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INSURANCE WEB SITES OF INTEREST

National Association of Insurance Commissioners
http://www.naic.org

Tennessee Department of Commerce and Insurance
http://tn.gov/commerce/

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DICKINSON WRIGHT'S

TENNESSEE INSURANCE **LEGAL**NEWS

COMMISSIONER OF TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE ISSUES POSITION ON FILING REQUIREMENTS OF NEW ENTERPRISE RISK FILING LEGISLATION

by John E. Anderson, Sr., who is a member in Dickinson Wright's Nashville office, and can be reached at 615.620.1735 or janderson@dickinsonwright.com

On May 28, 2014, Governor Haslam signed legislation revising the State's Holding Company Act ("Act"). The Act revisions include a provision in Section 13 of the bill that requires the ultimate controlling officer of every insurer file an annual Enterprise Risk Report to the Tennessee Department of Commerce and Insurance ("Department").

Section 13 of the bill, T.C.A. § 56-11-105(l), states as follows:

> (l) ENTERPRISE RISK FILING. The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

The Commissioner of the Department, Julie Mix McPeak, issued a memorandum dated April 10, 2014 ("Memorandum"). The purpose of the Memorandum was to inform applicable insurance companies that the Department will not penalize them if they are not able to file the report by April 30, 2014. The Commissioner explained that the Department found that in the absence of rules implementing the new legislation that specify the form to be used by the Enterprise Risk Filing, companies may not be able to make the Enterprise Risk Filing with the Department by April 30, 2014. "The Department, therefore, takes the position that just cause exists under § 56-11-111(a) for companies not to file the Enterprise Risk Filing as required by PC583. The Department will not penalize a company under § 56-11-111(a) for non-compliance with the Enterprise Risk Filing provision in calendar year 2014." The memorandum notes that the Department encourages companies to make this filing by October 31, 2014. It concluded by stating that it applied only to the Enterprise Risk Filing under the Holding Company Act revisions and only for calendar year 2014.

LEGISLATION PERMITTING HEALTHCARE PROVIDERS TO NEGOTIATE JOINTLY WITH HEALTH INSURERS INTRODUCED IN CONGRESS

by James M. Burns, who is a member in Dickinson Wright's Washington, D.C. office, and can be reached at 202.659.6945 or jmburns@dickinsonwright.com

Legislation was recently introduced by Representative John Conyers (D. Michigan) that would permit healthcare providers to negotiate jointly with health insurers concerning contract terms without running afoul of the antitrust laws. The bill, the "Quality Health Care Coalition Act of 2014," (H.R. 4077), has been referred to the House Judiciary's Subcommittee on Regulatory Reform, Commercial and Antitrust Law for further action.

In introducing the legislation, Representative Conyers stated that "over the last several decades, the health insurance market has become exceedingly concentrated, dominated by a few large insurers offering a limited number of health insurance plans. This has occurred in large part because of insurers' immunity from federal antitrust laws. In contrast, our nation's physicians and health care providers are afforded no comparable protections. This unbalanced playing field ultimately means consumers lose out with higher healthcare costs and poorer care. H.R. 4077 allows for physicians to negotiate with insurers on a level playing field, ensuring heightened quality standards for patient care."

Notably, Representative Conyers has introduced similar legislation in the past, without success. However, the legislation enjoys a degree of bipartisan support this Congress, with Republicans in both the House and Senate having also introduced legislation containing provisions similar to those in Representative Conyers's bill. Specifically, H.R. 2300, which was introduced by Representative Tom Price (R. Georgia) last June, would permit healthcare providers to negotiate jointly with insurers, as does S. 1851, which was introduced by Senator John McCain (R. Arizona) last December. However, both H.R. 2300 and S. 1851 are much larger bills that also seek to repeal the Affordable Care Act, and thus those bills are unlikely to garner Democrat support in the House or Senate.

Nonetheless, the fact that these Republican-sponsored bills contain language that is virtually identical to that in Representative Conyers's bill suggests that the prospects for H.R. 4077 are probably brighter this year than they have been at any time since 2000, when similar legislation was passed in the House but failed to get acted upon in the Senate. Will Representative Conyers's legislation finally "cross the finish line" this Congress? Time will tell; stay tuned.

CYBER-COVERAGE: CLARITY OR CONFUSION?

by Autumn L. Gentry, who is a member in Dickinson Wright's Nashville office, and can be reached at 615.620.1755 or agentry@dickinsonwright.com

As the number of data breaches and disclosure of personally identifiable information ("PII") increases, courts are being asked to decide whether such claims for data breach and disclosure of PII are covered by traditional commercial general liability (CGL) policies. Most often, companies who have only traditional CGL policies, argue that such claims should fall under their policies' coverage for "personal and advertising injury," which is typically defined as injuries arising out of the oral or written publication of material that violates a person's right of privacy.

Sony made this same argument in the recent case of *Zurich American Insurance v. Sony Corporation of America*. Sony argued that coverage for a consumer class action filed against Sony for a 2011 data breach of Sony's Playstation network should fall under its CGL policy's coverage for "personal and advertising injury" which included the typical definition. A New York trial judge disagreed, finding that the definition required "some kind of act or conduct by the policyholder in order for coverage to be present." Because the data breach was committed by third-party hackers who broke into Sony's security system, rather than by an "act or conduct perpetuated by Sony," the trial court held that the policy did not provide coverage for the data breach claims against Sony.

Courts in other jurisdictions have held otherwise, finding that coverage under a CGL policy extended to claims for data breach and disclosure of PII based upon each policy's definition of "personal injury." *See e.g. Netscape Communications Corp. v. Federal Ins. Co.*, 343 Fed.Appx. 271 (9th Cir. 2009);*Tamm v. Hartford Fire Ins. Co.*, 16 Mass.L.Rptr. 535, 2003 Mass. Super. LEXIS 214 (Mass. Super. Ct. 2003).

In response to the rising number of claims for data breach and cyber coverage being filed, Insurance Services Offices, Inc. (ISO) filed in many jurisdictions a new set of exclusionary endorsements. These exclusionary endorsements, which effect provisions under a CGL's policy for "Bodily Injury and Property Damage" (Coverage A) and "Personal and Advertising Injury Liability" (Coverage B), are scheduled to take effect this month.

Insurers who issue these exclusionary endorsements will likely argue that these provisions apply to and, therefore, exclude coverage for any cyber liability or data breach claims. However, insurers will have to prove that they do so. If insurers do not issue these exclusionary endorsements, policyholders will likely argue that their traditional CGL policies cover such claims, otherwise their insurers would have issued the exclusionary endorsements based upon the ISO's guidance. Only time will tell how the varying jurisdictions will decide these issues.

A ROSE IS A ROSE IS A ROSE: THE SAME CANNOT BE SAID FOR ASSIGNMENTS

by Kelly M. Telfeyan, who is an associate in Dickinson Wright's Nashville office, and can be reached at 615.620.1721 or ktelfeyan@dickinsonwright.com

Can an individual who is not named as an insured on a health insurance policy, under which benefits are presumably available, assign his/her rights in favor of a healthcare provider? This question was recently answered by the Tennessee Court of Appeals in *Action Chiropractic Clinic, LLC v. Hyler,* No. M2013-01468-COA-R3-CV, 2014 Tenn. App. LEXIS 73 (Tenn. Ct. App. Feb. 12, 2014).

In *Hyler*, Prentice Hyler ("Hyler") and William Burnette, Jr. ("Burnette") were involved in an automobile collision that was caused by Burnette. At the time of the accident, Burnette's automobile was insured by Erie Insurance Exchange ("Erie"). Following the accident, Hyler received medical treatment at Action Chiropractic Clinic, LLC ("Action"). As consideration for the healthcare provided and in order to satisfy any payment owed, Hyler executed an Assignment of Rights (the "Assignment") to Action for medical expense benefits allowable and otherwise payable to Hyler from his "Health Insurance, Auto Insurance, or any other party involved." When Hyler's treatment ended, Action sent Erie a copy of the Assignment.

When Erie did not remit payment, Action filed a civil warrant in Davidson County General Sessions Court. Erie removed the case to Circuit Court, where it filed a motion for summary judgment. The Circuit Court granted Erie's motion, holding that: (1) Hyler had no vested rights against Erie when he executed the Assignment to Action; (2) the insurance policy required written consent to the assignment of any rights thereunder and there was no evidence of such consent; (3) there was no contractual privity between Action and Erie; (4) Action was not a third-party beneficiary of the policy; and (5) the suit was a direct action against an insurance company and, hence, prohibited by Tennessee law.

On appeal, Action argued: (1) that the Assignment was valid under Tenn. Code Ann. § 56-7-120(a)(1) and Tennessee common law; (2) that Hyler could assign his rights to Action despite the language regarding assignments in the automobile insurance policy; (3) that public policy favored the assignment of benefits to a health care provider by an injured party; (4) that the Assignment was valid despite a lack of contractual privity with Erie; and (5) that it could sue Erie directly even though Tennessee is not a direction action state.

The Tennessee Court of Appeals first addressed whether the Assignment to Action was valid under Tenn. Code Ann. § 56-7-120(a)(1), which states, in pertinent part, as follows:

> Notwithstanding any law, rule, or regulation to the contrary, whenever any policy of insurance issued in this state provides for coverage of health care rendered by a provider covered under title 63, the insured or other persons entitled to benefits under the policy shall be entitled to assign these benefits to the healthcare provider and such rights must be stated clearly in the policy. Notice of the assignment must be in writing to the insurer in order to be effective; provided, however, such notice can be provided by other means if so stated in the policy.

Tenn. Code Ann. § 56-7-120(a)(1).

In determining whether the Assignment from Hyler to Action was valid under the foregoing statutory provision, the Tennessee Court of Appeals stated that the dispositive question was whether, Hyler, who was not a named insured under the policy, otherwise qualified as a "person entitled to benefits under the policy." After evaluating the portion of the policy identifying the persons protected under the policy and determining that there was nothing to suggest that Hyler was such a person, the Court held that the Assignment was not valid under Tenn. Code Ann. § 56-7-120(a)(1).

Having determined that the Assignment was not valid under Tenn. Code Ann. § 56-7-120(a)(1), the Court addressed whether the Assignment was valid under Tennessee common law. In this regard, the Court ultimately concluded that, while Hyler had a common law right to assign the proceeds of his claim against Burnette to Action to pay for his treatment, Action's rights were no greater than Hyler's. Because Hyler was not a named insured or otherwise within the class of persons protected by the policy and because there was no evidence that Burnette, who was the named insured, had taken any action to assign his benefits under the policy to Hyler, it followed that Hyler had no rights against Erie that he could assign to Action. For that reason, while holding that Hyler had a common law right to assign his proceeds to Action, the Court ruled that Erie was not obligated to honor the Assignment.

The Court next addressed Action's argument that the Assignment was valid and, hence, enforceable against Erie despite the lack of contractual privity between Action and Erie. Action argued that because there will never be privity between a healthcare provider and the insurance company, lack of privity should not serve as a basis for refusing to honor the Assignment. The Court of Appeals disagreed, stating that insurance contracts are, by their very nature, personal contracts between the insured and the insurer. The Court further reiterated that Hyler had no claim or right to performance against Erie and, therefore, nothing to assign relative to Erie.

The Court then turned to Action's assertion that the trial court erred in holding that Action could not bring suit against Erie because Tennessee is not a "direct action" state. The Court of Appeals found Action's contention unavailing, stating that, because Action's lawsuit against Erie sought to enforce a duty arising from the policy, it indisputably amounted to a direct action.

Lastly, the Court addressed Action's argument that the language in the policy requiring Erie's consent to any assignment of benefits did not apply to Hyler because Hyler was not a party to the contract of insurance and, hence, not bound the policy's consent requirement. In response, the Court stated that, while it agreed the Hyler's ability to assign the proceeds of his claim against Burnette were not constricted by the language of the policy, it disagreed with Action's contention that, as a result, Erie was bound to honor the Assignment. In explaining the reason for its decision, the Court stated that because Hyler was not a named insured or otherwise protected or entitled to benefits under the policy, Erie was not obligated to honor Hyler's Assignment to Action.

For the foregoing reasons, the Court of Appeals affirmed the judgment of the trial court.

There are two points that insurance companies should take away from this decision. First, it would be advisable for insurance companies to include language in their policies stating that assignments executed by individuals who are not either named insureds or otherwise protected

or entitled to benefits under the policy will not be honored by the insurer. Second, even when no such language is included in the policy, there is now precedent clearly establishing that such an assignment will not be enforceable against the insurer.

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