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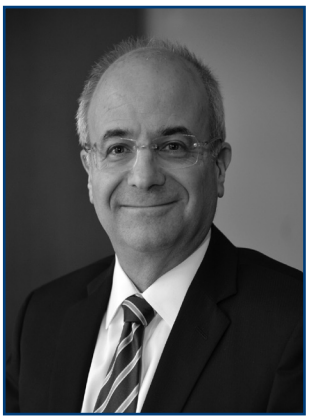

HASSETT'S OBJECTIONS

JUDICIAL INTERVENTION IN THE STYMIED ARBITRATION

By Lewis E. Hassett

While most insurers, reinsurers and attorneys pay lip service to the importance of a fair and efficient arbitration, one side or the other often perceives fairness and efficiency as undesirable. Arbitration is not unique in this regard; courts wrestle with obstruction during litigation, and try to curtail it through sanctions under Rule 11, Rule 37 and 28 U.S.C. § 1927. Recent legislation directs courts to charge attorneys' fees against a party rejecting a settlement offer more favorable than the ultimate result at trial. See, e.g., Fla. Stat. § 768.79; Nev. R. Civ. P. 68(f)(2); N.J. Ct. R. 4:58-2; Ga. Code Ann. § 9-11-68. However, arbitration carries a unique potential for disruption, *i.e.*, delay and obstruction in forming the arbitration panel.

In its purest form, a party may simply refuse to appoint an arbitrator. Fortunately, most insurance-related arbitration agreements now allow one party to choose the other party-appointed arbitrator where the opposing party fails to appoint its nominee within a set deadline. Courts regularly uphold the unilateral appointment of arbitrators in these circumstances. *See, e.g., Universal Reinsurance Corp. v. Allstate Ins. Co.,* 16 F.3d 125, 129 (7th Cir. 1993) (strictly enforcing 30-day arbitration provision); *Certain Underwriters at Lloyd's, London v. Argonaut Ins. Co.,* 444 F.Supp. 2d 909, 916-17 (N.D. Ill. 2006), *aff'd,* 500 F.3d 571 (7th Cir. 2007) (same); *Nat'l Planning Corp. v. Achatz,* 02-CV-0196E(SR), 2002 WL 31906336, at *2 (W.D.N.Y. Dec. 17, 2002) (strictly enforcing parties' agreement

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TO BE A GROUP, OR NOT TO BE A GROUP, THAT IS THE QUESTION

By L. Chris Petersen

The Department of Health and Human Services ("HHS") recent adoption of fixed indemnity insurance regulations[1] has drawn new attention to the disconnect between federal and state law as to what constitutes group health insurance coverage. HHS's new fixed indemnity insurance regulations and FAQ guidance that HHS released on January 9, 2014, establishes separate rules for fixed indemnity products offered in the group and individual markets. Under federal law, only employee welfare benefits plans are considered group coverage[2], but state laws recognize additional types of group coverage unrelated to employee welfare benefit plans including association, trust, franchise, etc.[3]

The HHS fixed indemnity benefit final rule amends 45 C.F.R § 148, which regulates the individual health insurance market. The final rule amends the types of benefits that are excluded from the Public Health Service Act's ("PHSA") insurance reform regulations as amended by the Patient Protection and Affordable Care Act. The rule provides that the insurance reform requirements and the group and individual insurance reform provisions do not apply to

1. The requirements of these new regulations were discussed in the article *"HHS Regulates, and Confuses, Fixed Indemnity Market"* published in the firm's Summer 2014 newsletter.

2. This limited definition of group health insurance was created as part of the Health Insurance Portability Act ("HIPAA"), but state regulators generally only applied it to major medical coverage.

3. *See, for example* NAIC Model 100

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Inside this Issue

LETTER FROM WASHINGTON

CAPTIVES UNDER SCRUTINY

By Robert H. Myers

A mere decade ago, captive insurers were viewed by most regulators as a small, even exotic, part of the insurance industry. Most were assumed to be offshore and aroused little attention. Now, captives have gone mainstream. A sizable, but undetermined, portion of the property casualty coverage is placed through, or issued by, captives. A good guess is 30 to 40%, but no one has been able to establish an accurate number. Thirty-nine states have some form of captive or self-insurance law. Captives are now part of everyday life for regulators, and the result is more scrutiny.

The issues now on the agenda for captives are significant:

a. *XXX and AXXX Reinsurance Captives.* According to Superintendent Joseph Torti (Rhode Island), 80% to 85% of life and annuity insurance is ceded to reinsurers. Much of the so-called "excess reserves" required by Rules XXX and AXXX are ceded to captive reinsurers or special purpose vehicles owned by the same licensed life and annuity companies which cede the risk. Because the amount of this risk is so large, any trouble collecting this reinsurance could have a major effect on the industry. Some regulators, even some who approved these cessions, have criticized these arrangements. In some cases, the collateral for the reserves has been subject to parental guarantees, which tends to undermine the confidence which can be placed in the transaction. The NAIC is continuing its examination and has met stiff resistance from the industry.

b. *"Multistate Insurers"*. The proposal to amend the preamble to the NAIC Accreditation Standards to treat captive reinsurers as "multistate insurers" (with some limited exceptions) was withdrawn at the last NAIC meeting in Louisville. A new proposal should be forthcoming (and may have already been issued by the date of publication of this Newsletter). The premise of this proposed change is that non-domiciliary regulators need to know how insurance issued in another state may affect the citizens of their state. The opposite point of view is that the regulators of the domicile have done their job and should be trusted by their regulator colleagues and that the transaction should not affect third parties, anyway. Some say the risk to the domestic captive industry is existential. If enacted and enforced, the proposed change could, ironically, drive much of the industry offshore and therefore beyond the authority of the regulators promoting it.

c. *Nonadmitted and Reinsurance Reform Act*. Captives have been inadvertently drawn into the regulatory structure imposed by this federal legislation intended to streamline the reporting and payment of surplus lines taxes. It has shined a spotlight on the payment (or non-payment) of state self-procurement taxes, but ironically, does not in any way alter either the application of them or their payment. While risk retention groups were able to get an exemption from the law during its formative phase, captives, because they are (generally) single state entities and therefore not doing business as a "non-admitted" insurer, did not even attempt to get an exemption. Now there is a group, the Coalition for Captive Insurance Clarity, which is seeking a legislative exemption on Capitol Hill.

d. *Insurance Company Income Taxation.* The Internal Revenue Service is investigating several insurance pooling mechanisms and, in some cases, the captives which have utilized them to establish "third party risk," which is essential for an insurer to get the benefit of insurance tax treatment. This investigation is presumably a response to the rapid growth of "micro-captives" as mechanisms to assist with avoidance of taxation in estate planning and wealth transfer. This process is in its early stages, but is likely to produce some dramatic results.

e. *Federal Home Loan Bank (FHLB)*. Who would have thought that the FHLB would have anything to do with captives? It appears that some captives and at least one risk retention group are members of the FHLB, which allows them to obtain federal funds at advantageous rates. The Federal Housing Finance Agency (FHFA), which regulates the twelve FHLBs, has proposed a rule that would exclude all captives from membership by defining "insurance company" to mean an entity which "has as its primary business the underwriting of risk for nonaffiliated persons."

So, why is all this happening now? While there are numerous reasons for these kinds of actions, there are two primary motivators. First, regulation is always subject to the problem "what's worth doing is worth overdoing." Reasonable minds can differ on the interpretation of statutes and regulations. Each of the above includes an element of "pushing the envelope," which can be significant or insignificant issues depending on your point of view. Second, captives have been caught in the vortex of regulatory competition. As we have discussed before in this column, the National Association of Insurance Commissioners (NAIC), the Federal Insurance Office (FIO), and the International Association of Insurance Supervisors (IAIS) are jockeying for position and power. Add to the mix the position of the Organization for Economic Cooperation and Development (OECD) that captives may be used as a device to avoid taxation ("base erosion" in OECD parlance), and you have a tumult of regulatory action which at the same time can be challenging and conflicting in its goals and implementation.

What does this bode for the future of captives? Once you have been seen on the radar, it is hard to drop off. Captives can expect more of the same for the foreseeable future.

Robert "Skip" Myers is Co-Chair of the firm's Insurance and Reinsurance Practice and focuses in the areas of insurance regulation, antitrust and trade association law. Mr. Myers received his bachelor's degree from Princeton University and his law degree from the University of Virginia.

RETAINED DEATH BENEFIT TRANSACTIONS – WILL REGULATION KILL THEM?

By James W. Maxson

A life settlement is the sale of a life insurance policy for a cash payment greater than the policy's surrender value, but less than its face value. Historically, policy owners who found themselves with a policy that they no longer wanted or needed had only one option – to surrender the policy to the issuing carrier for whatever surrender value it possessed. The creation of the secondary market for life insurance has given consumers another option – the ability to sell their unneeded life insurance policies for fair market value.

As the life settlements market has matured, another category of seller has emerged – a policy owner who no longer wants to pay premiums on the policy, but still needs or wants some insurance coverage. For instance, assume a 75-year-old purchased a policy with a $1,500,000 death benefit when he was 60-years-old. His children are grown and moved out, but he has a special needs grandchild to whom he wishes to leave a specific bequest. Instead of selling the entire policy for a lump sum cash payment, he could, instead, sell a portion of the death benefit either in lieu of cash or as reduction to the cash purchase price. For example, the policy owner might agree to sell $1,000,000 of the death benefit in exchange for a $500,000 retained death benefit. This means that even though he has sold his rights to the policy, and no longer has to make another premium payment, his estate (or designee) will receive $500,000 upon his passing.

This sounds like a sensible win-win for both the investor, who gets to purchase a $1,000,000 death benefit for little or no cash up front, and the seller, who never has to pay another premium and whose grandchild will receive $500,000 upon his death. The California Department of Insurance has decided to weigh in on retained death benefit transactions in a manner that could, unfortunately, result in this option no longer being available to California residents.

Specifically, the California DOI has proposed Section 2548.8 as an amendment to its life settlement regulations. Much of the amendment is reasonable as it creates a process for retained death benefit transactions and ensures that the policy seller is given important disclosures. However, the amendment also addresses the situation in which a policy purchaser might decide that it no longer wants to keep the policy. This can happen, for instance, if the insured significantly outlives his life expectancy or the issuing carrier increases significantly the cost of insurance to keep the policy in force. The amendment requires that the provider (whether or not the provider then owns the policy) "notify the owner that the policy will lapse thirty (30) days before the policy lapses, and provide the owner the opportunity to pay the entire premium to maintain the policy. . . ." This obligation assumes that the provider will know that the funder who purchased the policy has decided to lapse a policy, which may well not be the case. In addition, the original funder could have subsequently sold the policy without the provider's knowledge. However, a far more troubling provision is triggered in the event the original owner does not want to pay the premium to keep the policy in force, which is a virtual certainty. In that event, the provider is required to pay the original owner "an amount equivalent to the death benefit that the owner's designated beneficiary would have received had the policy reached maturation within 30 days after the policy lapses."

In essence, the California DOI is making the provider in the transaction a guarantor of the retained death benefit obligation to the original owner, even though the provider is extremely unlikely to own the policy at the time the decision to lapse is made. The result of this unfortunate obligation is that it is unlikely that providers licensed in the State of California will be willing to offer the retained death benefit option to California consumers, once again proving the old adage, "If it ain't broke, regulate it."

James W. Maxson is a Partner in the firm's Insurance and Reinsurance Practice and Co-Chair of the firm's Life Settlements Practice. Mr. Maxson concentrates his practice in corporate and regulatory matters for the life settlement industry, as well as focusing on mergers and acquisitions and securities transactions. Mr. Maxson received his bachelor's degree from Denison University and law degree from Ohio State University.

DRAFTING EFFECTIVE DATA PRIVACY AND SECURITY PROVISIONS FOR SERVICE PROVIDER AGREEMENTS

by Joseph T. Holahan

As the financial and reputational risks associated with a data security breach have grown in recent years, it has become more important for insurers, administrators, broker-dealers, agencies and other companies to include strong and effective controls on data privacy and security in the contracts they execute with service providers.

Moreover, state and federal rules implementing standards for safeguarding customer information established under the Gramm-Leach-Bliley Act ("GLBA") provide that insurance licensees, broker-dealers and other financial institutions must require their service providers to implement "appropriate measures" to protect the security of customer information. The GLBA standards which apply across all lines of insurance business, do not state specifically what appropriate measures regulated entities must take.

In addition, federal rules implementing the Health Insurance Portability and Accountability Act (the "HIPAA Rules") require health insurers and other covered entities to hold their service providers to certain specific contractual standards for data privacy and security. These standards are reflected in the business associate agreement covered entities and business associates are required to execute.

This article reviews some of the key provisions governing data privacy and security that should be included in any service provider agreement and offers recommendations for ensuring that these provisions establish appropriate controls. It does not cover all of the provisions required under a HIPAA business associate agreement but does note

Announcements

Morris, Manning & Martin is pleased to announce **Tony Roehl** has been elected to Partner of the firm. He was also recently elected to the board of the Georgia Captive Insurance Association (GCIA) as well as to the Insurance Industry Charitable Foundation (IICF). Mr. Roehl's principal areas of concentration are insurance regulation and corporate matters involving entities within the insurance industry.

Chris Petersen spoke at the Professional Insurance Marketing Association's Mid-Year Meeting in Napa, California on July 19. Chris discussed ongoing efforts by the National Association of Insurance Compliance Professionals (NAIC) to update their existing model laws to conform with the Affordable Care Act. Chris' presentation focused on potential changes to the minimum standard models including fixed indemnity and other supplemental health insurance products, as well as possible changes to the group model act.

Tony Roehl spoke at the Georgia Association of Health Underwriters annual conference in Savannah on July 31 about Do's and Dont's for acquiring and selling insurance agencies.

Joe Holahan and **Skip Myers** attended the Vermont Captive Insurance Association conference in Burlington, VT on August 11-14. Skip spoke on hot topics in captive regulation.

Chris Petersen spoke at the Association of Insurance Compliance Professional's Annual Conference in Phoenix, Arizona. Chris discussed the legal uncertainties created by the differing state and federal definitions of group health insurance. Please contact Chris at cpetersen@mmmlaw.com if you would like a copy of his presentation from the conference.

Jim Maxson attended the International Secondary Market's for Life Insurance's International Life Settlement Conference in Munich, Germany on September 29.

Lew Hassett and **Kelly Christian** have been retained by an insurer to assert claims against other insurers arising from a wrongful death action.

Skip Myers was a panelist at "RRGs 101" and "Ask the Regulators" presentations at the National Risk Rentention Association conference in Chicago on September 30.

Lew Hassett and **Eric Larson** obtained a dismissal with prejudice of federal RICO claims asserted in West Virginia against an association with limited medical insurance benefits.

Jim Maxson attended the 20th Annual Fall Life Settlement Conference in Scottsdale, Arizona on October 5-7.

Ross Albert and **Brian Levy** co-authored a chapter entitled "Practical Considerations for Representing Directors and Officers in Securities Litigation," which will be featured in Inside the Minds: Representing Officers and Directors Charged with Corporate Malfeasance, a new book to be published this Fall by Aspatore Books/West Publishing, a division of the Thomson Reuters conglomerate. The chapter discusses ethical implications of dual representation of a corporation and its directors and officers, directors' and officers' liability insurance, and securities class actions.

Skip Myers spoke at the Captive Live conference in Chicago on October 7 on regulatory issues affecting captive insurers.

Lew Hassett and **John Northup** have just been retained to represent an automobile insurer in a commingling dispute against a managing general agency.

Jessica Pardi attended the Surplus Lines Law Group Conference in Seattle on October 8-9. Jessica spoke on developments in GA law affecting surplus lines.

Paul Arne, Larry Kunin and **Jessica Pardi** participated in the Technology Law Institute, presented by the Technology Section of the State Bar of Georgia on October 24. Larry and Jessica spoke on a panel discussing crisis management related to a data security breach.

Skip Myers will be presenting "Is the future of US Captives Secure?" at the European Captive Forum in Luxembourg on November 11.

A national insurer has retained **Lew Hassett** and **Sam van Volkenburgh** to advise regarding a retailer's liability for injuries arising from an allegedly defective product that the retailer's principals transferred to friends as a gift.

Since retiring, **Tom Player** has concentrated on sculpting, mostly creating bronzes. His work will be shown in the 86th Grand National Exhibit of the American Artists Professional League from November 10-21 at the Salmagundi Club, 47 Fifth Avenue., New York. For more information on Tom and his work, please go to his website, www.tomplayersculpture.com or contact him at tap@tomplayersculpture.com.

certain areas where contracting parties may want to build in greater protections than those mandated by the HIPAA Rules.

Restrictions on Use and Disclosure

Defining the permissible uses and disclosures of personal information handled by a service provider is, of course, central to protecting the confidentiality of such information. For many contracts, a statement that the provider may use and disclose personal information only as necessary to perform the agreed upon services is sufficient for this purpose. However, where a service agreement encompasses a narrow, clearly defined set of services, it may be possible to state with specificity the permissible uses of and disclosures of personal information. Defining permissible uses and disclosures with specificity provides greater protection to the disclosing party.

For its part, outside of the business associate context, the service provider may want the contract to state explicitly that disclosure is permitted for certain additional purposes—for example, as required by legal process or otherwise required by law. The disclosing party may want to include the right to seek a protective order or other appropriate remedy before any disclosure required by law is made and the right to receive reasonable cooperation from the service provider in pursuing such a remedy. The service provider also may want to reserve the right to use and disclose personal information for activities reasonably necessary to its own operations such as security audits and to prepare for and defend itself in actual or anticipated legal proceedings. In addition, the service provider may want to seek the right to de-identify personal information and allow free use of information that has been de-identified.

Data Security

It is common for service provider agreements to state data security requirements in general terms—for example, by requiring the provider to protect the data under a reasonable security program that is in accordance with industry standards and complies with applicable law. Such a provision should specify that the provider must maintain reasonable and compliant administrative, technical and physical safeguards to protect against unauthorized destruction, loss or alteration of data as well as unauthorized use, disclosure or access to the data.

It is important that data security standards be stated in a way that requires the service provider to maintain reasonable protections as risks change and technologies evolve. In some cases, however, it may be appropriate to establish specific security measures for a particular relationship. Such measures are best developed in consultation with security experts and are beyond the scope of this article. In some cases, specific standards may be mandated by a third party—for example, companies that outsource their payment card processing operations to a service provider must ensure that the provider complies with Payment Card Industry Data Security Standards.

Data Breach Notification and Response

The service agreement should state with specificity the types of security incidents that require the service provider to notify the principal. The agreement also should state how soon after discovery of an incident notice must be given and the information that should be included in the notice, such as the nature of the incident, the personal information involved, the individuals affected, the date on which the incident occurred, the date on which the incident was discovered, and what steps the service provider has taken in response.

The laws of many states require a service provider that maintains personal information on behalf of another party to notify the principal of any security breach. Similarly, the HIPAA Rules require business associates to provide notice of security incidents and breaches to the covered entity or upstream business associate, as the case may be. But the duty to provide notice under these laws is limited to particular circumstances and particular types of personal information. For example, many state laws require notice only when a breach involves computerized data and then only when certain types of data are involved, such as a Social Security number, driver's license or other ID number or account number coupled with an access code. An effective security breach provision should require notice from the service provider under a sufficiently broad range of circumstances that the principal is made aware of significant security incidents and can evaluate for itself whether the incident rises to the level where notification of individuals, law enforcement authorities or regulators is required by law or advisable for other reasons.

To offer another example, under the HIPAA Rules whether a "breach" has occurred requiring a business associate to give notice to its covered entity or upstream business associate is, at least in part, a subjective determination. The covered entity or upstream business associate may want to define the circumstances triggering notice under the service contract more specifically so that it can decide for itself whether a breach has occurred.

The service agreement also should require the service provider to collect and preserve evidence concerning any breach, including documentation concerning response to the incident and actions taken to mitigate the breach, and cooperate in the investigation and response to any breach. In addition, the agreement should require the service provider to indemnify the principal for liabilities and costs arising in connection with the breach, including legal fees and expenses associated with investigating and mitigating the breach; providing notice to affected individuals, law enforcement agencies, and regulators; providing credit monitoring services; staffing call centers to answer customer inquiries; and responding to government investigations.

Audit Rights

The service agreement should give the principal the right to audit the service provider's security program and compliance with applicable privacy and security laws. Service providers may want to place certain reasonable limitations on audit rights—for example, the agreement might specify that the principal may audit no more frequently than once annually or after a reportable security incident or where there is other reasonable cause to believe the service provider is not maintaining reasonable security controls or complying with law.

Return or Destruction of Information Following Termination

HIPAA business associate agreements must require the business associate to return or destroy all protected health information if feasible and if this is not feasible, continue to protect the information and limit further uses and disclosures to the purposes that make return or destruction infeasible.

Service provider agreements for non-HIPAA business should contain a similar provision and, regardless of the business is HIPAA or non-HIPAA, the principal may want to define the circumstances under which the service provider may retain a copy of personal information following termination with some specificity rather than allowing retention under the rather vague standard of infeasibility. The principal also may want to state that it makes the decision of whether the service provider returns or destroys the data and specify that whatever action is taken, it will be at the service provider's expense.

Other Issues

Service providers often seek to limit their liability, usually based on a multiple of annual fees, and with a waiver of liability for incidental or consequential damages. Given the financial risk associated with a breach of personal information, principals will want to carve out liability arising from a data breach from any agreed upon limitation of liability.

Insurance for data breach risks has become widely available in recent years. Principals may want to require their service providers to maintain such insurance. Because the coverage available under such policies can vary considerably, the service provider agreement should specify the required coverage and appropriate limits.

Joseph T. Holahan is Of Counsel in the firm's Insurance and Reinsurance 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. He often advises clients on the development of captive programs and reinsurance arrangements. Mr. Holahan received his bachelor's degree from the University of Virginia and his law degree from the Catholic University of America.

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to designate arbitrators within the time required by the NASD rules). *But see New England Reinsurance Corp. v. Tennessee Ins. Co.,* 780 F.Supp. 73, 77 (D. Mass. 1991) (excusing failure to comply with 30-day deadline due to honest mistake).

Even where the arbitration clause does not authorize the unilateral appointment of arbitrators, the Federal Arbitration Act provides a statutory remedy. In the event of a "lapse" in the naming of an arbitrator or umpire, either party may request a court to appoint the missing arbitrator. 9 U.S.C. § 5.

A similarly quick solution may not be available where arbitrators are nominated but their qualification or bias is challenged. In numerous decisions, courts have declined to address qualification or bias or other challenges prior to entry of a final award. *See, e.g., Gulf Guaranty Life Insurance Co v. Connecticut General Life Insurance Co.,* 304 F.3d 476, 487-88 (5th Cir. 2002) (holding that court could not adjudicate before entry of the arbitration award whether an executive of a reinsurer constitutes an "executive of a life insurance company"); *Baylor Health Care Sys. v. Beech St. Corp.,* 3:13-MC-054-D, 2014 WL 66470, at *2 (N.D. Tex. Jan. 8, 2014) (refusing to consider pre-arbitration argument that party's nominee was tainted by prior service as umpire in a related matter); *Serv. Partners, LLC v. Am. Home Assur. Co.,* CV-11-01858-CAS EX, 2011 WL 2516411, at *3-4 (C.D. Cal. June 20, 2011) (refusing to consider pre-arbitration argument that nominee was improperly "under the control of" the opposing party).

The judicial reluctance to intervene generally is supported by a healthy deference to the arbitration process. A significant purpose (in theory, anyway) of arbitration is a speedy adjudication. Few things are more antithetical to that than judicial intervention.

Therefore, courts' reluctance to intervene makes sense when the named arbitrator is challenged as biased. The necessary judicial inquiry would be fact-intensive and involve subjective judgments. Because bias is easy to charge, pre-arbitration judicial intervention to investigate charges of arbitrator bias could become the norm, rather than the exception. This would frustrate the purpose of arbitration.

However, immediate judicial intervention makes sense when the challenge involves an objectively measured qualification. For example, many arbitration clauses in reinsurance agreements require that the arbitrators be active or former officers of an insurer or reinsurer. Sometimes, a party may try to circumvent these requirements by naming a former regulatory official, rating agency personnel or outside counsel with insurance experience. While such a nominee might be a capable individual, he or she also plainly fails to satisfy the terms that the parties bargained for in their arbitration agreement.

Where one side names an arbitrator unqualified under the agreement's objectively-measureable qualification thresholds, it is neither speedy nor efficient to delay ruling until after the arbitration is complete. Nevertheless, this is the practice of many modern courts. *See, e.g., Gulf Guaranty,* 304 F.3d at 487-488 (refusing to adjudicate whether an executive of a reinsurer constitutes an executive of a "life insurance company"); *Odyssey Reinsurance Co. v. Certain Underwriters at Lloyd's London Syndicate* 53, 13 CIV. 9014 PAC, 2014 WL 3058377, at *1 (S.D.N.Y. June 30, 2014) ("Petitioner argues that Respondents' selected candidates are not qualified. But 'a district court cannot entertain an attack upon the qualifications or partiality of arbitrators until after the conclusion of the arbitration and the rendition of an award.'" [cit.]); *Ins. Co. of N. Am. v. Pennant Ins. Co.,* 97-MC-154, 1998 WL 103305, at *1-2 (E.D. Pa. Feb. 18, 1998) (refusing to determine, pre-arbitration, whether nominee met qualification as an "active or retired disinterested official of insurance or reinsurance companies"). Such delay rewards obstruction and eviscerates efficiency.

A few decisions support early intervention in these circumstances. *See, e.g., Oakland-Macomb Interceptor Drain Drainage Dist. v. Ric-Man Const., Inc.,* 304 Mich. App. 46, 59, 850 N.W.2d 498, 505-

06 (2014) (granting pre-arbitration motion to appoint a lawyer with a background in construction litigation as required by the selection procedures specified in the arbitration agreement); *Safety Nat. Cas. Corp. v. Certain Underwriters at Lloyd's London*, 02-CV-1146, 2011 WL 3610411 (M.D. La. Aug. 16, 2011) (indicating that although it was improper to *remove* an already-seated umpire, a court might have the authority to intervene when the parties were stalled at the selection phase, pursuant to FAA's purpose of expediting arbitration). *Cf. Aviall, Inc. v. Ryder Sys., Inc.,* 913 F.Supp. 826, 834 (S.D.N.Y. 1996) *aff'd,* 110 F.3d 892 (2d Cir. 1997) (observing that pre-award removal of an arbitrator may be possible "when the court concludes that one party has deceived the other, that unforeseen intervening events have frustrated the intent of the parties, or that the unmistakable partiality of the arbitrator will render the arbitration a mere prelude to subsequent litigation").

Allowing judicial intervention in objectively-based qualification disputes makes sense. Of course, the line between objective and subjective judgments is not always distinct. For example, an arbitration clause may limit arbitrators to "executive officers," which are generally defined as "corporate officer[s] at the upper levels of management," an admittedly ambiguous phrase in itself. *See* Black's Law Dictionary, "Executive" (9th ed. 2009). Similarly, *Gulf Guaranty,* 304 F.3d at 487-488, involved whether an executive of a reinsurer qualifies as an executive of a life insurer. However, while such an inquiry may require some judgment on the court's part, it should not be time-consuming or fact-intensive.

Note: The author would like to thank associate Sam VanVolkenburgh for his valuable contributions to this article.

Lew Hassett is Co-Chair of the firm's Insurance and Reinsurance Practice and Chair of the firm's Litigation Practice. His focus is complex civil litigation, including insurance and reinsurance matters, business torts and insurer insolvencies. Mr. Hassett received his bachelor's degree from the University of Miami and his law degree from the University of Virginia.

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individual health insurance in relation to the provision of hospital indemnity benefits or any other fixed indemnity benefits, and sets new standards for offering those new benefits.

The key to interpreting the impact of the HHS rule is understanding what constitutes individual health insurance coverage under federal law. Under the PHSA regulations, "individual health insurance coverage" includes all health insurance coverage (as defined in § 144.103) that is neither health insurance coverage sold in connection with an employment-related group health plan, nor short-term, limited-duration coverage.[4]

Under the PHSA, and implementing regulations, all coverage is individual coverage unless the coverage is 1) employment-related, and 2) a group health plan. Both conditions must be met. Thus, some employment-based coverage might be regulated as individual coverage under the federal rules if is not a "group health plan." The PHSA defines a "group health plan" as an employee welfare benefit plan as defined by the Employee Retirement Income Security Act ("ERISA") to the extent that the plan provides medical care.[5] As a result, if coverage is not part of an employee welfare benefit plan under ERISA, it is individual coverage under the federal rules.

This creates the situation, and the ensuing confusion, that a hospital indemnity or other fixed indemnity product might have different standing under state and federal law. Federal regulators contemplated this situation. The federal rules state that "In some cases, coverage that may be considered group coverage under State law (such as coverage sold through certain associations) is considered individual coverage" under federal rules.[6]

HHS also noted that this was permissible under the PHSA. Federal rules provide that the "individual market rules of this part do not prevent a State law from establishing, implementing, or continuing in effect standards or requirements unless the standards or requirements prevent the application of a requirement of this part."[7]

Finally, HHS addressed this issue in the preamble to the final fixed indemnity rule. HHS noted that the PHSA "defines the individual market in terms of health insurance (that is, not in terms of excepted benefits), and defines individual health insurance coverage." HHS further states that it was its "intention that new fixed indemnity rule applies to excepted benefits sold in the 'individual market' …This would preempt any state law that classifies an individual product as a 'group' product (for example, individual policies sold through associations)."[8]

These new rules have created confusion at the state level. State regulators are still grappling with issues such as whether a product that is regulated as an individual product at the state level should still be filed as a group product at the state level. States need to resolve how these new federal regulations impact policies that were previously filed under what was the common state regulatory interpretation of the HIPAA excepted benefits rules. A related issue is whether these new rules should even apply to policies that were issued on a guaranteed renewal basis. Unfortunately, the new rules create more questions than they answer and the industry and state regulators remain in a "wait and see" mode.

4. 45 C.F.R. § 148.102.

5. 42 U.S.C. § 300gg–91(a)(1).
6. 45 C.F.R. § 148.102.
7. 45 C.F.R. § 148.210(b).
8. Federal Register, Vol. 79, May 27, 2014 at 30256.

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