INSURANCE**LEGAL**NEWS

HEALTH INSURANCE EXCHANGE FRAMEWORK BEGINNING TO TAKE SHAPE

by Cynthia A. Moore, Member

A key part of expanding access to health insurance coverage under the Patient Protection and Affordable Care Act ("PPACA") is the establishment of state-level "exchanges" where individuals and small employers will be able to purchase health insurance coverage effective January 1, 2014. The Department of Health and Human Services ("HHS") has issued two sets of proposed regulations which begin to establish the framework for the creation and operation of the exchanges.

The first set of proposed regulations, issued on July 11, 2011, (1) sets out federal requirements that states must meet if they elect to establish and operate an exchange, and (2) outlines minimum requirements that health insurance issuers must meet to participate in an exchange and offer qualified health plans.

Both the statute and the proposed regulations give the states flexibility in establishing and operating an exchange. For example, an exchange may be established as a state agency or as a nonprofit organization; a state can partner with other states to create a regional exchange; or a state can establish one or more subsidiary exchanges in a state. If a state does not take steps to establish an exchange by January 1, 2013, the federal government will operate the exchange in that state.

Some of the functions of an exchange include:

- Determining whether an individual or small employer is eligible to purchase health insurance through the exchange;
- Implementing quality activities such as quality improvement strategies and enrollee satisfaction surveys;
- Providing for the operation of a toll-free call center;
- Maintaining an up-to-date internet website providing information on qualified health plans;
- Having a consumer assistance function (including a navigator program);
- Establishing privacy and security standards for the use and disclosure of personally identifiable information; and
- Establishing a process for enrolling eligible persons into qualified health plans during annual or special enrollment periods and for facilitating premium payments.

An exchange must also establish procedures for the certification, decertification, and recertification of qualified health plans. The basic standard is that a health plan may be certified if the exchange

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determines that it is in the interest of qualified individuals and qualified employers in the state. An exchange may establish other criteria for certification. To give a state flexibility in operating its exchange, exchanges may utilize "any willing plan" for certifying qualified health plans, or they may undertake a competitive bidding or selective contracting process and limit certification to only those plans that meet exchange criteria. Further, an exchange could negotiate with issuers on a case-by-case basis.

The following are some of the minimum requirements that will apply to qualified health plan issuers who participate in the exchange:

- The issuer must have a certification issued or recognized by the exchange to demonstrate that each health plan it offers in the exchange is a qualified health plan and that the issuer meets all requirements applicable to qualified health plan issuers.
- The issuer must comply with any exchange processes, procedures, and standards for the small group market.
- Each qualified health plan offered by the issuer must cover essential health benefits and comply with other benefit design standards set forth in PPACA.
- The issuer must be licensed and in good standing to offer health insurance coverage in each state in which the issuer offers health insurance coverage.
- Qualified health plan issuers must comply with quality standards set forth in PPACA.
- The qualified health plan issuer must offer at least one qualified health plan at the silver coverage level and one qualified health plan at the gold coverage level.
- Qualified health plan issuers must submit qualified health plan rate and benefit information to the exchange, including rate increase justifications.
- Qualified health plan issuers must comply with broad "transparency" standards, which means that they must make a range of information relating to the plan's quality and cost available to the public, the exchange, HHS, and the state insurance commissioner.
- Qualified health plan issuers must maintain networks that comply with any network adequacy standards established by the exchange.
- Qualified health plan issuers must charge the same premium rate without regard to whether the plan is offered through an exchange or whether the plan is offered directly from the issuer or through an agent.

A state-operated exchange must be financially self-sustaining by January 1, 2015, and is permitted to apply state user fee assessments on participating health insurance issuers or other methods of funding to support state exchange functions.

The second set of proposed regulations, issued on August 12, 2011, sets out standards by which the exchange is to determine whether an individual or a small employer is eligible to enroll in a qualified health plan. The exchange must also determine whether an individual is eligible for "insurance affordability programs," which include advance payment of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and any state-established Basic Health Program. HHS visualizes a "one stop shop" approach, where consumers can apply for enrollment in a qualified health plan and receive a determination of eligibility for the insurance affordability programs.

Many states are moving forward to enact legislation which will create the exchange in that state. On September 14, 2011, Michigan Governor Rick Snyder delivered a Special Message to the Legislature on Health and Wellness. Among many other items, Governor Snyder strongly supports the establishment of a Michigan-based online health insurance exchange to be called "MI Health Marketplace." The exchange will emphasize free market principles and serve as a competitive marketplace for individuals and businesses to obtain health insurance. Governor Snyder identified four guiding principles to be used in structuring MI Health Marketplace:

- It must empower individuals and small businesses by enabling them to easily compare health insurance options.
- It must not add bureaucracy and complexity that increases the cost to customers.
- It should be another tool for health insurance customers, but not the only available option for purchasing health insurance coverage.
- It must be customer-service oriented, accountable, reliable, transparent, and expedient.

Governor Snyder is asking the Legislature to enact legislation creating MI Health Marketplace by Thanksgiving. Senate Health Policy Committee Chair James Marleau introduced Senate Bill 693, which would authorize the creation of the MI Health Marketplace, on September 22, 2011.

STATE-BASED SURPLUS LINES INSURANCE REFORM FACES UNCERTAIN FUTURE

by Adam M. Wenner, Associate

On July 21, 2010, President Obama signed the Dodd-Frank Wall Street Reform and Consumer Protection Act into law ("the Act"). Incorporated into the Act is language mandating sweeping reform in the excess and surplus lines insurance industry. Dubbed the "Nonadmitted and Reinsurance Reform Act" (NRRA), the primary purpose of the NRRA is to facilitate the collection and allocation of premium taxes for nonadmitted insurance carriers among the states.

In other words, Congress ambitiously set out to require each state to "adopt nationwide *uniform* requirements, forms, and procedures, such as an interstate compact, that provide for the reporting, payment, and allocation of premium taxes for nonadmitted insurance . . . ."[1]

Of particular importance to the states, as of July 21, 2011, when most of NRRA's provisions took effect, only the home state of the insured is authorized to tax a surplus lines transaction.[2] As such, absent an agreement to the contrary, the states will not be able to allocate tax revenue according to where the risk is actually insured. In addition, outside of the implications on premium tax collection, unless a state has adopted nationwide requirements and procedures, a state may only impose eligibility requirements on nonadmitted insurers domiciled in a United States jurisdiction in conformance with the Non-Admitted Insurance Model Act.[3] Assuming the nationwide agreements currently under consideration (NIMA & SLIMPACT) loosen eligibility requirements, this could present a particularly difficult problem for states on the outside looking in.

While Congress intended to create a more navigable environment, the differing political and financial landscapes of the states have spawned two different models for the implementation of the NRRA: the Nonadmitted Insurance Multi-State Agreement ("NIMA"), and the Surplus Lines Insurance Multi-State Compliance Agreement ("SLIMPACT").

Under NIMA, member states are provided with a uniform procedure for the collection and allocation of surplus lines premium taxes where a policy covers risk in more than one state. In addition, NIMA provides a fairly expansive "exposure allocation methodology" for the allocation of premium taxes amongst the states. NIMA's proposed legislation is consistent with the NRRA and has been adopted by eleven states.

While similar in overall effect, SLIMPACT is the second and arguably more complex of the proposed allocation mechanisms. SLIMPACT attempts to streamline regulatory requirements by providing a uniform tax allocation formula and a clearinghouse to facilitate the reporting of all premium taxes. In addition, SLIMPACT calls for increased cooperation between member states to encourage the sharing of implementation-related resources. To date, SLIMPACT has been adopted by nine states and requires a minimum of ten members in order to go into effect.

As differences exist between NIMA and SLIMPACT, there is presently the prospect of two independent agreements operating in an already complicated environment. Moreover, at least a few states have taken no legislative action whatsoever related to the NRRA requirements. Given that the states are well beyond the July 21, 2011, deadline mandated under the NRRA, the coming months are certain to prove interesting for both the states who have elected membership under an agreement and those that have not. In order to help sort out some of the confusion, below is a summary of recent state action in each of Dickinson Wright's respective jurisdictions:

Arizona

- On April 8, 2011, Arizona enacted legislation providing the state's insurance director with authorization to "enter into a compact or multistate agreement . . . if, after a hearing conducted pursuant to section 20-161, it is determined that entering into a compact or multistate agreement is in the best interests of [the] state."[4] The statute provides a variety of factors to be considered in the "best interest" analysis.[5]

- As of the date of this publication, Arizona has yet to take additional action pursuant to the aforementioned directive.

District of Columbia

- The federal government has yet to take action specific to the District of Columbia with regard to the implementation of the NRRA or the ratification of a multistate agreement.

Michigan

- To date, Michigan has taken no legislative action relating to the NRRA mandate. According to the state's Office of Financial and Insurance Regulation ("OFIR"), however, proposed legislation has been drafted and is currently being discussed with lawmakers in the House and Senate. OFIR's website notes that "[t]he laws and regulations of Michigan will continue to apply to premium reporting and premium tax due on multi-state placements until July 21, 2011. It is the intent of the Office of Financial and Insurance Regulation to post additional information on its website if and when Michigan begins participating in a multistate clearinghouse or tax sharing arrangement."[6]

Nevada

- On July 13, 2011, the Nevada legislature authorized the Commissioner of Insurance to enter into a multi-state agreement to preserve the ability of the state to collect premium tax on multi-state risks.[7] Acting pursuant to that authority, on July 13, 2011, the Commissioner, in concert with the National Association of Insurance Commissioners ("NAIC") opted to ratify the NIMA agreement. Nevada is one of twelve states to adopt the NIMA agreement.

Tennessee

- Tennessee is one of a select number of states which has actually incorporated one of the multistate compacts into its statutory code. On June 11, 2011, Tennessee became the ninth state to adopt the SLIMPACT agreement. Interestingly, within Tennessee's SLIMPACT legislation it provides for the prospect of the compact never reaching fruition: "[i]n the event this [SLIMPACT] compact fails to become effective as described in article XIII by February 28, 2012, the state is authorized to enter into a cooperative agreement, compact, or reciprocal agreement with another state or states. . . . " In other words, should SLIMPACT fail to attract a tenth state party (as required under the terms of the compact in order to become effective), Tennessee would be within its rights to withdraw at that time.

- In addition, under Tennessee's SLIMPACT legislation, the state would retain any premium tax allocated to a state that is not a party to the SLIMPACT agreement. Furthermore, the bill also provides that Tennessee's surplus lines law would apply only to surplus lines transactions where Tennessee is the insured's home state.

[1] 15 U.S.C. § 8201(b)(4) (emphasis added).
[2] *Id.* at § 8201(a).
[3] *Id.* at § 8204(1).
[4] Ariz. Rev. Stat. § 20-416.01(A).
[5] *Id.*
[6] Office of Financial and Insurance Regulation, Nonadmitted and Reinsurance Reform Act of 2010 FAQs, *available at*, http://www.michigan.gov/lara/0,4601,7-154-10555_13648-260773--,00.html
[7] S.B. 289, 76th Leg., (NV. 2011).
[8] Tenn. Code. Ann. § 56-14-201 (Lexis 2011).

RECENT CASE LAW SUMMARIES

SIXTH CIRCUIT HOLDS PRIVATE PROVIDER NEED NOT DEMONSTRATE RESPONSIBILITY OF GROUP HEALTH PLAN PRIOR TO SUIT UNDER THE MEDICARE SECONDARY PAYER ACT

by Ryan M. Shannon, Associate

In *Bio-Medical Applications of Tennessee, Inc v Central States SE & SW Areas Health & Welfare Fund*, 2011 US App LEXIS 18450 (6th Cir, Sept 2, 2011), the Sixth Circuit held that, under the Medicare Secondary Payer Act (the "Act"), a group health plan may not immediately deny coverage to one of its insureds on the basis that that insured became eligible for Medicare after being diagnosed with end-stage renal disease. The court also held that a healthcare provider need not previously "demonstrate" a private insurer's responsibility to pay before bringing a lawsuit under the Act's private cause of action provisions.

The defendant group health plan, Central States, had a policy which provided that "coverage under this Plan shall terminate on … the date [the insured] first becomes entitled to Medicare benefits." Two months after the insured became entitled to Medicare benefits, Central States stopped paying the plaintiff provider, Bio-Medical and terminated coverage to the insured. Medicare conditionally paid the remaining balance for renal disease treatments provided by Bio-Medical up to the point of the insured's death.

Bio-Medical subsequently sued Central States under both ERISA and the Act, seeking double damages pursuant to 42 USC §1395y(b)(3)(A). The court found that the policy provision automatically terminating coverage based on eligibility for Medicare was in blatant violation of the Act's prohibition in 42 USC § 1395y(b)(1)(C) against a plan's consideration of Medicare eligibility for benefits due to end-stage renal disease. To hold otherwise, the court noted, would subvert the Act's goal of preventing private plans from shifting costs to Medicare.

The defendant argued that Bio-Medical had not yet "demonstrated" the defendant's responsibility, and cited 42 USC § 1395y(b)(2)(B)(ii), which states that a primary plan shall reimburse Medicare for any payment made by Medicare "if it is demonstrated that such primary plan has or had a responsibility to make payment" with respect to such item or service. The court considered legislative history and the plain language of the statute, which only requires demonstrated responsibility where the primary plan must reimburse Medicare, and concluded that the Act did not require a provider to prevail in a suit against a group health plan before bringing a private action under the Act.

MICHIGAN COURT OF APPEALS HOLDS CONSENT CLAUSE IN UNDERINSURED MOTORIST POLICY MUST BE SPECIFICALLY ENFORCED AND PRECLUDES COLLATERAL ESTOPPEL AGAINST THE INSURER

by Ryan M. Shannon, Associate

In *Dawson v Farm Bureau Mutual Insurance Company of Michigan*, 2011 Mich App LEXIS 1483 (Aug 15, 2011), the Michigan Court of Appeals held in a published decision that a provision in a policy for underinsured motorist benefits specifically stating that the insurer's consent was required for the insurer to be bound to any judgments for damages or settlements was enforceable.

The plaintiff was injured while riding as a passenger in the backseat of a car, and subsequently sued the driver. The driver's insurer, Auto-Owners, offered to settle the case for the $20,000 policy limit, but Farm Bureau, with which plaintiff maintained an underinsured motorist policy expressly requiring Farm Bureau's consent for it to be bound to any judgment or settlement, refused to consent. Plaintiff's case proceeded to trial, in which Farm Bureau did not participate. The driver did not contest that she was negligent or that plaintiff suffered a serious impairment of a bodily function and stipulated to plaintiff's requested damages of $100,000.

Following the award, plaintiff filed suit against Farm Bureau for underinsured motorist benefits, and the driver signed interrogatories stating that she lacked assets from which the plaintiff could collect the $80,000 sum outstanding from the judgment following Auto-Owners payment of the first $20,000. Plaintiff filed a motion for summary disposition, arguing that Farm Bureau was collaterally estopped from denying underinsured motorist coverage, which the trial court granted.

The Michigan Court of Appeals reversed the trial court, holding that the trial court "erred by failing to enforce the unambiguous contractual provision which expressly stated that, for purposes of underinsured motorist coverage, Farm Bureau is not bound by any judgment unless it gives its written consent." *Id.* at *4. The court first noted that, "like

uninsured motorist benefits, underinsured motorist coverage is not required by Michigan law," and thus the terms of coverage are exclusively controlled by the language of the contract itself, rather than the statute. *Id*. at *6. Because, under basic contract law, the agreement must be enforced as written, Farm Bureau could not be held to any prior judgment without its express consent, even where Farm Bureau chose not to contest issues of liability or damages in plaintiff's suit against the driver.

THIRD CIRCUIT RECOGNIZES STATE LAW CLAIM FOR DEEPENING INSOLVENCY

BY RYAN M. SHANNON, ASSOCIATE

In *In re Lemington Home for the Aged*, 2011 US App LEXIS 19312 (3d Cir, July 11, 2011), the Third Circuit in a published case held that the plaintiffs had established a genuine issue of material fact with respect to their claim for deepening insolvency against the defendant board of directors of a nonprofit facility. While the case involved a health care entity undergoing federal bankruptcy, the analysis may apply to other entities undergoing receivership, including those involved in state level insurance receiverships.

In May of 2004, after years of financial decline, an administrator recommended to the board of directors of the Lemington Home for the Aged that bankruptcy protection was necessary. Despite numerous warning from audits and outside studies, as well as citations from the state health department, the board refused to declare bankruptcy or conduct a viability study necessary to receive a loan to continue operations. After several patients died under conditions potentially involving neglect, the board ultimately decided to declare bankruptcy in January 2005, but delayed the filing of bankruptcy for a period of four months while the board continued to do business with vendors, failed to collect Medicare receivables, upheld a policy of no new patient admissions, and commingled the home's funds with related entities. *Id.* at *31-32.

With permission from the bankruptcy court, a committee of creditors filed suit against the board alleging violations of fiduciary duties as well as a claim for deepening insolvency. The Western District Court of Pennsylvania granted summary judgment to the defendants, finding the business judgment rule prevented the court from second-guessing the board's decisions. The Third Circuit reversed, finding a genuine issue of material fact existed as to both the fiduciary duty and deepening insolvency claims.

Though Pennsylvania's state courts had not formally recognized a claim of "deepening insolvency," the Third Circuit, relying on law from other jurisdictions and the policy underlying Pennsylvania tort law, cited federal precedent for the proposition that "the Pennsylvania Supreme Court would determine that 'deepening insolvency' may give rise to a cognizable injury." *Id.* at *27-28. The court defined such a claim as "an injury to a debtor's corporate property from the fraudulent expansion of corporate debt and prolongation of corporate life." *Id.* As there was sufficient evidence on all of plaintiff's claims to show a genuine issue of material fact, the court vacated the district court's order and remanded the case for trial.

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