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STATES TARGET MEDICAID FRAUD IN THE PHARMACEUTICAL INDUSTRY

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Introduction

Medicaid is the jointly funded state-federal health care program for low-income families, the elderly, and people with disabilities. It pays for acute health care (physician, inpatient, outpatient, pharmacy, lab, and X-ray services), as well as long-term care for the aged and disabled. The federal government funds approximately 61 percent of the cost of the Texas Medicaid program. In Texas, fiscal year 2005 Medicaid expenditures (both state and federal) comprised 25.5% (about $16.6 billion) of all state expenditures. **1**

The Texas Medicaid program covers most outpatient prescription drugs through the Vendor Drug Program. Medicaid participants obtain their prescription drugs at over 4,000 pharmacies that have contracted with the Vendor Drug Program. In state fiscal year 2005, the Texas Medicaid program paid $2.4 billion for over 37.9 million prescriptions, with an average cost per prescription of $63.73. **2**

To maintain the integrity of this massive spending program, the federal government oversees Medicaid Fraud Control Units (MFCUs) in 48 states and the District of Columbia. Forty-two of the state MFCUs are located within Offices of the State Attorneys General. MFCUs investigate and prosecute Medicaid provider fraud and attempt to recover overcharges for the Medicaid program. In federal fiscal year 2006, State Medicaid Fraud Control Units (MFCUs) recovered more than $1.1 billion in court-ordered restitution, fines, civil settlements, and penalties. **3**

The Texas Medicaid Fraud Statutory and Regulatory Scheme

In 1995, Texas adopted its own version of the federal False Claims Act called the Texas Medicaid Fraud Prevention Act. **4** The Act defines several "unlawful acts," including if a person:

• knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;
• knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized; or
• knowingly makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning . . . information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program. **5**

In recent litigation by the Texas Attorney General's office, discussed in detail below, these provisions have been applied to certifications made by pharmaceutical manufacturers to qualify for reimbursement under the Texas Medicaid program.

In order to qualify for reimbursement through the Texas Vendor Drug Program, pharmaceutical manufacturers must complete a questionnaire for each drug and file it with the Medicaid program in order to get the drug

listed on the Texas Drug Code Index. [6] Texas is the only state in the country that requires drug companies to certify the prices of their drugs; most other states rely on published pricing data from private sources like First Data Bank. For each drug, the Texas certification requires the drug companies to report the suggested wholesale price to pharmacies, the price to wholesalers and distributors, the direct price to pharmacies, the price to chain warehouses, and the price for which the drug is sold to any other special purchasing groups. Texas also requires the drug companies to report subsequent changes in pricing within 15 days of any change. The Vendor Drug Program uses the pricing information reported by manufacturers to calculate the amount of reimbursements paid to pharmacies by estimating the pharmacies' acquisition cost (Estimated Acquisition Cost or EAC). [7]

Violators of the Texas Medicaid Fraud Prevention Act are liable to the state for damages, prejudgment interest, civil penalties, attorneys' fees and costs, and injunctive relief. [8] Penalties can be steep; the Act provides for civil penalties of two times single damages, plus a penalty of between $5,000 and $10,000 for each unlawful act (or between $5,000 and $15,000 for each unlawful act that results in injury to an elderly or disabled person, or to a minor). [9]

In 1999, then Texas Attorney General John Cornyn created a Civil Medicaid Fraud Section within the Attorney General's Office. Initially, the section was formed to pursue all types of fraud against the Medicaid program, including fraud by doctors, hospitals and other providers who had engaged in false billing, false cost reporting and overbilling activities. But whistle blowers soon presented the section with evidence that pharmaceutical manufacturers had engaged in "significant fraud in amounts which dwarfed the cases against other providers." [10]Accordingly, the section devotes most of its resources to pursuing those cases with the potential to recover the most money for the Medicaid program - qui tam lawsuits against pharmaceutical manufacturers.

Medicaid Fraud Litigation in Texas: The Ven-A-Care Cases

In September 2000, Texas became the first state to intervene in a qui tam case involving pharmaceutical manufacturer pricing with the unsealing of its complaint against Warrick Pharmaceuticals, Dey Laboratories, and Roxane Laboratories. [11] Since then, the Texas Attorney General has sued a total of nine pharmaceutical manufacturers for falsely inflating prices charged to the Medicaid Vendor Drug program. In all nine of those cases, the state intervened in a qui tam case brought to the state by a whistle blower called Ven-a-Care of the Florida Keys, Inc., a small Florida pharmacy. The Texas Medicaid Fraud Prevention Act establishes procedures for the initiation of an action under seal by private persons (the "qui tam plaintiff" or "relator") in their own name as well as of the state, assuming they are the original, non-public source of the information on which the allegations in the lawsuit are based. [12] The state may intervene in the case and unseal the case. The qui tam plaintiff is entitled to a percentage of the recovery (including any settlements) obtained by the state in the action. [13]

Ven-A-Care brought information to the Attorney General's office showing that certain drug manufacturers intentionally reported prices to the Texas Medicaid Program that differed unreasonably from the market price for their products. [14] The reporting of inflated prices causes the Medicaid Vendor Drug Program to miscalculate providers' Estimated Acquisition Cost and results in the payment of artificially inflated reimbursements to pharmacies. The difference between what a pharmacy pays for a drug and the amount Medicaid reimburses is called the "spread." The Attorney General's office has alleged that some pharmaceutical manufacturers have marketed their products to their customers based on the amount of the spread. For example, the Attorney General's office reported that a manufacturer created spreadsheets showing pharmacies how much additional profit could be made by comparing the spread on different products. [15]

So far, Texas has recovered over $64 million from four of the nine defendants in these cases. The Attorney General's first lawsuit, filed in September 2000, sought $79 million ($20 million in overpayments, and over $58 million in penalties) from three defendants: Dey, Inc.; Roxane Laboratories, Inc., and Warrick Pharmaceuticals Corporation (a subsidiary of Schering-Plough Corp.). The Attorney General's lawsuit alleged that these defendants falsely reported inflated drug prices to the Texas Medicaid program for their respiratory medications, including albuterol and ipratropium bromide, and marketed the "spread" to pharmacies to increase their market share. In June 2003, Dey, Inc. settled the case, agreeing to pay $18.5 million. **16** In May 2004, Schering-Plough and Warrick agreed to pay $27 million to the state and federal government to settle the case against them. **17** The settlement represented approximately two times the damages suffered by the Medicaid program as a result of the defendants' unlawful acts, plus attorneys' fees and costs. **18** Roxane Laboratories, the remaining defendant in the Sept. 2000 suit, finally settled in November 2005, agreeing to pay $10 million. **19**

In May 2004, the Attorney General unsealed its second Ven-A-Care lawsuit, this time naming Abbott Laboratories Inc., Baxter Healthcare Corp., and B. Braun Medical Inc. as defendants. **20** The lawsuit alleged that the defendants deliberately and falsely reported inflated wholesale prices of intravenous fluids to the Medicaid program. The Attorney General sought three times actual damages (estimated at $8 million), plus civil penalties, attorneys' fees and costs. **21** Baxter settled for $8.5 million in June 2006; the state in turn paid approximately $3.7 million of that amount to the federal government for its share of the recovery. **22** The litigation against the other two defendants is ongoing.

The Attorney General's most recent civil Medicaid fraud lawsuit was announced June 20, 2007. It is another Ven-A-Care qui tam suit, and the defendants are Mylan Laboratories Inc., Sandoz Inc., and Teva Pharmaceuticals USA, Inc., and their respective subsidiaries. **23** The attorney general's petition alleges that these defendants reported false or misleading price and cost information and concealed price reductions, causing the Texas Medicaid program to pay excessive reimbursements. **24** That litigation is ongoing.

More Litigation to Come: Texas Legislature Expands Medicaid Fraud Resources

The Texas legislature recognized that the Texas Attorney General's office has a significant backlog of Medicaid fraud cases that have not been pursued for lack of resources. As described above, with a staff of only ten attorneys, the Civil Medicaid Fraud Section of the Texas Attorney General's office has recovered approximately $72 million for Texas since 1999. **25** According to the state, the Civil Medicaid Fraud section has over 150 pending cases and investigations on its docket. **26** During the 2007 legislative session, Attorney General Greg Abbott told legislators that the top 20 of those cases could recover $700 million for the state. **27**

Accordingly, the Texas legislature recently dramatically increased funding for Medicaid fraud enforcement actions. From the fiscal year 2004 to the fiscal year 2009, the appropriations to the Attorney General for the investigation and referral for prosecution of Medicaid fraud has seen a percentage increase of over 550 percent (from $2,179,216 in fiscal year 2004 to $14,466,207 in fiscal year 2009). **28** This, despite an overall Attorney General budget increase of just over 18 percent ($413,321,371 in 2004 to $490,103,986 in 2007). **29** From fiscal year 2006 to fiscal year 2009, the increase for Medicaid fraud investigation and referral for prosecution is over 30 percent (from $10,891,555 to $14,466,210). **30** These increases in funding have led to, and will continue to fuel, a surge in enforcement action. Since the first half of fiscal year 2004, the number of criminal cases opened has grown from 134 in 2004, to 359 in the first half of fiscal year 2007; the number of cases presented for prosecution for each period increased from 57 to 169, and convictions increased from 12 to 31. **31** The MFCU pending caseload has increased from 353 to 1239; and the amount of overpayments has jumped from $13.4 million to over $29.1 million in the same time period. **32** The Civil Medicaid Fraud Section will be adding approximately 40 new employees, nearly tripling the number of lawyers available to tackle the backlog of pending Medicaid fraud cases.

Another important Medicaid fraud related bill passed during the 80th Legislative Session in 2007 was Senate Bill 362. 33 Applicable to conduct that occurs after May 4, 2007, the bill amended Texas' qui tam provisions to allow the state to receive a ten percent increase in recovered Medicaid overpayments filed under state law that would otherwise go to the federal government. The bill was passed in response to the Federal Deficit Reduction Act of 2005 ("DRA") which allows states to keep an additional ten percent of recovered Medicaid overpayments if the state passes Medicaid fraud provisions which meet certain federally mandated standards. Following the passage of the DRA, the Attorney General and Inspector General of the Health & Human Services Commission submitted the Texas Medicaid Fraud Control Act for federal approval, only to be told by their federal counterparts that the Texas law did not meet the standards set forth by the DRA. To bring Texas into line with those standards, Senate Bill 362 implemented five changes. First, the minimum civil penalty for Medicaid fraud that does not result in the injury of a child, disabled, or elderly person was raised from $1000 to $5000. A change was also made to explicitly establish the standard of proof for proving each element of a false claim, including damages, at a preponderance of the evidence. The statute now also allows a plaintiff to continue bringing a false claim action without the state's participation, despite a determination that the state will not take over the action. Previously, Texas law required dismissal of the case when such a determination was made. The state also increased the minimum amount of proceeds of an action to which a person bringing a false claim action is entitled from 10 to 15 percent. Finally, the new law entitles a person who proceeds without the state's participation to 25 to 30 percent of the proceeds under certain conditions.

Similarly, Senate Bill 1694, effective on September 1, 2007, was designed to give the Attorney General more tools to effectively prosecute Medicaid abuse by health care professionals. The bill eases restrictions on the sharing of information between the MFCU and various agencies and licensing boards that maintain information regarding Medicaid fraud and abuse. Senate Bill 1694 does so by eliminating administrative obstacles while maintaining confidentiality requirements and legal restrictions imposed by law on the agency that originally obtained or collected the information. Additionally, the bill prohibits a provider, third party contractor, or a public servant from receiving a kickback for influencing the decision to choose a product or service provided by Medicaid. Also, the bill provides that it is an offense under the Medicaid fraud statute to knowingly obstruct an investigation by the Attorney General of certain alleged unlawful acts and amends the penalties for the offense of Medicaid fraud by providing that it is either a misdemeanor or state jail felony depending on the amount of the claim for payment made under the Medicaid program.

House Bill 889, effective September 1, 2007, adds actions under the Medicaid anti-kickback law to the list of violations under the Medicaid fraud statute. In doing so, this allows the Attorney General the option to recover civil fines and injunctive relief against those who commit Medicaid fraud through false claims and kickbacks, bribes, or rebates in connection with the Medicaid program.

Senate Bill 10 34 was an omnibus bill relating to medical assistance programs and other programs that provide health care benefits and services to Texans. Effective on September 1, 2007, with certain provisions becoming effective a year later, the bill contains a requirement that state hospitals compute the cost of uncompensated hospital care. If a hospital fails to report the cost of uncompensated care in a timely manner, the Texas Office of Attorney General must impose an administrative penalty on a hospital in the amount of $1,000 each day after a report is not submitted, not to exceed $10,000. The bill also mandates the Attorney General impose an administrative penalty not to exceed $10,000 if such a report is incomplete or inaccurate. In the case that such a penalty needs to be defended, the Attorney General may receive attorney's fees and court costs. Also, included in the bill is the implementation of a study to be made by the Texas Health and Human Services Commission ("HHSC") concerning the increased use of technology to strengthen fraud detection and deterrence. That study must include the determination of the feasibility of using technology to verify a person's citizenship and eligibility for coverage.

Medicaid Fraud Enforcement Activity Against Non-Pharmaceutical Providers

In addition to the increased enforcement activities in pharmaceutical related Medicaid fraud, the Texas Attorney General has also gone after a variety of non-pharmaceutical related Medicaid fraud. Examples of this type of fraud include billing for tests and other procedures that were never performed or falsifying patient diagnosis to justify unnecessary tests, transporting patients by ambulance when not medically necessary, misappropriation of patient trust funds, requiring vendors to kick back part of the money received for providing services to Medicaid patients, and billing for services already paid for by Medicaid.

Recently decided cases show a concentration of fraudulent Medicaid billing. In June 2007, a person pled guilty and was sentenced to six years in prison and made to pay restitution for her part in the illegal billing of Medicaid for counseling services that were never provided to Medicaid patients, while the defendant's husband pled guilty to similar charges in May 2007, resulting in probation and an order to pay restitution. **35** Also, in May 2007, two defendants each pled guilty to one count of Medicaid fraud for their part in fraudulently billing Medicaid $105,000 for adult diapers that were never provided to Medicaid patients. Another defendant pled guilty in the same month to illegally charging over $100,000 for incontinence supplies that were not provided to clients. **36** In terms of indictments in 2007, the MFCU of the Attorney General has been successful in receiving indictments from grand juries including charges of false billing schemes involving treatment and counseling sessions and charges of conspiring to commit health care fraud, money laundering and kickback schemes with physicians resulting from participation in a patient wheelchair delivery scheme. **37**

Conclusion

As states struggle to pay for Medicaid services, Medicaid Fraud enforcement will continue to be an important priority for state attorneys general. Texas has pioneered the use of its state false claims act to recoup tens of millions of dollars for its Medicaid program by partnering with private qui tam plaintiffs to litigate against pharmaceutical manufacturers. Other states are studying what Texas has done and amending their laws to take advantage of incentives in the Federal Deficit Reduction Act of 2005 through false claims act recoveries. Now that Texas has over five times more resources to prosecute Medicaid fraud cases, observers will be watching to see if the attorney general continues to make pharmaceutical pricing cases the primary focus, whether new types of fraud will be detected and prosecuted, and how much money will be recovered for the Medicaid program.

Endnotes

1. *Texas Medicaid In Perspective,* Sixth Ed., Texas Health and Human Services Commission, January 2007, p. 1-1.

2. *Id*., pp. 4-17, 4-18.

3. *State Medicaid Fraud Control Units Annual Report for Fiscal Year 2006*, Department of Health and Human Services, Office of the Inspector General.

4. Tex. Hum. Res. Code Ann. Chapter 36.

5. *Id*., at §§ 36.002(1), (2) and (4).

6. The Texas Medicaid Program pays only for approved pharmaceuticals listed on the Texas Drug Code Index. 1 Tex. Admin. Code § 355.8541. Tex. Admin. Code § 354.1921(b) requires drug companies to complete a questionnaire called "Request for Information for New Drug Product or for Additional Information of Products Currently Included in Texas Medicaid."

7. 1 Tex. Admin. Code § 355.8541(1).

8. Tex. Hum. Res. Code Ann. §§ 36.051 and 36.052

9. Tex. Hum. Res. Code Ann. § 36.052(a)(3) and (4).

10. Testimony of Patrick J. O'Connell, Chief, Civil Medicaid Fraud Section, Office of the Attorney General of Texas, before the U.S. House Committee on Oversight and Government Reform, February 9, 2007.

11. *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc. v. Warrick Pharmaceuticals Corporation, et. al.,* No. GV002327 (53rd Judicial Dist., Travis County, Tex. Sept. 2000).

12. Tex. Hum. Res. Code Ann. §§ 36.101 - 36.102; 36.113.

13. *Id.*, at § 36.110. Prior to the passage in 2007 of Senate Bill 362, discussed *infra*, qui tam plaintiffs were entitled to receive between 10 percent and 25 percent of the proceeds of the action, plus attorney's fees and costs. SB 362 increased the minimum amount to 15 percent. However, the court may reduce the award to less than 7 percent if it finds that the action is not based on information brought forward by the relator. *Id*. At 36.110(b).

14. Testimony of Patrick J. O'Connell, Chief, Civil Medicaid Fraud Section, Office of the Attorney General of Texas, before the U.S. Senate Committee on Finance, June 29, 2005, pp. 2-3.

15. *Id*., at p. 5.

16. Press Release, Office of the Attorney General, State of Texas (June 11, 2003), *available at* http://www.oag.state.tx.us/oagnews/release.php?print=1&id=68. Approximately half of the settlement went to the federal government, due to the fact that the federal government jointly funds the Medicaid program with the state.

17. Press Release, Office of the Attorney General, State of Texas (May 3, 2004), *available at* http://www.oag.state.tx.us/oagnews/release.php?id=453.

18. *Id.*

19. Press Release, Office of the Attorney General, State of Texas (November 28, 2005), *available at* http://www.oag.state.tx.us/oagnews/release.php?id=1273. Roxane Laboratories is a subsidiary of Boehringer Ingelheim Corp., which was also a party to the settlement.

20. *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc. v. Abbott Laboratories Inc., et. al*., No. GV401286 (201st Judicial Dist., Travis County, Tex. May 2004). See Press Release, Office of the Attorney General, State of Texas (May 26, 2004), available at http://www.oag.state.tx.us/oagnews/release.php?id=476.

21. *Id*.

22. Press Release, Office of the Attorney General, State of Texas (June 12, 2006), *available at* http://www.oag.state.tx.us/oagnews/release.php?id=1598.

23. *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc. v. Sandoz, Inc., et. al.*, No. D-1-GV-07001259 (201st Judicial Dist., Travis County, Tex. June 20, 2007). Press Release, Office of the Attorney General, State of Texas (June 20, 2007), *available at* http://www.oag.state.tx.us/oagnews/release.php?id=2066.

24. *See Plaintiff's First Amended Petition*, ¶ 7.1.

25. "Medicaid Fraud Backlog Catches Lawmakers' Eyes," Houston Chronicle, Feb. 17, 2007.

26. "Activities of the Health and Human Services Commission, Office of Inspector General and the Office of the Attorney General in Detecting and Preventing Fraud, Waste, and Abuse in the State Medicaid Program." Joint Semi-Annual Interagency Coordination Report, September 1, 2006 - February 28, 2007, at p. 8.

27. "Medicaid Fraud Backlog Catches Lawmakers' Eyes," Houston Chronicle, Feb. 17, 2007.

28. Figures taken from the budget bills of the HB 1, 78th Legislative Session, available at http://www.lbb.state.tx.us/Bill_78/7_FSU/Bill-78-7_FSU_1003.pdf and HB 1, 80th Legislative Session, available at http://www.lbb.state.tx.us/Bill_80/7_Conference/80-7_Conference_0507.pdf.

29. See *Id.*

30. Figures taken from the budget bills of the SB 1, 79th Legislative Session, available at http://www.lbb.state.tx.us/Bill_79/8_FSU/79-8_FSU_0905.pdf, and HB 1, 80th Legislative Session, available at http://www.lbb.state.tx.us/Bill_80/7_Conference/80-7_Conference_0507.pdf.

31. "Activities of the Health and Human Services Commission, Office of Inspector General and the Office of the Attorney General in Detecting and Preventing Fraud, Waste, and Abuse in the State Medicaid Program." Joint Semi-Annual Interagency Coordination Report, September 1, 2006 - February 28, 2007.

32. *Id.*

33. A copy of Senate Bill 362 as well as all other Texas legislation can be found through Texas Legislature Online at http://www.legis.state.tx.us/.

34. A copy of Senate Bill 10 as well as all other Texas legislation can be found through Texas Legislature Online at http://www.legis.state.tx.us/.

35. Press Release, Office of the Attorney General, State of Texas (June 12, 2007), *available at* http://www.oag.state.tx.us/oagNews/release.php?id=2055.

36. Press Release, Office of the Attorney General, State of Texas (May 23, 2007), *available at* http://www.oag.state.tx.us/oagNews/release.php?id=2029.

37. Press Releases, Office of the Attorney General, State of Texas (August 21, 2007), *available at* http://www.oag.state.tx.us/oagNews/release.php?id=2145 and (August 1, 2007), *available at* http://www.oag.state.tx.us/oagNews/release.php?id=2112.

MISREPRESENTATION AND RESCISSION OF INSURANCE CONTRACTS

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In today's hyper-litigious society, few insurers have escaped the challenge of bad faith litigation. Our insurance clients oftentimes find themselves facing allegations of bad faith and deceit relating to the denial of a claim for benefits made within the contestable period. Many states, Oklahoma included, have statutes relating to what constitutes "misrepresentation" of information contained in an application by a potential insured. Oklahoma's statute, 36 O.S. § 3609, allows an insurance company to avoid payment on a life insurance claim if the policy was issued based upon a material misrepresentation of a health condition by the insured.

The pertinent portion of Oklahoma's "misrepresentation" statute states:

A. All statements and descriptions in any application for an insurance policy or in negotiations therefore, by or on behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy unless:

1. Fraudulent; or
2. Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or
3. The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

This seemingly straightforward and innocuous statute has been the subject of a great deal of discussion and interpretation by Oklahoma courts in recent years, particularly in the life insurance area. Insurers should be mindful of the body of law which has resulted from courts interpreting this statute before refusing to pay benefits to an Oklahoma claimant based on misrepresentation in the application.

History of the Misrepresentation Defense and the Development of the "Intent to Deceive" Standard in Oklahoma

Prior to the enactment of 36 O.S. § 3609 in 1957, Oklahoma courts generally found that an insured's statements in his application for insurance had to be construed as "representations and not warranties." [1] The Oklahoma Supreme Court held that the untruth of any material representation relied on by the insurance company in making the contract would avoid the contract, wholly irrespective of the insured's intent, whether innocent or fraudulent, with which such misrepresentation was made. [2]

After the enactment of 36 O.S. § 3609, the first Oklahoma Supreme Court opinion dealing with the subject of an insurer avoiding payment of benefits to an insured based on a material misrepresentation was the 1965 case of *Massachusetts Mutual Life Insurance Co. v. Allen.* [3] According to the court, under 36 O.S. § 3609,

> A 'misrepresentation' in insurance is a statement as a fact of something which is untrue, and which the insured states with the knowledge that it is untrue and *with an intent to deceive*, or which he states positively as true without knowing it to be true, and which has a tendency to mislead, where such fact in either case is material to the risk. **4**

In its syllabus in *Massachusetts Mutual* concerning a discussion of the definitions of "omission" and "incorrect statement" the Court stated as follows:

> An "omission" in negotiations for a life insurance policy under 36 O.S. 1961 § 3609, is an *intentional omission* to disclose a fact or condition which is material to the acceptance of the risk or the hazard assumed....(emphasis supplied).
>
> An "incorrect statement" in negotiations for a life insurance policy under 36 O.S. 1961, § 3609, is a statement of fact which is untrue and known to be untrue, or so carelessly made that an *intent to deceive may be inferred*. **5**

The Oklahoma Supreme Court's interpretation of 36 O.S. § 3609, as enunciated in *Massachusetts Mutual*, informed insurers, albeit subtly, that a finding of an insured's intent to deceive is required before a misrepresentation, an omission or incorrect statement in an application can avoid the policy under § 3609.

In three subsequent cases, the Oklahoma Supreme Court relied upon *Massachusetts Mutual* in further indicating that a finding of intent to deceive is required before a policy may be avoided due to false statements or omissions in a policy application. **6 7 8** These cases interpreted the holding in *Massachusetts Mutual* to require insurers relying on the defense of misrepresentation to bear the burden of proving the facts necessary to sustain this defense and that questions of the insured's intent in making false statements in a policy application were to be left to a jury. **9 10 11**

The Tenth Circuit Court of Appeals has also visited the issue of "misrepresentation" under Oklahoma's statute and has determined that a finding of an insured's intent to deceive is required to deny policy benefits under 36 O.S. § 3609. **12 13** In *Hays v. Jackson Nat'l Life*, the Tenth Circuit stated:

> When *Massachusetts Mutual*, *Brunson*, and *Claborn* are considered together, we are persuaded that section 3609 requires a finding of intent to deceive before an insurer can avoid the policy.

The court in *Hays* rejected the lower court's finding that an insured's intent was irrelevant and again reiterated that the question of intent was a material issue of fact for the jury that precluded summary judgment. **14**

In *Vining v. Enterprise Financial Group, Inc*., the Tenth Circuit found that the insurer could not rely on the affirmative defense of misrepresentation under 36 O.S. § 3609 where the insurer admitted that the insured did not willfully or intentionally misrepresent his health history. **15**

In 2005, the Oklahoma Supreme Court had the opportunity to make a definitive ruling on the misrepresentation statute as a result of a certified question from the U.S. District Court for the Northern District of Oklahoma. The federal court asked the Oklahoma Supreme Court to answer the following certified question: "Whether Oklahoma law requires a finding that the insured intended to deceive the insurer before a misrepresentation, omission, or incorrect statement on an insurance application can serve as a ground to prevent recovery under the policy pursuant to Okla. Stat. Tit. 36 § 3609." The Oklahoma Supreme Court declined to answer the certified question, stating:

> We have three times followed *Massachusetts Mutual's* requirement of a finding of an "intent to deceive" the insurer before a policy may be avoided by reason of the insured's false statement or omission in the application.

The "intent to deceive" standard has thus been unequivocally announced, and any insurer relying on the defense of misrepresentation under 36 O.S. § 3609 is required to prove that an insured intentionally deceived it before a policy may be avoided by reason of false statement or omission in the application.

Proving the "Intent to Deceive" Standard in the Context of Bad Faith Litigation

The question for insurers is, how do they meet this burden of proving an "intent to deceive" on the part of the applicant/insured? Proving such an intent can be difficult for insurers, but to rescind a policy or deny a claim without doing so places the insurer at peril for bad faith tort claims. This hurdle is exacerbated by Oklahoma case law holding that the question of whether the insured intended to deceive the insurer is one for the trier of fact and may not be proved as a matter of law. [16] ("Where the evidence is conflicting as to either insured's state of health at the time of application, or the falsity of insured's statements in the application process, or the intent of the insured, the issues are properly tendered to the jury for resolution.") [17] [18]

As the case law discussed herein holds, an insurer must take into consideration the intent of the insured before rescinding a policy based on 36 O.S. § 3609. The failure to consider the "intent" of the applicant when asserting the misrepresentation defense is fatal to the insurer's claim that it conducted a claims investigation reasonably appropriate and/or had a reasonable belief that the claim was factually or legally insufficient. [19] [20]

Any insurer relying on a misrepresentation defense in Oklahoma should conduct a thorough investigation of the information asked and answered on the application, including the agent's recollection of the application process. A follow-up call to the insured, post-application, for the purpose of verifying the information on the application has been helpful in avoiding misrepresentations which could lead to litigated denials. Additional documentation as to what the insured actually knew at the time he or she made application for the insurance in question is a determination that must be made before a policy is rescinded.

Other possible methods of investigating and proving an insured's intent include: the dates and results of medical exams and tests, the subjects of conversations with various medical personnel, the extent of the insured's education and intelligence, the insured's conversations with friends and family, and any actions that the insured may have taken at relevant times which might indicate knowledge of serious medical problems, such as drawing or changing a will, or changes in personality or attitude. [21]

While Oklahoma courts have not spelled out directly what they expect of an insurer's investigation, some guidance may be gleaned from one case. In *Claborn v. Washington National Insurance Co.*, [22] in order to prove the insured intentionally misrepresented his health history, the insurer relied not only on the responses to the health questions contained in the policy application, but also on his affirmation that those answers were correct in a follow-up telephone interview conducted by the insurer. The Oklahoma Supreme Court ruled there was no conflicting evidence as to whether the insured intentionally misrepresented his health history because the insured admitted to the misrepresentation and his blatantly false answers to both the policy health questions and the follow-up phone interview. [23]

Opinions from courts in other jurisdictions provide additional insight into methods by which insurers can make a determination of the "intent" of the insured. Louisiana courts have stated that to determine whether there has been an intent to deceive on the part of an insured making representations in an application for insurance, courts look to surrounding circumstances indicating the insured's knowledge of falsity of representations and high recognition of their materiality, or from circumstances which create a reasonable assumption that the insured recognized materiality. [24] [25] Strict proof of fraud was not required in these cases.

[26] Courts have also allowed the intent of the insured to deceive the insurance company to be proven by circumstantial evidence. [27]

Additionally, an insured's intent to deceive can be established by extrinsic evidence that he or she actually and fully understood that an undisclosed medical condition was serious. A Federal Court in Louisiana held that an insured acted with intent to deceive by failing to report a malignant tumor where she clearly understood the gravity of her condition, as shown by the fact that she had discussed treatment options at length with her physician and had elected not to undergo further surgery. [28]

The act of making the false representation with knowledge that it is false can give rise to the inference that the insured intended to deceive the insurer. [29] Since it is common knowledge that life insurance decisions are based in large part on the health of the applicant, it may be impossible to characterize an applicant's conduct as anything other than fraudulent where there is a willful and intentional failure to disclose health information which has been clearly and directly requested. [30] [31] Factors such as the brevity of the time between the making of the representation and the occurrence of disability from disease may indicate that the insured unquestionably had knowledge at the time he or she made application for insurance that the insured was afflicted with such disease. [32]

An additional problem for insurers to navigate is an application filled out by the insurer's agent which contains incorrect information relating to the insured's health history. This poses a hurdle for an insurer when misrepresentation is utilized as a defense to a claim because an agent's acts are imputed to the insurer. [33] Insureds will often blame any false information contained in their policy application on the insurance company's agent, effectively creating a material fact question as to who was responsible for the false information, precluding summary judgment.

Having the insured sign a post application acknowledgment of the information contained therein is one means of attempting to ensure that the information contained therein is accurate. In the Illinois case of *Marionjoy Rehabilitation Hospital v. Lo*, an insurance agent filled out an application for health insurance that failed to disclose the true health history of the applicant, which was known by the agent. [34] The court ruled that normally, in such situations, an insurer could not rely on misrepresentations contained in the application to refuse benefits because the agent's knowledge is imputed to the insurer for a proposed insured. However, in Lo, this rule did not apply. The insurer sent a letter to the insured requesting that he look over the application to verify the information contained therein. [35] The insured sent back the letter affirmatively indicating that the information contained in the application was indeed correct. The court ruled that this was an independent act by the insured that could not be imputed to the insurer via the agent and stated, in regards to the verification letter sent to the insured: "The communication at least in part is an attempt by the insurer to avoid any problems that might arise due to unscrupulous agents and as such should be encouraged." *Id.*

Conclusion

Many insurance defense counsel have, in recent years, advised their clients that a "misrepresentation" which was "material to the loss" should be the standard in determining whether to rescind a policy. Juries are simply unsympathetic when an insurer denies a claim because the insured did not apprise the insurer on the application that he or she had been diagnosed or treated for a health condition that was material to the risk, but the death of the insured was actually caused by a traffic accident or some health condition not related to the undisclosed condition. If the misrepresentation was not "material to the loss," many insurers honored these types of claims, liberally construing the statutes to avoid bad faith litigation even in ostensibly "material to the risk" jursidictions.

As all defense counsel know, when a trier of fact gets an opportunity to review almost any matter relating to insurers and their claims handling, the insurer will generally not prevail. Keeping insurers out of litigation is

our goal, so we urge our clients to utilize caution before rescinding or denying a policy claim based upon misrepresentations, incorrect statements of fact or omissions in an application for insurance, as the standard of "intent to deceive" can be difficult, if not impossible, to meet.

Endnotes

1. *See*, *New York Life Ins. Co. v. Strong*, 65 P.2d 194 (Okla. 1937), *certiorari denied* 57 S. Ct. 796, 301 U.S. 693, 81 L. Ed 1349.

2. *Tri-State Insurance Co., v. Herzer*, 279 P.2d 329, 332-333 (Okla. 1954); (quoting *United Benefit Life Ins. Co. v. Knapp*, 175 Okla. 25, 51 P.2d 963, 964).

3. 416 P.2d 935 (Okla. 1965).

4. *Id*., at 941; *quoting* 29 Am. Jur., Insurance at § 698; (emphasis supplied).

5. *Id*., at 936-937; (emphasis supplied).

6. *Whitlatch v. John Hancock Mutual Life Insurance Co*., 441 P.2d 956 (Okla. 1968).

7. *Brunson v. Mid-Western Life Ins. Co*., 547 P.2d 970 (Okla. 1976).

8. *Claborn v. Washington National Insurance Co*., 910 P.2d 1046 (Okla. 1996).

9. *Whitlatch*, at 959.

10. *Brunson*, at 973.

11. *Claborn*, at 1049.

12. *Hays v. Jackson Nat'l Life Ins. Co*., 105 F.3d 583 (10th Cir. 1997).

13. *Vining v. Enterprise Financial Group, Inc*., 148 F.3d 1206 (10th Cir. 1998).

14. *Hays*, 105 F.3d at 586.

15. 148 F.3d at 1215.

16. *See Claborn v. Washington National Insurance Co*., 910 P.2d 1046, 1049 (Okla. 1996).

17. *Citing Brunson v. Mid-Western Life Ins. Co.,* 547 P.2d 970 (Okla. 1976).

18. *See also Johnson ex rel. Johnson v. Forethought Life Ins. Co*., 2006 WL 314446 (W.D. Okla. 2006).

19. *See Johnson ex rel. Johnson v. Forethought Life Ins. Co*., 2006 WL 314446 (W.D. Okla. 2006).

20. See also *Matlock v. Texas Life Ins. Co*., 404 F.Supp.2d 1307 (W.D. Okla. 2005).

21. *Couch on Insurance*, (6 Couch on Ins. § 87:22).

22. 910 P.2d 1046, (Okla. 1996).

23. *Id*., at 1049.

24. *See Parker v. Western Fidelity Ins. Co*., 560 So. 2d 953 (La. App. 3 Cir. 1990).

25. *See also Henry v. State Farm Mutual Auto Ins. Co*., 465 So. 2d 276 (La. App. 3 Cir. 1985).

26. (*Henry v. State Farm*, 465 So. 2d 276).

27. *Sharp v. Lincoln American Life Ins. Co.,* 752 S.W. 2d 673 (Tx. App. Corpus Christi, 1988).

28. *Watson v. United of Omaha Life Ins. Co*., 735 F. Supp. 684 (M.D. La. 1990).

29. *See Monarch Life Ins. Co. v. Donahue*, 708 F. Supp. 674 (E.D. Pa. 1989).

30. 1 COA2d 1 § 20 (2005).

31. *Citing Mutual Benefit Life Ins. Co. v. Chisholm*, 329 N.W.2d 103 (Neb. 1983).

32. 6 Couch on Ins. § 87:22.

33. *See City Nat'l Bank and Trust Co. v. Jackson Nat'l Life Ins*., 804 P.2d 463, 467 (Okla. Civ. App. 1990); (citations omitted).

34. 535 N.E.2d 1061 (Ill. App. 1989).

35. *Id*., at 1064.

FLORIDA RELAXES FORM A FILING REQUIREMENTS

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Insurance regulatory jurisdictions throughout the United States uniformly require a person seeking to acquire directly or indirectly a controlling interest in an insurance company or specialty insurer to obtain regulatory approval of the acquisition. An application for approval of a change of control, commonly referred to as a Form A application, must be filed with the insurance department in the insurer's state of domicile, and the acquiring party must also provide notice of the proposed transaction to the insurer.

Florida has a well-deserved reputation for rigorously reviewing change of control applications. Florida has also been something of an outlier in terms of the timing for filing the applications and its expansive view of

the circumstances under which regulatory approval has to be obtained. The Florida Legislature, however, recently enacted legislation, now known as Chapter 2007-138, Laws of Florida,[1] which somewhat relaxed the state's historically stringent rules on filing Form A applications.[2] The new rules apply to insurance companies and specialty insurers alike.[3]

A MATTER OF TIMING

Prior to the enactment of the new law, change of control filings required by sections 628.461, Florida Statutes, had to be made within five days after entering into any definitive agreement to acquire five percent or more of the outstanding voting securities of a domestic stock insurer or controlling company of a domestic insurer. In the case of specialty insurers, section 628.4615, Florida Statutes, required Form A filings to be made within five days after entering into any definitive agreement to acquire 10 percent or more of the outstanding voting securities of a domestic specialty insurer or controlling company of a specialty insurer. For many years, the NAIC Model Laws, Regulations and Guidelines have presumed that control existed if a person directly or indirectly owned or controlled 10 percent or more of the voting stock of an insurer.[4]

Regardless of whether Florida's Form A filing requirements were triggered by the proposed acquisition of five percent or 10 percent of the voting stock, persons seeking to acquire a "controlling interest" in a Florida insurer or specialty insurer found it more than a little challenging to comply with the requirement that a complete change of control application had to be filed within a mere five days "after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities if no tender offer or exchange offer is involved." The only silver lining to the requirement was that the Florida OIR traditionally interpreted the law such that the "clock" did not begin to run until the definitive purchase agreement was signed by all parties to the transaction.

Nevertheless, the five-day filing requirement continued to pose a challenging hurdle to acquirers because Florida regulators required Form A applications to be substantially complete when filed. Thus, a "skeleton filing" containing incomplete information or placeholders was subject to immediate rejection and return to the applicant, and, as a result, the application might be deemed to be out of compliance with the state's change of control statute. In recent years, Florida regulators have become even more aggressive in their enforcement of this requirement.

Provisions of Chapter 2007-138 substantially relax the time constraints facing an applicant who wishes to acquire a controlling interest in a Florida-domiciled insurer or specialty insurer. The new law essentially establishes bifurcated filing requirements. Although Form A applicants must still initially communicate with the Florida OIR within five days after agreeing to acquire a controlling interest in a domestic insurer or specialty insurer, the initial communication is now limited to a "letter of notification" which must be filed with insurance regulators by the acquiring person. A copy of the letter must also be sent to the insurer or specialty insurer and, if applicable, to the controlling company.[5]

Complete change of control applications must still be filed in Florida. Now, however, an acquirer may take up to 30 days after entering into a definitive agreement to acquire a controlling interest in a domestic insurer or specialty insurer (or its controlling company) to file a Form A application.[6] The additional time will no doubt allow an applicant to submit a more thorough and compliant application, which may in turn have the salutary effect of reducing the number of follow-up requests for information which applicants almost always receive from Florida insurance regulators.

WAIVERS FOR REORGANIZATIONS

In addition to bifurcating the change of control filing requirements, Chapter 2007-138 also revised both section 628.461 and section 628.4615 to allow the Florida OIR to waive the requirement for an acquiring person to submit a complete change of control application where the transaction is limited to a corporate reorganization. Historically, the Florida OIR did not interpret sections 628.461 and 628.4615 to allow it discretion to waive the change of control filing requirements where the change of control was limited to a corporate reorganization, even where the ultimate controlling persons remained the same. This left controlling persons in the unfortunate position of having to submit complete Form A applications and seek regulatory approval for the most basic of corporate reorganization transactions.

Under the new provisions of sections 628.461 and 628.4615, an acquiring person may, as part of its letter of notification, request the Florida OIR to waive the requirement to submit a full-blown change of control application if: (1) there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and (2) no unaffiliated parties acquire any direct or indirect interest in the insurer or specialty insurer.[7] The Florida OIR may grant the waiver if it determines that, in fact, there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the insurer or specialty insurer.

The Florida OIR, which reportedly supported the revisions to the Florida change of control statutes, has not yet adopted rules or forms for the notification letter or waiver request. The notification letter seems fairly straightforward. It would seem prudent, however, to communicate with the Florida OIR prior to submitting waiver applications in order to avoid a misstep which might cost an acquiring person valuable time in the process. That said, it is probably reasonable to expect the Florida OIR to require a party seeking a waiver of the requirement to submit a complete Form A application to submit the following information: (1) a Management Information Form for the acquiring person, including the identification of the person’s officers, directors or general partner, if applicable; (2) a Disclaimer of Control Affidavit; and (3) organizational charts showing the upstream ownership and control structure of the insurer and the holding company system to which it belongs, if applicable, prior to and after the proposed transaction.

In addition, the insurance company will still be required to file with the Florida OIR an amendment to its consolidated holding company system registration statement to reflect the change in ownership within 15 days after the end of the month in which the acquisition is concluded.[8] That requirement is beyond the scope of this discussion, however.

CONCLUSION

There is no reason to believe Florida insurance regulators will relax the rigorous review they give every change of control application. Chapter 2007-138, Laws of Florida, takes a step in the right direction, however, by acknowledging the difficulty of preparing a complete Form A filing within a mere five days after an agreement is reached to acquire an insurer or specialty insurer. The new law also rationally recognizes that requiring a Form A filing in the case of simple corporate reorganizations was a waste of scarce regulatory resources.

Endnotes

1. Effective June 15, 2007.

2. Chapter 2007-138, Laws of Florida, also modernized Florida law to allow licensed securities brokers and dealers that participate in a clearing corporation to serve as custodians of securities held by insurers. Previously, only national banks, state banks, and trust companies could serve in this capacity.

3. Section 628.461, Florida Statutes, governs change of control of insurance companies. Its counterpart, section 628.4615, Florida Statutes, governs change of control of specialty insurers, including premium finance companies.

4. NAIC Model Laws, Regulations and Guidelines, 440-1, section 1.C.

5. Section 628.461(1)(a), Florida Statutes, for insurers. Section 628.4615(2)(a), Florida Statutes, for specialty insurers.

6. This 30-day period appears to begin running from the same date which triggers the five-day period under sections 628.461 and 628.4615, Florida Statutes, such that a change of control application would be due within 25 days after the deadline to file the letter of notification.

7. Section 628.461(2), Florida Statutes for insurers. Section 628.4165(3), Florida Statutes, for specialty insurers.

8. Rule 69O-143.046(4), F.A.C.

MONTANA LEGISLATIVE AND REGULATORY UPDATE

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Montana's 60th biennial regular session adjourned *sine die* Friday, April 27, 2007, on the 90th day, the last day for meeting under Montana law. With a Democratic Governor, this legislature was the first split majority legislature in 14 years. Democrats controlled the Senate 26-24 as a result of one elected Republican switching parties after the election. Republicans controlled the House 50-49-1. While other recent legislatures have dealt with significant budget shortfalls, this legislature faced a projected budget surplus of $1billion+. More than 2,500 bills were requested and over 1,500 bills were introduced, with less than half becoming law. Because of strong philosophical disagreement about how to use the surplus, a deeply polarized legislature adjourned with its major tasks--budget (required), tax relief (desired by both parties), and school funding (to address litigation against the state)--undone. The Governor called the legislature back into special session on May 10, 2007, to address the unfinished business, reopening the door to issues already dealt with. The special session adjourned *sine die* May 15, 2007, major tasks now completed–budget, limited tax relief, and some additional school funding--and leaving most other action of the regular session intact. [2]

While fiscal differences of opinion dominated the 60th legislature, some significant legislation affecting insurance interests was enacted, which in turn has generated regulation of importance. Finally, some failed measures provide a cautionary tale, not only for future Montana legislatures, but also for other states. [3]

Property and Casualty

SB 70 - State Emergency Response Commission

SB 70 revises the composition of the State Emergency Response Commission, increasing its membership from 27 to 29 and adding a member from the Montana insurance producer and company representatives. **Signed by Governor. Chapter 67. Eff. 10/1/07. Codified 10-3-1204, MCA.**

SB 204 - Prohibiting insurers from requiring estimates at a specified location

As introduced, SB 204 prohibited an insurer from requiring that a claimant have repair estimates performed at a particular location. Montana law already prohibited insurers from requiring repairs to be performed at a specified location. This bill would have prohibited insurers from obtaining competitive estimates, and insurers thus opposed it as anticonsumer. Responding to insurer concerns, the bill was amended to allow insurer access to a vehicle for the purpose of obtaining competitive estimates. **Signed by Governor. Chapter 339. Eff. 10/1/07. Codified 33-18-224, MCA.**

SB 300 - Primary seatbelt law

Introduced at the request of the Montana Motor Carriers Association and with insurance industry support, SB 300 would have enacted primary seatbelt and child passenger safety legislation. Historically, Montana has not looked favorably on mandatory seatbelt legislation. This remained true in this session, although the bill failed by only one vote in the second house. **Failed on 2nd reading in House.**

SB 537 - Prepaid legal plans

Sellers of legal services expense plans (often called "prepaid legal plans") would no longer have been required to be licensed as insurance producers. SB 537 moved regulation of legal services expense plans from the Commissioner of Insurance to the Department of Justice under the Consumer Protection Act and related sections (Title 30, chapter 14, MCA). Plans marketed through multilevel distribution companies would still have been required to register the marketing plan with the Commissioner of Securities. **Returned by Governor with recommended amendments; Governor's amendments rejected by legislature; passed 2nd time by legislature; to Governor for reconsideration. Governor vetoed. Veto override attempt failed.**

HB 543 - Disclosure of insured's liability limits to claimants

After failing in the 2005 session, this bill was again introduced to require an insured or the insured's insurer to disclose liability limits upon request from potential claimants prior to claim being made or litigation being filed. It was advanced as a bill that would reduce litigation with the rationale that no one sues if there is no coverage. **Tabled by the House Business Committee.**

HB 565 - Comparative negligence application to Workplace Safety Act

At the request of the Montana Contractors Association, HB 565 was introduced to amend the Montana Workplace Safety Act to require application of comparative negligence principles in actions against workplace owners and lessees over alleged violations of the act. Currently, strict liability principles apply to workplace safety act violations. **Failed on 3rd reading in the House.**

HB 587 - Anti-stacking law

Introduced with strong company and producer support, HB 587 restores statutory permission to include antistacking clauses in auto insurance policies. Coverages provided under one policy, or under more than one policy, issued by the same insurer, cannot be added together where the premiums charged actuarially reflect limiting of coverage separately to the vehicles covered under the policy. **Signed by Governor. Chapter 201. Eff. 4/17/2007. Codified 33-23-203, MCA.**

Workers' Compensation

SB 108 - "Housekeeping"; medical utilization and treatment guidelines

Introduced at the request of the Department of Labor and Industry, SB 108 covers a number of "housekeeping" measures under the Workers' Compensation Act and authorizes the Department of Labor to develop medical utilization and treatment guidelines for injured workers. The measure is one component resulting from collaborative interim work of insurance industry, labor, employer, and Department stakeholders responding to the results of a recent WCRI administrative inventory and other Department-supported analysis of cost drivers in Montana's workers' compensation system. **Signed by Governor. Chapter 117. Eff. 7/1/07. Codified in multiple sections of Title 39, chapter 71, MCA.**

SB 304 - Limitation on access to worker health care information

Responding to recent litigation, SB 304 would have prohibited the disclosure of claimant health care information by a health care provider to a workers' compensation insurer or representative without notice to and participation by the claimant's attorney. **Tabled in Senate Business and Industry**.

SB 474 - State Fund regulatory parity

At the request of private companies writing workers' compensation insurance in Montana, SB 474 would have required State Compensation Insurance Fund rates to be developed and filed under the Montana Insurance Code and also required parallel notice provisions on policy renewals. In the current three-way competitive market, private carriers file their rates with the Insurance Commissioner under a NCCI loss cost competitive rating law. The State Fund establishes its rates under an administrative process regulated by the Legislative Auditor. While it is required to report its loss costs to NCCI, Montana's designated advisory organization, the State Fund is not required to employ NCCI class codes or statistical rating plan in establishing its rates. SB 474 would have required both State Fund and private carriers to use the same rating law and the same time frames in establishing their rates and in noticing policyholders of renewals with altered terms. **Tabled in Senate Business Committee.**

HB 213 - Healthy Workplace Act

HB 213 would have added additional tort remedies to Montana employment law for emotional and psychological injury occurring in the workplace, whether inflicted by employer, coworker, or third parties. If enacted, the bill would have overlapped and conflicted with existing employment, discrimination, and workers' compensation law. **Tabled by the House Business Committee.**

HB 738 - Treatment guidelines/medical rates

Again, a product of collaborative work among industry, regulatory, and user stakeholders, HB 738 establishes the rate for workers' compensation medical services based on the average of conversion factors used by the top five insurers or third-party administrators providing disability [health] insurance in Montana using the

resource-based relative value scale to determine fees for covered services; provides for evidence-based utilization and treatment guidelines for primary and secondary medical services; and establishes a rebuttable presumption that the utilization and treatment guidelines are correct medical treatment for the injured worker. Insurers are not responsible for treatments or services not within utilization and treatment guidelines unless providers obtain prior authorization. There is an independent medical review process for insurer denial of treatment or services. **Signed by Governor. Ch. 330. Eff. 7/1/07. Codified 39-71-704, -743, MCA.**

HB 785 - Athlete exemption

HB 785 exempts from workers' compensation coverage athletes engaged in contact sports, including football and hockey. **Signed by Governor. Ch. 288. Eff. 4/26/07. Codified 39-71-401, MCA.**

HB 786 - Motor Carriers

HB 786 exempts from workers' compensation coverage persons performing the services of intrastate or interstate common or contract motor carriers when hired by brokers. **Signed by Governor. Ch. 179. Eff. 7/1/07. Codified 39-71-401, MCA.**

Life Insurance

SB 276 - Funeral insurance sales by funeral directors

Brought forward by the Montana Funeral Directors Association, SB 276 allows funeral directors to be licensed as life insurance producers for the purpose of selling limited life insurance policies with a benefit of not greater than $15,000. Persons selling the limited policy are required to hold dual licensure as funeral director and insurance producer. **Signed by Governor. Ch. 507. Eff. 1/1/08. Codified in multiple sections in Title 33, chapters 17, 18, and 20, MCA.**

SB 535 - Annuity suitability

SB 535 enacts the NAIC Suitability in Annuity Transactions Model Regulation and the NAIC Annuity Disclosure Model Regulation, jointly implementing suitability protections developed by the NAIC and industry in responding to concerns about annuity sales practices. **Signed by Governor. Chapter 476. Eff. 10/1/07. Codified in multiple sections in Title 33, chapter 20, parts 8 and 9, MCA.**

SB 542- Modernization of group life insurance

SB 542 for the modernization of the group life insurance law in Montana permits group life insurance policies to be purchased with premiums paid entirely by the employee. The bill also removes the requirement that group life insurance plans cover at least 75 percent of eligible group members. These changes provide greater access to affordable life insurance coverage and are consistent with the most recent NAIC "Group Life Insurance Definition and Group Life Insurance Standard Provisions Model Act" (October 2005). **Signed by Governor. Chapter 430. Eff. 10/1/07. Codified 33-20-1101, -1111, -1209, MCA.**

HB 108 - Withholding of an estimated tax from pension and annuity distributions

Introduced at the request of the Department of Revenue, HB 108 proposed to require withholding of an estimated tax from pension and annuity distributions. Purportedly based upon IRC Sec. 3405, the measure did not parallel Sec. 3405 and engrafted other requirements and liabilities for the payor of a distribution not contemplated by Sec. 3405. **Tabled in House Taxation Committee.** 4

HB 156 - Long term care insurance Representing general revision and updating of Montana's long-term care [LTC] insurance law, HB 156 revises pertinent definitions; revises provision relating to nonforfeiture benefits; expands rulemaking authority for the Commissioner of Insurance; revises provision relating to delivery of policy summaries and benefit triggers; provides additional standards for LTC contracts; and expands training requirements for LTC insurance producers. **Signed by Governor. Ch. 32. Eff. 7/1/07. Codified in multiple sections of Title 33, chapters 20 and 22, MCA.**

HB 764 - Life insurance sales practices to military personnel

HB 764 implements Federal mandates passed by Congress in September 2006 providing that states should work together to develop guidelines ensuring that active military personnel are protected from unscrupulous life insurance sales practices and to require certain standards and disclosures in the sale of life insurance products to military personnel. **Signed by Governor. Chapter 333. Eff. 4/27/07. Codified 33-18-103, MCA. Administrative rules implementing NAIC Model Rules have been noticed and adoption is anticipated.** [5]

Regulation and Litigation

SB 116 - Identity theft; credit freezes

SB 116 enacts additional consumer protections for victims of identity theft and for "freezes" and "thaws" of consumer credit reports. Insurers are exempt from the provisions of SB 116. **Signed by Governor. Ch. 138. Eff. 7-1-107. Codified 30-14-1726 through - 1736, MCA.**[6]

SB 138 - Insurer Subsidiaries; "Stuffing"

Introduced at the request of the Montana Director of Revenue, SB 138 would have prohibited the practice of "insurance stuffing" and specified when corporations could take dividends-received deductions for dividends received from insurers, provided procedures to calculate dividends-received deductions, permitted disregarding permanent deferral of gain recognition for transactions, and permitted the Department of Revenue to include in gross income taxpayer's pro-rata share of the insurers' current earnings and profits in the taxable year. The bill would have been effective immediately and provided a retroactive applicability date. **Died in House Taxation Committee on April 13, 2007.** [7]

SB 157 - Insurance Commissioner "housekeeping"

Commissioner Morrison's "housekeeping" bill corrects incorrect references, cleans up conflicts, and updates language in the Montana Insurance Code. A product of industry and regulatory collaboration, the bill contains only legislation upon which there was agreement. **Signed by Governor. Ch. 399. Eff. Multiple dates. Codified in multiple sections of MCA.**

SB 161 - Captive insurers

Represents a general revision and significant expansion of the Montana captive insurance law, including provisions amending investment, and capital and surplus requirements. **Signed by Governor. Ch. 518. Eff. 10/1/07. Codified in multiple sections of Title 33, chapter 28, MCA.**

HB 212, SB 330, SB 429 - Credit Scoring

After three contentious sessions over credit scoring, in 2005, Montana enacted the NCOIL credit scoring model with minor revisions. The law became effective October 1, 2005. Nevertheless, three bills, each attempting a wholesale or partial repeal of statutes permitting the use of credit scoring were introduced in

2007. **All three bills tabled in the business committee in the house of origin.** [8]

HB 464 - Third party bad faith

After an intense lobbying effort and two bitter floor debates on second reading, HB 464, introduced to counter supreme and federal court opinions upholding current law regarding available damages and attorney fees in insurance UCSPA ("bad faith") actions was indefinitely postponed by the Senate. The bill would have provided for damages for "all detriment" caused by an act of insurance bad faith and awarded attorney fees incurred in the *underlying claim* to a prevailing plaintiff. Insurance industry opposition stressed the pressure the enactment would have on settlement, claims costs and premium. At the time, only two states, Montana and West Virginia, allowed third party bad faith causes of action against insurers. Had HB 464 passed, Montana would have been the only state to allow the recovery of attorney fees as damages. **Failed on 2nd reading and indefinitely postponed in Senate.** [9]

HB 724 - Service contracts

Based upon the Service Contract Industry Council model law, HB 724 introduces new requirements in Montana law for service contracts as part of certain business arrangements. Regulation of service contracts is under the authority of the Department of Justice. **Signed by Governor. Ch. 162. Eff. 4/6/07. Codified 30-14-1301 through - 1304, MCA.**

Endnotes

1. Jacqueline Lenmark is Montana retained counsel for the American Insurance Association and the American Council of Life Insurers.

2. While presumably called only for funding emergency wildfire expenses, the Montana legislature convenes again in special session on September 5, 2007.

3. Information on the 60th Montana general session is available at http://leg.mt.gov/css/sessions/60th/default.asp. Detailed information on bills is at http://laws.leg.mt.gov/pls/laws07/law0203w$.startup. Special session information is available at http://leg.mt.gov/css/sessions/special_session/may_2007/default.asp. Detailed information on special session bills is at http://laws.leg.mt.gov/pls/laws0507/LAW0200W$.startup.

4. Reintroduced in SB 220 and tabled in Senate Taxation Committee; reintroduced in the Special Session and part of omnibus taxation bill HB 5 which was tabled in House Taxation.

5. HB 764 was preceded by HB 542, which was requested by Commissioner John Morrison to address the same purpose. A coalition of insurer and producer interests defeated HB 542 on the basis that it was an overbroad delegation of legislative authority to the Commissioner to promulgate rules regarding *all* lines of insurance and *all* military personnel regardless of status. After killing HB 542, the legislature enacted HB 764, drafted to closely reflect Congressional direction on the issue. The redrafted legislation garnered support from HB 542's sponsor and Commissioner Morrison, who issued a press release commending the legislation.

6. Independent consumer protections for insurance consumers are contained in Title 33, chapter 19, MCA, the Montana Insurance Information Privacy and Protection Act.

7. SB 138 was amended into HB 833, along with other dead tax bills, which died at the end of Regular Session. Amended again into SpS-SB9, it again died at the end of the special session. All three bills were based upon California legislation addressing the constitutionality of California statute.

8. Rep. Jonathan Windy Boy brought HB 212 arguing that credit scoring was having an adverse effect on his constituents, many of whom resided on reservations with high unemployment. Sen. Steven Gallus also introduced two bills to ban credit scoring: SB 330 directed to auto insurance only and SB 429 directed to homeowners insurance. Arguing that an individual's credit score should have the privacy protection of the Montana Constitution, Gallus has introduced credit score bans in every session since 1999, when he vowed to do so as long as he was in the legislature or until he is successful. Although he participated in the compromise leading to enactment of the NCOIL model, Insurance Commissioner John Morrison supported all three bills to repeal.

9. Introduced by trial lawyer Rep. Ken Peterson (R-Billings), HB 464 was the No. 1 priority of the Montana Trial Lawyers Association in 2007.

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