The Insurance Business and Regulatory Group was formed in 1990 by Robert B. Sullivan and is currently chaired by Steven L. Imber. The group concentrates on providing outstanding service and expertise to the insurance industry with respect to virtually any type of individual or entity subject to insurance regulation by the state insurance departments or enforcement actions by the state Attorneys General. For more information and a list of contacts within the group, see page 8.

Market Conduct Examinations on the Rise in Missouri

There has been a recent uptick in market conduct examination activity with respect to insurance companies by the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

Since 1998, Section 374.205 of the Missouri statutes has given the DIFP broad authority to perform examinations of any person subject to the DIFP’s regulatory oversight. Until 2008, the DIFP routinely conducted comprehensive on-site examinations under Section 374.205 that inquired into the full range of an insurance company’s market conduct activities within Missouri.

In 2008, the DIFP adopted new rules that significantly impacted how it would conduct market conduct examinations going forward. Under the new rules, it was intended that the DIFP would routinely utilize “desk examinations” and data requests prior to commencing any on-site examination activities, which were the norm prior to 2008. Additionally, the new rules required the DIFP to complete its post-examination work with respect to an ongoing examination before commencing another examination regarding the same insurance company.

Generally, the 2008 rules call for a market conduct examination to proceed along the following lines:

1. The DIFP issues a warrant to the Insurance Market Regulation Division and the examination is commenced by serving the warrant on the insurance company. The warrant defines the scope of the examination by describing the specific line of business or specific business practices to be examined. The warrant also identifies whether the examination will be conducted as a desk examination, an on-site examination, or both.

2. After the examination, the DIFP issues a preliminary examination report that contains the DIFP’s findings of fact, conclusions, and recommendations. If the preliminary report contains any alleged violations, the report also cites the legal authority for the alleged violations.

3. After receiving the preliminary report, the insurance company has the opportunity to file written submissions or rebuttals regarding any matters contained in the report.

4. Once the insurance company has exhausted its opportunity to make written submissions and rebuttals, the director of the DIFP issues a final report.

5. If there are any alleged violations in the final report, the DIFP typically issues a proposed Stipulation of Settlement and Voluntary Forfeiture (STIP) when the final report is issued. The insurance company and the DIFP then negotiate the terms of the STIP.
6. Following the conclusion of negotiations, the DIFP will issue a final STIP – a document of public record – and the insurance company will begin its efforts to comply with the STIP.

Our firm has assisted a number of insurance companies with recent Missouri market conduct examinations and based on that experience, it appears that the DIFP has started to expand its on-site examination activity to heights not seen since 2008. Additionally, we have seen some other common themes develop with the DIFP’s recent examination activity. For instance, we have seen some preliminary reports where there appears to be no statutory authority for alleged violations or that cite rules that appear to lack statutory authority. Additionally, some of the data requests by the DIFP appear to exceed the records maintenance requirements set forth by statute and rule in Missouri. As such, it is advisable for examined insurers to be aware of their rights under the Missouri market conduct examination statutes and rules.

Captive Domicile Selection: Potential Impact of the Nonadmitted and Reinsurance Reform Act

By Zachary R. Dyer

Recently, many states have either created or revised captive insurance legislation in an effort to generate job growth, increase tax revenue, promote business travel to the state, and to otherwise spur economic development. This recent legislative activity among U.S. states seeking to become hospitable captive domiciles has led to some healthy competition among the potential captive domiciles.

Typically, an organization will consider many factors during the domicile selection process such as the state government’s level of education, regulatory infrastructure, and hospitality with respect to the captive insurance industry. Other factors that an organization may consider include the degree of flexibility afforded within the state’s regulatory structure and the existence of top-shelf service providers. In addition to these typical considerations, it has recently become clear that an organization should also carefully consider the potential impact of the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), which was enacted as part of the Dodd-Frank Wall Street Reform and Consumer Protection Act, on the taxation and regulation of the proposed captive insurance program.

The NRRA was designed to simplify regulation of the surplus lines insurance market by granting the “home state” of the insured the sole authority to regulate and tax surplus lines insurance. An unresolved issue, however, is whether the NRRA applies to captive insurance programs. The Vermont Captive Insurance Association recently commissioned a white paper that comments more broadly on the potential impact of the NRRA on the taxation and regulation of captive insurance companies in states beyond a captive’s domiciliary state.

Historically, captive insurance companies that transact insurance business directly with their parent organizations have strived to conduct their insurance business activities exclusively within the captive’s domiciliary state in order to avoid additional insurance-related taxes and regulatory compliance costs in other states where either the parent
organizations do business or the subject risks are located. This is a common practice, as discussed in an article in the Spring 2011 Insurance Business and Regulatory News entitled “Foreign Captives: State Regulation and Taxation.” But, the NRRA provides that only the insured’s “home state” – which, in most instances, will likely be the parent organization’s principal place of business – may tax and regulate “nonadmitted insurance.” If the NRRA is applicable to captives, a parent organization that procures insurance directly from a captive insurance company that is not admitted in the parent organization’s home state may be liable to pay self-procurement taxes to the home state. At this time, it remains unclear whether the NRRA applies to captive insurance companies, but prudence dictates that a parent organization should consider the potential application of the NRRA to its captive insurance programs.

Regardless of whether the NRRA applies to captive insurance companies, one thing is clear: The states’ awareness of the self-procurement tax provisions under state law has increased due to the public discussion of the NRRA and its potential impact on the captive insurance industry. Consequently, if the parent organization’s home state authorizes the imposition of self-procurement taxes, the parent organization should consider, as part of its domiciliary selection process, the likelihood that its home state insurance regulators will seek to collect self-procurement taxes in connection with the proposed captive insurance program.

For additional information on this topic, please contact Zach Dyer at 816.360.4352 or zdyer@polsinelli.com.

State Spotlights

Members of Polsinelli’s Insurance Business and Regulatory Law Group track major insurance developments across the country and offer insights impacting our industry in the following states.

Arizona Spotlight

By Richard M. Amoroso

In Arizona, insurance companies will likely be the beneficiaries of a recent Arizona Supreme Court ruling striking down the common carrier rule. In Nunez v. Professional Transit Management of Tucson, Inc., the Court held that common carriers owe a duty of reasonable care to passengers rather than a heightened duty to exercise the highest degree of care practicable under the circumstances – the so-called “common carrier rule.” 229 Ariz. 117 (2012). The Court found that the common carrier rule misled jurors, who interpreted the rule to imply a higher-than-intended standard of care.

The Court made this change because it found the common carrier rule to be an antiquated standard, previously necessary to address concerns of extreme danger with public transportation. The Court went on to hold that the duty of reasonable care is a fact-specific inquiry that accounts for the relationship between the victim and the common carrier. In this respect, the Court found that the duty of reasonable care is sufficient to address safety concerns related to common carriers, while the common carrier rule caused jury confusion. Consequently, the Court’s decision likely reduces the probability of inconsistent jury decisions in tort suits against common carriers.
Insurance companies that insure common carriers will be in a position to better evaluate their litigation risk exposure, as *Nunez* should lead to more predictable jury decisions in cases involving common carriers.

For additional information, please contact Richard M. Amoroso at ramoroso@polsinelli.com or 602.650.2048.

**Colorado Spotlight**

*By Justin T. Liby*

Effective July 1, 2012, House Bill 1311 clarifies that the reduction of nonmedical workers’ compensation benefits to an injured worker, due to the presence of a controlled substance in the worker’s blood, does not apply where such substance was medically prescribed.

House Bill 1289, effective Aug. 8, 2012, modifies the manner by which automobile insurers must inform policyholders of their intention to reclassify, non-renew, reduce coverage or make other changes to the insured’s policy.

Also effective Aug. 8, 2012, House Bill 1215 is intended to bring Colorado’s nonadmitted insurance statutes into compliance with the requirements of the federal Nonadmitted and Reinsurance Reform Act of 2010, which was adopted as part of the Dodd Frank Act.

House Bill 1071 adds a new chapter to the Insurance Code, effective Jan. 1, 2013, regarding portable electronics insurance. Among other things, the new chapter requires vendors of portable electronics to hold a limited lines producer license in order to offer or sell insurance on the portable electronics. The special limited lines license will allow authorized representatives and employees of the vendor to sell or offer this coverage without the need for each individual to also become independently licensed.

The Colorado insurance laws permit health insurance carriers to contract with downstream risk-bearing entities for the delivery of health care services to covered persons. A carrier that elects to contract with a downstream entity assumes responsibility by statute to pay for covered health care services that are not paid by the downstream entity, unless the carrier obtains approval from the Colorado Division of Insurance to use an alternative mechanism to ensure the covered health care services will be paid by the downstream entity. In 2001, the Division of Insurance adopted regulations establishing an acceptable alternative mechanism. Effective July 1, 2012, those regulations were amended to authorize the Division of Insurance to enforce the regulations by imposing any sanctions pertaining to the business of insurance, or other laws, under the Colorado statutes, including civil penalties, cease and desist orders, and suspensions or revocation of licenses.

In 2010, the Division of Insurance adopted regulations to define the standardized electronic identification and communication systems to be used by carriers and providers of health benefit plans in Colorado. Effective July 1, 2012, the Division of Insurance amended the regulations to postpone the compliance date for the implementation of certain standards from Sept. 1, 2012 to Jan. 1, 2013. According to the amended regulations, the postponement is intended to ensure that an unnecessary burden is not placed on health carriers doing
business in Colorado to comply with information exchange rules on a shorter time frame than those imposed by the federal government.

For additional information, please contact Justin T. Liby at jliby@polsinelli.com or 913.234.7427.

**Illinois Spotlight**

By Justin T. Liby

Effective Jan. 1, 2013, House Bill 3443 and Senate Bill 2867 amend 215 ILCS 5/4 to provide an exemption from state insurance laws and regulations for cost-sharing arrangements between a religious organization and the organization’s members or participants provided the arrangement meets certain criteria. The bill also imposes requirements regarding the operation and marketing of such arrangements, including consumer disclosures, complaint procedures, prohibitions on amassing reserves and the use of offshore trust or bank accounts.

Senate Bill 2885 amends existing statutes regarding the authority of health care purchasing groups (HPGs). The bill is effective Jan. 1, 2013 and increases the maximum number of employees that may be covered through an HPG from 500 to 2,500. It also requires HPGs to use licensed insurance producers to negotiate, solicit, market, obtain proposals for, and enter into group or master health insurance contracts on behalf of their employer-members and their employees and employee dependents.

The Illinois Department of Insurance issued Bulletin 2012-2 advising insurance producers and insurance companies that as of Aug. 1, 2012, the Department will process all new and renewal licensure applications electronically and will no longer mail applications to licensees.

The Department of Insurance issued Bulletin 2012-3 on May 21, 2012 informing insurers that the use of electronic funds transfer (EFT) for product filing submissions to the Department is mandatory beginning June 1, 2012.

The Illinois Department of Insurance and the Illinois Department of Healthcare and Family Services awarded a contract to Health Management Associates (HMA) to assist with health insurance exchange planning under the Patient Protection and Affordable Care Act, including the potential design of Illinois’ navigator program. Navigator programs will provide grants to eligible public and private entities to assist consumers who seek services from an exchange. On July 6, 2012, the Department of Insurance released the final report presenting HMA’s findings and recommendations for the Illinois navigator program. The report – entitled Illinois Navigator Program Design – is available on the Department of Insurance’s website at insurance.illinois.gov.

For additional information, please contact Justin T. Liby at jliby@polsinelli.com or 913.234.7427.

**Kansas Spotlight**

By Jennifer L. Osborn

The difference between agents and brokers remains viable and distinct in a recent holding by the Kansas Court of Appeals. In *Golden Rule Ins. Co. v. Tomlinson*, 277 P.3d 421 (Kan. App. 2012), decided April 27, 2012, the court determined that an insurance producer was acting as an agent for the insured
when it submitted an application to the carrier, not as an agent of the carrier. As a result, the court ruled that the carrier was not responsible for the producer’s failure to disclose information on the application and did not engage in an unfair trade practice by refusing to pay the insured’s claim.

In this case, the producer sold health insurance from multiple carriers. He submitted an application for the insured that was rejected by a carrier, and then received permission from the insured over the phone to submit an application to Golden Rule Insurance Company (Golden Rule). This application did not include all of the insured’s health history. Golden Rule subsequently denied coverage for a preexisting condition, and the insured filed a complaint with the Kansas Insurance Department. The Department found that Golden Rule had engaged in unfair trade practices pursuant to K.S.A. 40-2404(9)(d) and (f), which was affirmed by the Kansas District Court.

On appeal, the court focused on the key issue of whether the producer was Golden Rule’s agent. The court rejected the Department’s arguments that the producer was Golden Rule’s agent on the basis of the agent licensing laws and the fact that he was appointed as an agent for Golden Rule, placing more weight instead on the “Independent Broker’s Contract” between the producer and Golden Rule. The court also rejected the district court’s implied agency theory, analyzing the concept of independent brokers as addressed in Kansas case law, particularly *Earth Scientists v. United States Fidelity & Guar.*, 619 F. Supp. 1465 (D. Kan. 1985) and *Rosedale Securities Co. v. Home Ins. Co.*, 120 Kan. 415, 243 P. 1023 (1926). The court ultimately concluded that the producer was acting as an independent broker because he was acting on behalf of the insured in selecting coverage for her; therefore, Golden Rule was not responsible for his actions and did not engage in any unfair trade practices.

For additional information, please contact Jennifer L. Osborn at josborn@polsinelli.com or 913.234.7472.

**Missouri Spotlight**

The following legislation of interest was passed by the Missouri General Assembly this year:

- A bill prohibiting employees from suing co-workers over workplace injuries and illnesses (HB 1540). Originally, there was also discussion of the General Assembly passing a fix for the Second Injury Fund and occupational disease provisions, but these ideas met political roadblocks.

- An expansion of the immunity afforded to insurers and others for filing reports and furnishing other information related to an insurance fraud investigation so that they will not be subject to civil liability of any kind, including libel and slander (HB 1495).

- A prohibition against the establishment and operation of health insurance exchanges in Missouri unless certain criteria are met (SB 464).

- A requirement that all administrative rules be reviewed periodically (SB 469).

- Changes to the laws regarding salvage motor vehicle titles, scrap...
metal operators, and statutory liens (HB 1150).

- Changes to the Missouri Auto Insurance Plan (SB 470).

- A provision stating that a landowner, with limited exception, has no duty of care to a trespasser except for intentional acts (SB 628).

- A provision that allows life insurers licensed in Missouri to write limited amounts of non-life business outside of the United States, subject to specified limitations, and permits a Missouri-domiciled insurance company to write or assume involuntary unemployment insurance in connection with group life insurance business as well as credit insurance business, but only to the extent that such business is written or assumed outside of the United States (HB 1112).

The General Assembly did not pass the tort reform measures that received attention this year, which included a bill that changed the laws regarding the recovery of costs and attorney fees in a civil action and joint and several liability provisions.

**Texas Spotlight**

*By Zachary R. Dyer*

Effective Sept. 1, 2012, Texas House Bill 300 (HB 300) will place stricter requirements on patient health privacy by mandating new patient privacy protections and harsher penalties for privacy violations related to electronic health records (EHR). According to the Texas House Research Organization, HB 300 was prompted by concerns that the federal privacy requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA) did not provide enough protection over protected health information (PHI) and that the federal government was not enforcing existing HIPAA provisions.

Signed by Governor Rick Perry in June 2011, HB 300 provides an expanded definition of covered entities and will require covered entities to comply with standards that exceed HIPAA requirements. Prior to HB 300 taking effect, Texas law defined “covered entities” as health plans, health care clearinghouses, and health care providers that “transmit any health information in electronic form.” The newly enacted definition is broader and includes any individual or entity that: (i) engages, in whole or in part, and with real or constructive knowledge, in the practice of assembling, collecting, analyzing, using, evaluating, storing or transmitting PHI; (ii) comes into possession of PHI; or (iii) obtains or stores PHI.

HB 300 requires covered entities to provide ongoing and customized training to their employees regarding state and federal law with respect to the maintenance and protection of electronic PHI, set deadlines for completion and maintain training attendance records for all employees.

Under HB 300, patients have increased rights and remedies over their EHRs. Specifically, patients must be provided with electronic copies of their health information within 15 days of the patient’s written request for the records. Covered entities are also required to provide patients notice that their PHI is subject to electronic disclosure.

A covered entity is prohibited from disclosing a patient’s PHI to any other person in exchange for direct or indirect
payment except to another covered entity for purposes of treatment, payment, health care operations, insurance or health maintenance organization functions, or as authorized or required by federal or state law. Texas covered entities could be subject to penalties ranging from $5,000 up to $1.5 million per year for unlawful disclosures of a patient’s PHI.

In addition to covered entities, HB 300 provides that any entity that conducts business in Texas and owns or licenses computerized data that includes sensitive personal information (not just PHI) must provide notification to Texas residents if their sensitive personal information was wrongfully acquired by an unauthorized person.

For additional information, please contact Zach Dyer at zdyer@polsinelli.com or 816.360.4352.

Insurance Business and Regulatory Law

With decades of experience assisting the insurance industry with corporate transactions and various compliance and regulatory issues across the country, the Insurance Business and Regulatory Group at Polsinelli has the experience to provide outstanding services to this industry. With several former state insurance department attorneys, including two who served as General Counsel, and five attorneys who were former in-house counsel to various insurance organizations, our attorneys understand the unique needs of our insurance clients on matters involving state insurance departments, state Attorneys General, and other state and federal regulatory agencies.

We routinely handle business and regulatory issues, such as:

- Serving as national outside counsel for various property and casualty insurers, workers’ compensation insurers, life and health insurers, third-party administrators and discount medical plan organizations.
- Conducting corporate mergers and acquisitions.
- Making holding company transaction and other related regulatory filings.
- Completing complex national and multi-state regulatory and compliance research.
- Filing Uniform Certificate of Authority Applications, including Primary, Expansion and Corporate Amendment Applications.
- Conducting national and multi-state licensing and compliance projects for third party administrators, agencies, adjusters and discount medical plan organizations.
- Assisting with market conduct examinations and financial examinations, including a multi-state market conduct examination involving 50 states.
- Assisting with insurance company corporate governance requirements, including the Model Audit Rule, and development of appropriate committee charters, conflict of interest statements, codes of conduct and ethics statements, record retention and destruction policies; whistle blower policies, and others.
Serving as the Deputy Receiver or General Counsel to the Deputy Receiver with respect to insurance company receiverships.

Forming captive insurers and risk retention groups and assisting with their ongoing compliance and business issues.

Clients include insurance companies, insurance brokers and agencies, third-party administrators, discount medical plan organizations and associations – virtually any individual or entity subject to regulation by state insurance departments, state Attorneys General or other state agencies. The Insurance Business and Regulatory Group has the depth to provide quality and responsive legal services to regulated entities in the insurance industry with respect to all of their business and regulatory needs.

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