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*Levine on Eight for '08: Insurance Measures in Review*

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**SUMMARY:** "Eight for '08" reviews in an in-depth and readable fashion key state and federal legislative efforts on insurance topics such as catastrophic loss, suitability, bad faith civil liability, health care reform and federal regulatory efforts. The commentary highlights common themes and provides a singular reference for significant legislation and various related regulatory pronouncements that will affect the insurance industry for years to come.

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**ARTICLE: EIGHT FOR 08: INSURANCE MEASURES IN REVIEW**

**INTRODUCTION**

At the risk of stating the obvious, 2008 has been an historic and memorable year. From the historic presidential election, creating for many a new opportunity for hope, to the floods in the Midwest or the collapse of Wall Street, resulting for many in lost opportunity and fear, 2008 will be a year that is hard to forget. In addition to the major headlines of the year, 2008 was also a memorable year for state and federal efforts pertaining to insurance. For some, it was a year creating opportunity for hope; for others, 2008 resulted in lost hope and lost opportunity. In honor of this memorable year for insurance regulation memorable for that which occurred as well as that which did not below are some highlights from 2008 in eight insurance topics: (1) Life Settlement Agreements/Stranger-Originated Life Insurance; (2) Suitability; (3) Bad Faith Civil Liability; (4) Property and Casualty: Flood and Other Natural Disaster; (5) Health (Autism, Mental Health Parity, and Accessibility/Affordability); (6) Producer Licensing; (7) Interstate Compact; and, (8) Federal Regulatory Effort.

**LIFE SETTLEMENT AGREEMENTS and STRANGER-ORIGINATED LIFE INSURANCE**

The year 2008 proved legislatively significant for the viatical and life settlement industries. According to one report, approximately 60 bills were introduced in legislatures across the nation. Life Settlement Solutions Market Watch, Regulatory and Compliance Update (Sept. 2008). Of those some 60 bills, 14 bills were signed into law. Two bills were vetoed: California (S.B. No. 1543, vetoed Sept. 30, 2008) and Rhode Island (Sub. A for S.B. No. 2603, vetoed July 3, 2008).

Most of the newly-adopted Acts serve as extensive revisions to existing statutes, to provide increased accountability and consumer protection against fraud, stranger-originated life insurance (STOLI) policies, and other

unscrupulous practices. Hawaii and West Virginia, two states that previously did not regulate life settlement agreements, adopted new regulatory programs. Three states Maine, Arizona, and Indiana addressed STOLI transactions without adopting extensive revisions to the current regulatory approach. Florida adopted clarifying amendments to section 627.404, FLORIDA STATUTES, addressing insurable interest requirements, effective July 1, 2008. See 2008 Fla. Sess., Comm. Sub. for S.B. 648. The National Association of Insurance Commissioners (NAIC) and National Conference of Insurance Legislators (NCOIL) model acts provided the basis for most of these bills. A listing of states following the NAICs Viatical Settlements Model Act (amended June 4, 2007) and the states following the NCOIL Life Settlements Model Act (adopted Nov. 17, 2007) is provided below.

**State****Legislation****Model****Effective Date****Connecticut**

Sub. for H.B. No. 5512, Act No. 08-175 (*codified at § 38a-465, Ct. Gen. Stat.*)

NCOIL

Oct. 1, 2008

**Hawaii**

H.B. No. 94, Act No. 177 (*codified at §§ 431E-2, et seq., Haw. Rev. Stat.*)

NCOIL

June 16, 2008

**Iowa**

S.F. No. 2392, Ch. No. 2007-1155 (*codified at §§ 508E.1-508E.1A, et seq., Iowa Code*)

NAIC

July 1, 2008

**Kansas**

S. Sub. for H.B. No. 2110, Ch. No. 2008-96 (June 9, 2008) (*codified at K.S.A. 2007 Supp. §§ 40-5001, et seq.*)

NCOIL

July 1, 2008

**Kentucky**

H.B. No. 348, Acts No. 32 (*codified at KRS §§ 304.15-020, and 304.15-700 to 304.15-725*)

NCOIL

July 15, 2008

**Nebraska**

L.B. No. 853, Laws 2008, LB853, §§ 1, *et seq.* (codified at §§ 44-1101, *et seq.*, Rev. Stat. Neb.)

NAIC

July 18, 2008

**Ohio**

H.B. No. 404, Sess. Law No. 94 (codified at §§ 3916.01, *et seq.*, Ohio Rev. Code)

NAIC

Sept. 11, 2008

**Oklahoma**

S.B. No. 1980 and S.B. 565, Laws 2008, c. 183 (codified at §§ 36-4055.1 to 17, Ok. Stat.).

NCOIL

Nov. 1, 2008

**West Virginia**

S.B. No. 704, Act No. 2008-124 (codified at §§ 33-13C-1 to 18, W.Va. Code)

NAIC

May 29, 2008

Hawaiiis Act sunsets in 2010.

Some provisions of the Ohio Act, such as Division (A) of section 3916.20, OHIO REV. CODE, addressing licensing, are effective December 11, 2008.

All of the newly-adopted acts employ various schemes to deter STOLI transactions and similar investment practices with the potential for negatively affecting the life insurance market by making life insurance significantly more expensive and less available. See Testimony of Mary Jo Hudson, Director, Ohio Department of Insurance, before the House Insurance Committee of the Ohio Legislature (Jan. 15, 2008). Some states, such as Ohio, Iowa, and Nebraska, increased the amount of time a life insurance policy must be held before a viatical agreement may be signed from two to five years. West Virginias new legislation also set this threshold at five years. Even in these states, it is possible to enter into a viatical settlement if the viator undergoes certain life changing events, such as terminal or chronic illness, the death of a spouse or child, divorce, retirement from full-time employment, or bankruptcy. These programs also allow for viatical agreements prior to two years after the issuance of a life insurance policy in limited circumstances where it can be proven, for example, that at all times during that period, the policy was (a) purchased with unencumbered assets, (b) no agreement to transfer ownership exists, and (c) neither the policy nor the insured has been evaluated for settlement.

The NAIC and the NCOIL model acts, and their recently-enacted state progeny, prohibit fraudulent life settlement acts. Certain specified acts, including STOLIs, or omissions will qualify as fraudulent if there is an intent to defraud for the purpose of depriving another of property or for pecuniary gain. Other acts or omissions may likewise qualify as fraudulent without a similar showing of fraudulent intent.

Other methods used to deter fraudulent practices, and found as common elements, if not identical language, throughout the new acts address advertising and promotional materials, required disclosures to the viator as well as the insurer, proof of financial responsibility requirements for providers and brokers, annual reporting to the regulating entity disclosing information related to policies settled within five years since issuance, requirements to obtain affidavits or similar documents confirming that the insured is of sound mind and under no undue influence to enter into a contract as well as consenting to the release of medical records, new or revised broker and provider registration requirements, new or revised disclosure requirements, increased examination powers, required fraud warnings, requirements to adopt anti-fraud measures, and continuing education requirements for brokers. In addition, life insurers will not be held responsible for the acts or omissions of a provider or broker in connection with a viatical settlement transaction unless the insurer received some form of compensation in connection with the transaction. Listed below are examples of some of the mentioned revisions:

(a) Advertising and Promotional Materials. Various efforts to assure clear and truthful advertising of the risk and benefits of viatical agreements include requiring the filing of promotional, advertising and marketing materials with the regulating entity (i.e., Superintendent or Commissioner of Insurance), and prohibiting the use of certain words such as free, no cost, or the like.

(b) Annual Statements. Annual statements to be filed by March 1st of each year are now required in those states adopting or revising their regulatory programs. In addition to information required as adopted by agency rule, most of the newly required annual statements require detailed information relating to viatical agreements settled within the previous five years, such as total number settled and aggregate face amount. The details of this new requirement vary from state to state, but to provide an example, Connecticut registered viatical providers will be required to file in their annual statements, at a minimum, for any policy settled within five years of policy issuance, the total number, aggregate face amount and life settlement proceeds of policies settled during the immediately preceding calendar year, a breakdown of the information by policy issue year, the names of the insurance companies whose policies have been settled and the brokers that have settled said policies. 2008 Conn. Pub. Acts 08-175, § 5(a).

With the adoption by the Ohio General Assembly of House Bill 404, effective September 11, 2008, viatical settlement providers, as part of the application for registration process, are now required to provide proof of financial responsibility in the amount of \$250,000. In addition to the annual statement required by March 1st, viatical settlement providers in Ohio are required to file by May 1st of each year, an independently audited financial statement and unaudited financial statements on a quarterly basis within 45 days after the end of each quarter.

(c) Anti-Fraud Measures. Providers and brokers are required to adopt anti-fraud measures reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. In addition, many states have adopted mandatory reporting requirements for persons engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a fraudulent settlement activity has occurred or will occur and discretionary reporting for any other person having knowledge or a reasonable belief of a fraudulent viatical settlement act. See §§ 33-13C-14(c)(1) and (2), W.VA. CODE.

(d) Continuing Education Requirements. Some states like Connecticut, Hawaii, Iowa, Nebraska, and Ohio require brokers to attend on a biennial basis 15 hours of continuing education. Oklahoma requires 8 hours.

Ohios House Bill 404 imposes new requirements on life insurance companies too, creating, as referred to by some, a shared responsibility by all parties to protect consumers and prevent stranger originated life insurance policies. Pursuant to section 3916.05(B), OHIO REVISED CODE, an insurance company that issues life insurance policies in Ohio shall include questions in its life insurance applications that are reasonably structured to identify and prevent

stranger-originated life insurance. Insurers are required to file amended applications including such questions within 12 months following the adoption of rules by the Superintendent of Insurance. Life insurers are also required to file, on or before June of each year, a description of the measures taken by the insurance company to detect and prevent stranger-originated life insurance. § 3916.021, OHIO REV. CODE.

Two more examples of Ohio's shared responsibility approach, with regard to licensing revisions, include: (a) requiring that any business licensed as a viatical settlement broker must maintain at least one person who is individually licensed as a broker to be responsible for the licensee's compliance, § 3916.031, OHIO REV. CODE; and, (b) requiring that viatical settlement providers provide, as a condition of licensing, information concerning their providers' receipt and use of life expectancy information and life expectancy providers, and a written plan of policies and procedures used to determine life expectancies. § 3916.03(C)(1)(c), OHIO REV. CODE.

In virtually all Acts adopted during 2008, STOLI transactions are specifically defined and listed as a prohibited fraudulent life settlement act or activity. Few of the definitions are identical, but among the subtle differences are two key elements: (a) the policy is purchased for the benefit of a third party beneficiary; and (b) the third party beneficiary has no insurable interest. In addition to identifying STOLI transactions among the list of prohibited activities, several states, such as Arizona, have declared STOLI transactions as violations of insurable interest laws and unfair trade practice laws. States addressing STOLI during 2008 without adopting extensive statutory revision include the following:

## **State**

### **Legislation**

#### **Effective Date**

#### **Arizona**

H.B. No. 2513, Laws 2008, Ch. 240, § 1 (*codified at* § 20-443.02, Az. Rev. Stat.)

Sept. 26, 2008

#### **Indiana**

H.B. No. 1379, Pub. Law No. 112-2008, §§ 3 and 4 (*codified at* §§ 27-8-19.8-7.8 and 27-8-19.8-20.1, In. Code)

July 1, 2008

#### **Maine**

LD2091 (HP 1477), Chapter Law 543 (*codified at* 24-A MRSA § 6802-A)

June 30, 2008

## **SUITABILITY**

During 2008, Florida, Connecticut, and Idaho passed legislation affecting suitability determinations in annuity transactions. Concurrently, the Financial Industry Regulatory Authority adopted new suitability standards for variable annuities and the U.S. Securities and Exchange Commission pressed forward with federal regulation of equity-indexed annuities.

During Floridas regular 2008 legislative session, the Florida Legislature passed Senate Bill 2082, known as the John and Patricia Siebel Act, to amend section 627.4554, FLA. STAT. The amended statute retained some standard information from the 2004 legislation and clarified or added new information which the agent, or insurer in direct sales, must obtain from the consumer to analyze suitability. For example, the agent must continue to determine the applicants tax status, investment objectives, and such other information used or to be considered relevant by the agent (with the term relevant replacing the term reasonable in this latter criterion). The bill clarified the financial status inquiry, by replacing that term with an examination of the applicants annual income; existing assets, including investment holdings; liquid net worth and liquidity needs; and, financial situation and needs. Further, SB 2082 added several new criteria: personal information, including the age and sex of the parties to the annuity and the ages and number of any dependents; the source of the funds to purchase the annuity; the applicants intended use of the annuity; and, the applicants risk tolerance. 2008 Fla. Laws ch. 237, §§ 9 and 13. These new criteria appear to have been culled from the Financial Industry Regulatory Authoritys (FINRA) new suitability standards for variable annuities, adopted by way of FINRA Rule 2821(1)(B)(2), effective May 5, 2008, as to all registered representatives.

This information must now be transcribed onto a Florida Department of Financial Services (FDFS)-adopted form, signed by the agent and the applicant, and, within 10 days of execution, forwarded on to the insurer or any third-party contracted by the insurer to supervise the agents suitability compliance. The consumers refusal to provide this information must also be documented on a FDFS-adopted form. Also on a FDFS-adopted form, before consummating an annuity exchange, the agent must indicate the differences between the consumers current and proposed annuity contracts.

The Florida Legislature also furnished the FDFS with an objective standard for determining the propriety of an agents suitability recommendation. The agent must now have an objectively reasonable basis for believing that the recommendation is suitable based on the facts disclosed by the consumer. This objective basis, coupled with the revised consumer information criteria for the agents analysis of suitability, arguably will enable the FDFS to apply an objective measure against the agents conduct.

In contrast with the Connecticut and Idaho statutory amendments, discussed below, Florida suitability law remained focused on the states senior population. Notwithstanding, during 2008, Florida endeavored by other means to address suitability in annuity transactions with other segments of the state. For example, by rule effective July 28, 2008, Florida seeks to ensure suitability in the sale of any annuity product by an [insurance producer or] insurer to an active duty service member of the United States Armed Forces. FLA. ADMIN. CODE rr. 69B-240.001(2) (2008) (applicable as to producers) and 69O-142.200(2) (2008) (applicable as to insurers). For legislative authority to promulgate this rule, the FDFS drew from its broad grant of rulemaking authority under Floridas Unfair Insurance Trade Practices Act, FLA. STAT. §§ 626.9541(1) and 626.9611 (2007). Under this new rule, the sale of an annuity to an enrollee of the Servicemembers Group Life Insurance (SGLI) program is deemed unsuitable unless, after a needs assessment, the producer and/or insurer demonstrate(s) that the applicants SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicants needs. FLA. ADMIN. CODE rr. 69B-240.001(6)(v) and 69O-142.200(6)(v) (2008); see also FLA. ADMIN. CODE rr. 69B-240.001(4)(f) and 69O-142.200(4)(h) (2008) (defining life insurance as including annuities, concerning regulation of producers and insurers, respectively).

A second example may be found in another statutory section amended by SB 2082. The Florida Legislature amended section 626.99(4)(a), FLORIDA STATUTES, to require that all annuity contracts, regardless of the purchasers age, provide an unconditional refund for a period of at least 14 days. 2008 Fla. Laws ch. 237, §8. A prior version of this bill limited this free look period to purchasers of annuities who were 75 years or older. This expanded free look period is intended to provide all annuity consumers adequate time after the transaction to review the suitability of their purchase. A third example may be found in a new requirement for agent continuing education. SB 2082 requires that, regardless of the age of any consumer to whom an agent intends to market an annuity, persons holding a life license in Florida must complete at least 3 hours of FDFS-approved continuing education coursework on the subject of suitability in annuity and life insurance transactions. *Id.* at § 3 (amending FLA. STAT. § 626.2815(3)(k)). SB 2082 included a

couple of amendments which suggest that the insurer retains ultimate responsibility for the actions of parties which it appoints, but leaves this question somewhat unanswered with regard to parties transacting the insurers products either without proper authorization or in contravention of the supervisory system the establishment of which the insurer ensured.

First, SB 2082 now specifically authorizes the Florida Office of Insurance Regulation (FOIR) to order the insurer to rescind the contract and either fully refund all premium paid on the contract or the accumulation value, whichever is greater. The fact that this penalty is directed at the insurer, without reference to the agent, suggests the insurers administrative exposure for harm to a senior by violation of the Florida suitability law, whether caused by the insurer or the agent. Second, in an apparent effort to temper this administrative penalty, SB 2082 amends the law to indicate that nothing in the amended statute shall subject an insurer to criminal or civil liability for the acts of independent individuals not affiliated with that insurer for selling its products, when such sales are made in a way not authorized by the insurer. Presumably, a way not authorized signals that the insurer can avoid evidence of a violation of Floridas suitability statute in a civil or criminal proceeding if the agent either lacked due authorization to represent the insurer by appointment, failed to adhere to the supervisory system enabled by the insurer, or otherwise exceeded the authority delegated the agent by way of other agreement or authorization. Insurers, thus, should endeavor to assure that a specific and clear supervisory system is established and followed, that business may only be produced by duly-authorized agents, and that the parameters of an agents authority are clearly delineated. The Sunshine States governor signed Senate Bill 2082 into law on June 30, 2008, with an effective date as to the suitability provisions, as amended, to take effect on January 1, 2009.

Meanwhile, Connecticut lawmakers amended that states authorizing legislation to enable the Connecticut Insurance Department (CID) to match the agencies suitability regulations with the National Association of Insurance Commissioners (NAIC) broadened version of the NAICs Suitability in Annuity Transactions Model Regulation (Suitability Model). During June 2006, the NAIC amended the Suitability Model to make it applicable to purchases and exchanges involving annuity consumers of all ages. By 2008, in keeping with the NAICs revision of the Suitability Model, the CID determined to broaden the scope of the Connecticuts regulations to address the suitability of recommendations to any annuity consumer regardless of age. The statutory authority for the CIDs rules, though, specifically limited the scope of regulation to seniors. To address this qualification, the CID proposed legislation to remove the term seniors from Section 38a-432a of the Connecticut General Statutes.

House Bill 5158 passed the Connecticut General Assembly on May 7, 2008, and the Governor signed the bill into law on June 12, 2008, repealing section 38a-432a, CONNECTICUT GENERAL STATUTES, and re-enacting the same language less any reference to seniors. On June 17, 2008, the CID formally published for adoption the agencies rules on Suitability in Annuity Transactions, indicating the agencies intent to remove all references to seniors. The 30-day comment period following publication passed without the CID receiving any comment. The CIDs suitability rule thus sets forth the standards and procedures for producer recommendations, commencing July 17, 2008, to all consumers that result in a transaction involving annuities.

The fifty-ninth Idaho Legislature passed House Bill 411, amending section 41-1940, of the Idaho Code, to remove reference to seniors in keeping with the NAICs amended Suitability Model. Thus, Idaho, like Connecticut, broadened the requirement for suitability determinations to annuity purchasers of all ages. In contrast to Connecticut, Idahos operative suitability provisions are set forth in the Idaho Code, facilitating a self-executing statutory implementation in lieu of Connecticuts additional step for implementation by way of rulemaking. The Gem States governor signed House Bill 411 into law on March 19, 2008, and the broadened version of the statute became effective on July 1, 2008.

The sale of equity-indexed annuities has grown dramatically since the introduction of these products during the mid-1990s. By 2008, more than \$123 Billion had been invested in indexed annuities. Public Meeting, U.S. Securities and Exchange Commission (Dec. 17, 2008) (opening statement of SEC Chairman Christopher Cox). The U.S. Securities and Exchange Commission (SEC) actively observed the escalating sale of these products and identified the need for federal intervention in the traditional regulatory bailiwick of state insurance regulators, to guard against inappropriate

sales to persons, particularly seniors, who misunderstood the product. On June 25, 2008, the SEC proposed rule 151A, to be codified at 17 C.F.R. § 230.151A, to regulate indexed annuities as securities under the Securities Act of 1933 (the Securities Act). On December 17, 2008, the SEC voted 4 to 1 to adopt proposed rule 151A for application to annuities issued on or after January 12, 2011.

Rule 151A defines the terms annuity contract and optional annuity contract for purposes of clarifying the status of indexed annuities under federal securities law. Specifically, section 3(a)(8) of the Securities Act, 15 U.S.C. § 77c(a)(8), exempts from regulation as a security [a]ny insurance or endowment policy or annuity contract or optional annuity contract, issued by a corporation subject to the supervision of the insurance commissioner . . . of any State or Territory of the United States or the District of Columbia. The rule removes from the Security Acts exemption an annuity contract or optional annuity contract under which: (a) the amounts payable by the insurer are calculated, in whole or in part, by reference to the performance of a security, including a group or index of securities; and, (b) the amounts payable by the insurer under the contract are more likely than not to exceed the amounts guaranteed under the contract. Indexed Annuities and Certain Other Insurance Contracts, Securities Act Release No. 8933 (June 25, 2008) [73 Fed. Reg. 37,752, 37,774 (July 1, 2008)]. The first prong of this two-factor test clearly ties the benefits of the annuity to the performance of an equity-based index. As to the principles-based standard of the second prong, the rule further specifies that an insurers determination with regard to amounts payable versus amounts guaranteed will be conclusive if, among other things, both the insurers methodology and the insurers economic, actuarial, and other assumptions are reasonable. *Id.* (to be codified at 17 C.F.R. § 230.151A(b)(2)(i)).

The SECs proposal of this rule did not go unnoticed. The National Association of Insurance Commissioners, several individual state insurance commissioners, the National Conference of Insurance Legislators, the Financial Industry Regulatory Authority (FINRA), members of Congress, trade associations, and various affected insurance and securities industry participants, filed some 4,800 comments with the SEC. A majority of these comments, most of which represented insurance interests, voiced strong opposition to the SECs potential displacement of state insurance departments current regulation of these equity-indexed annuities as a form of fixed annuities. Not surprisingly, many comments in support of the rule came from FINRA and representatives of the securities industry. For its analysis, the SEC posited that senior investors will now be able to benefit from the federal Securities Acts requirements concerning registration and disclosure, as well as protection against fraud, misrepresentation, and sales practice abuses. On the other hand, the SEC also estimated significant costs to insurers with the adoption of the rule, stating:

For purposes of the PRA, we have estimated an annual increase in the paperwork burden for companies to comply with the proposed rules to be 60,000 hours of in-house company personnel time and \$72,000,000 for services of outside professionals. We estimate that the additional burden hours of in-house company personnel time would equal total internal costs of \$10,500,000 annually, resulting in aggregate annual costs of \$82,500,000 for in-house personnel and outside professionals.

Securities Act Release No. 8933, 73 Fed. Reg. 37,752, 37,770 (July 1, 2008) (footnote omitted). Of course, printing and providing prospectuses, registration of persons as broker-dealers, actuarial analysis to determine amounts payable versus amounts guaranteed, and other expenses will necessarily add to these figures, and will weigh heavily on an insurers determination as to whether to forego the revenue generated by the sale of these products. It may be that these costs are pushed down to the consumers of these products, making these products a less attractive purchase when compared to other products.

Perhaps in a subtle attempt to mitigate against additional costs or to appease the concerns of state insurance regulatory officials, the SEC also proposed to exempt insurance companies from the periodic reporting requirements of sections 13 and 15(d) of the Securities Exchange Act of 1934 (Exchange Act), 15 U.S.C. §§ 78m(a) and 780(d), respectively, concerning indexed annuities and other securities that are now to be registered under the Securities Act. The SEC formally indicated the basis for proposing this rule as follows: We have proposed this exemption because the concerns that Exchange Act financial disclosures are intended to address are generally not implicated where an insurers financial condition and ability to meet its contractual obligations are subject to oversight under state law and where



there is no trading interest in an insurance contract. Securities Act Release No. 8933, 73 Fed. Reg. 37,752, 37,771 (July 1, 2008). Accordingly, rule 12h-7, to be codified at 17 C.F.R. § 240.12h-7, will provide insurers with an exemption from Exchange Act reporting with respect to indexed annuities and certain other securities that are regulated as insurance under state law, provided that the insurer and its financial condition remain subject to state insurance regulatory supervision and examination (assuming that the securities are not publicly traded), as well as other criteria. In contrast to the some 4,800 comments filed as to rule 151A, the SEC received 12 comments on rule 12h-7, all in favor of the new rule but suggesting slight textual revision.

Notwithstanding the anticipated tempering effect of rule 12h-7, the regulatory impact of rule 151A will have lasting repercussions for those competing to offer indexed annuities. These repercussions will adversely affect the competition among insurers and issuers of the product and the ability of the product to compete effectively against other products. The life insurance industry, though, tends to stand resilient in the face of adversity. One should not be surprised to learn of new products to replace the indexed annuity offerings of insurers who seek refuge from federal regulation.

### **BAD FAITH CIVIL LIABILITY**

Since the adoption of Washingtons Insurance Fair Conduct Act of 2007, two more states have adopted legislation addressing insurer conduct: Colorado and Minnesota. The titles of the bills alone demonstrate the differences in manner in which these states have approached this issue. Colorados House Bill No. 08-1407 is entitled An Act Concerning Strengthening Penalties for the Unreasonable Conduct of an Insurance Carrier, and Making an Appropriation in Connection Therewith. Minnesotas Senate File No. 2822, on the other hand, is described as an Act Providing for penalties and recovery of attorney fees for certain insurance claims practices. The difference in approaches brings to mind the age-old question of how one approaches life, by looking at a glass as half-empty or as half-full; and, now, how one views insurers, as good faith actors or bad faith actors.

Colorados House Bill 08-1407, effective August 5, 2008, codified at sections 10-1-205(3)(d), 10-2-804(4), 10-3-1108(1)(a), 10-3-1114, 10-3-1115, 10-3-1116, 10-3-105(4)(c), 10-16-106.5 (5) (b), COLORADO REVISED STATUTES, prohibits an insurer from unreasonably delaying or denying payment of a claim for benefits owed to or on behalf of any first-party claimant, and creates a private cause of action to recover reasonable court fees and attorney costs and two times the covered benefit. Denial or delay is considered unreasonable if there was no reasonable basis for the action. In cases where the court finds an action brought pursuant to the Act to be a frivolous action, the court must award costs and attorney fees to the defendant.

In addition to creating a cause of action, House Bill 08-1407 amends section 10-3-1108, COLORADO REVISED STATUTES, to increase the monetary penalties for engaging in unfair or deceptive acts or committing other violations from \$1,000 to \$3,000 for each act or violation, and to increase the aggregate penalty from \$10,000 to \$30,000 unless the insurer knew or reasonably should have known that the insurer was in violation of new provisions prohibiting unreasonable delay or denial of payment. For this willful conduct, the bill increases the penalty to \$30,000 for each act up to an annual aggregate amount of \$750,000.

Other highlights of House Bill 08-1407 include:

(a) Amending section 10-3-1116(2), COLORADO REVISED STATUTES, to prohibit policies, contracts, and plans from containing any provision reserving discretion to the insurer to interpret the terms of the contracts.

(b) Revising the current definition of restitution to include costs and expenses for lost time from work and attorney fees. § 10-3-105(4)(c), COLO. REV. STAT.

House Bill 1407 does not apply to workers compensation, title, or life insurance.

Minnesotas Senate File No. 2822, Chapter 208, Laws 2008, effective August 1, 2008, codified at section 604.18,

MINNESOTA STATUTES, raises the standard for seeking penalties against insurers by allowing the award of taxable costs when an insured can show that the insurer lacked a reasonable basis for denying benefits and that the insurer knew of the lack of a reasonable basis for denying or acted in reckless disregard of the lack of a reasonable basis. S.F. No. 2822, § 1, Subd. 2 (2008). Pursuant to subdivision 3 of the bill, a court may award, in addition to permissible pre- and post-judgment interest and costs, an amount equal to one-half of the proceeds awarded that are in excess of an amount offered by the insurer at least ten days before the trial begins, or \$250,000, whichever is less and attorneys fees actually incurred not to exceed \$100,000. Attorneys fees must be separately accounted for and not duplicative of the fees for the insurers attorneys. Punitive and exemplary damages are not allowed.

Subdivision 4 of the bill describes the procedure for seeking recovery. First, a claimant must file suit in court, but may not initially seek recovery under the Act. After initiating the action, the claimant may file a motion to amend the pleadings to claim recovery of taxable costs. The motion may be opposed by one or more affidavits showing no factual basis for the claim. If the court finds prima facie evidence in support of the motion, the court may grant the motion. An award of taxable costs is determined in a proceeding subsequent to any determination of the amount to which the insured may be entitled.

Insurance policies exempted from the Minnesota Act include workers compensation, health, nonprofit dental coverage, life insurance, annuities and fidelity insurance, as well as bonds. Section 2 of the bill clarifies that the Act only applies to causes of action that occur on or after the effective date.

## **PROPERTY AND CASUALTY: FLOODS AND OTHER NATURAL DISASTERS**

### **Midwestern Response**

Much of the Nation was effected by various storms and flooding throughout 2008. However, the Midwest suffered the brunt of the resulting flood damage. Iowa alone suffered estimated losses of approximately \$4 billion in damage to agriculture and \$4 billion in damage to businesses. Nonetheless, no Midwestern state enacted a legislative response in the form of an insurance mandate to these conditions. However, various states did employ regulatory means to govern the market.

For example, several states, such as Illinois and Indiana, issued directives setting in place moratoriums on policy cancellations and nonrenewals. For Illinois policyholders, Director Michael McRaith issued a bulletin, on June 17, 2008, to All Companies and Other Entities Licensed or Authorized to Transact Insurance Business in the State of Illinois. The Director recognized the disruption in mail service, due to flooding and displacement, and the possibility of inadvertent cancellations and nonrenewals of policies caused by this disruption. The bulletin directed that the following safeguards be immediately implemented for all lines of business, regardless of whether an insured resided in a county designated as disaster area:

(a) Tolling of Cancellations and Nonrenewals. The bulletin required that insurers reinstate any policy, with no lapse in coverage, cancelled or nonrenewed by notice issued on or after June 10, 2008. Further, the bulletin prohibited insurers from issuing any new cancellation or nonrenewal notices to affected policyholders until August 18, 2008, or a later time if deemed reasonable given an individual policyholders circumstance. The Division expected that any doubt as to this reasonableness standard would be resolved in favor of the policyholder.

(b) Other Insurance-Related Time-Period Extensions. The bulletin further required that insurers grant policyholders an extension of any policy provisions or other requirements that imposed a time limit for an insured or claimant to perform any act, such as the submission of a claim or proof of loss, reporting of information, submission of bills, or payment of funds. The Division set sixty days as the minimum period of time for this extension or, again, longer if deemed reasonable given an individual policyholders circumstance.

(c) Time-Period Extension for Repairs. The bulletin also required that insurers provide policyholders with an extension of at least sixty days within which to repair affected property which cannot be repaired within any time period

set forth in the operative policy, or within the statutory ninety-day time period for repairs prior to termination due to condition of the property.

(d) Cancellation or Nonrenewal Due to Increase in Risk. Although otherwise allowed under Illinois law, the bulletin prohibited insurers from canceling or nonrenewing policies covering property due to increase in the risk originally accepted or due to the geographic location of the risk.

(e) Other Exceptions to Policy Requirements or Rating or Underwriting Rules. The bulletin also required that insurers consider exceptions to any other policy requirements, or rating or underwriting rules, not otherwise identified in the bulletin, when such requirements or rules are not met as a result of the disaster. An example might be the use of network providers for non-emergency medical treatment.

(f) Medicare Beneficiaries. The bulletin required that insurers receiving inquiries from Medicare beneficiaries, regarding disaster-related health care delivery disruptions, provide these beneficiaries with the latest available Medicare information.

(g) Insurer Websites. Insurers were directed to post on their websites all actions taken to implement the requirements of the bulletin.

(h) Availability of the Division. Insurers were required to advise Illinois consumers of the availability of and contact information for the Division for filing a complaint regarding any disaster-related dispute or issue.

(j) Notice of Noncompliance; Grace Periods. The bulletin also directed any insurer unable or unwilling to comply with the directives of the bulletin to inform the Division in writing of the reasons for the insurers noncompliance. Where permitted by law, the Division would consider exceptions to insurer-specific requirements, such as grace periods for license renewals. Likewise, insurers were not required to file policy or rating manual changes with the Division in order to comply with any of the foregoing directives.

Iowa Governor Chet Culver suggested that the Iowa Legislature reconvene for a special session as floodwaters continued to ravage the Hawkeye State. Many prominent legislators agreed. Charlotte Eby, *The Need for a Special Session is Growing*, THE WATERLOO CEDAR FALLS COURIER, July 27, 2008. However, this suggestion never evolved into a session as the states budget continued to recede with the economy. The Division of Insurance issued Bulletin 08-08, on June 12, 2008, concerning Disaster Planning, wherein the Commissioner proclaimed: I am calling upon the Iowa insurance industry to provide maximum consideration to your insureds in the coming days. Four days later, the Division issued Bulletin 08-09, entitled Deferral of Premium Payments and Policy Time Frames for Flood and Tornado Victims, which supplements and expands on Bulletin 08-08. Unlike the directives of the Illinois bulletin, Iowa bulletin 08-09 expressly qualified itself as a request. Specifically, the Commissioner indicated a request that all insurance companies and other entities authorized to transact business in this state give their customers affected by this disaster the option of deferring payments coming due before the end of June, interest free, for up to 60 days from the original premium due date. Further, companies were requested to extended any contractual time limits by an additional 60 days or, like Illinois, any longer period that may be deemed reasonable under the specific circumstances related to the subject insured or claimant. The compulsory language of the bulletin came in the form of the Illinois directive: that noncomplying insurers notify the Division of their noncompliance. On June 24, 2008, the Division issued Bulletin 08-09a as a clarification of Bulletin 08-09 in the form of answers to questions apparently posed by insurers attempting to comply.

For Indiana policyholders, the Indiana Department of Insurance re-released a Consumer Alert, though also identified as a News Release and as Bulletin 163, on June 9, 2008. This document, unlike the directives of the Illinois bulletin, set forth various answers to common questions posed by Indiana residents concerning flood insurance.

The Wisconsin Commissioner of Insurance issued a similar set of answers to commonly asked questions. These answers came in the form of a press release issued on June 12, 2008, targeting policyholders with Insurance

Commissioner Offers Answers to Storm Damage Questions. Perhaps coincidental, perhaps not, the Commissioner issued a Bulletin to All Property and Casualty Insurers, on July 17, 2008, to remind these recipients of the statutory requirements for the proper issuance of notices for the renewal and nonrenewal of personal and commercial policies aside from workers compensation policies.

In contrast, legislation was introduced in the Minnesota Senate on February 21, 2008, mandating a flood insurance noncoverage disclosure for homeowners insurance policies issued in that state. The Governor signed Senate File No. 2980 into law on May 13, 2008, becoming 2008 Session Law Chapter No. 293, codified at section 65A.302, MINNESOTA STATUTES, and effective August 1, 2008. This new law requires that insurers annually notify policyholders in writing with a notice entitled, Important Information About Damage Caused by Flooding, in at least 18-point type. The notice must disclose that the policy does not cover damage caused by flooding and disclose sufficient information to allow the policyholder to contact the National Flood Insurance Program to inquire about purchasing flood insurance. The goal of this legislation was to eliminate much of the confusion that occurs when residents first learn that they are not insured against flood damage after a storm.

### **Southeastern Response, including Gulf Coast**

Alabama passed two significant measures during 2008. First, Senate Bill 3 authorizes captive insurance companies to sell residential insurance along the Alabama coast. Proponents of the bill said the measure should create and encourage competition in the homeowners' insurance business along the coast because companies have cut back coverage since Hurricanes Ivan and Katrina. Governor Bob Riley signed Senate Bill 3 into law on May 8, 2008, designated as Act No. 2008-391, and codified at section 27-31B-3, and sections 27-31C-1 to 27-31C-9, CODE OF ALABAMA.

Alabamas second legislative measure, in the form of Senate Bill 296 codified the legal authority for Alabamas insurer of last resort, the Alabama Insurance Underwriters Association (AIUA). The joint underwriting association provides wind coverage on real estate on or near the Gulf Coast. The AIUA has been created and operated in accordance with a plan of operation approved by the Alabama Commissioner of Insurance. Now, as a creature of statute, the AIUA may carry over unexpended surplus from year-to-year, without lapse or transfer to the States General Fund for redistribution. Senate Bill 296 also authorizes the AIUA to deposit for its own account interest and investment earnings, and to issue bonds, surplus notes and other debentures, and accept goods, loans, and grants. This legislative authorization is intended to bolster the AIUAs financial viability. Governor Riley signed Senate Bill 296 into law on May 8, 2008, designated as Act No. 2008-392 (codification forthcoming).

Louisiana passed Senate Bill 160, authorizing insurers to file with the Insurance Commissioner a written petition for authorization to increase a policy deductible up to 4% of the value of the property being insured for named storms or hurricanes on a homeowners policy that has been in effect for more than three years. The legislation requires the Commissioner to promulgate rules to describe the prerequisite contents of the petition, including a requirement that the insurer itemize for the insured the premium savings based on the increase in the insureds deductible. Additionally, the bill prohibits insurers from including in a homeowners policy any provision which would apply more than one deductible to a loss resulting from a single incident. Governor Bobby Jindal signed Senate Bill 160 into law on July 9, 2008, designated as Act No. 854, and codified at sections 22:635.3(D), (E), and (F) and 636.2(E), (F), and (G), LOUISIANA REVISED STATUTES.

Louisiana also passed Senate Bill 44, which authorizes a "third invitation" for grants under the Insure Louisiana Incentive Program, provides for the recovery of unearned grants, and requires any unused money from the program to be used for a homeowner policy premium assistance program to reduce homeowner insurance premiums. Governor Jindal signed Senate Bill 44 into law on June 21, 2008, designated as Act No. 390, and codified at sections 22:3304(C), (D), and (F), and 36:696(B), and sections 22:3309(E) and 3312, LOUISIANA REVISED STATUTES.

Florida passed Senate Bill 2860, entitled the Homeowners Bill of Rights Act, signed into law on May 28, 2008,

designated as Chapter No. 2008-66, and codified at various sections in chapters 215, 624, 626, and 627, FLORIDA STATUTES. This bill includes many provisions, covering an extensive range of insurer conduct, rate regulation and appeal, and a host of other issues. Some aspects of the bill are summarized below:

(a) Insurance Capital Build-Up Incentive Program. Revises the requirements for the Program, which provides for surplus note loans to insurers of up to \$25 Million, repayable over 20 years at the 10-year Treasury bond rate, as approved by the State Board of Administration (SBA).

(b) Notice to OIR of Nonrenewal. Requires an insurer planning to nonrenew more than 10,000 policies within a 12-month period to notify OIR 90 days before issuing any notices of nonrenewal.

(c) Payment of Undisputed Claim Amounts. Prohibits an insurer from failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after determining the amount and agreeing to coverage, unless payment of the undisputed benefits is prevented by specified circumstances.

(d) Required Filing of Claims-Handling Procedures. Authorizes the Office of Insurance Regulation (OIR) to order an insurer to file its claims handling practices and procedures as a public record based on findings of a market conduct examination.

(e) Extension of Prohibition on Use and File. Extends for one additional year, until December 31, 2009, the current prohibition on insurers using the use and file option for property insurance rate increases.

(f) Repeal of Rate Arbitration Statute. Repeals the option for an insurer, for any property and casualty insurance rate filing (or any other filing), to appeal a rate filing disapproved by OIR to an arbitration panel in lieu of an administrative hearing.

(g) Expedited Hearings on Rate Filings. Provides for an expedited hearing process for rate filings.

(h) Required Use of Models Approved by Florida Commission on Hurricane Loss Projection Methodology. Requires that for purposes of a rate filing insurers must use a model or method found to be accurate or reliable by the Commission on Hurricane Loss Projection Methodology.

(i) Hurricane Mitigation Premium Credits. Requires OIR to develop, by February 1, 2011, a proposed method for insurers to establish windstorm mitigation premium credits (discounts) that correlate to the numerical rating of a structure pursuant to the uniform home rating scale.

(j) Extension of Rate Freeze. Extends the freeze on rate increases in Citizens Property Insurance Corporation (Citizens) from January 1, 2009, to January 1, 2010.

(k) Assessments for Citizens Deficits. Revises the required assessments to fund a deficit in each of Citizens three accounts (high risk, personal lines, or commercial lines).

(l) Access to Claims and Underwriting Files. Provides that a policyholder who has filed suit against Citizens has the right to discover the contents of his claims file to the same extent that discovery would be available from a private insurer.

(m) Disclosure of Windstorm Mitigation Rating. Effective January 1, 2010, requires disclosure of a homes windstorm mitigation rating, for a home insured by Citizens in the wind-borne debris region with an insured value of \$500,000 or more.

(n) Increased Notice of Nonrenewal. Increases the required notice of nonrenewal of a personal or commercial residential insurance policy from 100 days to 180 days if the policy has been written for five years or more.

(o) **Public Hurricane Loss Model.** Allows insurance companies to use, for a fee, the Public Hurricane Loss Model to determine rate requests in advance of filing.

(p) **Multi-Policy Discount.** Allows insurers to offer a multi-policy discount if the policyholder has wind-only coverage with Citizens or an insurer that has removed a policy from Citizens, provided that the same insurance agent services both policies.

(q) **Transparency in Rate Regulation.** For residential property insurance rate filings, requires the OIR to provide information on an Internet website of: all assumptions made by any OIR actuary; the overall rate change requested by the insurer; a statement describing any assumptions that deviate for actuarial standards of the Casualty Actuarial Society; and, a certification by the OIRs actuary that the actuaries recommendations are consistent with accepted actuarial principles.

### **Atlantic Coast Response**

Maryland passed House Bill 1353, entitled the Omnibus Coastal Property Insurance Reform Act, and signed into law on May 13, 2008, as Chapter No. 540, codified at sections 19-208 through 19-211, CODE OF MARYLAND. The bill makes numerous changes to the law governing property insurance in coastal areas of Maryland, briefly described below:

(a) **Hurricane and Storm Policies.** The bill prohibits an insurer, issuing a homeowners policy, from adopting an underwriting standard that requires a deductible that exceeds 5% of the Coverage A-Dwelling Limit of the policy in the case of a hurricane or other storm unless the insurer has filed the underwriting standard for approval at least 60 days before the insurer proposes to implement that underwriting standard. The insurer must also provide the policyholder with an annual statement explaining the manner in which the deductible is applied.

(b) **Loss Mitigation Discounts.** The bill requires an insurer to offer at least one actuarially justified premium discount on a homeowners policy to a policyholder who submits proof of improvements made to the insured premises as a means of mitigating loss from a hurricane or other storm. These improvements must be inspected by a licensed contractor, and the insurer must be allowed to inspect the improvements.

(c) **Risk Planning Models.** Under the bill, insurers that use a catastrophic risk planning model or other model in setting homeowners insurance rates, or in refusing to issue or renew homeowners insurance because of the geographic location of the risk, must file a description of the specific model with the Commissioner and make arrangements to explain the model to the Commissioner.

(d) **Material Reduction Plans.** The bill prohibits an insurers withdrawal or reduction in writings unless in accordance with an approved plan of material reduction filed with the Commissioner at least 60 days before implementing the plan. The bill creates procedures for insurers to implement plans to reduce homeowners coverage in the State. A material reduction is defined as a reduction of homeowners policies in force for an insurer on a statewide basis by 3% or more due to cancellations or nonrenewals solely because the subject of the risk or the insureds address is located in a certain geographic area of the State.

(e) **Department of Housing and Community Development.** The bill requires the Department of Housing and Community Development to review current statewide building codes and develop enhanced codes for coastal regions of the State that promote disaster-resistant construction in these regions.

The provisions of the bill apply to all homeowners insurance policies issued, delivered, or renewed in the State on or after October 1, 2008, except for those concerning material loss mitigation discount plans, which apply to such policies issued, delivered, or renewed in the State on or after June 1, 2009.

### **National Flood Insurance Program Reauthorization**

The most memorable event with regard to federal efforts to tinker with property and casualty insurance turned out to be somewhat of a non-event the simple reauthorization of the National Flood Insurance Program (NFIP) until March 2009. Despite efforts by both the House and the Senate to address the financial solvency of the program and propose other program reforms as part of the NFIP reauthorization, the key differences between the House and the Senate reauthorization packages could not be resolved before being eclipsed by the \$700 Billion Wall Street bailout package. In the end, the NFIP was reauthorized until March 6, 2009, as part of the Homeland Security Appropriations bill, H.R. 2638.

The unresolved differences between the House and Senate versions of the NFIP reauthorization legislation boiled down to two issues: 1) wind coverage, and 2) loan forgiveness. The House bill, H.R. 3121, entitled the Flood Insurance Reform and Modernization Act of 2007, would have expanded the NFIP to make wind coverage available in the form of a multiperil policy. Senate Bill 2284, proposed forgiveness of almost \$20 Billion of debt incurred as a result of Hurricane Katrina and other storms since 2005, and did not include any provision for wind coverage.

As described in Senate Report 110-214, the purpose of SB 2284 was to adopt key reforms to ensure that the program can continue to operate, is self-sustaining, and adequately identifies areas at risk of flood loss. The concern of the Senate sponsor was that the program would become nonfunctional causing policyholders to leave the program, leaving themselves unprotected and leaving the federal government subject to being called upon in the case of disaster. Senate Report 110-214, at 2. According to the Report, the Congressional Budget Office (CBO) could not predict when this would occur, but cautioned the program faces a future with inadequate resources to pay its obligations. *Id.* The CBO also projected that the proposed Senate reforms combined with the debt forgiveness would increase premium revenue over the next ten years by close to \$19 Billion and reduce outlays by about \$10.6 Billion relative to then-current law. *Id.* at 4. Some of the reforms would have included: 1) increasing the ceiling on average annual rate increases from 10% to 15%, 2) phasing out subsidized premiums for some policyholders, 3) requiring larger deductibles, 4) prohibiting FEMA from subsidizing new or previously unsubsidized policies; and 5) increasing civil penalties from \$350 to \$2,000 for lenders that do not enforce the mandatory flood insurance requirement. *Id.* at 6.

There was an attempt to amend SB 2284 to include wind coverage provisions offered by Senator Wicker of Mississippi. The amendment was defeated with only 19 Senators voting in support. Another amendment that received much attention, but ultimately was withdrawn by its sponsor, was Senator Bill Nelsons proposal to create a federal loan program for states that have created reinsurance funds.

## **HEALTH**

### **Autism**

During 2008, several states passed measures to require insurance coverage for individuals with autism, including Arizona, Louisiana, Florida, Pennsylvania, Connecticut, Illinois, and Massachusetts. Most of these measures will be discussed below. With the addition of the legislation in these states, some 27 states and the District of Columbia now have enacted legislation to afford coverage to insureds afflicted with autism spectrum disorders. According to a study by the Centers for Disease Control and Prevention, autism is now considered the most prevalent developmental disability in the United States.

The Arizona Legislature enacted House Bill 2847, also referred to as Stevens Law and signed into law on March 21, 2008, which prohibits certain insurers from excluding or denying coverage for a treatment or imposing dollar limits, deductibles and coinsurance provisions based solely on a diagnosis of an autism disorder, Aspergers syndrome, or pervasive developmental disorder. Stevens Law also prohibits the denial of coverage for medically necessary behavioral therapy services. Insurers affected by the law include hospital service corporations, medical service corporations, health care service organizations, group disability insurers, and blanket disability insurers; however contracts issued to an individual or small employer (an employer who employs at least two but not more than fifty employees) are exempt. Limited benefit coverage contracts and contracts for out-of-state service are also exempt. Coverage for behavioral

therapy is limited to a \$50,000 maximum benefit per year for an eligible child up to the age of nine and \$25,000 maximum benefit per year for an eligible child between the ages nine to sixteen. Stevens Law is codified at sections 20-826.04, 20-1057.11, 20-1402.03, and 20-1404.03, ARIZONA REVISED STATUTES, and applies to policies, contracts, and other evidence of coverage issued or renewed on or after June 30, 2009.

Legislation adopted by the Louisiana Legislature and signed into law on July 1, 2008, focuses on early detection and treatment. House Bill 958 (Act No. 648), codified at section 22:215.26, LOUISIANA REVISED STATUTES, requires coverage by most private insurance plans delivered or renewed on or after January 1, 2009, for the diagnosis and treatment of autism spectrum disorders in children less than seventeen years of age. Health coverage plans issued to employers with fifty or fewer employees and individually underwritten, guaranteed renewable policies are exempt from the new requirements. Insurers are prohibited from limiting the number of visits an individual may make to an autism services provider; however, annual and lifetime benefits are limited to \$36,000 per year and a \$140,000 lifetime maximum. Parity language included in the bill allows for financial requirements such as copayments and deductibles but only to the same extent that other medical services covered by the plan are subject to the same provisions. Treatment of autism spectrum disorders is defined to include five categories of care: 1) habilitative or rehabilitative care, 2) pharmacy care, 3) psychiatric care, 4) psychological care, and 5) therapeutic care.

On May 20, 2008, Florida Governor Charlie Crist signed into law the Steven A. Geller Autism Coverage Act (SB 2654) (the Geller Act). This Act requires coverage by group health plans and HMOs for screening, intervention and treatment of autism spectrum disorder in children younger than eighteen years of age, or children who have been diagnosed with a developmental disorder by the age of eight or younger and are still in high school. Small employers and individually written plans are specifically excluded from the mandate. Health plans and HMOs subject to the Act are required to provide coverage for well-baby and well-child screening for the presence of autism spectrum disorder and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis provided by certified providers. Parity language requires that coverage may not be subject to dollar limits, deductibles, or coinsurance provisions less favorable to an insured than those that apply to physical illnesses, except as otherwise provided by the Act. However, pursuant to sections 627.6686(4) and 641.31098(4), FLA. STAT., coverage is limited to \$36,000 annually and \$200,000 over a life and treatment must be prescribed by a physician in accordance with a treatment plan. Coverage may also be subject to other general exclusions and limitations of the insurers policy or plan, such as coordination of benefits, participating provider requirements, and other managed care provisions.

Floridas Window of Opportunity Act is that portion of SB 2654 which sets forth the process for creating a Developmental Disabilities Compact through a workgroup comprised of private insurers, consumer groups, and other interested parties. Group insurance plans or HMOs who have signed the compact by April 1, 2009, and complied with the terms of the compact by April 1, 2010, will not be subject to the Geller Act autism mandates. If the compact workgroup is unsuccessful in drafting a compact, the autism mandate provisions of the Geller Act take effect April 1, 2009. The compact language was added to SB 2654 by the Florida House. One source has raised the possibility that such provisions might constitute an unconstitutional delegation of legislative authority. See Florida Senate House Message Summary (May 2, 2008).

Pursuant to section 624.916, FLA. STAT., the Florida Office of Insurance Regulation (FOIR) is charged with convening a workgroup for the purpose of negotiating a compact that includes a binding agreement among the participants relating to insurance and access to services for persons with developmental disabilities. Statutorily required members of the workgroup include: representatives of Florida licensed health insurers; representatives of licensed HMOs; representatives of employers with self-insured plans; two designees of the Governor, one of whom must be a consumer advocate; and, a designee of both the Senate President and the House Speaker. The Act sets forth four components that must be included in the agreement: a) a requirement that each signatory increase coverage for certain behavior analysis, services, and therapies when medically necessary due to the presence of a developmental disability; b) procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which coverage is provided; c) penalties for documented cases of denial of claims for medically necessary services; and, d) proposals for new product lines that would complement traditional health insurance.



The workgroup held its first meeting on October 14, 2008. One of the key topics discussed centered on whether applied behavioral analysis should be considered a reasonable and necessary treatment for a developmental disabled person. FOIR Media advisory on Workgroup Discussing Coverage Options (Oct. 15, 2008). The group was charged with drafting specific proposals for coverage for the next meeting, which was scheduled for November 20, 2008. On November 18, 2008, the meeting was cancelled because no draft proposals had been submitted to the workgroup Chair.

Pennsylvania also enacted legislation, signed into law on July 9, 2008, requiring certain private insurers to provide coverage for diagnostic assessments and treatment of autism spectrum disorders. Like Florida, Arizona and Louisiana, House Bill 1150 (Act No. 62, codified at § 635.2, PA. STAT.) caps coverage at \$36,000 per year; but, coverage is for children or adults up to the age of 21, and Pennsylvania does not impose a lifetime maximum. Pennsylvania's new requirements do not apply to small employer group plans.

Illinois likewise passed legislation in the form of Senate Bill 934 (to be codified at 215 ILCS 5/356z.14). This bill responded to a complimentary veto message as to House Bill 4255 by Governor Rod R. Blagojevich. This revised legislation passed both Houses on November 20, 2008, and, on November 11, 2008, was sent to the Governor for signature into law. The Governor approved the bill on December 12, 2009. Senate Bill 934 will require insurers to provide to individuals who are under 21 years of age coverage of up to \$36,000 annually for the diagnosis and treatment of autism spectrum disorders not already covered by health insurance or a managed care plan. Thus, this mandate applies only to fully insured individual and group policies, not to self-insured benefit plans.

Connecticut and Massachusetts both took a different approach. The Connecticut Legislature amended its mental health parity law to include autism, by way of Substitute House Bill No. 5696, signed into law on June 5, 2008. Effective January 1, 2009, individual and group health insurance policies providing coverage for basic hospital expenses and basic or major medical surgery are required to provide coverage for physical therapy, speech therapy and occupational therapy services for the treatment of autism spectrum disorders as set forth in the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed.) [DSM-IV] to the extent such services are a covered benefit for other diseases and conditions under such policy. Public Act No. 08-132, §§ 1 and 2. The General Court of the Commonwealth of Massachusetts also amended its mental health parity law to include on a nondiscriminatory basis autism and other disorders, such as eating disorders, obsessive-compulsive disorder, post traumatic stress disorders, panic disorder and more, effective July 1, 2009. Chapter 256 of the Acts of 2008.

### **Mental Health Parity**

Congress \$700 billion emergency economic assistance bill served as one of the most memorable legislative events in 2008. The passage of this Act ironically shared the spotlight with one of the 110th Congress most anticipated pieces of health insurance legislation, H.R. 1424, the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act (the Wellstone Act). The irony lies in the fact that H.R. 1424 was used as a legislative vehicle to bail out Wall Street. Comprehensive mental health parity has been a goal for more than a decade, since the passage of the Mental Health Parity Act of 1996, which addressed parity requirements related to lifetime and annual dollar limits for mental health coverage. By contrast, governmental bail-out bills are rarely popular, nor does the average citizen perceive there to be much parity in such legislative efforts.

H.R. 1424 passed the House on March 5, 2008. From March 7, 2008, to October 1, 2008, H.R. 1424 simply rested on the Senate Legislative Calendar. In a flurry of activity between October 1 and October 3, 2008, amendments addressing the metastasized economic crisis were added to H.R. 1424, and the bill was renamed as the Emergency Economic Stabilization Act of 2008, the Energy Improvement and Extension Act of 2008; and the Tax Extenders and Alternative Minimum Tax Relief Act of 2008. President Bush signed the bill into law on October 3, 2008. The Wellstone Act is found at Section 512, Title V, Subtitle B, of Division C, the Tax Extenders and Alternative Minimum Tax Relief Act of 2008.

The Wellstone Act is intended to achieve more comprehensive and permanent parity by eliminating the sunset

provisions of the 1996 Act and expanding coverage to substance-related disorders as well as prohibiting discrimination with regard to financial requirements, treatment limitations, and out-of-network coverage. According to House Report 110-374, Part II, true parity is accomplished by amending the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act of 1944 and the Internal Revenue Code so that all group health plans with 50 or more employees, whether they are self-funded or fully insured, equitably provide the delivery of physical and mental health benefits. The individual health market is not affected by this Act, nor does it apply to Medicare patients.

It is not the purpose of the Act to mandate mental health and substance use coverage. Group plans that do not currently provide mental health benefits are not affected by this Act. However, if a group plan provides mental health or substance use coverage, the plans mental health benefits must be equivalent to the plans physical health benefits. So, if a plan does not require cost-sharing among the plan and plan participant or beneficiary, such as a copayment or deductible, on medical and surgical benefits, the plan cannot impose cost-sharing with regard to mental health or substance use benefits. If a group plan includes such a requirement, out-of-pocket costs must be the same for both types of coverage. In addition, criteria for medical necessity determinations and reasons for denial of reimbursement under the plan must be made available by the plan administrator to current or potential participants, beneficiaries, or contract providers upon request.

The Wellstone Act also includes a cost exemption provision to relieve group plans of purported financial hardship imposed by these federal requirements. Under this exemption, if the new requirements result in an increase during a plan year of the actual total costs by an amount that exceeds 1% , or 2% in the case of the first year to which the requirements apply, of the actual total plan costs, such requirements do not apply to the plan for the following plan year. This cost exemption only applies for one plan year and the determination as to whether the exemption applies must be made after the plan has complied with the Acts requirements for the first six months of the plan year involved. Cost exemption determinations must be certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.

Pursuant to subsection (e) of the Wellstone Act, the amendments made by this section shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of the enactment of this Act, regardless of whether regulations have been issued to carry out such amendments by effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5), relating to striking of certain sunset provisions, shall take effect on January 1, 2009. Collective bargaining agreements ratified before the enactment of H.R. 1424 are subject to a different effective date: The Wellstone Act shall not apply to plan years beginning before the later of (A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after enactment of this Act, or (B) January 1, 2009.

In addition to mental health parity, on May 21, 2008, President Bush signed into law H.R. 493, prohibiting discrimination on the basis of genetic information with respect to health insurance and employment. The newly enacted law, Public Law 110-233, prohibits group health plans from adjusting premiums or contribution amounts on the basis of genetic information and from requesting or requiring genetic testing. This new measure employs excise taxes as for enforcement.

### **Accessible/Affordable Health Care**

No end-of-the-year wrap-up would be complete without a discussion on health care reform and access to affordable health care. However, health care reform has the potential to become all-consuming. This discussion briefly examines three different reform packages and one ballot initiative, to sample the national temperament for measures addressing access and affordability.

### **Florida**

On May 21 2008, Governor Charlie Crist signed into law CS/CS/SB 2534, Chapter No. 2008-32, Florida Laws,

effective upon becoming law, creating two new programs designed to provide affordable access: a) the Cover Florida Health Access Program, and b) the Florida Health Choices Program.

The Cover Florida Health Access Program does not rely on mandates. Rather, the Program creates a partnership program where private insurers negotiate with the state to provide affordable health for uninsured Floridians. Pursuant to the Act, Cover Florida plans must be portable, issued on a guaranteed-issue basis to enrollees, subject to exclusions for pre-existing conditions, and provide for cost containment through limits on services and caps on benefits and copayments. Cover Florida plans are required to provide inter alia, at a minimum, coverage for preventative services, screening, office visits, outpatient and inpatient surgery, urgent care, prescription drugs, durable medical equipment, and diabetic supplies. Persons eligible for coverage must be between the ages of 19 and 64, and cannot be covered by private insurance or eligible for coverage through a public health program such as Medicare, Medicaid or Floridas KidCare, and not have been covered for the past six months unless coverage was terminated for certain reasons. Interestingly, the bill expressly states that the Program is not an entitlement, clarifying that there is no cause of action for failure to make coverage available to eligible persons.

As an update, in late October, after a thorough bid process, United HealthCare and BlueCross Blue Shield were selected to provide statewide coverage under the Cover Florida Health Access Program. Regional plans were also chosen to provide coverage in northeast and southeast Florida.

The second program created by the Florida Legislature, the Florida Health Choices Program, is designed to be a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care, including: health insurance plans, HMO plans, prepaid services, service contracts, and flexible spending accounts. Program participants may purchase these products over the Internet or through the services of a participating health insurance agent. The bill requires that the Program utilize methods for pooling the risk of individual participants and preventing selection bias. Policies sold as part of the Program are not subject to the licensing requirements, or various offering or coverage mandates, of the Florida Insurance Code.

Other matters covered by CS/CS/SB 2534 include:

(a) Amending Floridas Health Flex Plan Program, a program created to offer basic affordable health care to low income, uninsured residents, by expanding the population eligible to purchase such programs by raising the family limit income from 200 to 300 percent of the federal poverty level and extending the expiration date to July 1, 2013; and,

(b) Amending section 627.6562, FLORIDA STATUTES, to allow insurance policyholders the option to insure their unmarried, dependent children who are not married, without dependents of their own, and are either residents of the State or students, coverage until the age of 30.

Florida Senate Bill No. 2534 affected the following statutory sections of Florida law: sections 112.363, 408.909, 408.9091, 408.910, 409.814, 624.1265, 624.91, 627.602, 627.6562, 641.31, FLORIDA STATUTES.

## **Minnesota**

Minnesota Governor Tim Pawlenty signed Senate File No. 3780, into law on May 29, 2008, as Chapter 358, Minnesota Laws 2008. This comprehensive health care reform bill addressed various issues such as health improvement and certification requirements for health care homes. Relevant to this discussion, Articles 3 and 4 of the bill addressed access and affordability. Here, the bill aims to increase access through better sharing of information to identify persons eligible for MinnesotaCare and modifying outreach requirements to make the application and renewal process easier to understand.

Specifically, Article 3 contains provisions relating to increasing access and improving the continuity of care. Article 4 of the bill contains provisions related to health insurance purchasing and making health coverage more affordable. The provisions related to the reform described in Article 4 include:

- (a) Establishing an electronic prescription drug program;
- (b) Recommending an essential health benefit set;
- (c) Developing a system of quality incentive payments to providers who meet specified targets;
- (d) Developing a method to calculate providers' relative cost of care and relative quality of care;
- (e) Developing a peer grouping system for providers;
- (f) Establishing uniform definitions for baskets of care, starting with a minimum of seven baskets;
- (g) Requiring employers with eleven or more current full-time equivalent employees in the State to establish a cafeteria or premium-only plan under Section 125 of the Internal Revenue Code;
- (h) Developing a proposal to provide employees with income below 300 percent of the federal poverty guidelines or less and with employer-subsidized coverage with a subsidy;
- (i) Establishing a health care review council.

S.F. 3780 also raised the income limit of \$50,000 to \$57,500 for parents on Minnesota Care and increased limit for adults with no children from 200 to 250 percent of the federal poverty level guidelines.

Minnesota Senate File No. 3780 affected the following statutory sections of Minnesota law: sections 43A.23, 62J.495, 62J.497, 62U.01 to 62U.09, 124D.1115, 145.986, 256B.0751 to 256B.0754, 256.01, 256.962, 256B.057, 256L.04 to 256L.07, 256L.15, MINNESOTA STATUTES.

### **New Jersey**

On July 7, 2008, Governor Corzine of New Jersey commended the Legislature of the Garden State for actually doing something about universal health care, rather than just engaging in dialogue, with the passage of S1557, P.L.2008, ch. 38. Press Release, Office of the Governor, Governor Signs Progressive FamilyCare Legislation (July 7, 2008). S1557 adopts reform in three key areas:

- (a) Health care coverage, including expanding eligibility for the New Jersey FamilyCare Program to include parents whose income is between 133 percent and 200 percent of the federal poverty level and providing a KidsFirst mandate requiring health insurance coverage for all children 18 years or younger by July 2009;
- (b) Individual and small employer health reforms, such as revising the rating system for individual plans and reducing the number of standard plans a carrier must offer from five to at least three plans;
- (c) Increasing dependent coverage so that coverage does not terminate before the dependent reaches 30.

New Jersey Senate Bill No. 1557 affected the following statutory sections of New Jersey law: sections 2:14-17.29k, 17:22A-41.1, 26:2H-18.59j, 26:15-1, 26:15-2, 30:4J-11, 30:4J-11.1, 30:4J-12, 30:4J-18, 30:4J-19, 54:50-9, 54A:8-6.2, 17:22A-41.1, 17:48-6.19, 17:48A-7.13, 17:48E-30.1, 17B:27-30.5, 17B:27A-2, 17B:27A-2.1, 17B:27A-3, 17B:27A-4, 17B:27A-4.5, 17B:27A-4.7, 17B:27A-6, 17B:27A-7, 17B:27A-9, 17B:27A-11, 17B:27A-12, 17B:27A-16.5, 17B:27A-17, 17B:27A-19, 17B:27A-19.11, 17B:27A-19.16, 17B:27A-23, 17B:27A-25, 26:2J-10.3, 30:4J-18, 30:4J-19, NEW JERSEY STATUTES.

### **Wisconsin**

Voters in 22 counties across Wisconsin showed overwhelming support for health care reform, by voting in the

2008 election in favor of a non-binding advisory referendum that posed the following question: Shall the next state Legislature enact health care reform legislation by December 31, 2009, that guarantees every Wisconsin resident affordable health care coverage with benefits that are substantially similar to those provided to state legislators? Without providing more detail as to how such coverage would be provided, it is difficult to speculate on the exact disposition for this measure in Wisconsin. Perhaps Wisconsinites are eager for major health care reform, or it may be that they simply want parity with the privileged few.

## **PRODUCER LICENSING**

### **NARAB II**

On September 17, 2008, the U.S. House of Representatives passed by voice vote H.R. 5611, the National Association of Registered Agents and Brokers Reform Act of 2008. Drafted with the assistance of the National Association of Insurance Commissioners, individual state insurance commissioners, and industry representatives, the bill, also referred to as NARAB II, received strong bipartisan support, including 48 bipartisan cosponsors.

H.R. 5611 proposes to amend the Gramm-Leach-Bliley Act to re-establish the National Association of Registered Agents and Brokers, a nonprofit corporation the purpose of which is to provide a mechanism through which licensing, continuing education, and other nonresident insurance producer qualification requirements and conditions can be adopted and applied on a multi-state basis while preserving states rights in licensing, supervision, enforcement, consumer protection, and unfair trade practices. The purpose of the bill, to paraphrase primary sponsor Representative David Scott, is to address the problem of reciprocity that has become worse as more and more agents operate across state lines, making it apparent that true nonresident licensing reform for insurance agents could only be achieved through legislation at the Federal level. 154 Cong. Rec. H8368 (daily ed. Sept. 17, 2008) (statement of Rep. Scott).

Despite its strong support in the House and support from industry groups such as the Independent Insurance Agents and Brokers of America, the National Association of Insurance and Financial Advisors, the National Association of Mutual Insurance Companies, the Property Casualty Insurers Association of America, and the Council of Insurance Agents and Brokers, H.R. 5611 has advanced no further in the Senate since the bill was referred to the Senate Committee on Banking, Housing and Urban Affairs on October 2, 2008.

### **California Broker/Agent Distinction**

As background, on October 29, 2004, the California Court of Appeal for the First Appellate District decided the case of *Krumme v. Mercury Insurance Company*, 123 Cal. App. 4th 924, 20 Cal. Rptr. 3d 485, 2004 Cal. App. LEXIS 1832 (Cal. App. 1st Dist. 2004), cert. denied, 2005 Cal. LEXIS 597; 2005 Daily Journal DAR 768 (Cal. 2005). In *Krumme*, the court held that Mercury Insurance Company producers acting as brokers were considered agents and not brokers; and, as such, were not entitled to collect any broker fees. The court identified various functions of these producers as qualifying them as agents transacting on behalf of Mercury, such as: binding authority for Mercury; use of application forms, and rating and underwriting guidelines supplied by Mercury; advertisement that they represent Mercury in the same manner as appointed agents; and, other evidence of direct dealings with Mercury. Mercury, on the other hand, argued that the California Insurance Code did not differentiate a broker from an agent, and utilized the term broker-agent.

Debate over *Krumme* resonated among industry, consumer groups, the Department of Insurance, and others, in the years that followed the ruling. Some argued that the ruling in *Krumme* replaced California's totality of circumstances standard with an any one act test for determining an agency relationship. In reflecting upon the *Krumme* decision, the California Assembly attempted, in the Assembly's Third Reading Analysis, to place *Krumme* in a historic context, indicating: But there are two important elements to the decision: (1) the Court did nothing to change the longstanding common rule that whether a person is acting as a broker or an agent depends on the totality of circumstances; and (2) the Court rejected the any one act theory. The analysis further stated that certain groups have read more into the

Krumme Courts conclusions with regard to the application of a five-part test to determine broker or agent, and that the Insurance Staff were unable to locate any case that has held that any standard such as the one act test has replaced the totality of circumstances standard.

Confusion as to the roles and responsibilities of brokers and agents would hang over personal lines brokers and agents, insurers and consumers in California for more than three years after the *Krumme* decision. Finally, on February 22, 2008, Assembly Bill 2956 was filed for introduction in the California Assembly. By September 25, 2008, both Houses of the Legislature passed the bill, and Governor Arnold Schwarzenegger signed the measure into law as Chapter 304, Statutes of 2008, codified at sections 1621, 1623, and 1732, of the CALIFORNIA INSURANCE CODE. The new law, which only applies to admitted line producers, clarifies the distinction between a broker and an agent by establishing a new rebuttable presumption for qualification of a producer as a broker. No longer will the presumption of broker exist if a producer is simply licensed as a broker and acts like a broker. To enjoy the presumption, a producer must be licensed as a broker, maintain a specified bond, and disclose specific information to the consumer in a written agreement. The required disclosures are intended to eliminate any questions consumers may have regarding the role of the broker vis--vis the consumer or the insurer, the basic services the broker will provide, and the fees to be charged or the compensation the broker may receive from the insurer.

The presumption of broker status is rebutted if one of four conditions is present: (1) the licensee is appointed as an agent of the insurer for the particular type of insurance being transacted; (2) the licensee is authorized by written agreement with the insurer to obligate the insurer without first obtaining notification from the insurer to accept the risk; (3) the licensee is authorized by written agreement with the insurer to appoint other licensees as agents of the insurer; or (4) the licensee is authorized by written agreement with the insurer to pay claims on behalf of the insurer. In the absence of one of these conditions, the presumption of broker is rebutted based on the totality of circumstances indicating that the producer is acting on behalf of the insurer, putting to rest the notion that the any one act test is the correct standard for distinguishing a broker from an agent.

According to Senate staff, the bill was not intended to alter or affect existing caselaw regarding the significance or weight to be accorded factors that indicate that a broker-agent is acting on behalf of an insurer. Assembly Concurrence in Senate Amendments to AB 2956, p. 2 (Assembly Floor Aug. 13, 2008). Furthermore, section 1732 now clarifies that a broker may on behalf of an insurance company, collect and transmit premium or return premium and deliver policies and other documents evidencing insurance without such actions being construed to qualify the broker as an agent.

## **INTERSTATE COMPACT**

The Interstate Insurance Product Regulation Commission (IIPRC) welcomed several new member states during 2008. For membership, each compacting state enacted into law the Model Interstate Insurance Product Regulation Compact (Compact). The IIPRC continued its efforts to expand its charge, to provide a uniform central filing point under one set of rules, for speed-to-market product review for asset-based insurance products to meet the demands of a competitive global insurance market while maintaining a heightened level of consumer protection. Wisconsin became the 31st state to join the Compact, with the enactment of 2007 Wisconsin Act 168, on March 25, 2008, to create section 14.82, WIS. STAT.

By mid-year Louisiana and South Carolina also joined the Compact, bringing to 54 percent the national premium volume represented by the IIPRC. The Governor of South Carolina signed Act 339 into law on June 11, 2008, codified at sections 38-95-10, et seq., SOUTH CAROLINA CODE. This Act becomes effective January 1, 2009, and will expire on June 1, 2014, unless extended by the South Carolina General Assembly. Louisiana House Bill 369 evolved into Act 353 upon approval by the Governor on June 21, 2008, with an effective date of August 15, 2008, codified at sections 22:1450.51 and 1450.52, LOUISIANA REVISED STATUTES.

In contrast, legislators in California, New Jersey, and New York introduced measures to adopt the Compact. However, these efforts failed to achieve passage during 2008. Legislation was introduced in California by way of Senate

Bill 1434 on February 21, 2008. The bill was to be heard before committee on March 27, 2008, but that hearing was cancelled at the request of the bills author. A second hearing was set for April 16, 2008, at which the committee received testimony. No further action was taken on the bill, while the deadline for passage of the bill out of its house of origin elapsed on May 30, 2008, and last day for passage of any bill occurring on August 31, 2008.

The New York Legislature passed Senate Bill No. S5053 on June 18, 2008. However, the Assemblys companion, Assembly Bill No. A8068, languished in committee. Meanwhile, in New Jersey, the Senate Commerce Committee reported favorably on Senate Bill No. 949. By October 23, 2008, the Assembly Financial Institutions and Insurance Committee reported favorably, with committee amendments, on the measure via Assembly Bill No. 2614. No further action occurred.

Since its inception in 2006, by 2008, the IIPRC adopted 44 uniform standards for the streamlined review of asset protection insurance products such as life, annuity, disability income, and long-term care insurance products. By early August 2008, the IIRC approved its 100th life insurance product.

### **FEDERAL REGULATORY EFFORT**

Throughout 2008, there was much discussion regarding insurance industry regulatory reform at the federal level. But, as has been the case time and again, there was more action and political intrigue than solid results.

On March 31, 2008, the United States Treasury Department released its Blueprint for a Modernized Financial Regulatory Structure, which included various short-term, intermediate, and long-term recommendations for improving the countrys financial regulatory structure, enhancing financial innovation and strengthening consumer protection. The federal charter debate was clearly back in the spotlight. With regard to the insurance sector, the Blueprint recommended creating an optional federal charter, similar to the current dual-chartering system for banking, to encourage a more competitive U.S. industry. As contemplated by the Blueprint, an Office of National Insurance within the Treasury Department would oversee the new structure. The Blueprint also recommended, as an intermediate step, that Congress create a Federal Office of Insurance Oversight within Treasury to establish a federal presence in insurance for international and regulatory issues.

On March 17, 2008, Representative Paul E. Kanjorski, Chairman of the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises, Representative Deborah Pryce, Ranking Member of the Subcommittee, and others, introduced H.R. 5840, the Insurance Information Act of 2008. Somewhat similar in concept to the Blueprints recommendation, but bearing various modifications, H.R. 5840 proposed establishing the Office of Insurance Information within the Department of Treasury to: (a) receive, analyze, collect and disseminate information regarding all lines of insurance, except health insurance; (b) establish federal policy on international insurance matters and ensure consistency between state insurance laws and agreements relating to such policy and entered into with foreign governments; and (c) advise the Treasury Secretary on major domestic and international insurance policy issues.

On June 10, 2008, Chairman Kanjorskis subcommittee conducted a hearing on H.R. 5840, and on July 9, 2008, the subcommittee and full committee approved the bill with modifications addressing protection of confidential information and state preemption. Modifications were based on concerns raised at the hearing on June 10. The Subcommittee had also previously conducted a hearing on April 16, 2008, to discuss various state and federal proposals on insurance regulatory reform. Having completed the committee process and ready for the House Floor, H.R. 5840 was eventually scheduled to be considered by the House of Representatives on the suspension calendar, a calendar typically reserved for non-controversial bills. This set in motion a response from those opposed to the bill, including various consumer groups and the National Conference of Insurance Legislators. Allegations were made of disingenuous remarks linking the need for legislation with the recent AIG financial predicament as well as a failure to fully air all of the issues.

On September 16, 2008, Congressman Jackie Speier, representing San Francisco and San Mateo, California, released a harsh statement criticizing the bill for setting a dangerous precedent by allowing preemption of any state

insurance law or regulation deemed discriminatory toward foreign companies. In her statement, Representative Speier recognized California as having adopted some of the strongest consumer protection laws in the country. To quote Representative Speier, H.R. 5840 is the camels nose under the consumers tent toward abolishing hard-won [state] protections. Press Release, Office of Congresswoman Jackie Speier, Insurance Information Act Bad for Consumers (Sept. 16, 2008). On September 17, 2008, fellow Californian and Speaker of the House, Representative Nancy Pelosi removed H.R. 5840 from the House calendar.

## CONCLUSION

Year 2008 saw no shortage of legislative proposals, at both the state and federal level, which will have a lasting effect upon the insurance industry. State legislatures and agencies, as well as the Congress and the SEC, diligently sought to address eight areas of significant interest to the industry discussed in this commentary. Indeed, 2008 will likely be cast as a trend-setting year for each of these topics and as a catalyst for related topics.

For constituents struggling with autism or mental health disorders, 2008 will likely be seen as the year upon which new hope was built. With regard to insurer conduct and bad faith civil liability, the two vastly differing approaches adopted in Colorado and Minnesota will likely provide models for legislative proposals in other states during 2009. There was much anticipation in 2008 with regard to the reauthorization of the National Flood Insurance Program. In the end, no significant changes were made. For some, this non-event will be remembered as the best possible result; while, for others, the year will be seen as one of lost opportunity. In contrast, major changes were adopted in various Gulf region states with the hope of protecting homeowners and affected state budgets from devastating loss. Despite the historic losses in the Midwestern States wrought by the floods of 2008, no major legislative responses were adopted. Future events will educate many legislators and regulators as to which approach best served their respective constituencies. Likewise, 2008 will serve as the prelude to the forthcoming discourse on the financial underpinnings of the industry. The demise of various financial giants affiliated with the industry may never be understood completely, but it is highly likely that 2008 will be remembered as the year that set the stage for change. As with each topic, depending on each participants unique perspective, opportunity abounds.

## ABOUT THE AUTHOR(S):

**Ken Levine** is widely regarded as one of the nations premier insurance and warranty regulatory lawyers. With almost two decades of regulatory and administrative experience, Mr. Levine has represented purchasers in some of Floridas largest mergers and acquisitions, and represented several of the countrys largest trade associations in administrative proceedings, bid protests, rule challenges, and negotiated solutions, before numerous agencies of the State. During the early 90s, Mr. Levine served in various legal capacities at the Florida Department of Insurance (now the Florida Office of Insurance Regulation), including service as senior counsel in the Chief of Staffs Office and as the agencys Hearing Officer. He also led the Departments prosecutions of unauthorized insurers in federal courts from Florida to California; and successfully negotiated, through the U.S. Department of Commerce, to save from preemption by NAFTA various provisions of the insurance codes of Florida and of the various states in the Southeastern Zone of the NAIC. After having managed an office and the practice groups of two of Floridas largest law firms, Mr. Levine now serves as the senior partner of The Levine Law Group, in Tallahassee, Florida.

**Sheri Holtz Levine** has held positions directly involved with legislative and regulatory policy development at both the federal and state levels. Ms. Levine began her legal career twenty years ago in the Office of the General Counsel for the Florida Department of Natural Resources. She then moved to Washington, to serve as a legislative advisor to a prominent Florida Congressman on policy issues affecting proposed federal legislation. This experience returned Ms. Levine to various senior-level positions with the Florida House of Representatives. During her tenure in the House, Ms. Levine served as a Council Attorney, a Staff Director, and as a House Council Director, while also honoring a distinguished appointment by both the Florida Speaker of the House and the Florida Senate President to serve as the first Staff Director for the Joint Legislative Committee on Everglades Oversight. These experiences have enabled Ms.



Levine to provide superior service to clients in the form of legislative drafting, interpretation, application, and policy implication in her present role as managing partner of The Levine Law Group, in Tallahassee, Florida.

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