

STATE OF INDIANA)
) SS:
COUNTY OF MARION)

IN THE MARION CIRCUIT COURT
CAUSE NO. 49C01-0811-MI-053358

JIM ATTERHOLT, as the Insurance)
Commissioner of the Department of Insurance)
of the State of Indiana,)
)
Petitioner,)
)
v.)
)
MEDICAL SAVINGS INSURANCE COMPANY,)
)
Respondent.)

FILED

32

JAN 23 2009

Elizabeth J. White
CLERK OF THE MARION CIRCUIT COURT

**REHABILITATOR'S RECOMMENDATIONS CONCERNING
LIQUIDATION PROCEDURES, CLAIMS AND NOTICES**

Indiana Insurance Commissioner Jim Atterholt, as Rehabilitator of Medical Savings Insurance Company ("MSIC"), submits the following Recommendations Concerning Liquidation Procedures, Claims and Notices ("Liquidation Procedures"), pursuant to and in accordance with Ind. Code 27-9-3. The Rehabilitator is also filing herewith a Verified Petition for Liquidation against MSIC ("Liquidation Petition") and requests that the Court consider the recommendations set forth herein in conjunction with the hearing to be held on the Liquidation Petition.

I
Background

1. MSIC is an Indiana domestic stock life insurance company that is also licensed to write business in certain other states. MSIC is a wholly owned subsidiary of Medical Savings Investment, Inc. ("MSII"). MSIC conducts its business primarily out of offices located in Indianapolis, Indiana.

2. On December 1, 2008, the Commissioner filed a Verified Petition for Rehabilitation (“Rehabilitation Petition”) against MSIC. As confirmed in the Rehabilitation Petition, both MSIC and MSII consented to the entry of an Order of Rehabilitation.

3. After a hearing held in open court on December 1, 2008, an Order of Rehabilitation was entered as against MSIC.

4. As noted above, the Rehabilitator is also filing the Liquidation Petition against MSIC, on the grounds that MSIC is insolvent and that further attempts to rehabilitate the company would be futile. The Rehabilitator requests that the recommendations contained herein as to liquidation procedures, claims and notices be heard and considered in conjunction with the Liquidation Petition.

II Recommended Notice

5. In the event that an Order of Liquidation is entered against MSIC, the Rehabilitator recommends that it should be directed to provide notice of that Order, both by mailings and publications, as set forth below.

6. The Rehabilitator recommends that the Court direct the Liquidator to mail, by regular first class United States mail, postage prepaid, within fifteen (15) days of the Court’s entry of the Order of Liquidation, a copy of the Notice to Persons Interested in Medical Savings Insurance Company (attached hereto as Exhibit A), a copy of the Order of Liquidation (as entered by the Court) and a copy of the Order on Liquidation Procedures (as entered by the Court) to the last known address as indicated in MSIC’s records, or the records of the Liquidator, for the following groups of persons:

- (a) Former officers and directors of MSIC;
- (b) MSII;

- (c) Reinsurers of MSIC, if any;
- (d) All insureds of MSIC;
- (e) All insurance producers of MSIC;
- (f) All known parties or their counsel of record in pending litigation and/or in claims involving MSIC or insureds of MSIC, including all known health care providers who have rendered services to MSIC insureds and who continue to assert claims for payments;
- (g) All known creditors of MSIC;
- (h) The Insurance Commissioners or Departments in each state or jurisdiction and the National Association of Insurance Commissioners;
- (i) The Indiana Life and Health Insurance Guaranty Association, similar associations in the other states and jurisdictions where MSIC was licensed to do business and the National Organization of Life and Health Insurance Guaranty Associations;
- (j) The Indiana Secretary of State;
- (k) The Indiana Attorney General;
- (l) The Indiana Department of Revenue;
- (m) The Auditor of Marion County, Indiana;
- (n) The Internal Revenue Service, both at its national and local offices;
- (o) The United States Attorney for the Southern District of Indiana;
- (p) The Department of Justice; and
- (q) All who have filed their appearance in this proceeding.

7. To the extent that any of the above notices are returned to the Liquidator as a result of the mailing address no longer being current, it is recommended that this be noted in MSIC's records and that any subsequent mailings or notices, whether ordered by the Court or otherwise, not be sent to such addresses.

8. Pursuant to the terms of Ind. Code 27-9-3-10(a)(1), the Liquidator is to provide Notice of an Order of Liquidation by “first class mail and either telegram or telephone to the Insurance Commissioner of each jurisdiction in which the insurer is doing business”, unless otherwise directed by the Court. (Emphasis added) The Rehabilitator recommends that Notice to insurance commissioners by mail only is sufficient, since the commissioners will have previously been sent Notice of the filing of the Liquidation Petition and the scheduled hearing thereon.

9. The Rehabilitator also recommends that the Liquidator be directed to cause the Notice to Persons Interested in Medical Savings Insurance Company (attached hereto as Exhibit A, but modified to delete the reference to all enclosures) to be published once in a newspaper of general circulation in Marion County, Indiana, within ten (10) days of the Order of Liquidation being entered against MSIC.

III

MSIC Overview and Recommended Procedures for Addressing Claims Arising Out of MSIC Policies

10. If MSIC is found insolvent and ordered to be liquidated, one of the primary challenges will be to identify the claims against MSIC, organize those claims pursuant to the priority system set forth in Ind. Code 27-9-3-40 and determine which claims should be approved against MSIC and in what amount. The Rehabilitator proposes to determine priority levels and claim amounts in accordance with Ind. Code 27-9-3 as set forth below.

11. MSIC wrote high deductible health insurance policies (typically in conjunction with a health savings account (“HSA”) established by the insured), which coverage was issued almost exclusively as Association Group business with certificates issued to individuals (“MSIC

Insureds”).¹ MSIC offered a number of coverage forms, whereby the applicant for insurance had the option to procure coverage for only certain types of health care services (with a corresponding lower premium) or for a broader range of health care services (with a corresponding higher premium).²

12. As of the date the Order of Rehabilitation was entered, there were numerous lawsuits pending around the country against MSIC and/or MSIC’s Insureds.³ While the Rehabilitator is still investigating these suits, it appears that there were at least 50 lawsuits pending as of the date the Order of Rehabilitation was entered, brought by more than 30 different provider and/or hospital groups. In addition, some of the lawsuits were brought by the MSIC Insureds against MSIC. All of these lawsuits included claims for the payment of benefits under the MSIC Policies and certain of the lawsuits included additional counts against MSIC like fraud and interference with contract.

13. At the heart of these lawsuits are issues requiring that a determination be made under the terms and conditions of the MSIC Policy. One of the more significant disputes in these lawsuits involves the language from MSIC’s Policies that obligated MSIC to pay only the “Reasonable and Customary Charge” for a Covered Expense, which was typically defined within the policy as follows:⁴

“Reasonable and customary charge” means, with respect to fees by a medical practitioner or by a supplier of professional services,

¹ The underlying policies and the certificates as issued by MSIC, will hereafter collectively be referred to as “MSIC Policies.” Depending on the application submitted to and accepted by MSIC, the individuals insured by a particular MSIC Policy could include only the primary insured who purchased the policy, or could also include, as dependants, the spouse and/or eligible children of the primary insured.

² The scope of the health care services covered by a particular MSIC Policy is defined within the policy as a “Covered Expense”.

³ Per the terms of the Order of Rehabilitation, all such actions were stayed for a period of ninety (90) days.

⁴ MSIC has various policy forms that differ in the precise definition of “reasonable and customary charge.” In addition, there are certain MSIC Policy forms which do not include the Reasonable and Customary Charge concept and those policies will need to be reviewed and adjudicated in accordance with their specific terms and conditions. Those policies are, however, relatively few in number and, therefore, the Rehabilitator’s summary will focus on the more typical policy forms, without waiving the specific and express terms and conditions of any MSIC Policy.

medicines, or supplies, the *most common charge* for similar professional services, medicines, or supplies within the area in which the charge is incurred, so long as those charges are reasonable. *Reasonable and customary charges* will be determined by *us*.

The amount which would equal or exceed the amounts charged by two-thirds of the providers within the area in which the charge is incurred will be considered the *most common charge*. "Area" means: (a) the three digit zip code in which the service or supply is provided; or (b) a greater area if necessary to obtain a representative cross section of charges for a like service or supply. In determining whether a charge is reasonable, *we* may consider one or more of the following factors:

- (NN) Medicare reimbursement rates;
- (OO) the level of skill, extent of training, and experience required to perform the procedure or service;
- (PP) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar procedures or services;
- (QQ) the severity or nature of the *illness* or *injury* being treated;
- (RR) the amount charged for the same or comparable services or supplies in the locality;
- (SS) the amount charged for the same or comparable services or supplies in other parts of the country;
- (TT) the cost to the provider of providing the services or performing the procedure; and
- (UU) such other factors as *we*, in the reasonable exercise of *our* discretion, determine are appropriate.

Most of the MSIC Policies also included the following exclusion:

EXCLUSION OF CHARGES IN EXCESS OF REASONABLE AND CUSTOMARY: If a charge incurred by a covered person for services or supplies is in excess of the *reasonable and customary charge*, no payment will be made with respect to the excess amount of the charge. That part of the charge which is in excess of the reasonable and customary charge will not qualify as a covered expense under the policy.

14. Unlike many health insurers, MSIC typically did not enter into contracts with individual health care providers or provider networks for the purpose of reaching contractual agreements as to agreed discounts or other approaches to define the amounts which MSIC would

pay, and which the providers would accept, for services rendered to MSIC's insureds. Accordingly, health care providers who rendered services to MSIC's Insureds have typically billed their full rates for such services. In the lawsuits pending as of the Rehabilitation date, the plaintiffs (whether doctors, hospitals or other health care providers – hereafter collectively referred to as “Providers” – or MSIC Insureds) are typically seeking payment of the full rates charged by the Providers, along with other counts or theories.

15. In contrast, the prior management of MSIC did not calculate the MSIC Policy to permit the payment of full rates and charges under those circumstances. Instead, upon receipt of a Provider invoice, MSIC would review the charges and, if the services were for a Covered Expense, would issue payment to the Provider or the MSIC Insured, typically at a discounted amount which MSIC calculated to be the “Reasonable and Customary Charge” for such services under the MSIC Policy. The drafts as issued by MSIC typically included conspicuous wording that the amount was offered in full satisfaction of the claim. If the Provider obtained payment and negotiated the draft, then the claim would be considered resolved. However, various Providers and MSIC Insureds have contested MSIC's calculation of the “Reasonable and Customary Charge” under the MSIC Policies and refused to cash the drafts so as not to waive their claims.⁵ Where MSIC's calculations were challenged, if MSIC and the Provider were not thereafter able to reach a settlement of such claims, then the Providers often filed lawsuits naming either MSIC or the individual insureds as the defendant, or as in some cases naming both as defendants. In those cases where the MSIC Insured was named as a defendant, MSIC typically paid the costs associated with defending that litigation.

⁵ Additionally, some Providers obtained payment and negotiated the drafts, yet continue to pursue MSIC Insureds for additional payments in contravention of general principles of commercial law. See, e.g. UCC § 3-311.

16. Regardless of how benefits are calculated under the MSIC Policies, MSIC is insolvent and is not able to pay its contractual obligations. However, upon entry of the Liquidation Order, the MSIC Policies continue in force for periods and under terms as is provided by an applicable guaranty association. Ind. Code 27-9-3-8. Each state where MSIC was licensed has enacted legislation creating a life and health insurance guaranty association that provides statutory protections for certain policy benefits (subject to statutory limits) for residents of its state. See e.g. 27-8-8-1 et seq. The claims will be processed in accordance with the policy terms by the guaranty associations, subject to their statutory limits.⁶

17. As explained above, the plaintiffs in the approximately 50 lawsuits that were pending against MSIC as of December 1, 2008, refused to accept the policy benefits as previously calculated by MSIC. There are, of course, other outstanding claims for health care services rendered to MSIC Insureds that have not been resolved.

18. The guaranty associations (with respect to covered claims) and the Liquidator (with respect to uncovered claims) are prepared to participate in discussions on outstanding policy claims following the entry of an Order of Liquidation that includes a finding of insolvency against MSIC. With respect to outstanding policy claims which now exist or may hereafter arise against MSIC, the primary claimant is, of course, the MSIC Insured.⁷ However, the bulk of the policy claims arise from the health care services rendered by the Providers and the Providers' request for payment. Of significance is the fact that MSIC Insureds were routinely being seen and treated by the same Providers or Provider networks. The Rehabilitator has determined that

⁶ To the extent a guaranty association makes payment on an MSIC policy obligation consistent with its enabling legislation, then that guaranty association acquires the right to assert a Class 2 claim in the MSIC liquidation proceeding in the amount of such payment.

⁷ As of the date the Order of Rehabilitation was entered, MSIC had approximately 2,600 primary insureds and approximately 6,500 insured lives (considering both the primary insureds and their covered dependants).

approximately eighty-five percent (85%) of the dollar volume of the claims for health care services, involve approximately thirty (30) Providers or Provider networks.

19. The Rehabilitator submits that the most efficient and cost effective approach to consider outstanding claims, is to cooperate with the guaranty associations in discussing the claims directly with the Providers. It will clearly be quicker and more efficient, with a corresponding savings of administrative expenses, for the Liquidator and guaranty associations to discuss the bulk of the claims with a limited number of Providers, rather than try to address individual claims with over 2,600 primary insureds and then attempt to collectively bundle all claims that apply to a particular Provider. Given the volume of claims which now exist against MSIC, the Rehabilitator estimates that it should take no more than six (6) months from the date an Order of Liquidation is entered, for meaningful discussions to be held with all such Providers.

20. To the extent a dispute cannot be resolved and must be litigated, the sole and exclusive venue for the calculation of benefits under the MSIC Policies is this Court under the terms and provisions of the Liquidation Act.

- (a) First, the Liquidation Act expressly provides that upon an entry of an Order of Liquidation, “an action at law or equity may not be brought against the insurer or the liquidator, whether in Indiana or elsewhere, nor shall any existing actions be maintained or further presented after issuance of an order.” Ind. Code 27-9-3-12(a).
- (b) Second, the Liquidation Act establishes a mandatory priority for the payment of claims – providing for policy benefits (including guaranty association claims) as Class 2 and general creditor claims as Class 5. Ind. Code 27-9-3-40. “Every claim in each class must be paid in full (or adequate funds retained for payment) before the members of the next class receive any payment. Subclasses may not be established within any class.” *Id.* If the MSIC Policy interpretation of what is “Reasonable and Customary” is litigated in 50 different courts, rather than one exclusive forum, it could create multiple different interpretations of the same policy language. Simply put, having this Court serve as the sole and exclusive forum to decide the same policy language issue is critical to ensure equitable treatment of all policyholder level creditors making claims under the same policy language.

- (c) Third, the Liquidation Act provides a precise mechanism for each of the plaintiffs to assert their claims and to have their claims resolved by this Court. Any and all persons with claims against MSIC must file a proof of claim before a claims bar deadline to be established by this Court. Ind. Code 27-9-3-33. Moreover, the claims process expressly applies to situations where third parties (i.e. the Providers) are asserting a cause of action against an MSIC Insured. Ind. Code 27-9-3-36. Under the Liquidation Act, the Receiver reports to the Court recommending a claim amount and priority level for the claim under Ind. Code 27-9-3-40. To the extent the Receiver denies claims and the denial cannot be resolved, the Liquidation Act provides for a hearing before this Court. Ind. Code 27-9-3-37. It would be wholly inequitable and a violation of the Liquidation Act to permit certain Providers or MSIC Insureds to opt out of the claims process and instead determine the calculation of benefits under the MSIC Policies by means of separate lawsuits. As a practical matter any such effort by the Providers or MSIC Insureds would also be a waste of their time and effort, since pursuant to Ind. Code 27-9-3-34(d) this Court need not consider as evidence of liability or the measure of damages any judgment or order entered after the successful filing of a petition for liquidation, any judgment or order entered by default or collusion or any judgment or order entered not more than four (4) months before the filing of a petition for liquidation.
- (d) Fourth, the Liquidation Act expressly authorizes the Court to grant “restraining orders, preliminary and permanent injunctions, and other orders as considered necessary and proper to prevent any of the following: (4) Waste of the insurer’s assets. (6) The institution or further prosecution of any actions or proceedings. (7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders. (8) The levying of execution against the insurer, its assets, or its policyholders. Ind. Code 27-9-1-4. If lawsuits were permitted to go forward in other venues as to the extent of the MSIC policy obligations, they would undoubtedly result in different interpretation of the same policy language. These judgments could not be enforced as part of the claim process in this Court, since they would create preferences between the same class of claimants which is prohibited by the Liquidation Act. It would also be inequitable to allow Providers, in a forum outside of this Court, to obtain and enforce a judgment against an MSIC Insured which purports to establish the MSIC Policy obligation, when the sole and exclusive venue having jurisdiction to decide that issue and to which the MSIC Insured would then have to assert his or her claim, is this Court.

