INSURANCE**LEGAL**NEWS

HEALTH CARE REFORM MOVES FORWARD

by Cynthia A. Moore, Member

In a stunning 5-4 decision authored by Chief Justice John Roberts, the United States Supreme Court upheld the controversial individual mandate and most other provisions of the Patient Protection and Affordable Care Act (the "ACA") in *National Association of Independent Business, et al. v Sibelius* (Docket 11-393).

Individual Mandate Upheld

It was widely anticipated that the Supreme Court would uphold or strike down the individual mandate under the Commerce Clause of the U.S. Constitution. Chief Justice Roberts held that the individual mandate exceeded Congress's power under the Commerce Clause because it regulated "inactivity"—the decision not to purchase health insurance—and Congress does not have the power to compel activity in commerce. However, noting that it was the Court's obligation to uphold a law if there is any basis on which to do so, he held that the individual mandate passed Constitutional muster under Congress's taxing power.

Justice Ginsburg's opinion, joined by Justices Kagan, Sotomayor and Breyer, would have found the individual mandate constitutional under both the Commerce Clause and the taxing power. Justice Ginsburg argued that the fact that an individual does not purchase insurance will inevitably result in activity in the health care market, as every citizen uses the health care system sooner or later. Applying traditional Commerce Clause analysis, this inevitable use results in a substantial effect on interstate commerce and Congress had a rational basis for including the individual mandate as a solution to the "free rider" problem.

The dissent, in which Justices Scalia, Kennedy, Thomas and Alito joined, would have found the individual mandate unconstitutional under both the Commerce Clause and the taxing power. The dissent agreed that the individual mandate exceeded Congress's power to regulate under the Commerce Clause. The dissent disagreed that the penalty associated with the failure to maintain minimum essential coverage is a constitutional "tax." In the dissent's view, the penalty is just that—a penalty for failing to comply with a mandate—and cannot be fairly characterized as a tax.

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INSURANCE WEB SITES OF INTEREST

National Association of Insurance Commissioners
http://www.naic.org

Michigan Office of Financial and Insurance Regulation
http://www.michigan.gov/dleg/0,1607,7-154-10555---00.html

Dickinson Wright PLLC also publishes a separate informational newsletter with emphasis on Tennessee insurance regulation, case law, and legislation. For further information and to subscribe to Dickinson Wright PLLC's *Tennessee Insurance Legal News*, please contact John E. Anderson, Sr. (janderson@dickinsonwright.com) or Autumn L. Gentry (agentry@dickinsonwright.com).

Medicaid Expansion Survives but Is Optional

A major objective of the ACA was to provide universal, or near-universal, access to health insurance coverage. One of the major pillars in achieving this objective was to expand the categories of persons eligible for Medicaid by allowing any person with income

below 133% of the federal poverty level to enroll in Medicaid. Although the federal government will provide a significant level of funding for the Medicaid expansion, its funding will decrease over time, leaving states to fund the difference. If a state refused to change its Medicaid eligibility rules, the "stick" employed by Congress was to cause that state to lose all of its federal Medicaid funds.

Chief Justice Roberts, joined by Justices Breyer and Kagan, found that this "stick" violated the Constitution. Congress is allowed to create incentives under the Spending Power to encourage states to act in accordance with federal policies. But when "pressure turns into compulsion," the law fails. In other words, states must have a legitimate choice as to whether to accept the federal conditions in exchange for federal funds. Here, the threat to withhold all federal Medicaid funds is a "gun to the head" of states and is impermissibly coercive.

Even though the law as written violated the Constitution, Chief Justice Roberts determined that under the severability clause of the Medicaid Act, the Secretary of Health and Human Services has the authority to administer it in a constitutional manner. That is, if a state chooses to expand Medicaid, it will receive the federal funds to pay for the expanded coverage. If a state chooses not to expand Medicaid, it will only lose the federal funds that would have been granted for the expansion—not all of the state's federal funding for the Medicaid program.

Justices Ginsburg and Sotomayor would have found the Medicaid expansion constitutional. In her opinion, Justice Ginsburg noted that the Court had never before found a federal grant to cross the line between temptation and coercion.

The joint dissent agreed that the Medicaid expansion is a coercive exercise of federal power and violated the Constitution. However, the dissent did not agree that using the severability clause of the Medicaid Act as a way to uphold the Medicaid expansion as a voluntary program was a permissible way in which to interpret the law. The dissent's view was that the invalidity of the Medicaid expansion, coupled with the invalidity of the individual mandate, resulted in the unconstitutionality of the entire ACA.

Implications for Insurers

First and foremost, health insurers should continue down the path of compliance. Although Governor Romney and the Republicans have repeatedly vowed to repeal the ACA, if President Obama is re-elected or if the Democrats maintain control of the Senate or gain control of the House, repeal of the entire law is unlikely. Therefore, it would not be prudent to count on wholesale repeal after the November elections, although some changes are possible depending on the make-up of Congress and the Presidency.

In the near term, insurers should be preparing for:

- The distribution of the summary of benefits and coverage (SBC) on September 23, 2012; and
- Payment of the comparative effectiveness fee for the policy year ending after September 30, 2012.

Longer term, the Supreme Court's decision and continuing resistance by some state governors/legislatures makes implementation of the ACA uncertain and potentially challenging. For example, only 14 states are moving forward with implementing a state-level exchange at this time (10 have enacted legislation and 4 by executive order), and only 6 other states have legislation pending as of August 2, 2012. This resistance makes it likely that insurers will be dealing with a federal-level exchange in many states—the outline of which has not yet emerged, although regulators have assured the public that the federal exchange will be up and running by October 2013.

Further, it is uncertain how many states will adopt the Medicaid expansion. Several large states, including Texas and Florida, have announced that they will not be adopting the expanded Medicaid rules. If a significant number of states do not adopt the Medicaid expansion, there may continue to be a problem with the cost of uncompensated care, which may mean that the health care market will not achieve the savings originally anticipated by Congress and the President, and health insurance premiums may continue to rise. CMS officials have attempted to address state concerns by signaling that the Medicaid expansion could be added or dropped at any time—making it a truly voluntary expansion.

Finally, there is still a significant amount of guidance under the ACA yet to be issued by the Departments of Health and Human Services, Labor, and Treasury, including the definition of "essential health benefits" which will drive plan design in the individual and small group markets. Lack of guidance contributes to uncertainty in many key areas, which will make timely implementation challenging.

MICHIGAN JOINS STATES AUTHORIZING INSURERS' USE OF CREDIT INFORMATION

by Ryan M. Shannon, Associate

On June 14, 2012, and following nearly a decade of litigation, review, and compromise, Governor Snyder signed a package of bills that permit and regulate the use of credit information by insurers in establishing individual policy rates. The practice of using credit information to determine rates for specific consumers, known as "insurance scoring," was banned by the Office of Financial and Insurance Regulation (OFIR)[1] in 2005 under then-Governor Jennifer Granholm. In subsequent litigation, *Ins Inst of Michigan v Comm'r*, 486 Mich 370 (2010), in which Dickinson Wright represented the Plaintiff Insurance Institute of Michigan, the Supreme Court determined that

the prohibition against an insurer's use of credit information was contrary to the insurance code, and it struck down the ban.

The enacted legislation will add Chapter 21A to the insurance code. Under this chapter, insurers are permitted to use credit scoring information to determine discounts and the availability of premium installment payment plans. But insurers' use of credit information can only extend so far: the new Chapter 21A prohibits an insurer from using credit information or an insurance score as part of a decision to deny, cancel, or nonrenew most personal insurance policies.

An insurer that uses credit information in determining a particular rate under a policy must disclose that use to the applicant, and insurers must notify consumers when an adverse action has been taken based on credit information. Additionally, insurers are prohibited from taking an adverse action against a consumer because the consumer lacks a credit card, and insurance regulators must approve of the insurer's use of discount rates that differentiate on the basis of a consumer's lack of credit history.

Under the enacted legislation, insurers must obtain a new credit report upon the request of an insured, though an insured may only make such a request once during every 12-month period. Additionally, insureds may request, and insurers are required to provide, reasonable exceptions to the use of credit information in deriving rates where an insured's credit information has been directly influenced by catastrophic events, the death of a spouse, child, or parent, identity theft, or a military deployment, among other factors. Chapter 21A will provide that, upon receiving notice that the credit information of a current insured was determined to be incorrect or incomplete through the dispute resolution process as set forth by the Fair Credit Reporting Act, 15 USC § 1681 *et seq*., the insurer must reevaluate the insured within 30 days. Finally, insurers are required to defend and indemnify producers against liability, fees, and costs arising out of errors or omissions resulting from the use of credit information as long as the producer remains in compliance with the insurer's promulgated policies and the state's insurance laws.

Chapter 21A was based primarily on model legislation drafted by the National Conference of State Insurance Legislators. Similar legislation has been adopted in at least 26 other states.

Michigan's credit scoring legislation will be effective 91 days after the final adjournment of the 2012 Regular Session of the Michigan Legislature, which typically occurs in late December.

[1] At the time of the ban, OFIR was still known as the Office of Financial and Insurance Services or "OFIS."

RECENT CASE LAW SUMMARIES

SIXTH CIRCUIT FINDS "ACTUAL CHARGES" TERM AMBIGUOUS; HOLDS INSURER LIABLE FOR FEES BILLED RATHER THAN ACCEPTED AS PAYMENT

by Ryan M. Shannon, Associate

On June 21, 2012, in *Pedicini v Life Ins Co*, 682 F3d 522 (6th Cir 2012), the United States Court of Appeals for the Sixth Circuit affirmed the lower court's grant of summary judgment to the plaintiff insured on the basis that the term "actual charges" as it appeared in the plaintiff's insurance policy was sufficiently ambiguous to encompass the fees billed by the medical provider rather than the amount ultimately accepted as payment.

In *Pedicini*, the plaintiff held a supplemental cancer-insurance policy under which the cash benefits were to be paid directly to the plaintiff. The benefits conferred under the policy were based on "actual charges" "made by a person or entity furnishing the services, treatment or material." *Id*. at 724. The plaintiff was subsequently diagnosed with cancer and received treatment. The defendant insurer released benefits equal to the discounted amount accepted by the plaintiff's medical provider in light of the plaintiff's status as a Medicare recipient.

The plaintiff filed suit in Kentucky state court alleging breach of the insurance contract, and the action was removed on the motion of the insurer. The United States District Court for the Western District of Kentucky granted the plaintiff's motion for summary disposition, and the Sixth Circuit affirmed on appeal.

In affirming, the court noted that Kentucky law required that "an ambiguous term in an insurance policy be liberally construed so as to resolve all doubts in favor of the insured." *Id*. at 526 (citation omitted). Because a reasonable person could find the term "actual charges" to be "susceptible to different or inconsistent interpretations," the court construed that term in the plaintiff's favor. *Id*. The court cited decisions from the Fourth and Fifth Circuits which had determined that "actual charges" could be just as easily read to mean the amount billed rather than the amount accepted as full payment. *Id*. at 527 (citing *Ward v Dixie Nat Life Ins Co*, 257 F App'x 620, 627 (4th Cir 2007); *Guidry v Am Pub Life Ins Co*, 512 F3d 177, 184 (5th Cir 2007)). The court also noted that until recently the defendant insurer had issued benefits based on the amount billed rather than the amount accepted as payment, and the insurer's recent shift was further evidence that the term could be construed both ways. *Id*. at 528.

Having found there was no reasonable basis for the defendant's arguments, the Sixth Circuit affirmed. The court also reversed the district court's grant of summary judgment in favor of the defendant insurer on the plaintiff's bad faith claims and remanded for further proceedings. *Id*. at 530.

EASTERN DISTRICT OF MICHIGAN HOLDS MICHIGAN'S ADMINISTRATIVE RULES PRECLUDE DENIALS BASED ON DISCRETIONARY CLAUSES IN DISABILITY BENEFITS PLANS

by Ryan M. Shannon, Associate

In *Gray v Mutual of Omaha Life Ins Co*, 2012 US Dist LEXIS 101682 (ED Mich July 23, 2012) (published), the United States District Court of the Eastern District of Michigan held that Michigan regulations prevented a disability plan administrator from relying on a discretionary clause in denying short-term disability benefits to a plan participant.

The plaintiff in *Gray* had been deemed ineligible to receive short-term disability benefits under her employer-offered disability insurance plan. Though her psychiatrist and primary care physician both supported a recommendation that the plaintiff stop working due to a variety of ailments (including a diagnosed mood disorder), the plan administrator, Mutual of Omaha Life Insurance Company ("MUO") denied the plaintiff's benefits claim. Under the plan's plain language, benefits were to be paid only after MUO 'receive[d] acceptable proof of loss." *Id*. at *9. MUO considered this language to confer discretion on the plan administrator, and it conducted a file review, after which MUO denied the plaintiff's claim on the basis that there was inadequate objective support for the diagnoses given by the plaintiff's physicians. The plaintiff subsequently sued MUO in Michigan state court, and the case was removed to the Eastern District on MUO's motion.

In its decision, the court explained that, where a plan confers discretionary authority on its administrator, the court generally applies an "arbitrary and capricious" standard in reviewing a denial of benefits. *Id*. at *9 (citing *Jones v Metro Life Ins Co*, 385 F3d 654, 660 (6th Cir 2004)). However, in 2007, Michigan's Office of Financial and Insurance Services promulgated administrative rules, Mich Admin Code 500.2201-.2202, which prohibit discretionary clauses in insurance contracts issued, advertised, or delivered to any person in Michigan. *Id.* Michigan's administrative rules further require any reviewing court to apply a *de novo* review standard to administrator denials.

Applying the *de novo* standard, the court found that MUO's review of the plaintiff's file was inadequate to reject the diagnoses of the plaintiff's medical examiners. The court stated that "[i]f the file reviewer did not believe there was adequate evidence to support [the] diagnosis …, she could have ordered an independent examination of Plaintiff as is authorized under the policy." *Id.* at *18. The court then cited to a recent decision of the Sixth Circuit Court of Appeals which held that "where an administrator exercises its discretion to conduct a file review, credibility determination without the benefit of a physical examination support a conclusion that the decision was arbitrary." *Id*. at *18-19 (quoting *Helfman v GE Grp Life Assur Co*, 573 F3d 383, 395-96 (6th Cir 2009)). The court thus reversed the plan administrator's decision to deny short-term disability benefits to the plaintiff.

MICHIGAN COURT OF APPEALS FINDS INSURER'S TOLLING PROVISION VOID AS IN CONTRAVENTION OF THE INSURANCE CODE

by Ryan M. Shannon, Associate

In a published decision, *Smitham v State Farm Fire & Cas Co*, 2012 Mich App LEXIS 1574 (August 9, 2012), the Michigan Court of Appeals held that an insurance policy's tolling provision was void as it contravened the tolling provision mandated by the insurance code.

In *Smitham*, the plaintiff filed a claim under her homeowner's insurance in February of 2008, the day after personal property was stolen from her apartment in the course of a robbery. Nearly six months later, in August of 2008, State Farm denied the claim for failure to submit a sworn statement and other information as required by the insurance policy. *Id*. at *2. State Farm briefly reopened the claim in June of 2009, but ultimately refused to pay the plaintiff all but a small part of the amount claimed, issuing a letter and settlement check in August of 2010. The plaintiff filed suit in October of 2010, alleging breach of the insurance contract.

The defendant argued, as an affirmative defense, that plaintiff's suit was barred by the one-year limitations period in the insurance policy, as the loss occurred in February of 2008 and the plaintiff did not file her complaint until in excess of two and a half years later. The trial court granted State Farm's subsequent motion to dismiss, finding the plaintiff's action to be time-barred. The Michigan Court of Appeals reversed.

The court first quoted MCL 500.2833(1)(q), which states that an action on a policy of fire insurance (which the parties agreed was the type of policy at issue) "must be commenced within 1 year after the loss or within the time period specified in the policy, whichever is longer," and that "[t]he time for commencing an action is tolled from the time the insured notifies the insurer of the loss until the insurer formally denies liability." *Id*. at *6. Under the insurance policy, tolling was applicable only "[i]n the event a claim is formally denied." *Id*. at *6-7. State Farm argued that, because it had paid part of the claim through settlement, it had never "formally denied the claim," and thus the action had to be filed, if at all, within one year. The court rejected this argument, noting a "denial of liability" was broader than a "denial of coverage." *Id*. at *8. As the court explained: "A formal denial, such as is necessary to end tolling, must be explicit and unequivocally impress upon the insured the need to pursue further relief in court." *Id*. at *9 (citing *Jiminez v Allstate Indemnity Co*, 765 F Supp 2d 986, 992 (ED Mich 2011)).

Further, the court in *Smitham* found that State Farm's limitation provision was void, as it conflicted with the "one year" provision mandated by MCL 500.2833(1)(q). *Id*. at *12. "[T]he policy language is not compatible with the statutorily mandated provision," the court explained, "which is not conditional. Because the provision is contrary to the statute, it is absolutely void." *Id*. at *15 (citing MCL 500.2860,

which provides that "[a]ny provision … which is contrary to the provisions of this chapter, shall be absolutely void ….").

Applying the one-year tolling limitation as contained in MCL 500.2833(1)(q), the court determined that the action was not time barred. It remanded to the trial court for further proceedings. *Id*. at *19.

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