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"Many of the recent enforcement actions involve the marketing of medical discount plan products bundled with limited benefit health insurance."

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FTC and States Crack Down on Improper Marketing Practices

By Steven L. Imber and Jennifer L. Osborn

At a joint news conference on August 11, 2010, officials from the Federal Trade Commission (FTC), New York Department of Insurance and attorneys general offices from several states, announced their intent to aggressively target what the officials claim are misleading marketing practices by medical discount plan companies. However, a review of some of the lawsuits filed by the FTC indicates that officials are concerned with misleading marketing practices by companies selling products that include limited benefit health plans bundled with medical discount benefits.

Specifically, the FTC announced that it filed three lawsuits in early August charging several companies with deceptive practices and asking the courts to order the companies to halt their business operations. The FTC lawsuits are based on its jurisdiction over fraudulent telemarketing and broadcast advertisements and include allegations that these companies misrepresented various items about the plans, including refund policies. The FTC also claims that the companies were selling plans disguised


Steve Imber


Jennifer Osborn

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Recent Insurance Case Decisions

By Lauren E. Tucker McCubbin

In August, the Missouri Court of Appeals for the Western District issued an opinion that severely restricted the scope of the exclusive remedy section in the Missouri Workers' Compensation Act, which acts as a bar to civil litigation by employees for injuries suffered in the course of their employment. See Robinson v. Hooker, Case No. WD71207 (Mo. App. W.D. August 3, 2010) citing RSMo. § 287.120. Historically, courts in Missouri had extended the section to bar civil lawsuits made by injured workers related to injuries suffered as a result of acts by co-employees unless the injured worker could show "something more" than a breach of the employer's duty to provide a safe workplace.


Lauren Tucker McCubbin

The "something more" test required proof that the co-employee engaged in an affirmative negligent act that purposefully and dangerously caused or increased the risk of injury. Citing the principles of strict statutory construction, the Western District determined in Robinson v. Hooker that the provisions of Section 287.120 do not apply to co-employees. As such, injured workers are now permitted to file claims against co-employees without satisfying the previous "something more" standard.

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NAIC Corner *By Justin T. Liby*

State Implementation of Surplus Lines Reform

During the Summer National Meeting, the NAIC created the Surplus Lines Implementation (EX) Task Force to help the states implement the surplus lines reform measures contained in the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), which was signed into law on July 21, 2010, as part of the Dodd-Frank Wall Street Reform and Consumer Protection Act. Since the conclusion of the Summer National Meeting, the Task Force has been working to develop a document entitled "Guiding Principles for Surplus Lines Reform Implementation" and has taken comments on the document from state regulators and the insurance industry.

The NRRA restricts premium tax payments with respect to surplus lines insurance to the insured's home state and limits state regulatory authority to the insured's home state. Incentives are provided for the states to work together to develop a uniform premium tax allocation system within approximately 330 days beginning on the date of the NRRA's enactment.

The Guiding Principles, once finalized, will outline the recommended actions by states to implement the surplus lines reforms under the NRRA. Recommended state actions are lumped into two broad categories—"premium tax allocation issues" and "general regulatory issues." For example, premium tax allocation issues include a recommendation that states change their laws "to provide for the authority to tax 100 percent of the gross premium of a surplus lines policy for which that state is the home state." As another example, general regulatory issues include taking steps to permit licensure and renewal of surplus lines producers through the National Insurance Producer Registry.

Perhaps one of the most controversial issues will involve the recommendation that "states should agree on the rate at which premium taxes will be assessed." Another matter that may lead to much discussion is the form being developed by the Surplus Lines Multi-State Premium Tax (C) Working Group for the reporting of surplus lines premium taxes on a multi-state basis—the "Multi-State Surplus Lines Premium Tax Report." Although the reporting form is not yet complete, the Working Group presented the form to the Surplus Lines (C) Task Force at the Summer National Meeting "to provide the Task Force members with an understanding of the form's basic functionality and its potential within an integrated approach to solutions for supporting legislated NRRA surplus lines reforms."


Justin Liby

Following the conclusion of the Summer National Meeting, the Task Force has been meeting regularly by conference call.

Revisions to the Third-Party Administrator Model Act

The Large Deductible (EX) Working Group (LDWG) has been considering revisions to the Third-Party Administrator Model Act for a number of years now, primarily to make the model applicable to workers' compensation business. During the Summer National Meeting, the LDWG and the Workers' Compensation (C) Task Force adopted revisions to the model, which were then presented to the Producer Licensing (EX) Task Force (PLTF) for review. It is expected that the PLTF will consider whether any final modifications are necessary before the revisions are presented to the Property and Casualty (C) Committee for consideration.

One area that the PLTF will likely revisit is the definition of "home state," which was extensively discussed by the LDWG. There was disagreement at the LDWG level as to whether the home state definition should mirror the definition of that term in the Producer Licensing Model Act (PLMA) or whether the PLMA definition contains certain anomalies that make it unsuitable for the TPA Model Act. As of this writing, it is unclear when the NAIC will ultimately adopt the revisions to the TPA Model Act.

For additional information regarding these issues, you may contact Justin Liby at 913- 234-7427 or jliby@polsinelli.com. ◆

FTC and States Crack Down on Improper Marketing Practices

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as major medical health insurance. State officials announced during the conference that 24 states recently took enforcement actions against various entities, which include allegations of sham insurance, illegal robocalls and fax blasting, and licensing violations.

> "Most of the industry testimony focused on concerns regarding the impact of PPACA on limited benefit health policies."

One of the states that recently took action against a company selling limited benefit plans was the New York Insurance Department, which assessed a $700,000 monetary penalty against American Medical Life Insurance Company for allegedly marketing limited benefit health insurance policies through misleading advertisements. Other states have also become concerned regarding the manner in which limited benefit plans have been advertised. For example, Florida insurance regulators filed a complaint alleging deceptive advertising against one marketer of limited benefit health insurance. Following Florida's lead, the Arkansas Insurance Department temporarily suspended the license of the marketer, and an investigation of the marketer is underway by the California Insurance Department.

More recently, the National Association of Insurance Commissioners (NAIC) held a Joint Meeting of the Antifraud (D) Task Force and ERISA (B) Subgroup on August 12 to address limited benefit plans. Testimony was received in person and in writing from numerous consumer and industry groups, as well as a number of state insurance regulators. Most of the industry testimony focused on concerns regarding the impact of PPACA on limited benefit health policies. State insurance regulators spoke primarily about how limited benefit coverage is being sold through group policies issued to discretionary membership associations and expressed concern that consumers were harmed by misrepresented coverage, bundled payments, and association dues/fees that may far exceed the premium. A few consumer representatives also spoke at the Joint Meeting, primarily with respect to whether limited benefit plans offer consumers any benefit.

On August 14, 2010, the NAIC issued a news release summarizing the outcome of the Joint Meeting. The news release stated, in part: "The hearing was precipitated by a growing number of instances where health plans sold were misrepresented as comprehensive coverage, and consumers were left without medical insurance and often with significant debt."

Many of the recent enforcement actions involve the marketing of medical discount plan products bundled with limited benefit health insurance. This suggests that the joint federal and state efforts to target misleading marketing practices may have been triggered by regulator's concerns that certain companies are allegedly attempting to take advantage of consumers in the wake of the new health care reform laws. Several states have issued guidance regarding the minimum marketing requirements for bundled discount and insurance products, many of which are duplicative of the regulations that already apply to the insurance products. Some examples of the special marketing requirements applicable to bundled products are identified below, though this should by no means be considered an exhaustive list.

- Medical discount plan components should be clearly identified separately from the insurance product components
- Insurance products must be underwritten by an insurer that is licensed in the consumer's state of residence
- Licensed insurers that underwrite each insurance product must be identified
- Specific insurance policy form number for each insurance product must be disclosed
- Insurance products must be in compliance with the policy form filing and rate filing requirements under the insurance laws in the consumer's state of residence
- Business entity or natural person who sells, solicits, or negotiates the bundled product must be a licensed insurance agent in the consumer's state of residence
- Health insurance advertising regulations and all applicable disclosure requirements must be complied with in the consumer's state of residence

We will continue tracking litigation and regulatory activity by the FTC, state attorneys general offices, state insurance departments and the NAIC with respect to limited benefit plans and bundled products. If you have further questions regarding these issues, please contact Steve Imber at 913-234-7469 or simber@polsinelli.com or Jennifer Osborn at 913-234-7472 or josborn@polsinelli.com. ◆

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Recent Insurance Case Decisions

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The practical impact of this decision is two fold. First, an employee injured as the result of a co-employee's conduct now has a private cause of action outside of the Workers' Compensation Act against the co-employee and/or the employer; and second, the employer's workers' compensation policy likely will not cover these claims, as most policies tie coverage to the language of the Act. Because standard commercial general liability policies exclude coverage for claims arising out of acts by fellow employees, those policies too would not cover these claims. Given the recency of this decision, we have yet to see whether this increases the filings made against co-employees and/or employers or how workers' compensation or commercial general liability carriers may amend their policies to address coverage for injuries to employees resulting from the conduct of co-employees. This is definitely something for carriers and employers to watch.

In *Travelers Property Casualty v. National Union Insurance Company*, the Eighth Circuit addressed an excess carrier's right to recover in a subrogation action. Travelers was the excess insurer for Kansas City Power & Light (KCP&L) in February 1999, when a faulty burner management system caused a natural gas explosion at one of the company's power plants. Following the explosion, KCP&L and its primary insurer, National Union, pursued claims against numerous defendants and collected more than $126 million in settlement monies and obtained a $97.6 million jury verdict against Rockwell Automation, which designed and manufactured a troubleshooting guide for the controller used by the burner management system responsible for the explosion. KCP&L and National Union split the proceeds of that verdict. Travelers, which issued the excess coverage, had declined to participate in the litigation against all of the defendants. In February 2005, Travelers paid KCP&L $10 million to settle KCP&L's claim for coverage. Under the terms of the settlement agreement, Travelers reserved its right to collect against the Rockwell verdict. After the finalization of the Rockwell verdict, Travelers filed an action in federal court seeking a return of the $10 million it had paid on the basis of its subrogation interests.

The trial court found that Travelers was owed nothing by virtue of its failure to participate in the litigation. Travelers appealed, and the Eighth Circuit confirmed that an excess carrier in a subrogation matter has the first right of recovery and ordered that KCP&L return the $10 million that Travelers had paid it. This case confirmed that the primary carrier is tied to the excess carrier by way of the insured, and when the insured's contract with the excess carrier gives the excess carrier priority in collecting the money, that priority must be recognized regardless of whether the excess carrier participates in the litigation.

For more information on these issues or other litigation matters in Missouri or Kansas, please contact Lauren Tucker McCubbin at 816-360-4116 or ltucker@polsinelli.com. ◆

Update: Rate Filings in Kansas

By William W. Sneed

In the Summer 2010 edition of the Polsinelli Shughart Insurance Business and Regulatory News, our firm discussed the recent activity dealing with open records and rate filings at the Kansas Insurance Department. The Kansas Attorney General issued Opinion 2010-17, which basically stated that there is no specific exemption for open records containing trade secrets and that the Kansas Insurance Department cannot refuse to provide copies of rate filings on that basis.

Bill Sneed

In late August, representatives of the property and casualty insurance industry met with Commissioner Praeger and her staff to discuss this issue. In an effort to conform to the Attorney General's opinion, the Department advised the industry that if a particular company had any material it deemed "confidential" or a "trade secret," it should not be included in the filing. If, at the time the filing is reviewed, the Department requests additional information, the Department agreed to contact the particular company to discuss whether there was additional material that could be provided. Since no "confidential" or "trade secret" material had been filed, the companies would be protected from that information getting out to the public.

On the other hand, if the Department needed such material in order to approve the filing, the company could request an administrative hearing on the filing and request at the hearing that the material not be provided to the public under the Kansas Open Records Act. Additionally, based on the ultimate decision by the Hearing Officer, the matter then could be removed to the district court

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Update: Rate Filings in Kansas

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(and potentially, to the appellate courts) and the district court could decide whether such documents are or are not included in the Open Records Act. This procedure would then provide confidentiality to the documents while the matter was being moved through the court system.

Additionally, representatives from the insurance industry met with the Department to consider an amendment to the rate filing statute to clarify that these types of trade secret documents are, in fact, to be exempt from the Open Records Act. This would provide safeguards for these documents that are similar to those that are provided to other regulated industries in the state.

We will continue to monitor this matter and the potential legislation that may be introduced in January 2011. If you have any questions, please contact Bill Sneed at 785-233-1446 or wsneed@polsinelli.com. ◆

SPOTLIGHT: Missouri and Kansas

Missouri Spotlight

The Missouri Department of Insurance Financial Institutions and Professional Registration is authorized by statute to appoint a Health Insurance Advisory Committee. The purpose of the Committee is to advise the Department on issues relating to health care insurance. A Health Insurance Advisory Committee was appointed in approximately 2001 and met several times, but in recent years has been inactive. With the passage of the federal Patient Protection and Affordable Care Act (PPACA), Director John M. Huff has reconstituted the Committee, and it met on September 9, 2010. The Committee is comprised of representatives of the insurance industry, healthcare representatives and consumer groups.

Director Huff has identified three areas for the Committee to offer advice:

- Whether the State of Missouri should establish a healthcare exchange
- Should the State of Missouri consider establishing regional exchanges with other states, primarily Kansas, for residents of Kansas City, and Illinois for residents of St. Louis
- How an exchange should be governed

The Advisory Committee will provide advice to the Department, but any decisions made by the Committee will not be binding upon the Department.

The September 9, 2010 Committee meeting was primarily organizational. Various Department personnel summarized their duties with respect to PPACA and explained some of issues they are currently addressing. Director Huff would like to reconvene the Committee following the October meeting of the National Association of Insurance Commissioners (NAIC). Director Huff believes that the NAIC will be moving very quickly with respect to the implementation of the PPACA and that the Committee should be prepared to provide advice to the Department in a timely fashion.

Kansas Spotlight

The Kansas Insurance Department (KID) issued its second Bulletin of the year, Bulletin 2010-2, on August 30, 2010. The Bulletin prohibits insurance agents from issuing certificates of insurance that have not been filed and approved by the KID, or which violate K.S.A. § 40-955(b), the statute that addresses property and casualty form filing requirements. Apparently some insurers are using an older version of the standard accord certificate of insurance that does not list the date when the insurer may provide written notice of cancellation to the certificate holder. In the older version of the certificate of insurance, the notice of cancellation date is typically left blank and completed when the certificate is issued. This practice is in conflict with KSA 40-955(b) because the notice provided to the certificate holders must be the same notice that is specified in the policy. The newer certificate of insurance form, Accord 25 dated September 2009, specifies that a notice of cancellation will be delivered in accordance with the policy provisions.

Since the KID has received reports that insurance agents are being requested to issue certificates that do not provide notice of cancellation within a specific number of days or to issue certificates that are neither filed nor in conformity with KSA 40-955(b), the Bulletin was issued to specifically prohibit such practices. The Bulletin does exempt certificates issued under federal law by the United States Department of Defense. Insurers or agents that have questions regarding this matter may contact Marty Hazen with the KID at 785-296-3405. ◆

Insurance Business & Regulatory News

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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 Shughart PC has the experience to provide outstanding services to this industry. With five former state insurance department attorneys, including a former director of insurance, 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 recently amended Model Audit Rule, and development of appropriate committee charters, conflict of interest statements, code 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.

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