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LETTER FROM WASHINGTON

GAO REPORT ON RRGS SERIOUSLY FLAWED

By Robert H. Myers, Jr.

On December 8, 2011, the U.S. Government Accountability Office ("GAO") issued a report to Congress entitled "Clarifications Could Facilitate States' Implementation of the Liability Risk Retention Act" ("GAO Report"). The GAO had been charged by Congress with examining: (1) the regulatory health of the RRG industry and; (2) the extent to which non-domiciliary states were exceeding their authority under federal law. The report concluded that: (1) the industry was healthy from a regulatory and financial perspective and; (2) Congress should "clarify" the registration requirement, fee and coverage provisions of the Liability Risk Retention Act, 15 U.S.C. § 3901 *et seq.* ("LRRA").

However, the GAO's underlying analysis for its findings regarding non-domiciliary state behavior imprecisely conflates multiple issues and is not substantiated by existing case law. In short, the GAO finds "silence" and "ambiguity" under the LRRA's current provisions, when such provisions are indisputably clear and upheld as such by federal courts.

Registration Requirements

The GAO Report incorrectly states that the "LRRA does not provide for a specific process for RRGs to register to conduct business in non-domiciliary states." GAO Report at 24. In fact, the LRRA is quite clear that the registration requirements in a non-domiciliary state are limited to submitting the documents enumerated under 15 U.S.C. § 3902(d)(2). *All* other state laws are broadly preempted, unless expressly excepted under 15 U.S.C. § 3902(a)(1).

The *only* federal court to address the issue of registration requirements under the LRRA also has found that the plain language of the LRRA limits registration requirements to those provided under § 3902(d).

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HASSETT'S OBJECTIONS

THE FILED RATE DOCTRINE: A LOVE STORY

By Lewis E. Hassett

Because many states have statutes barring or restricting the enforcement of arbitration clauses in insurance contracts, the U.S. Supreme Court's decision last year in *AT&T Mobility, LLC v. Concepcion*, Case No. 09-893 (U.S. April 27, 2011) (upholding class arbitration waivers) has been of limited benefit to insurers. *See* Ga. Code Ann. § 9-9-2(c) (arbitration clauses in insurance contracts unenforceable); Miss. Code Ann. § 83-11-109 (disallowing arbitration clauses in uninsured motorist coverage); Neb. Rev. St. § 25-2602.01; S.C. Code Ann. § 15-48-10; Ark. Code Ann. § 16-108-230; Nev. Rev. St. § 689B.067 (group health insurance); *United Ins. Co. of Am. v. Fla. Office of Ins. Regulation*, 985 So. 2d 665 (Fla. App. 2008) (upholding insurance department's denial of application to include arbitration clause in life insurance contracts); *Appleton Papers, Inc. v. Home Indemn. Co.,* 612 N.W.2d 760 (Wis. App. 2000) (arbitration clause unenforceable where form not approved by commissioner of insurance). The majority of decisions uphold insurance-specific restrictions on arbitrability based upon the McCarran-Ferguson Act, which allows state law to control the

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NAIC ADOPTS LANDMARK NEW STANDARDS ON CREDIT FOR REINSURANCE

By Joseph T. Holahan

During its Fall 2011 meeting, the National Association of Insurance Commissioners ("NAIC") adopted important changes to its Credit for Reinsurance Model Law and Regulation following years of work on this issue.

The centerpiece of the amendments is a process by which unauthorized reinsurers may qualify to post reduced collateral to satisfy state credit for reinsurance standards that apply to U.S. cedants. Other important aspects of the amendments include new regulatory notice requirements for ceding insurers concerning concentrations of risk and clauses required to be included in reinsurance agreements for ceding insurers to receive credit for reinsurance.

The amendments to the NAIC model law and regulation follow a general trend among the states and at the federal level towards modernization of reinsurance regulation. Florida, Indiana, New Jersey and New York already have adopted laws permitting unauthorized reinsurers to post less than 100% collateral if they qualify based on financial strength ratings and other factors. In 2010, Congress enacted the Nonadmitted Insurance and Reinsurance Reform Act ("NRRA") as part of the Dodd-Frank financial reform legislation. The NRRA, which became effective July 21, 2011, generally preempts the application of state credit for reinsurance laws to insurers not domiciled in the state. Thus, under the NRRA, a ceding U.S. insurer need only satisfy the credit for reinsurance requirements of its domicile state.

Major aspects of the amendments to the NAIC Credit for Reinsurance Model Law and Regulation include the following:

Regulatory Notice Regarding Cedant's Concentration of Risk

Under the amendments, an insurer must notify its domestic regulator within 30 days if reinsurance recoverables from any single reinsurer or group of affiliated reinsurers exceed 50% of the insurer's last reported surplus to policyholders or if the insurer has ceded to any single reinsurer or group of affiliated reinsurers more than 20% of the insurer's gross written premium in the prior calendar year. An insurer also must notify its domestic regulator within 30 days if, at any time, it determines it is likely to exceed these limits. The notice must demonstrate the insurer is safely managing its exposure.

The amendments do not specify what action, if any, the regulator may take following notice. Regulators likely will require a notifying insurer to implement a plan to reduce its concentration of risk, unless the insurer can demonstrate it is managing the risk

Announcements

Partner **Skip Myers** was named to the Top 5 of *Captive Review's* 2012 Global Power 50 List.

Chris Petersen conducted a webinar on behalf of the Association of Insurance Compliance Professionals regarding the impact of the Patient Protection and Affordable Care Act on "non-traditional" health insurance products. The webinar focused on the unique compliance issues confronting these products and examined potential business opportunities for insurers in this market niche.

Skip Myers spoke at the World Captive Forum on regulatory change affecting captives.

On February 3, the mentoring program at **Morris, Manning & Martin, LLP** won first place at the *Chambers & Partners* 2012 Women in Law Awards held in New York City. Since 1990, *Chambers* has published the world's leading guides to the legal profession and has built a reputation for in-depth, objective research.

Chris Petersen will speak at the Delta Dental Plans Association Public Policy Conference in Washington, D.C. on March 26 and 27. Mr. Petersen will discuss the role of dental carriers in exchanges and how state legislative proposals will impact that role.

Skip Myers will speak at the Captive Insurance Companies Association (CICA) annual conference in Scottsdale, Arizona on March 12 about the implications for captives of the National Risk and Reinsurance Reform Act and again on issues affecting risk retention groups.

Lew Hassett will speak at the American Conference Institute's Reinsurance Disputes in Litigation and Arbitration Forum in New York City on May 1. Lew will participate on a panel entitled "Reinsurance Claims in the Context of Insolvencies: How to Navigate Disputes with Receivers." For further information or to attend, please contact Jill Hurley at J.Hurley@americanconference.com.

The National Conference of Insurance Legislators (NCOIL) invited **Chris Petersen** to speak on a panel session entitled "Essential Health Benefits: Balancing the Costs and Coverage." The session was part of NCOIL's Spring Meeting and focused on the cost impacts of the essential health benefits required under the Patient Protection and Affordable Care Act.

Jim Maxson will speak on a panel entitled "Life Settlements as an Asset Class - Protecting the Primary Market While Establishing a Legitimate Secondary Market" at the AALU Annual Conference in Washington, D.C. on April 30.

Chris Petersen spoke at the Professional Insurance Marketing Association's Annual Meeting in Palm Coast, Florida. He participated in a panel discussion about legislative and regulatory developments impacting associations and the health insurance industry.

appropriately on its own – for example, by obtaining appropriate collateral. Insurers domiciled in states that adopt these requirements must be certain their policies governing concentration of risk reflect these limits. They also may want to consider inserting a provision in outbound reinsurance agreements requiring the assuming insurer to give notice of mergers and acquisitions within its affiliated group so that any resulting concentrations of risk can be tracked and managed.

Contract Clauses Required to Obtain Credit for Reinsurance

The amendments add new, required contractual provisions for the ceding insurer to obtain credit for reinsurance. They also clarify an existing clause of this type. The amendments provide that the reinsurance agreement must include "a proper reinsurance intermediary clause, if applicable," stipulating that credit risk for the intermediary is carried by the reinsurer. Such a clause will be necessary where a reinsurance intermediary handles payment of reinsurance premiums or claims.

In addition, the amendments clarify that to obtain credit for reinsurance, the reinsurance agreement must contain an insolvency clause stipulating that if the ceding insurer is placed in liquidation or similar insolvency proceedings, reinsurance claims are payable directly to the ceding insurer's liquidator or successor without diminution, regardless of the ceding insurer's status. Such clauses already are standard and generally required in U.S. jurisdictions to obtain credit for reinsurance.

Finally, reinsurance agreements with a certified reinsurer must contain a funding clause requiring the reinsurer to provide security in an amount sufficient to avoid the imposition of financial statement penalty on the ceding insurer.

Reduced Collateral Requirements for Certified and Rated Reinsurers

The amendments establish a scheme whereby an unauthorized reinsurer may be "certified" and rated by the domestic state regulator of a ceding U.S. insurer. Insurers ceding to a reinsurer that has been certified will be granted full credit for reinsurance while being permitted to obtain security according to a sliding scale, with the level of required collateral varying from 0% to 100% of ceded liabilities according to the certified reinsurer's rating.

To be eligible for certification, a reinsurer must meet the following criteria: (1) be domiciled and licensed in a "qualified jurisdiction;" (2) maintain capital and surplus of no less than $250 million; (3) maintain financial strength ratings from two or more acceptable rating agencies; (4) submit to the jurisdiction of the certifying state and agree to provide security for 100% of its liabilities attributable to cessions by U.S. insurers if it resists enforcement of a final U.S. judgment; (5) agree to provide certain informational filings, including notice within 10 days of any regulatory action taken against the reinsurer, an annual list of disputed and overdue reinsurance claims regarding U.S. cedants and annual audited financial statements and auditor's report; and (6) comply with any other requirements established by the certifying state. If a reinsurer applying for certification has been certified by another state accredited by the NAIC, the regulator may defer to that state's certification.

The amendments call for the state regulator to publish a list of "qualified jurisdictions," which are jurisdictions that may serve as the domicile for a certified reinsurer. The NAIC will publish a list of jurisdictions it considers to be qualified, which many states may follow. All U.S. jurisdictions that are accredited by the NAIC will be recognized as qualified automatically. Non-U.S. jurisdictions will be evaluated for qualified status based on a number of factors, including the effectiveness of reinsurance supervision, including financial surveillance; whether the jurisdiction accords reciprocal rights to U.S. reinsurers; any documented evidence of problems with the enforcement of U.S. judgments in the jurisdiction; and the jurisdiction's agreement to share information and cooperate with the state regulator with respect to certified reinsurers.

Certified reinsurers will be rated by the certifying state. The maximum rating that a reinsurer may be assigned will be correlated to the reinsurer's financial strength ratings as set forth in Table 1.

Ratings	Best	S&P	Moody's	Fitch
Secure - 1	A++	AAA	Aaa	AAA
Secure - 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure - 3	A	A+, A	A1, A2	A+, A
Secure - 4	A-	A-	A3	A-
Secure - 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable - 6	B, B-C++, C+ C, C-, D, E, F	BB+, BB, BB- B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3 B1, B2, B3, Caa, Ca, C	BB+, BB, BB- B+, B, B-, CCC+, CC CCC- DD

Table 1

The amendments direct the regulator to use the lowest financial strength ratings assigned to the reinsurer in arriving at a rating. Other factors the regulator may consider include the reinsurer's business practices, its reputation for prompt payment of claims based on an analysis of cedants' Schedule F reporting, its financial condition and the liquidation priority of claims in its domicile. The regulator also may review the reinsurer's NAIC annual statement blank schedule concerning reinsurance ceded and assumed or for non-U.S. reinsurers a new annual Form CR, which will be required for certified companies. If a reinsurer has been rated by another state accredited by the NAIC, the regulator may defer to that state's rating.

As shown in Table 1, the ratings follow a scale of 1 through 6. Varying levels of collateral are required to ensure credit for reinsurance, depending on the reinsurer's rating as follows: Secure - 1 (0%), Secure - 2 (10%), Secure - 3 (20%), Secure - 4 (50%), Secure - 5 (75%), Vulnerable - 6 (100%). Thus, for example, an insurer ceding to a reinsurer rated "Secure - 1" will earn full credit for reinsurance even if it obtains no collateral from the reinsurer. An insurer ceding to a reinsurer rated "Vulnerable - 6" will need to obtain collateral for 100% of the ceded liabilities to obtain full credit for reinsurance.

The amendments' reduced collateral provisions for a certified reinsurer will apply to reinsurance agreements entered into on or after the effective date of the certification. In addition, the amendments state that any reinsurance agreement entered into prior to the effective date of certification that subsequently is amended and any new reinsurance agreement covering risk for which collateral previously was provided will qualify for reduced collateral only with respect to losses incurred and reserves reported from and after the effective date of the amendment or new agreement. The amendments' limited effectiveness with respect to in-force business could make it difficult for parties to take advantage of them for existing reinsurance arrangements.

For unauthorized reinsurers who use a multi-beneficiary trust to meet collateral requirements, the amendments permit the reinsurer to reduce the amount of trusteed surplus if it has permanently discontinued underwriting new business secured by the trust for at least three years and the state regulator with primary regulatory oversight of the trust authorizes the reduction based on a risk assessment. In addition, the amount of trusteed surplus is lower for a multi-beneficiary trust established by a certified reinsurer.

NAIC model laws, of course, do not have the force of law in any U.S. jurisdiction. Therefore, at this point the amendments essentially constitute a recommendation by the NAIC to the states. Although many states adopt laws following NAIC models in whole or in part, it remains to be seen how many states will adopt the amendments. This dynamic would change if the NAIC were to make adoption of the amendments a condition of state accreditation, in which case all states almost certainly would adopt them in full. Nevertheless, because changes to NAIC accreditation standards generally take at least four years to become effective, any such development is a long way off. ❑

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REMEMBER WHEN RICO WAS ABOUT THE MAFIA?

By Jessica F. Pardi

In 1970, Congress enacted the Organized Crime Control Act within which is the Racketeer Influenced and Corrupt Organizations Act better known as "RICO" (codified as amended at 18 U.S.C. §§ 1961-68 (2011)). The primary target of RICO was organized crime, but the statute was drafted without any such limitation to its applicability. Indeed, RICO has been compared to the Ku Klux Klan Act of 1871, which while aimed at the Klan in the south after the Civil War, could be applied to any person depriving another of his or her civil rights. (18 U.S.C. §§ 241-242 and 42 U.S.C. § 1981, *et seq.*).

Because RICO's civil sanctions include injunctions, treble damages, costs and attorneys' fees, it is a desirable vehicle to attack all types of business practices including those of insurers. In addition to the Federal RICO statute, 33 states have enacted their own racketeering legislation. Under the Federal RICO statute, plaintiffs must show both a criminal enterprise and a pattern of racketeering activities, though the term "enterprise" can be broadly defined and encompass almost anything. Indeed, the Eleventh Circuit held that a pick-up basketball game could be considered an "enterprise." *U.S. v. Pipkins*, 378 F.3d 1281 (11th Cir. 2004), citing *U.S. v. Elliott*, 571 F.2d 880 (5th Cir. 1978). Some state's statutes have lesser requirements. For example, in Georgia, there is no requirement that a plaintiff plead or establish an "enterprise."

In essence, plaintiffs now easily convert allegations of garden variety misdeeds or simple fraud into RICO claims and subject insurers to the threat of treble damages, attorneys' fees and costs. Class actions now routinely contain RICO claims because the class criteria such as numerosity and commonality lend themselves to the requisite pattern of racketeering activity. Insurers facing RICO allegations are not without defenses however. To take advantage of RICO's enhanced damages, plaintiffs must plead sufficiently each

statutory component or have their RICO claim dismissed. Two recent examples of insurer victories in RICO claims are CIGNA's victory in *North Cypress Medical Ctr. Operating Co. v. CIGNA Healthcare,* U.S. Dist. Ct. S.D. Tex. Case No. 4:09-CV-2556 (order dated November 3, 2011), and Aetna's victory in *Association of New Jersey Chiropractors v. Aetna, Inc.,* 2011 WL 2489954 (D.N.J.) (decided June 20, 2011).

North Cypress claimed CIGNA reimbursed amounts substantially less than what should have been paid under CIGNA's subscriber healthcare plans. To successfully plead a RICO claim under § 1962(a), North Cypress had to allege the following: (1) the existence of an enterprise; (2) that CIGNA derived income from a pattern of racketeering activity; and (3) that CIGNA used any part of that income in acquiring an interest in or operating the enterprise. Additionally, North Cypress was required to plead a nexus between the alleged violation and injury. CIGNA moved to dismiss on the following three grounds: (a) North Cypress failed to plead any distinction between or among the different CIGNA affiliates involved in the alleged scheme and therefore failed to plead the existence of both the requisite RICO "person" and RICO; (b) North Cypress's failure to plead that CIGNA used its income to acquire or operate the alleged enterprise; and (c) North Cypress failed to allege how CIGNA's use or investment of purported racketeering income injured North Cypress. Alleged injury flowing solely from the predicate acts themselves (and not from use or investment of racketeering income in the enterprise) is not sufficient to state a federal RICO claim. North Cypress alleged CIGNA's extortion caused it harm, but North Cypress failed to explain in the complaint how it was injured because CIGNA acquired or maintained an enterprise. Accordingly, the court dismissed the RICO claim against CIGNA.

Similarly, in *Association of New Jersey Chiropractors v. Aetna, Inc.,* 2011 WL 2489954 (D.N.J.) (decided June 20, 2011), the court found that the Association of New Jersey Chiropractors failed to state a RICO claim against Aetna for three reasons. First, they failed to plead a RICO "enterprise." The court found that Aetna and its affiliates alleged to be part of the "enterprise" had nothing more than ordinary business relationships. Facts describing the ordinary operation of business relationships are not sufficient to state a RICO claim. Second, the RICO claim failed because the "enterprise" as alleged by the chiropractors was insufficiently distinct from Aetna itself. A RICO claim requires the existence of two distinct entities – a person or company charged with violating the RICO statute and an "enterprise." The "person" charged with violating the RICO statute cannot be the same entity as the "enterprise." Finally, the chiropractors did not plead adequately the requisite injury to business or property proximately caused by the alleged RICO violation. A plaintiff cannot bring a RICO claim unless he has suffered a concrete financial loss. Boilerplate allegations of an injury to business or property resulting from an alleged RICO violation are not sufficient.

While insurers face the potential of stiff penalties with the increasing commonality of RICO claims, carefully parsing the statutory requirements and comparing them to the allegations of the RICO claims may reveal winning RICO defenses.❑

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In *National Risk Retention Association v. Brown*, 927 F. Supp. 195 (M.D. La. 1996), the court expressly rejected Louisiana's attempt to impose extensive extra-statutory application requirements on a non-domiciliary RRG. Louisiana conditioned registration of a non-domiciliary RRG upon submission of a $600 fee, policy forms and applications, articles of incorporation, bylaws, biographical affidavits and fingerprints of directors and officers, a certificate of compliance from the domiciliary state, a domiciliary state certificate of authority, responses to interrogatories and a completed questionnaire from a domiciliary state regulator.

The court held the Louisiana application requirements were "broader than is allowed by the LRRA." 927 F. Supp. at 201. Instead, the court found that § 3902(d) specifies the registration requirements for a non-domiciliary RRG and that provision limits the requirements to a copy of the RRG's plan of operation or feasibility study and an annual statement. *Id.* Although the court held the non-domiciliary regulator also may require documents necessary to show compliance with the state's unfair claim settlement practice laws, it concluded that RRGs "are exempted from any further requirements under § 3902(a)(1)." *Id.*

No other published case has considered the issue of non-domiciliary registration requirements. Thus, there is no ambiguity as to the meaning of the plain language of the LRRA.

Fees

The GAO Report also mischaracterizes the LRRA's provisions regarding fees by stating:

> LRRA allows non-domiciliary states to require RRGs to pay premium and other taxes but does not explicitly state whether non-domiciliary insurance regulators can or cannot charge fees. The silence of LRRA on fees has prompted state insurance regulators and RRG representatives to interpret the law differently.

GAO Report at 27.

The LRRA is not "silent" on fees. The GAO Report's analysis is directly contrary to the plain language of the LRRA which broadly and expressly exempts non-domiciliary RRGs from *any* law other than those exempted under § 3902(a)(1). Among the laws expressly exempted from preemption are those relating to premium and other taxes. Thus, the plain language of the LRRA specifies the monies that may be levied against RRGs and the only type permitted are premium taxes.

Again, of the federal courts that have addressed the issue of fees under the LRRA, *none* has held that fees other than premium taxes are permissible. The GAO Report acknowledges the court findings in *Brown* and *Attorneys' Liability Assurance Society, Inc. v. Fitzgerald,* 174 F. Supp. 2d 619 (W.D. Mich. 2001) wherein fees assessed by non-domiciliary regulators were barred under the LRRA. Although the GAO Report attempts to narrow the application of those decisions by stating that the courts did not hold that "all fees" charged by non-domiciliary regulators were barred, it concedes the *Fitzgerald* court held the fees that were not a "tax" and used for regulatory purposes only were impermissible under the LRRA. *See* GAO Report at 29. Thus, implicitly, the GAO Report recognizes any fee that cannot be characterized as a tax is barred by the LRRA.

In *Fitzgerald*, the court correctly reasoned:

> The LRRA's purpose would be thwarted if every state could exact a regulatory fee this large from non-resident risk retention groups, since that fee collectively affects prices for coverage, and thus affects the ability to operate. Congress could have provided an exception for non-chartering states to collect a fee sufficient to cover costs of permitted regulation, over and above allowing collection of premium taxes. But it did not, which require the conclusion that the regulatory fee was preempted.

Fitzgerald, 174 F. Supp. 2d at 636.

Accordingly, the provisions of the LRRA relating to fees and federal case law interpreting those provisions unanimously conclude regulatory fees that are not "taxes" are barred under the LRRA.

Financial Responsibility and Non-Discrimination

Because the LRRA permits states to specify "acceptable means of demonstrating financial responsibility" under § 3905(d), some state regulators have relied upon § 3905(d) as a basis for regulating non-domiciliary RRGs. However, § 3905(d) is subject to the non-discrimination provisions of § 3902(a)(4) and thus, any required demonstration of financial responsibility must be non-discriminatory against RRGs.

The GAO Report correctly recognizes a split in federal courts' interpretation of the LRRA's financial responsibility and non-discrimination provisions. *See* GAO Report at 31-33. In *Ophthalmic Mut. Ins. Co. v. Musser*, 143 F.3d 1062 (7th Cir. 1998) and *Mears Transp. Group v. Dickinson,* 34 F.3d 1013 (11th Cir. 1994), the courts held state financial responsibility requirements that did not "intentionally" discriminate against RRGs did not violate the LRRA's non-discriminatory provision. However, the GAO Report failed to recognize that the *Musser* and *Mears* decisions are in direct conflict with express Congressional intent of the LRRA, as recognized in the more recent case of *National Warranty Ins. Co. RRG v. Greenfield,* 214 F.3d 1073 (9th Cir. 2000); *see also Charter Risk Retention Groups Ins. Co. v. Rolka, et al.,* 796 F. Supp. 154 (M.D. Pa. 1992).

Conclusion

The GAO generally addresses its work with thoroughness and impartiality. It succeeded in its analysis of the financial and regulatory health of the RRG industry, but failed in its analysis of state regulatory behavior. Why? The meaning of the federal law and the cases interpreting it could not be more clear regarding the prohibitions on the states charging fees and imposing excess registration requirements. The GAO's unwillingness to state the obvious regarding state behavior is an unqualified failure.❑

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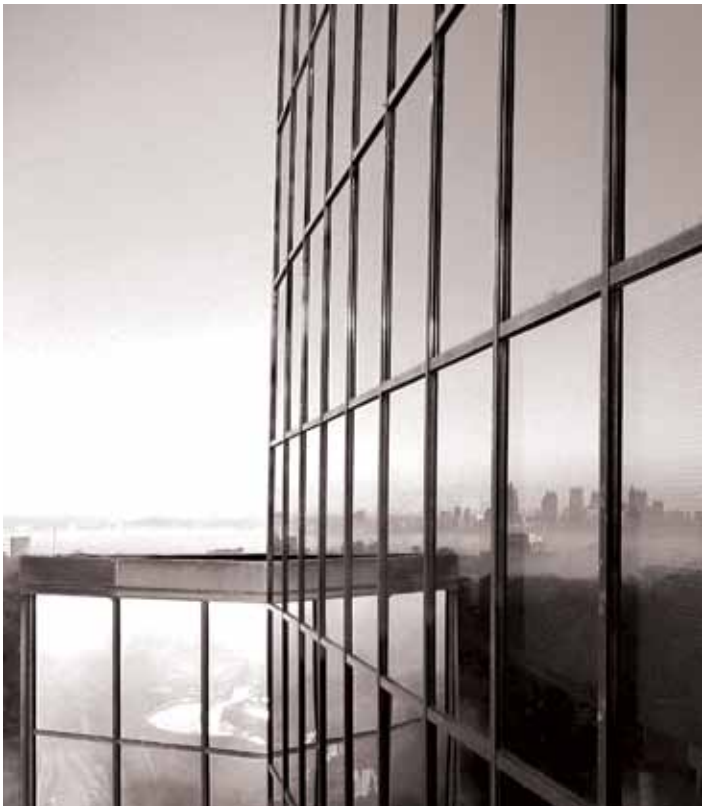

HASSETT'S OBJECTIONS

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insurance industry unless Congress expressly provides otherwise. *See Am. Bankers Ins. Co. of Fla. v Inman,* 436 F.3d 490 (5th Cir. 2006); *McKnight v. Chicago Title Ins. Co.*, 358 F.3d 854 (11th Cir. 2004).

Just in time for insurers, the filed rate doctrine has gained momentum. Most recently, in *Armour v. Transamerica Life Ins. Co.,* Case No. 11-2034 (D. Kan. January 25, 2012), the court dismissed a putative class action as barred by the filed rate doctrine. The plaintiff alleged that Transamerica had sold long-term care policies under an unreasonable actuarial assumption which, unknown to the plaintiff but known to Transamerica, would and did result in subsequent rate increases. Based on that premise, the plaintiff asserted purported causes of action for fraud, negligent misrepresentation, breach of duty of good faith and fair dealing, breach of contract and unjust enrichment. *Id.* at 2. Transamerica moved to dismiss the case under the filed rate doctrine. Specifically, because it had filed its rates with the Kansas Department of Insurance, Transamerica claimed those rates could not be altered collaterally via litigation. The court agreed and dismissed the case.

The essence of the filed rate doctrine is that a rate that is filed or approved by a governing regulatory authority is *per se* reasonable and unassailable in judicial proceedings. *Id.* at 3. The doctrine originated in cases involving federal regulatory agencies but over the years has spread to state agencies (particularly utilities) and ultimately to insurance companies. *See Keogh v. C.N. Ry. Co.,* 260 U.S. 156 (1922) (Interstate Commerce Commission); *Ark. La. Gas Co. v. Hall*, 453 U.S. 371 (1981) (Federal Energy Regulatory Commission); *Taffet v. Southern Co.,* 967 F.2d 1483 (11th Cir. 1992) (State Public Service Commissions); *Coll v. First Am. Title Ins. Co.,* 642 F.3d 876, 886 (10th Cir. 2011) (title insurance); *Clark v. Prudential Ins. Co. of Am.,* 736 F. Supp. 2d 902, 913-914 (D.N.J. 2010) (health insurance); *Schilke v. Wachovia Mortg. FSB,* Case No. 09-CV-1363 (N.D.Ill. Sept. 28, 2011) (hazard insurance) (vacated on other grounds); *Richardson v. Standard Guar. Ins. Co.,* 371 N.J.Super. 449, 853 A.2d 955, 964 (N.J.Super. A.D. 2004) (holding the filed rate doctrine applies to the insurance industry and noting "the considerable weight of authority from other jurisdictions that have applied the filed rate doctrine to ratemaking in the insurance industry"); *Schermer v. State Farm Fire and Cas. Co.,* 721 N.W.2d 307 (Minn. 2006) (applying the filed rate doctrine to the insurance industry); *In re Cincinnati Ins. Co.,* 51 So. 3d 298 (Ala. 2010).

The filed rate doctrine promotes two policy goals: (1) eliminate discrimination among rate payers; and (2) prevent courts from engaging in disguised rate-making, which should be reserved to regulatory agencies. As a result, the filed rate doctrine bars not only breach of contract claims, where the insured claims the insurer promised a rate less than the filed rate, but also bars tort claims where the relief sought would be essentially a disguised deviation from the filed rate. *See Armour* at 3. *See also AT&T Co. v. Central Office Tel., Inc.,* 524 U.S. 214, 222 (1998) ("Even if a carrier intentionally misrepresents its rates and a customer relies on the misrepresentation, the carrier cannot be held to the promised rate"); *Cincinnati Ins.,* 51 So. 3d at 309 (filed rate bars judicial inquiry into adequacy of disclosure of rate). While the rule is "sometimes harsh and seemingly merciless," it accords with the legal presumption that all persons are presumed to know the filed rates. *Armour* at 3; *see also Kansas City Rwy. Co. v. Carl,* 227 U.S. 639, 653 (1913) (consumer's knowledge of filed and approved rates conclusively presumed); *Cincinnati Ins.,* 51 So. 3d at 309 (same).

The *Armour* court applied the filed rate doctrine where the regulator did not affirmatively approve rates but retained the right to disapprove them. *Armour* at 4. Similarly, it did not matter whether the public was allowed to comment on proposed rates prior to implementation. *Id.* Given that the application of the filed rate doctrine to state law claims does not implicate important federal interests, as do the antitrust laws, courts have not drilled into the depth of the state regulation. *Compare F.T.C. v. Ticor Title Ins. Co.,* 504 U.S. 621 (1992) (state ratemaking immune from federal antitrust laws only where state supervision is active). The level of rate regulation is up to the states.

Finally, the *Armour* decision addressed a practical consideration. The typical class plaintiff's main objective is to survive a motion to dismiss and go straight to class certification, which might lead to a settlement. As a result, the typical complaint is broad and as vague as allowed under pleading rules. If a defendant seeks to introduce evidence, the motion may be converted to one for summary judgment and, perhaps, stayed pending discovery.

In *Armour*, the defendant introduced rate filings in support of its motion to dismiss. Rejecting the plaintiff's challenge, the court held it could take judicial notice of the rate filings on the motion to dismiss. Other courts agree. *See Pacificorp v. Northwest Pipeline GP,* Case No. CV-10-99 (D. Ore. June 23, 2010); *see also Bryant v. Rich*, 530 F.3d 1368 (11th Cir. 2008) (evidence properly considered in adjudicating motion to dismiss for failing to exhaust administrative remedies).

The battle is not over. Insurers should expect plaintiffs to devise theories and measures of recovery to avoid the filed rate doctrine, but insurers should be gratified to see the growing application of the doctrine in insurance class actions. ❑

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