

#MoSummit2016



DIFP
Department of Insurance,
Financial Institutions &
Professional Registration

State and Federal Case Law Update



**2016 Director's
Regulatory Summit**

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Panelists

Kara Binderup, National Association of Insurance
Commissioners

Jennifer McAdam, National Association of Insurance
Commissioners

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Moderated by:

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Topics Covered

- Financial Solvency and Insurance Regulation
- ERISA Preemption
- Unclaimed Life Insurance Benefits
- Affordable Care Act Developments
- Producer Licensing



Financial Solvency and Insurance Regulation

MetLife, Inc. v. Financial Stability Oversight Council, No. 1:15-cv-45 (D.
D.C. March 30, 2016)



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MetLife, Inc. v. FSOC

- FSOC, a division of Treasury, was created by the Dodd-Frank Act and empowered to designate certain nonbank financial companies for supervision by the Federal Reserve. 12 U.S.C. § 5323(a)



MetLife, Inc. v. FSOC

- Criteria for designation as Systemically Important Financial Institution (SIFI):
- If “material financial distress at the U.S. nonbank financial company, or the nature, scope, size, scale, concentration, interconnectedness, or mix of the activities of the U.S. nonbank financial company, could pose a threat to the financial stability of the United States.”



MetLife, Inc. v. FSOC

Timeline of designations:

- AIG – July 2013
- GE Capital – July 2013
- Prudential Financial – September 2013
- MetLife, Inc. – December 2014
- Non U.S. institutions include Allianz, Aegon, AXA



MetLife, Inc. v. FSOC

- MetLife is the first to file a lawsuit seeking to vacate the designation – January 2015
- Alleged failure to undertake activities based review, assess vulnerability, examine consequences of designation
- Alleged arbitrary and capricious reliance on unsubstantiated speculation and irrational economic behavior



MetLife, Inc. v. FSOC – NAIC brief

- At MetLife’s request, the NAIC filed an amicus brief and supported the contention that the SIFI designation was arbitrary and capricious.
- NAIC brief focused on a statutory provision requiring FSOC, before designating a nonbank institution, to consider “the degree to which the company is already regulated by 1 or more primary financial regulatory agencies.” 12 U.S.C. § 5323(a)(2)



MetLife, Inc. v. FSOC

- March 30, 2016 - Judge Rosemary Collyer denies FSOC's motion to dismiss in part.
- As part of this judgment, FSOC is directed to rescind the designation of MetLife as a SIFI.



MetLife, Inc. v. FSOC

- “FSOC made critical departures from two of the standards it adopted in its Guidance, never explaining such departures or even recognizing them as such.”
- “FSOC purposefully omitted any consideration of the cost of designation to MetLife.”



MetLife, Inc. v. FSOC – Assessing the threat

- FSOC failed to establish a basis for a finding that MetLife’s material financial distress would materially impair MetLife counterparties.
- “Every possible effect of MetLife’s imminent insolvency was summarily deemed grave enough to damage the economy.”



MetLife, Inc. v. FSOC – What's next?



ERISA Preemption

Gobeille v. Liberty Mut. Ins. Co., 136 S.Ct. 936 (U.S. 2016)



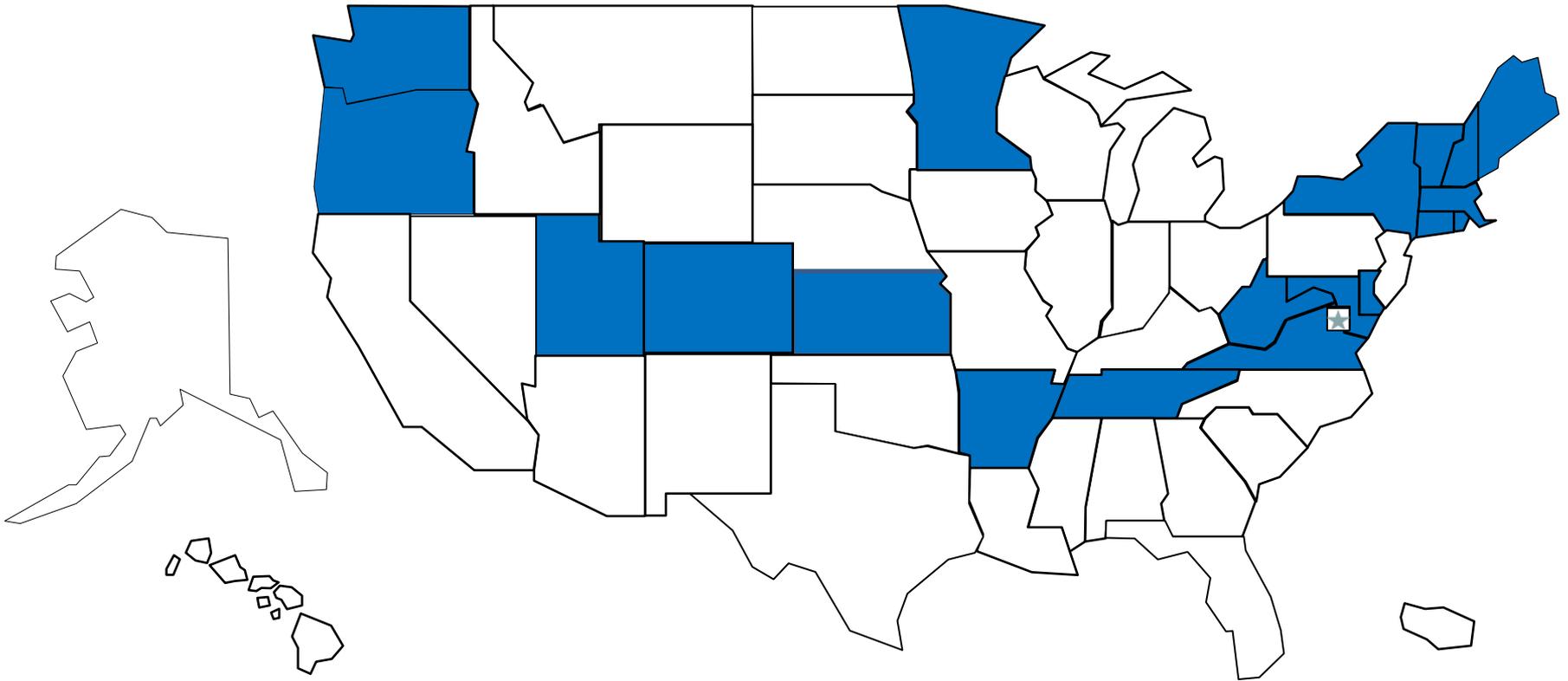
APCD Laws

19 states have All-Payer Claims Database (APCD) Laws:

These laws require all health care payers to submit data from paid health care claims. The data is used to analyze health care utilization, cost, quality, and population health, as well as to support health care reform initiatives. Some states also focus on transparency for consumers, to better inform the populace of the true costs of health care services.



States with APCD Laws



19 States: AR, CO, CT, DE, KS, MA, MD, ME, MN, NH, NY, OR, RI, TN, UT, VA, VT, WA, WV



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Gobeille v. Liberty Mut. Ins. Co.

Procedural History

- Liberty Mutual is the administrator of a self-funded employer health care plan. Blue Cross Blue Shield of Massachusetts acts as the Plan's 3rd-party administrator (TPA) for the Vermont participants.
- Vermont subpoenaed Liberty Mutual's claims data from Blue Cross (Liberty Mutual is a voluntary reporter but Blue Cross is mandatory due to its size).
- Liberty Mutual filed suit in federal district court seeking a declaration that ERISA preempts the Vermont statute and regulation.



Gobeille v. Liberty Mut. Ins. Co.

District Court Holding: Summary judgment granted in favor of Vermont.

Second Circuit Holding: Reversed the grant of summary judgment, finding that the state law and regulation impermissibly burdened one of ERISA's core functions – reporting.

Supreme Court: Affirmed the Second Circuit. Court held that “reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA.”

Vermont's reporting regime, intrudes upon “a central matter of plan administration” and “interferes with nationally uniform plan administration.”

“Any presumption against preemption . . . cannot validate a state law that enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does.”

The Secretary of Labor “may be authorized to require ERISA plans to report data similar to that which Vermont seeks, though that question is not presented here.”



Post-*Gobeille* Actions

Department of Labor Rulemaking:

- DOL proposed revisions to the Form 5500 Annual Return/Report, including new schedule J (Group Health Plan Information).
- Agencies: Employee Benefits Security Administration, Labor, Internal Revenue Service, Treasury, Pension Benefit Guaranty Corporation
- Comments due Dec. 5, 2016.



Unclaimed Life Insurance Benefits

Perdue v. Nationwide Life Ins. Co., 236 W. Va. 1, 777 S.E.2d 11 (2015)

United Ins. Co. of Am. v. Com., Dep't of Ins., No. 2013-CA-000612-MR, 2014 WL 3973160 (Ky. Ct. App. Aug. 15, 2014), review granted (Aug. 12, 2015)(unpublished)

United Ins. Co. of Am. v. Maryland Ins. Admin., 2016 WL 4499175 No. 101, Sept. Term, 2015, 2016 WL 4499175 (Md. Aug. 25, 2016) (unpublished)



Unclaimed Life Insurance Benefits



Unclaimed Life Insurance Benefits Background

| Annuities | Term Life | Whole Life |
|---|---|---|
| Insurers use Social Security Death Master File (DMF) to locate deceased policyholders and cut off payments. | Insurers have not used DMF to locate deceased policyholders to find beneficiaries who may be unaware of the policy. | When policyholder dies, insurers take money from the underlying cash value to pay “phantom premiums” until exhausted. |



Unclaimed Life Insurance Benefits Background

Sample policy language:

- We agree to pay the Death Proceeds to the Beneficiary ***upon receiving proof*** that the Insured has died while this Policy is in force and before the Maturity Date.
* * *
- [Insurer] will pay the Death proceeds to the Beneficiary ***after we receive at our Home Office proof of death*** satisfactory to us and such other information as we may reasonably require.



Unclaimed Life Insurance Benefits Background

U.S. Supreme Court – 1948

Connecticut Mutual Life Insurance Co. v. Moore, 333 U.S. 541 (1948)

New York's Abandoned Property Law: insurers must report and pay over to the state the proceeds of life insurance policies on which no claim had been made within seven years following the death of the insured.

Holding: Court rejected insurers constitutional challenges to the law Court rejected insurers argument that the state must seek judicial authorization prior to any transfer of proceeds. State is acting as a conservator; not a party to a contract.



Unclaimed Life Insurance Benefits Background

National Conference of Commissioners on Uniform State Laws

Uniform Unclaimed Property Act

Provides a system for transferring intangible personal property and personal property in safety deposit accounts, held by an entity other than the rightful owner, to the state when it is deemed abandoned by the rightful owner.



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Unclaimed Life Insurance Benefits Background

National Conference of Commissioners on Uniform State Laws

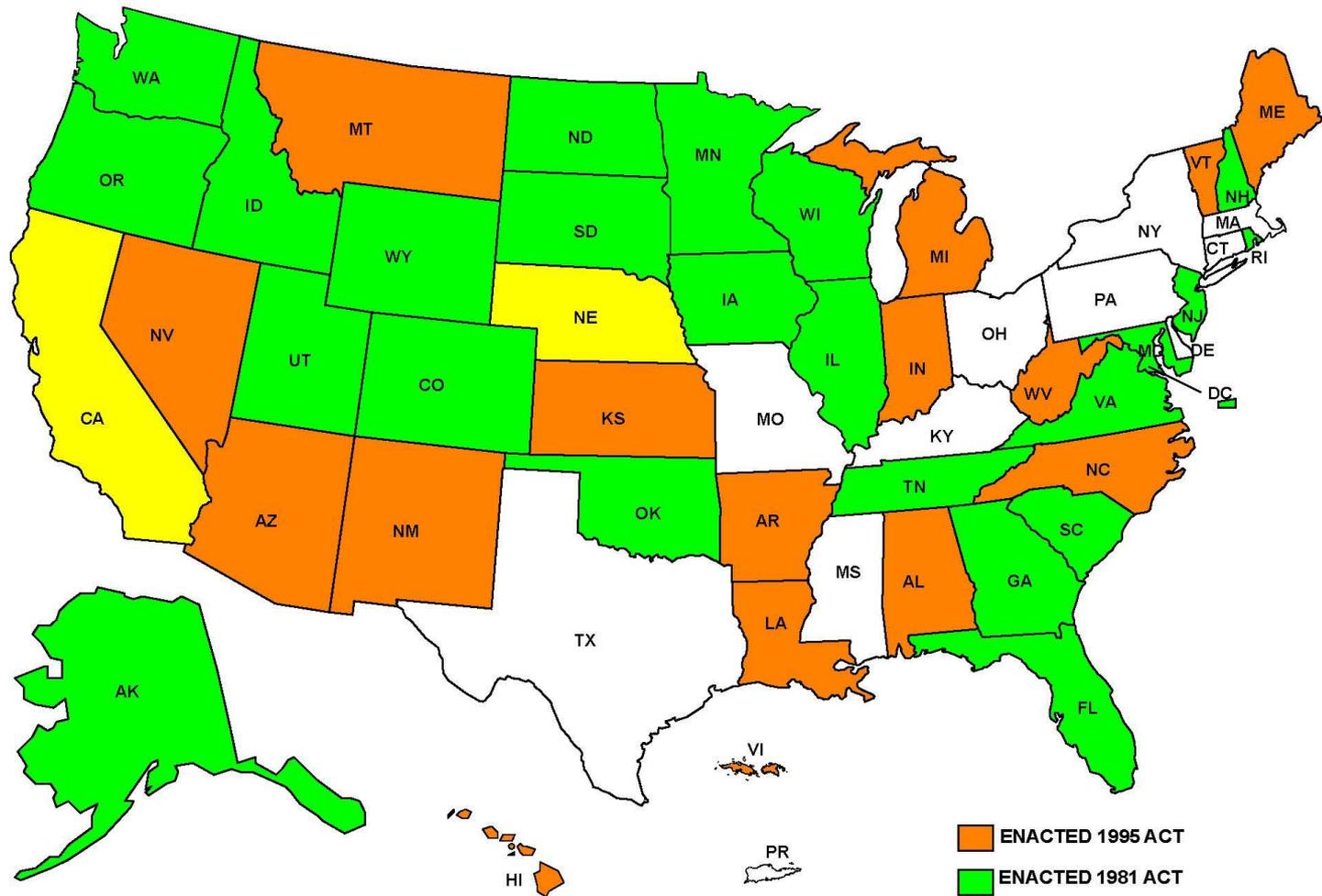
1954: Uniform Disposition of Unclaimed Property Act

1981: Uniform Unclaimed Property Act

1995: Uniform Unclaimed Property Act (revised)



UNIFORM UNCLAIMED PROPERTY ACT



May 5, 2016



Legislative information provided by the Uniform Law Commission.



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Perdue v. Nationwide

WV Unclaimed Property Act (Uniform Law Commission model):

“[p]roperty is payable or distributable [to the state] ... *notwithstanding the owner's failure to make demand or present an instrument or document otherwise required to obtain payment.*” W. Va.Code § 36–8–2(e) (1997) (emphasis added).

Holding: W.V. statute is a codification of *Conn. Mut. v. Moore*. Therefore, state has no obligations to the insurers under the law.

Case remanded to circuit court, where state treasurer will examine insurers' records for compliance. Still pending in the circuit court.

Perdue v. Nationwide Life Ins. Co., 236 W. Va. 1, 777 S.E.2d 11 (2015)



Unclaimed Life Insurance Benefits Model Act

November 2011: National Conference of Insurance Legislators (NCOIL) resolution supporting a model law.

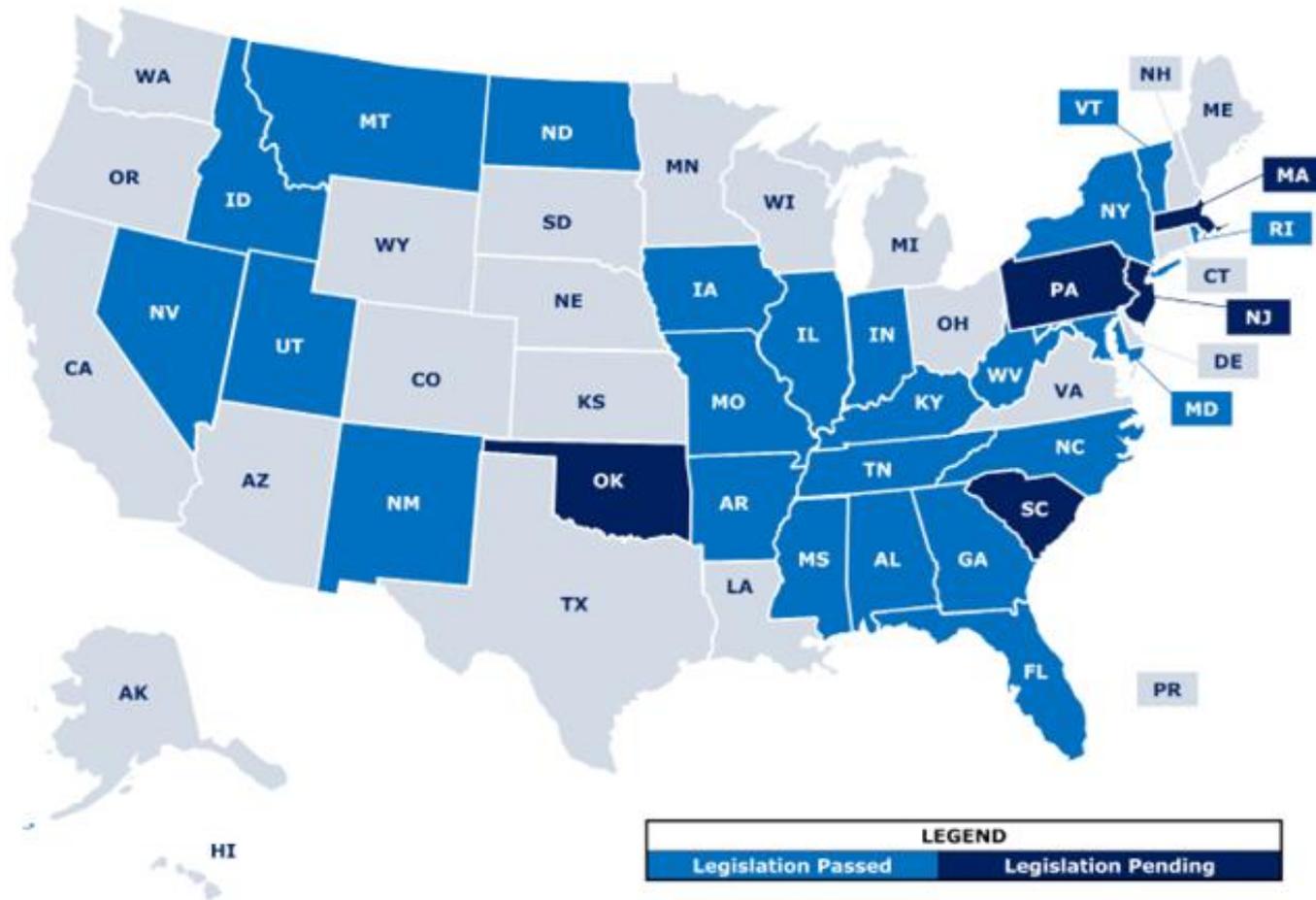
- Mandates the use of DMF as a cross-reference against an insurers list of in-force life insurance policies and retained asset accounts semi-annually.
- Insurer must perform a good-faith effort to locate any beneficiaries and provide the necessary claim forms and instructions.





Unclaimed property. Uncompromising performance.

States Passing or Proposing Unclaimed Life Insurance Benefits Legislation



Disclaimer: The above graphics depicts states that have proposed or passed legislation similar to the NCOIL Model Unclaimed Life Insurance Benefits Act as of August 31, 2016. The graphic does not constitute legal opinion or legal advice, and should not be relied upon without first verifying the same with your internal or external counsel. © 2016 Keane



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Unclaimed Life Insurance Benefits



United Ins. Co. of Am. v. Kentucky

KY Unclaimed Life Insurance Benefits Law (NCOIL model)

Insurers challenged retroactive application of the law:

- Act does not expressly provide that it is to be retroactively applied, and
- Retroactive application of the obligations imposed is unconstitutional because it alters the substantive contractual relations between the insurer and the insured.

Holding: Act cannot apply retroactively. While the Act's requirements are regulatory and do not directly alter the operation of any conditions precedent for coverage under the contracts, it falls within the rule prohibiting retroactive application of any statute, *unless otherwise expressly declared in the law itself*. Because it did not explicitly apply retroactively, it can operate only prospectively. Court did not reach constitutional question.

United Ins. Co. of Am. v. Com., Dep't of Ins., No. 2013-CA-000612-MR, 2014 WL 3973160 (Ky. Ct. App. Aug. 15, 2014), *review granted* (Aug. 12, 2015)(unpublished)



United Ins. Co. of Am. v. Maryland

MD Unclaimed Life Insurance Benefits Law (NCOIL model)

Similar facts and arguments as made in the Kentucky case.

Procedural History: Insurers filed a declaratory judgment action after the Commissioner stated at a meeting that she interpreted the law to apply to contracts already in-force.

MD insurance procedure: Commissioner shall hold a hearing on written demand by a person aggrieved by any “act of, *threatened act* of, or failure to act by the commissioner.”

MD law to determine if a statute applies retroactively: “require[s] a ‘process of judgment concerning the nature and extent of the change in the law and the degree of connection between the operation of the new rule and a relevant past event.’”

Holding: Insurers failed to exhaust administrative remedies as this was a “threatened act” by the Commissioner. Court doesn’t reach substantive arguments.

United Ins. Co. of Am. v. Maryland Ins. Admin., 2016 WL 4499175 No. 101, Sept. Term, 2015, 2016 WL 4499175 (Md. Aug. 25, 2016) (unpublished)



Unclaimed Life Insurance Benefits Act

Contract Clause & Constitutional Concerns

United States Constitution Contract Clause (art. I, § 10, cl. 1):

- “No State shall . . . pass any . . . Law impairing the Obligation of Contracts [.]”
- Many states have similar provisions in their state constitutions.
- This issue has not yet been addressed by a court in this context but a case has been filed – *United Insurance Co. of Am. v. Florida Dept. of Fin. Servs.*, Fla. Cir. Ct., 2d Cir. Leon Co. (filed May 3, 2016).



NAIC Efforts on Unclaimed Life Insurance Benefits

Investigations of Life Insurance and Annuities Claims Settlement Practices (D) Task Force

- Multi-state examinations to determine asymmetrical use of DMF
- All 26 companies examined (76.8% of market) were using DMF. Those using it asymmetrically, have agreed to use it to locate life insurance beneficiaries. Many of these companies were fined millions of dollars.

Unclaimed Life Insurance Benefits Model Drafting (A) Subgroup

- Draft model law incorporates the NCOIL model with model developed by the Lead States of the multi-state examination.
- Current draft applies the law retroactively but notes that states should conduct legal analysis to determine whether retroactive laws are permitted.



ACA Developments

Cent. United Life Ins. Co. v. Burwell, 827 F.3d 70 (D.C. Cir. 2016)

Zubik v. Burwell, 136 S. Ct. 1557 (2016)



Cent. United Life Ins. Co. v. Burwell

Insurers that offered fixed indemnity policies brought action against Secretary of Health and Human Services (HHS), challenging a regulation that required fixed indemnity plans to be provided only to individuals who had minimum essential coverage required by Patient Protection and Affordable Care Act (ACA) in order for such plans to be considered an excepted benefit plan under Public Health Service Act (PHSA).



Cent. United Life Ins. Co. v. Burwell

The Public Health Service Act, 42 U.S.C. § 201 (“PHSA”), establishes coverage requirements for all health insurance plans except those it deems “excepted benefits.”

Only those forms of insurance specifically enumerated in the PHSA can qualify as an excepted benefit and, for the benefits at issue in this case, that status is further conditioned on two specific requirements:

- (1) the insurance plans must be “provided under a separate policy, certificate, or contract of insurance,” and
- (2) they must be “offered as independent, noncoordinated benefits.”



Cent. United Life Ins. Co. v. Burwell

The ACA updated the PHSA's coverage requirements and mandated that all applicable individuals maintain “minimum essential coverage.”

Despite the ACA's sweeping reforms to the health insurance market, it left intact and incorporated the PHSA's rules regarding excepted benefits.

HHS foreclosed that option four years later in the regulation under review here. In May 2014, it announced its plan “to amend the criteria for fixed indemnity *73 insurance to be treated as an excepted benefit” in the individual health insurance market.



Cent. United Life Ins. Co. v. Burwell

On top of the requirements codified in the PHSA, HHS added another:

To be an “excepted benefit,” the plan may be “provided only to individuals who have ... minimum essential coverage.”

Now, those who had previously purchased these plans as a substitute for minimum essential coverage would have to find a fixed indemnity plan that satisfies the PHSA's coverage requirements for non-excepted benefits.

The court added that the “very nature of fixed indemnity insurance, however, renders such plans incapable of satisfying those requirements, so this new rule effectively eliminated stand-alone fixed indemnity plans altogether.”

In response, several providers challenged the rule as an impermissible interpretation of the PHSA, and after a hearing, the district court permanently enjoined HHS's enforcement of the rule under Chevron Step One.



Zubik v. Burwell

Nonprofit religious employers sued the Secretary of Health and Human Services and other government officials, challenging the regulatory mandate to provide insurance coverage for contraceptives imposed by the ACA.

Federal regulations require companies to cover certain contraceptives as part of their health plans, unless they submit a form either to their insurer or to the Federal Government, stating that they object on religious grounds to providing contraceptive coverage.

The nonprofit religious organizations argued that submitting this notice substantially burdens the exercise of their religion in violation of the Religious Freedom Restoration Act of 1993.



Zubik v. Burwell

Following oral argument, the Court requested supplemental briefing from the parties regarding “whether contraceptive coverage could be provided to petitioners' employees, through petitioners' insurance companies, without any such notice from petitioners.”

Both petitioners and the Government now confirm that such an option is feasible. Petitioners have clarified that their religious exercise is not infringed where they “need to do nothing more than contract for a plan that does not include coverage for some or all forms of contraception,” even if their employees receive cost-free contraceptive coverage from the same insurance company.

The Supreme Court held that it was appropriate to vacate and remand so the courts of appeals could address the arguments made by the parties in response to the order for supplemental briefing.



Legal Challenges – Risk Corridors

- Affordable Care Act provided for risk corridors to reduce risk for insurers who were no longer able to contain costs through medical underwriting
- Risk corridors are intended to be in effect until 2017



Legal Challenges – Risk Corridors

- If claims are at least 3% greater than projected, federal government reimburses for half the excess
- If claims are at least 8% greater than projected, government reimburses for 80%
- If actual spending is less, insurer reimburses government by same percentages



Legal Challenges – Risk Corridors

- Under ACA, the risk corridor program was not revenue neutral
- Later Congressional action required CMS could only pay out to insurers from funds collected under the program
- CMS acknowledges payment will be due at end of the program, but has been able to pay only 12% of insurers' losses
- Insurers had more shortfall than excess



Legal Challenges – Risk Corridors

- Insurer lawsuits filed under the Tucker Act in the U.S. Court of Federal Claims
- Tucker Act permits claims against the federal government when it violates statutory or contractual obligations
- Administration argues the risk corridor program has all three years to pay out, not required to do so on annual basis
- Under Tucker Act, funds must be “presently due”



Health CO-OPs

- The Affordable Care Act established the Consumer Operated and Oriented Plan (“CO-OP”)
- Nonprofit health insurance issuers to offer qualified health plans to individuals and small groups



Health CO-OPs

- CO-OPs that are now failing are subject to state law
- “In the potential case of insurer financial distress, a CO-OP follows the same process as traditional issuers and must comply with all applicable State laws and regulations.” HHS Final Rules.
- However, the Department of Justice is claiming HHS may collect debts before policyholders (“Super-priority”)



Health CO-OPs – Iowa Litigation

- Gerhart v. HHS, No. 16-cv-00151 (S.D. Iowa July 6, 2016)
- “By recognizing and preserving the states’ jurisdiction over any insolvency proceeding, the federal government, as the largest investor in the CO-OPs, consented to application of state law in relation to all aspects of the liquidation, including priority of claimants.”



Health CO-OPs – Iowa Litigation

Court denied the motion, finding the Iowa Department had adequate remedy at law through a Tucker Act claim



Producer Licensing

Holden v. Dir. of Dep't of Ins., Fin. Institutions & Prof'l Registration, 470 S.W.3d 390 (Mo. Ct. App. 2015)

Walsh v. Illinois Dep't of Ins., 54 N.E. 3d 207 (Ill. App. Ct. 2016)



Holden v. Dir. of Dep't of Ins.

In 2009, the Director of the Department of Insurance denied Michael Holden's license application because Holden "transacted business as a title insurance agent without a license and because he intentionally provided materially incorrect, misleading, incomplete or untrue information on his application."



Holden v. Dir. of Dep't of Ins.

The Administrative Hearing Commission (AHC) found that:

- While unlicensed, Holden advised insurance agents thirteen separate times that they could insure certain properties.
- Holden transacted business as an insurance producer without an individual insurance producer license in violation of RSMO 381.115.1 and 381.115(2) by calculating insurance rates and determining insurability.
- On his 2009 application, Holden responded “No” to the following question:

Have you or any business in which you were an owner, partner, officer or director, or member or manager of [a] limited company, ever been involved in an administrative proceeding regarding any professional or occupational license or registration?
- The AHC agreed with the Director’s assertion that “when Holden answered ‘no’ to that question, he intentionally provided materially incorrect, misleading, incomplete or untrue information on his application. The AHC further found that three voluntary forfeiture agreements Holden signed on behalf of a former employer were administrative proceedings, the undisclosed information was material, and the non-disclosure was intentional.



Walsh v. Illinois Dep't of Ins.

On June 21, 2012, the Director of the Illinois Department of Insurance issued an Order of Revocation against Joseph M Walsh's insurance producer license.

The order was issued after a Department investigation revealed that:

- (1) Walsh's insurance producer license had been revoked by the Ohio Department of Insurance;
- (2) Walsh had received a letter of denial from the Wisconsin Office of the Insurance Commissioner in response to a license application he filed; and
- (3) Walsh had entered into a Consent Order and Stipulation with the Michigan Office of Financial and Insurance Regulation.

The investigation further revealed that, those incidents notwithstanding, Walsh had answered “no” in response to a question on various Illinois Insurance Producer applications inquiring whether he had “an insurance license denied, revoked, suspended or surrendered for disciplinary reasons in any state?”



Walsh v. Illinois Dep't of Ins.

The Director found that Walsh “provided incorrect, misleading, incomplete and materially untrue information in his license application and obtained a license through misrepresentation.”

Walsh requested a hearing to challenge the Director's decision.

At the hearing, an investigator with the Illinois Department of Insurance explained that in 2002, Walsh, acting on behalf of a consumer, submitted an application to an insurance company in which the consumer's signature had been forged.

The Court found that Walsh repeatedly gave false answers to questions on insurance applications in various states that inquired whether Walsh's license had ever been subject to discipline.

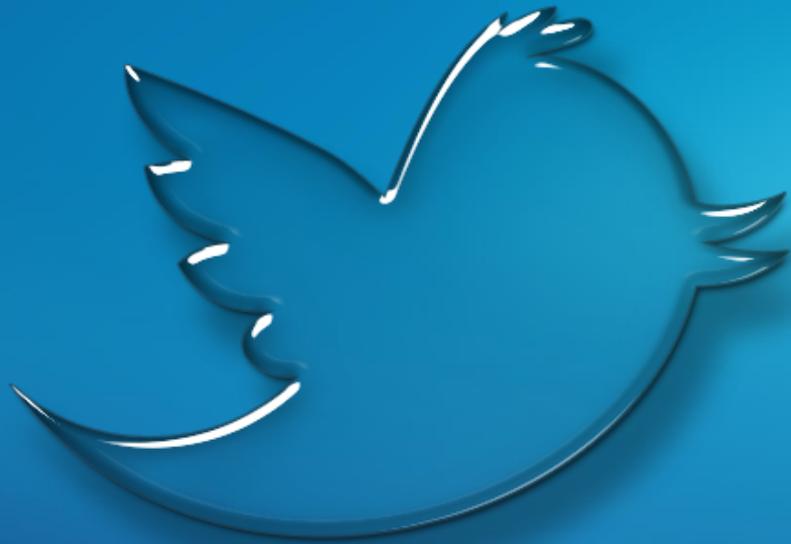
The court further found that each instance of dishonesty in Walsh's 2007, 2009, and 2011 Illinois license applications in which Walsh falsely answered “no” was an independent episode of sanctionable misconduct.



Any
questions



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