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Litigation Update Panel
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I. LIFE INSURANCE

A. Cost of Insurance

Cost of insurance ("COI") determinations continue to generate litigation. *E.g.*, *EFG Bank AG v. John Hancock Life Ins. Co. (U.S.A.)*, No. 2:19-cv-01696 (C.D. Cal. Mar. 1, 2019); *LSH CO v. John Hancock Life Ins. Co. (U.S.A.)*, No. 1:19-cv-01009 (S.D.N.Y. Feb. 1, 2019); *Hamra v. Transamerica Life Ins. Co.*, No. 18-cv-06262 (C.D. Cal. July 19, 2018); *Thompson v. Transamerica Life Ins. Co.*, No. 18-cv-5422 (C.D. Cal. June 18, 2018); *Advance Trust & Life Escrow Servcs.*, No. 18-cv-3444 (Apr. 19, 2018). COI cases generally allege either: (1) improper COI rate increases ("increase claim"); or (2) that, in initially setting COI rates, insurers considered factors beyond those explicitly allowed under the policy language ("Day 1 claim"). Over the last several years, Day 1 claim cases have also alleged that insurers breached policies by failing to lower COI rates, despite generally improving mortality, and including in COI rates administrative costs, despite separate policy provisions for administrative/expense charges. During the past year, there have been several significant results, including class certification decisions, class action settlements, jury verdicts, and dismissal rulings addressing the Seventh Circuit's decisions in *Norem v. Lincoln Benefit Life Co.*, 737 F.3d 1145 (7th Cir. 2013) and *Thao v. Midland National Life Ins. Co.*, 549 F. App'x 534 (7th Cir. 2013). In addition, the Actuarial Standards Board ("ASB") recently proposed substantial changes to Actuarial Standard of Practice ("ASOP") 2, which governs actuarial determinations of non-guaranteed elements ("NGEs").

Class Certification Decisions. In *Hanks v. Lincoln Life & Annuity Co. of New York*, the court certified a nationwide Rule 23(b)(3) class alleging breach of contract claims stemming from the factors considered in implementing a 2016 COI rate increase. 2019 WL 1167752 (S.D.N.Y. Mar. 13, 2019). In so doing, the court distinguished the class certification denial in *Thao v. Midland National Life Insurance Co.*, by explaining that the plaintiff did "not propose an alternate rate calculation," as had the plaintiff in *Thao*. *Id.* at *4 n.1 (citing 2012 WL 1900114 (E.D. Wis. May 24, 2012)). The court also discounted the potential for individualized issues arising from varying state laws regarding the consideration of extrinsic evidence to determine the existence of an ambiguity. *Id.* at *6. At the same time, the court found that variations in state law precluded certification of the plaintiff's unjust enrichment claim. *Id.* at *7-9. On the other hand, in *Taylor v. Midland National Life Insurance Co.*, the court denied certification of a putative nationwide class asserting Day 1 claims because of the individualized issues stemming from the need to apply differing state laws. No. 16-CV-00140-SMR-HCA (S.D. Iowa May 3, 2019). In particular, the court determined that individualized issues predominated based on divergent state laws concerning the use of evidence to interpret contract terms and the elements of fraudulent concealment to toll the statute of limitations. *Id.* at *15-26.

Class Action Settlements. COI litigation has also spawned significant class action settlements. For example, in *Feller v. Transamerica Life Insurance Co.*, the court granted final approval to a more than $110 million settlement in a COI case alleging claims based on 2015 and 2016 COI rate increases for certain UL policies. No. 16-cv-01378 (C.D. Cal. Feb. 6, 2019) [ECF Nos. 444, 445]. And, in *Larson v. John Hancock Life Insurance Co.*, the court granted final approval to a nearly $60 million settlement in a COI case alleging Day 1 claims regarding certain UL policies. No. RD16813803 (Cal. Sup. Ct. May 8, 2018).

Final Judgments on Jury Verdicts. In *DCD Partners, LLC v. Transamerica Life Insurance Co.*, the court entered a final judgment awarding nearly $7.8 million in damages following a jury verdict in an increase case. No. 15-03238 (C.D. Cal. Dec. 13, 2018). Around the same time, in *Vogt v. State Farm Life Insurance Co.*, the court entered final judgment awarding more than $34 million following a jury verdict in a Day 1 case. No. 16-cv-04170 (W.D. Mo. Oct. 11, 2018).[1]

Early Dispositive Motions. Results on early dispositive motions continue to be mixed, hinging largely on the specific policy language at issue and often on whether a court is willing to accept the Seventh Circuit's reasoning in *Norem* and *Thao*. *E.g.*, *Fairlie v. Transamerica Life Ins. Co.*, 2018 WL 3381405, at *6-9 (N.D. Iowa July 11, 2018) (rejecting reasoning in *Norem* on motion to dismiss); *McMahon v. Transamerica Life Ins. Co.*, 2018 WL 3381406, at *4-7 (N.D. Iowa July 11, 2018) (same); *see Couch v. Wilco Life Ins. Co.*, 363 F. Supp. 3d 886, 900 & n.2 (S.D. Ind. 2019) (explaining that, even assuming policy at issue included "based on" language, "the Seventh Circuit . . . has determined that where a COI provision lists factors that the insurer will consider, the insurer is not limited to considering only the factors listed," and rejecting as unpersuasive analysis from *McMahon*, "particularly in light of Seventh Circuit precedent to the contrary").

ASOP 2. The ASB is currently considering significant changes to ASOP 2 – "Nonguaranteed Charges of Benefits for Life Insurance Policies and Annuity Contracts." The proposed revisions are currently in the comment period, which is set to end July 15, 2019. Thus, it is unclear at this point when such changes may go into effect and what the final revisions will entail. Nevertheless, it appears that the proposed changes to ASOP 2 could significantly impact initial and subsequent determinations of NGEs in universal life insurance policies (as well as other products). For example, the proposed changes would impact the establishment of classes, changes to NGEs for in-force and new products, illustrations of NGEs, and the level of detail required in performing and documenting determinations, as well as providing additional examples of experience factors used in determinations. Given the current litigation climate for universal life policies, any changes to ASOP 2 may be used in pending and future litigation.

B. Contestability, Rescission and Suicide

Litigation concerning the contestability and rescission of life insurance policies is a basic staple for many insurers seeking to challenge fraudulent representations and omissions in the underwriting process. Some decisions reached within the past year include:

Dispositive Motions. *Peterson v. USAA Life Insurance Co.*, 353 F. Supp. 3d 1099 (D. Colo. 2018) involved a claims by the widow of an insured who died unexpectedly within life insurance policy's two-year contestability period. Based on his application, the decedent was issued a policy under USAA's "Preferred Ultra" risk class which is the least expensive risk class offered by the company. A year later, the decedent passed away from an unspecified cause. Records received by USAA

[1] During the *Vogt* proceedings, the court echoed the Southern District of New York's treatment of *Norem* from *Fleisher v. Phoenix Life Ins. Co.*, 18 F. Supp. 3d 456, 472 (S.D.N.Y. 2014). *Vogt*, 16-cv-04170 (W.D. Mo. Apr. 10, 2018). *Vogt* is currently before the Eighth Circuit, where the parties cross appealed several of the district court's decisions. *Vogt v. State Farm Life Insurance Co.*, Nos. 18-3419, 18-3434 (8th Cir.).

after the decedent's passing (upon beneficiary's execution of a HIPAA form) indicated that he had submitted to a number of sleep apnea studies, was diagnosed with moderate obstructive sleep apnea (OSA), and treated with a Continuous Positive Airway Pressure (CPAP) machine. Decedent omitted his OSA diagnosis notwithstanding several relevant questions in the life insurance application designed to solicit information regarding treating physicians, dates of diagnoses, tests, treatments and, more specifically, whether he had ever consulted a health care provider for a respiratory system disorder.

Plaintiff, as the named beneficiary under the policy, brought claims for breach of contract, bad-faith breach of contract, and violation of the Colorado Consumer Protection Act (CCPA) against the insurer after it denied her claim for benefits on ground that the insured materially misrepresented his medical history by failing to disclose his OSA diagnosis on his insurance application.

The Court found that the questions posed by USAA were not ambiguous or misleading, and by failing to answer the relevant applications truthfully, the decedent made false statements of fact pertaining to his medical history. As such, the decedent's misrepresentations materially affected the risk that the Defendant assumed. Based on his medical records, the court found that the decedent would have been classified as "Preferred" which is two risk classes below "Preferred Ultra" and would have offered the decedent almost 50% less coverage than the $1,000,000 policy he was issued, and entered summary judgment for USAA. The case is currently on appeal to the Tenth Circuit Court of Appeals.

Other courts have similarly granted summary judgment in favor of the insurer and affirming rescission of the policy during the contestability period. *See New York Life Insurance Co. v. Saul*, 2018 WL 4932861, at *5 (D.N.M. Oct. 11, 2018) (material misrepresentations in the policy application regarding the decedent's history of alcoholism and related conditions rendered the policy void and warranted judgment for the insurer); *American General Life Insurance Co. v. Estate of Chad Jude*, 2019 WL 2193850 (E.D. Ky. May 21, 2019) (insurer entitled to summary judgment where policy rescinded during contestability period when insurer learned of the insured's medical condition after he applied for increased coverage); *Colonial Penn Life Insurance Company v. Parker*, 362 F. Supp. 3d 380 (S.D. Tex. 2019) (granting summary judgment for the insurer where insured/decedent failed to disclose treatment for substance abuse and because the policy lapsed for non-payment of premiums prior to the insured's death).

In *Banner Life Insurance Co. v. Holland*, 2018 WL 3518473 (W.D.N.C. July 20, 2018), the insurer was entitled to rely on a renewed contestability period. Banner Life issued a life insurance policy to the insured in 2008. The policy lapsed in 2016 as a result of the insured's failure to pay premiums. The insured sought to reinstate the policy and submitted a Reinstatement Application. On the basis of the insured's responses in the Reinstatement Application, Banner Life reinstated the policy in August 2016. A little over four months later, in December 2016, the insured committed suicide. Pursuant to North Carolina law, the reinstatement restarts the two-year contestability period, and the life insurance policy may be contested on account of fraud or material misrepresentation during the two-year period following reinstatement of the policy.

The medical records collected during Banner Life's contestability investigation revealed treatments, medications, and medical conditions that the insured had failed to disclose in response to questions on the Reinstatement Application, including a history of depression, an attempted suicide and hospitalization in May 2012 (after initial issuance of the policy but in the 5 year period preceding the reinstated policy), a suicide risk assessment, and subsequent diagnosis and treatment for depression. Banner Life would not have reinstated the policy had the insured/decedent truthfully disclosed this information, so Banner Life rescinded the policy, denied the claim for benefits and refunded the premiums paid under the policy. The Court found that Banner Life properly terminated the reinstated policy as void *ab initio* due to the decedent's misrepresentation. And, because the plaintiff deposited the premium refund check, his actions were an accord and satisfaction of any claims that he might have had against Banner Life under the policy.

Intentional Self-Inflicted Injury Exclusion. In *Tran v. Minnesota Life Insurance Co*., the U.S. Court of Appeals for the Seventh Circuit ruled that an insured's death from autoerotic asphyxiation fell under the policy exclusion for deaths resulting from "intentionally self-inflicted injury" within the meaning of accidental death and dismemberment (AD&D) riders to two life insurance policies issued to Mr. Tran. 922 F.3d 380 (7th Cir. 2019).

Minnesota Life paid the insured's widow the life insurance coverage, but denied her claim for AD&D coverage because it concluded that the insured's death did not result from an accidental bodily injury. The district court ruled that the only issue in dispute was whether autoerotic asphyxiation qualified as an "injury" under the policy's language. After reviewing precedent on autoerotic asphyxiation from other courts, the trial court determined that reasonable minds could disagree about whether the insured's intentional act to restrict blood flow to the brain to induce a feeling of euphoria was a self-inflicted injury within the meaning of the AD&D rider language. *Id*. at 382. Construing the ambiguity in favor of coverage, the district court ruled that the exclusion for intentionally self-inflicted injuries did not apply to autoerotic asphyxiation and entered judgment in favor of the insured's widow. *Id*.

The Seventh Circuit reversed, and applied a subjective/objective test to determine whether the autoerotic asphyxiations was accidental or intentional, that is, whether the injured individual had a *subjective* expectation of injuring himself or whether an expectation of injury was *objectively* reasonable. The Court concluded that the decedent's subjective intent was clear because "[s]trangling oneself to cut off oxygen to one's brain is an injury, full stop [and] [w]hen that injury kills, it is 'an intentionally self-inflicted injury which resulted in death,' regardless of whether it was done recreationally or with an intent to survive." *Id*. at 386 (citations omitted).

Suicide Exclusions. Recent suicide exclusion decisions include *Arena v. RiverSource Life Insurance Co.*, 356 F. Supp. 3d 413 (D.N.J. 2018) (suicide exclusions applied even if insured would not have committed suicide but for the effect that medications had on her state of mind); *Lann v, Metropolitan Life Insurance Co.*, 371 F. Supp. 3d 1185 (N.D. Ga. 2019) (insurer was justified in relying on medical examiner's report and finding that cause of death was suicide in denying claims for supplemental life insurance and accidental death & dismemberment benefits pursuant to suicide exclusion clause); and *Amica Life Ins. Co. v. Wertz*, 2018 WL 5249997 (D. Colo. Oct. 19, 2018) (two-year suicide exclusion provision contained in a policy approved under

the Interstate Insurance Product Regulation Compact was enforceable although it conflicted with a Colorado statute which limited such exclusions to a one year duration).

Some recent regulatory developments may soon alter the litigation landscape for contestable claims in certain states.

C. Improper Lapse Claims

Improper lapse claims generally arise under two sets of circumstances: (1) improper lapse notification, or (2) failure to obtain third party information or to notify appropriate third parties of a lapse. These types of cases are usually brought as either breach of contract or statutory claims, depending on the language in the contract and the language of the state statutes. However, litigation this year also saw claims for negligence and fraudulent misrepresentation in these cases.

The information included by an insurer on a grace notice and the mechanics of when it will be mailed out – and to whom – depends on the language of the insurance policy and relevant state statutes; therefore, the outcome of any particular case is largely dependent on the terms of each policy and which state's law governs the policy.

Customary Procedures. Where an insurer can prove that it adhered to its routine, customary procedures with respect to policies and correspondence such as lapse notices, courts are hesitant to find breach of contract. In *Rees v. Jackson Nat'l Life Ins. Co.*, the court granted Jackson National's motion for summary judgment on plaintiff's breach of contract claim. 2019 WL 2004137 (N.D. Ga. Mar. 19, 2019). The Court found that Jackson National had shown that it adhered to its routine, customary computerized procedures for policies; thus, there was no breach of contract. *Id.* at *5. "Any contractual obligation Defendant had was fulfilled upon sending the notices. Mere denial of receipt on the part of Plaintiff does not raise a jury issue . . . ." *Id.* at *4.

Similarly, in *Peak v. Reliastar Life Ins. Co.*, the Court granted Reliastar's motion for summary judgment, finding that no breach of the policy had occurred. 2018 WL 6380772 (N.D. Ga. Sept. 28, 2018). The Court found that the language of the policy only required premium notices to be sent out after the level premium period had expired, but that Reliastar had sent out premium notices even during the level premium period. *Id.* at *10-11. The Court stated that the evidence showed that Reliastar followed its routine and customary computerized procedures surrounding creation and mailing of policy notices and Reliastar adhered to these procedures in plaintiff's case. *Id.* at *14.

Legally Insufficient Lapse Notices. Courts have found lapse notices to be legally insufficient where an insurer demanded more premium than it was entitled. In *Halberstam v. Allianz Life Insurance Co. of North America*, the Court granted the plaintiff's motion for summary judgment where the lapse notice required four months of premiums to prevent lapsing of the policy. 349 F. Supp. 3d 164 (E.D.N.Y. Oct. 2018). While the language of the policy did not state that the grace notice had to state the amount due, Section 3211(b)(2) of the New York insurance law required the amount to be stated. *Id.* at 170-71. Further, under Section 3203(a)(1) of New York insurance law, Allianz could only request three months of premiums during the grace period, and the notice demanded four months of premiums to keep the policy in force. *Id.* at 170. The Court found that

because the lapse notice was legally insufficient, the policy did not lapse and the termination of the policy was void. *Id.* at 171.

Issues such as change of address can also have an effect on whether a lapse notice is adequate or proper. In *CFCS Investments, LP v. Transamerica Occidental Life Insurance Co.*, 2018 WL 3870084 (E.D. Mo. Aug. 15, 2018), the plaintiff brought claims of negligence and breach of contract against Defendants where Defendants failed to send lapse notices to the correct address for CFCS. The Court found that there was no record of a change of address report, and only the checks sent for premium payment reflected the plaintiff's new address. *Id.* at *3. The Court denied the plaintiff's summary judgment motion on the breach of contract claim, because a question of fact existed as to whether Transamerica was properly notified of the new address and whether Transamerica acted properly upon the notification. *Id.* at *7.

Improper Third Party Notification. Some states have statutes requiring that a life insurance owner be given the right to designate a person to receive notification of termination for nonpayment of premium. In California, for example, the insurer must notify the policy owner annually of this right. Prior to lapse, notification must be given to that person, as well as the owner.

In a class action filed in the Central District of California, plaintiff alleged that United of Omaha had failed to provide adequate notice to third parties under California's statute which was enacted in 2013. *Bentley v. United Omaha Life Ins. Co.*, 371 F. Supp. 3d 723 (C.D. Cal. 2019). The insured received lapse notices advising that his next premium payment was due August 28, 2014, and subsequent notices advising that his August payment was not received. The insured died on November 7, 2014. Plaintiff, the beneficiary of the life insurance policy filed a class action on behalf of other United policyholders.

In 2018, the Court granted class certification to the following class:

> All beneficiaries who made a claim, or would have been eligible to make a claim, for the payment of benefits on life insurance policies renewed, issued or delivered by [United of Omaha] in the State of California that lapsed or were terminated by Omaha for the non-payment of premium after January 1, 2013 …, and as to which policies the policyholder(s) did not receive one or more of the notices of the right to designate under Section 10113.72 of the California Insurance Code.

Id. at 726. On summary judgment, the Court found that the statute applied to policies enacted prior to 2013, as the policies in the action renewed periodically, therefore the statute applied. *Id*. at 732. The Court did not rule that the statute applied retroactively; rather, that it applies prospectively to policies upon each renewal period. *Id*.

The Court also clarified that only beneficiaries who did not receive a third party notice could be considered a class member; beneficiaries who did receive an annual notice prior to lapse were not part of the certified class. *Id*. at 738-39. On these fact, the Court granted summary judgment in favor of the plaintiff on the breach of contract claim, as United of Omaha failed to provide the requisite notice to the beneficiary prior to terminating the policies.

In *Waskul v. Metropolitan Life Insurance Co.*, the Court found that the plaintiff had plausibly alleged a claim for breach of contract for failure to inform the lapse designee of non-payment of premium. 2018 WL 3647102 (E.D. Mich. July 31, 2018). However, the Court dismissed the plaintiff's claim for fraudulent misrepresentation as there had been no misrepresentation regarding the insured's ability to appoint a lapse designee. *Id.* at *4. Further, the Court dismissed the plaintiff's statutory claim under Michigan's insurance statute, as the statute did not provide a private right of action. *Id.*

D. STOLI Litigation

STOLI litigation continues to slow down, but some cases decided within the last year include:

Sun Life Assurance Co. of Canada v. Wells Fargo Bank, N.A., 2019 WL 2345444 (N.J. June 4, 2019), the New Jersey Supreme Court considered stranger-originated life insurance ("STOLI") policies as a matter of first impression. The case arose out of two certified questions of law from the U.S. Court of Appeals for the Third Circuit:

> (1) Does a life insurance policy that is procured with the intent to benefit persons without an insurable interest in the life of the insured violate the public policy of New Jersey, and if so, is that policy void ab initio?
>
> (2) If such a policy is void ab initio, is a later purchaser of the policy, who was not involved in the illegal conduct, entitled to a refund of any premium payments that they made on the policy?

Id. at *6-7. With respect to the first question, the Court concluded "that STOLI policies are against public policy and are void ab initio, that is, from the beginning." *Id.* at *5. STOLI policies, the Court explained, "commonly involve life insurance policies procured and financed by investors -- strangers -- who have no insurable interest in the life of the insured yet, from the outset, are the ultimate intended beneficiaries of the policy." *Id.* at *14.

In the case leading up to *Sun Life*, a $5 million policy was taken out on the life of Nancy Bergman. *See id.* at *5. The application listed a recently created trust as sole owner and beneficiary of the policy. *See id.* Nancy Bergman was grantor of the trust; her grandson was trustee; and the trust's remaining four members were investors—strangers to Bergman. *See id.* The investors provided the funds to pay most, if not all, of the policy's premiums. *See id.* About five weeks after the policy was issued, the grandson resigned as trustee and appointed the investors as successor co-trustees. *See id.* at *6. The trust agreement was also amended to give the investors most of the policy's proceeds and authorize them to sell the policy. *See id.* Two years later, the investors sold the policy and received nearly all the proceeds from the sale. *See id.* After a second sale and a bankruptcy settlement, Wells Fargo ultimately acquired the policy. *See id.* The Court concluded that such an arrangement violates New Jersey's policy and statutory requirement that the policyholder have an insurable interest in the life of the insured and, particularly, "an interest in the continued life of the insured rather than in his early death." *Id.* at *14 (internal quotation marks and citations omitted).

The fact that the insured's grandson was involved in the transaction at the outset and that there may have been initial, albeit "feigned," compliance with insurance interest statute did not alter the result. The Court explained: "It would elevate form over substance to conclude that feigned compliance with the insurable interest statute -- as technically exists at the outset of a STOLI transaction -- satisfies the law. Such an approach would upend the very protections the statute was designed to confer and would effectively allow strangers to wager on human lives." *Id.* at *5; *see also id.* at *13 ("If a third party without an insurable interest procures or causes an insurance policy to be procured in a way that feigns compliance with the insurable interest requirement, the policy is a cover for a wager on the life of another and violates New Jersey's public policy.").

The Court recognized that circumstances existed under which a life policy could be sold to an investor and remain enforceable. According to the Court, "[a] key difference between non-STOLI and STOLI policies, as the Second Circuit has explained, is simply one of timing and certainty; whereas a non-STOLI policy might someday be resold to an investor, a STOLI policy is intended for resale before it is issued." *Id.* at *12 (internal quotation marks and citation omitted). Thus, a key factor rendering the policy at issue in *Sun Life* unenforceable was its "swift transfer of control . . . from a named beneficiary who had an insurable interest to investors who did not." *Id.* at *5.

The Court also concluded that the presence of a incontestability provision in the Sun Life policy did "not bar a challenge to" insurance contracts, like STOLI policies, that "are contrary to public policy." *Id.* at *15. The Court explained: "If a policy never came into effect, neither did its incontestability clause; the clause thus cannot stand in the way of a claim that the policy violated public policy because it lacked an insurable interest." *Id.* In so holding, New Jersey joined the "majority of courts," which "have held that the lack of an insurable interest can be asserted as a defense even after a policy has become incontestable." *Id.* at *10.

With respect to the second question, the Court concluded that, depending on the circumstances, a party may be entitled to a refund of premium payments it made on a void STOLI policy. The Court followed a "fact-sensitive approach" adopted by a number of other federal courts, guiding trial courts to "develop a record and balance the relevant equitable factors" (including a party's level of culpability, participation in or knowledge of the illicit scheme, and failure to notice red flags) in deciding the appropriate remedy. *Id.* at *22. The Court noted that a refund may particularly be appropriate for "a later purchaser who was not involved in any illicit conduct." *Id.*

Other recent STOLI-related decisions include *Estate of Malkin v. Wells Fargo Bank, N.A.*, 2019 WL 1429660, at *1 (S.D. Fla. Mar. 29, 2019) (concluding that life insurance policy was a STOLI policy under Delaware law because, even though insured's husband was beneficiary and had insurable interest at time of application, investors provided insured the financial means to obtain policy and ultimately purchased the policy; holding that insured's estate was entitled to recover the policy's benefits pursuant to Delaware statute precluding STOLI investors from retaining death benefits of policy procured through STOLI scheme); and *Sun Life Assurance Co. of Canada v. Imperial Premium Finance, LLC*, 904 F.3d 1197 (11th Cir. 2018) (holding, *inter alia*, that incontestability clauses did not bar RICO fraud claims and insurer adequately pled RICO conspiracy claims in action challenging premium finance company's acquisition of STOLI policies)

E. DOL Fiduciary Rule Litigation

Soon after the Department of Labor issued the long-awaited and controversial final fiduciary investment advice regulation (the "fiduciary rule"), litigation was filed challenging the rule in *Chamber of Commerce of the United States of America v. Hugler*.

Several business groups claimed that the fiduciary rule exceeded the DOL's statutory authority under the Employee Retirement Income Security Act (ERISA); that the creation of the Best Interest Contract Exemption exceeds the DOL's exemptive authority in regulating fiduciaries; the rule impermissibly created a private right of action; the rule violates the First Amendment; and the contractual provisions of the rule violate the Federal Arbitration Act. *Chamber of Commerce*, 231 F. Supp. 3d 152, 167-68 (N.D. Tex. 2017). The district court rejected each argument and granted summary judgment to the then-acting Secretary of Labor.

The U.S. Court of Appeals for the Fifth Circuit reversed and held that the DOL's expansion of the scope of the fiduciary rule to include broker-dealers and insurance agents conflicts with both the plain text of ERISA and violates the Administrative Procedure Act (APA). *Chamber of Commerce of the United States of America v. United States Department of Labor*, 885 F.3d 360 (5th Cir. 2018). In vacating the final rule, the Fifth Circuit determined that the original DOL regulation defining "investment advice" drew the correct distinction between "an 'investment adviser,' who is a fiduciary regulated under the Investment Advisers Act, and a 'broker or dealer,' whose advice is 'solely incidental to the conduct of his business as a broker or dealer and who receives no special compensation therefor.'" *Id.* at 365.

The DOL did not appeal or seek reconsideration of the decision, and it now appears the DOL is preparing to roll out a new fiduciary rule later this year which is expected align with the Securities and Exchange Commission (SEC) Regulation Best Interest.

F. New York Reg 187 Litigation

On November 16, 2018, two cases were filed in New York against the New York Department of Financial Services (NY DFS) in an effort to invalidate the first amendment to New York Insurance Regulation 187 (NY Reg 187), which, among other requirements, expanded the scope of New York's suitability rule to apply to life insurance and in-force transactions as well as annuities and applied a best interest standard of conduct. The first case, *Independent Insurance v. NYS Department of Financial Services*, was filed in Albany County. The second case, *National Ass'n of Insurance & Financial Advisers - New York State, Inc. v. New York State Department of Financial Services and Maria T. Vullo*, in her official capacity as Superintendent of The New York State, was filed in New York County. Both cases sought an order and judgment vacating and annulling the first amendment to NY Reg 187.

The Albany County petition alleged six causes of action: 1) NY Reg 187 conflicts with the governing statutory scheme and common law and is beyond the NY DFS' authority to impose; 2) NY Reg 187 constitutes improper regulatory policymaking; 3) NY Reg 187 violates the state administrative procedures act; 4) NY Reg 187 is arbitrary and capricious, unreasonable, and lacks

a rational basis; 5) NY Reg 187 is unconstitutionally vague; 6) NY Reg 187 improperly extends the agent/broker relationship.

New York County petition avers that: 1) NY Reg 187 lacks any statutory authority and places obligations on agents that are inconsistent with New York Insurance Law Section 2103; 2) NY Reg 187 is unconstitutional and void because: (a) broad delegation of authority to promulgate NY Reg 187 would violate the separation-of-powers doctrine, (b) NY Reg 187 contains impermissibly vague and confusing terms, and (c) NY Reg 187 violates due process by purporting to act retroactively; and 3) Regulation 187 is arbitrary and capricious.

The cases were consolidated on March 28, 2019, because "the issues [were] so similar that it would be a waste of judicial economy to address them in two separate forums." A motion to dismiss is pending in the consolidated case.

G. Automatic Revocation of Beneficiary Designation

The U.S. Supreme Court weighed in on an issue affecting the life insurance industry in *Sveen v. Melin*, 138 S. Ct 1815 (2018). Kaye Melin was the primary beneficiary of her husband Mark Sveen's life insurance policy. After Sveen listed his wife on the policy, Minnesota enacted legislation providing that its revocation-upon-divorce statute would automatically revoke the life insurance beneficiary status of former spouses upon divorce without any action by the policyholder. Sveen and Melin later divorced, but Melin continued to be listed as the primary beneficiary of Sveen's policy. Sveen passed away.

The federal district court held that the revocation-upon-divorce statute revoked Melin's beneficiary status, even though Sveen designated her as a beneficiary before the statute went into effect. On appeal, the U.S. Court of Appeals for the Eighth Circuit held that retroactive application of the statute violated Sveen's rights under the Contracts Clause of the United States Constitution. The U.S. Supreme Court reversed the Eighth Circuit, holding that retroactive application of the Minnesota statute did not violate the Contracts Clause.

II. ANNUITY LITIGATION

There has been a general slowdown in annuity litigation in recent years, and the following cases highlight some of the annuity issues decided by the courts in the past year.

Denial of class certification. In *Thompson v. Allianz Life Insurance Co. of North America*, 330 F.R.D. 219 (D. Minn. 2019), the plaintiff alleged that Allianz "impermissibly reduced the value of and/or the payouts from its annuities . . . by applying what Allianz called an 'Expense Recovery Adjustment' ('ERA') . . . ." *Id.* at 221. The plaintiff sought to represent a nationwide class consisting of other owners and beneficiaries under the same deferred annuity contracts for the Allianz products affected by the ERA. *Id.* at 222. The court denied plaintiff's motion for class certification, concluding that Minnesota law, on which plaintiff's breach-of-contract claim relied, "[could] not be constitutionally applied to all of the claims at issue." *Id.* at 226. The court reasoned that "[t]he class raises breach-of-contract claims under the laws of multiple states, and each state's laws regarding extrinsic evidence and limitations are different. These individual differences

simply overwhelm any common questions, and [the plaintiff] has failed to satisfy predominance." *Id*.

Dispositive motions. The plaintiff in *O'Brien v. Transamerica Premier Life Ins. Co*. initiated a breach of contract claim against Transamerica seeking recovery under a "Death Benefit Rider" incorporated in an annuity contract. 745 F. App'x 349, 350 (11th Cir. 2018). The district court granted Transamerica's motion for summary judgment, finding that the Rider "has no application to instances where the designated annuitant dies after the annuity date," as occurred in this case. *Id*. at 352. The Eleventh Circuit affirmed, reasoning that "the language of the Rider is susceptible to only one *reasonable* interpretation," which is "that the parties intended to confer a death benefit only in those circumstances where the annuitant dies before the annuity date." *Id*. at 354.

In *Ryan v. Salisbury*, 2019 WL 2121518 (D. Haw. May 14, 2019), the trustee of a family trust sued Defendant Christopher Salisbury, an investment and financial planning advisor, as well as Salisbury's employer, National Asset Management, Inc. ("NAM"), among other affiliated entities. The trustee alleged that Salisbury caused the trustee to surrender at least two annuities issued by Allianz "at a sizeable loss," amounting to more than $570,000 in surrender charges, all while advising the trustee that the surrenders were in her best interest. *Id*. at *1-2. The trustee asserted claims against Salisbury and NAM under Hawaii's Unfair and Deceptive Acts or Trade Practices Act as well as claims for fraudulent suppression, fraudulent misrepresentation, breach of fiduciary duty, vicarious liability, violation of the Hawaii Securities Act, and RICO. *Id*. at *2-3. NAM moved for judgment on the pleadings, arguing that the plaintiff's claims were untimely as well as insufficiently pleaded. *Id*. at *7. The court agreed, reasoning that "although Plaintiff makes various assertions regarding these defendants' fraudulent conduct, she stops far short of alleging 'the who, what, when, where, and how of the misconduct charged.'" *Id*. The court also found that the trustee failed to allege the "nature or scope of her relationship with Defendant NAM" sufficient to establish that NAM acted as a fiduciary. *Id*. at *9. The court dismissed with prejudice a portion of the trustee's claims under Hawaii's Unfair and Deceptive Acts or Trade Practices Act as well as the Hawaii Securities Act, but permitted the trustee an opportunity to amend the complaint to state a claim under the other theories asserted. *Id*. at *19.