MORRIS, MANNING & MARTIN, LLP

# Insurance Reinsurance Managed Healthcare Review

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Summer 2010

## LETTER FROM WASHINGTON

### INSURANCE INDUSTRY BARELY TOUCHED BY FINANCIAL SERVICE REFORM BILL

**By Robert "Skip" H. Myers, Jr.**

Congress squandered a rare opportunity to reform the financial markets that spun out of control and wreaked havoc on our economy and the lives of millions of Americans. In the process, it revealed its inability to overcome the influence of vested interests and to generate a solution that is more than a patch for the holes in the existing flawed model.

H.R. 4173 (now known as the Dodd-Frank bill) contains more than 2,000 pages of new legislation and amendments to existing law. It creates the Consumer Financial Protection Bureau and a Resolution Authority to determine "systemic risk" and break up troubled financial institutions. The bill also enhances bank capital standards and limits a bank's ability to trade for its own account, invest in hedge funds and to trade derivatives unless on open exchanges (although these three limitations were significantly diminished in the final conference committee rush to arrive at a compromise bill). What is more significant, however, is what Dodd-Frank does *not* address: insurance regulation.

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## PLAYER'S POINT

### A TRANSITION

**By Thomas A. Player**

This is my last regular "Player's Point." I am retiring from the full-time practice of law, with the exception that I will continue to accept engagements as an arbitrator or umpire.

I am now a sculptor. Don't rub your eyes, you read it right. I have morphed from a caterpillar into a butterfly. To my lawyer friends, I apologize for the caterpillar analogy.

I never got tired or bored in the practice of law, but the old adage "the law is a jealous mistress" is true. It cannot be practiced on a part time basis. In order to give sculpting a chance, I decided I would have to jump into it virtually full time. So I did.

The transition has been seamless mainly because of the efforts and talents of my partners: Skip Myers, Chris Petersen, Lew Hassett, Ward Bondurant, Jessica Pardi and Bill Winter, and the solid support of Joe Holahan and Tony Roehl. They made sure our clients were, and are, well cared for.

During the summers of 2008 and 2009, I lived in Florence, Italy. The first summer I attended classes at the Florence Academy of Art; the second summer, I immersed myself in independent study with the head of the Academy's Sculpture Department. As most of you know, Florence is an elixir for the arts, especially sculpture. The citizens of Florence feel they pulled the world from the Dark Ages by its boot straps. They are correct.

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# Announcements

**Joe Holahan's** article, "Healthcare Reform: The Captive Outlook," appears in the June 2010 issue of *Captive Review*. In the same issue, Morris, Manning & Martin was mentioned as one of only three U.S. law firms providing offshore and direct-writing insurance legal services. **Skip Myers** was listed as the principal contact for the firm.

**Chris Petersen** spoke at the Delta Dental Plans Association's Tactical Skills Conference. Mr. Petersen participated on a panel that examined health care reform, its business implications and its impact on future strategies.

On June 18, **Tony Roehl** spoke at the annual conference of the Georgia Associations of Health Underwriters. Mr. Roehl was on the panel discussing "The Perspective of Businesses on the Federal Healthcare Reform Legislation."

**Lew Hassett's** article, "Pretty Soon You're Talking Real Money: Federal Court Shifts Cost of E-Discovery," was reprinted in the latest edition of *Litigation Commentary and Review*.

On July 23, **Joe Holahan** spoke on the topic of "Drafting and Negotiating the Reinsurance Contract: Case Studies in Professional Responsibility," at the Reinsurance Association of America Conference on Re Contracts: The Art of Designing Reinsurance Contracts and Programs in New York.

**Chris Petersen** spoke at the National Association of Health Underwriters' 80th Annual Convention in Chicago, Illinois. Mr. Petersen discussed issues relating to implementing the insurance reform provisions of the Patient Protection and Affordable Care Act.

On July 30, **Tony Roehl** spoke on the effects of healthcare reform at the Association of Insurance Compliance Professionals Gulf States Chapter Education Day in Atlanta.

On September 24, **Tony Roehl** will speak to the Atlanta Association of Health Underwriters regarding the operation of health exchanges, subsidies and regulations under the Patient Protection and Affordable Care Act.

**Chris Petersen** spoke at the Delta Dental Plans Association's Operations and Technology Conference. Mr. Petersen discussed the impact of the Patient Protection and Affordable Care Act on dental plans.

## FEDERAL AGENCIES ISSUE FIRST INTERIM REGULATIONS IMPLEMENTING PPACA

**By Chris Petersen and Joseph T. Holahan**

With the enactment of the Patient Protection and Affordable Care Act on March 23, 2010, Pub. L. No. 111-148 (hereinafter "PPACA" or the "Act") and the Health Care and Education Reconciliation Act, Pub. L. No. 111–152, President Obama and the Congress have ushered in what will be, barring major amendment or repeal, a new era for the regulation of private health insurance.

In order to implement PPACA, the Department of Health and Human Services, the Department of Labor and the Department of the Treasury (collectively, the "Agencies") have begun issuing interim regulations for key components of the Act. The Agencies have issued interim regulations in the following areas: lifetime and annual limits, preexisting condition limitations, grandfathered health plans, policy rescissions, patient protections, dependent coverage and early retiree reinsurance programs. This article examines some of the highlights from these interim regulations with a focus on fully insured plans.

The discussion below refers to group and individual "plans" meaning major medical insurance plans. The requirements discussed in this article do not apply to "excepted benefits" as defined by the Health Insurance Portability and Accountability Act of 1996 and implementing regulations.

On June 28, 2010, the Agencies issued an interim regulation implementing PPACA requirements with respect to lifetime and annual limits on coverage, preexisting condition exclusions, recessions and certain patient protections.

### *No Lifetime or Annual Limits*

PPACA provides that plans may not impose lifetime limits on the dollar value of "essential benefits," as defined by the Act, for plan years beginning on or after September 23, 2010. The prohibition on lifetime limits applies to all plans, including grandfathered plans. PPACA further provides that plans generally may not impose annual limits on the dollar value of essential benefits for plan years beginning on or after September 23, 2010. The prohibition on annual limits is subject to an exception under which plans may establish "restricted annual limits," as defined by the Secretary of Health and Human Services (the "Secretary"), for plan years beginning prior to January 1, 2014. The prohibition on annual limits applies to new plans and grandfathered group plans but not to grandfathered individual plans.

The June 28 interim regulation establishes certain exceptions to the Act's general prohibitions against lifetime and annual limits. For example, health flexible spending accounts are excluded from the prohibition on lifetime and annual limits. In addition, the interim regulation establishes standards for the "restricted annual limits" that plans may impose until January 1, 2014. The permitted annual limits are as follows: $750,000

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for plan years beginning on or after September 23, 2010, but before September 23, 2011; $1,250,000 for plan years beginning on or after September 23, 2011, but before September 23, 2012; and $2,000,000 for plans years beginning on or after September 23, 2012, but before January 1, 2014.

It appears the June 28 interim regulation does not prohibit limits that apply to specific types of treatments without establishing total lifetime or annual limits. For example, limits on the maximum number of outpatient visits for a specific type of treatment or limits on the maximum amount payable per procedure for specified types of medical procedures appear to be allowed. This aspect of the interim regulation may need to be clarified. The interim regulation does not define the term "essential benefits" except by reference to the limited definition contained in PPACA. In the preamble to the interim regulation, the Agencies say they will take into account "good faith efforts" to comply with a "reasonable interpretation" of the term "essential health benefits."

In another important development, the June 28 interim regulation provides that the Secretary may, for plan years beginning before January 1, 2014, establish a program to waive the restriction on annual limits for any plan that has an annual dollar limit below the restricted annual limits discussed above if the Secretary determines that imposing the restriction would result in decreased access to the benefits or would significantly increase premiums for the plan. Finally, the interim regulation also includes transitional rules for individuals whose coverage or benefits ended by reason of reaching a lifetime limit.

### *Ban on Preexisting Condition Exclusions*

Under PPACA, group and individual plans are prohibited from imposing preexisting condition exclusions on individuals under 19 years of age for plan years beginning on or after September 23, 2010. This requirement is extended to all insureds, regardless of age, for plan years beginning on or after January 1, 2014. The Act's requirements regarding preexisting condition exclusions apply to all plans, except for grandfathered individual plans.

The Agencies have taken the position that the Act's ban on preexisting condition exclusions for individuals under 19 years of age effectively acts as a requirement to guarantee issue coverage to such persons. The June 28 interim regulation sets forth the rationale for this stance. An example included in the interim regulation is a denial of coverage because of a preexisting condition is an "exclusion of benefits based on a preexisting condition" in violation of the Act.

### *Patient Protections—Access to Primary Care Providers, Emergency Care and Specialists for Women and Children*

If a plan requires or provides for designation of a primary care provider, for all plan years beginning on or after September 23, 2010, the plan must allow covered individuals to designate any participating primary care provider who is available to accept the individual. If the covered individual is a child, the plan must allow designation of a participating physician specializing in pediatrics as the child's primary care provider. In addition, a plan may not require a woman to obtain authorization or a referral for a participating provider specializing in obstetrics or gynecology. These requirements do not apply to grandfathered plans. Among other things, the June 28 interim regulation provides that if a plan requires designation of a primary care provider, it must provide participants with notice of the terms and conditions applicable to such designations, including the PPACA rights that apply. The interim regulation provides model language for this purpose.

PPACA provides that if a plan covers hospital emergency services, for all plan years beginning on or after September 23, 2010, the plan must cover emergency services without requiring prior authorization and regardless of whether the provider furnishing the services is in-network or out-of-network. This requirement does not apply to grandfathered plans. The June 28 interim regulation provides that access to emergency services must be provided without imposing any administrative requirement or limitation on coverage that is more restrictive for out-of-network services than in-network services and without regard to any other term or condition of coverage other than any applicable exclusion of benefits, coordination of benefits, waiting period or cost sharing. With respect to cost sharing, the interim regulation clarifies that, as to emergency services, a plan may impose a deductible or out-of-pocket maximum with respect to out-of-network coverage if the deductible or out-of-pocket maximum applies to all out-of-network benefits generally, and not just emergency services.

### *Grandfathered Health Plan Coverage*

PPACA provides that "grandfathered health plans" are not subject to certain requirements of the Act. For example, they are not subject to PPACA's prohibition against applying deductibles, co-payments or other cost sharing requirements to coverage for certain preventive healthcare services. On June 17, 2010, the Agencies published an interim regulation defining which plans qualify as grandfathered health plans and what such plans must do to maintain their grandfathered status. The interim regulation provides that to be a grandfathered plan, a plan must have had at least one individual enrolled in coverage on March 23, 2010, and the plan must have covered someone continuously since March 23, 2010 (even if not the same individual). Any new policy, certificate, or contract of insurance issued after March 23, 2010, is not grandfathered. Renewal of an existing contract does not cause it to lose its grandfathered status.

The June 17 interim regulation provides that in order to maintain grandfathered status, a health plan must provide a notice to plan beneficiaries that the plan believes it is a grandfathered health plan. The notice must also include contact information. The interim regulation includes model notice language that can be used to satisfy this disclosure requirement. The interim regulation also sets forth several examples of activities that will result in a plan losing its grandfathered status, including: 1) eliminating benefits, 2) increasing the percentage of cost sharing requirements, 3) increasing a fixed amount cost sharing requirement (other than copayments), 4) increasing fixed-amount copayments in certain ways, 5) decreasing contribution rates and 6) changing annual or lifetime limits.

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### *Extension of Dependent Coverage*

PPACA requires plans that provide dependent coverage of children to make such coverage available for an adult child until the individual turns 26 years of age. This requirement is effective for all plan years beginning on or after September 23, 2010, and applies to all plans, including grandfathered plans.

On May 13, 2010, the Agencies issued an interim regulation implementing the dependent coverage requirement of the Act. The interim regulation states that a plan may define eligibility for dependent coverage only in terms of the relationship between a child and the plan participant. Thus, a plan may not deny or restrict coverage based on factors such as financial dependency, residency, student status, employment, marital status or eligibility for other coverage, except that for plan years beginning before January 1, 2014, a grandfathered group plan may exclude an adult child if the child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. Plans are not required to cover grandchildren or the spouse of an adult child. The interim regulation also provides that the dependent coverage requirement applies to children whose eligibility for coverage previously terminated and to children who were previously denied coverage or were not eligible for coverage because of age. Plans are required to make coverage for such dependents available under a special 30-day enrollment period.

The interim regulations published to date are just the beginning of what will be an extensive body of new regulations and guidance implementing PPACA. Many more regulations will be forthcoming from Agencies. In addition, many states will soon begin the legislative and regulatory processes necessary to implement the state health insurance exchanges that are a centerpiece of the Act. All of these activities will require careful scrutiny, as they will give shape to many important aspects of the Act that have yet to be defined. ❑

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*Joseph T. Holahan is Of Counsel in the firm's Insurance Practice and a member of the firm's Privacy Practice. Mr. Holahan advises insurers and reinsurers on a variety of legal matters, including all aspects of regulatory compliance. Mr. Holahan received his undergraduate degree from the University of Virginia and his law degree from the Catholic University of America.*

## PLAYER'S POINT

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I'm working mostly in bronze but some in stone (limestone and marble). I have had the good fortune of having a half-dozen commissions and currently have two pending. My work is mostly figurative and mostly scenes that I remember. For example, during law school I worked as a deckhand on a Mississippi towboat. I am currently sculpting in bronze three figures from that era: the deckhand (tightening a cable with a ratchet); the cook (having a smoke while sitting on a milk crate); and the steersman (peering upstream on a foggy night). The deckhand is finished and the cook is nearing completion.

It is difficult to know when you are being taken seriously as a sculptor. Not often will friends tell you your stuff is bad.

Two benchmarks happened recently that give me encouragement. First, a piece of mine was accepted in the 77th annual exhibition of the National Sculpture Society. It is the oldest and the most prestigious of the societies. Secondly, an old-line gallery on Charleston's Broad Street named the Edward Dare Gallery has started exhibiting my work. I am humbled by these events.

In conjunction with the October NAIC meeting in Orlando, the firm and others are hosting a reception. I hope to see you there in order to express my appreciation for helping me along in this exciting journey. Meanwhile, keep on being creative with those confusing federal and state regulations, and I will keep on being creative playing in the mud.

You may view my work at www.tomplayersculpture.com ❑

## LETTER FROM WASHINGTON

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### *Insurance Regulation*

Insurance as a "financial service" could easily have been drawn into the Dodd-Frank maelstrom, but it was not, except in two respects. First,

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the bill creates an Office of National Insurance ("ONI"), which has only minimal investigative and oversight authority. Second, the bill enacts the "Nonadmitted and Reinsurance Reform Act." This Act has nothing to do with the financial crisis and is indeed so non-controversial that it was easily added to H.R. 4173 as a vehicle of opportunity.

Why was the insurance industry barely affected? Even though the collapse of AIG was a precipitating force in the financial crisis, it became clear that AIG's insurance companies were not at risk of insolvency. In fact, the insurance industry as a whole has survived the financial crisis quite well.

The insurance industry survived without any government bail out funds (with the exception of a few of the very largest insurers which had dabbled in derivatives) because almost all insurers are not "too big to fail." There are probably 5,000 insurers in the United States, each of which is regulated by its state of domicile and the other states in which it is licensed. The state-based regulatory system, with all its complexity and administrative cost, has the salutary effect of limiting the concentration of risk so the failure of any single insurer presents no risk to the entire system. No one in Congress or the White House seems to understand this obvious lesson that 5,000 competing financial institutions are safer to the public than the current banking model; i.e., numerous very small banks and a handful of banks that are "too big to fail."

Even the ONI is a diminished version of the originally introduced office. It is authorized to conduct a study of the insurance regulatory system. This should be helpful in future efforts at reform, but ONI's preemptive authority is very limited. It can preempt a state law only if such law "results in less favorable treatment of a non-United States insurer domiciled in a foreign jurisdiction that is subject to an international insurance agreement on prudential measures than a United States insurer domiciled, licensed or otherwise admitted in that State." In order to do this, the ONI will have to consult with the "appropriate State regarding any potential inconsistency or preemption" and then adhere to the federal Administrative Procedure Act by providing notice in the *Federal Register*, opportunity for comment and a further notice that the preemption has become effective. Any such finding is subject to judicial review. The Director of the ONI further has the opportunity (in addition to the opportunities presented by the Administrative Procedure Act) to "consult with State insurance regulators, individually or collectively…."

***Freddie, Fannie and "Too Big to Fail"***

H.R. 4173 does not even mention Fannie Mae and Freddie Mac, the Government Sponsored Entities ("GSEs") whose debts are growing daily without any relief in sight. Fannie and Freddie are at the heart of the financial crisis. The politically driven easy credit for unqualified borrowers spurred mortgage brokers, lenders and Wall Street investment bankers into a frenzy of risky behavior and short term profit taking.

Why has Congress avoided dealing with perhaps the biggest problem in Washington? Because the solution will be difficult, and no one inside the Beltway will benefit from it. By mandating that banks provide easy credit and forcing GSEs to take the risk, the politicians received the two things they live on - votes from constituents who received easy credit and money from the financial industry that benefitted from it.

Now, the house of cards has collapsed. In order to reform the mortgage lending system, Congress would have to acknowledge fault and impose the duty to clean up the mess on the taxpayers. There is no "upside" for Congress to do this, and there is no measurable "good government" lobby in Washington to force Congress to act. Moreover, there has been no leadership from the White House (which is the normal counterweight to Congress) to address this issue. So, Fannie and Freddie roll on, untouched.

While Congress pretended in Dodd-Frank to address the "too big to fail" problem, it only made it worse. Working on the assumption that the crash of the financial markets was the result of regulatory failure, Congress enacted provisions that will facilitate the recognition of "systemic risk" and the winding down of those institutions that are "too big to fail" by the FDIC under the auspices of the Resolution Authority. This, ultimately, will encourage the moral hazard that creates the risk in the largest financial institutions.

What Congress has refused to do (and what the White House has refused to advocate) is to limit the size of financial institutions so that none of them are too big to fail. Again, this seemingly obvious solution was not considered seriously.

In sum, even though the United States suffered the worst financial collapse since the Great Depression, Congress failed to produce legislation to prevent the next big crash. At best, it will help to modulate the boom and bust cycle.

Insurance regulation, as cumbersome as it can be, should have been at least considered by Congress as a model to end the "too big to fail" problem. It wasn't. ❑

*Robert "Skip" Myers is Co-Chairman of the firm's Insurance and Reinsurance Practice and focuses in the areas of insurance regulation, antitrust and trade association law. He serves as outside general counsel to the National Risk Retention Association. Mr. Myers received his bachelor's degree from Princeton University and his law degree from the University of Virginia.*

## AGENCY ACQUISITION DUE DILIGENCE CHECKLIST

**By Tony Roehl**

Insurance agency mergers and acquisitions are expected to increase as the economy continues to improve and the continuation of the soft insurance market limits internal and organic insurance agency growth. In addition, the threat of an increase in the capital gains rate will provide further incentive to owners of agencies to sell and lock in profits at a more favorable tax rate.

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With the expected increase in agency merger and acquisition activity in mind, we have prepared a condensed diligence check list for the acquisition of an agency. The checklist is intended only to spur thought and discussion of some the considerations necessary when acquiring an agency. It is by no means an exhaustive listing of all things that must be considered and reviewed before acquiring an agency. If a purchaser is interested only in purchasing certain assets from an agency, then the diligence process can be streamlined since the purchaser will not also be acquiring the agency's liabilities. Hence, the diligence questions focused on liabilities in the checklist may have limited applicability in an asset purchase.

The checklist also may be helpful for owners considering selling an agency as an example of the types of information potential purchasers likely will want to review. Having this information well organized once a seller decides to entertain offers will make the sales process progress much more smoothly. ❑

*Tony Roehl is an Associate and member of Morris, Manning & Martin's Insurance and Reinsurance and Corporate Practices. Mr. Roehl's principal areas of concentration are insurance regulation and corporate matters involving entities within the insurance industry. Mr. Roehl received his bachelor's degree from the University of Florida and his law degree from the University of Michigan.*

## Agency Acquisition Due Diligence Checklist

| Category | Action Item |
|---|---|
| **General Business** | • Identify clients including annual fee and commission volume, lines of business and number of years as a client<br>• Identify all strategic alliances and partnerships with other companies including agreements, contracts and associated client service and pricing detail<br>• Provide minute books relating to meetings of the shareholders, board of directors and other board committees during the preceding ten years<br>• Provide the stock certificate book and stock register<br>• Prepare a chart and list of all entities the company owns, a list of all company locations including entire address and indicate whether leased, owned or sublet |
| **Financial Statement Review** | • Provide annual financial statements for the last three years and all auditor reports to management during such period<br>• Prepare capital expenditure plans including current budget and revisions to date along with any cash flow and liquidity analysis, sources of funding, if any, and their allocation to expenditures<br>• Calculate working capital requirements to support business plan<br>• Prepare interim financial statements since most recent year end<br>• Provide access to general ledger trial balance<br>• Provide access to ledger for premium and fiduciary accounts including reconciliation demonstrating that fiduciary account assets equal or exceed the fiduciary account liabilities<br>• Provide the most recent aging schedule for accounts receivable with comments regarding the collectability of any balance over 90 days old<br>• Provide a summary of all insurance contracts in place including workers' compensation and E&O coverages<br>• Provide copies of all auditor reports to management and any management responses during the preceding five years |
| **Legal** | • Compile current copies of articles of incorporation and bylaws<br>• Compile current copies of any shareholder and/or voting agreements<br>• List all officers and directors, agency's subsidiaries and affiliates including the number of shares of stock held by each<br>• List all stockholders<br>• Gather copies of good standing certificates for all jurisdictions in which the company operates and is qualified to do business<br>• Provide copies of any contracts or agreements which would or might contain a change of control clause which would be triggered by the proposed acquisition<br>• Provide a list of intellectual property owned or licensed |

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## Agency Acquisition Due Diligence Checklist

| Category | Action Item |
|---|---|
| **Litigation and Regulatory Complaints** | • Include a complete list of all litigation pending or threatened at any time over the past ten years including, but not limited to, arbitration proceedings and include as to each matter a full statement regarding the background of the dispute and its resolution<br>• Gather all files related to correspondence with regulators during the preceding five years involving complaints to the regulators or any allegation of impropriety |
| **Permits and Licenses** | • List states in which the agency or any of its directors, officers or employees holds an insurance license pursuant to which the company does business and include in the list whether the license is held on a resident or non-resident status and the license number |
| **Information Technology** | • Provide overview of the following systems:<br>o Agency management system<br>o Rating system<br>o Document management system<br>o Primary email system<br>o Primary network operating system<br>o Website hosting company and platform<br>o All other purchased or developed applications<br>• Include copies of vendor agreements and licensing agreements |
| **Taxes** | • Include copies of federal, state and local tax returns for the last five years<br>• Provide copies of all payroll tax returns for the last three years<br>• Provide back-up of computation of current deferred income tax amounts |
| **Insurance** | • Provide a complete schedule of insurance covering the agency including type of insurance, limit of insurance, deductibles and retentions, policy term and premium<br>• List all losses and claims under insurance policies for the past five years |
| **Human Resources** | • Prepare a detailed organizational chart listing all supervisory or professional employees<br>• List all employees showing full name, date hired, present salary and job title or category, employment status (full time, part-time, temporary, on leave) and details of any restrictive covenants and next salary review date<br>• Provide example of employment contracts<br>• Provide example of independent contractor agreements |
| **Employee Benefits / Compensation** | • Provide summary of plan descriptions of all ERISA benefit plans<br>• Provide audited financial statement of plan assets for previous two years<br>• Provide most recent IRS Form 5500 filing<br>• Provide copies of documents related to health insurance, flexible spending accounts, short and long-term disability insurance and life and accidental death and dismemberment insurance |
| **Executive Compensation** | • Provide detailed information on executive compensation including base salary, most recent bonus, history of all stock options, copies of any in force employment agreements or previously terminated employment agreements that still have active covenants<br>• Provide employee handbook<br>• Provide the annual incentive plan and long-term incentive plan documents (if any) |

MORRIS, MANNING & MARTIN, LLP

# Insurance Reinsurance Managed Healthcare Review

www.mmmlaw.com Summer 2010

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