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Abstracts of Significant Cases Bearing on the Regulation of Insurance

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Abstracts of Significant Cases Bearing on the Regulation of Insurance 2024

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United States Court of Appeals

Federal Circuit

Barbara D. Richardson v. United States, 110 F.4th 1375 (Fed. Cir. 2024).

The United States appealed a United States Court of Federal Claims decision granting summary judgment in favor of Barbara D. Richardson, the Nevada Commissioner of Insurance, acting in her position as the Receiver for the Nevada Health CO-OP. This case concerns a series of programs in which the government distributes payments to certain health insurers. The programs include reinsurance, risk corridors, and risk adjustment programs that are "aimed at stabilizing health insurance premiums." *Id*. at 1378. This case also involves loans issued under the Affordable Care Act's Consumer Operated and Oriented Plan program. Federal law requires the United States Department of Health and Human Services ("HHS") to issue two types of loans to "persons applying to become qualified nonprofit health insurance issuers." *Id*. Including loans to assist with start-up costs and grants to assist in meeting state solvency requirements. This case concerns a start-up loan issued under the CO-OP program. *Id*.

Hospitality Health was a Nevada health maintenance organization that received two loans as a part of the CO-OP program. These loans were subsequently assigned to Nevada Health. In 2015, Nevada Health experienced financial distress and was declared "unsound" by state regulators. *Id*. at 1379. In December 2015, the Centers for Medicare & Medicaid Services ("CMS") terminated the loan agreement, citing the suspension of Nevada Health's operating license and prohibition from offering health insurance in 2016. *Id*. CMS placed an "administrative hold" on payments due to Nevada Health. In August of 2016, CMS began to offset payments to Nevada Health with amounts allegedly owed to the government pursuant to the start up loan. *Id*.

In September 2016, the state court placed Nevada Health in liquidation. The government filed a proof of claim seeking repayment of the loans, stating that they were "'entitled to treatment as secured claims to the extent they are subject to set-off by a claim of [Nevada Health] against the United States.'" *Id*. In June 2017, the Receiver denied the government's claim stating that, due to the state law and the loan agreement, the government's claim was subordinate in priority to policyholder and administrative expense claims. Additionally, Nevada Health's estate was not anticipated to be sufficient to satisfy even claims with a higher priority than the government's

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claim, and the government's claimed setoff would violate the receivership order. The government did not appeal this decision.

In November 2018, the Receiver filed suit in the Court of Federal Claims to recover amounts allegedly owed to Nevada Health. The Receiver alleged that the government's offsets for Nevada Health's obligations under the Start-Up Loan were improper and breached the loan agreement. The Court of Federal Claims granted the Receiver's motion for summary judgment, finding the government liable for each payment. The government appealed this decision. The government argued that the trial court erred by holding that HHS contracted away its offset rights in the loan agreement. *Id*. at 1380. The court held that the government waived its offset rights by subordinating the Start-Up Loan through the loan agreement. The court further held that under the plain text of the loan agreement between Nevada Health and the government, the government's claim under the loan agreement is subordinate to claims payments and basic operating expenses and that the government may not withhold payments it owed the Nevada Health to jump ahead of policyholders before these superior creditors are fully satisfied. *Id*. at 1381.

State Court

Arkansas

Arkansas Blue Cross & Blue Shield v. Freeway Surgery Ctr., 702 S.W.3d 376 (Ark. Ct. App. 2024).

Arkansas Blue Cross & Blue Shield ("ABCBS") was sued by multiple outpatient and ambulatory surgery centers that alleged noncompliance with Arkansas Code Annotated Section 23-79-115. ABCBS negotiated with the surgery centers for rates of payment for services that were lower than rates negotiated with full-service hospitals. ABCBS responded by claiming that Section 115 applies to contracts between insurance companies and insureds, not between insurance companies and health care providers (network participation agreements). Therefore, parity is not mandated. The Arkansas Insurance Commissioner agreed that Section 115 did not apply to network participation agreements. The circuit court reversed the Commissioner's determination that Section 115 did not apply to network participation agreements based "solely on the language of the statute and without reference to the Commissioner's supporting findings of facts and conclusions of law." *Id*. at 380.

The court of appeals reversed the circuit court's decision holding that the bifurcation of rates was proper. The court relied on the plain language of the statute, which specifically refers to "persons" and not "entities," as well as the fact that network participation agreements were not legal at the time the statute was enacted. The court further held Section 115 was enacted to ". . . protect insureds on a going-forward basis, regardless of the nature of the agreement." *Id*. at 386.

Indiana

Grundy v. Indiana Dept. of Ins., 231 N.E.3d 841 (Ind. Ct. App. 2024).

Scott Grundy ("Petitioner") was offered employment from State Farm Insurance contingent upon him obtaining proper licensure. Petitioner submitted an application to the Indiana Department of Insurance ("Department") for a resident producer license. Petitioner disclosed that he had two felony convictions. The commissioner of insurance issued a denial to Petitioner, stating that Indiana law authorizes the Commissioner to refuse to issue a producer's license for having been convicted of a felony and that Petitioner had not met the requirements for licensure as defined by Indiana law. Petitioner appealed the denial, and the administrative law judge ("ALJ") affirmed the denial of licensure. Petitioner filed a petition for judicial review asserting that the ALJ's findings and conclusions lacked specificity as to the nature of the felonies and that his felonies were not crimes of dishonesty. Petitioner argued that his criminal history would not prevent his performance of his duties and asked that the Department provide him with an order with greater specificity. The Department argued that the commissioner had a statutory right to deny Petitioner's application based on any felony. The trial court affirmed the commissioner's order. The court of appeals affirmed the trial court's decision holding that it is within the commissioner's statutory authority to deny a producer's license based on a felony and there is no restriction to a particular felony or class of felonies.

Michigan

*Nationwide Agribusiness Ins. Co. v. Dept. of Treasury, No. 364790, 2024 WL 3075129 at *1 (Mich. Ct. App. June 20, 2024).*

In its 2023 edition, the *Journal of Insurance Regulation* reported on *Nationwide Agribusiness Ins. Co. v. Dept. of Treasury*, No. 21-000039, at *1 (Mich. Tax Tribunal, Jan. 23, 2023), where the court held that an insurance company cannot be a part of a unitary business group ("UGB") for the purposes of premium tax, retaliatory tax, or tax credits because the statutory definitions of UBG did not include an insurance company. Nationwide Agribusiness Insurance Company ("Appellant") appealed this decision. The Michigan Court of Appeals reversed and remanded the Michigan Tax Tribunal's holding that Appellant was required to file an individual tax return for premiums and retaliatory taxes and that it could not file a combined return as a part of a UBG. The court of appeals held that because Appellant is a UBG under Michigan law, the separate entities within the UBG cease to be separate taxpayers. Therefore, Appellant was entitled to claim a tax refund resulting from its portion of Michigan Automobile Insurance Placement Facility tax credits that were claimed on the UBG's combined return for premium and retaliatory taxes. The court further held that it did not make sense to conclude that Appellant met the definition of a UBG and then exclude UBGs from premium and retaliatory tax provisions.

New Jersey

Caride v. Lapinski, No. A-1686-22, 2024 WL 2799287 at *1 (N.J. Super. Ct. App. Div. May 31, 2024).

This case involves an appellate review of an administrative agency's decision. The New Jersey Department of Banking and Insurance ("DOBI") entered a decision holding that Appellants, two bail bonds companies and individuals associated with those companies, violated multiple subsections of New Jersey law, and the DOBI revoked their licenses as insurance producers and imposed fines. The court of appeals affirmed DOBI's decision holding that appellate review of an administrative agency's decision is limited and that the court will "reverse the decision of the administrative agency only if it is arbitrary, capricious[,] or unreasonable[,] or it is not supported by substantial credible evidence in the record as a whole." *Id*. at *4. The court held the DOBI's decision was based on credible evidence, and it refused to second guess the DOBI findings.

North Carolina

North State Deli, LLC v. Cincinnati Ins. Co., 908 S.E.2d 802 (N.C. 2024).

Plaintiffs are a group of bars and restaurants in North Carolina that were forced to suspend business operations due to COVID-19-related orders by government authorities. Plaintiffs carried a materially similar commercial property insurance policy with Cincinnati Insurance Company ("Defendant"). The policies protect the businesses' building and personal property as well as business income from any "direct physical loss" to property not excluded by the policy. *Id*. at 805. At issue in this case is whether a "direct physical loss" occurred when government orders forced temporary restrictions on the use and access to the restaurants' physical property. Defendant argued that these temporary physical closures did not constitute a direct "loss" that is contemplated by the policy and refused to cover the loss. Plaintiffs argued that the closures are a covered property loss under the policy's ordinary meaning.

The trial court held in favor of Plaintiffs, holding that those losses are covered. The court of appeals reversed the trial court's decision holding that the insurance contract excluded these losses. The North Carolina Supreme Court reversed the court of appeals' decision holding that "a reasonable person in the position of the insured would understand the restaurants' policies to include coverage for business income lost when virus-related government orders deprived the policyholder restaurants of their ability to physically use and physically operate property at their insured business premises." *Id*. at 812. The court further held that it is the insurance company's responsibility to define essential policy terms.

Cato Corp. v. Zurich Am. Ins. Co., 909 S.E.2d 144 (N.C. 2024).

This is a companion case to *North State Deli, LLC v. Cincinnati Ins. Co*., 908 S.E.2d 802 (N.C. 2024).

Washington

Schiff v. Liberty Mut. Fire Ins. Co., 2 Wash.3d 762 (Wash. 2024).

Schiff ("Appellant") brought a class action suit against Liberty Mutual arguing that Liberty Mutual's practice of using a computer-generated calculation from the FAIR Health Database System to reduce bills to the 80th percentile for the geographic area violated personal injury protection ("PIP") statutes and the Washington Consumer Protection Act ("CPA"). Appellant claimed that by using this system, Liberty Mutual was in violation of PIP statutes requiring "reasonable investigation" into bill pricing. The Supreme Court of Washington concluded that ". . . the 80th percentile practice and the use of the FAIR Health Database is not unfair or unreasonable and does not violate the CPA or the PIP requirements to establish standards under which reasonable charges for medical procedures are determined." *Id*. at 777.

West Virginia

Wright v. West Virginia Off. of Ins., No. 22-581, 2024 WL 692996 at *1 (W. Va. Feb. 20, 2024).

In this case, Wright ("Petitioner") appealed the decision of the West Virginia Workers' Compensation Board of Review ("Board of Review") regarding whether Petitioner was entitled to workers' compensation. The claims administrators decided not to grant permanent partial disability award. Petitioner was a coal miner and filed a claim in January 2020 alleging that he sustained permanent impairment because of occupational pneumoconiosis. In support of this claim, Petitioner submitted a physician's report where the physician diagnosed Petitioner with impairment due to occupational pneumoconiosis but did not provide an impairment assessment. *Id*. at *1. The claims administrator held the claim compensable for occupational pneumoconiosis pursuant to West Virginia law because Petitioner had ten years of exposure during the fifteen years immediately preceding his date of last exposure and referred Petitioner to the Occupational Pneumoconiosis Board ("OP Board"). After further examination, the OP Board found that Petitioner did not exhibit the symptoms required to establish a diagnosis of occupational pneumoconiosis. The claims administrator granted no permanent partial disability award based on the OP Board's findings. The Office of Judges affirmed the OP Board's decision. The court of appeals held that it agreed with the reasoning and conclusions of the Office of Judges holding that the court can only reverse or modify decisions of the Office of Judges if it is in clear violation of constitutional or statutory provisions.