Abstracts of Significant Cases Bearing on the Regulation of Insurance 2017

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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

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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

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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

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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,

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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

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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

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