INSURANCE**LEGAL**NEWS

FEDERAL HEALTH CARE LEGISLATION UPDATE

by Cynthia A. Moore, Member

Sixth Circuit Upholds the Constitutionality of PPACA

On June 29, 2011, the Sixth Circuit Court of Appeals issued the first appellate court decision on the constitutionality of the Patient Protection and Affordable Care Act ("PPACA"). In a 2-1 decision, the Sixth Circuit held that PPACA is a valid exercise of the federal government's power under the Commerce Clause of the Constitution. *Thomas More Law Center, et al v. Obama, et al,* No. 10-2388 (6th Cir. June 29, 2011).

The constitutional challenge is aimed at the minimum coverage provision of PPACA. Under the minimum coverage provision, all applicable individuals must maintain minimum essential coverage or pay a penalty. 26 U.S.C. §5000A. The plaintiffs alleged that (1) Congress lacked authority under the Commerce Clause to enact the minimum coverage provision and (2) the penalty for a failure to maintain minimum coverage is an unconstitutional tax.

Based on existing Supreme Court decisions, the Court reviewed whether the minimum coverage provision falls within Congress's power under the Commerce Clause to regulate activities that substantially affect interstate commerce. The Court found that an individual's decision to self-insure for health care services *(i.e.*, not to purchase health insurance) is an economic activity and Congress had a rational basis to conclude that, in the aggregate, this activity substantially affects interstate commerce. Alternatively, even if self-insuring for the cost of health care is not economic activity with a substantial effect on interstate commerce, Congress could still properly regulate the practice because the failure to do so would undercut its regulation of the larger interstate markets in health care delivery and health insurance. The plaintiffs also argued that the minimum coverage provision regulates "inactivity" rather than "activity" which is an impermissible expansion of the Commerce Clause power. The majority opinion did not agree with this argument; a dissenting opinion by Judge Graham found this argument persuasive.

Because the Sixth Circuit found the minimum coverage provision to be a valid exercise of the Commerce Clause power, it did not address plaintiffs' alternative argument that the provision is an unconstitutional tax.

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INSURANCE WEB SITES OF INTEREST

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

Michigan Office of Financial and Insurance Regulation
http://www.michigan.gov/dleg/0,1607,7-154-10555---00.html

There are other appellate court reviews of PPACA underway, and almost all observers believe that the U.S. Supreme Court will ultimately decide whether PPACA is constitutional.

Amendments to Interim Final Rules on Internal and External Claim Appeal Process

On June 22, 2011, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and Treasury issued an amendment

("Amendment") to the interim final rules and other guidance on the internal and external claim appeal process under Section 2719 of PPACA. The changes are effective on July 22, 2011, and amend the interim final rules issued on July 23, 2010 (the "July 2010 Rules"). These rules apply to non-grandfathered plans.

The Amendment makes the following changes to the July 2010 Rules:

- The July 2010 Rules required that a claimant be notified of a benefit determination on an urgent care claim within 24 hours after receipt of the claim by a plan or issuer. The Amendment reverts to the original DOL rule that the claimant be notified as soon as possible after receipt of an urgent care claim, taking into account the medical exigencies, but in no event longer than 72 hours. The Departments emphasize that the 72-hour time frame is an outside limit on rendering a decision.

- With respect to the requirement to provide additional content in any notice of an adverse benefit determination or final adverse benefit determination, the Amendment provides that diagnosis and treatment codes (and their meanings) are not required to be automatically provided. Instead, the plan or issuer must notify the claimant that the diagnosis and treatment codes are available on request.

- The July 2010 Rules provided that any violation of the internal claim procedure rule would enable a claimant to seek external review without exhausting the entire internal claim appeal process. Under the Amendment, this approach still applies, unless the violation is (1) *de minimis*, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's or issuer's control, (4) in the context of an ongoing and good-faith exchange of information, and (5) not reflective of a pattern or practice of noncompliance.

- The July 2010 Rules tied the requirement to provide non-English language notices in the group market to the number of non-English language plan participants. Under the Amendment, with respect to group health plans and health insurance issuers offering group or individual health insurance coverages, the plan or issuer will first determine if the notice is being delivered to an address in a county with 10% or more of the population who are literate in the same non-English language. If the claimant resides in such a county, then the notice must include a one-sentence statement in the relevant non-English language about the availability of language services. The Amendment includes a chart with a list of affected counties, which will be updated annually.

- If a state's external review process does not comply with the minimum consumer protections of the NAIC Uniform Health Carrier External Review Model Act (the "NAIC Uniform Model Act"), then issuers in that state would be subject to a federal external review process. In the Amendment, the Departments moved the transition period for states to comply with the new rules to December 31, 2011. Until then, any currently effective state external review process is deemed to satisfy the PPACA external review criteria.

- The July 2010 Rules provided for external review for any adverse benefit determination (unless it related to eligibility under a group health plan). Comments on the July 2010 Rules expressed concern that the scope of external review is broader than in the NAIC Uniform Model Act, and that independent review organizations ("IROs") have experience in adjudicating medical claims, but not legal and contractual claims. In response to the comments, the Amendment suspends the original rule and provides that the federal external review process will apply only to claims that involve (1) a rescission of coverage or (2) medical judgment, including the appropriate health care setting for providing medical care, whether treatment by a specialist is necessary or appropriate, whether treatment involves "emergency care" or "urgent care," and other similar issues. The suspension of the broad review rule is expected to be lifted by January 1, 2014.

- The July 2010 Rules provided that an IRO's external review decision is binding on the plan or issuer and the claimant, except to the extent that other remedies are available under state or federal law. The amendment clarifies that the plan or issuer must provide benefits pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless and until there is a judicial decision otherwise.

HHS contemporaneously issued Technical Release 2011-02, which provides additional guidance on the state- and federally-administered external review process and updated versions of the model notice of adverse benefit determination, model notice of final internal adverse benefit determination, and model notice of final external review decision, which reflect changes made in the Amendment.

MICHIGAN SENATE PASSES HEALTH INSURANCE CLAIMS ASSESSMENT LEGISLATION

On June 30, 2011, the Michigan Senate voted 26 to 9 in passing SB 348, which if enacted would be known as the Michigan Health Insurance Claims Assessment Act. As reported in a prior edition of *Insurance Legal News*,[1] SB 348 would replace the current health maintenance organization use tax with a 1% tax on most health care claims paid in Michigan. The proposed legislation, with an effective date of October 1, 2011, would place obligations for payment on a wide variety of insurance carriers, but also on third-party administrators and group health plan sponsors.

The proposed assessment would, together with federal matching dollars, replace $1.2 billion in funding for the state Medicaid program

currently provided by the HMO use tax. On June 30, the Michigan Senate also passed tie-barred legislation, SB 347, which would repeal the current HMO use tax 90 days after the effective date of the assessment tax, creating a three-month period in which both assessments would apply simultaneously.

After passage in the Senate, SB 348 was sent to the House for review and referred to the Committee on Appropriations. No hearings on SB 348 have yet been scheduled.

Available at http://www.dickinson-wright.com/bdsfiles/News/efe8d970-5102-4d3d-8ec7-5dca7d2bcac9/Presentation/NewsAttachment/fe4967c1-18b5-4c22-9bb6-5ebc80c873fe/Insurance Newsletter 6.11_supplement.pdf

TENNESSEE REVISES CAPTIVE INSURANCE LAW

by John E. Anderson, Sr., Member, and Rodney D. Butler, Associate

On June 10, 2011, the "Revised Tennessee Captive Insurance Act," 2011 Tenn. Pub. Acts 468, was signed into law by Governor Bill Haslam. The amended law will permit the creation, within the state of Tennessee, of special purpose captive insurance companies, cell captive insurance companies, and branch captive insurance companies. Previously, the laws of the state of Tennessee did not allow for the formation of sponsored captive insurance companies, branched captive insurance companies, or special purpose financial captive insurance companies.

A captive insurance company is a wholly owned subsidiary of a corporation that provides insurance or reinsurance services to its parent company and to its parent company's customers and suppliers. Captive insurance companies may be formed because the parent company cannot find an outside insurance company to insure against particular business risks or because the parent company simply wants greater flexibility or voice in determining the amounts and types of coverage, overseeing of claims handling, and settlement. Captives may also provide cost-effective insurance coverage at stable rates that cannot be otherwise found in the traditional insurance marketplace.

Besides permitting certain types of captives to be formed, the revised Tennessee law will further allow captives to offer workers' compensation coverage to employers and affiliates who would otherwise qualify as self-insured. Additionally, the captives will be granted the ability to write excess or stop loss workers' compensation insurance where employers would not be able to qualify as self-insured.

Moreover, this legislation also modified the tax provisions of the former law. Based upon the new statute, the minimum premium tax will be $5,000 annually, whereas the maximum annual tax under the law will be set at $100,000. With respect to protected cell companies, the maximum aggregate premium tax on an annual basis would be assessed against each cell individually, and not to the protected cell captive as a whole. The amended version of the law identifies an "incorporated cell captive insurance company" as a "protected cell captive insurance company" which is organized as a corporation or other legal entity distinct from its incorporated cells, which are also established as separate legal entities. Therefore, the aforementioned taxes will be levied on each "individual" cell insurance company rather than on the "total collection" of cell insurance companies taken together as a single entity.

Beyond these revisions, the overhaul to the law will require single-parent captives to have a minimum of $250,000 in capital and surplus. In comparison, the minimum capital and surplus amounts required for an association captive insurance company, protected cell captive insurance company, and industrial insured insurance company will be $500,000, with $1 million required for risk retention groups. These amounts may be increased by the state's insurance commissioner depending upon the type and volume of business of the captive.

The "Revised Tennessee Captive Insurance Act" is scheduled to take effect on September 1, 2011.

MICHIGAN'S OFFICE OF REGULATORY REINVENTION APPOINTS AREA RESIDENTS TO ITS INSURANCE AND FINANCE ADVISORY RULES COMMITTEE

On May 27, 2011, the Office of Regulatory Reinvention ("ORR"), a division of Michigan's Department of Licensing and Regulatory Affairs ("LARA"), appointed thirteen individuals to its Insurance and Finance Advisory Rules Committee ("IFARC"). The ORR was created under Executive Order 2011-5, which required the ORR to establish certain Advisory Rules Committees in order to obtain input from a wide range of stakeholders. [2]

According to LARA, the IFARC will assist the ORR with identifying duplicative, obsolete, unnecessary, or unduly restrictive rules affecting the insurance, banking, and finance industries.[3] The IFARC will issue a report to the ORR containing advisory recommendations upon the completion of its work.

As of May 27, 2011, the ORR had identified approximately 575 rules to be evaluated by the IFARC appointees based upon the factors enumerated in Executive Order 2011-5, including: (1) the health and safety benefits of the rules, (2) the cost of compliance with the rules, and (3) whether the rules are duplicative or obsolete.[4] After reviewing the IFARC's final report and recommendations, the ORR will ultimately submit its findings and recommendations to Governor Snyder.

The ORR appointed the following thirteen individuals to serve on the IFARC:

- Bill Berenson, Lansing, Michigan Market President, AETNA;
- Lorray Brown, Ypsilanti, Michigan Poverty Law Program;

- Patty Campbell, Roseville, President & CEO, Christian Financial Credit Union;
- Kevin Clinton, East Lansing, Office of Financial and Insurance Regulation (OFIR) Commissioner;
- Mark Cook, Lansing, Vice President of Governmental Affairs, BCBSM;
- Allan Daniels, Bloomfield Hills, President, AA Mortgage Corp.;
- David Field, Northville, Regional Counsel, Law and Regulation, Allstate Insurance Company;
- Kurt Gallinger, Brighton, Vice President & Counsel - Government Relations, Amerisure Mutual Insurance Company;
- Lawrence Kish, Okemos, President and General Counsel, Life Insurance Association of Michigan;
- W. Howard Morris, Detroit, President & Chief Investment Officer, Prairie & Tireman;
- Robert Pierce, Lansing, CEO, Michigan Association of Insurance Agents;
- Jeanne Richter, Williamston, President/CEO, Farmers State Bank of Munith; and
- Robert Worthington, Grand Rapids, Senior Vice President, General Counsel & Risk Management Director, Mercantile Bank of Michigan.

According to Steve Hilfinger, Michigan's Chief Regulatory Officer, director of the ORR, and chair of the IFARC, "Michigan is fortunate to have so many highly-credentialed citizens excited to serve and put in the time necessary to make Michigan's regulatory system more efficient and effective."[5]

Hilfinger also noted that "all members of the regulated community - including insurers, credit unions, banks, and consumers - will have their voices heard on this committee."[6]

[2]*See* EXECUTIVE ORDER 2011-5, State of Michigan Department of Licensing and Regulatory Affairs (February 23, 2011) (http://www.michigan.gov/documents/snyder/2011-5_346312_7.pdf).

[3]OFFICE OF REGULATORY REINVENTION APPOINTS MEMBERS TO THE INSURANCE AND FINANCE ADVISORY RULES COMMITTEE, Michigan Department of Licensing and Regulatory Affairs (May 27, 2011) (http://www.michigan.gov/lara/0,1607,7-154-10576_35738-256951--,00.html)

[4] *Id.*

[5]*Id.*

[6]*Id.*

RECENT CASE LAW SUMMARIES

SECOND AND THIRD CIRCUIT COURTS OF APPEAL CLARIFY INSURER STANDING IN CHAPTER 11 BANKRUPTCY PROCEEDINGS

by Ryan M. Shannon, Associate

Two recent decisions by the Second and Third Circuit United States Courts of Appeals have set forth with more clarity the standards by which insurers may establish standing in Chapter 11 bankruptcy proceedings and have opened the door for increased insurer involvement in such proceedings.

In *In re Global Industrial Technologies*, No. 08-3650, 2011 US App LEXIS 9109 (3d Cir, May 4, 2011), the United States Court of Appeals for the Third Circuit held in a published decision that various insurers had sufficient interests to meet constitutional and bankruptcy standing requirements such that the insurers could challenge the confirmation of the Chapter 11 plan of reorganization put forth by their insureds.

In 2002, citing adverse business conditions and a large number of asbestos-related lawsuits pending against them, Global Industrial Technologies and its subsidiary, A.P. Green Industries, Inc. (collectively, the "debtors"), sought Chapter 11 protection. The debtors also faced a number of silica-related claims. The debtors submitted a plan of reorganization which would establish a trust to pay silica-related claims and which would be funded by assignment of the insurers' policies. In seeking confirmation votes from claimants, the debtors recognized through solicitation a much larger number of silica-related claims (over 4,600) than the 169 which had been previously pending. The insurers sought to oppose the plan of reorganization on the basis that the plan was neither necessary nor appropriate under the Bankruptcy Code, and also alleged collusion between the silica-related claimants and the debtors. In evidentiary hearings, the insurers presented evidence questioning the legitimacy of 91.5% of the silica claims made against the debtors. *Id*. at *16.

The bankruptcy court confirmed the debtors' plan of reorganization and held that the insurers lacked standing to object to the plan. Because the insurers would still be able to assert their coverage defenses if ever faced with putative obligations to reimburse the silica-claims trust, the bankruptcy court determined that the insurers had not suffered the requisite injury to object. *Id*. at *18. The district court affirmed.

On appeal, the Third Circuit reversed, finding that the insurers met both the Federal Constitutional requirement of "injury in fact" as well as the Bankruptcy Code's standing requirement as "parties in interest." *Id*. at *25. As the funding sources ultimately responsible for contesting the liabilities of the silica trust, the insurers were ostensibly injured by the creation of the trust and the resulting dramatic increase in silica-related claims. "Here," the court explained, "the plan's creation of the

[trust] led to a manifold increase in silica-related claims. That constitutes a tangible disadvantage to [the insurers]" as it "creates an entirely new set of administrative costs, including the investigative burden," of determining which of the claims, if any, were valid. *Id*. at *35.

The Third Circuit remanded for further development of the factual record with respect to the insurer's allegations of collusion in the creation of the silica-claims trust.

Just two weeks after *In re Global Industrial Technologies*, in *In re Heating Oil Partners LP*, No. 10-733-bk, 2011 US App LEXIS 9978 (2d Cir, May 16, 2011) (unpublished), the United States Second Circuit Court of Appeals similarly found that an insurer was sufficiently impacted by its insured's bankruptcy proceedings such that the insurer could enforce the terms of the automatic stay in the proceedings.

In *In re Heating Oil Partners*, a third-party claimant had secured a default judgment against the debtor. The debtor's insurer moved in bankruptcy court for an order declaring a default judgment against the debtor void on the basis that the order was entered in violation of the automatic stay triggered by the debtor's Chapter 11 bankruptcy petition. *Id*. at *2. The bankruptcy court granted the motion, and the district court affirmed.

On appeal, the third-party claimant argued that the insurer lacked standing to invoke the protections of the automatic stay.

Under the Bankruptcy Code "party in interest" standard, which takes into consideration whether the party has a "sufficient stake" in the outcome of the bankruptcy proceeding (including a pecuniary interest directly affected), the Second Circuit found that the insurer had a sufficient interest in whether the default judgment was void in that the insurer would have to indemnify the insured in full or in part for the judgment. "Without a doubt," the court stated, the insurer "has a personal stake" and "is a party in interest pursuant to" the Bankruptcy Code. *Id*. at *5. As such, the bankruptcy court's declaration that the default judgment was void was affirmed.

SIXTH CIRCUIT COURT OF APPEALS ADDRESSES SCOPE OF INSURER'S DUTY TO DEFEND UNDER MICHIGAN LAW

In *Federal Mogul US Asbestos Personal Injury Trust v Continental Casualty Co*, No. 10-1290, 2011 US App LEXIS 13894 (6th Cir, July 8, 2011), the Sixth Circuit affirmed in a published decision the district court's dismissal of the Federal-Mogul U.S. Asbestos Personal Injury Trust's ("Trust") complaint. The Sixth Circuit held that under the express terms of the subject policy, Continental Insurance Company's ("Continental") duty to defend had not been triggered.

The Trust had previously been created under the Chapter 11 bankruptcy plan of the Federal-Mogul Corporation in order to bear liability for certain asbestos-related bodily injury claims ("Claims"). *Id*. at *2. The Trust was also assigned the right to insurance proceeds and coverage under three primary-level general liability policies issued by Travelers Indemnity Company ("Travelers") and two other insurers. According to the Trust, the limits of the Travelers policy were exhausted prior to its initiation of this action. *Id*.

The Trust alleged that exhaustion of the Travelers policy triggered Continental's duty to defend under its umbrella policy ("Umbrella Policy") and sought a declaration of same. However, the district court disagreed and dismissed the Trust's complaint. *Id*. at *3. On appeal, the Sixth Circuit applied Michigan law. Under Michigan law, an insurer's duty to defend is "defined by policy language," and thus "the policy language [was] most important in [its] analysis[.]" *Id*. at *4.

The Trust's Umbrella Policy required Continental to defend any suit against the Trust "[w]hen an occurrence is not covered by the underlying insurance listed in the underlying insurance schedule or any other underlying insurance collectible by the insured, but covered by the terms of this policy, without regard to the retained limit contained [t]herein." *Id*. at *7-8. After determining that the language of the Umbrella Policy was "not ambiguous," the Sixth Circuit concluded that the Trust's claim that exhaustion of the Travelers policy triggered Continental's duty to defend was "untenable" because it ignored the words "*or any other underlying insurance collectible by the insured*." *Id*. at *8 (emphasis added). Specifically, the court found that the allegations contained in the Trust's complaint – *i.e.*, that the Claims fell "within the scope of coverage" of the Travelers policy, as well as the other two primary policies held by the Trust, and that "[t]hose primary insurers [were] defending the Trust with respect to the" Claims – were dispositive based upon the Umbrella Policy's express language. *Id*. at *9. Although the Travelers policy had been exhausted, the two other underlying primary insurers continued to defend the Claims. Accordingly, the Sixth Circuit held that Continental's duty to defend was not yet triggered. *Id*. at *9-10.

MICHIGAN COURT OF APPEALS HOLDS POLICY DEFENSES MAY BE PRESERVED BY TIMELY FILED DECLARATORY JUDGMENT ACTION EVEN WHEN RESERVATION OF RIGHTS LETTER IS NOT ISSUED

In *Cincinnati Ins Co v Hall*, No. 297600, 2011 Mich App LEXIS 1048 (June 14, 2011) (unpublished), a panel of the Michigan Court of Appeals reversed the judgment of the trial court and remanded the plaintiff Cincinnati Insurance Company's ("Cincinnati") declaratory action for further proceedings. The court held that Cincinnati's failure to issue a reservation of rights letter to its insured-defendant Social Resources, Inc. ("SRI") will not preclude its right to assert defenses to coverage under the policy if the declaratory judgment action in fact provided adequate notice of Cincinnati's intent to reserve its rights. *Id*. at *8.

This case arose from an underlying personal injury action alleging that SRI was liable for a permanent eye injury sustained by a developmentally disabled adult while under its care. Prior to undertaking SRI's defense in this underlying action, the parties executed a "non-waiver" agreement. *Id*. at *1-2. Thereafter, Cincinnati filed this action seeking a declaration that it had preserved its right to assert coverage defenses under the policy. The trial court dismissed this action, concluding that Cincinnati was estopped from asserting coverage defenses because it had failed to issue a reservation of rights letter. *Id*. at *2.

On appeal, the court's determination of this issue turned on whether an insurer is required to issue a formal reservation of rights letter as a prerequisite to raising policy defenses in a subsequent action. According to the court, in a case of potential coverage, an insurer must either defend "under a reservation of rights or seek a declaratory judgment that there is no coverage; if an insurer fails to exercise one of these two options, it is estopped from raising policy defenses in a later action." *Id*. at *3. A "reservation of rights" letter "must provide timely and specific notice of [the insurer's] intention" and "explain the policy provisions upon which it bases its opinion that coverage may not be afforded." *Id*. at *3-4. A reservation of rights letter, or non-waiver notice, is not adequate if it simply informs the insured that the insurer reserves "any defense" or "waives none of its rights." *Id*. at *4. Because the non-waiver agreement at issue in this case merely reserved "any" defenses, the court concluded that it was inadequate to reserve Cincinnati's right to raise any defenses under the policy. *Id*. at *5.

Nevertheless, the court explained that issuance of an adequate reservation of rights letter is unnecessary where an insured is notified of the insurer's intention to reserve its right to deny coverage and the policy provisions upon which it the reservation is based by filing a "timely" declaratory judgment action. *Id*. at *5. Determination of whether Cincinnati's declaratory action was timely turned on whether SRI was "*actually prejudiced by the delay*." *Id*. at *7-8 (emphasis added). For example, actual prejudice may exist if SRI in any way relied on Cincinnati initially appearing to provide a defense and coverage. *Id*. at *8. Accordingly, the court reversed the trial court's judgment of dismissal and remanded this case for a factual determination of whether Cincinnati's declaratory judgment action was "timely."

For Further Information

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