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CYBERSECURITY PROGRAMS WILL BECOME INCREASINGLY SCRUTINIZED BY THE INSURANCE REGULATORS

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A. New York Cybersecurity Regulation

On March 1, 2017, 23 NYCRR 500[1] became effective. The New York Cybersecurity Regulation applies to anyone "operating under a license, registration, charter, certificate, permit, accreditation or similar authorization under" the banking law, insurance law, or financial services law of the State of New York. However, for certain small organizations, they are exempt.[2] Until last summer, no known enforcement action had been initiated by New York pursuant to 23 NYCRR 500. That all changed on July 21, 2020, when the New York Department of Financial Services ("NYDFS") filed an action against First American Title Insurance Company and then amended the same.[3]

According to the statement of charges: "From at least October 2014 through May 2019, due to a known vulnerability on Respondent's public-facing website (the "Vulnerability"), these records were available to anyone with a web browser." The records included "bank account numbers and statements, mortgage and tax records, Social Security numbers, wire transaction receipts, and drivers' license images."[4] The charges allege that even after learning of the Vulnerability in 2018, First American did not remediate it for a period of time. The charges refer to journalist Brian Krebs report that First American "had exposed 885 million documents — dating as far back as 2003 and many containing NPI — by rendering the documents openly accessible to the public."[5]

After setting out the facts in detail, the NYDFS charged First American with violations of: 1) 23 NYCRR 500.02 (maintenance of cybersecurity program), 2) 23 NYCRR 500.03 (written policy or policies), 3) 23 NYCRR 500.07 (limit user access privileges), 4) 23 NYCRR 500.09 (periodic risk assessment), 5) 23 NYCRR 500.14(b) (cybersecurity awareness training), and 6) 23 NYCRR 500.15 (implantation of controls, including encryption).

NYDFS' regulated entities, and insurers in other jurisdictions which have enacted versions of the NAIC cybersecurity model law, will watch this action closely. The NYDFS often has been a leader in the development and enforcement of laws that have spread to other states. Businesses who fall under the oversight of the NYDFS should review their cyber policies and practices to ensure they are in good shape in light of the regulations that have been in place for more than three years and have begun to be enforced by the NYDFS.

While the First American action is the first action against an insurer for alleged violations of 23 NYCRR 500, it was not the first action. In March 2021, the NYDFS entered into a consent order[6] with Residential Mortgage Services, Inc., a mortgage banker and mortgage servicer licensed in New York. The NYDFS, unlike most departments of insurance, regulates a variety of other financial services companies.[7]

B. NAIC Model Insurance Data Security Model Law

In late 2017, after much discussion and in large part based on the New York Cybersecurity Regulation, the NAIC adopted the Model Insurance Data Security Model Law.[8] To date, eleven states have adopted the Model Law (often with modifications).[9] That includes three states that adopted the Model Law during 2020: Virginia on March 10, 2020;[10] Indiana on March 20, 2020;[11] and, Louisiana on June 11, 2020.[12] At least five other states are considering adopting the Model Law.[13] In 2019, Maryland adopted a code provision and issued a bulletin[14] dealing with data security, but it is not as detailed or formal as the Model Law.[15]

Insurance regulators continue to focus on cybersecurity and privacy obligations of those companies they regulate. We expect more states to adopt the Model Law in coming years, as the issue of computer hacks continues to grow. For example, in March 2021, CNA Financial suffered a "sophisticated cybersecurity attack" that crippled the large insurer for several days.[16] Regulators might consider the Model Law to address the needs of insurers to protect themselves.

Conclusion

Cybersecurity is a continued area of law where all organizations, including insurers, face increased attacks and danger due to hackers and other cyber criminals. The 23 NYCRR 500 and Model Law initiatives are attempts by regulators to ensure that insurance organizations have in place robust cybersecurity programs and processes to help prevent major breaches.

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[1] N.Y. COMP. CODES R. & REGS. tit. 23, § 500 (2017).

[2] N.Y. COMP. CODES R. & REGS. tit. 23, § 500.19(a) (2017). Exemptions apply for those with fewer than 10 employees in New York; for companies with less than $5 million in annual revenues; and entities with less than $10 million in assets.

[3] https://www.dfs.ny.gov/system/files/documents/2020/07/ea20200721_first_american_notice_charges.pdf. The DFS filed an amended complaint, available at https://www.dfs.ny.gov/system/files/documents/2021/03/ea20200721_first_american_notice.pdf

[4] *Id.*

[5] *Id., p. 33.*

[6] https://www.dfs.ny.gov/system/files/documents/2021/03/ea20210303_residential_mortgage_0.pdf.

[7] This was not always the case. The consolidation of the New York State Insurance Department and the New York State Banking Department happened in 2011, when the state legislature and Governor Andrew Cuomo effectuated the consolidation, creating the New York Department of Financial Services.

[8] https://content.naic.org/sites/default/files/inline-files/MDL-668.pdf.

[9] The other eight states are: South Carolina, Ohio, Michigan, Mississippi, Alabama, Connecticut, New Hampshire, and Delaware.

[10] VA. CODE ANN. §§ 38.2-621 to 38.2-629 (2020).

[11] IND. CODE ANN. §§ 27-2-27-1 to 27-2-27-32 (2020).

[12] H.B. 614 (2020).

[13] https://content.naic.org/sites/default/files/inline-files/Model_%23668_Map06.17.20.pdf.

[14] Bulletin 2019-14, https://insurance.maryland.gov/Insurer/Documents/bulletins/19-14-Breach-of-Security-of-a-Computer-System-Notification-Requirement.pdf.

[15] Md. Code Ann. Ins. § 4-406.

[16] *See, https://www.cpomagazine.com/cyber-security/cyber-insurance-firm-suffers-sophisticated-ransomware-cyber-attack-data-obtained-may-help-hackers-better-target-firms-customers/.*

CYBERSECURITY IN THE INSURANCE INDUSTRY: NAVIGATING THE PATCHWORK OF U.S. DATA BREACH NOTIFICATION REQUIREMENTS

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In recent years, there have been several major data breaches involving large companies that have exposed and compromised the sensitive personal information of millions of individuals across the United States. Despite record-shattering data breaches, the United States has yet to develop a uniform and comprehensive regulatory scheme for regulating how companies store and protect the personal, nonpublic information of their customers and employees. Instead, cybersecurity regulation is left primarily to individual states, which has led to the creation of a patchwork of varying, and sometimes inconsistent, data protection requirements.

California enacted the first data-breach notification law in 2003. Since then, all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have enacted data breach laws that require individuals to be notified if their information is compromised. These laws have different and sometimes incompatible provisions regarding what categories and types of personal information warrant protection, which entities are covered, and what constitutes a breach. Notification requirements also vary greatly among states.

Navigating this patchwork of requirements can be challenging for companies that operate across state lines; this is especially true for multi-state insurance companies and agencies, which are not only subject to state-wide cybersecurity and consumer protection laws, but are increasingly being required to comply with new and evolving cybersecurity requirements that apply specifically to insurance industry participants. Indeed, legislatures and insurance regulators across the country have taken note of high-profile breaches involving U.S. insurers and have made cybersecurity and consumer data protection a top priority. As a result, the insurance industry is subject to some of the most recent and comprehensive data protection laws and regulations in the United States.

This article focuses on two key data breach notification requirements applicable to insurance companies and agencies: The New York Department of Financial Services (NYDFS) Cybersecurity Regulation (the NYDFS Regulation) and the National Association of Insurance Commissioners (NAIC) Data Security Model Law (the NAIC Model). This article does not address laws or regulations that require notice to individuals whose personal information has been compromised as a result of a breach. For the most part, individual data breach notification obligations are tied to the state of residency of the individual whose information is potentially affected, so even though an insurer may only be licensed in certain jurisdictions, notification obligations to any potentially affected individuals are triggered by the individuals' respective state residencies.

New York DFS Cybersecurity Regulation

The New York Department of Financial Services' landmark Cybersecurity Regulation for insurance companies and financial institutions became effective March 1, 2017 with a two-year implementation period. The NY Regulation requires insurance companies, producers, banks, and other financial services companies regulated by the NYDFS (*i.e.,* "Covered Entities") to adhere to strict standards to protect consumer data. The rule implements a host of requirements, including requiring that Covered Entities establish a cybersecurity policy and perform an annual risk assessment to evaluate their cybersecurity policies.

Although planning for cybersecurity breaches is implicit in the requirements, there is a specific requirement for Covered Entities to prepare incident response plans. These written plans must be prepared in advance based on the Risk Assessment, and should describe the procedures personnel will follow, and the roles and responsibility of to remediate or mitigate the harm caused. Notably, the NY Regulation requires that Covered Entities provide notice to the Superintendent of the NYDFS as promptly as possible, but in no event later than 72 hours from making a determination that a cybersecurity event has occurred; however, it is important to note that this is not a blanket requirement to report every breach. Rather, if a Covered Entity is required to report the breach to another government agency or supervisory body, such as a state attorney general's office or another insurance department, then notice must also be provided to the Superintendent. Covered Entities must also report any breaches that "have a reasonable likelihood of materially harming any material part of the normal operation(s)" of a Covered Entity.

The determination of whether a breach has triggered the reporting requirement under the NY Regulation is a fact-specific exercise that must be made on a case-by-case basis; however, Covered Entities should keep in mind that it is the NYDFS' interpretation of the reporting requirements, as applied to any particular set of circumstances, that will carry the day. Accordingly, it is important for entities to stay abreast of interpretive guidance published by the NYDFS which can be helpful in understanding how the regulator interprets the requirements. Indeed, the NYDFS has an extensive Frequently Asked Questions section on its website that is dedicated exclusively to the NY Regulation, pursuant to which it has indicated that the "notice requirement is intended to facilitate information sharing about serious events that threaten an institution's integrity and that may be relevant to the Department's overall supervision of the financial services industries." The guidance further indicates that the NYDFS "trusts that Covered Entities will exercise appropriate judgment" in determining which attacks must be reported "and does not intend to penalize Covered Entities for the exercise of honest, good faith judgment." As such, good regulatory hygiene requires Covered Entities, that have been subject to a data breach, conduct a thorough investigation of the circumstances leading up to the event and give due consideration to the notification requirement. Where the line blurs and a Covered Entity is on the fence regarding whether

to report, the prudent approach in most cases will be to report the incident.

NAIC Insurance Data Security Model Law

The NAIC Model was adopted by the NAIC in October 2017 following extensive deliberations and input from state insurance regulators, consumer representatives and the insurance industry. State Adoption of the model by state legislatures is critical for state insurance regulators to have the tools they need to better protect sensitive consumer information.

The NY Regulation had a significant impact on the development of the NAIC Model. The Model requires insurers and other entities licensed by a state department of insurance to develop, implement, and maintain an Information Security Program (ISP). Importantly, the NAIC Model requires that licensees investigate cybersecurity events and notify the insurance commissioner of cybersecurity events that satisfy certain criteria. The model defines a "cybersecurity event" as an event resulting in unauthorized access to, or disruption or misuse of, an information system or information stored on such information system.

Specifically, the NAIC Model requires that all domestic insurers and all home state producers notify the insurance commissioner as promptly as possible, but in no event later than 72 hours from a determination that a cybersecurity event has occurred. This 72-hour notice requirement may also apply to non-domestic (*i.e.,* foreign) insurers and producers if the breach involves the nonpublic information of 250 or more consumers residing in the state and either of the following is true:

- The insurer or producer is required to provide notice of the breach to any government body, self-regulatory agency or any other supervisory body pursuant to any state or federal law; or
- The breach has a reasonable likelihood of materially harming: (i) any consumer residing in the state; or (ii) any material part of the normal operation(s) of the insurer or producer.

Thus, insurers and producers that are domiciled in states that have adopted the NAIC Model without modification are required to notify the insurance commissioner within 72 hours of determining that a threat actor has gained access to, disrupted, or misused their information systems. Moreover, nondomestic insurers and producers may also have reporting obligations if the breach has resulted in the access or misuse of the nonpublic information of at 250 or more of the state's consumers and one of the above two conditions has been satisfied. Regarding the condition identified in the first bullet above, it is important to remember that the condition is satisfied if the insurer or producer is required to provide notice to *any* state government body, self-regulatory agency or any other supervisory body pursuant to any state or federal law (*i.e.,* it is not limited to circumstances where the insurer or producer is required to provide notice to another insurance commissioner).

As of the drafting of this article, Alabama, Connecticut, Delaware, Indiana, Louisiana, Michigan, Mississippi, New Hampshire, Ohio, South Carolina, and Virginia have adopted the NAIC Model. While most states that have adopted the Model included the breach notification requirements with little or no substantive changes, Virginia's version of the NAIC Model includes a more expansive notification requirement for non-domestic insurers and producers. Insurers and producers should be mindful that there may be additional data breach laws in any given state that should be considered. Specifically, notice of a breach is required to the Virginia Commissioner of Insurance within three business days if:

- The licensee reasonably believes that the nonpublic information involved is of 250 or more consumers residing in the Commonwealth or the licensee is required under federal law or the laws of another state to provide notice of the cybersecurity event to any government body, self-regulatory agency, or other supervisory body.

Accordingly, if the breach does not involve the nonpublic information of at least 250 Virginia consumers, non-domestic insurers and producers may nonetheless be required to provide notice to the Virginia Commissioner of Insurance if it is determined that the licensee is required to provide notice to another government body, self-regulatory agency, or other supervisory body under federal or state law. Thus, a company may be required to report a breach even if the breach did not affect a single Virginia consumer.

Conclusion

One of the primary goals of the NAIC Model is to bring much-needed uniformity to the regulation of cybersecurity for the U.S. insurance industry, but whether the majority of U.S. jurisdictions will enact the NAIC Model remains unclear. Barring universal adoption of the NAIC Model, which is unlikely unless it becomes an accreditation standard, or action at the federal level, insurance companies and other licensees will continue to closely monitor developments at the state level and implement protocols to ensure that their cybersecurity response plans comply with the laws of each state in which they transact insurance.

In developing cybersecurity breach response plans, companies must consider a wide-range of information, including the kinds of information that are protected by individual state breach laws, the conditions that trigger breach notification requirements, and the timeframes within which breach notifications must be made. It is imperative that companies understand their reporting obligations, have a streamlined incident response plan in place that has been tested via tabletop exercises to ensure they are prepared to handle a cybersecurity event.

Insurance company boards must also be involved in their companies' cybersecurity activities and must go beyond merely "check-the-box" compliance. During the last few years, cybersecurity risk has quickly morphed into enterprise risk, which creates the need for a whole-company approach. This means that cybersecurity is not just a problem for the company's IT department—today, it is everyone's problem, especially the board's.

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REPEAL OF THE FEDERAL ANNUAL FEE ON HEALTH INSURANCE PROVIDERS AND THE CREATION OF NEW MEXICO'S NEW HEALTH CARE AFFORDABILITY FUND

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During the 2021 legislative session of the New Mexico Legislature, the State of New Mexico enacted legislation that created a new "Health Care Affordability Fund" (the "Fund").[1] This article will examine the origin and establishment of the Fund, its funding source, and its proposed attempt to provide increased health insurance coverage beginning January 1, 2022.[2]

I. Federal Health Insurance Tax

The creation of New Mexico's new Fund, and the associated increase in the existing health insurance premium surtax, is connected to the federal health insurance tax in the Patient Protection and Affordable Care Act and is a direct result of the repeal of that federal health insurance tax. This federal tax was first enacted as part of the Patient Protection and Affordable Care Act ("PPACA") and was called an annual fee on health insurance providers (Section 9010).[3] It was also referred to as the health insurance tax ("HIT"). While the tax was enacted as an annual fee on health insurance providers, the annual fee essentially functioned as a sales tax on most health insurance plans in the United States. The tax was enacted as a means to financially support the coverage expansion under the PPACA.

Concerns about the financial impact of the tax on health insurance consumers emerged even before the passage of the tax.[4] The Congressional Research Service estimated that the total allocable fee would $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion in 2018.[5] Concerns related to the impact of the tax lead to a reluctance to let the tax remain in effect. The tax was active in 2014, 2015, 2016, and 2018, but it was suspended in 2017 and 2019 in an effort to reduce premium costs. Then in December of 2019, actuaries at the Office of the Actuary within the Centers for Medicare & Medicaid Services issued an analysis identifying the HIT as a major driver of health care cost growth in 2018.[6] This analysis confirmed that the burden of the annual fee on health insurance providers would be borne by health insurance consumers.

Recognizing the financial burden posed by the imposition of the HIT on health insurance consumers, Congress repealed the federal tax. In late December of 2019, Congress passed legislation on a bipartisan basis that repealed three health care and life science taxes: (1) annual fee on insurance providers effective January 1, 2021; (2) the medical device tax; and (3) the excise tax on high cost employer-sponsored health coverage (the so-called "Cadillac tax"), both effective January 1, 2020.[7] As a result of the repeal of the HIT, 2020 was the last fee year.[8]

II. State Replacement of the Repealed Federal Tax

After the repeal of the HIT, several states saw an opportunity to fill the void and enact state taxes to replace the repealed federal tax. In addition to New Mexico, new state health insurance taxes have been adopted in Colorado, Delaware, Maryland, and New Jersey. The new taxes have been enacted to increase the affordability for some, but not all purchasers, of health insurance. The following is brief description of each state's approach to the new state taxes and the use of the revenue generated.

A. Colorado

In 2020, Colorado enacted a new law that imposes an assessment of one and fifteen-hundredths of a percent (1.15%) of premiums collected by nonprofit carriers and imposes an assessment of two and one-tenth percent (2.1%) of premiums collected by for-profit carriers.[9] The primary uses of the funds generated by the assessment are to provide: (1) funding for Colorado's reinsurance program; (2) payments to carriers to increase the affordability of health insurance on the individual market for consumers who receive the premium tax credit; (3) subsidies for state-subsidized individual health coverage plans purchased by qualified individuals; (4) funding for actual administrative costs of the enterprise for implementing and administering health insurance affordability enterprise; and (5) funding for costs for consumer enrollment, outreach, and education activities regarding health care coverage, including increasing grants to the Colorado's state based exchange's certified assistance network, marketing for the exchange, grants to community-based organizations that are able to assist with outreach and enrollment, particularly in communities that face the greatest barriers to enrolling in health care coverage, and improving the connection between unemployment services and enrollment in health care coverage.[10]

B. Delaware

In Delaware, a new law enacted in 2019 imposed an assessment of two and seventy-five hundredths percent (2.75%) on carriers for all amounts used to calculate the entity's premium tax liability or the amount of the entity's premium tax exemption value for the previous calendar year.[11] "Carrier" is defined as any entity that provides health insurance in Delaware and includes an insurance company, health service corporation, health maintenance organization, managed care organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.[12] The assessment is not imposed on Medicare, Medicaid, stand-alone dental insurance, stand-alone vision insurance, long-term care insurance, disability income insurance and all accident-only insurance.[13] The purpose of the assessment is to fund the Delaware Health Insurance Individual Market Stabilization and Reinsurance Program ("Program").[14] The Program is projected to lower premium rates in the individual health insurance market by approximately twenty percent (20%) and improve the morbidity of the individual single risk pool by as much as six-tenths of a percent (0.6%).[15]

C. Maryland

In 2019, the State of Maryland imposed an assessment of two and seventy-five hundredths percent (2.75%) on all amounts used to calculate an entity's premium tax liability or the amount of the entity's premium tax exemption value for the calendar year 2018.[16] The assessment applies to an insurer, a nonprofit health service plan, a health maintenance organization, a dental plan organization, a fraternal benefit organization, and any other person subject to regulation by the state that provides a product that was subject to Section 9010 of the Affordable Care Act.[17] For calendar years 2020 through 2023, in addition

to the amounts otherwise due, those same entities are subject to an assessment of one percent (1%) on all amounts used to calculate the entity's premium tax liability or the amount of the entity's premium tax exemption value for the immediately preceding calendar year.[18] The assessment is also imposed on managed care organizations for the Medicaid program.[19] The purpose of the assessment is to assist in the stabilization of the individual health insurance market by assessing a health insurance provider fee that is attributable to state health risk for calendar years 2019 through 2023.[20]

D. New Jersey

In 2020, the State of New Jersey enacted an assessment of two and five-tenths percent (2.5%) of a health benefits plan's net written premiums that must be annually filed by April 1 and paid by May 1.[21] The assessment is imposed on insurance companies, health service corporations, hospital service corporations, medical service corporations, health maintenance organizations, or dental plan organizations authorized to issue health benefits or dental benefits plans in New Jersey, and registered multiple employer welfare arrangements.[22] The assessment is not imposed on Medicaid, Medicare, Medicare Advantage, Medicare supplement, accident-only, credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance, small employer health benefits plans, and hospital confinement indemnity coverage.[23] The revenue generated by the assessment will be deposited into the Health Insurance Affordability Fund for the purposes of increasing affordability in the individual market and providing greater access to health insurance to the uninsured, including minors, with a primary focus on households with an income below four hundred percent (400%) of the federal poverty level.[24] The revenue will also be used for the purpose of expanding eligibility, or modifying the definition of affordability in the individual market, through subsidies, reinsurance, tax policies, outreach and enrollment efforts, buy-in programs, such as the NJ FamilyCare Advantage Program, or any other efforts that can increase affordability for individual policyholders or that can reduce racial disparities in coverage for the uninsured.[25] The assessment went into effect in 2021.[26]

III. New Mexico's Health Coverage Landscape

In New Mexico, government programs are the dominant forms of health coverage. Medicaid coverage is by far the leader with more than forty percent (40%) of New Mexicans covered by Medicaid.[27] In June 2020, 869,000 thousand total beneficiaries were in the program with forty-three (43%) of beneficiaries being children.[28] The majority of children in the state, fifty-six percent (56%), are enrolled in Medicaid.[29] Another seventy-two percent (72%) of all births in New Mexico are covered by Medicaid.[30] In addition, fifteen percent (15%) of New Mexico's population is covered by Medicare.[31] These large enrollment numbers in government health coverage programs lead some to believe that additional government involvement might be a solution to providing health coverage to the uninsured population in New Mexico.

As of 2019, the uninsured population in New Mexico was approximately ten percent (10%) of the population.[32] Providing coverage for this uninsured population, and well as reducing health care premiums and cost sharing for those who purchase health care coverage on the New Mexico health insurance exchange, was a primary motivation for the sponsors of the New Mexico legislation. While there was no debate regarding the goal of the coverage proposal, there was strong debate over how to pay for it and who should pay for it.

In contrast, according to the New Mexico Superintendent of Insurance, those purchasing health insurance (fully-insured private major medical coverage) comprised less than 169,000 or less than twelve percent (12%) of the total population of New Mexico in July 2020.[33] This small population will bear the burden of the surtax increase in order to provide coverage to the target populations.

IV. Taxation of Health Insurance in New Mexico

Prior to the enactment of the new Fund, health insurance in New Mexico was subject to both a general premium tax of three and three-thousandths percent (3.003%) and an additional surtax of one percent (1.0%).[34] The premium tax and the surtax were collected by health insurance companies from purchasers of health insurance and then remitted to the State of New Mexico. Under the new law, the health insurance premium surtax will be increased to a rate of three and seventy-five hundredths percent (3.75%) of the gross health insurance premiums and membership and policy fees received by the taxpayer on hospital and medical expense incurred insurance or contracts; nonprofit health care plan contracts, excluding dental or vision only contracts; and health maintenance organization subscriber contracts covering health risks within New Mexico during the preceding calendar year.[35] This amount is in addition to the general premium tax (3.003%) and will result in a total premium tax of six and seven hundred fifty-three thousandths percent (6.753%) on health insurance products purchased in New Mexico. This combined rate will make New Mexico's premium tax rate the highest in the United States.[36]

V. State Receipt of Health Care-Related Taxes from the Federal Government

A key consideration for the new Fund is the application of the surtax to the Medicaid program in New Mexico. According to the Office of Superintendent of Insurance's estimates, approximately seventy-five percent (75%) of the revenue generated by the new law will come from Medicaid managed care organizations ("MCOs").[37] This revenue paid to the state by the MCOs will be remitted from funds that were paid to the MCOs by the New Mexico Human Services Department ("HSD"). In turn, HSD will receive additional funds from the federal government as a part of its draw down of the federal financial participation for the Medicaid program in New Mexico. The application of the state surtax to the Medicaid program is possible under the federal Medicaid rules, which provide that a state may receive health care-related taxes from the federal government, without a reduction in the federal financial participation, if certain conditions are met.[38]

The required conditions for a state to receive health care-related taxes from the federal government are the following: (1) the taxes are broad based; (2) the taxes are uniformly imposed throughout a jurisdiction; and (3) the tax program does not violate hold harmless provisions.[39] A health care-related tax is a licensing fee, assessment, or other mandatory payment that is related to health care items or services, the provision of, or the

authority to provide, the health care items or services, or the payment for the health care items or services.[40] A health care-related tax is considered broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-federal, non-public providers in the state, and is imposed uniformly.[41]

Under the New Mexico approach, the Medicaid program will pay the surtax to the MCOs that implement the program, and then HSD will draw down those amounts from the federal government as part of the federal matching portion associated with the surtax increase. While the proposal was being considered by the New Mexico Legislature, HSD stated that the Medicaid program would increase the per-member per-month capitation rates that it pays to the Medicaid managed care organizations.[42] For the 2nd half of FY22, this would result in an estimated total cost of approximately $75 million, with a general fund estimated impact of $15.1 million, which would draw down approximately $59.9 million in federal funds. In FY23, the total cost is estimated at $150.1 million, with an estimated general fund impact of approximately $30.2 million, which would draw down approximately $119.9 million in federal funds.[43]

VI. New Mexico Health Care Affordability Fund

The Fund has very broad, general uses identified for the revenue generated by the surtax increases. The expressed purposes of the new Fund are to: (1) reduce health care premiums and cost sharing for New Mexico residents who purchase health care coverage on the New Mexico health insurance exchange; (2) reduce premiums for small businesses and their employees purchasing health care coverage in the fully insured small group market; (3) provide resources for planning, design and implementation of health care coverage initiatives for uninsured New Mexico residents; and (4) provide resources for the administration of state health care coverage initiatives for uninsured New Mexico residents.[44] The Superintendent of Insurance is charged with the administration of the Fund.[45]

The Superintendent of Insurance, in consultation with other relevant state agencies, is required to promulgate rules to implement the new law. The rules must: (1) provide enhanced premium and cost-sharing assistance to individuals and families for the purchase of qualified health plans on the New Mexico health insurance exchange; and (2) establish income eligibility parameters for the health care affordability criteria for plan year 2023 and each subsequent calendar year based on available funds.[46] In providing assistance, the Superintendent of Insurance is required to develop health care affordability criteria designed to reduce the amount that individuals pay in premiums and out-of-pocket medical expenses for qualified health plans offered on the New Mexico health insurance exchange.[47] Under the new law, New Mexico residents who qualify shall have an income that is eligible for advanced premium tax credits under the Patient Protection and Affordable Care Act.[48]

Finally, the Superintendent of Insurance, in consultation with other relevant state agencies and consumer groups, is required to develop a plan for extending health care coverage access to uninsured New Mexico residents who do not qualify for federal premium assistance or, except by reason of incarceration, qualified health plans, through the New Mexico health insurance exchange.[49] The Superintendent of Insurance must submit a plan to the Legislature no later than June 30, 2022, that can offer health care coverage to eligible New Mexico residents beginning July 1, 2023.[50] The plan must include: (1) details about health care benefits; (2) health care affordability criteria designed to reduce the amount that individuals pay in premiums and out-of-pocket medical expenses under the plan and that result in, to the greatest extent possible, health care costs comparable to costs for New Mexico residents; and (3) income eligibility parameters that prioritize eligibility for New Mexico residents with incomes under two hundred percent (200%) of the federal poverty level.[51]

VII. Contingency Provisions

While the proposed legislation was under consideration, concerns were raised regarding potential future changes in federal law, including the complete repeal of the PPACA and the potential reinstatement of the HIT. In response to these concerns, the new law provides that if the PPACA is repealed in full or in part by an act of Congress or invalidated by the United States Supreme Court and eliminates or reduces comprehensive health care coverage for New Mexico residents through Medicaid or the New Mexico health insurance exchange, the Fund may be used to maintain coverage through the New Mexico health insurance exchange or through medical assistance programs administered by HSD, provided that coverage is prioritized for New Mexico residents with incomes below two hundred percent (200%) of the federal poverty level.[52] In addition, while the possibility of reinstatement of the HIT is subject to debate, the new law addressed this potential reinstatement. The new law provides that if an Act of the United States Congress is signed into law that imposes the annual fee on health insurance providers pursuant to Section 9010 of the PPACA, or that imposes a substantially similar fee on the same class of taxpayers, the rate of the health insurance premium surtax shall be decreased at a rate equal to the rate of the annual fee imposed.[53] A reduction in the health insurance premium surtax shall go into effect on the later of the effective date of the imposition of the federal annual fee or ninety days after the congressional Act imposing the federal annual fee is signed into law.[54]

VIII. Conclusion

While the goal of increasing health insurance coverage is an admirable and worthy pursuit, it remains to be seen whether the imposition of the highest premium tax in the United States on less than twelve percent (12%) of New Mexicans is the correct approach to accomplishing this goal. There were sound reasons for the repeal of the HIT at the federal level, and the conversion of the federal tax to a state tax does not relieve the concerns that prompted the federal repeal. The new law requires the Superintendent of Insurance to develop and report on performance measures relating to the Fund and provide actuarial data from the Fund to the Legislature. Time, and the New Mexico Legislature, will tell whether New Mexico is on the right path to increasing health insurance coverage.

[1] S.B. 317, 55th Leg., 1st Sess., Chap. 136 (N.M. 2021). While the original proposal in SB317 was to remove all cost sharing for behavioral health services, the new health care affordability fund (introduced as HB122) was amended into SB317 on the House floor near the end of the legislative session. While the new health care affordability fund proposal was approved by the full Senate on a concurrence vote, the proposed new fund was never heard in a Senate committee.

[2] *Id.* § 11.

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9010, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act, Pub. L. 111-152, 124 Stat. 1029 (2010).

[4] CONG. BUDGET OFF., AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT., at 15-16 (2009).

[5] SUZANNE M. KIRCHHOFF, CONG. RSCH. SERV., PATIENT PROTECTION AND AFFORDABLE CARE ACT: ANNUAL FEE ON HEALTH INSURERS, (Dec. 12, 2013).

[6] Micah Hartman et al., *National Health Care Spending In 2018: Growth Driven By Accelerations In Medicare And Private Insurance Spending,* COSTS & SPENDING, CMS Off. of the Actuary, Dec. 5, 2019, at 8.

[7] Further Consolidated Appropriations Act of 2020, H.R. 1865, 116th Cong. § 501(a)-503(a) (2020).

[8] *Id.; see also Affordable Care Act Provision 9010 – Health Insurance Providers Fee,* I.R.S. Pub., https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

[9] COLO. REV. STAT. ANN. § 10-16-1205(1)(a)(I) (West 2020).

[10] COLO. REV. STAT. ANN. § 10-16-1205(1)(b)(I)-(V) (West 2020).

[11] DEL. CODE. ANN. tit. 18, § 8703(b) (West 2019).

[12] DEL. CODE. ANN. tit. 18, § 8701(3) (West 2019).

[13] DEL. CODE. ANN. tit. 18, § 8702(b)-(c) (West 2019).

[14] DEL. CODE. ANN. tit. 18, § 8703(a), (h) (West 2019).

[15] Delaware Dept. of Ins., Domestic and Foreign Insurers Bull. No. 113, https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/12/domestic-foreign-insurers-bulletin-no113.pdf.

[16] MD. CODE ANN., INS. § 6.102.1 (West 2020).

[17] MD. CODE ANN., INS. § 6.102.1(a)(1) (West 2020).

[18] MD. CODE ANN., INS. § 6.102.1(c)(2) (West 2020).

[19] MD. CODE ANN., INS. § 6.102.1(a)(2) (West 2020).

[20] Md. CODE ANN., INS. § 6.102.1(b) (West 2020).

[21] N.J. STAT. ANN. § 17B:27A-66 (West 2021).

[22] N.J. STAT. ANN. § 17B:27A-65 (West 2021).

[23] *Id.*

[24] N.J. STAT. ANN. § 17B:27A-67(a) (West 2021).

[25] *Id.*

[26] N.J. STAT. ANN. § 17B:27A-65 (West 2021).

[27] David R. Scrase, M.D., & Nicole Comeaux, J.D., M.P.H., Hum. Serv. Dept. (presentation to Legislative Health and Human Services Committee, Sept. 4 2020), p. 22, https://www.nmlegis.gov/handouts/LHHS%20090420%20Item%201%20A%20MAD%20Comeaux.pdf.

[28] *Id.*

[29] *Id.*

[30] *Id.*

[31] *Health Insurance Coverage of the Total Population, N.M.,* KAISER FAMILY FOUNDATION (2019), Health Insurance Coverage of the Total Population | KFF.

[32] *Id.*

[33] Russell Toal, Off. of Superintendent of Ins. (presentation of Superintendent of Insurance to Legislative Health and Human Services Committee, Sept. 4, 2020), p. 5, https://www.nmlegis.gov/handouts/LHHS%20090420%20Item%203%20OSI%20Toal.pdf.

[34] N.M. STAT. ANN. § 7-40-3(A), (D) (2018) (*amended by* 2021 N.M. Laws Ch. 65 (H.B. 98).

[35] S.B. 317, § 2(E), 55th Leg., 1st Sess. (N.M. 2021).

[36] NAIC, *Retaliation: A Guide to State Retaliatory Taxes, Fees, Deposits and Other Requirements,* Vol. 1 (Dec. 2020), https://content.naic.org/sites/default/files/publication-ret-zu-retaliation-volume-one.pdf.

[37] LFC, Fiscal Analysis Report, S.B. 317 (Apr. 2021), p. 10, https://www.nmlegis.gov/Sessions/21%20Regular/firs/SB0317.PDF.

[38] 42 C.F.R. § 433.68(b) (2008).

[39] *Id.*

[40] 42 C.F.R. § 433.55(a) (2008).

[41] 42 C.F.R. § 433.68(c)(1) (2008).

[42] LFC, Fiscal Analysis Report, S.B. 317 (Apr. 2021), https://www.nmlegis.gov/Sessions/21%20Regular/firs/SB0317.PDF.

[43] *Id.*

[44] S.B. 317, § 3(B), 55th Leg., 1st Sess. (N.M. 2021).

[45] S.B. 317, § 4(A), 55th Leg., 1st Sess. (N.M. 2021).

[46] S.B. 317, § 5(A)(1), 55th Leg., 1st Sess. (N.M. 2021).

[47] *Id.*

[48] S.B. 317, § 5(A)(2), 55th Leg., 1st Sess. (N.M. 2021).

[49] S.B. 317, § 5(B), 55th Leg., 1st Sess. (N.M. 2021).

[50] *Id.*

[51] *Id.*

[52] S.B. 317, § 3(C), 55th Leg., 1st Sess. (N.M. 2021).

[53] S.B. 317, § 2(F), 55th Leg., 1st Sess. (N.M. 2021).

[54] *Id.*

UPDATE ON SURPRISES IN EMERGENCY MEDICAL CARE AND OTHER SURPRISE MEDICAL BILLS

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The end of an era of nasty surprises for consumers of emergency medical care, and of surprise medical bills, is at hand. The terms "surprise medical bill" or "balance bill" describe charges arising when an insured patient receives care from an out-of-network provider.[1]

When I last surveyed the state of play in all fifty states in my article entitled ***Review of the States' Surprise Billing Laws and Efforts to Find an End to Surprise Billing in New York and on the Federal Level***, published in The FORC Summer Journal, August 2020[2], I noted that in 2017, researchers had found more than half the states did not have any laws in place protecting consumers from balance billing and only six states had comprehensive balance billing statutes. 18 months later, in February 2020, at the cusp of our national COVID-19 nightmare, the experts at the Georgetown University Center for Health Insurance Reform (CHIR) found that just nine states had comprehensive consumer protection laws against surprise billing: **NY, CA, OR, FL, IL, NJ, VT, DE and CT**.

Moreover, four states—**Arizona, Maine, Minnesota and Oregon**—had adopted their first-ever balance billing laws during the 2018 session.[3]

Until recently, no Federal law currently limited "balance bills" or "surprise bills" but just over half the states had enacted laws to protect enrollees from them, to some degree.[4]

Now, thanks to a new Federal bill, officially medical providers will be prohibited from charging out-of-network rates for emergency and ancillary services, such as anesthesiology, delivered during scheduled procedures at in-network facilities.

In the final days of the 116th Congress, legislation was passed containing COVID-19 relief and fiscal year 2021 government funding. The bill, officially titled as a bill "To amend title XXVII of the Public Health Service Act to protect health care consumers from surprise billing practices, and for other purposes" (hereafter referred to as the "No Surprises Act" or the Act"), is scheduled to take effect in 2022. The Act provides new guidelines for private insurers. The No Surprises Act was the result of months-long negotiations between House and Senate leadership. While 32 states already have legislation that deals with surprise billing practices, the new federal provisions apply to markets not controlled by the states. How states will be impacted continues to be evaluated.

Under the Act, health plans will be required to hold patients harmless from surprise medical bills, and patients will be required to pay only the "in network cost-sharing for out-of-network emergency care or certain services performed by out-of-network providers at in-network facilities. A patient's in-network payments for out-of-network surprise bills will go toward the patient's in-network deductible. Examples of cost-sharing can include copayments, coinsurance and deductibles.[5]

Although more than two dozen states have passed laws to regulate surprise medical billing, they exclude self-funded insurance plans favored by large employers.

Out of Network Rates

So, what will happen to claims with out-of-network rates and how will they be paid? Providers and payers will have a 30-day negotiation period to settle. If they cannot reach a negotiated agreement, the parties can use a binding arbitration process, also known as independent dispute resolution (IDR), where one offer prevails. Processes will be administered by independent, unbiased entities with no affiliation to the providers or payers. The administrators must consider the market-based median in-network rate, along with other relevant information provided by the parties. Following the IDR, the party who initiated the process may not take the same party or parties back to resolution for the same item or service for 90 days following a decision.[6]

When it comes to out-of-network providers and facilities, both will be prohibited from sending patients surprise medical bills for more than the in-network cost-sharing amount. Certain out-of-network providers will also be prohibited from surprise billing patients unless they give the patient notice of their network status. Providers will have to provide patients an estimate of the charges they will receive 72 hours prior to receiving out-of-network care. Patients will have to provide consent to receive the care, and if an appointment is made within a 72-hour window, a patient must receive the notice the day the appointment is made and be asked for consent to receive care.

In addition, a group or individual health plan will be required to include on their plan or insurance identification card issued to the enrollee the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations.[7]

About 42% of inpatient admissions had at least one claim submitted by an out-of-network doctor in 2016, up from 26% in 2010, according to a study published in the medical journal JAMA Internal Medicine. Out-of-network costs also rose over that period, from an average of $804 to $2,040.[8]

Air Ambulance Billing

Under the Act, patients are held harmless from surprise air ambulance medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances (including attributing the bill to the in-network deductible).

Air ambulances are barred from sending patients balance bills for more than the in-network cost-sharing amount.

- The Act provides for a 30-day open negotiation period for air ambulance providers and issuers to settle out-of-network claims.
- If the parties are unable to reach a negotiated agreement, they may access a baseball-style, binding arbitration – referred to as Independent Dispute Resolution (IDR).
- If a bill goes to IDR, the IDR entity is required to consider the market-based median in-network rate, as well as information brought by the parties related to the training, experience, and quality of the provider, location where the patient was picked up and the population density of that location, the air ambulance vehicle type and medical capabilities, extenuating factors such as patient acuity

and the complexity of furnishing the item or service, demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement, prior contracted rates during the previous four plan years, or other information submitted by the parties.[9]

- Finally, providers of emergency air medical services are required to submit to a group health plan or health insurance issuer offering group or individual health insurance coverage, together with an electronic claims transaction with respect to an enrollee in such plan or coverage, a description of charges for such services that are separated by—

  (1) the cost of air travel; and

  (2) the cost of emergency medical services and supplies.

In Conclusion

Although more than two dozen states have passed laws to regulate surprise medical billing, they exclude self-funded insurance plans favored by large employers. Those plans, which are regulated by federal law, cover more than 60% of people with private insurance.

When the new No Surprises Act takes effect, disputes over these bills will be settled between the insurer and medical provider, and if both parties can't agree, the case will go to arbitration. How arbitrators rule will likely affect health insurance premiums. The Congressional Budget Office predicts that the new law could reduce premiums up to 1% as some not knowing whether the in-network surgeon selected for the procedure will be using an out--of -network anesthesiologist, as one example. Clearly, the new Federal law has potential to reduce the degree of anxiety experienced by patients scheduled to undergo surgery.

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[1] Out-of-network billing appears to have become common for privately insured patients even when they seek treatment at in-network hospitals. The mean amounts billed appear to be sufficiently large that they may create financial strain for a substantial proportion of patients. https://pubmed.ncbi.nlm.nih.gov/31403651/

[2] https://www.forc.org/Public/Journals/2020/Articles/Summer/Vol31Ed2Article5.aspx

[3] https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

[4] https://www.kiplinger.com/personal-finance/insurance/health-insurance/602648/no-surprises-act-everything-you-must-know#:~:text=With%20the%20No%20Surprises%20Act,care%20and%20other%20ancillary%20services.&text=Instead%2C%20doctors%20will%20need%20a,out%2Dof%2Dnetwork%20rate

[5] https://www.ncsl.org/research/health/congress-passes-surprise-medical-billing-legislation-magazine2021.aspx

[6] Id.

[7] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/No%20Surprise%20Act%20Section-by-Section%2012-11-20.pdf

[8] https://jamanetwork.com/journals/jama/article-abstract/2776697 (sections 105-106 summarized)

[9] Id

DIVIDED WE STAND

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American states have risen to the challenge. Faced with a decided advantage that re/insurers have to shed books of business under Part VII of the UK's Financial Services and Markets Act, and responding to requests by US re/insurers for a similar mechanism, the American states have enacted a variety of legislative approaches to enable such transactions in the US.

The two leading alternatives are insurance business transfers and divisions. Oklahoma took an early lead in approving the first transfer in an intra-group transaction, and Illinois most recently approved the inaugural US division, also in an intra-group transaction.[1] In each instance, the two states developed template materials, procedural protocols, and easily accessed dedicated websites to facilitate further transactions.

The purpose of this article is to provide an overview of the Illinois transaction for practitioners.

The Illinois Division Law[2]

The Department developed a dedicated website[3] which provides helpful "Guidance Regarding Domestic Stock Company Division Law," including FAQs which explain that:

- The Division Law applies to all lines of insurance business;
- In order to effect a Division, an applicant must file a division plan with the Illinois Department of Insurance (Department) that incorporates all relevant details, including, but not limited to, the names of the Dividing[4] and Resulting Companies, their respective proposed (new or revised) organizational documents, how Assets and Liabilities (including, but not limited to, Capital and Surplus) will be allocated between or among the Resulting Companies, the manner of distributing to the Dividing Company and/or other owners the Shareholder interests in the New Companies, and a reasonable description of Policies, Policy Liabilities, reinsurance contracts, or other property to be allocated to each Resulting Company. The Division Law contains provisions that protect the confidentiality of information submitted;[5]
- A hearing is required only if the Director of the Department (Director) deems it to be in the public interest or if it is requested by the Dividing Company;
- In order to approve a plan, the Director must find (among other things) that each New Company (except a New Company that is a non-surviving party to a merger) is eligible to receive a license to do insurance business in Illinois and in each state where Policies to be allocated to it were written by the Dividing Company; and
- Allocation of a Policy or Liability will not either (i) affect the rights or obligations of a policyholder, except those rights only will be available against the Resulting Company responsible for the Policy or Liability, or (ii) release any reinsurer, surety or guarantor of such Policy or Liability.

The Allstate Transaction

Eight Illinois-domiciled members of the Allstate group underwrote auto liability policies in Michigan and were members of the Michigan Catastrophic Claims Association. On February 2, 2021, they each filed a plan of division with the Department in order to effect a transition of certain specified inactive policies with outstanding claims into eight New Companies which would then merge into three Resulting Companies, one of which would reinsure the other two. They also made requisite filings with the Michigan Department of Insurance and Financial Services and requested a hearing.

The Department retained outside practitioners experienced in legacy transactions, including a project manager (Luann Petrellis), an independent consulting actuarial expert (Risk & Regulatory Consulting), and legal counsel (DLA Piper LLP (US)) to assist. This team and Department staff (under the leadership of Chief Dep. Dir. Shannon Whalen) expended more than 2000 hours on the evaluation of preliminary filings, drafts of the final versions of the division applications (relying upon the Department's existing analysis and examination processes), as well as developing division best practices and repeatable processes. The Acting Director also appointed a retired Illinois Appellate Court Justice and former Circuit Court (trial) Judge, May Anne Mason, to serve as hearing officer.

Meanwhile, counsel for the Applicants and in-house counsel at Allstate worked virtually around the clock for months to develop all of the transactional documents and regulatory filings necessary to effectuate the transaction.

Pre-Hearing Preparation

The Applicants and the Department jointly (but at arms' length) developed a procedure for notice, comment and hearing, as well as a communication plan for sending written notice to each policyholder and each person with an outstanding claim under the specified policies and for publishing notice in Illinois and Michigan newspapers of general circulation. Notice also was provided to the Illinois and Michigan guaranty funds, the National Conference of Insurance Guaranty Funds, and the Michigan Catastrophic Claims Association (MCCA). The notices provided background information on the proposed division, included contact information for the Department, and advised of the right to appear, object, and/or intervene in the hearing.

Due to the COVID-19 pandemic, counsel for the Applicants and the Department worked cooperatively (at arms' length) to prepare for a virtual hearing. They developed a Stipulated Virtual Hearing Protocol, the Applicants retained FTI to facilitate and manage the hearing, and the Department posted all non-confidential transaction-related material on its website.

Pre-hearing status conferences with the Hearing Officer resulted in the Applicants submitting pre-filed testimony, along with a jointly developed list of exhibits. The Applicants and the Department also submitted Proposed Findings, Conclusions of Law, and Recommendations to the Hearing Officer.

No objections or petitions to intervene were filed.

The Hearing

Justice Mason opened the hearing at 9 a.m. on March 3, 2021. A court reporter recorded welcoming remarks by Department COO Kevin Fry[6] and the Hearing Officer's preliminary remarks setting the agenda for the hearing. In addition to the parties, their representatives, and witnesses, a number of participants identifying themselves as members of the public appeared for the Hearing, including lawyers, regulators, guaranty association representatives, and experienced legacy transaction counterparties.

Allstate made an opening statement, and then presented live testimony from Allstate SVP and Treasurer Michael Padraja. He summarized the business reasons for the division and described the four main transaction steps:

(1) commutation of the existing reinsurance relationship between Allstate Insurance Company and the Dividing Companies;

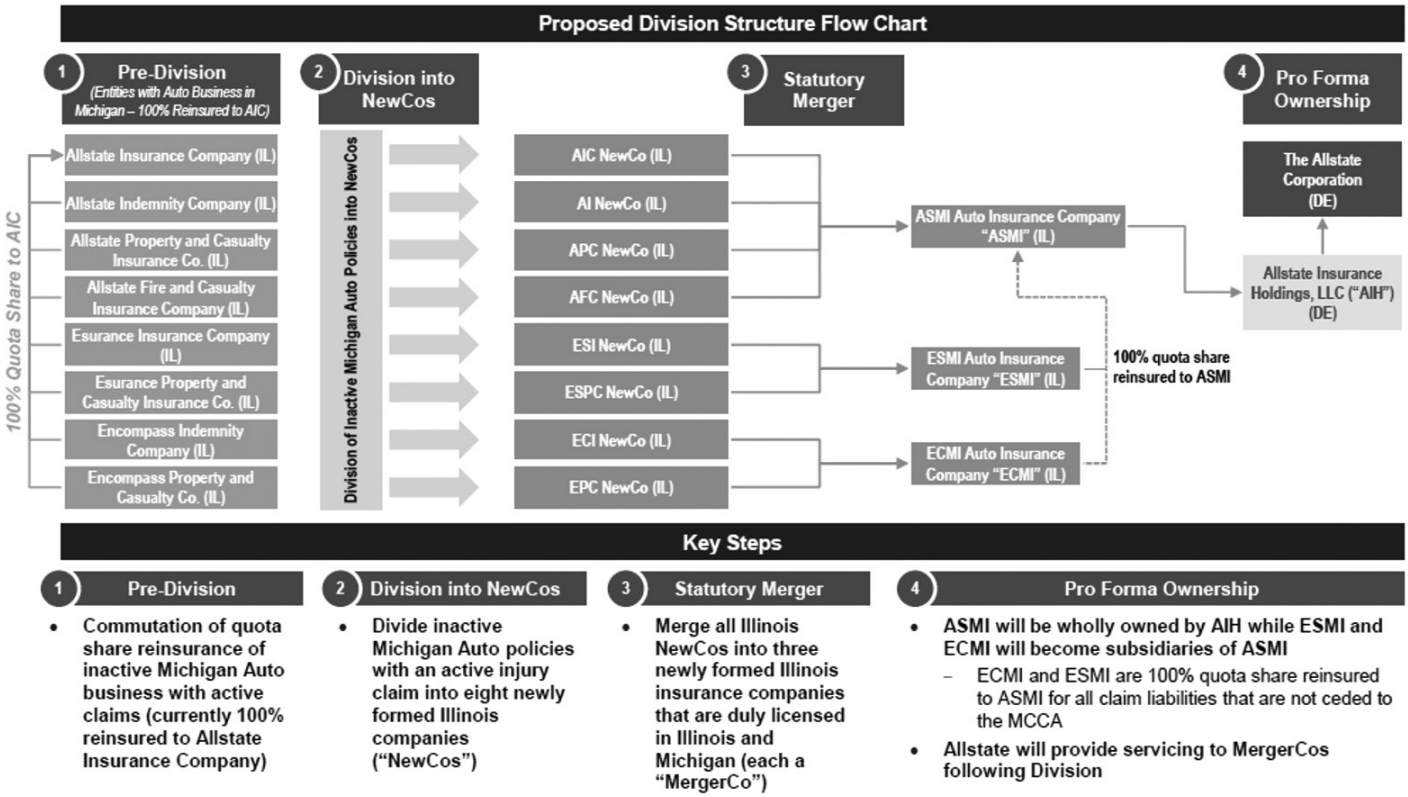
(2) division of each of the Dividing Companies into Surviving and New Companies and allocation of assets, liabilities including MCCA obligations), contracts, and required surplus to each;

(3) simultaneous merger of the eight New Companies into the three Merger Companies (representing three main brands of Allstate, Encompass, and Esurance), and the passing to the New Companies by operation of law of allocated assets, liabilities, contracts, and required surplus; and

(4) 100% cession from two of the Merger Companies of their insurance liabilities to the third.

The following diagram depicts the various steps of the proposed restructuring:

Figure A:



The Applicants also presented live testimony from independent financial expert Joseph Cassanelli, Managing Director and Co-Head, Financial Institutions (North America) for Lazard, Frères & Co. LLC, who testified to the fairness of the transaction and satisfaction of the financial requirements of the Division Law. The Department cross examined both witnesses.

The Department then presented its opening statement and live testimony from Chief Dep. Dir. Whalen. She explained that the Department focused significant analysis on the Merger Companies. She also described information that the Department considered important: (i) claims would continue to be managed by the same Allstate entity; (ii) the Merger Companies would become parties to existing Allstate intercompany agreements (investment management, service and expense, tax sharing, and tax settlement); and (iii) the Merger Companies could not pay dividends to its shareholders for five years without Director approval. She also described the Department's evaluation of the adequacy of the New Companies' loss and LAE reserves and initial capital, the four transaction steps described above, and the protection of (and lack of adverse impact on) policyholders and claimants.

At the close of the evidentiary portion of the Hearing, the Hearing Officer afforded members of the public attending the Hearing, either online or by telephone, the opportunity to raise objections, make comments, or ask questions. No one indicated that they wished to be heard. After hearing closing arguments from counsel, the Hearing was closed and the Applicants' request that the Hearing Officer recommend approval of the Plans of Division to the Director was taken under advisement.

Approval

In her Findings, Conclusions and Recommendations, the Hearing Officer summarized the applicable statutory

requirements and the evidence establishing the Applicants' satisfaction of them. In particular, she found no evidence of a violation of the Uniform Fraudulent Transfer Act; *i.e.*, (i) that the allocation of assets and liabilities was not made with intent to hinder, delay, or defraud any creditor; (ii) the assets would not be unreasonably small in the relation to the Resulting Companies' business; (iii) the Resulting Companies did not intend to incur debts beyond their ability to pay as such debts come due; and (iv) the Resulting Companies would not be or become insolvent upon finalization of the transactions.

The Hearing Officer concluded that timely, good, sufficient and appropriate notice and an opportunity to be heard had been provided; due process had been accorded to all; the Director and the Hearing Officer had subject matter and personal jurisdiction over the parties, policyholders, and claimants; all requirements had been satisfied to effect a transition by operation of law of all assets, liabilities, and contracts associated with the Specified Policies; and treatment of the Merger Companies as the "original insurers" of the Specified Policies would apply to all contractual rights, obligations, and liabilities, and ensure seamless application of regulatory law.

On March 5, 2021, on these bases, the Hearing Officer further concluded that the plans comport and comply with the statutory requirements and recommended that the Director approve the plans and enter an order consistent with such bases. The Director did so by Final Orders dated March 19 and 31, 2021, conditioned upon execution of the plans according to their terms, conditions, and covenants; receipt by the Department of all specified material and information; and receipt from the Michigan DIFS of the requisite licenses to transaction the business of insurance in Michigan.

Observations

Many insurers operating in the US support insurance business divisions or transfers. Some lines of legacy business will continue challenge regulators for decades and may benefit from the broad resolution flexibility that insurance business division and transfer are intended to provide. Guaranty associations have challenged certain iterations of resulting legislation, and regulators have focused appropriate attention on the issues. Long-term care insurance is the latest line of insurance in need of a long-term solution and may well benefit from business division. Pricing and reserving practices appear to have sufficiently evolved to cover the underlying liabilities. We could well be in the advent of significant transactional activity. We encourage legacy business practitioners to study the Allstate transaction as one form of successful business division model.

As demonstrated above, the Illinois Division Law proved to be a nimble regulatory apparatus for legacy transactions. While there could be many reasons for the lack of objections, it appears that the many knowledgeable observers of the hearing concluded that appropriate regulatory oversight by experienced professionals had been exercised in respect of a well-known and trusted insurer group.

[1] The author represented the Director of the Illinois Department of Insurance and the Department in the matter. The views expressed in this article are solely the author's.

[2] 215 ILCS 5/35B-1 *et seq*.

[3] https://insurance.illinois.gov/Hearings/ConsumerHearing.html

[4] Initially capitalized terms are as defined in the Division Law.

[5] For example, 215 ILCS 5/35B-25(f) states:

> All information, documents, materials, and copies thereof submitted to, obtained by, or disclosed to the Director in connection with a plan of division or in contemplation thereof, including any information, documents, materials, or copies provided by or on behalf of a domestic stock company in advance of its adoption or submission of a plan of division, shall be confidential and shall be subject to the same protection and treatment in accordance with Section 131.14d as documents and reports disclosed to or filed with the Director pursuant to Section 131.14b (Enterprise Risk Filing) until such time, if any, as a notice of the hearing is issued.
>
> From and after the issuance of a notice of the hearing (a) all business, financial, and actuarial information that the domestic stock company requests confidential treatment, other than the plan of division, shall continue to be confidential and shall not be available for public inspection and shall be subject to the same protection and treatment in accordance with Section 131.14d as documents and reports disclosed to or filed with the Director pursuant to Section 131.14b.

[6] COO Kevin Fry oversaw the Allstate transaction for the Department.

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