vacations. Insurance Regulation 208 was clear that the list was not exhaustive. Petitioner argued that Regulation 208 and its provisions were arbitrary and capricious, and that the regulation exceeds DFS's regulatory authority.

The appeals court found in favor of DFS, holding that Insurance Law § 6409(d) unambiguously prohibits an insurer from "offer[ing] or mak[ing], directly or *indirectly*, . . . any commission, any part of its fees or charges, or *any other consideration or valuable thing*, as an *inducement* for, or as compensation for, *any* title insurance business" (emphasis added). The appeals court further explained that the "word 'any' unambiguously indicates that this legislative prohibition was intended to be broadly construed, allowing for DFS to define 'any other consideration or valuable thing. . . .'" The court found that clarifying Insurance Law § 6409(d) through Insurance Regulation 208 was within DFS' regulatory authority. The appeals court upheld the lower court's ruling as to two other provisions that were adopted to clarify Insurance Law § 6409(d) and affirmed the decision to annul these provisions only.

Independent Ins. Agents and Brokers of New York, Inc. v. New York State Dep't of Fin. Servs., 65 Msc.3d 562 (Sup. Ct. Albany Co. July 31, 2019)

Independent Insurance Agents and Brokers of New York, Incorporated ("Plaintiff"), representing insurance agents, brokers, and financial advisors challenged the New York State Department of Financial Services' ("DFS") Amendment to NYCRR 224.0 *et seq*. The Amendment, also known as the Suitability and Best Interests in Life Insurance and Annuity Transactions, was issued by DFS on July 17, 2018. It adopted a uniform standard of care which must be met by agents and brokers, requiring them to act in the best interests of their client. Plaintiff offered many arguments including that the Amendment must be annulled for because the DFS exceeded its authority and that the regulation conflicts with the governing statutory scheme. DFS argued that it has broad supervisory power over the banking, insurance, and financial services. DFS further argued that the Amendment "is based on the principle that agents and brokers making recommendations about complex insurance transactions are more informed about market intricacies and potential impacts, and thus should be obligated to provide guidance in the best interests of the customer when making a recommendation."

The trial court agreed with DFS and held that the Amendment is a proper exercise of its regulatory power and that DFS complied with the State Administrative Procedure Act in adopting the Amendment. The court held that the insurance statues provide DFS with the authority to ensure "the continued safety and soundness of New York's banking, insurance, and financial services industries, as well as the prudent conduct of the providers of financial products and services, through responsible regulation and supervision."

Tennessee

Bible v. Tennessee Dep't of Commerce and Ins., Ins. Div., No. 17-1353-III (Aug. 28, 2019)

The Tennessee Department of Commerce and Insurance, Insurance Division (the "Department") filed an order revoking Petitioners Bible and Jacoway's producer licensure and assessed them each $250,000 in fines and costs. The Department ordered the Petitioners to cease and desist from engaging in insurance business. The Department's order found that from September 2010 through November 2012, the Petitioners "knowingly and intentionally failed to remit a total of some $407,038.31 of unearned premiums to 13 policyholders or their financing companies upon cancellation of the policyholders' insurance" through their insurance business, Truck Insurance Group, LLC ("TIG"). Petitioners challenged the Department's order on multiple grounds, with the most notable being that under

"Tennessee Code Annotated [§] 56-37-111, it is the responsibility of the insurance company, not TIG, to refund premium."

The chancery court affirmed the Department's order holding that the Petitioners had a statutory fiduciary duty to return unearned premiums to the policyholders or their finance companies upon cancellation of a policyholder's insurance policy. The court explained that Tenn. Code Ann. § 56-37-111 provides, "whenever a financed insurance contract is cancelled, the insurer shall return whatever gross unearned premiums are due under the insurance contract directly to the premium finance company. . . . In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund the excess to the insured. . . . ." The court further stated that Tennessee case law supports its holding that Tenn. Code Ann. §56-37-111 places a fiduciary duty on an insurer to return unearned premium.

Cases in Which the NAIC Filed as *Amicus Curiae*

Maine Cmty. Health Options v. United States, No. 18-1023 (NAIC brief filed Sept. 6, 2019)

On September 6, 2019, the NAIC filed its fourth amicus brief supporting insurers who were paid only 12.6% of what they are owed under the Affordable Care Act's risk corridor program. The United States Supreme Court has consolidated the appeals of Moda Health Plan, Land of Lincoln, and Maine Community Health. The NAIC argued that the collective $12 billion owed by the Federal Government under the risk corridor program has destabilized the insurance market and undermined regulatory effectiveness. The defunding of the risk corridor program has had implications larger than a breach of contract between the insurers and the Federal Government. State regulators also relied on the Government to keep its promises and manage the risk to insurers entering this new marketplace. The Government's failure to do so compromised regulators' ability to set rates, accelerated the financial problems of new insurers induced to participate in the state exchanges, and left consumers with few choices for health coverage. The Supreme Court's decision in this case will determine whether the Federal Government can be relied upon to be a fair partner to state regulators not only in the area of health insurance, but in any joint initiative in future years.

The Supreme Court heard oral arguments in this consolidated action on December 10, 2019.

Amica Life Ins. Co. v. Wertz, No. 18-1455 (NAIC brief filed April 10, 2019)

The NAIC and the Interstate Insurance Product Regulation Commission ("IIPRC") filed a joint amicus brief with the Tenth Circuit Court of Appeals in this case on April 10, 2019. This appeal follows an order issued by the United States District Court for the District of Colorado, which upheld a life insurance policy's two-year suicide exclusion contained in a policy issued pursuant to the Uniform Standards approved by the IIPRC. The appellant continued to argue that Colorado's one-year suicide exclusion statute applied and that adoption of the IIPRC's Uniform Standards represented an unconstitutional delegation of authority to an interstate agency. The NAIC and IIPRC again argued that Colorado's adoption of the Compact model law, as well as its adherence to the Uniform Standards, was an appropriate delegation of authority to the IIPRC.

On July 24, 2019, the Court of Appeals issued an Order requesting the Colorado Supreme Court to exercise its discretion and accept the following constitutional question, "May the Colorado General Assembly delegate power to amend statutes to an interstate administrative agency?" On August 7, 2019, the Colorado Supreme Court issued an Order accepting the certified question but reframing it as follows, "May the Colorado General Assembly delegate power to an interstate administrative commission to approve insurance policies sold in Colorado under a standard that differs from Colorado statute?"

The Colorado Supreme Court heard oral arguments on this matter on February 11, 2020.

Guardian Flight, LLC v. Godfread, No. 19-1343, No. 19-1381 (NAIC brief filed June 18, 2019)

The NAIC submitted an amicus brief to the Eighth Circuit Court of Appeals in this case on June 18, 2019. The NAIC argued that two North Dakota air ambulance statutes were not preempted by the Airline Deregulation Act (ADA) as they were intended to regulate the business of insurance and did not relate to airline prices, routes or services. The NAIC also argued, in the alternative, that if the Court were to find that the statutes were in fact preempted by the ADA, both statutes are saved by the reverse preemption provision of the McCarran-Ferguson Act (MFA) because the purpose of the laws is to regulate the business of insurance. Oral arguments should be scheduled in the Spring or early Summer, 2020.