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INSURANCE BUSINESS AND REGULATORY NEWS

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Inside This Issue

The Insurance Business and Regulatory Group was formed in 1990 by Robert B. Sullivan and is currently chaired by Steven L. Imber. The group concentrates on providing outstanding service and expertise to the insurance industry with respect to virtually any type of individual or entity subject to insurance regulation by the state insurance departments or enforcement actions by the state Attorneys General. For more information and a list of contacts within the group, see last page.

State Health Insurance Exchanges Update

By Julius W. Hobson, Jr.

With the goal of increasing access to coverage, the Patient Protection and Affordable Care Act (ACA) established health insurance exchanges that are intended to serve as marketplaces for qualified individuals and small businesses to shop for private health insurance coverage. The coverage offered by exchanges must be comprehensive and meet all applicable private market reforms specified in the ACA. They must be operational for individuals and small businesses on (or before) Jan. 1, 2014. The focus here is on state-operated exchanges.

States wishing to operate their own exchanges had until Dec. 14, 2012, to submit a "Declaration Letter" and an "Exchange Blueprint" application to the U.S. Department of Health and Human Services (HHS). Eighteen states and the District of Columbia met the deadline. To date, HHS has conditionally approved applications from 17 states and D.C. In the remaining states, either HHS will operate the exchanges or there will be a federal-state partnership.

There are several important exchange funding issues. First, the March 1, 2013, sequestration order resulted in $44 million being cut from exchange grants. Any additional states desiring to operate a state exchange in the future will receive lower funding. Under the Budget Control Act of 2011 (P.L. 112-25), absent congressional action, sequestration will occur each additional year for nine years until the $1.2 trillion deficit reduction target is met.

Second, sequestration (if not overturned) will result in furloughs of HHS staff. The process for implementing these furloughs will determine their impact on federal-state communication concerning exchanges.

Third, on March 6, 2013, the U.S. House of Representatives passed H.R. 933, the "Department of Defense, Military Construction and Veterans Affairs, and Full-Year Continuing Appropriations Act, 2013," which provides funding for government operations for the balance of the fiscal year. The bill did not contain discretionary funds to implement the ACA, which is a section that the Senate is not likely to alter. At issue is how potentially lower exchange funding will impact the states' working relationship with HHS.

Fourth, future funding and federal government guidance may be hampered by the continued intent of House and Senate Republicans to deny funding for any ACA authorized program not automatically funded.

A key date for state exchanges is Oct. 1, 2013. As of this date, state exchanges must have their health information technology structures in place and be operationally ready to begin enrolling consumers into coverage. The state exchanges must also prove sustainability by 2015, when federal funding is scheduled to terminate.

If federal funding uncertainty continues, state-operated exchanges may face fiscal stress prior to 2015. Private health insurers desiring to sell insurance products under state exchanges need to keep a watchful eye on both federal and state governments.

For additional information, please contact Julius Hobson at jhobson@polsinelli.com or 202.626.8354. ■

Middle Market Utilization of Captives

By Zachary R. Dyer

While captive insurance companies have historically been structured in offshore domiciles and used mostly by larger companies, including a high percentage of the *Fortune* 500, a growing number of middle-market companies are also realizing the benefits associated with these alternative risk planning vehicles.

In general, captives are insurance companies formed to insure the risks of a parent company or other companies affiliated with its owner (or owners). Captives insure risks like those covered by conventional insurers and provide a number of business and tax benefits. These benefits include stabilized insurance costs, increased focus on risk management and loss control, enhanced control over cash flows and the ability to generate investment income, and providing a tax-efficient mechanism for managing risk.

Captives also provide an effective option to protect against risks that may otherwise have been either prohibitively expensive or generally unavailable in the conventional market. Other benefits include the ability to customize policy forms and coverage lines and having direct access to the lower-cost reinsurance market. Accordingly, captives have become an integral part of a middle-market company's overall insurance and risk management program.

A primary goal of a captive is to recapture the profit that would have been made by the conventional insurance company. For example, the price of insurance coverage purchased in the conventional market typically reflects a significant markup to pay for the insurer's acquisition costs (sales commissions), administration and overhead, while building in a profit margin for the insurer. As a result, captive owners who are able to manage their risk better than the industry average may be able to profit from the underwriting gains, while also benefiting from investment gains on reserve funds.

A properly structured captive will qualify as an insurance company for U.S. federal tax purposes. As such, premiums paid to the captive should be deductible as an ordinary and necessary business expense under Internal Revenue Code (IRC) § 162, assuming that they are classified as "insurance premiums" (i.e., whether there is sufficient risk shifting and risk distribution).

Captives that receive less than $1.2 million of annual premium income for property and casualty lines may also be able to benefit from IRC § 831(b) and be taxed only on their investment income and not on their underwriting gain. For middle-market companies that own a captive, this section potentially provides additional cost-saving benefits over purchasing insurance from a conventional insurance company.

It is important to note that, among other factors, the Internal Revenue Service will examine any captive arrangement to ensure that it is not an economic sham and that it operates in a traditional insurance business manner. This includes consideration of whether a valid non-tax purpose motivates the formation of a captive and the associated insurance transactions.

While properly structured and managed captives provide flexibility and numerous benefits to middle-market companies, captives are not right for every organization. However, middle-market companies should at least consider a captive as part of their overall insurance and risk management programs.

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State Spotlights

Members of Polsinelli's Insurance Business and Regulatory Law Group track major insurance developments across the country and offer insights impacting our industry in the following states.

Arizona Spotlight

By Richard M. Amoroso and Lauren A. Crawford

Introduced in January 2013 in the Arizona House of Representatives, House Bill 2239 addresses the admissibility of collateral source evidence in certain civil actions and has already passed one chamber of the legislature (as of the date of this article, Arizona's legislative session, the Fifty-First Legislature – first regular session, had not closed).

The collateral source rule permits plaintiffs to recover sums from defendants irrespective of their own insurance coverage. It prevents a jury from considering evidence that the plaintiff received payments or benefits from sources other than the defendant when determining the defendant's liability. The rule's rationale is generally that a defendant should not benefit from a plaintiff's foresight in purchasing private insurance and paying premiums. The rule permits a plaintiff to get double recovery to the extent that the plaintiff's medical bills have already been paid by a private insurance carrier. The traditional rule prevents a defendant

from informing a jury that a plaintiff has already been compensated by private insurance.

In its current form, House Bill 2239 extends the abrogation of the collateral source rule to all civil actions involving personal injury, wrongful death or destruction of property claims. The bill permits a plaintiff to counter a defendant's collateral source evidence with the following:

- Amounts the plaintiff has paid or contributed to secure the plaintiff's right to any benefits;
- That any recovery for damages is subject to a lien;
- That the benefit provider has a right of recovery against the plaintiff as reimbursement for the benefits; and,
- That the benefit provider has a right of subrogation to the rights of the plaintiff.

A similar bill, House Bill 2547, was introduced during the 2012 legislative session. Due to strong opposition by subrogation professionals, specifically health care providers, this bill was successfully defeated. The bill permitted a defendant to introduce evidence that a plaintiff received collateral source benefits that reduced the plaintiff's alleged civil damages. House Bill 2547 included a provision that would prohibit a collateral source benefit provider from recovering any amount from a plaintiff "unless otherwise expressly permitted by statute." House Bill 2547 also prohibited a collateral source benefits provider from recovering any amounts whatsoever from a plaintiff as reimbursement for benefits. The bill also proposed that the provider "shall not be subrogated to the rights of the plaintiff."

House Bill 2239 attempts to remedy the anti-subrogation provision contained in House Bill 2547 by specifically providing that the proposed provision "shall not be construed to impair or affect a health care provider or collateral source benefits provider's ability to pursue any lien or right of reimbursement pursuant to state or federal law or contract."

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Colorado Spotlight

By Justin T. Liby

Division of Insurance Amends Requirements for Annual Cost Reports

The Colorado Division of Insurance (Colorado DOI) has amended Regulation 4-2-31 requiring that entities providing health insurance plans or health benefits now include in their Annual Cost Reports information regarding excess loss insurance used in conjunction with self-insured employer benefit plans under the federal Employee Retirement Income Security Act (ERISA). This form of excess loss insurance is commonly referred to as medical stop-loss insurance. The amendment was made effective Dec. 31, 2012, and applies to Annual Cost Reports due no later than June 1.

Colorado DOI Announces Plan to Opt Out of Reinsurance Program

On Sept. 7, 2012, the Colorado DOI issued a memorandum to interested stakeholders announcing that it will not operate a reinsurance program that the federal Affordable Care Act (ACA) calls upon states to offer as a way to stabilize high-risk coverage until the state's health insurance exchange reaches a critical mass of healthy enrollees. Under the program, all health insurance issuers and third party administrators of self-insured group health plans are required to contribute to a nonprofit reinsurance entity to support reinsurance coverage for individual market issuers that cover high-cost individual enrollees. The reinsurance program is temporary, beginning in 2014 and ending in 2016. The DOI announced that it "will defer the administration of the reinsurance program to the federal government."

Colorado DOI Will Not Operate Risk Adjustment Program

The ACA also calls upon each state to operate a risk adjustment program intended to level the playing field between markets inside and outside of the state's health insurance exchange and reduce the potential for excessive premium growth or instability inside the exchange. In its September 2012 memorandum to stakeholders, the Colorado DOI announced that it does not intend to operate the risk adjustment program and will "defer the administration of the risk adjustment process to the federal government." The risk adjustment program requires funds to be shifted from plans with lower-than-average actuarial risk experience to plans with higher-than-average actuarial risk experience. The program applies to insurers in the individual and small group markets, inside and outside of the state's exchange, but does not apply to self-insured ERISA plans, large group plans, or grandfathered plans. The risk adjustment program begins in 2014 and is slated to continue indefinitely.

Carriers Not Required to Duplicate Qualified Health Plans

On Feb. 11, 2013, the Colorado DOI issued Bulletin B-4.48 announcing its conclusion that nothing in current federal or Colorado law requires carriers to offer the same qualified health benefit plans they will offer through the state's health insurance exchange, outside the exchange. The Colorado DOI, however, also reminded interested stakeholders that the ACA requires carriers to charge the same premium rate for a particular qualified health plan regardless of whether the plan is offered through the exchange or outside the exchange, and regardless of whether the plan is offered directly from the carrier or through an agent.

Capping Rate Changes Considered Unfairly Discriminatory

The Colorado DOI issued Bulletin B-5.32 on March 7, 2013, directed to all property and casualty insurance companies, announcing the Colorado DOI's conclusion that capping or limiting rate changes at renewal for existing policyholders and charging new policyholders the filed rates without any cap or limitation constitutes the use of unfairly discriminatory rates. The Colorado DOI further suggests that using a filed and approved transition plan might be a means to provide existing policyholders with preferential smoothing of rate changes when a company believes it is appropriate to transition policyholders from one rating plan to another and to use rate caps or floors in the transition process.

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Illinois Spotlight

By Steven L. Imber

On Dec. 20, 2012, the Director of the Illinois Department of Insurance (Department), Andrew Boron, issued Company Bulletin #2012-12 (Bulletin) to all insurers, registered utilization review organizations (UROs) and licensed third party administrators (TPAs) conducting business affecting Illinois insureds. The Bulletin states that to reduce costs, many insurance companies have been considering the outsourcing of administrative and utilization review (UR) functions to facilities located outside of Illinois and the United States. The Bulletin is intended to provide guidance for TPAs and UROs performing services regarding Illinois insureds.

The Bulletin prohibits TPAs from conducting their activities outside the U.S. and states that UROs must perform their services within the state of Illinois. The Bulletin further specifies that UR must be conducted within the state of Illinois, as the Department believes this "ensures that the UR decision-makers will be familiar with appropriate standards of care and accessible by the Illinois courts and administrative processes." Additionally, the Bulletin asserts that the offshoring of TPA functions and the "outsourcing" of UR functions deny the Department "convenient and free access to books and records due to the additional time, preparation and expense attendant with foreign travel." As indicated in the Bulletin, the maintenance of the records on a domestically located server will not satisfy the requirement.

Finally, the Bulletin states that insurers utilizing the services of a TPA or a URO are subject to market conduct examinations under the Illinois Insurance Code.

On Jan. 18, 2013, the Department issued Company Bulletin #2013-1, which superseded Company Bulletin #2012-12. Bulletin #2013-1 stated that TPAs and UROs performing services regarding Illinois insureds are prohibited from conducting their activities offshore. However, Bulletin #2013-1 removed the prohibition contained in Bulletin #2012-12 that UROs performing services for Illinois insureds must be performed within the state of Illinois.

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Kansas Spotlight

By William W. Sneed

In the fall of 2012, Kansas Insurance Commissioner Sandy Praeger confirmed widely circulated rumors when she announced that she would not seek re-election in 2014. With that announcement, an onslaught of potential candidates started making the rounds in an attempt to secure the republican nomination and, at the same time, the Insurance Department quickly experienced several considerable staff changes.

Notably, longtime Assistant Commissioner Bob Tomlinson left the Insurance Department to become the Director of the Kansas Office of Administrative Hearings. As hearing officer, Mr. Tomlinson handled all of the Insurance Department's administrative hearings, and with his vast experience as a former legislator, he was a top prospect for Governor Brownback to tap for this new role.

With Mr. Tomlinson's departure, Zachary Anschutz, former General Counsel for the Insurance Department, was promoted to Assistant Commissioner, and his deputy, John Wine, was promoted to General Counsel.

Outside of the legal division, Kevin Davis, who was the Director of Consumer Affairs and Government Relations, left for the private sector. With his departure, Jennifer Sourk moved from the legal department to become the Director of Consumer Affairs.

Most observers believe that we won't see such considerable staff changes and departures at the Insurance Department until the time a new commissioner is elected.

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Missouri Spotlight

By Michael A. Moorefield

According to the Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP) website, since 2009, the market conduct section has generated nearly $13.1 million in payments from insurance companies due to market conduct enforcement actions. In 2012 alone,

enforcement actions resulted in nearly $5.1 million in fines paid.

Perhaps in response to the increased activity in market conduct examinations, two bills have been introduced in the Missouri legislature seeking to reform the market conduct examination process. Senate Bill 402 and House Bill 735, introduced by the chairmen of each respective bodies' insurance committees, aim to make several changes to the warrant issuance process.

Under the proposed bills, market conduct examinations can only be conducted upon the issuance of a warrant by the director of the DIFP or with written consent of the insurance company. The warrant, which must be signed by the chief market conduct examiner, must state facts sufficient to support the Director's belief that: (1) the insurer may have engaged in a practice in violation of the insurance code and the examination is calculated to provide information in regard to the alleged violation; (2) the insurer's market share has experienced a significant change and the insurer cannot provide a satisfactory explanation to the DIFP; (3) significant market share changes threaten the availability or affordability of the insurer's insurance coverage; or (4) an examination is required to be performed by law.

Additionally, the proposed revisions would limit the scope of the warrant to the cause supporting its issuance. If an examiner intends to expand the scope, a request must be made in writing to the director and notice must be given to the insurer detailing the extent and reasons for the expansion. Within 15 days following service of the original warrant, the insurer can request a hearing before the director to review whether the market regulation division established the necessary cause to issue the warrant.

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Texas Spotlight

By Justin T. Liby

The Texas Department of Insurance (Texas DOI) adopted amendments to the existing regulations regarding preferred provider benefit plans (PPBPs) and exclusive provider benefit plans (EPBPs) at Texas Admin. Code title 28, § 3.3701 et seq. According to the amendments, the regulations will be applied to any PPBP policy or EPBP policy that is offered, delivered, or issued for delivery, or renewed on or 150 days after Feb. 21, 2013. EPBPs are closed network plans where only network provider services are covered, with the exception of emergency services and out-of-network services provided when no network provider is available. The rules address the disclosure of ownership interests in referred providers; safe harbors from the prohibitions on unjust or unfair discrimination; mandatory disclosures to insureds; provider contract requirements; network adequacy requirements; Texas DOI approval of EPBPs; quality improvement programs; and handling of out-of-network claims.

Effective Feb. 20, 2013, the Texas DOI repealed and replaced existing regulations pertaining to utilization reviews under a health benefit plan, health insurance policy, and workers' compensation coverage. The new regulations are located at Texas Admin. Code title 28, § 19.1701 et seq. for health benefit plans or health insurance policies and at Texas Admin. Code title 28, § 19.2001 et. seq. for workers' compensation coverage. Utilization Review Agents (URAs) that were certified or registered before the effective date of the new regulations are required to submit an application in compliance with the new regulations within 90 calendar days after Feb. 20, 2013. The new regulations address mandatory utilization review plans; qualifications for URA health care providers; medical record reviews; on-site URA reviews; rules regarding adverse determinations and appeals; minimum URA access requirements; confidentiality; specialty URA certificates; independent reviews; and preauthorization requirements.

In 2011, the Texas Legislature adopted Senate Bill 7 establishing a regulatory scheme governing Health Care Collaboratives (HCCs). This regulatory scheme includes a licensing requirement, an antitrust review and determination by the Texas Attorney General's Office, and other operational compliance requirements. On March 11, 2013, the Texas DOI issued an order adopting new regulations further clarifying the HCC regulatory scheme and adopting several forms for purposes of licensing and overseeing HCCs. The new regulations are located at Texas Admin. Code title 28, § 13.401 et seq. An HCC is an entity that (i) undertakes to arrange for medical and health care services for insurers, health maintenance organizations, and other payors in exchange for payments in cash or in kind, (ii) accepts and distributes payments for medical and health care services, (iii) consists of physicians, physicians and other health care providers, physicians and insurers or health maintenance organizations, or physicians, other health care providers, and insurers or health maintenance organizations, and (iv) is certified by the Texas DOI to lawfully accept and distribute payments to physicians and other health care providers using the reimbursement methodologies authorized by the HCC law. Delegated Entities under the Health Maintenance Organization laws are excluded from the licensing and antitrust determination under the HCC laws. The new regulations clarify the regulatory scheme applicable to HCCs and seek to expand on the antitrust review and determination, the working capital and reserve requirements, and other operational compliance requirements applicable to HCCs.

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Insurance Business and Regulatory Law

With decades of experience assisting the insurance industry with corporate transactions and various compliance and regulatory issues across the country, the Insurance Business and Regulatory Group at Polsinelli has the experience to provide outstanding services to this industry. With several former state insurance department attorneys, including two who served as General Counsel, and five attorneys who were former in-house counsel to various insurance organizations, our attorneys understand the unique needs of our insurance clients on matters involving state insurance departments, state Attorneys General, and other state and federal regulatory agencies.

We routinely handle business and regulatory issues, such as:

- Serving as national outside counsel for various property and casualty insurers, workers' compensation insurers, life and health insurers, third-party administrators and discount medical plan organizations.
- Conducting corporate mergers and acquisitions.
- Making holding company transaction and other related regulatory filings.
- Completing complex national and multi-state regulatory and compliance research.
- Filing Uniform Certificate of Authority Applications, including Primary, Expansion and Corporate Amendment Applications.
- Conducting national and multi-state licensing and compliance projects for third party administrators, agencies, adjusters and discount medical plan organizations.
- Assisting with market conduct examinations and financial examinations, including a multi-state market conduct examination involving 50 states.
- Assisting with insurance company corporate governance requirements, including the Model Audit Rule, and development of appropriate committee charters, conflict of interest statements, codes of conduct and ethics statements, record retention and destruction policies, whistle blower policies, and others.
- Serving as the Deputy Receiver or General Counsel to the Deputy Receiver with respect to insurance company receiverships.
- Forming captive insurers and risk retention groups and assisting with their ongoing compliance and business issues.

Clients include insurance companies, insurance brokers and agencies, third-party administrators, discount medical plan organizations and associations – virtually any individual or entity subject to regulation by state insurance departments, state Attorneys General or other state agencies. The Insurance Business and Regulatory Group has the depth to provide quality and responsive legal services to regulated entities in the insurance industry with respect to all of their business and regulatory needs. ■

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