Nos. 15-2665,

15-3504, 15-3553, and 15-4189

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 15-2665

Jonathan Ross, David Levin, Plaintiffs-Appellants,
Andrew Yale, on behalf of himself and all others similarly situated,
Plaintiff,
v.
AXA Equitable Life Insurance Company, Defendant-Appellee.

(*For Continuation of Caption See Inside Cover*)

On Appeal from the United States District Court
for the Southern District of New York

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No. 15-3553

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AXA Equitable Life Insurance Company, Defendant-Appellee.

No. 15-4189

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INTRODUCTION AND SUMMARY

The insurance companies seek to divert attention from this straightforward case of financial harm to consumers by making assertion after assertion about their financial strength and their purported compliance with various insurance regulations. None of their assertions, however, can erase the simple facts actually at issue in this appeal. First, under New York Insurance Law Section 4226, a life insurer must avoid misleading statements about its financial condition and its reserves. Second, defendants' own insurance regulator, the New York State Department of Financial Services (NYDFS), determined that defendants made misleading statements about their financial condition and reserves. JA156-57; JA160; JA166; JA176-77. It found that defendants had painted their financial strength as being materially greater—and their risk of default materially less—than it actually was. *See* JA156-57.

As a result of the defendants' conduct, the individual policyholders—not the public at large—suffered a concrete injury giving rise to Article III standing. That injury can be understood in three ways: the policyholders face an increased risk that they will not be paid what

they are owed under their policies; the policies are worth less than they were represented to be; and the policyholders have been deprived of their statutory right to accurate disclosures. Those are not prospective injuries; they have already happened. The district court erred in concluding that the policyholders lack standing, and the insurance companies' efforts to defend its conclusion are unavailing.

ARGUMENT

I. The insurance companies' factual assertions are misdirected and erroneous

The insurance companies devote much of their briefs to challenging the facts as alleged in the complaints. To that end, their briefs contain numerous references to facts, documents, and articles outside the complaints. "In reviewing a motion to dismiss," however, this Court's review is "'limited to the facts as presented within the four corners of the complaint, to documents attached to the complaint, or to documents incorporated within the complaint by reference.'" *Looney* v. *Black*, 702 F.3d 701, 716 (2d Cir. 2012) (quoting *Taylor* v. *Vt. Dep't of Educ.,* 313 F.3d 768, 776 (2d Cir. 2002)). In any event, the companies' assertions do not undermine the key facts that govern this appeal: (1) defendants were under an obligation to refrain from making mislead-

ing statements about their financial condition and reserves; (2) defendants made misleading statements about their financial condition and reserves; and (3) the policyholders were injured by defendants' misrepresentations.

A. The insurance companies mischaracterize the NYDFS Report

AXA contends (Br. 5, 12) that the NYDFS Report was only "forward-looking" and that NYDFS did not explicitly find that AXA had violated any laws. While the report was aimed at exposing a dangerous practice rather than prosecuting wrongdoing, it described past practices at length, and it amply supports the allegations of misleading representations by defendants and injury to plaintiffs. Indeed, one of the main points of the report was that life insurers—including AXA and MLIC—had not properly disclosed their shadow insurance practices. Thus, the report expressly criticized numerous misrepresentations, including the failure to disclose parental guarantees and the manipulation of reserves in order to artificially boost risk-based capital buffers that insurers report to policyholders and the public. JA157 (shadow insurance makes insurers' capital reserves "appear larger and rosier than they actually are"); *see also* JA50 ¶80; JA51 ¶85.

The insurers highlight (AXA Br. 13; MLIC Br. 17) various actions NYDFS took after the issuance of the report, noting that NYDFS promulgated a new mandate for disclosure of additional information about shadow insurance transactions. But NYDFS's decision to add a requirement expressly addressing the specific misconduct in which the insurance companies had engaged does not mean that disclosure was not already required or that the companies' conduct did not violate the law. Defendants had an obligation to comply with Section 4226, regardless of any additional regulatory actions that NYDFS may have taken after it issued the report.

AXA notes that NYDFS recently lowered the amount of required reserves for certain life insurance products, contending (Br. 13) that NYDFS took this action in recognition that conservative reserve requirements "create incentives to employ captive reinsurance." *See* MLIC Br. 17-18 (contending that prior reserve requirements were "*in excess of what prudence dictates*"). That does not mean, however, that the defendants accurately reported their financial condition in the past. To the contrary, it simply illustrates the companies' motive for

using shadow insurance in the first place: circumventing what they considered overly burdensome reserve requirements.

Defendants also observe that they are subject to "stringent requirements" under New York Insurance Law and NYDFS regulations. AXA Br. 6; *see* MLIC Br. 14. But any such regulations are beside the point because the NYDFS Report does not endorse defendants' compliance with New York insurance regulations. Instead, it details how defendants employed a lack of transparency in their disclosures, to the detriment of policyholder protection. JA156. In doing so, defendants violated a fundamental aspect of policyholder protection required by Section 4226: truthful disclosures concerning financial conditions and reserves.

B. The insurance companies' factual assertions are contradicted by the complaints and the NYDFS Report

The insurers tout the purportedly "secure" nature of shadow insurance transactions, but their assertions are contradicted by both the NYDFS Report and the allegations here. AXA, for example, downplays the significance of its use of parental guarantees, contending (Br. 10) that "[t]he bank alone bears the risk of nonpayment" on the letter of

credit. In fact, the NYDFS Report explains, and the complaints allege, that because of parental guarantees, shadow insurance "does not actually transfer the risk for those [reinsured] insurance policies because . . . the parent company is ultimately still on the hook for paying claims if the shell company's weaker reserves are exhausted." JA156; JA47 ¶69; JA113 ¶81. As a result, according to NYDFS, and as alleged in the complaints, "when the time finally comes for a policyholder to collect promised benefits after years of paying premiums . . . there is a smaller reserve buffer available at the insurance company to ensure that the policyholder receives the benefits to which they are legally entitled." JA156; JA47 ¶69; JA114 ¶81.

Similarly, AXA claims (Br. 9) that the collateral posted by its captive reinsurer met "exacting regulatory requirements." But the NYDFS Report and the complaints reject the suggestion that defendants' policyholders were as protected by defendants' shadow insurance arrangements as they would have been if defendants had not used parental guarantees. *See* JA47-50 ¶¶71-80; JA114-17 ¶¶86-95. Indeed, the NYDFS Report revealed that none of the 17 life insurers identified in that report had established significant reserves to support their

obligations under the parental guarantees. JA177. As NYDFS explained, the failure of a life insurer to hold *actual assets* sufficient to meet its guarantee obligations imperils its solvency: "the potential unfunded liability that would be incurred by the parent company should a drawdown of the letter of credit occur . . . could lead to a liquidity issue within the holding company and thus adversely impact policyholders." *Id.* AXA suggests that the NYDFS Report did not explicitly claim that users of shadow insurance faced an "imminent risk of financial distress" (AXA Br. 12), but the report concluded that shadow insurance substantially increased an insurer's risk of financial distress at the expense of policyholder protection. JA156 (shadow insurance transactions produce a "smaller reserve buffer" to ensure that policyholders receive their benefits); *id.* (shadow insurance "could potentially put the stability of the broader financial system at greater risk"). Defendants were required to disclose the impact of these arrangements on their financial conditions.

AXA insists (Br. 4) that the "omitted information" was not material, but that assertion is false. Throughout the complaints, the plaintiffs alleged that financial condition and reserve information is of

critical importance for life insurance purchasers. JA51 ¶81-83; JA58 ¶121-23; JA59 ¶126-28. Indeed, MLIC accepted plaintiffs' allegations of materiality for purposes of this appeal. MLIC Br. 53 n.20.

Finally, MLIC argues (Br. 18-19) that its use of parental guarantees was disclosed by its parent, MetLife, Inc., suggesting that these purported partial disclosures by a different entity, in a different filing, obviates MLIC's liability for making misleading statements in its own statutory annual statements. But MLIC's failure to disclose in its principal publicly filed financial statement these material aspects of reinsurance transactions on which reserve credits, risk-based capital ratios, and other important aspects of MLIC's financial condition are based violates Section 4226 irrespective of any separate disclosures MetLife may have made elsewhere. In any event, even the disclosures in MetLife's annual report do not explain (nor did MLIC ever disclose) the key fact that "no significant reserves or contingent liabilities were established by MetLife for the parental guarantees." JA139 ¶175.

II. The complaints allege injury in fact

The complaints allege that the insurance companies evaded reserve requirements by using inadequately disclosed shadow insurance

transactions to reduce the amount of assets they were required to hold, leaving the companies and their policyholders "substantially exposed to the very risk that the insurer had ostensibly transferred to the company-affiliated captive reinsurer." JA49 ¶78. That conduct has harmed the policyholders by exposing them to a hidden, increased risk of nonpayment, by decreasing the value of the policies that they had purchased, and by depriving them of the accurate information that New York Insurance Law § 4226 guarantees.

A. The policyholders have suffered injury in the form of an increased risk of nonpayment

The Supreme Court has held that "the risk of real harm" can "satisfy the requirement of concreteness" needed to establish an injury in fact. *Spokeo, Inc.* v. *Robins*, 136 S. Ct. 1540, 1549 (2016). As explained in the opening brief (at 27-35), the policyholders have alleged such a risk here: the insurance companies' shadow insurance practices allowed them to "offer life insurance with fewer reserves and less sound financial backing," subjecting policyholders to "undisclosed risks" of nonpayment. JA60 ¶132.

While MLIC concedes (Br. 26) that the risk of harm can establish a concrete injury, AXA attempts to argue (Br. 35-36) that it cannot do

so except "in narrowly defined circumstances" involving "environmental conditions and harmful products cases." MLIC is correct, and AXA's efforts to limit risk-based standing to particular contexts are unpersuasive because AXA can identify no principled basis for restricting the scope of cognizable injuries to risks of some kinds of harm but not others. Indeed, elsewhere in its brief, AXA recognizes that financial risks can sometimes confer standing. Br. 41 (discussing alteration in pension plan that was held to support standing in *Johnson* v. *Allsteel, Inc.*, 259 F.3d 885, 890 (7th Cir. 2001), because it "increased the likelihood" that the plaintiff would not receive benefits).

In *Motorola Credit Corp.* v. *Uzan*, 388 F.3d 39 (2d Cir. 2004), this Court held that the dilution of collateral securing a debt can give rise to standing because it increases the risk that the creditor will be unable to recover. Neither AXA nor MLIC offers a persuasive distinction of that decision, which establishes a principle that governs here. AXA points out (Br. 42-43) that the loss reserves about which it misled its policyholders are not technically collateral, overlooking that they serve the same economic function as collateral—ensuring that the creditor will be paid. MLIC, for its part, argues (Br. 33) that the lender in

Motorola "suffered a present and non-contingent injury since the allegation was that the bargained for collateral was presently worthless." But a lender has no right to possess collateral unless the borrower defaults, so the decrease in value of collateral creates a "present" harm in exactly the same sense as here; it increases the risk of non-payment in the event of unknown future contingencies.

The insurers similarly struggle to account for this Court's observation, in the criminal-fraud context, that a defendant who lies to obtain a loan has inflicted a cognizable harm on the lender. MLIC argues (Br. 34 n.11) that there is "an immediate harm from being presented with false financial information," which is hardly a distinction, since "present[ing] . . . false financial information" is precisely what the insurance companies are alleged to have done here.

Much of the companies' argument is devoted to attempting to show that the risks alleged in the complaints are too speculative to be cognizable, and that the policyholders could suffer harm only in the event of an "unlikely chain of highly speculative events." MLIC Br. 25; *see* AXA Br. 33 ("parade of catastrophes"). AXA, for instance, contends (Br. 31-32) that at least "nine distinct events" must occur "in exact

order" before there is any risk that AXA will not pay policyholder claims. MLIC offers (Br. 3-4) a sequence of eleven events.

It requires little imagination to break down even the most inexorable chain of causation into a large number of intermediate steps. The relevant question for standing analysis is not how many steps there are but whether the harm at the end of the chain is "too speculative for Article III purposes." *Lujan* v. *Defs. of Wildlife*, 504 U.S. 555, 565 n.2 (1992). There, both AXA and MLIC fall short. Despite the companies' assertions, the "chain[s] of contingencies" they offer do not consist of nine (or eleven) "distinct events" that are "each highly unlikely standing alone." AXA Br. 26, 31. To the contrary, the contingencies are strongly correlated with each other because, in an economic downturn, both the parent company and the captive reinsurer are likely to experience financial stress at the same time. JA48 ¶73 ("In the event that the parent company's guarantees under an LOC supporting shadow insurance transactions are actually triggered, the parent is likely already experiencing independent sources of financial stress.")

The companies' hypotheticals also assume that the insurer will always be able to draw on its letter of credit, ignoring the context in

which it might seek to do so. For example, if the parent is experiencing financial difficulty while the captive reinsurer has insufficient assets to pay out claims, the parent company or its regulator may pressure the ceding insurer not to draw on the letter of credit—which would trigger the parent's guarantee obligations—and may instead terminate the reinsurance transactions. Similarly, if the ceding insurer's parent company is experiencing financial stress, bank lenders may decide not to renew outstanding letters of credit. In either scenario, without the option of drawing on the letter of credit, the insurer would have significantly less capital to meet its policyholder obligations. And given the magnitude of the risks hidden by the undisclosed shadow insurance transactions, neither scenario is implausible. Indeed, the captive reinsurance companies involved in these transactions are often domiciled in jurisdictions with lower reserve and capital requirements than those applicable to the ceding insurer. JA45-46 ¶87 (detailing how a captive reinsurer can use "much less conservative accounting rules in calculating their reserve liabilities for ceded business than can a cedant insurer").

As recent experience has shown, the risk of financial stress from a significant economic downturn, or even a "financial meltdown" (MLIC Br. 29), is not merely theoretical. Before the 2008 financial crisis, for example, American International Group (AIG) was considered by many to be a "financial fortress." "Overdue Examination: AIG and the Financial Crisis," *The Economist*, Jan. 9, 2013. AIG representatives made bullish statements about the company, including statements touting the purported near-absolute security of its credit-default swaps. *See*, *e.g.*, Gretchen Morgenson, "Behind Insurer's Crisis, Blind Eye to a Web of Risk," *N.Y. Times*, Sept. 27, 2008 ("It is hard for us, without being flippant, to even see a scenario within any kind of realm of reason that would see us losing one dollar in any of those [credit-default swap] transactions."). Those statements, of course, proved false, and AIG, one of America's leading insurers, needed $85 billion in bailout money to stay afloat.

The insurers' argument that a risk of financial harm is insufficient to confer standing on their own policyholders is particularly odd in the insurance context. The entire purpose of an insurance transaction, after all, is to reduce financial risk. And Section 4226 and New

York's disclosure requirements are aimed at stopping just the sort of conduct in which the companies engaged. Those laws were intended to prevent insurer insolvency, but under the insurers' theory, the only time a policyholder could sue would be after an insurer had failed to pay. At that point, however, the insurer would be insolvent and the insured could not get relief. The companies' theory is consistent neither with standing law nor with a commonsense understanding of the insurance industry.

B. The policyholders have suffered injury because they obtained policies that are less valuable than those they paid for

The policyholders' injury can also be understood as a diminution in the value of the policies that they purchased. MLIC suggests (Br. 35) that this is a "new argument on appeal," but the Third Amended Complaint contains exactly the language quoted in MLIC's brief—namely, that the policies are "less financially secure than [the companies] represented them to be." JA149 ¶ 212. In any event, an allegation that the policyholders paid "inflated premiums" is logically equivalent to an allegation that the policies the policyholders obtained were worth less than what they paid.

As explained in the opening brief (at 36-39), the pricing of securities confirms the commonsense observation that a weak institution's promise to pay is worth less than a strong institution's promise to pay. MLIC objects to that analogy, pointing out (Br. 39-40) that there is no secondary market for insurance policies. That misses the point, which is that the *value* of a promise of future payments depends on who is making the promise. That economic reality exists in the insurance industry as much as in the securities market.

The insurance companies also struggle to distinguish cases in which courts held that the purchasers of a defective physical product had standing because the defect made the product worth less. MLIC insists (Br. 36-37) that those cases are "particularly inapt," but only because it erroneously insists that its policies offer "no less protection" than those issued by a company not engaging in shadow insurance practices, an assertion flatly at odds with the allegations here. Similarly, AXA argues (Br. 51) that the cases involved "a present defect that has actually manifested in the product." Not so. In *Cole* v. *General Motors Corp.*, 484 F.3d 717 (5th Cir. 2007), for example, the Fifth Circuit held that the purchasers of a car with a defective airbag had

"suffered economic injury at the moment [they] purchased" the car because of their "overpayment" or "loss in value." *Id.* at 723. A defective airbag will not be "manifested," in AXA's terms, unless the car happens to be involved in an accident. Nevertheless, the car is worth less because of it, and that diminution in value, like the one suffered by the policyholders here, is sufficient to confer standing. *See also Eljer Mfg., Inc.* v. *Liberty Mut. Ins. Co.*, 972 F.2d 805, 809 (7th Cir. 1992) (cognizable injury occurs when a defective product is incorporated into a larger structure, even though, like a "ticking time bomb," it "does not injure the structure in which it is placed . . . until it explodes").

According to MLIC (Br. 39), an exhibit to the complaint "undermines the implausible notion that Plaintiffs paid more than the policies were worth" because it shows "that captive reinsurance *lowers* premiums." *Accord* AXA Br. 48-49. Captive reinsurance, by freeing up capital, may indeed encourage companies to sell defective policies in the market, thus increasing the supply of policies and driving down the price for the market as a whole. In fact, this often happens when products with hidden defects flood a market, but the lowering of the average market price says nothing about whether the defective prod-

uct is underpriced or overpriced. The *risk-adjusted* price of an insurance policy sold by a company with improperly inflated capital is *not* lower. The insurance companies may disagree about the impact of shadow insurance on price, but that factual dispute is not relevant to a motion to dismiss.

C. New York Insurance Law § 4226 confirms that the policyholders have suffered concrete injuries

The concreteness of the policyholders' injuries is further demonstrated by the judgment of the New York Legislature as reflected in Section 4226, and by the close relationship between the injuries recognized by that statute and injuries that would have been sufficient to confer the right to sue at common law. The insurers misunderstand this point, devoting much of their brief to attacking a strawman by refuting the proposition that the policyholders "do not need to" show injury (MLIC Br. 41) because "a violation of a state law inherently satisfies Article III" (AXA Br. 56). The policyholders have not suggested that the existence of Section 4226 eliminates the need for a plaintiff to show injury. Rather, "[i]n determining whether an intangible harm constitutes injury in fact, both history and the judgment of Congress play important roles." *Spokeo*, 136 S. Ct. at 1549. Because "Congress,"

like a state legislature, "is well positioned to identify intangible harms that meet minimum Article III requirements, its judgment is also instructive and important," and it "may 'elevat[e] to the status of legally cognizable injuries concrete, de facto injuries that were previously inadequate in law.'" *Id.* (quoting *Lujan*, 504 U.S. at 578); *see Church* v. *Accretive Health, Inc.*, No. 15-15708, 2016 WL 3611543, at *3 (11th Cir. July 6, 2016) (plaintiff had standing based on failure to make disclosures required by the Fair Debt Collection Practices Act because the statute "has created a new right—the right to receive the required disclosures in communications governed by the FDCPA—and a new injury—not receiving such disclosures"). Section 4226 does just that.

1. The Supreme Court reaffirmed in *Spokeo* that "the violation of a procedural right granted by statute can be sufficient in some circumstances to constitute injury in fact," and that in such cases, a plaintiff "need not allege any *additional* harm beyond the one" identified in the statute. 136 S. Ct. at 1549. As an example, the Court cited *FEC* v. *Akins*, 524 U.S. 11 (1998), which established that voters' "inability to obtain information" that Congress had decided to make public was a sufficient injury to establish standing. *Spokeo*, 136 S. Ct. at 1549 (also

citing *Public Citizen* v. *Dep't of Justice*, 491 U.S. 440 (1989)). Much like the statute at issue in *Akins*, Section 4226 creates a right to truthful information—here, about the financial condition of life insurers—and a private right of action to enforce that right.

AXA suggests (Br. 59) that this Court rejected the concept of informational injury in *W.R. Huff Asset Mgmt. Co., LLC* v. *Deloitte & Touche LLP*, 549 F.3d 100, 110 n.10 (2d Cir. 2008), but in fact the Court simply declined to express a view on whether the plaintiff in that case would have had a cognizable informational-injury claim under the Securities Act. And while the insurers attempt to distinguish the Supreme Court's informational-injury cases, their efforts to do so are unavailing. MLIC describes the statutes at issue in *Akins* and *Public Citizen* as "meant to 'creat[e] broad rights to information' necessary to the integrity of the political process," and it suggests that this case involves the lesser concern of information that pertains only "to a purely private, economic interest." Br. 61-62 (quoting *Am. Canoe Ass'n* v. *City of Louisa Water & Sewer Comm'n*, 389 F.3d 536, 549 (6th Cir. 2004) (Kennedy, J., concurring in part)). That distinction strengthens the case for standing here, for as Justice Thomas has

explained, "the concrete-harm requirement does not apply as rigorously when a private plaintiff seeks to vindicate his own private rights" as it does when a plaintiff brings suit "for violations of 'public rights'—rights that involve duties owed 'to the whole community, considered as a community, in its social aggregate capacity.'" *Spokeo*, 136 S. Ct. at 1552 (Thomas, J., concurring) (quoting 4 William Blackstone, *Commentaries on the Laws of England* 5 (1769)). Having purchased policies from the insurance companies, the policyholders have suffered a particularized injury from the companies' conduct, not merely a "generalized societal wrong" (MLIC Br. 46).

The insurers argue that Section 4226 does not create "a right to full and accurate disclosures," asserting (MLIC Br. 44-45) that it prohibits only misrepresentations made directly to plaintiffs. New York courts, however, have rejected that interpretation. *In re Empire Blue Cross & Blue Shield Customer Litig.*, 622 N.Y.S.2d 843 (N.Y. Sup. Ct. 1994). AXA cites legislative history (Br. 14-15) supposedly establishing that the purpose of the statute was "to curb the deceptive sales practice known as 'twisting,' by which unscrupulous agents misled policyholders into switching carriers." But much of the legislative history

pertains to the version of the statute before the legislature prohibited misleading representations concerning an insurer's financial conditions and reserves. In addition, that version of the statute applied to the actions of both agents and insurance companies. *See* Act of Apr. 13, 1935, ch. 429, § 1, 1935 N.Y. Sess. Laws 979, 979-81. Since 1939, separate statutes have governed agents and insurers. *See* Act of June 15, 1939, ch. 882, § 211, 1939 N.Y. Sess. Laws 2530, 2714-15 (insurers); Act of June 15, 1939, ch. 882, § 127, 1939 N,Y. Sess. Laws 2530, 2627-28 (agents). Today, Section 4226 applies only to insurance companies. N.Y. Ins. Law § 4226(a). And while Section 4226(a)(5) prohibits making false statements "for the purpose of inducing, or tending to induce, such person or persons to lapse, forfeit or surrender any insurance policy or contract," Section 4226(a)(4)—the provision at issue here—prohibits a much broader array of bad conduct, including misrepresentations about an insurer's financial condition. Only Section 4226(a)(5), prohibiting "twisting," includes the word "induce." *See also In re Empire Blue Cross & Blue Shield Customer Litig.*, 622 N.Y.S.2d at 850. The insurers' effort to read that requirement into Section 4226(a)(4) is contrary to the statutory text.

2. The insurance companies argue (AXA Br. 64-65; MLIC Br. 44) that the policyholders lack standing under Section 4226 because the statute gives a right to sue only to "aggrieved" persons and, in their view, the policyholders were not aggrieved by the companies' inaccurate disclosures. That is incorrect.

Under New York law, plaintiffs are "aggrieved" if they have been "adversely affected by the activities of defendants," which requires a showing of harm "different in kind and degree from the community generally"; the plaintiffs' interest must also be "'arguably within the zone of interest to be protected by the statute.'" *Sun-Brite Car Wash, Inc.* v. *Bd. of Zoning & Appeals of Town of N. Hempstead*, 69 N.Y.2d 406, 413 (1987) (quoting *Matter of Dairylea Coop.* v. *Walkley*, 38 N.Y.2d 6, 9 (1975)). That standard parallels the prudential-standing test applied by federal courts, under which a "person aggrieved" is someone "fall[ing] within the 'zone of interests' sought to be protected by the statutory provision whose violation forms the legal basis for his complaint," and a plaintiff falls outside the "zone of interests" only if the interests "are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed

that Congress intended to permit the suit." *Thompson* v. *N. Am. Stainless, LP*, 562 U.S. 170, 177-78 (2011); *see Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians* v. *Patchak*, 132 S. Ct. 2199, 2210 (2012) (noting that the zone-of-interests test "is not meant to be especially demanding") (quoting *Clarke* v. *Sec. Indus. Ass'n,* 479 U.S. 388, 399 (1987)).

Section 4226 was enacted to protect purchasers of life insurance from misleading representations about the financial condition of the companies from which they have purchased policies. The policyholders allege such misleading representations, which affect them individually rather than the public at large, and they therefore fall squarely within the zone of interests protected by the statute. They have standing as "aggrieved persons" under New York law.

That conclusion is supported by the statutory history of the "person aggrieved" language. The 1939 New York procedural code set forth three different types of "action for penalty": an "action for penalty or forfeiture to people" (brought by the attorney general), an "action for penalty or forfeiture by person aggrieved," and an "action for penalty or forfeiture by common informer." Civil Practice Act, Art. 71, §§ 1178-

80, 1939 N.Y. Laws 1619, 1774-75. The "action for penalty" by "person aggrieved" statute provided that "when a penalty or forfeiture is given by statute to a person aggrieved by the act or omission of another, the person to whom it is given, if it is pecuniary, may maintain an action to recover the amount thereof." *Id.* § 1179. When the legislature added a private cause of action against insurers that same year in order to enforce the right against misleading representations, it used the "person aggrieved" language in order to distinguish the enforcement mechanism from the one available to the public at large and the one available only to a specific government official. Act of June 15, 1939, ch. 882, § 211, 1939 N.Y. Sess. Laws 2530, 2714-15 (replacing § 60, the predecessor to § 4226, with § 211).

The distinction between the general public and "persons aggrieved" has long been recognized at common law. *See*, *e.g.*, 3 William Blackstone, *Commentaries on the Laws of England* 159-60 (1768) ("The party offending [the penal statute] is here bound by the fundamental contract of society to obey the directions of the legislature, and pay the forfeiture incurred to such persons as the law requires. The usual application of this forfeiture is either to the party aggrieved, or else to

any of the king's subjects in general."). Despite AXA's attempt to re-make the term "aggrieved person" into a threshold requirement of immediate financial harm, the phrase has always been used to distinguish a group of people affected by the harm addressed by a statute from the general public. The policyholders fit comfortably within the former category.

3. The concreteness of the policyholders' injury is demonstrated not only by Section 4226 but also by the traditional common-law recognition of similar injuries. *See Spokeo*, 136 S. Ct. at 1549 (noting the importance of "history" in assessing "whether an intangible harm constitutes injury in fact"). Insurers regularly seek to cancel coverage and retain premiums when policyholders make misrepresentations on applications for insurance, including misrepresentations concerning their financial condition; in some cases, insurers seek cancellation even before the policyholder has died. *See*, *e.g.*, *PHL Variable Ins. Co.* v. *Sheldon Hathaway Family Ins. Trust ex rel. Hathaway*, 819 F.3d 1283, 1289, 1292 (10th Cir. 2016) (misstatement about applicant's net worth supported rescission of life insurance policy, allowing insurer to retain premiums); *Indianapolis Life Ins. Co.* v. *Herman*, 204 F. App'x

908, 909 (1st Cir. 2006) (false verification of financial statement submitted with life insurance application was sufficient for rescission of policy, even without proof that intentional misrepresentation increased insurer's risk of loss); *AXA Equitable Life Ins. Co. v. Infinity Fin. Grp., LLC*, 608 F. Supp. 2d 1349, 1355–56 (S.D. Fla. 2009) (allowing AXA to proceed with claims for rescission of life policies based on alleged misrepresentations in applications). That practice demonstrates the error of AXA's claim (Br. 16-17) that, by allowing an insured party to obtain a refund of its premiums if the insurer has failed to disclose material facts about its financial condition, Section 4226 provides "windfall" relief. It also illustrates the continued viability of the common-law understanding that all parties to an insurance contract have a right to disclosure of material facts.

AXA argues (Br. 59) that the common law addressed only "misrepresentation *by* an insured *to* an insurer," but that is incorrect. In fact, courts have recognized "a reciprocal duty on the part of the insurer to deal fairly, to give the assured fair notice of his obligations, and to furnish openhandedly the benefits of a policy of 'all risks' insurance." *Contractors Realty Co. v. Ins. Co. of N. Am.*, 469 F. Supp. 1287,

1294-95 (S.D.N.Y. 1979). Accordingly, a policyholder had a common-law cause of action to rescind a policy based on an insurer's misrepresentation. *See, e.g.*, *Jones* v. *Dana*, 24 Barb. 395, 400 (N.Y. Gen. Term 1855) (identifying "a fraudulent representation of the agents and officers of the company in regard to its capital or pecuniary resources and ability" as a basis for rescission); *accord Robinson* v. *Mut. Reserve Life Ins. Co.*, 182 F. 850, 858 (C.C.S.D.N.Y. 1910), *aff'd*, 189 F. 347 (2d Cir. 1911); *Moore* v. *Mut. Reserve Fund Life Ass'n*, 106 N.Y.S. 255, 262-63 (N.Y. App. Div. 1907). The injury redressed by Section 4226 thus "has a close relationship to a harm that has traditionally been regarded as providing a basis for a lawsuit." *Spokeo*, 136 S. Ct. at 1549.

III. The policyholders' injuries are traceable to the defendants' conduct

AXA argues (Br. 44-47) that the policyholders' injuries are not causally related to the insurance companies' inaccurate disclosures. AXA fails to appreciate, however, that the traceability test for standing purposes imposes "a lesser burden" than a proximate cause or "substantial factor" requirement, and that "even harms that flow indirectly from the action in question can be said to be 'fairly traceable' to that action for standing purposes." *Rothstein* v. *UBS AG*, 708 F.3d 82,

92 (2d Cir. 2013) (quoting *Barbour* v. *Haley*, 471 F.3d 1222, 1226 (11th Cir. 2006)). At the pleading stage, "the plaintiffs' burden . . . of alleging that their injury is fairly traceable to the challenged act is relatively modest." *Id.* (internal quotation marks omitted). The policyholders have carried that burden here.

AXA appears to advocate a categorical rule that a misrepresentation can be causally related to an injury only if the plaintiffs themselves were actually misled by the misrepresentation. The cases it cites (Br. 46-47) do not support that broad rule, and while a plaintiff's direct reliance on a misrepresentation is one way a misrepresentation can cause injury, it is not the only way. *See*, *e.g.*, *Basic Inc.* v. *Levinson*, 485 U.S. 224, 246 (1988). The New York Legislature has determined that accurate public disclosure of insurers' financial condition is necessary to protect policyholders. Indeed, more than a century of regulation in both the securities and insurance contexts have been based on the idea that requiring truthful disclosures in public filings protects all consumers. Whether or not purchasers of insurance personally review those disclosures, others—including regulators, journalists, insurance agents, and financial advisors—undoubtedly do, and their actions

influence the purchasers. Inaccurate disclosures cause harm to policyholders by undermining a disclosure regime designed to protect them.

For similar reasons, the insurance companies are wrong to argue (AXA Br. 45 n.9; MLIC Br. 46-47) that the policyholders must show reliance. As an initial matter, if the statute contained a reliance requirement, that would bear on whether the policyholders had stated a claim, but it would not mean that the policyholders did not satisfy Article III. But in any event, the statute does not require reliance. Nothing in the statutory text refers to reliance, and courts addressing claims under Section 4226 have not imposed any reliance requirement. *See*, *e.g.*, *In re Empire Blue Cross & Blue Shield Customer Litigation*, 622 N.Y.S.2d at 843; *see also Stutman* v. *Chem. Bank*, 731 N.E.2d 608, 612 (N.Y. 2000) (no reliance requirement for claim under New York General Business Law § 349, which prohibits "[d]eceptive acts or practices in the conduct of any business" and allows "any person who has been injured by reason of any violation" to bring an action "to recover his actual damages").

IV. MLIC's merits arguments do not provide a basis for affirming the judgment

MLIC argues that "the district court had numerous alternative grounds upon which to dismiss the case with prejudice" under Federal Rule of Civil Procedure 12(b)(6). Br. 51 (capitalization omitted). Those "alternative grounds" are not a basis for affirming the judgment.

The district court dismissed these cases under Rule 12(b)(1) for lack of federal jurisdiction. A dismissal for lack of jurisdiction is a dismissal without prejudice. *See Vandor, Inc.* v. *Militello*, 301 F.3d 37, 38-39 (2d Cir. 2002) ("[A]bsent jurisdiction federal courts do not have the power to dismiss with prejudice.") (internal quotation marks and emphasis omitted). The dismissal under Rule 12(b)(6) that MLIC is seeking would be a dismissal with prejudice. What MLIC is asking this Court to do, therefore, is not to affirm the judgment entered by the district court but instead to alter the judgment in MLIC's favor. In the absence of a cross-appeal, an appellate court may not expand the judgment in favor of an appellee by "changing a dismissal without prejudice to a dismissal with prejudice." *Standard Inv. Chartered, Inc.* v. *Nat'l Ass'n of Sec. Dealers, Inc.*, 560 F.3d 118, 126 (2d Cir. 2009); *accord Lewert* v. *P.F. Chang's China Bistro, Inc.*, 819 F.3d 963, 969-70

(7th Cir. 2016) (reversing dismissal for lack of standing and noting that "[b]ecause P.F. Chang's did not file a cross-appeal, we cannot and do not consider whether the plaintiffs failed to state a claim").

Even if this Court had authority to reach the merits issues that MLIC raises, it should not do so. This Court generally declines to exercise its discretion "to answer [a] complex question in the first instance" when the district court has not addressed it. *No Spray Coal., Inc.* v. *City of New York*, 351 F.3d 602, 606 (2d Cir. 2003). That course is particularly appropriate where, as here, an appellee presents its arguments only in passing, with little authority or discussion—and, in the case of its statute-of-limitations argument, only in a footnote. *See Rentas* v. *Ruffin*, 816 F.3d 214, 226 (2d Cir. 2016) ("We exercise our discretion not to consider arguments raised only in a footnote.").

In any event, all of MLIC's arguments fail on the merits.

1. MLIC claims that Appellants fail to state a claim under Section 4226, but its description of the elements of the cause of action is incorrect. Section 4226(a) prohibits an insurer from "mak[ing] any misleading representation, or any misrepresentation of the financial condition of any such insurer or of the legal reserve system upon which

it operates." N.Y. Ins. Law § 4226(a)(4). In addition, it makes insurers who "knowingly" violate that provision "liable to a penalty in the amount of such premium or compensation, which penalty may be sued for and recovered by any person aggrieved for his own use and benefit, in accordance with the provisions of the civil practice law and rules." N.Y. Ins. Law § 4226(d). Thus, a plaintiff proceeding under § 4226 must show that (1) an insurer made misleading representations concerning its financial condition or reserve system; (2) the misleading representations were material; and (3) the insurer made the representations knowingly. The policyholders have alleged facts establishing each of those elements.

MLIC attempts to add additional elements to the statute. It insists (Br. 52) that the policyholders must identify "an actual statement that they saw or heard" that was misleading. But it points to no statutory language imposing that requirement, and none exists. As a statute designed to deter insurer misconduct, Section 4226 permits a policyholder to recover from an insurer that makes misleading disclosures about its financial condition in its statutory annual statement,

as MLIC has done here. It does not require that the policyholder have personally reviewed those disclosures.

MLIC claims (Br. 53) that the policyholders "do not allege that MLIC failed to disclose anything required" by New York's disclosure regime, and that MLIC need not disclose captive insurance transactions undertaken by its parent company or other affiliates. But the complaint specifically alleges that NYDFS requires statutory annual statements that disclose a "full and true statement" of assets and liabilities, capital and surplus, reinsurance transactions, and collateral. JA105 ¶49. The actions taken by MLIC's affiliates—of which it was fully aware—affected the reserve system available to MLIC and the risks still borne by MLIC itself. MLIC's incomplete description of those risks and reserves was materially misleading.

MLIC next argues (Br. 54) that the word "knowingly" in Section 4226(d) requires plaintiffs to plead that MLIC had a "fraudulent intent." But Section 4226 is not a fraud statute, and it does not require plaintiffs to plead a specific intent to deceive. *See Friedman* v. *Conn. Gen. Life Ins. Co.*, No. 603058/2001, 2004 WL 5487476 at *4-5 (N.Y. Sup. Ct. Sept. 30, 2004).

2. MLIC also raises (Br. 57-58) the doctrine of primary jurisdiction. That doctrine has a "relatively narrow scope," and it is generally reserved for circumstances in which "enforcement of the claim requires the resolution of issues which, under a regulatory scheme, have been placed within the special competence of an administrative body." *Goya Foods, Inc.* v. *Tropicana Prods., Inc.*, 846 F.2d 848, 851 (2d Cir. 1988).

The claims at issue here are well "within the conventional experience of judges" and do not "involve[] technical or policy considerations within the agency's particular field of expertise." *Ellis* v. *Tribune Television Co.*, 443 F.3d 71, 82-83 (2d Cir. 2006). And the New York Legislature has not placed these issues "particularly within the agency's discretion." *Id.* Instead, the legislature specifically provided that disputes concerning misleading representations should be resolved by the courts in actions by policyholders as private plaintiffs. NYDFS is not responsible for enforcing Section 4226, and there is no basis for a primary jurisdiction referral.

3. Finally, MLIC maintains (Br. 58 n.23) that the policyholders' claims are time-barred. That argument rests on the premise that the statute of limitations runs from when a policy is purchased. In fact, a

claim based on a misleading representation is triggered by the representation and the payment of premiums, not by the original purchase of the policy, which could have occurred years earlier. *See Gaidon* v. *Guardian Life Ins. Co. of Am.*, 96 N.Y.2d 201, 212 (2001).

CONCLUSION

The judgments of the district court should be reversed, and the cases should be remanded for further proceedings.

Respectfully submitted.

s/ Timothy W. Burns

September 28, 2016

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because it contains 6,973 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). I further certify that the brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Century Schoolbook font.

s/Timothy W. Burns

Dated: September 28, 2016

CERTIFICATE OF SERVICE

I certify that on September 28, 2016, I electronically filed the foregoing brief with the Clerk of Court for the United States Court of Appeals for the Second Circuit by using the CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

s/ Timothy W. Burns