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LETTER FROM WASHINGTON

DOES THE FIO MATTER?

By Robert H. Myers, Jr.

Title V of the Wall Street and Consumer Protection Reform Act (commonly known as "Dodd-Frank") includes the creation of the Federal Insurance Office ("FIO"). Headed by former Illinois Insurance Commissioner Michael McRaith, the FIO is located in the U.S. Treasury. In the two years since passage of Dodd-Frank, the FIO has begun hiring staff and working on an examination of the regulation of insurance.

A reasonable question for observers of the insurance industry is: does the FIO matter? Its stated authority in Title V is very limited. It is authorized to "monitor all aspects of the insurance industry," to collect data concerning the industry (including the use of subpoenas), to represent the U.S. in international insurance regulatory and prudential negotiations, and to provide annual reports to Congress. It also has the authority to preempt state law but only after a determination that the state law in question "results in less favorable treatment of a non-United States insurer ... that is subject to a covered agreement." A "covered agreement" is an agreement regarding insurance prudential matters between the U.S. and another country (or countries) or its regulatory authority. The FIO can exercise its right of preemption only after an elaborate procedure including notice to the relevant state, the relevant committees of Congress and notice in the Federal Register.

Most importantly, the FIO is directed to prepare a report on "how to modernize and improve the system of insurance regulation in the United States" including an examination of "the costs and benefits of potential Federal regulation of insurance across various lines of insurance...." This study was due January 21, 2013 (18 months after the Dodd-Frank enactment date of July 21, 2012). Needless to say, we are almost a year past that date and no study is in sight. We are told the study is

Continued on page 6

HASSETT'S OBJECTIONS

BAD FAITH RESERVATION OF RIGHTS: THE PERFECT AS ENEMY OF THE EFFICIENT

By Lewis E. Hassett

Most policyholders would prefer that an insurer defend under a reservation of rights rather than deny coverage and a defense altogether. Not only does a defense under a reservation save the policyholder the cost of the defense, it also may trigger certain rights for the policyholder, such as the right to choose independent counsel.

It is not unusual for allegations in a complaint to include both covered and uncovered claims, and for allegations of intentional misconduct, if proven, to preclude coverage altogether. Given the small margin often present between some indication of coverage versus an indication of no coverage, policyholders seize on the former and hope to obtain a funded defense.

Similarly, an insurer often would prefer to defend under a reservation of rights so that it need not then expend substantial funds arguing about whether the complaint possibly could trigger a duty to indemnify and, therefore, a duty to defend. It often makes economic sense to defend the lawsuit and then argue about indemnification in the event of an adverse decision.

Therefore, an insurer's defense under a reservation of rights often is the most economically efficient method of handling potential coverage disputes. Against this economic reality, some courts have recognized a policyholder's right to claim bad faith damages where the insurer is providing a defense. The latest is a California federal court in *Lehman*

Continued on page 7

Inside this Issue

Announcements

Factset, a Financial Research Firm, included **MMM** in their list of Top 50 legal advisors for announced deals thus far in 2013.

Skip Myers will discuss new issues in insurance regulation at the Risk Insurance Management Society (RIMS) annual meeting in Los Angeles on April 22.

On May 4, **Chris Petersen** will moderate a panel discussion on health insurance exchanges at the State Law Resources' annual meeting. The panel will examine the role of state regulation in federally facilitated exchanges and will include representatives from a state insurance department, an exchange board, the U.S. Department of Health and Human Services and the health insurance industry.

On May 8, **Tony Roehl** will speak at the Northeast Georgia Health Underwriters Ethics Day in Gainesville, Georgia on the topic of insurance exchanges and their effects on agents.

Skip Myers will speak on May 30 at the annual tax conference of the Federal Bar Association in Washington, DC on regulatory changes affecting captives.

Lew Hassett and **Shannon McNulty** are representing a title insurer in an appeal addressing the measure of a loss under a mortgagee title insurance policy where only one of several insured parcels are affected by superior encumbrance.

On January 22, **Tony Roehl** spoke before the Metro Atlanta Chamber of Commerce to discuss employer obligations and subsidies under the Patient Protection and Affordable Care Act ("PPACA").

On April 11, **Chris Petersen** spoke at the National Alliance of Life Companies conference in St. Simons, Georgia, where he discussed the impact of the PPACA on supplemental health insurance.

Chris Petersen and **Joe Holahan** conducted a webinar on HITECH privacy and security issues on behalf of the Professional Insurance Marketing Association. The webinar focused on the impact of the new HITECH rules on business associates.

On January 29, **Tony Roehl** and the Hays Companies of Georgia hosted a webinar devoted to presenting facts related to the PPACA and how it impacts employers.

Lew Hassett and **Brian Levy** have been retained to represent a national automobile insurer in a putative class action in Ft. Lauderdale.

On March 11, **Jim Maxson** moderated the institutional investor legal panel at the Life Insurance Settlement Association's 3rd Institutional Investor Life Settlements Conference in New York.

On March 12, **Skip Myers** spoke at the Captive Insurance Companies Association meeting in Palm Springs on regulatory change in the insurance industry and corporate governance. **Joe Holahan** also attended and spoke on issues related to collateral in the context of fronting.

Jessica Pardi participated in the Surplus Line Law Group meeting sponsored and hosted by the Excess Lines Association of New York (ELANY). The event took place March 21 – 22 in New York.

On January 10, **Tony Roehl** provided a post-election update on health insurance reform to the Macon Chapter of Georgia Health Underwriters.

On March 21, **Tony Roehl** spoke at the South Atlanta Health Underwriters meeting in Atlanta on the topic of insurance exchanges and their effects on agents.

MMM Establishes Two New Practice Areas

MMM established a **Consumer Finance Litigation Practice** representing lenders with regard to special litigation needs ranging from privacy, collection, data breach and usury disputes to class actions and regulatory problems. **Lew Hassett** in the firm's Atlanta office and **Caren Enloe** in the firm's Raleigh-Durham office will co-chair the group. Laws and regulations with which the group is familiar include the Credit Repair Organizations Act (CROA), Equal Credit Opportunity Act (ECOA), Fair Credit Reporting Act (FCRA), Fair Debt Collections Practices Act (FDCPA), Real Estate Settlement Procedures Act (RESPA), Telephone Consumer Protection Act (TCPA), Truth-in-Lending Act (TILA), Regulation Z and state Unfair and Deceptive Acts and Practices (UDAP) statutes.

The firm also established a **Crisis Management Practice** led by **Robert L. Alpert, Sr.** and other senior lawyers who undertake operational and management responsibility for high-risk, high-profile situations and crises. The team will help clients to prepare for or instantaneously respond to crisis situations, including investigations, evidence preservation, public relations selection, local counsel management, issue coordination, liability analysis and damage control. As demonstrated recently (e.g. Penn State, the BP oil spill, etc.), without proper preparation and correct execution, a manageable but serious situation could quickly become a bet-the-company catastrophe.

LIFE SETTLEMENTS AND LONG-TERM CARE: THE BEGINNING OF A BEAUTIFUL FRIENDSHIP?

By James W. Maxson

The Medicaid program is the largest single payer of nursing home bills in America and the payer of last resort for those who do not have the resources to pay for their own care. Medicaid eligibility rules are complicated and differ from state to state, but an important and often difficult to meet hurdle in all such laws is the asset and resource standard. If an applicant has assets which exceed the maximum limits, they will be ineligible for benefits even if they cannot otherwise afford the necessary care. In an attempt to address this issue, Florida and Kentucky are each considering innovative laws that utilize life settlements (the sale of life insurance policies into the secondary market for life insurance) to make it easier for seniors with life insurance to afford critical care.

Legislators in Florida and Kentucky have submitted legislation that would, among other things, allow owners of life insurance policies to use the proceeds from the sale of their policies to cover the cost of Medicaid long-term care services.

The Florida bill (HB 535) and the Kentucky bill (HB 314) contain nearly identical provisions authorizing the owner of a life insurance policy with a face value in excess of $10,000 to enter into a life settlement contract in exchange for guaranteed periodic payments (in Florida, the payments are made to the healthcare services provider; and, in Kentucky, to the Kentucky Medicaid program), so long as such payments are used solely to provide Medicaid-covered long-term care services for the policy owner. In addition, the contract for the sale of the policy must contain the following provisions: 1) the lesser of 5% of the face value of the policy or $5,000 must be reserved as a death benefit payable to the owner's beneficiary; 2) the balance of the payments required under the sale agreement unpaid at the death of the owner must be paid to the owner's beneficiary; 3) each contract must contain a schedule setting forth the total amount payable, the number of payments and the amount of each payment; and 4) all funds must be held in an irrevocable state or federally insured account.

Additionally, under the draft Florida law, the value of a life insurance policy owned by a person who meets the state's nursing home level of care will not be considered as a resource or an asset in determining that person's eligibility for Medicaid if his or her life insurance policy is assigned to the state for an amount not greater than the amount of Medicaid benefits provided to the recipient, plus the premium costs of keeping the policy in force.

While it remains to be seen if the target population of seniors who need Medicaid assistance own eligible life insurance policies that can be utilized to cover the costs of care, one thing is clear: if these bills are passed into law, it will be further evidence life settlements are versatile, valuable and allow average Americans to unlock value in a hidden asset they might not know they own. ❑

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FINAL HIPAA/HITECH OMNIBUS RULE MAKES SIGNIFICANT CHANGES FOR HEALTH PLANS AND THEIR BUSINESS ASSOCIATES

By Joseph T. Holahan and Chris Petersen

After a very long wait, the Department of Health and Human Services ("HHS") has issued a final HIPAA/HITECH Omnibus Rule (the "Rule") implementing provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the Genetic Information Nondiscrimination Act ("GINA").

Some aspects of the Rule mirror statutory requirements of HITECH that have been in effect since February 2010. Many HIPAA covered entities and business associates already may have brought themselves into compliance with these requirements. Other aspects of the Rule, however, make important changes that will affect covered entities, business associates and the downstream subcontractors of business associates.

Regulated entities generally have until September 23, 2013, to comply with the requirements of the Rule. As discussed below, additional time is provided to bring certain existing business associate agreements into compliance and for health plans to circulate revised privacy notices.

This article discusses the aspects of the Rule likely to be of most interest to health plans and the business associates of health plans.

Subcontractors

One significant change made by the Rule involves downstream subcontractors of business associates. Under the Rule, the subcontractor of a business associate is itself considered a business associate if it handles protected health information ("PHI").

The Rule defines a subcontractor as any person to whom a business associate delegates a function, activity or service, other than as a member of the business associate's workforce. For example, a vendor providing data storage for a third party administrator would be considered a business associate of the administrator if the data is PHI.

Deeming subcontractors to be business associates has two major consequences. First, business associates will be required to have HIPAA compliant business associate agreements in place with their subcontractors that handle PHI. Failure to do so will be considered a violation of law. Second, subcontractors handling PHI will be subject to all HIPAA requirements that apply to business associates, including compliance with the HIPAA Security Rule.

Regulatory Duties of Business Associates

As required by HITECH, the Rule imposes certain regulatory duties on business associates and makes any violation of these duties subject to HIPAA's civil and criminal penalties. The regulatory duties applicable to business associates, including subcontractors that qualify as business associates, include the following:

- Business associates must implement administrative, technical and physical safeguards to protect the security of electronic PHI as required by the HIPAA Security Rule. Business associates also must

comply with the Security Rule's documentation requirements.

- Business associates contracting directly with a covered entity must provide timely notice to the covered entity of any security breach involving unsecured PHI. It appears subcontractors that are business associates must give notice of breach to the business associate with which they have a direct contractual relationship, although the Rule is not entirely clear on this point.
- Business associates must use and disclose PHI only as permitted by their business associate agreement.
- Business associates must not use or disclose PHI in a way that would violate the Privacy Rule if done by the covered entity.
- Business associates must execute business associate agreements with their subcontractors that handle PHI. If a subcontractor engages in a pattern of conduct or practice in material breach of its business associate agreement, the business associate must take reasonable steps to cure the breach and, if such steps are unsuccessful, terminate the agreement if feasible.
- Business associates must make reasonable efforts to limit uses and disclosures of, and requests for, PHI to the minimum necessary. This requirement suggests that business associates should have reasonable written policies and procedures for limiting uses and disclosures of, and requests for, PHI to the minimum necessary and limiting the access of personnel to PHI necessary for their job function.
- Business associates must disclose PHI to the covered entity, individual or the individual's designee when required to provide an electronic copy of PHI. Business associates also must disclose PHI to the Secretary of Health and Human Services when lawfully requested to do so.

Changes to Business Associate Agreements

The Rule requires covered entities to include certain new provisions in their business associate agreements. Business associate agreements with their subcontractors also must include these provisions.

After HITECH was enacted, many covered entities added language to their business associate agreements reflecting the law's statutory requirements, including a catch-all provision designed to incorporate by reference any regulatory changes that might occur. Such catch-all provisions may comply with the Rule without further amendment, but it is advisable to include language in business associate agreements specifically reflecting the new requirements, at least for new agreements and renewals of existing agreements. Including specific language helps ensure that business associates are on notice of their responsibilities.

In addition to the provisions previously required by the Privacy and Security Rules, business associate agreements must include the following new provisions:

- The agreement must require the business associate to comply with the applicable provisions of the Security Rule.
- The agreement must require the business associate to report any use or disclosure of PHI not in compliance with the agreement, specifically including breaches of unsecured PHI. The same provision already is required for business associate agreements, except now the provision must specifically state the business associate's duty to give notice of any breach involving unsecured PHI.
- The agreement must require the business associate to execute a business associate agreement with any subcontractor that handles PHI.
- The agreement must state that to the extent the business associate carries out the covered entities obligations under the Privacy Rule, the business associate will comply with the requirements of the Privacy Rule that apply to the covered entity.

In general, covered entities must have compliant business associate agreements in place with their business associates and business associates must have compliant business associate agreements in place with their subcontractors no later than September 23, 2013. If, however, a covered entity or business associate had a written agreement in place prior to January 25, 2013, and the agreement complied with regulatory standards at that time, so long as the agreement is not renewed or modified between March 26 and September 23, 2013, the agreement will be deemed compliant until the earlier of (i) the date it is renewed or modified or (ii) September 22, 2014. "Evergreen" contract renewals will not count as a renewal for this purpose and therefore will not end the deemed compliance period.

Liability for Conduct by Business Associates

The Rule makes an important change to the circumstances under which covered entities may be liable for a HIPAA violation based on the conduct of their business associates. Previously, the HIPAA Enforcement Rule established a safe harbor under which a covered entity could not be found liable for a HIPAA violation based on misconduct by its business associate. Under the safe harbor, a covered entity could not be found liable so long as the covered entity had a compliant business associate agreement in place and either did not know of any pattern of activity or practice by the business associate in material breach of the business associate agreement or, if it did know of such a pattern or practice, it took reasonable steps to cure the breach and, if unsuccessful, terminated the agreement or reported the problem to the Secretary of Health and Human Services if termination was not feasible.

The Rule eliminates the safe harbor so that a covered entity is liable for a violation arising from the conduct of any common law agent of the covered entity, as defined by the federal common law of agency, including a business associate acting as the covered entity's agent. The same liability attaches to a business associate for the conduct of any agent of the business associate, including a subcontractor.

Under the federal common law of agency, a business associate performing services for a covered entity generally would be considered an agent of the covered entity only if the covered entity has authority to control the business associate's conduct in performing the services—for example, by giving interim instructions to the business associate concerning how to carry out its contractual obligations. If, however, the only avenue of control over the business associate is to amend the contract between the covered entity and the business associate, the business associate would not be considered the covered entity's agent. The same principles apply to business associates and their subcontractors.

A covered entity or business associate also will be liable for a HIPAA

violation if it knows of a pattern of activity or practice by a business associate in violation of the business associate agreement and it fails to take reasonable steps to cure the breach and if unsuccessful, terminate the contract if feasible.

Breach Notification

In another important change, the Rule eliminates the "significant risk of harm" standard for determining whether an impermissible use or disclosure of unsecured PHI constitutes a security breach requiring notification. Instead, the Rule applies a new, more stringent standard.

Under the new standard, if PHI is subject to any acquisition, access, use or disclosure in violation of the Privacy Rule, and none of three existing exceptions applies, it is presumed that a breach has occurred unless the covered entity or business associate, as the case may be, demonstrates a low probability that the information has been compromised. In every case, the burden is on the covered entity or business associate to demonstrate that a breach has not occurred.

The determination of whether there is a low probability that PHI has been compromised must be based on a risk assessment involving at least the following factors:

- The nature and extent of the PHI involved, including the types of personal identifiers and likelihood of re-identification if de-personalized information is involved;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

The new standard for breach shifts the balance towards a determination that a breach has occurred, making it more likely that notification will be required if unsecured PHI is involved. Nevertheless, the factors that must be considered in determining whether there has been a breach are much the same as under the old standard.

For example, under the first required element of the risk assessment—the nature and extent of the PHI involved—HHS states in the preamble to the Rule that entities should consider whether the incident "involved information that is of a more sensitive nature…" such as credit card numbers, social security numbers or other information that increases the risk of identity theft or detailed clinical information such as treatment plans, diagnoses, medications or test results. In addition, the preamble states that considering the type of information involved "will help entities determine the probability that the protected health information could be used by an unauthorized recipient in a manner adverse to the individual or otherwise used to further the unauthorized recipient's own interests."

Clearly, then, determining whether PHI has been compromised includes an assessment of the risk of harm to affected individuals. In the preamble, HHS suggests the determination of breach under the new standard is broader than merely assessing risk of harm, yet the factors identified in the preamble tend to focus on the risk that PHI might be used in a way that would harm the individual. Nevertheless, other factors also may come into play—for example, the preamble states one factor to consider is whether the unauthorized recipient of PHI could use the information to further the recipient's own interests.

Covered entities and business associates should recognize that risk of harm is still an important consideration under the new standard for determining whether a breach has occurred. Nevertheless, other factors that would compromise the privacy of PHI, even without doing tangible harm to affected individuals, should be considered. In addition, it is important to keep in mind that the balance in determining whether a breach has occurred now weighs heavily in favor of breach.

Changes to HIPAA Privacy Notice

The Rule requires covered entities to make several material changes to their HIPAA privacy notice to reflect new rights of individuals under the Rule. The privacy notice must include the following new elements:

- A description of the types of uses and disclosures of psychotherapy notes that require an authorization (covered entities that do not record or maintain psychotherapy notes are not required to include this statement);
- A statement that any use or disclosure of PHI for marketing that involves financial remuneration to the covered entity requires an authorization;
- A statement that the covered entity must obtain an authorization to sell PHI;
- If the covered entity intends to engage in any of the following activities, a separate statement as follows:
  - That the covered entity may contact the individual to raise funds for the covered entity and the individual has a right to opt out of receiving such communications (this will likely apply only to healthcare providers);
  - If the covered entity is a health plan, other than a long term care insurer, and uses PHI to underwrite, a statement that it is prohibited from using or disclosing genetic information for underwriting purposes (genetic information includes family history);
- For healthcare providers only, a statement informing individuals of their new right to restrict certain disclosures of PHI to a health plan where the individual pays out of pocket in full for a healthcare item or service; and
- A statement that the covered entity is required to provide notice of any breach of the individual's unsecured PHI.

A health plan that posts its HIPAA privacy notice on its website and makes material changes such as those required by the Rule must post the revised notice on its website no later than the effective date of the changes (September 23, 2013 for revisions reflecting the Rule) and provide the revised notice, or information about the changes and how to obtain the revised notice, in its next annual mailing to covered individuals. Most health plans are required by the Privacy Rule to post their privacy notices on their websites.

If a health plan does not post its HIPAA privacy notice on a website, and it makes material changes to the notice, it must provide the revised notice, or information about the changes and how to obtain the revised notice, to covered individuals no later than 60 days following the effective date of the changes (November 22, 2013 for revisions reflecting the Rule).

Right of Access to Information

The Rule provides that if an individual requests an electronic copy of PHI, and the covered entity maintains the PHI in electronic form in a designated record set, the covered entity must provide a copy of the information in the electronic form and format requested, if it is readily producible, or, if not, in a readable electronic form and format as agreed to by the covered entity and individual. HHS states in the preamble to the Rule that it expects covered entities to provide a machine readable copy of electronic PHI to the extent possible.

A covered entity is not required purchase new software or systems to comply with this new requirement, so long as it can provide an electronic copy of PHI in some reasonable format. If an individual refuses to accept any of the electronic formats in which electronic PHI is readily producible by the covered entity, the covered entity may provide a hard copy to fulfill the request.

The fee a covered entity charges for providing an electronic copy of PHI may include, among other allowable costs, the reasonable cost for skilled technical staff time spent copying an electronic file and the cost of the disk, flash drive or other medium on which the copy is provided. Fees associated with maintaining systems or the capital expenditures to maintain data access, storage and infrastructure may not be charged.

The Rule also requires that, if requested by the individual, a covered entity must transmit a copy of PHI directly to a person designated by the individual. This requirement applies to all requests for PHI, regardless of whether an electronic copy is requested.

The Rule eliminates the Privacy Rule provision that allowed 60 days for providing access to PHI when the information is not maintained or accessible to the covered entity on-site. If PHI is not readily accessible, a covered entity still may rely on the provision of the Privacy Rule allowing a one-time extension of 30 days to the usual 30-day period for responding to a request for access.

Genetic Information

The Rule makes GINA's prohibition against using genetic information for underwriting purposes apply to all health plans subject to the HIPAA Privacy Rule, except for long-term care plans. Genetic information includes family history. Previously, all HIPAA "excepted benefits" were exempt from this restriction under federal law. Now, any excepted benefit, other than long-term care, that is subject to the HIPAA Privacy Rule will be prohibited from using family history or other genetic information for underwriting purposes.

Other Changes

Other changes made by the Rule include the following:

The Rule creates new standards for the investigation of complaints, initiation of compliance reviews and resolution of violations. Consistent with HHS's more aggressive approach to HIPAA enforcement, if a case of noncompliance involves willful neglect, regulators no longer are required the case by informal means, such as demonstrated compliance or a corrective action plan. HHS retains discretion to resolve cases not involving willful neglect through informal means. The Rule also clarifies how federal regulators will apply the four-tiered civil money penalty scheme implemented under HITECH.

The Rule sets new limits on how covered entities may use or disclose protected health information for marketing and fundraising purposes and prohibits the sale of PHI without the individual's authorization.

The Rule changes the standards that apply to the PHI of decedents and student immunization records. The Rule also changes the standards for research authorizations.

Conclusion

Many of the requirements of the Rule reflect statutory requirements established by HITECH with which many covered entities and business associate already have complied. Yet the Rule contains a number of significant new requirements that will require material changes to the policies and procedures, business associate contracts and HIPAA privacy notices of regulated entities.

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Chris Petersen is a Partner in the firm's Insurance and Reinsurance Practice where he concentrates on legal and compliance services relating to the Health Insurance Portability and Accountability Act (HIPAA), privacy, state small group and individual insurance reform regulation and the interaction between state and federal law. Mr. Petersen received his bachelor's degree from Washington University in St. Louis, Mo. and his law degree from Georgetown University School of Law.

LETTER FROM WASHINGTON

Continued from page 1

in the process of review within Treasury and could be published at "any time."

The importance of the FIO, and the role it will play in the insurance industry, should not be underestimated. In order to understand why, one has to examine how the regulation of the insurance business actually operates and what forces are driving the U.S. regulatory agenda. First, the structure of U.S. insurance regulation has been cobbled together over the years. While the McCarran-Ferguson Act established the primacy of the states in insurance regulation, the federal government has always had a role in taxation (Internal Revenue Service), healthcare (Health and Human Services) and securities (Securities and Exchange Commission). Second, the solvency crisis of 2008 put domestic and international pressure on the U.S. to improve its financial solvency regulation, including insurance. Two laws were passed by Congress which interrupted the dominance of state law over insurance: Dodd-Frank and the Patient Protection and Affordable Care Act.

These new influences have resulted in both regulatory uncertainty and competition among regulators. The key to understanding this new regulatory environment is the National Association of Insurance Commissioners ("NAIC"). The states are the regulators of insurance. However, the states (or more correctly the Commissioners of the states) belong to the NAIC, the purpose of which is to gather information and

provide the opportunity for states to establish a common understanding of insurance regulatory issues and to promulgate rules and regulations which the states voluntarily can adopt. However, the NAIC has evolved into more than just an association for the benefit of regulators. The NAIC has things that the states do not have. It has both a sizeable staff and a substantial budget and, more importantly, it has the only database of insurance information. This places it in the position to drive the insurance regulatory agenda and to participate in activities that arguably are the province of the states.

The NAIC has been described as a tax-exempt organization, a trade association and a "standard setting" organization. In fact, it carries real power in the insurance regulatory world for two reasons: (1) the state accreditation process and (2) there is no other organization with the funding, staff and information to fulfill the role of a national regulator. While the NAIC does not have the legal authority to regulate, it does have the money, staff and history of having done so, and it has the accreditation process as its enforcement mechanism. No state wants to lose its accreditation.

So, why is the FIO important? Even though its stated authority is quite limited, the Dodd-Frank Act establishes in law that the FIO has the authority to: (1) represent the U.S. in international matters, (2) collect insurance industry information and (3) study U.S. insurance regulation. It also has a budget and a staff. In other words, it has the legal authority to influence the regulation of insurance, which is what the NAIC has been doing for decades without any authority in the law but unchallenged because there is a need for such a national organization.

So far, the NAIC and the FIO have been getting along quite well. The two entities are cooperating on international regulatory matters such as the International Association of Insurance Superintendents and in other international gatherings. The FIO has diplomatically become a force in the international insurance regulatory world, an area previously dominated by the NAIC.

How will this *entente cordiale* be affected by the publication of the FIO study of domestic U.S. insurance regulation? The FIO has the ability and the legal authority to promote its own agenda; however, it does not have the legal authority to implement it domestically. By contrast, the NAIC has the ability to promote its own agenda and effectively implement it without legal authority. This puts these two organizations on a collision course. We cannot predict the outcome but, without a doubt, the FIO matters. ❑

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HASSETT'S OBJECTIONS

Continued from page 1

Commercial Paper, Inc. v. Fidelity Nat'l. Title Ins. Co., Case No. SACV-12-570 (C.D. Ca. January 2, 2013).

In *Lehman*, the policyholder received a mortgagee title policy from Fidelity National Title Insurance Company ("Fidelity") with respect to a loan in the amount of $235 million. The borrowers went into bankruptcy, and lien claimants asserted priority over the Lehman deeds of trust. Fidelity and another title insurer defended the lien claims at their own expense and resolved several lien claims via negotiated payments. At the time of the decision noted above, all lien claims either had been defended successfully or satisfied. Nevertheless, Lehman brought an action for bad faith alleging the loss of "intangible benefits." The trial court denied Fidelity's motion for summary judgment, holding that, even where an insurer is complying with its contractual obligations, it still may bear bad faith liability for "*other* conduct – such as unreasonably refusing to determine coverage . . . ." *Id.* at 8 (Emphasis by court).

Because the court was sitting under diversity jurisdiction, it applied California substantive law. The court cited language in *Dalrymple v. United Svcs. Auto Ass'n*, 46 Cal. Rptr.2d 845, 854 (Cal. App. 1996), as follows:

> There may be cases in which the insurer's delay in paying the claim or other misconduct causes special harm to the insured even though the claim is ultimately paid or settled. Such payment fulfills the insurer's contractual obligations. However, under appropriate circumstances, tort liability may still be imposed for the insurer's misconduct apart from performance of its contract obligation.

Accord: James River Ins. Co. v. Hebert Schenk, P.C., 523 F.3d 915 (9th Cir. 2008) (applying Arizona law). Other courts disagree. *Acuity v. Rana*, 2012 WL 289860 (W.D.Mo. Jan. 31, 2012) (declaratory judgment action allows insurer to avoid liability for a bad faith refusal to defend); *Cardenas v. Navigators Ins. Co.,* 2011 WL 6300253, *7 (W.D. Wash. Dec. 16, 2011) (bad faith claim dismissed where insurer defending under reservation of rights); *Alaska Nat'l Ins. Co. v. Bryan,* Wash. App. 104 P.3d 1, 9 (2004) (providing defense under reservation of rights precludes bad faith liability); *Carolina Cas. Ins. Co., v. Draper & Goldberg*, PLLC, 369 F.Supp.2d 667 (E.D.Va 2004) (not bad faith to defend under reservation).

When an insurer provides a defense, any intangible injury because coverage had not been accepted should be insufficient to state a claim. Not every potential legal and factual question related to coverage need be answered, the importance of lawyer employment notwithstanding. If the insurer funds the defense, other issues often resolve themselves through success in the underlying litigation. The law should encourage this type of reasonable behavior, regardless of the policyholder's uncertainty.

Precluding bad faith liability for a reservation of rights would not allow insurers *carte blanche* to refuse to cover policyholders. If the underlying litigation is resolved against the insured, and the insurer refuses to indemnify, the usual risks of bad faith liability would apply. The law should encourage the economically reasonable interim step of allowing an insurer to defend under a reservation of rights without risk of bad faith liability. Those courts that disagree would say that an insurer has nothing to fear if its conduct is reasonable. Such assurances are of scant comfort when courts are so ready to toss the issue to a jury. There is a reason that jurors are not informed in tort cases that a defendant has insurance. Those same concerns mandate that reservations of rights be allowed without fear of bad faith liability. ❑

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