



Insurance Reinsurance Managed Healthcare Review

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LETTER FROM WASHINGTON

THE EMERGING NAIC

“NATURE ABHORS
A VACUUM”
-- ARISTOTLE

By Robert H. Myers, Jr.

The financial crisis of 2008 and the changing global insurance market place is stressing the regulatory structure that has been in place since the passage of the McCarran-Ferguson Act in 1945. For decades, the U.S. insurance industry had to contend with state regulators and the federal government only in regard to securities (SEC), tax (IRS) and healthcare (HHS). The National Association of Insurance Commissioners (“NAIC”) was the agent of the states, a forum where the states could get together to discuss common problems, try to find common solutions, and then develop model laws and regulations to be adopted by the states.

The adoption by the NAIC of the state accreditation program was the first step toward a more uniform system of regulation on a national scale. In order to be accredited, a state must adopt all of the laws, regulations and staffing requirements established by the NAIC (as developed and voted on by the states). The precipitating force was a series of hearings held in the early 90’s by the House Energy and Commerce Committee, which exposed the lack of coordination among many of the states on various issues, but particularly solvency regulation. While the accreditation program is entirely voluntary for the states, there is a penalty for failure to comply with all the accreditation standards, namely loss of accreditation, which no state wants and no state has yet suffered.

The power to grant and revoke accreditation resides with the NAIC. This raises the question of whether the NAIC is merely facilitating state regulation or whether it is either directly or indirectly regulating.

This issue has been acknowledged by the industry, but has remained relatively dormant until recently. The emergence of insurance as an issue of such importance to the financial well-being of the U.S. has pushed the NAIC to take an ever more visible role on the national stage.

There are numerous examples. The most obvious is the role played by

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HASSETT’S OBJECTIONS

SUPREME COURT ROUND-UP

By Lewis E. Hassett



During its most recent term, the Supreme Court issued one of the most significant insurance decisions in decades. The Court’s decision in *National Federation of Independent Business v. Sebelius*, Case Nos. 11-393, 11-398, 11-400 (U.S. June 28, 2012), has been and will be debated for years. The essential holding of the majority is that the individual mandate of the Patient Protection and Affordable Care Act is within Congress’s power to tax and that Congress cannot condition existing levels of Medicaid funding on a state’s participation in the expansion of Medicaid under the Act. A different majority held the Act unconstitutional under the Commerce Clause, accepting the challengers’ argument that Congress may not require the purchase of insurance and then regulate it.

In *Armour v. City of Indianapolis*, Case no. 11-161 (U.S. June 4, 2012), the Court addressed constitutional considerations in the context of refunds of taxes and assessments. The City of Indianapolis funded sewer projects by apportioning the costs equally among abutting lots. After the completion of a particular project, the City sent

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NINTH CIRCUIT RULES THAT A POLICY-LIMIT DEMAND IS NOT A CONDITION TO BAD FAITH LIABILITY IN THIRD-PARTY CLAIMS

By Lewis E. Hassett and J. Ben Vitale



Insurers are well aware of the typical bad faith scenario in third-party claims. Counsel for a claimant sends a demand for policy limits to the insurer in the hope that the insurer does not accept within a time limit specified in the demand. For one

reason or another, the insurer does not accept within the allotted time frame, the claimant declares the policy limits to be open and, following a verdict well in excess of the policy limits, the claimant takes an assignment of the bad faith claim from the insured and sues the insurer.

Insurers understandably despise these types of claims and, as a practical matter, if unable to prevail on summary judgment, will settle them. They fear, with justification, that a jury will focus on the claimant's injuries and the insurer's deep pockets without regard to the merits of the actual claim for bad faith. With those parameters in mind, the claimant need only raise a question of fact as to the insurer's bad faith.

In most states, a policy-limit demand is a condition for bad faith liability. *See American Guarantee & Liability Ins. Co. v. U.S. Fidelity & Guar. Co.*, 668 F.3d 991 (8th Cir. 2012) (applying Missouri law); *Yorkshire Ins. Co. v. Seger*, 279 S.W.3d 755, 768 (Tex. App. 2007); *Little Princess Express Cab Corp. v. American Transit Ins. Co.*, 785 N.Y.Supp. 2d 430 (N.Y.App. Div. 2004); *Chandler v. American Fire & Cas. Co.*, 879 N.E.2d 396 (Ill. App. 2007); *Tokio Marine v. Macready*, 803 F.Supp. 2d 193 (E.D.N.Y. 2011) (applying New York law); *Pride Transp. v. Continental Cas. Co.*, 804 F.Supp. 2d 520 (N.D.Tex 2011) (applying Texas law); *Phillips v. Bramlett*, 288 S.W.3d 876 (Tex. 2009); *Haddick ex rel. Griffith v. Valor Ins.*, 763 N.E.2d 299 (Ill. 2001); *Fulton v. Woodford*, 545 P.2d 979 (Ariz. App. 1976); *CBLPath, Inc. v. Lexington Ins. Co.*, 900 N.Y.S. 2d 462 (N.Y.App. Div. 2010); *Ortega-Maldonado v. Allstate Ins. Co.*, 519 F.Supp. 2d 981 (D.Minn. 2007) (applying Minn. law). Other states go the other way, holding that the insurers' conduct as a whole is subject to examination, regardless of a policy-limit demand. *See ACCC Ins. Co. v. Carter*, 621 F.Supp. 2d 1279 (N.D.Ga. 2009) (applying Georgia law); *Alexander Mfg., Inc. Employee Stock Ownership & Trust v. Illinois Union Ins. Co.*, 688 F.Supp. 2d 1170 (Dist. Or. 2010) (applying Oregon law).

The Ninth Circuit Court of Appeals recently held that California law does not require that a bad faith claim be predicated on the insurer's rejection of a claimant's settlement demand. *See Du v. Allstate Ins. Co.*, Case No. 10-56422 (9th Cir. June 11, 2012). Instead, the court held that an insurer has an affirmative duty to initiate settlement negotiations and make a settlement offer where liability is reasonably clear. Thus, even in the absence of a settlement demand, an insurer may be liable for a bad faith claim. Examining California cases, the court focused on a California statute addressing unfair claims settlement practices. *See Cal. Ins. Code § 790.03(h)*. That section addresses unfair claims settlement practices in the context of the Insurance Unfair Trade Practices Act. While California courts do not allow a private right of action under that Act,

the Ninth Circuit held that a violation of section 790.03(h) can serve as evidence that an insurer breached the implied covenant of good faith and fair dealing and acted in bad faith. *See Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 250 Cal. Rptr. 116 (Cal. 1988) (no private right of action under California Unfair Insurance Trade Practices Act).

Section 790.03(h)(5) specifically identifies as an "unfair claims settlement practice," "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlement of claims in which liability has become reasonably clear." The court held this language required an insurer to not only accept, but to also make reasonable settlement offers once liability has become reasonably clear. Section 790.03(h)(5) was taken directly from the NAIC Unfair Trade Practices Model Act, Section 4(D), which has been adopted by most states. Therefore, in jurisdictions that have not directly addressed the issue of whether an insurer can face bad faith liability in the absence of a settlement demand, insurers should be cautious of waiting for the underlying claimant to make a settlement demand within policy limits before initiating settlement discussions. □

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J. Ben Vitale is an Associate in the firm's Litigation and Insurance and Reinsurance Practices, where he focuses on complex civil and commercial litigation in state and federal court. He regularly handles insurance and reinsurance, real estate and contractual and tort-based business disputes and defends class actions and other complex litigation claims. Mr. Vitale received his undergraduate degree from the University of Florida and his law degree from Vanderbilt University School of Law.



SUPREME COURT DECISION SETS THE STAGE FOR FURTHER REGULATORY ACTION ON THE AFFORDABLE CARE ACT

By Chris Petersen, Joe Holahan and Tony Roehl



The Supreme Court's recent decision¹ upholding most of the Patient Protection and Affordable Care Act ("ACA") raises more questions than it answers, as the focus now will shift to how the ACA's major provisions will be implemented, especially in the states.

In a 5-4 opinion, the Court upheld the ACA's mandate requiring individuals to maintain "minimum essential" health insurance coverage or pay a penalty to the Internal Revenue Service. To reach

1. *Nat'l Federation of Ind. Business v. Sebelius*, 56 U.S. ___ (2012).

Announcements

Skip Myers was elected to the Captive Insurance Companies Association Board.

Larry Kunin was elected to the Executive Council of the Out of State Practitioners Division of the Florida Bar. Larry also serves on the Executive Council of the Business Law Section and is vice-chair of the Computer Law Committee for the Florida Bar.

Jim Maxson was elected to serve on the Executive Committee of the European Life Settlement Association.

Jessica Pardi spoke at the American Conference Institute on Litigating Life Insurance and Annuity Claims in New York City on July 30-31.

Morris, Manning & Martin recently welcomed ERISA specialist **Anthony (Tony) A. Dreyspool** to the firm as Special Counsel. His practice is focused on fiduciary responsibility under ERISA, particularly as it relates to the investment of ERISA plan assets. While a member of the Law Department of The Equitable Life Assurance Society of the United States (now AXA Equitable Life Insurance Company), Tony advised Equitable regarding ERISA as it applied to the investment of Equitable's pension clients' assets and established many separate accounts for pension plans.

Ward Bondurant was named in *Corporate Counsel's* 2012 Top Rated Lawyers Guide to Healthcare. Those included in this list were selected based upon their AV Preeminent Peer Review Rating from Martindale-Hubbell.

Jessica Pardi, Lew Hassett and **Ben Vitale** recently obtained the dismissal of a putative class action prior to any discovery. The plaintiff filed her action in the Superior Court of DeKalb County, Georgia, and alleged misstatements and failures to disclose in connection with the sale of ancillary insurance products. She sought refunds and RICO sanctions for the putative class.

Lew Hassett, Larry Kunin and **Ben Vitale** recently obtained an order dismissing a putative class action in federal court in Florida. The case had been filed in Florida state court and attacked the sale of surplus lines products ancillary to the sale of automobile insurance. The MMM team removed the case to federal court under the Class Action Fairness Act and defeated the class plaintiffs' efforts to remand the case to state court.

Joe Holahan was quoted in an article on the cyber liabilities faced by RRGs and other self-insurance entities appearing in the June edition of the *Risk Retention Reporter*.

Ward Bondurant represented Thompson Insurance Enterprises ("THOMCO"), a privately held program administrator underwriting multi-line, industry-focused insurance programs, in its recent acquisition by Markel Corporation (NYSE: MKL). THOMCO will continue to operate as a separate business operating unit of Markel Specialty.

Chris Petersen was quoted in *LifeHealthPro's* article on the role of state enforcement of major medical insurance in the wake of the Supreme Court's ruling on healthcare reform. Mr. Petersen noted in the article that the individual states must adopt the ACA's insurance reforms if the states want to remain as the front-line regulator on health insurance reform matters.

Ben Vitale recently won a trial on behalf of the sole heir at law to a multimillion-dollar estate. The court entered a directed verdict that the purported will was invalid and unenforceable.

Former insurance associate **Cindy Chang** joined the U.S. Department of Justice as the Special Assistant and Attorney Advisor to Associate Attorney General Tony West.

In June, **Joe Holahan** spoke at the RAA Reinsurance Contracts Conference in New York City on the topic of "Drafting the Access to Records Clause."

On July 12, the MMM Insurance Practice hosted its annual **Insurance Forum** with special guest speaker **Georgia Attorney General Sam Olens**. Topics included recent U.S. Supreme Court decisions, legislative and regulatory updates and an overview of insurance-linked securities, reinsurance, bad faith, class actions, and misrepresentations and rescission.

Skip Myers is speaking at Captive Review Live USA in Chicago, Illinois, September 9-11.

Jim Maxson is moderating a panel entitled "The Evolving Regulatory Landscape" at the 2012 European Life Settlement Association Investor Summit in London on September 26.

Chris Petersen is speaking at the Association of Insurance Compliance Professionals National Conference on October 2. Mr. Petersen will be speaking on The Micro-Markets for Ancillary Insurance Products in a post-healthcare reform world.

this holding, the Court construed the mandate as a tax within Congress's constitutional taxing authority.

At the same time, the Court struck down a provision of the ACA under which the states would have been required to accept a major and costly expansion of Medicaid or risk losing all funding for existing Medicaid programs. Under the ruling, the states may accept the Medicaid

expansion but will not be penalized if they elect not to do so. All other provisions of the ACA are left in place.

The Court's decision means that all of the ACA's insurance reforms remain valid and enforceable, including guaranteed issue, community rating of insurance and the establishment of insurance exchanges, all of which will become effective in 2014. Also surviving are the ACA's

revenue-generating provisions relating to health insurers and insurance plans, including the limit on deductibility of executive compensation, the annual policy fee, the “Cadillac plan” excise tax and the provision under which health insurers collectively will pay the federal government a large annual assessment, starting at \$8 billion in 2014 and growing to \$14.3 billion by 2018.

The Supreme Court’s decision will increase the pressure on states to take action to implement all or parts of the ACA. States, in particular, will need to examine closely the ACA’s provisions regarding exchanges, insurance market reforms and Medicaid expansion to determine what action, if any, the state should take in reaction to the Court’s ruling.

As a result of the ruling, it is clear that exchanges will play a significant role in the future distribution of health insurance. The ACA, and the Department of Health and Human Services’ (“HHS”) regulation implementing the ACA, envision three potential forms of exchanges: (1) a state-created and run exchange (“state-based exchange”); (2) a federally-created, but state-managed exchange (“partnership exchange”); or (3) a federally-created and run exchange (“federally-facilitated exchange”).

Issues that states must consider include to what extent the state will want to influence the operation of the exchange and their individual citizens’ experience with the exchange. If a state chooses to manage a federal partnership exchange, the state also will need to consider how to finance these management functions. Will the funds come from the federal exchange through the exchange’s ability to assess participating insurers, or will the state need to create its own funding source to pay for the cost of managing with the federal exchange?

Perhaps the largest exchange-related issue states must consider will be the availability of subsidies for those individuals that qualify for premium assistance under the ACA. Republican members of Congress have argued the subsidies are available only through state-based exchanges. If this position prevails, states might feel compelled to adopt exchanges to ensure the subsidies are available for their residents. The final issue is how much leeway HHS will provide states to meet their obligations to offer a state-based exchange or to participate in a partnership exchange.

All of the ACA’s “insurance reforms” remain in place under the Court’s ruling, thus confronting states with the question of whether they will adopt the reforms at the state-level. Absent state action, the enforcement of the insurance reforms falls back to HHS. Following adoption of insurance reforms under the Health Insurance Portability and Accountability Act (“HIPAA”), each of the states enacted similar reforms to ensure that state insurance departments could enforce the reforms under state authority. This process, however, took some time, resulting in direct federal enforcement of the law in a few states for a period of time before state authorities were willing or able to assume enforcement powers.

States also will likely debate whether to expand their Medicaid programs. The Court’s ruling provides that the ACA’s Medicaid expansion is voluntary, i.e., states will not lose their existing Medicaid funding if they fail to expand their programs as contemplated under the

ACA. Each state must weigh the pros and cons of the ACA’s significant influx of federal dollars against existing state budgetary woes.

On the federal level, there likely will be a lot of activity in Congress, but it is quite unlikely there will be much, if any, action with real effect until after the November elections. On the regulatory front, HHS was operating under the assumption that the ACA was constitutional, so it will be business as usual there. As a result, expect to see several new regulatory initiatives released over the next several months. Like HHS, the National Association of Insurance Commissioners also has been moving forward on ACA implementation, most recently with the development of five exchange plan management white papers. Next up for the NAIC is consideration of model legislation to implement the ACA insurance reforms at the state level. □

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BACK TO BASICS: REQUIRED ELEMENTS OF AN MGA AGREEMENT¹

By Tony Roehl



Managing General Agent (“MGA”) Agreements are unique and can be exceedingly complex. They often include detailed underwriting guidelines and strict limits on an MGA’s authority. After all, an MGA is authorized to bind an insurer on substantial risks often with little direct supervision by the insurer. While no two MGA Agreements are the same, all must incorporate certain required provisions. The NAIC has promulgated the Managing General Agents’ Act (NAIC Model No. 225) (“Act”), which has been adopted in some form in every state. The Act sets forth the minimum requirements for an MGA Agreement, and those requirements

1. This article addresses only the required contract provisions. Insurers entering into an MGA Agreement also are required to take certain steps to audit and monitor the MGA.

are the subject of the chart that follows. Because states often modify an NAIC Model law, the chart is only a starting point for analyzing an MGA Agreement's compliance. A complete analysis requires a review of governing state law.

The Act defines Managing General Agent as any person who: (1) manages all or part of the insurance business of an insurer (including management of a separate division, department or underwriting office);

and (2) produces separately or together with affiliates an amount of gross direct written premium equal to or greater than 5% of the insurer's policyholder surplus as reported on its last annual statement and who (i) adjusts or pays claims in excess of \$10,000 per claim; or (ii) negotiates reinsurance on behalf of the insurer. The Act requires a written contract which sets forth the responsibilities of each party and contains the following provisions:

Category	Action Item
Termination	<ul style="list-style-type: none"> • The insurer must be able to terminate the contract for cause upon written notice to the MGA.
Premium Reporting and Payment	<ul style="list-style-type: none"> • The MGA is required to provide detailed transaction reports on a monthly basis including remitting all funds due under the contract. • The MGA must hold all funds collected for the account of the insurer in a fiduciary capacity in an FDIC-insured financial institution. The bank account shall be used for all payments on behalf of the insurer, and the MGA may retain no more than three months estimated claims payments and allocated loss adjustment expenses. • The MGA is required to maintain separate records of all business written, and the insurer must have the right to access and copy all accounts and records related to its business. The Commissioner of Insurance is required to have similar access.
Underwriting Guidelines	<ul style="list-style-type: none"> • The agreement must include appropriate underwriting guidelines including at a minimum: <ul style="list-style-type: none"> • Maximum annual premium volume on the basis of the rates to be charged • Types of risks which may be written • Maximum limits of liability • Applicable exclusions • Territorial Limitations • Policy cancellation provisions • Maximum policy period • The insurer must maintain the right to cancel or non-renew any policy written by the MGA subject to applicable laws and regulations. • The insurer may suspend the MGA's underwriting authority during the pendency of any dispute regarding the cause for termination.
Insurance Coverage	<ul style="list-style-type: none"> • The MGA is required to maintain a surety bond for the protection of the insurer of at least \$100,000 or 10% of the MGA's total annual written premium produced for the insurer, but in no event greater than \$500,000. The insurer may also require the MGA to maintain an errors and omissions insurance policy.
Claim Settlement	<ul style="list-style-type: none"> • If the MGA is permitted to settle claims on behalf of the insurer: <ul style="list-style-type: none"> • All claims must be reported to the company in a timely manner; • A copy of the claim file must be sent to the insurer at its request or as soon as it becomes known that the claim: <ol style="list-style-type: none"> 1. has the potential to exceed a predetermined amount set by the insurer's domiciliary Commissioner of the insurer; 2. involves a coverage dispute; 3. may exceed the MGA's claims settlement authority; 4. is open for more than six months; or 5. is closed by payment equal to or in excess of an amount set by the Commissioner of the insurer. • All claim files are the joint property of the insurer and the MGA. However, if the insurer is subject to an order of liquidation, the claim files become the sole property of the insurer. • The insurer may terminate the MGA's claim settlement authority upon written notice or the termination of the MGA Agreement. • MGAs are prohibited without prior approval from the insurer from paying a claim in excess of 1% of the insurer's policyholder surplus as of the end of the previous calendar year. • If electronic claim files are used, the MGA Agreement must include requirements for the timely submission of electronic claims data.

Category	Action Item
Profit Sharing	<ul style="list-style-type: none"> • If the agreement provides for interim profit sharing between the MGA and the insurer, and the MGA has the authority to determine loss reserves or controls claims payments, profits cannot be paid to the MGA until one year after they are earned for property insurance and five years after they are earned on casualty insurance, and then only once the insurer has verified the adequacy of the loss reserve estimate through an actuarial opinion.
Reinsurance	<ul style="list-style-type: none"> • The agreement must prohibit MGAs from binding reinsurance or retrocessions on behalf of the insurer except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines. These guidelines need to include both reinsurance assumed and ceded, a list of reinsurers with whom such automatic agreements are in effect, and the coverages and amounts or percentage that may be reinsured with commission schedules. • MGAs are prohibited from committing the insurer to participate in insurance or reinsurance syndicates. • MGAs are prohibited from collecting any payment from a reinsurer or committing the insured in a claim settlement with a reinsurer without the insurer's prior approval.
Miscellaneous	<ul style="list-style-type: none"> • The agreement may not be assigned either in whole or in part by the MGA. • The MGA is restricted to using only advertising materials that have been approved in writing by the insurer in advance of their use. • The agreement must prohibit the MGA from: <ul style="list-style-type: none"> • permitting a subproducer to serve on the insurer's board of directors (unless the subproducer is affiliated with the insurer); • jointly employing an individual with the insurer or appointing a sub-MGA; or • appointing any producer without first determining that the producer is lawfully licensed to transact the type of insurance for which he is appointed.

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the NAIC in the legislative debate surrounding the Patient Protection and Affordable Care Act ("PPACA"). The NAIC has been a vigorous advocate of state regulation and has had a substantial impact on PPACA and its interpretation by regulation. The NAIC's involvement in PPACA is substantially greater than it was, for example, in the Health Insurance Portability and Accountability Act ("HIPAA") and the Terrorism Risk Insurance Act ("TRIA"). In both those cases, the NAIC served only as an instrumentality of the states to work with the federal government in the development and adoption of laws and regulations implementing federal law.

Another example is the passage of the Wall Street Reform and Consumer Protection Act ("Dodd-Frank"), which was almost exclusively a banking bill, but did include one title (Title V) addressing insurance issues. Title V established the Federal Insurance Office ("FIO") within the Department of the Treasury. The FIO was created to be a repository of information about the insurance industry within the federal government, the lack of which had always limited Congress's ability to enact well-crafted legislation. Title V grants to the FIO the ability to collect information about the insurance industry, publish a study on insurance regulation

and represent the federal government in international negotiations affecting insurance. It has no other authority, and the NAIC was a key participant in the legislative haggling that resulted in this legislative constraint on FIO's authority.

The second part of Title V, the Nonadmitted Insurance and Reinsurance Act ("NRIIRA"), drew the attention of the NAIC, as well. NRIIRA was designed to streamline the administration of the surplus lines market. While the legislation could not mandate that the states implement a system (e.g. interstate compact) to allocate the surplus lines tax paid to a single state to all the relevant states, it did encourage the states to do so. The NAIC developed a plan for the states to do so but has not succeeded in generating a critical mass of support.

Another example would be the Government Accountability Office's ("GAO") recent report on risk retention groups ("RRGs") (GAO-12-16), which addressed the financial and regulatory health of the RRG market and the extent to which non-domiciliary states exceeded their authority in regulating RRGs. Interestingly, the GAO treated the NAIC (not the states) as if it were the relevant regulating agency and allowed the NAIC to present the regulator's perspective in the final report.

The common thread in all of the above is that the NAIC was able to act (and some would say was required to act) because there is no other actor. The NAIC is the only entity that has the information and capability to opine on insurance regulation on a national basis. Because insurance always has been regulated by the states, there is no federal agency with oversight authority and no committee in Congress with the experience and information to play a regulatory role.

However, the recent visibility of the NAIC has attracted the attention of Rep. Edward Royce, a supporter of a greater role for the federal

government in the regulation of insurance. Rep. Royce first wrote to the NAIC in February asking some pointed questions about the NAIC's status as a private entity and whether it was a "standard setting organization." Rep. Royce followed up with a letter in July to the FIO in which he asked the FIO to review the "nature and scope of NAIC operations" to determine, among others things, whether the NAIC is engaging in "regulatory activity."

This will be one of the more interesting insurance stories in the coming year. The NAIC stepped up to fill the regulatory void. What will be the consequence? Will the FIO respond to Rep. Royce's request? Will Congress and federal agencies continue to rely on the NAIC as a source of information about the insurance industry? Will the FIO emerge as an alternative source of insurance information for Congress and federal agencies? Will any of the above affect the way insurance will be regulated? Or, will everything revert to the *status quo ante* when the financial crisis subsides? ☐

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Mr. Myers received his bachelor's degree from Princeton University and his law degree from the University of Virginia.



HASSETT'S OBJECTIONS

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affected homeowners formal notice of their payment obligations. The assessed owners could pay the assessment either in a lump sum or in installments. Of 180 affected homeowners, 38 elected to pay the lump sum. The following year, the City abandoned that method of financing in favor of bond issues. The City then relieved owners who had elected to pay in installments from any further obligation but refused to refund lump sum payments. The City contended that the administrative burden of refunds constituted a sufficient distinction under the Equal Protection Clause.

The Supreme Court agreed, finding that the City's distinction needed to pass only a rational basis test and that administrative convenience may justify tax-related distinctions. The rational basis test applied because it did not involve fundamental rights or a suspect classification, such as race or religion, and the City did not distinguish between out-of-state owners and in-state owners.

The practical teaching is that procrastination is good. Unless a particular statute or administrative regulation provides for a refund mechanism based upon changes in the law, any business paying taxes may not benefit from any change in the tax assessment method.

In *Radlax Gateway Hotel, LLC v. Amalgamated Bank*, Case No. 11-166 (U.S. May 29, 2012), the Court upheld a secured creditor's right to credit bid in an auction under the bankruptcy code's "cram-down" provisions. The bankruptcy plan at issue provided for the sale of a hotel

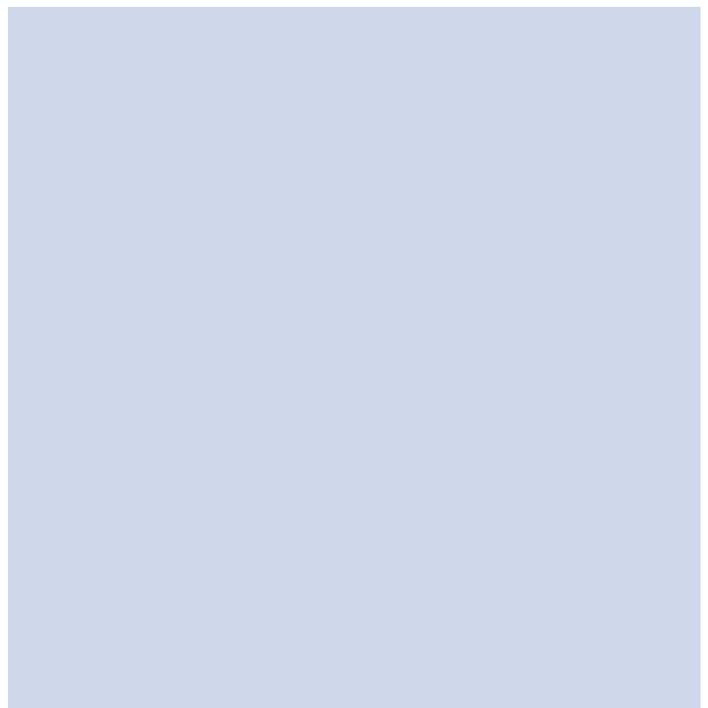
property at auction with the proceeds distributed according to statutory priorities. The twist was that the plan provided that secured creditors could not "credit bid," i.e. submit bids based upon the offset of secured debt as opposed to a cash payment.

The Supreme Court held that creditors have a statutory right to credit bid and that an asset cannot be sold free and clear of a secured lien without the consent of the creditor.

This decision is important to the insurance industry in two ways. First, insurers often are secured creditors in bankruptcy, given that substantial assets are held in real estate loans. Second, state insurer insolvency decisions often look to bankruptcy decisions for guidance. The insolvency laws of many states do not even mention secured creditors, but decisions generally recognize that an insolvency court cannot affect the rights of secured creditors.

The Real Estate Settlement Procedures Act ("RESPA") requires certain disclosures in real estate transactions and prohibits kick-backs or fee-splitting. See 12 U.S.C. § 2607. Over the last several years, title insurers have been the target of numerous putative class actions attacking payments to title insurers and title agents. In *Freeman v. Quicken Loans, Inc.*, Case No. 10-1042 (U.S. May 24, 2012), the Court held that RESPA does not regulate the payment and retention of unearned fees. In that case, consumers alleged that a loan company had charged them for fees for which services were not provided in return. The Supreme Court rejected the consumers' contention, holding that RESPA proscribes only fee-splitting, not a single provider's retention of an unearned fee. ☐

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