LIFE INSURANCE LITIGATION UPDATE

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Over the last year, plaintiffs' lawyers have continued to press some familiar issues in the life insurance arena. In this paper, we address lapse-related litigation, "cost of insurance" litigation, a U.S. Supreme Court decision on a beneficiary revocation by divorce statute, litigation over the "Fiduciary Rule," and a few other cases of interest. While this outline is not all-inclusive, we attempt to capture developments on several of the most litigated issues in the last twelve months.

I. Lapse Litigation

A. Lapse Litigation in California

A number of lapse-related cases have been or are being litigated based upon two statutes in California: California Insurance Code Sections 10113.71 and 10113.72. These statutes primarily do three things: (1) mandate that life insurance policies issued or delivered in California have a 60 day grace period;[1] (2) set forth notice of pending lapse and termination requirements;[2] and (3)

[1] 10113.71 (a) Every life insurance policy issued or delivered in this state shall contain a provision for a grace period of not less than 60 days from the premium due date. The 60-day grace period shall not run concurrently with the period of paid coverage. The provision shall provide that the policy shall remain in force during the grace period.

[2] 10113.71 (b)(1) A notice of pending lapse and termination of a life insurance policy shall not be effective unless mailed by the insurer to the named policy owner, a designee named pursuant to Section 10113.72 for an individual life insurance policy, and a known assignee or other person having an interest in the individual life insurance policy, at least 30 days prior to the effective date of termination if termination is for nonpayment of premium.

* * *

(b)(3) Notice shall be given to the policy owner and to the designee by first-class United States mail within 30 days after a premium is due and unpaid.

require insurers to provide notice to applicants and annual notice to policyholders of their right to designate someone other than themselves to receive lapse notices.[3] These statutes went into effect on January 1, 2013. Noticeably absent from either statute is an express statement that they apply to policies issued or delivered prior to January 1, 2013. The following cases involve alleged violations of the California statutes and are presented chronologically based on when they were filed.

1. Blakely McHugh v. Protective Life Insurance Company, San Diego Superior Court Case No. 2014-00019212 (filed June 13, 2014).

The insured in *McHugh* purchased a life insurance policy on January 9, 2005. The insured failed to make his 2013 premium payment; therefore, on February 9, 2013, the policy lapsed per its express terms. Defendant Protective never received an additional premium payment or reinstatement application from the insured. The insured died in August 2013. Plaintiffs, the policy beneficiaries, sued for breach of contract and bad faith. Plaintiffs claimed that, despite the insured's policy being issued eight years prior to their enactment, Insurance Code Sections 10113.71 and 10113.72 applied to his policy. Among other things, the plaintiffs alleged that because defendant Protective did not provide the insured with a 60-day grace period per code section 10113.71, the lapse notices and subsequent termination of the policy were void.

10113.72 (c) No individual life insurance policy shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the policy owner and to the person or persons designated pursuant to subdivision (a), at the address provided by the policy owner for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail within 30 days after a premium is due and unpaid.

[3] Section 10113.72 contains two provisions pertaining to designation:

(a) An individual life insurance policy shall not be issued or delivered in this state until the **applicant** has been given the right to designate at least one person, in addition to the applicant, to receive notice of lapse or termination of a policy for nonpayment of premium. The insurer shall provide each applicant with a form to make the designation. The form shall provide the opportunity for the applicant to submit the name, address, and telephone number of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy for nonpayment of premium.

(b) The insurer shall notify the **policy owner annually** of the right to change the written designation or designate one or more persons. The policy owner may change the designation more often if he or she chooses to do so. (emphasis added)

The court granted plaintiffs' Motion for Summary Adjudication, finding that Insurance Code Sections 10113.71 and 10113.72 applied to the insured's policy that was issued in January 2005. The case was tried, and despite the summary adjudication ruling, the jury returned a defense verdict. The jury found that there was no harm to plaintiffs due to any breach of the life insurance policy contract by Protective. Protective's argument at trial was twofold: (1) Protective complied with the statute in any event (so no breach) and (2) even if Protective did breach, there was no damage to plaintiffs. The reason Protective was able to assert the latter defense was due to Protective's internal policy – what Protective referred to as the "prompt reinstate" program. Plaintiffs' life insurance policy had a 30-day grace period. Through its communication to policyholders in its lapse notice letters, however, Protective essentially provided the policyholder an additional 30 days to pay the premium and allowed for policy reinstatement without evidence of insurability. Protective argued that the insured effectively had 60 days to reinstate, rendering Protective in compliance with the statute. Any harm that occurred to plaintiffs was due to the insured's refusal to pay his premium.

Plaintiff appealed the order entered on the jury's verdict to the Fourth Appellate District. Briefing is underway but incomplete at this time.

2. Jennifer Bentley v. United of Omaha Life Insurance Company, Case No. 2:15-cv-07870-DMG-AJW (C.D. Cal.) (filed October 7, 2015).

In *Bentley*, the plaintiff's core argument is that the 2013 California statutes apply to pre-2013 policies that renewed in California after the statutes became effective. Notably, the insurance policy in *Bentley* was issued in February 2001 and renewed annually pursuant to an express provision in the insurance contract. The *Bentley* court, in addressing United's motion to dismiss, held that while Sections 10113.71 and 10113.72 "do not apply retroactively," when the policy at issue renewed after January 1, 2013, it incorporated "any changes in the law that occurred prior to the renewal," including the changes imposed by Sections 10113.71 and 10113.72. (ECF Doc. No. 46 at p. 4). The import of the *Bentley* court's ruling is that, absent an annual renewal provision, Sections 10113.71 and 10113.72 do not apply to policies issued prior to January 1, 2013. The court certified a California class on May 1, 2018. United filed a motion for summary judgment on June 15, 2018, arguing that the statutes at issue "plainly and unambiguously apply only to policies issued after the effective date." The court has yet to rule on the motion.

3. Mojgan Gholamnejad v. Pruco Life Insurance Company, Case No. 16-cv-006151 (N.D. Cal.) (filed October 25, 2016)

Defendant Pruco Life issued a life insurance policy on May 9, 2012. The policy had an annual premium due date of September 9th. The insured did not remit the 2015 premium; therefore, on October 10, 2015, the policy terminated. The insured passed away on November 14, 2015. Plaintiffs contend that Pruco Life breached the insurance contract and acted in bad faith by failing to provide to the insured the 60-day lapse notice or the ability to designate a third party to receive notice of lapse per Insurance Code Sections 10113.71 and 10113.72. Defendant Pruco Life filed

an answer to the complaint. The case was dismissed with prejudice due to a confidential settlement on August 18, 2017.

4. Betsy Sullivan v. United Omaha Life Insurance Company, Case No. 4:17-cv-00363-DMR (N.D. Cal.) (filed January 24, 2017)

In *Sullivan*, the plaintiff brought a class action on behalf of herself and all other beneficiaries of guaranteed issue life insurance (GILI) or simplified issue life insurance (SILI) policies issued or delivered in the State of California after January 1, 2013 who received alleged reduced death benefit payments because the United of Omaha GILI or SILI policies lapsed and were continued as reduced paid-up life insurance for nonpayment of premiums without providing notice to policyholders and their designated third parties. Plaintiff alleged that Defendant United of Omaha systematically violated the California statutes by failing to provide the required notice of nonpayment and continuing the policies as Reduced Paid-Up Life Insurance, which results in a significantly lower death benefit payout. This case was dismissed with prejudice on May 1, 2017, due to the parties' confidential settlement.

5. Carmen Clemons v. Transamerica Premier Life Insurance Company, San Bernardino Superior Court Case No. CIVDS1702068 (filed February 6, 2017)

In 2011 Defendant Transamerica issued a life insurance policy to plaintiff insuring the life of her husband. The insured failed to make the required premium payment in 2013 and the policy was cancelled on December 7, 2013. The insured passed away on March 20, 2015. Thereafter, plaintiff submitted a claim for death benefits. Defendant Transamerica conducted a review of its 2013 cancellation of the policy and denied plaintiff's claim for benefits. Plaintiff contended that Defendant Transamerica did not abide by Insurance Code Sections 10113.71 and 10113.72 when it initially lapsed the policy, making the lapse void.

Plaintiff filed a class action complaint claiming that there the common questions of law and fact included whether the provisions of Insurance Code Sections 10113.71 and 10113.72 "applied to Transamerica policies issued before the Effective Date." Defendant Transamerica filed a demurrer, arguing that the statutes only applied prospectively to policies issued and delivered after January 1, 2013. The court denied the demurrer, holding that the 30 day notice provision of Insurance Code 10113.71(b)(1) and 10113.72(c) applied to all policy owners: "[t]his is so even if the policy was issued and or delivered prior to January 1, 2013." Discovery is ongoing in this matter. Plaintiff has indicated that she intends to file a motion for class certification in the near future.

6. Arthur Avazian v. Genworth Life and Annuity Insurance Company, Case No. 2:17-cv-03215-RGK-JEM (C.D. Cal.) (filed April 28, 2017)

In *Avazian*, plaintiff Arthur Avazian brought a class action on behalf of himself and all insureds and beneficiaries of life insurance policies issued or delivered by Defendant Genworth Life and Annuity Insurance Company in California before January 1, 2013 who lost either their coverage or their ability to make a claim owing to the termination of their policies by Defendant Genworth for nonpayment of premium. Plaintiff alleged that Defendant Genworth failed to (a)

provide policyholders an opportunity to designate a third party to receive notice of a potential termination of benefits for nonpayment of premium; (b) provide notice to the designated third party of any nonpayment of premium prior to terminating any policy; and (c) provide 30 days written notice to the policyholder prior to cancelation. Defendant Genworth filed a motion to dismiss the class action complaint, alleging that the statutes do not apply retroactively and that, in any event, Defendant Genworth's practices and policies already complied with California Insurance Code 10113.71 and 10113.72, and thus there was no breach. Plaintiff voluntarily dismissed the action without prejudice on July 12, 2017.

On August 4, 2017, Avazian and additional named plaintiff Michael Torres filed another action against Genworth Life and Annuity Insurance Company, United States District Court for the Central District of California Case No. 2:17-cv-06459-RGK-JEM. The plaintiffs asserted claims for breach of contract, breach of the implied covenant of good faith and fair dealing, and fraudulent business practices in violation of California Business & Professions Code Sections 17200, et seq.

Plaintiffs alleged that, in 1993, Genworth issued a policy to Avazian. Avazian timely made all premium payments to Genworth until 2016. In January 2016, Avazian missed his premium payment, and Genworth subsequently advised Avazian that his policy had lapsed.

Plaintiffs also alleged that, in 1989, Genworth issued a policy to Julio Torres, the father of plaintiff Michael Torres. A trust created by Julio Torres paid over $1,000,000 in premiums before it inadvertently missed the August 2015 premium payment. As a result, Genworth terminated the policy.

The plaintiffs alleged that Genworth terminated their policies without abiding by the requirements in California Insurance Code Sections 10113.71 and 10113.72. More specifically, the plaintiffs alleged that Genworth failed to allow policy holders to designate a third party to receive notice of lapse or termination and failed to give notice of pending lapse and termination at least thirty days before the date of termination to both the policy holders and to the designated third parties. The plaintiffs also alleged that Genworth informed the insureds, the policy owners, and the beneficiaries that it was under no obligation to abide by the statutes with respect to policies issued or delivered prior to January 1, 2013, the date the statutes went into effect.

Plaintiffs brought the action on behalf of themselves and a statewide class defined as all insureds, policy owners, and beneficiaries of life insurance policies issued or delivered by Genworth in California before January 1, 2013, who lost either their coverage or their ability to make a claim owing to the termination of their policies by Genworth for nonpayment of premium.

Genworth filed a motion to dismiss, which was granted on December 4, 2017. With respect to the breach of contract claim, the court ruled that plaintiffs failed to plead sufficient facts to allege a breach. In so ruling, the court stated that it was assuming, but not deciding, that Section 10113 applies retroactively. However, the court stated in a footnote that "a plain reading of § 10113's language ('policies shall not be issued until the applicant has been given the right . . .') indicates no retroactive application." The court stated, however, that it need not decide that issue for purposes of the motion at issue.

The court granted the motion to dismiss the bad faith claim on the grounds that the plaintiffs had not alleged facts showing that Genworth's cancellation of the subject policies was unreasonable or without proper cause, and that the plaintiffs' other allegations were impermissibly conclusory.

Similarly, the court ruled that plaintiffs' claim for fraudulent business practices failed because it was not pleaded with the requisite specificity.

7. Delia Cano Diaz v. American General Life Insurance Company, Case No. 2:17-cv-04095-SVW (KSx) (C.D. Cal) (filed June 1, 2017)

American General issued and delivered the subject life insurance policy to Jorge Diaz on December 28, 2011. The policy required monthly premium payments and contained provisions stating that the policy would lapse and terminate if the premium was not paid before the end of a 31 day grace period. The insured made premium payments during the first four years of the policy's existence, *i.e.*, until December 28, 2015, but then stopped. He died on July 13, 2016. The plaintiffs, beneficiaries of the policy, made a claim for benefits, and American General denied the claim because the policy had lapsed and terminated due to nonpayment of premium. Plaintiffs subsequently sued American General for breach of contract and breach of the implied covenant of good faith and fair dealing. American General filed a motion to dismiss.

Plaintiffs' breach of contract claim was premised on their assertion that the life insurance policy did not lapse because American General purportedly did not comply with California's statutory requirements imposing a longer grace period than appears in the policy and requiring the statutory notifications prior to a policy lapsing or terminating for nonpayment of premium. Plaintiffs also relied on the *Bentley* decision to assert that, once the policy renewed, any change in the law that occurred since the policy's inception would apply – including the mandates of 10113.71 and 10113.72. American General argued in its motion to dismiss, however, that in addition to the argument against retroactive application in general, the statutes do not include "renewal". In other words, the statutes apply to policies "issued or delivered," not "issued, delivered, *or renewed*." American General argued that numerous other statutes contain explicit language stating they apply to policy renewals in addition to policy issuance and delivery, demonstrating that the Legislature would have included language in the statutes pertaining to policy renewals if it wanted the statutes to apply to renewals. The absence of such language demonstrated that the Legislature did *not* intend the statutes to apply to renewals.

Finally, plaintiffs in *Diaz* argued that application of the statutes to the policy at issue would not have a retroactive effect. American General pointed the court to case law stating that "[g]enerally, a law has a retroactive effect when it functions to change the legal consequences of past conduct by imposing new or different liabilities based upon such conduct." *USS-Posco Industries v. Case*, 244 Cal. App. 4th 197, 217 (2016) (internal quotations and citations omitted). "If preexisting rights or obligations are substantially affected, then application of a statute to preenactment conduct is retroactive and forbidden, absent an express legislative intent to permit such retroactive application." *Id.* Here, an application of the statutes to the policy would obviously have a retroactive effect because such an application would effectively rewrite the policy to impose

additional obligations on American General such that it could potentially be sued for violating those obligations.

While American General's motion to dismiss was pending, the case settled on a confidential basis and was dismissed.

8. Michelle L. Moriarty v. American General Life Insurance Company, et al., Case No. 3:17-cv-1709 BTM BGS (S.D. Cal.) (filed August 23, 2017)

In *Moriarty*, the crux of the complaint is that American General was required to comply with California's statutory requirements of: (1) 60 day grace period, (2) 30 day written notice prior to lapse or termination (but after premium payment was due and unpaid) and (3) an annual right to designate someone else to also receive notices of pending lapse or termination. Plaintiff alleged that these statutes apply to all policies issued or delivered prior to January 1, 2013. In other words, the application of these statutes retroactively was central to the survival of their allegations. Plaintiff identified three beneficiary classes that represent those "afforded protections," and three policyholder classes that similarly represent those "afforded protections." American General, along with all other insurers in California, interpreted the statute as only applying to policies issued ***on or after*** January 1, 2013. It does not appear that any policy at issue contained an annual renewal provision akin to that in *Bentley* and consequently would not incorporate any changes promulgated by these statutes -- a key distinction.

The case remains pending. Plaintiff filed a motion to strike American General's defense that the subject statutes apply prospectively only. The court denied plaintiff's motion to strike in an order issued on September 11, 2018, finding that the prospective application issue was unsettled and "more appropriate for a motion for summary judgment on a developed record."

B. Lapse Litigation in New York

1. Lebovits v. PHL Variable Ins. Co., 199 F. Supp. 3d 678 (E.D.N.Y. 2016)

Plaintiff, trustee of the Weberman Family Irrevocable Life Insurance Trust ("Trust"), sued PHL Variable Insurance Company in 2012, seeking a declaration that a universal life insurance policy held by the Trust did not lapse due to nonpayment of premiums. On June 22, 2010, the policy's cash value was depleted and was no longer sufficient to cover the monthly charges. As a result, the policy's grace period went into effect. Under New York Insurance Law § 3203(a)(1), the policyholder had 61 days to cure such default. PHL sent the Trust notice of its default in payment and entrance of the grace period.

Two days before the policy's lapse date, the Trust sent PHL a check for the purported amount due; however, the check was returned for insufficient funds. Two days after the lapse date, PHL received a wire transfer from the Trust exceeding the amount due. PHL rejected the transfer, asserting that the policy had lapsed.

Plaintiff argued that PHL's lapse notices were void because they incorrectly stated the amount due under the contract's terms. In interpreting New York Insurance Law § 3211(a)(1), the court determined that PHL's notices were ineffective if they misstated the premium amount due.

The court then determined that PHL had misstated the amount due, construing the contract's ambiguous definition of amount necessary to cure a default in favor of the insured. Therefore, the court found that the policy remained in effect and ordered Plaintiff to pay the unpaid premiums accrued during the six years since the initial default – stipulated by the parties to be $2,128,542.48. However, because the insured refused to pay the premiums, the court dismissed the case with prejudice on January 13, 2017.[4]

2. Weiss v. Security Mutual Life Insurance Company of New York, 45 N.Y.S.3d 169 (N.Y. App. Div. 2017)

Plaintiff, Benjamin Weiss, sued Security Mutual Life Insurance seeking a declaration that his life insurance policy remained in full force and effect. Plaintiff failed to pay the premium on his life insurance policy for two years, despite numerous notices sent by the insurer. Plaintiff argued that one of the notices was insufficient under New York Insurance Law § 3211(b). New York Supreme Court, Kings County, granted defendant's cross motion for summary judgment, declaring that the policy was no longer in effect. Plaintiff appealed to the Supreme Court Appellate Division. There, the court affirmed the grant of summary judgment, finding that even if the Defendant's notice was insufficient, the Plaintiff's policy lapsed by its terms, and in accordance with New York Insurance Law, one year after the due date of the missed premium payment due to the Plaintiff's failure to seek reinstatement of the policy before the expiration of that one-year period.

3. Jakobovits v. Allianz Life Insurance Company of North America, 2017 WL 3049538 (S.D.N.Y. July 18, 2017)

In June 2017, Plaintiff, trustee of LITE Trust I ("Trust"), sued Allianz Life Insurance Company for breach of contract and declaratory judgment. The claims surround nine life insurance policies purchased by the Trust, an investment trust, during an acquisition of 40 high-value insurance contracts. Aside from two small premium payments made on two of the policies, no payments other than the initial premium payments were made on the policies. As a result, the policies lapsed in 2009 and 2010.

Plaintiff's primary argument was that Allianz's grace notices overstated the minimum payments required to keep the policies in force by between 74% and 584%. In addressing the parties' motions for summary judgment, the court granted complete summary judgment for the insurer on six of the nine policies, finding that the insurer was not notified of changes in ownership, as required by the policies' terms. Due to the lack of notice, the court determined that the Plaintiff lacked an insurable interest in the policies, and therefore also lacked standing to sue on those policies.

On the remaining three policies, the court found that factual issues regarding notification of changes in ownership precluded summary judgment. On the merits of the claims, the court found that Allianz had not breached the contract by overstating the minimum payment required to keep the policies in force, as the policies did not require that the grace notice contain an amount. However, the court found that triable issues of fact remained on Plaintiff's claim of breach of the

[4] *See Lebovits v. PHL Variable Ins. Co*., 2017 WL 5495797 (E.D.N.Y. Jan. 13, 2017).

implied covenant of good faith and fair dealing, under the theory that Allianz intentionally demanded excess premiums to force the policies to lapse. Finally, the court dismissed the declaratory judgment claim, since the court determined it was duplicative of the breach of contract claim.

The court dismissed the case without prejudice on February 14, 2018, due to a confidential settlement reached between the parties.

II. Cost of Insurance Litigation

A. Background on Universal Life Insurance

Very generally, universal life insurance is a hybrid life insurance policy that combines elements of term life insurance with an investment or savings component. Universal life insurance premiums typically are broken into two parts: (1) a cost of insurance amount, which is the minimum amount of premium required to keep the policy in force, and (2) an investment component, which provides a cash value. The cost of insurance includes charges for mortality, policy administration, and other expenses associated with keeping the policy in force. Collected premiums in excess of the cost of insurance accumulate into the cash value of the policy, which earns a rate of return. The cost of insurance will increase as the insured ages, but that increase in cost may be balanced, if guideline premiums continue to be paid, by an increase over time in the cash value. Ideally, the cash value that builds over time will cover the increased cost of insurance.

B. National Class Action Trends

In 2015 and 2016, a number of life insurance carriers raised the cost of insurance rates on universal life policies, resulting in increases to the premiums required to keep the policies in force. In reaction to these cost of insurance increases, universal life policyholders have filed class action lawsuits nationwide.

1. Feller v. Transamerica Life Ins. Co., No. 2:16-cv-01378 (C.D. Cal.) (filed June 10, 2016)

In early 2016, plaintiffs in California and Florida filed three class actions against Transamerica Life Insurance Company, challenging a cost of insurance increase. The actions were consolidated later that year, and in December 2017, the U.S. District Court for the Central District of California certified three classes of plaintiffs: a national class, a California subclass, and a senior California subclass for those 65 and older.[5]

The plaintiffs are policyholders of universal life policies issued by Transamerica. Like other universal life policies, premiums are deposited into each account every month, Transamerica withdraws the monthly deduction, and the remainder is held in an interest-bearing account. Policyholders may alter the amount and frequency of their premium payments so long as their

[5] *Feller v. Transamerica Life Ins. Co.*, No. 2:16-cv-01378, 2017 WL 6496803 (C.D. Cal. Dec. 11, 2017), *leave to appeal granted*, No. 18-55408 (9th Cir. Mar. 28, 2018).

account contains sufficient funds to cover the monthly deduction. If a monthly deduction exceeds an account's value, the policy may lapse.[6]

In the Transamerica accounts at issue, the monthly deduction is determined by adding a policy fee, a deduction for any policy riders, and a number derived from the "monthly deduction rate" (MDR), which factors in a mortality expense among other items and varies from policy-to-policy. In 2015, Transamerica announced that plaintiffs' MDRs would increase by as much as 100%. Plaintiffs claim that the resulting increased deductions caused "an astronomical increase in the premiums necessary to maintain coverage under the policies."[7]

The plaintiffs allege that Transamerica impermissibly increased the MDRs to "recoup past losses" based on changes in interest rates, lapse rates, and diminished returns on Transamerica's overall portfolio. Further, they allege the increase resulted from a need to "negate or offset Transamerica's obligation to pay credited interest to the policies at the minimum guaranteed rates." They additionally allege Transamerica prohibitively increased MDRs to induce "shock lapses" in elderly policyholders to avoid paying death benefits to individuals who paid premiums for decades.[8]

On behalf of the national class of policyholders, the plaintiffs asserted a claim for breach of contract and injunctive relief. On behalf of the California subclass, plaintiffs included claims for breach of the implied covenant of good faith and fair dealing, tortious breach of the duty of good faith and fair dealing, and violation of California's unfair competition law. Finally, plaintiffs included a claim for elder abuse on behalf of the California senior citizen subclass. [9] Transamerica filed an appeal of the class certification order in the Ninth Circuit Court of Appeals on March 27, 2018.[10] However, on October 5, 2018, the district court issued a preliminary approval order of the parties' proposed settlement, in which Transamerica agreed to pay $195 million to resolve all claims of class members in *Feller* and its consolidated actions.[11]

2. Brach Family Found., Inc. v. AXA Equitable Life Ins., No. 2:16-cv-01378 (S.D.N.Y.) (filed February 1, 2016)

In 2016, Plaintiff Brach Family Foundation filed a putative class action in the Southern District of New York based on cost of insurance increases in universal life insurance policies issued by AXA Equitable Life Insurance Company. The claims concern an October 2015 announcement by AXA that it planned to implement a cost of insurance increase on approximately

[6] *Id*. at 2–3.

[7] *Id.* at 3.

[8] *Id*.

[9] *Id*. at 1–2.

[10] *See Feller v. Transamerica Life Ins. Co., leave to appeal granted*, No. 18-55408 (9th Cir. Mar. 28, 2018).

[11] *See Feller*, No. 2:16-cv-01378, Preliminary Approval Order (C.D. Cal. Oct. 5, 2018); Jeff Sistrunk, *Transamerica to Settle Insurance Rate Class Action for $195M*, LAW360 (Oct. 4, 2018).

1,700 Athena Universal Life II policies with an issue age of 70 years or older and with a face value of $1 million or more.[12] The predicted increases ranged from 25% to 70%.[13] AXA stated the increase was prompted by less favorable expectations of future mortality and investment income than anticipated for this block of policies than when the schedule of COI rates was established.[14]

Plaintiffs brought claims for breach of contract, violation of New York consumer protection and insurer misrepresentation laws on behalf of a national class, as well as violations of California unfair competition and elder abuse laws on behalf of a California class.[15] The court dismissed the consumer protection claim, determining the statute requires that "the deception of a consumer must occur in New York," and here the plaintiffs, who are residents of California, fail to satisfy the requirement.[16] However, the court is allowing the plaintiffs to proceed at this stage on all other claims asserted.[17]

In February, in a sister class action based on the same underlying allegations, *EFG Bank AG, Cayman Branch v. AXA Equitable Life Ins. Co.*, 309 F.Supp.3d 89, 98 (S.D.N.Y. 2018), the court dismissed claims against AXA for violation of the covenant of good faith and fair dealing, finding that if the claims were based in contract, they were duplicative of the breach of contract claims, and if based in tort, the claims were only available to plaintiffs who were wrongfully denied benefits owed. No plaintiff made such allegations. Based on the failure of the tort-based claims, the court also denied the plaintiffs' punitive damages claims.[18] Because of the court's holding in *EFG Bank*, the Plaintiffs in *Brach Family* withdrew a request for leave to amend to add claims for violation of the covenant of good faith.[19] The court's opinion in *EFG Bank* challenged the *Feller* court's finding that the breach of good faith claims survived as a matter of law and stated the *Feller* court overlooked relevant authority on the issue.[20] This opinion could affect other courts' analyses of the issue moving forward.

3. Larson v. John Hancock Life Ins. Co., No. RG16813803 (Cal. Superior Ct.) (filed April 29, 2016)

On April 29, 2016, Plaintiff Barbara Larson filed a class action in California Superior Court, Alameda County against John Hancock, alleging breach of contract and seeking declaratory

[12] *Brach Family*, No. 16-CV-740, slip op. (S.D.N.Y. Dec. 19, 2016).

[13] *Id.* at 3.

[14] *Id.*

[15] *Id.* at 3; *Brach Family*, No. 16-CV-740, slip op. at 1 (S.D.N.Y. Mar. 9, 2018).

[16] *Brach Family*, No. 16-CV-740, slip op. at 2 (S.D.N.Y. Mar. 9, 2018).

[17] *Id.* at 3.

[18] *Id.*

[19] *Brach Family*, slip op. at n.1.

[20] *EFG Bank AG*, 309 F.Supp.3d at 97.

and injunctive relief. Unlike other cost of insurance lawsuits, plaintiffs in the *Larson* class action argued that the company *failed to decrease* the cost of insurance charges on one particular policy – Flex V Premium Variable Whole Life Insurance – despite improved mortality rates across the country. Specifically, plaintiffs alleged that John Hancock breached the terms of the Flex V policy by: (1) including non-mortality factors, such as expenses and profit, in determining the rates used to calculate the COI charge; (2) recovering expenses through COI charges in excess of the policy's maximum maintenance charge; and (3) failing to adjust the applied rates to reflect improving mortality expectations.[21] John Hancock maintained that the charges at issue were appropriate and permissible under the terms of the policy.[22]

The court certified a nationwide class on March 23, 2017, rejecting John Hancock's challenges to class certification, including the argument that variance in state laws would present individual issues resulting in a lack of commonality. The court instead determined that the policies' standard form rendered the case suitable for class treatment.[23]

On May 8, 2018, the court entered an Order of Approval regarding a settlement reached between the parties.[24] Under the terms of the agreement, John Hancock will establish a settlement fund of $59,750,000.[25] Similarly, in a corresponding suit in the Southern District of New York, *37 Besen Parkway, LLC v. John Hancock Life Insurance Co.*, John Hancock has agreed to pay $91,250,000 in exchange for a release of claims mirroring those in *Larson*.[26]

4. In re Lincoln National COI Litigation

On April 19, 2017, plaintiffs filed a class action against Lincoln National Life Insurance Company in the Eastern District of Pennsylvania, challenging a cost of insurance rate increase affecting policies in force for up to eighteen years, which Lincoln National announced in September 2016. Plaintiffs brought claims for breach of contract, breach of the covenant of good faith and fair dealing, injunctive and declaratory relief as to the COI increase, and violation of a number of state fraud and business laws.[27] Several putative class actions have been consolidated into this action.[28]

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[21] *See Larson v. John Hancock Life Ins. Co.*, No. RG16813803, settlement order at 3 (Cal. Superior Ct. Alameda Cty. May 8, 2018).

[22] *Id*.

[23] *See Larson*, Class Certification Order at 20 (Cal. Superior Ct. Alameda Cty. Mar. 23, 2017).

[24] *Larson v. John Hancock Life Ins. Co.*, No. RG16813803, settlement order at 3 (Cal. Superior Ct. Alameda Cty. May 8, 2018).

[25] *Id*. at 4.

[26] *37 Besen Pkwy, LLC v. John Hancock Life Ins. Co.*, No. 1:15-cv-09924-PGG-HBP, Motion for Preliminary Approval of Settlement (S.D.N.Y. July 20, 2018).

[27] *See In re Lincoln National COI Litigation*, 269 F.Supp.3d 622, 627 (E.D. Pa. 2017).

[28] *See Tutor v. Lincoln National Corp et al.*, No. 17-cv-04150-GJP, Order Consolidating Related Actions (E.D. Pa. March 28, 2018).

On September 11, 2017, the court issued an opinion in response to Lincoln National's Motion to Dismiss. The court denied the motion in large part, preserving plaintiffs' claims for breach of contract and breach of the implied covenant of good faith and fair dealing. The Court found that Lincoln National's stated reasons for the COI rate increase could be interpreted as supporting the plaintiffs' allegation that Lincoln had considered factors not permitted under the contract. The court also denied the Motion to Dismiss as to most of the plaintiffs' state statutory claims, including the claims brought under the North Carolina Deceptive and Unfair Trade Practices Act, New Jersey Consumer Fraud Act, New York General Business Law, and California Unfair Competition Law. Notably, the court acknowledged that in bringing the state statutory claims, Plaintiffs specifically allege Lincoln had engaged in an "overall scheme to recoup losses or force policy lapses by effectuating a pretextual COI rate increase, which not only constituted a breach of contract but also the kind of 'systemic behavior' that may qualify as unfair and deceptive."[29] The claims remain pending.

5. Vogt v. State Farm Ins., No. 2:16-cv-04170 (W.D.Mo.) (filed June 5, 2016)

On June 6, 2018, a federal jury in the Western District of Missouri awarded $34.3 million in compensatory damages to a class of approximately 43,000 current and former State Farm Life Insurance Company universal life policyholders. The complaint alleged that State Farm systematically deducted cost of insurance and expense charges from each policy owner's Account Value in amounts greater than those authorized by the policy. Class representative Michael G. Vogt first sued in 2016, claiming State Farm calculated policyholders' cost of insurance rates based not only on expressly permitted factors such as age, sex, and applicable rate class but also on other unauthorized factors to determine the rate. He alleged these other factors resulted in higher monthly charges than if State Farm relied only on the factors listed in the policy.

State Farm moved for summary judgment in December 2017, arguing that the rates the company charged did not exceed those listed in a table in the policy outlining cost of insurance rates. On April 10, 2018, the court denied the summary judgment motion and entered a pretrial ruling determining that State Farm violated the universal life policy as a matter of law.[30] The court agreed with plaintiffs that age, sex, and applicable rate class are the *only* factors that may be considered in setting the cost of insurance rate. Therefore, the jury was tasked solely with determining whether State Farm's use of the additional factors caused damages to its policyholders, and if so, to assess those damages. After a three and one-half day trial on damages, the jury awarded $34.3 million. The court, however, dismissed the plaintiffs' punitive damages claim prior to instructing the jury, finding there was no evidence that State Farm acted with evil motive or reckless indifference. The parties filed and briefed post-judgment motions. On October 11, 2018, the court denied State Farm's Rule 50 motion for judgment as a matter of law, its Rule 59 motion for a new trial, and its motion to decertify the class. It is likely that State Farm will appeal the adverse rulings, including the initial summary judgment ruling on liability.

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[29] *In re Lincoln National*, 269 F.Supp.3d at 642.

[30] *Vogt v. State Farm Ins. Co*., No. 2:16-cv-04170, slip op. (W.D.Mo., Apr. 10, 2018).

III. U.S. Supreme Court Ruling on Beneficiary "Revocation-on-Divorce" Statute

A. The Sveen *Decision*

In *Sveen v. Melin*[31], the United States Supreme Court held that applying Minnesota's "revocation-on-divorce" statute[32] to a life insurance policy whose beneficiary was designated before the statute's enactment did not violate the Constitution's Contracts Clause. Under Minnesota's statute, like many around the country,[33] whenever one spouse has made the other the beneficiary of a life insurance policy or similar asset, a divorce automatically revokes the designation so that the proceeds instead go to the insured's contingent beneficiary. The theory of the law is that the policyholder would not intend for the ex-spouse to remain the beneficiary of the proceeds; however, if he does so intend, he may rename the ex-spouse as beneficiary.

In the case, Kaye Melin challenged the application of Minnesota's revocation-on-divorce statute to her deceased ex-husband's life insurance policy. Melin married Mark Sveen in 1997. The following year, Sveen named Melin as the primary beneficiary on his life insurance policy and named his two children from a previous marriage as contingent beneficiaries. In 2002, Minnesota adopted its revocation-on-divorce statute. Sveen and Melin then divorced in 2007. The divorce proceedings did not address the life insurance policy, and thereafter Sveen made no revisions to the policy.

In 2011, Sveen died, and both Melin and Sveen's children claimed they were entitled to the life insurance proceeds. Sveen's children argued that the enactment of the revocation-on-divorce statute cancelled Melin's beneficiary designation. In turn, Melin argued that because the law was enacted after Sveen purchased the policy, the law's application to and revocation of her beneficiary status would violate the Constitution's Contracts Clause[34].

In an 8–1 opinion written by Justice Kagan, the Supreme Court concluded that application of the revocation-on-divorce statute to insurance policies entered before the statute's enactment did not violate the Contracts Clause. Laws affecting pre-existing contracts only violate the

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[31] 584 U.S. ____, 138 S.Ct. 1815 (2018).

[32] The statute provides that "the dissolution or annulment of a marriage revokes any revocable ... beneficiary designation ... made by an individual to the individual's former spouse." Minn. Stat. § 524.2-804, subd. 1.

[33] *See* Ala. Code § 30-4-17 (2016); Alaska Stat. § 13.12.804 (2016); Ariz. Rev. Stat. Ann. § 14-2804 (2012); Colo. Rev. Stat. § 15-11-804 (2017); Fla. Stat. § 732.703 (2017); Haw. Rev. Stat. § 560:2-804 (2006); Idaho Code Ann. § 15-2-804 (2017 Cum. Supp.); Iowa Code § 598.20A (2017); Mass. Gen. Laws, ch. 190B, § 2-804 (2016); Mich. Comp. Laws Ann. § 700.2807 (West 2018 Cum. Supp.); Minn. Stat. § 524.2-804 subd. 1 (2016); Mont. Code Ann. § 72-2-814 (2017); Nev. Rev. Stat. § 111.781 (2015); N.J. Stat. Ann. § 3B:3-14 (West 2007); N.M. Stat. Ann. § 45-2-804 (2014); N.Y. Est., Powers & Trusts Law Ann. § 5-1.4 (West 2018 Cum. Supp.); N.D. Cent. Code Ann. § 30.1-10-04 (2010); Ohio Rev. Code Ann. § 5815.33 (Lexis 2017); 20 Pa. Stat. and Cons. Stat. Ann. § 6111.2 (2010); S.C. Code Ann. § 62-2-507 (2017 Cum. Supp.); S.D. Codified Laws § 29A-2-804 (2004); Tex. Fam. Code Ann. § 9.301 (West 2006); Utah Code § 75-2-804 (Supp. 2017); Va. Code Ann. § 20-111.1 (2016); Wash. Rev. Code § 11.07.010 (2016); Wis. Stat. § 854.15 (2011).

[34] The Constitution's Contract Clause provides that "[n]o state shall … pass any … Law impairing the Obligation of Contracts." U.S. CONST. art. I, § 10.

Contracts Clause when they "operate[] as a substantial impairment on a contractual relationship."[35] In answering that question, the Court considers "the extent to which the law undermines the contractual bargain, interferes with a party's reasonable expectations, and prevents the party from safeguarding or reinstating his rights."[36]

The Court identified three reasons Minnesota's law does not substantially impair pre-existing contracts. First, the Court determined that the law was designed to effectuate the policyholder's intent and therefore furthers, rather than impairs, the ultimate contractual goal.[37] Second, the law is unlikely to frustrate the reasonable expectations of the policyholder, because divorce courts frequently alter beneficiary designations during post-divorce property divisions.[38] Finally, the Court observed that the law provides a mere default rule. The policyholder can always override the presumption by sending in a change of beneficiary form to his insurer following a divorce.[39]

Justice Gorsuch, the lone dissenter, disagreed, writing that the Constitution's framers intended the Contracts Clause to be a categorical rule that bars any retroactive application of legislation to contracts.[40] Under his view, the modern "substantial impairment" test fails to reflect the original meaning of the Clause.[41] Yet even under the modern test, Justice Gorsuch found a substantial impairment in the retroactive application of the law, writing that "when a state alters life insurance contracts by undoing their beneficiary designations it surely 'substantially impairs' them."[42]

B. Implications for Insurers

Revocation-on-divorce statutes typically build in protections for insurers who are unaware of an insured's divorce or annulment. For instance, Minnesota's law states that an insurer is not liable for having made a payment to a designated beneficiary before receiving written notice of a dissolution of marriage.[43] Rather, an insurer is only liable for payments made after receiving notice of such a dissolution. Thus, upon receipt of such notice, the insurer must withhold payment to the former spouse or else be liable to the contingent or other beneficiary. The Court's decision in *Sveen* expands this rule to *all* insurance policies, not merely to those issued after the enactment of the

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[35] *See Sveen*, 584 U.S. at __, 138 S.Ct. at 1821-22.

[36] *138 S.Ct.* at 1822.

[37] *Id*. at 1822-23.

[38] *Id*. at 1823.

[39] *Id*.

[40] *Id.* at 1826-27 (Gorsuch, J., dissenting).

[41] *Id*. at 1827-28 (Gorsuch, J., dissenting).

[42] *Id*. at 1828 (Gorsuch, J., dissenting).

[43] *See* Minn. Stat. § 524.2-804, subd. 5.

state's revocation-on-divorce statute. Therefore, insurers should be vigilant in documenting all notices they receive regarding changes in an insured's marital status and withhold payments accordingly.

IV. Fiduciary Rule Litigation

On June 21, 2018, the Fifth Circuit Court of Appeals finalized its judgment vacating the Department of Labor's "Fiduciary Rule."[44] The Fiduciary Rule is a package of seven rules promulgated by the Department of Labor (DOL) that "broadly reinterpret the term 'investment advice fiduciary' and redefine exemptions to provisions concerning fiduciaries" that appear in ERISA.[45] The stated purpose of the Fiduciary Rule was to "regulate in an entirely new way hundreds of thousands of financial service providers and insurance companies in the trillion dollar markets for ERISA plans and individual retirement accounts (IRAs)."[46] The Fiduciary Rule became effective June 9, 2017. In practice, the Fiduciary Rule required retirement plan advisors to offer advice to plans and plan participants that was free from conflicts of interest for the advisor. For example, plan recommendations that would result in increased payments to the advisor would often be treated as a conflict of interest that would violate the advisor's "fiduciary" obligations.

The DOL also issued exemptions permitting certain recommendations provided by these service providers, when the recommendation would otherwise be considered a conflict of interest under the rule. The most prevalent exemption allowed investment recommendations if the advisor contractually agreed to act only in the "best interest" of the plan or plan participant. This was known as the "Best Interest Contract Exemption" or "BICE".

The Fiduciary Rule was challenged as being an impermissible overreach of the DOL's authority. The Tenth Circuit Court of Appeals upheld the rule as a valid regulation in an opinion issued on March 13, 2018.[47] However, on March 15, 2018, in a three judge panel decision, the Fifth Circuit held that the Fiduciary Rule was inconsistent with ERISA's definition of fiduciary.[48]

Following the Fifth Circuit's March opinion, the AARP, New York, California, and Oregon sought to intervene in the case, requesting leave to file a petition for rehearing *en banc*. The Fifth Circuit denied those motions and a consolidated motion for reconsideration filed by the states. The DOL did not request a re-hearing of the case *en banc*. Therefore, the DOL had 90 days

[44] *Chamber of Commerce of the USA, et al. v. U.S. Dept. of Labor, et al*., Case No. 17-10238, Mandate (5th Cir. June 21, 2018).

[45] *Id*. at 2–3.

[46] *Id*. at 3.

[47] *Market Synergy Group, Inc. v. U.S. Dept. of Labor, et al*., 885 F.3d 676 (10th Cir. 2018).

[48] See *Chamber of Commerce of the USA, et al. v. U.S. Dept. of Labor, et al*., 885 F.3d 360 (5th Cir. 2018).

– until June 13 – to appeal the decision to the Supreme Court. Because the DOL did not appeal the ruling, the Fifth Circuit's June 21 mandate vacated the Fiduciary Rule "in toto."[49]

The DOL stated shortly after the Fifth Circuit ruling, "Pending further review, the Department will not be enforcing the 2016 fiduciary rule."[50] However, the Securities and Exchange Commission (SEC) voted on April 18, 2018, to release proposed rules reforming investment advice for broker-dealers and investment advisors, which would require these service providers to also offer advice that is in the "best interest" of plans and plan participants.[51] The public notice and comment period on the SEC's proposed rules ended on August 7, 2018.[52]

V. Other Litigation

A. *Personal Jurisdiction/Venue Developments*

Venue is an important consideration in every case, especially in those brought as putative class actions. Sophisticated plaintiffs' counsel certainly are selective about venues and judges, and they may dismiss cases without prejudice when they believe an unfavorable judge has drawn a case. In the following case, the United States Supreme Court's 2017 decision in *Bristol-MyersSquibb Co. v. Sup. Ct. of Cal.*, 137 S. Ct. 1773 (2017) played an important role in a change of venue based upon the defense of lack of personal jurisdiction raised by defendants.

> Dale Miller, et al. v. Metropolitan Life Ins. Co., et al., No. 2:17-cv-02668 (C.D. Cal.) (filed April 7, 2017); No. 1:17-cv-07284 (S.D.N.Y.) (filed Sept. 25, 2017)

On April 7, 2017, Plaintiffs Dale Miller and John F. Barton, Jr. ("Plaintiffs") filed a putative nationwide class action in the Central District of California against Metropolitan Life Insurance Company ("Metropolitan Life") and MetLife, Inc. alleging breach of contract and fraud. Plaintiffs alleged that they entered into contracts with Defendants for Group Variable Universal Life policies when their Optional Term Life or Group Variable Universal Life ("GVUL") policies were converted. Plaintiffs further alleged that Defendants charged them smoker rates on the GVUL policies despite their non-smoker status. Plaintiffs asserted that by charging them the smoker rate for GVUL policies, Defendants breached their contracts with Plaintiffs. Plaintiffs further alleged that Defendants' actions constituted a fraudulent scheme by which Defendants overcharged policyholders.

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[49] *Chamber of Commerce of the USA, et al. v. U.S. Dept. of Labor, et al*., Case No. 17-10238, Mandate at 67 (5th Cir. June 21, 2018).

[50] *See* Carmen Castro-Pagan & Madison Alder, *Labor Dept. Won't Enforce the Obama-Era Fiduciary Rule*, BLOOMBERG (Mar. 16, 2018), https://www.bna.com/labor-dept-wont-n57982089974/.

[51] *See Proposed Commission Interpretation Regarding Standard of Conduct for Investment Advisers; Request for Comment on Enhancing Investment Adviser Regulation*, OFFICE OF FEDERAL REGISTER (May 9, 2018), https://www.federalregister.gov/documents/2018/05/09/2018-08679/proposed-commission-interpretation-regarding-standard-of-conduct-for-investment-advisers-request-for.

[52] *Id*.

Pursuant to the Central District of California's local rules, throughout May and June 2017, Defendants' counsel discussed with Plaintiffs' counsel the inaccurate allegations in the complaint and seven legal bases for dismissal of the case, including that MetLife, Inc. was merely a holding company that did not issue any policies to Plaintiffs. On June 13, 2017, Plaintiffs filed a notice of dismissal as to MetLife, Inc., and three days later Plaintiffs filed an amended complaint against Metropolitan Life. The allegations in the Amended Complaint were substantially similar to those in the original complaint.

On June 19, 2017, the Supreme Court of the United States issued its opinion in *Bristol-Myers Squibb Co. v. Sup. Ct. of Cal.*, 137 S. Ct. 1773 (2017). In *Bristol-Myers Squibb*, the Supreme Court held that a court could not exercise personal jurisdiction over an out-of-state defendant sued by an out-of-state plaintiff for out-of-state injuries. In essence, the Supreme Court reaffirmed long-standing personal jurisdiction principles, holding Bristol-Myers Squibb was not subject to general personal jurisdiction in California because it was not incorporated in California and did not have its principal place of business in California, and that Bristol-Myers Squibb was not subject to specific personal jurisdiction in California because there was no link between California and the nonresident plaintiffs' claims.

Throughout June and July 2017, Defendants' counsel continued discussions with Plaintiffs' counsel regarding the inaccurate allegations in the complaint and the legal bases for dismissal and striking of the purported nationwide class, including lack of personal jurisdiction over Metropolitan Life as to the claims of Plaintiff Barton, a Colorado resident, and unnamed class members residing outside of California. Plaintiffs' counsel disagreed with Defendants' counsel's position regarding the application of *Bristol-Myers Squibb* to the lawsuit.

On September 25, 2017, however, Plaintiffs voluntarily dismissed their case in its entirety after Metropolitan Life filed a motion to dismiss the lawsuit, a motion to strike Plaintiffs' nationwide class action allegations, and a motion to stay discovery.

Plaintiffs re-filed their case in the Southern District of New York. As in the California lawsuit, shortly after filing, Plaintiffs voluntarily dismissed MetLife, Inc. On January 30, 2018, Metropolitan Life filed a motion to dismiss the New York lawsuit, asserting eight bases for dismissal, including that Plaintiffs' claims are barred by SLUSA, are time-barred, and fail to state a claim; that Plaintiffs lack Article III standing to assert claims on behalf of the New York Class; and that Plaintiffs' cursory class allegations do not meet the requisite pleading standard.

Exactly one year after Plaintiffs voluntarily dismissed their California Complaint, the Magistrate Judge assigned to the case in the Southern District of New York issued a Report and Recommendation that recommended Plaintiffs' class claims be dismissed, largely based upon SLUSA (discussed below), with leave only to attempt to assert contractual claims on a class basis, and otherwise, with leave to assert certain individual claims. The parties each filed certain objections to the Report and Recommendation, and those objections are in the process of being briefed at the time of this presentation.

B. *SLUSA*

The Securities Litigation Uniform Standards Act of 1998 ("SLUSA") continues to be an important statute to assert in defending and potentially dismissing putative class actions brought in state court and/or under state law when a covered security is at issue and the claims involve alleged misrepresentations or suppression.[53]

1. O'Donnell v. AXA Life Ins., 887 F.3d 124 (2d Cir. 2018)

In this case, plaintiffs alleged that AXA's conduct in implementing a volatility management strategy for variable annuity policies, resulting in being charged with misleading the New York State Department of Financial Services and ultimately resulting in a settlement with that regulator, constituted a breach of contract with annuity holders. The United States District Court for the Southern District of New York agreed with AXA that the alleged fraud or nondisclosure fit under the statutory scheme of SLUSA, and therefore the court denied a motion to remand and dismissed the class claims. The Second Circuit Court of Appeals, however, ruled that AXA's alleged misrepresentations to the state regulator were insufficient in this private action to meet SLUSA's "in connection with" test. That is, the fraudulent conduct alleged by plaintiffs that purportedly misled the NYDFS did not induce any action or inaction on the part of the plaintiffs. Therefore, the case, which had been removed to federal court pursuant to SLUSA and then transferred to the Southern District of New York, was remanded to Connecticut state court with all of its claims intact.[54]

2. Dale Miller, et al. v. Metropolitan Life Ins. Co., et al., No. 2:17-cv-02668 (C.D. Cal.) (filed April 7, 2017); No. 1:17-cv-07284 (S.D.N.Y.) (filed Sept. 25, 2017)

The *Miller* case is described above under section V.A. One of the grounds Metropolitan Life asserted in moving to dismiss the action was that the claims, asserted as they were on a class basis, were barred by SLUSA. The Southern District of New York Magistrate Judge agreed, ruling on September 25, 2018 that the class claims alleging fraud and suppression should be dismissed without prejudice, with leave for the plaintiffs to file individual claims. The magistrate judge did not agree with Metropolitan Life that the contract claims were in essence artfully pled fraud claims at this stage, but she ordered that plaintiffs restate their fraud claims with more particularity in order that the Court might better evaluate the claims. Plaintiffs have objected to the Report and Recommendation, and Metropolitan Life also has objected in part. Plaintiffs' objection regarding SLUSA centers on the "in connection with" element of the statute. Plaintiffs contend that the *Chadbourne & Parke, LLP v. Troice* decision by the United States Supreme Court[55] precludes a finding that the fraud in this instance is "in connection with" a purchase, sale, or the holding of a covered security, where it is the alleged "fraudster" who is making the operative decision to buy or sell securities to fund insurance charges. In *Miller*, however, Metropolitan Life argued, and the

[53] SLUSA expressly provides that: (1) no "covered class action" (2) based on state law may be maintained in any state or federal court by any private person if (3) it alleges misrepresentations or omissions (4) "in connection with" (5) the purchase or sale of a "covered security." 15 U.S.C. §§ 77p(b), 78bb(f)(1).

[54] 887 F.3d 124, 129–31 (2d Cir. 2018).

[55] 571 U.S. 377, 380 (2014).

Court adopted the position, that the purchase of the GVUL policy was itself a purchase of a covered security, allegedly induced by the fraud or suppression claimed by plaintiffs. In addition, as in the Ninth Circuit case of *Freeman Investments, L.P. v. Pac. Life Ins. Co.*, when the sale of units within an investment account in a variable universal life policy coincides with the alleged overcharges of premiums or insurance charges, then the "in connection with" standard is met.[56]

[56] 704 F.3d 1110, 1113 (9th Cir. 2013).