

FEDERATION OF REGULATORY COUNSEL, INC.

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INSURANCE SECURITIZATION THROUGH SPECIAL PURPOSE FINANCIAL CAPTIVES

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South Carolina continues to be one of the fastest-growing onshore captive insurance jurisdictions with 29 newly licensed captives in 2006. There are currently 165 licensed captives operating in the state of South Carolina, all of which have been licensed in the last six years. While, historically, our state has been ranked in the top three leading domiciles in the world in overall captive growth, South Carolina has undoubtedly taken the lead in the area of the Special Purpose Financial Captive ("SPFC") with a total of 21 SPFC's currently licensed. The precipitating factor behind what can fairly be described as phenomenal SPFC growth is the high level of interest demonstrated by the capital markets in intersecting with the capital needs of the insurance industry. Attracting capital market participation is an innovative and efficient use of the SPFC. This trend, coupled with the State of South Carolina's progressive, experienced and stable statutory structure, all combine to ensure continued growth. This article supplements and updates one published previously on insurance securitizations in South Carolina and SPFC legislation.

Background

The creation of the South Carolina SPFC statute was a response to the convergence of the insurance industry's desire to access alternative sources of capital in order to address reserve requirements. These needs, coupled with the readiness of the capital markets to provide access to these markets through a securitization, were a recipe for success. An insurance securitization is a means of transferring insurance risk to the capital markets. Securitization transactions are becoming increasingly important to the insurance industry. They allow insurers to transfer risk by accessing global financial markets and thereby expand and diversify capacity. A securitization transaction may also be appropriate where coverage in the traditional reinsurance market is either unaffordable or unavailable.

Securitizations are comprised of two facets. The first involves creating the SPFC, essentially a state-regulated function. The second is the financial transaction, usually administered through an underwriter familiar with the capital markets. In a typical capital markets securitization transaction, the SPFC sells surplus notes to an underwriter who converts the notes into money market securities for sale to institutional investors. The securities are highly rated debt instruments and pay interest on specified dates. The parent, or counterparty, cedes certain risks to the SPFC for a specified premium. The premium revenue stream, investment income and other revenue sources fund the surplus notes. The proceeds from the sale of securities are held in a specially drafted trust administered by a third party financial institution. The trust funds provide credit for reinsurance and pay the ceded obligations.

The Beginning

Since 2000, the South Carolina General Assembly has passed several pieces of legislation to "pave the way" for insurance securitization transactions, including protected cell statutes in 2000, and the Special Purpose Reinsurance Vehicle Model Act in 2001. The Special Purpose Captive ("SPC") insurance company structure, created in 2002, gave the South Carolina Director of Insurance (the "Director") great flexibility in licensing a captive that would not otherwise fit into a more traditional captive structure.

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South Carolina enacted the foregoing legislation, in part, due to increased interest by many insurance companies in securitization as a means of accessing alternative sources of capital to address reserve requirements imposed by the Valuation of Life Insurance Policies Model Regulation adopted by the National Association of Insurance Commissioners (the “NAIC”) effective January 1, 2000 (“Regulation XXX” or “Triple-X”). Triple-X requires term life insurance policies with guaranteed premiums to be supported by reserves that are substantially in excess of “economic reserves.” Traditionally, economic reserves are calculated to fund expected mortality risks on a given block of term life policies and essentially equal the premiums for the policies. Regulation XXX requires additional reserves which are often equal to two or more times the economic reserves. Insurers were concerned that once individual states adopted their versions of Triple-X, they would be required to maintain redundant cash reserves, resulting in excessive reserve strain.

Initial Legislation

In 2003, South Carolina became the first onshore jurisdiction to finalize an insurance securitization through a captive platform. This transaction, however, revealed many complicated issues regarding the securitization that would be obviated best by enactment of specific legislation. For example, the flexibility of the SPC structure which allowed the transaction to occur was, ironically, counter to the needs of ratings agencies, financial guarantors,¹ and investors who sought certainty and specificity. These risks translated into greater risk and higher transaction costs. Without a governing statute, there was inherent imprecision in an insurance securitization due to uncertainty over the permanency and reliability of the Director’s orders approving the transaction. South Carolina responded to these concerns in 2004 by enacting its SPFC law² to provide a very stable statutory structure underpinning for each transaction.

For some time, South Carolina was the only jurisdiction in the world with legislation specifically addressing insurance securitization through a captive platform.³ The SPFC law authorizes regulation of SPFCs in a manner tailored to the needs and requirements of each individual insurance securitization transaction.⁴ The SPFC law contains several requirements to ensure the SPFC is financially sound and competently operated, including:

- minimum capital and surplus requirements;⁵
- restrictions on risks to be insured/reinsured;⁶
- restrictions on reinsurance that can be purchased;⁷
- strict requirements for trust accounts;⁸
- allowable investments for the safekeeping of the securitized funds;⁹
- officer certifications regarding the SPFC’s financial condition;¹⁰ and
- procedures for rehabilitation and liquidation.¹¹

Further, the law defines an insurance securitization in a manner which allows the general practitioner to fully understand the components necessary to complete the securitization transaction and conform the SPFC to NAIC requirements. The provisions of the SPFC law were drafted to ensure that securitized funds would be given credit for reinsurance to the counterparty or reinsured.¹² To ensure the validity of credit for reinsurance, the SPFC legislation affords the counterparty’s domicile regulatory authority a review of the proposed securitization to ensure that they will allow the counterparty credit for reinsurance.¹³

There are several requirements set forth in the SPFC statute. The SPFC’s directors and officers must submit to an extensive NAIC background check.¹⁴ The SPFC is required to prove that the securities to be issued in the transaction are compliant with South Carolina securities law.¹⁵ Further, the application requires a detailed plan of operation which forms the roadmap for the insurance securitization itself.¹⁶ In addition, the SPFC must present evidence showing the amount and liquidity of its assets relative to the risks assumed, the adequacy of management’s expertise, experience, and character, the overall soundness of its plan of operation, and any other factors the Director considers relevant.¹⁷

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The SPFC statute also provides that information submitted in compliance with the filing requirements is confidential and subject to strict compliance with disclosure provisions.¹⁸ The statute also sets forth required examinations, investigations, and ongoing review processes to be conducted by the South Carolina Department of Insurance (the “SCDOI”).¹⁹ The Director, in their discretion (usually by an order), may exempt an SPFC from any provision of the SPFC law which they deem inappropriate given the nature of the risks to be insured.²⁰

The SPFC, although regulated and established through the insurance laws, contains general corporate powers under South Carolina law.²¹ An SPFC is required to file with the Director a certified copy of its organizational documents, hold at least one management meeting each year in South Carolina, maintain its principal place of business in South Carolina and appoint a registered agent for service of process.

Regulatory Risk Minimization

One of the most important provisions of the SPFC law relates to the three levels of regulatory authority through which regulatory risks associated with insurance securitization transactions are addressed.

First, the State of South Carolina has a special Administrative Law Court (“ALC”) designed to analyze and resolve disputes which may arise with an administrative agency like the SCDOI.²² Should there ever be any dispute between the SCDOI and any party regarding an SPFC, it will be resolved by the ALC. The ALC is an established part of the state judicial system and has a long track record of efficiently and definitively addressing administrative actions such as those inherent in an insurance securitization.

Secondly, pursuant to the state’s Administrative Procedures Act,²³ each insurance securitization is accompanied by a detailed order issued by the Director. Each order is specially tailored to address the particular nature and requirements of the specific insurance securitization and the authorized underlying transactions. The order also directly addresses issues which may materialize in the future, such as restructuring of the SPFC or additional capital and surplus requirements resulting from variances in actual performance as compared to expected performance.

Third, and most significantly, the ALC process and the Director’s order are effectively locked-in by the SPFC law,²⁴ ensuring a comprehensive degree of protection for the benefit of all parties to the insurance securitization. The statute maintains the SCDOI’s authority to protect the integrity of the Director’s order and effectively prohibits the Director or any third party from amending or changing an existing order, except for specifically delineated regulatory purposes.

In sum, once a securitization is in place, while it is not impossible to amend or revise an order of the Director by a third party, the probability of doing so is remote. This gives greater comfort to the parties involved in the transaction. This is particularly true for the financial guarantor, since the permanency of the order results in risk minimization which, in turn, commensurately lowers the amounts charged for the credit wrap insuring the money market securities.

Protected Cell SPFCs

Another example of South Carolina’s innovative approach to insurance securitization is the newly-enacted revisions to the SPFC law regarding the use of protected cells.²⁵ This addition came in response to several insurance companies expressing a desire to securitize more than one block of business within the same SPFC. The initial SPFC law allowed an SPFC to create and use protected cells; however, an important issue with respect to protected cells is whether or not assets and liabilities of each protected cell are truly segregated. Because the segregation of protected cells has never been judicially tested, there is an inherent risk in the insurance securitization.

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The new statute clarifies that there is a segregation of assets and liabilities and declares that, although a protected cell is not a separate legal entity, it can be sued and liquidated separately from the SPFC.²⁶ The revisions also provide for separate reporting and capitalization of each protected cell. It also imposes additional disclosure requirements on these structures.

Several changes were made to reflect suggestions of the ALC to clearly define terms, standards, and criteria applicable in a contested case brought by a third party before the ALC. The new SPFC law provisions significantly reduce the amount of risk involved in protected cells. Equally important, the use of protected cells should significantly reduce “friction costs” caused by duplication of effort of legal counsel, underwriters, and financial guarantors. Through enactment of this legislation, South Carolina is branding the jurisdiction as a worldwide leader in the use of captives for structured finance transactions. South Carolina now has the most efficient statutory framework in place for the ever-growing securitization market and continues to be recognized as a global leader in that arena.

Benefit to the State

Insurance securitization transactions involve substantial monetary amounts resulting in significant economic advantages to the state, including premium taxes, fees and collateral revenues generated by the SPFC’s ongoing operations. Because the transactions may span a period of thirty years, it is expected that the present value of the premium taxes to be paid will be significant and important to the state’s economy. For example, the present values of expected tax payments for most securitization transactions are in excess of \$1 million for each transaction, from inception to closure.

Growth and Future Prospects

The SPFC program has been a great success. In three years, South Carolina has licensed 21 SPFC’s, 12% of the total number of captives authorized to date by the SCDOI.²⁷ The 8 SPFCs newly-licensed in 2006 comprise 28% of the captives licensed that year. To address the rapid growth, the Director of Insurance for South Carolina has recently implemented an outsourcing program for application review and examinations. Additional resources have been provided to the program to facilitate more efficient and timely operations.

The most significant SPFC event in 2006 was the successful completion of an AXXX transaction. AXXX refers to the NAIC’s Actuarial Guideline 38 (AG38), which is a natural evolution of the Triple-X requirement that addresses reserve requirements for universal life policies. These are very different from term policies in that universal life policies often include no lapse guarantees and are especially interest sensitive. The unique nature of universal life policy benefits makes AG38 securitization transactions much more complex.

South Carolina’s SPFC statute envisions many other complex types of insurance securitizations. The numbers reflect how South Carolina has established a reputation as a world leader in utilizing alternative risk transfer platforms as vehicles for sophisticated structured finance transactions. The state is beginning to see different types of securitizations. For example, a discrete block of disability business has been securitized, wholly unrelated to Triple-X. South Carolina is currently evaluating an embedded-value securitization. This type of securitization will enable insurance companies with profitable blocks of business to increase capital efficiency by avoiding the need to wait for years to utilize the profits on these policies.

As more transactions are completed, South Carolina is gaining a better track record and more credibility, not only with ratings agencies and financial guarantors, but also with other regulators. Most of the counterparty states South Carolina has dealt with to date — Connecticut, Illinois, Maine, Minnesota, Michigan, Missouri, Tennessee, New York, Nebraska, Virginia, Washington — are now familiar with South Carolina’s insurance securitization program. With the SPFC law, and the seasoned SCDOI regulatory team, other domiciles know they are dealing with a competent jurisdiction that will not approve a transaction without ensuring all parties

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and the ultimate policy holders are protected.

Endnotes

1. Financial guarantors are also known as “wrappers.” These entities are generally involved in securitization transactions to ensure that the securitized paper that is ultimately issued to investors is AAA rated.
2. 2004 S.C. Acts 269, executed by Governor Mark Sanford on July 29, 2004.
3. S.C. Code Ann. §§ 38-90-410, et seq.
4. The SPFC law has been designed to facilitate insurance securitizations which previously were accomplished by forming a SPC.
5. S.C. Code Ann. § 38-90-460.
6. A SPFC may insure or reinsure only counterparty risks. S.C. Code Ann. § 38-90-440 (A). A “counterparty” is defined as the “SPFC’s parent or affiliated company, as ceding insurer to the SPFC contract, or subject to the prior approval of the director, a nonaffiliated company.” S.C. Code Ann. § 38-90-420 (5).
7. S.C. Code Ann. § 38-90-440 (A).
8. S.C. Code Ann. § 38-90-530.
9. S.C. Code Ann. § 38-90-520.
10. S.C. Code Ann. § 38-90-440 (C)(5).
11. S.C. Code Ann. § 38-90-600.
12. S.C. Code Ann. § 38-90-590.
13. S.C. Code Ann. § 38-90-440 (H)(4).
14. S.C. Code Ann. § 38-90-440 (C)(4).
15. S.C. Code Ann. § 38-90-440 (C)(5)(d). This provision was evidently added due to a concern that there be no “dual regulation” between the offices of the Securities Commissioner and the Insurance Director. Several provisions preserve this objective.
16. S.C. Code Ann. § 38-90-440 (E).
17. S.C. Code Ann. § 38-90-440 (C)(2).
18. S.C. Code Ann. § 38-90-610.
19. S.C. Code Ann. § 38-90-610.
20. S.C. Code Ann. § 38-90-430 (C).

FEDERATION OF REGULATORY COUNSEL, INC.

21. S.C. Code Ann. §§ 38-90-410. See also the South Carolina Business Corporations Act of 1988, S.C. Code Ann. §§ 33-1-10, et seq.
 22. S.C. Code Ann. § 1-23-350.
 23. S.C. Code Ann. §§ 1-23-310, et seq.
 24. S.C. Code Ann. § 38-90-620.
 25. 2005 S.C. Acts 363, executed by Governor Mark Sanford on July 1, 2005.
 26. S.C. Code Ann. § 38-90-485.
 27. Because two “Special Purpose Captives” as defined by S.C. Code Ann. § 38-90-10 (26) currently operate as SPFCs, they are included in these totals.
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DELAWARE'S NEW CAPTIVE INSURANCE STATUTE

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Hoping to capitalize on its well established reputation as a center for corporate and financial services, in 2005, Delaware completely revised chapter 69 of the Delaware Insurance Code respecting captive insurance companies, with the intention of developing Delaware as a preferred captive domicile. These revisions, combined with: 1) the creation of a special division within the Delaware Insurance Department devoted to captives, and 2) the formation of the Delaware Captive Insurance Association, dramatically changed the outlook for captive insurance in Delaware.

Captive insurance companies have been permitted under Delaware law for some time; however, Delaware has attracted but a handful of captives since the statute was first enacted over 20 years ago. Notable amongst this handful, however, is Nuclear Electric Insurance, Limited (“NEIL”). NEIL became a Delaware domiciled industrial insured captive in 1988 and today insures every nuclear electric generating unit in the United States as well as a number of units in Europe.¹ At year end 2005, NEIL boasted annual net premiums in excess of \$215 million and capital and surplus in excess of \$3.5 billion.²

History

Delaware became a captive domicile in 1984, when Senate Bill 527 was signed into law, creating a new chapter, Chapter 69, of the Delaware Insurance Code.³ Patterned after Vermont’s captive statute, SB 527 was intended to take advantage of changes in federal tax laws making offshore captives less attractive.⁴ It was hoped that Delaware would generate increased revenue from the growth of an indigenous captives industry, and that this would further enhance Delaware’s reputation as a financial center.⁵

Chapter 69 underwent two changes in the late 1980s and again in the mid 1990s. In 1988, House Bill 406 was adopted, adding a new subsection to then-section 6906.⁶ The purpose of this change was to allow captive insurers organized under the laws of jurisdictions other than Delaware to elect regulation as if such captives

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were organized under Delaware law. The impetus behind House Bill 406 was to allow NEIL, a Bermuda company, to move its principal place of business to Delaware and to become regulated as a Delaware domestic.⁷ The final substantive amendment to the pre-2005 version of Chapter 69 was embodied in Senate Bill 208, signed into law in 1995. This amendment was intended to allow association captives and industrial insured captives to write up to 50% of gross direct premiums outside their respective industrial insured or association groups.⁸ Both of these amendments granted unique flexibility to Delaware captives and, in concept or in letter, are preserved under the new law.

Despite the progressive nature of Delaware's captive statute, even as amended in 1988 and 1995, captive insurers did not flock to Delaware. Indeed, at the time of the revisions to the statute in 2005, Delaware had just five domiciled captives.⁹

Development of the New Statute

In response to the lackluster industry response to Delaware as a captive domicile, in early 2005, representatives from the financial services industry; legal, actuarial and accounting communities; the State Chamber of Commerce; the Delaware Department of State; the Delaware Economic Development Office and the Delaware Insurance Department convened a series of meetings throughout the winter and spring of 2005. The goal of these meetings was to completely revamp Chapter 69 to embody the latest statutory innovations in use in the most progressive domiciles, and to foster a business and regulatory climate that would accommodate innovation and flexibility without compromising regulatory oversight.

The result of these meetings was House Bill 218, introduced into the Delaware General Assembly on June 8, 2005.¹⁰ Typical of Delaware economic development legislation, HB 218 met with virtually unanimous approval in the General Assembly, and was amended only one time on its way to passage in both houses.¹¹ Just 34 days after its introduction into the House, HB 218 was signed into law by Governor Ruth Ann Minner.

The New Captive Insurance Statute

Although the new statute retains a number of features from its earlier form the captives statute is, in fact, entirely rewritten. The following are some of its more noteworthy features:

Flexibility as to corporate entity

As noted, the prior version of Chapter 69 expressly permitted non Delaware corporations to become regulated as Delaware domiciled companies. However, whether alien, foreign or domestic, a captive was limited to the corporation as the form it was required to take. As revised, Chapter 69 allows a captive to opt from a range of business organizations, i.e., corporation, limited liability company, partnership, limited partnership or statutory trust.¹² Moreover, the statute does not require that such companies be formed in Delaware, thus preserving the ability of a captive organized under the business laws of a jurisdiction other than Delaware to choose Delaware as its place of domicile for regulatory purposes.

Non-Captive business

The new statute preserves the unique ability of Delaware association and industrial insured captive insurers to write up to 50% of their business outside the association or industrial insured groups.¹³ The only limitations are that such business be limited to entities in the same, related or similar business as the members of the industrial insured or association group and that the business be in the same or similar insurance lines as that written for group members.

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Subject to rulemaking by the Insurance Department, the new statute also allows a pure captive to write risks for an unaffiliated company if the captive's parent or any affiliate thereof is (through contract) exercising control over the risk management function for such non-affiliated company.¹⁴

Permitted lines of business

Delaware captives are virtually unrestricted in the lines of business for which they can potentially obtain a certificate of authority, with the sole exception of workers compensation insurance.¹⁵ As for workers compensation, Delaware captives are permitted to write so-called "excess workers compensation insurance" for parent and affiliated companies.¹⁶ Excess workers compensation is a concept whereby a captive may begin insuring at or above a per incident or aggregate layer prescribed by the local insurance regulator. Under the new Delaware statute, however, the Commissioner is prevented from setting this limit at a point in excess of the level at which a parent or affiliated company is authorized to self-insure its own risks under applicable federal and state law. Thus, if a parent company is authorized to self-insure its workers compensation risks at dollar one, a Delaware captive can insure those risks at dollar one.

Captive investments and accounting

Delaware law previously extended great latitude to the ability of a pure or industrial insured captive to make investments of all types, and this has been retained.¹⁷ However, under the new statute, Delaware captives of all types are expressly permitted to own the securities of, or interests in, another captive.¹⁸ This allows a parent company or industrial insured group greater flexibility to segregate risks in multiple captives and to arrange those captives vertically in the corporate structure rather than horizontally. More importantly, the ability of one captive to hold another captive means that a captive can set up a subsidiary captive as a "special purpose reinsurance vehicle" for extraordinary purposes that might include issuing catastrophe bonds for use in covering the parent's exposure to otherwise uninsurable risks.

The new statute expressly allows a captive to prepare its annual report under generally accepted accounting principles ("GAAP"), statutory accounting principles ("SAP") or international accounting standards ("IAS").¹⁹ Although many jurisdictions provide varying degrees of flexibility as between GAAP and SAP, Delaware is the first to expressly allow the use of IAS. Delaware had previously eliminated all restrictions on a pure or industrial insured captive's investments; accordingly, additional provisions in the new statute permit a captive using SAP to record as "admitted" those assets that SAP would otherwise require be "non-admitted" and thus ignored for purposes of the insurer's balance sheet.²⁰

Protected cells

This is one aspect of captive insurance where Delaware law clearly lagged behind that of other jurisdictions. Under the new statute, Delaware has adopted "sponsored captive" provisions much like those in place in other progressive domiciles.²¹ Accordingly, Delaware captives may be organized to serve multiple members, each of which has the ability to segregate its risks in a protected cell that is insulated from the liabilities of other cells. The new statute makes clear that the Commissioner has the authority to take remedial action, specifically including rehabilitation or liquidation, against a single cell in the event that cell becomes impaired or insolvent, without such action spilling over into other, financially sound, cells.²² More important, members of a Delaware-sponsored captive need not be members in a particular association or industrial insured group in order to participate in a sponsored captive, and need not be the owners thereof.²³

Taxation, fees, and "bricks and mortar"

Business as a captive in Delaware naturally comes with a price. Fees associated with licensing are significantly steeper than under the prior version of the statute, with a \$200 application fee and \$3,000

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processing fee required with each application.²⁴ Annually, each captive is also required to pay a \$300 fee to maintain its certificate of authority.²⁵

Under the new statute, Delaware taxes its captives through a flat, capped premium tax structure which now provides a modest .2% (+.1% for reinsurance) tax capped at \$125,000.00 for direct written business and \$75,000.00 for reinsurance.²⁶ The aggregate maximum tax payable by a sponsored cell captive is \$200,000.²⁷ If a captive has 25 or more full time employees in Delaware, the cap on taxation is reduced to just \$50,000.²⁸

What one must also consider in addition to fees and taxes is the ongoing “bricks and mortar” requirements that a jurisdiction imposes in return for the privilege of being domiciled in that jurisdiction. A Delaware captive is required to maintain its principal place of business in Delaware.²⁹ Notably, however, there is no requirement to retain a Delaware based “captive manager” – although for smaller captives without an indigenous staff, retention of a manager in Delaware will satisfy the principal place of business requirement as well as provide the expertise and resources necessary to operate the company. While a Delaware captive with fewer than five full-time employees in Delaware is required to have at least one meeting of its governing body in Delaware,³⁰ another provision of Delaware law may serve to ease this requirement. The Delaware General Corporation law provides that directors may participate in a board meeting by conference telephone or other communications equipment, which participation constitutes the “presence in person” of such director. Accordingly, a Delaware captive organized as a corporation can comply with the Delaware board meeting requirement even though most of the directors are participating by phone from outside Delaware.³¹

Regulatory requirements

Delaware captives, naturally, are required to meet certain standards in order to obtain and maintain a certificate of authority. First and foremost, Delaware captives are required to maintain minimal levels of capital and surplus ranging from a low of \$250,000 for a pure captive to a high of \$1,000,000 for a risk retention group.³² § 6905(a). The Commissioner is given the discretion to require additional levels. These minimal levels must be maintained in Delaware, and can be in the form of cash, an irrevocable letter of credit, or other securities approved by the Commissioner.³³

An applicant for a certificate of authority must supply the Commissioner with information respecting the amount and liquidity of its assets, the competence and character of its personnel, its insureds’ loss prevention programs and such other information as the Commissioner may require.³⁴ Importantly, each applicant must satisfy the Commissioner of the overall soundness of its plan of operation.³⁵

Once granted a certificate of authority, the Commissioner is required to conduct triennial examinations of the captive,³⁶ and the Commissioner is broadly empowered to revoke the Certificate of Authority if he finds that the captive is insolvent, has failed to maintain minimum capital and surplus, has failed to file an annual report, is not in compliance with its organizational documents, has failed to pay its taxes, or is otherwise using methods that render operation detrimental to policyholders or make its condition unsound.³⁷

Delaware’s new statute requires that captives provide the Commissioner with 30 days prior written notice of certain “material transactions.” These include the dissolution of the company; sale, lease, mortgage, assignment, etc. of all or substantially all of the company’s assets; the incurrence of “material indebtedness” or the making of a “material loan”; a material payment out of capital and surplus; a merger or consolidation involving the company; its conversion to another form; transfer of domicile or any material amendment to its organizational documents.³⁸ The statute does not define “materiality” for purposes of material transactions reporting, and the Commissioner has yet to publish regulations that would otherwise accomplish this.

Activity beyond the statute

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Delaware's prior experience with its captive statute demonstrated clearly that having a progressive statute is not enough; to the contrary, without a business and regulatory climate that fosters the development of the domicile, the best statutory language imaginable will not populate the state with new applicants. This seems especially self-evident considering the recent proliferation of captive domiciles both domestically and off shore.

On October 13, 2005, the Delaware Captive Insurance Association (the "DCIA") was organized. The purpose of the DCIA is to "promote the common business interests of and improve business conditions among persons employed by or in, practicing or otherwise doing business in, or otherwise connected with the captive industry in Delaware."³⁹ The current membership of the DCIA includes captive insurance companies, captive managers, law firms, accounting firms and actuarial firms.⁴⁰ On October 4, 2006, the DCIA held its first annual captive insurance conference in the Hotel DuPont in downtown Wilmington, Delaware. The event was well attended for a first-time event – attracting over 100 attendees representing a broad spectrum of the captive insurance industry – and included speakers from Delaware captive insurers, service providers and regulators.⁴¹ Governor Minner was the event's keynote speaker.

Perhaps the most critical element beyond the statute itself is the regulatory regime established to administer it. In the past, Delaware did not regulate captive insurers apart from, or substantially different than, conventional insurers. As of August 2006, this has changed. Under Commissioner Matthew Denn, the Delaware Insurance Department has established a separate captives unit charged exclusively with regulating Delaware captives. This unit is headed by William P. White, the former director of the Captive Insurance Division for the District of Columbia Department of Insurance, Securities and Banking.

Conclusion

Delaware has enacted sweeping changes to its captive insurance statute which make it comparable to the most progressive domiciles available. These changes have enjoyed the backing and support of Delaware's General Assembly, its Department of State, its Economic Development Office and its Insurance Commissioner. With the creation of the DCIA, the Delaware business community is committed to developing Delaware as a domicile of choice. Finally, the creation of a specialized captives unit within the Insurance Department, headed by a director with substantial captive experience, will bring a greater level of sophistication to Delaware's regulation of these special purpose entities.

The three legs of the captive insurance tripod are now firmly in place in Delaware. It remains to be seen whether this effort will bear fruit, or whether the "market" for captive domiciles is too saturated to attract real interest in Delaware as a viable and attractive alternative.

Endnotes

1. 2005 NEIL Annual Report.
2. *Id.*
3. 64 Del. Laws c. 454 § 1.
4. *Id.* at synopsis.
5. *Id.*

FEDERATION OF REGULATORY COUNSEL, INC.

6. 66 Del. Laws c. 223 § 1.
7. *Id.* at synopsis. At the time NEIL was, in fact, two separate companies – Nuclear Mutual Limited and NEIL. Nuclear Mutual Limited was merged into NEIL in 1995. The author refers to both companies as “NEIL” for the sake of simplicity.
8. 70 Del. Laws c. 107 § 1.
9. Source: Delaware Department of Insurance.
10. 75 Del. Laws c. 150.
11. House Amendment No. 1 to HB 218 made technical corrections regarding the repeal of chapter 69 and the election of a previously licensed captive insurance company to become subject to the application of the new chapter 69.
12. 18 *Del. C.* § 6906.
13. 18 *Del. C.* § 6903(a)(2) (for association captives); 18 *Del. C.* § 6903(a)(3) (for industrial insured captives).
14. 18 *Del. C.* § 6919.
15. 18 *Del. C.* § 6903(a).
16. 18 *Del. C.* § 6903(a)(8).
17. 18 *Del. C.* § 6910(b). Association captives, risk retention groups and special purpose captives are still required to comply with investment requirements applicable to conventional insurers under chapter 13 of the Delaware Insurance Code.
18. 18 *Del. C.* § 6910(d).
19. 18 *Del. C.* § 6907(b)
20. *Id.*
21. 18 *Del. C.* §§ 6931 – 6938.
22. 18 *Del. C.* § 6938.
23. 18 *Del. C.* § 6936.
24. 18 *Del. C.* § 6903(d).
25. *Id.*
26. 18 *Del. C.* § 6914(a) – (b). Under this provision, two or more captives under common ownership are taxed as though they were a single company.
27. 18 *Del. C.* § 6914(c).

FEDERATION OF REGULATORY COUNSEL, INC.

28. 18 *Del. C.* § 6914(h).
 29. 18 *Del. C.* § 6903(b)(3); *Del. C.* § 6906(f).
 30. 18 *Del. C.* § 6903(b)(2).
 31. 18 *Del. C.* § 141(i).
 32. 18 *Del. C.*
 33. 18 *Del. C.* § 6905(c).
 34. 18 *Del. C.* § 6905(c).
 35. 18 *Del. C.* § 6903(c)(2)(C).
 36. 18 *Del. C.* § 6908(f). These examinations are to be conducted in accordance with those requirements applicable to conventional insurers.
 37. 18 *Del. C.* § 6909(a).
 38. 18 *Del. C.* § 6922.
 39. DCIA Certificate of Incorporation at Article III.
 40. Source: DCIA Website www.delawarecaptive.org
 41. *Id.*
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RISK-BASED REINSURANCE COLLATERAL REQUIREMENTS: A NEW ERA?

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During the December 2006 Winter National Meeting of the National Association of Insurance Commissioners (“NAIC”), the NAIC Reinsurance (E) Task Force (the “Task Force”) was presented with a proposal to change the current reinsurance collateral requirements for domestic and foreign reinsurance companies. The proposal, adopted by the Task Force, would change the collateral rules by focusing on the financial strength of reinsurers doing business in the U.S., rather than fixing collateral requirements based exclusively on licensure and accreditation status.

This proposal has been met with opposition by parties interested in preserving the current collateral requirements and with support from parties interested in amending the regulatory system governing domestic and foreign reinsurers. This article explores the current collateralization requirements, the history and substance of this proposal, and the arguments made in favor of and against amending the U.S. reinsurance

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collateral requirements.

Regulation of Reinsurance

In general, reinsurance is regulated with an almost exclusive focus on the cedent company's solvency, the financial condition of the ceding company, and the financial impact on insurance consumers. Regulatory scrutiny is limited to financial condition and solvency, rather than incorporating rate and form filing protections and other regulatory requirements¹ typical of insurance regulation in the U.S., because "a reinsurance contract is entered into between two sophisticated parties each of which is fully aware of the risks and rewards associated with such contract."²

Thus, "consumers" of reinsurance are more typically able to fend for themselves and do not warrant the intense regulatory protections imposed throughout primary insurance regulation.

Collateral Requirements:

U.S. regulators actively supervise the solvency of U.S. authorized reinsurance companies. The regulator in the state of domicile for a U.S.-based reinsurer, or in the state of entry for U.S. branches of alien reinsurers, conducts financial examinations to assess the solvency of the reinsurer. This is frequently referred to as the "direct" approach to reinsurance regulation.

Regulators also take an "indirect" approach to regulate authorized and unauthorized assuming reinsurers by controlling the statutory credits granted to U.S. ceding insurance companies on their balance sheets and income statements for risk transferred via reinsurance. Under the various state Credit for Reinsurance Laws and Regulations, a U.S. ceding company will be granted credit for reinsurance ceded, as an asset on its balance sheet or as a reduction from liabilities (hereinafter referred to as "credit"), provided that one of the following requirements is met:

1. The reinsurance is ceded to an assuming reinsurer that is licensed to transact business in the same state of domicile as the ceding company.³
2. The reinsurance is ceded to an assuming reinsurer that is accredited as a reinsurer in the same state of domicile as the ceding company.⁴
3. The reinsurance is ceded to an assuming reinsurer that is licensed to transact business in a state with credit for reinsurance standards that are substantially similar to the cedent's state of domicile.⁵
4. The reinsurance is ceded to an assuming reinsurer that provides collateral in the form of a multi-beneficiary trust.⁶
5. The reinsurance is ceded to an assuming reinsurer that provides collateral or other security to the ceding company.⁷

If reinsurance is ceded to an assuming reinsurer that is not directly regulated by state regulators (licensed or accredited in the ceding company's state of domicile, or licensed in another U.S. state with similar credit for reinsurance laws), the ceding company may take credit for reinsurance only if the reinsurer posts collateral for at least 100% of its gross liabilities to U.S. ceding companies. This imposes not only direct regulation of the U.S. ceding insurer, but also indirect regulation on unauthorized non-U.S. reinsurers as an alternative to submitting to full regulation under the states' licensing/accreditation requirements, as unauthorized reinsurers satisfy the state regulator's collateral requirements.

NAIC Proposal to Amend Collateral Requirements

In March of 2006, the NAIC Executive Committee directed the Task Force to:

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...develop alternatives to the current reinsurance regulatory framework, including the use of collateral within the U.S. and abroad. Consider approaches that account for a reinsurer's financial strength regardless of domicile, i.e., state or country...

Pursuant to this charge, the Task Force considered a proposal that would change the current reinsurance collateral requirements by focusing on the financial strength of reinsurers doing business in the U.S., rather than fixing collateral requirements based exclusively on licensure and accreditation status. The proposal, entitled "NAIC Reinsurance Evaluation Office: Proposal to Grant Credit for Ceded Reinsurance," followed extensive consideration of alternatives to the current reinsurance regulatory structure. The substance of the proposal and a summary of the salient points raised in support and opposition to the proposal are presented below.

Substance of the Proposal

Current collateral rules require that reinsurance obligations assumed by unauthorized reinsurers be fully collateralized before U.S. cedent companies can take credit for the reinsurance ceded. The collateral requirements apply across the board for all assumed reinsurance obligations by unauthorized reinsurers, are wholly dependent upon the reinsurers' state or country of domicile, and in no way account for the financial condition of the assuming reinsurer. The NAIC proposal would eliminate the across the board requirement for at least 100% collateralization for all unauthorized reinsurers, and would instead require collateral from reinsurers on the basis of their financial strength relative to credit risk, adjusting the required collateralization levels accordingly.

Reinsurance Evaluation Office

The proposal also creates a Reinsurance Evaluation Office ("REO") that would develop procedures for evaluating the financial strength and operating integrity of all reinsurance companies doing business in the United States, both authorized and unauthorized reinsurers alike. The REO would assign each reinsurer a rating as a result of its evaluation, and this rating would determine the level of collateral required to be posted for reinsurance obligations assumed by the reinsurer.

In addition to analyzing various criteria to assess reinsurers' financial strength and credit risk rating, the REO would periodically reexamine reinsurer ratings by evaluating quarterly, annual and ad hoc reports filed by reinsurers.

Rating Criteria

The REO proposal envisions the use of rating criteria that are "consistent with the standards used by markets to assess credit risk."⁸ As a result, the REO rating criteria would be pegged to the insurance financial strength ratings assigned to reinsurers by nationally recognized statistical rating organizations ("NRSRO").

Additional criteria to be used in the proposed REO assessment process would include: the strength of solvency regulation in the reinsurer's domiciliary jurisdiction; the reinsurer's risk assumption experience; the reinsurer's reputation for claims payment; and collateral requirements for unaffiliated reinsurance assumptions. These criteria are explained below.

NRSRO Ratings

A reinsurer's REO rating would be assigned as one of six "rating bands," ranging from "REO-1" to "REO-6." The primary criteria for determining a reinsurer's REO rating would be the financial strength rating assigned to the reinsurer by an NRSRO. The proposal correlates each REO rating to equivalent ratings levels used by

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the various NRSROs (including AM Best, Standard and Poor's, Moody's and Fitch). Rating bands REO-1 through REO-4 are presented as "secure" ratings. REO-1 is the most secure rating, with the equivalent of an AM Best ("Best") rating of A++. Bands REO-5 and REO-6 are categorized as "vulnerable" ratings, with REO-6 having an equivalent Best rating of C, C-, D, E, or F.

For reinsurers with inconsistent ratings from multiple NRSROs, the REO rating would reflect the rating given by the majority of the NRSROs.

Insolvency Regulation in Domiciliary Jurisdiction

Although the REO rating is initially tied to the NRSRO rating, the REO may adjust the rating higher or lower than the corresponding NRSRO rating based upon other factors, including the strength of existing financial solvency regulation in the reinsurer's jurisdiction of domicile.⁹

Length of Time

Another factor considered in adjusting the REO rating higher or lower than the corresponding NRSRO rating would be the length of time that the reinsurer has actively assumed risks. This time period may not be less than three years, unless specifically permitted by the REO.¹⁰

Reputation for Prompt Payment

The REO would also consider the reinsurer's reputation for prompt payment of valid claims under reinsurance agreements in assessing the reinsurer's REO rating. The analysis of the reinsurer's prompt payment trends would include consideration of the reinsurer's aging obligations or those owed to distressed companies.¹¹

Unaffiliated Reinsurance Assumptions

The last specific criterion for assessing the REO ratings are collateral requirements for unaffiliated reinsurance assumptions for certain U.S. authorized reinsurers. Although not specifically related to setting a reinsurer's REO rating, the proposal provides that collateral may be required for unaffiliated assumptions by U.S. authorized reinsurers unless the authorized U.S. reinsurer has an adequate secure rating, complies with U.S. capital requirements, and satisfies other specified requirements. Collateral would not be required from either U.S. authorized reinsurers for any affiliated reinsurance assumptions,¹² or for non-U.S. affiliate reinsurance assumptions of U.S. authorized reinsurers.

Discretionary Criteria

The proposal last provides that "[o]ther factors deemed appropriate by the REO" may also be considered as rating criteria.¹³

Collateral requirements

The collateral required for liabilities arising out of reinsurance agreements will depend on the reinsurer's REO rating. The proposal sets forth minimum collateral requirements by REO rating band, expressed as a percentage of reinsurance obligations assumed from ceding companies, as follows:

1. REO-1: 0%
2. REO-2: 20%
3. REO-3: 40%
4. REO-4: 60%

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5. REO-5: 80%
6. REO-6 or unrated: 100% or such higher amount as the REO may determine based upon risk of adverse loss development.¹⁴

The proposal also provides for credits to be taken by ceding companies for reinsurance secured by qualifying Multi-Beneficiary Trusts (“MBTs”).¹⁵

Reporting Requirements

The REO proposal not only rates reinsurers’ risks for the purpose of determining collateralization requirements, but also provides continued monitoring of reinsurers’ financial condition to ensure that the assigned ratings and collateral levels are appropriate for the levels of risk present. To this end, the REO requires reinsurers to report their financial condition at regular intervals and upon the occurrence of specified events as outlined below.

Quarterly Reporting Requirements

Rated reinsurers must file with the REO: a quarterly statement providing any changes to their licenses or NRSRO rating; information comparable to quarterly NAIC financial statement information; lists of all disputed and overdue claims regarding reinsurance obligations assumed from U.S. ceding companies; and “any other information that the REO may reasonably require.”¹⁶

Annual Recertification Requirements

The REO provides a minimum frequency for re-rating reinsurers. Although the proposal provides that reinsurers may be re-rated as frequently as the re-licensing period of the reinsurer’s domiciliary jurisdiction, the REO requires that reinsurers be re-certified at a minimum on an annual basis.¹⁷

Continuous Duty to Update Information

In addition, rated reinsurers must immediately advise the REO of any changes in their NRSRO rating, domiciliary license status, or changes in directors and officers.¹⁸ The proposal provides that the REO will continuously monitor NRSRO ratings to determine if rated reinsurers’ collateral amounts require adjustment.¹⁹

Change/Revocation of REO Rating

The REO proposal will preserve the authority to adjust or withdraw reinsurers’ ratings if a reinsurer fails to meet the minimum requirements provided in the proposal or if the REO determines the need to reconsider the reinsurer’s ability or willingness to meet its contractual obligations.²⁰

In the event that a reinsurer’s rating improves, the proposal permits the reinsurer to meet the collateral requirements that correspond to the improved rating band, on a prospective basis. If, however, the reinsurer’s REO rating deteriorates, the reinsurer will be required to immediately meet collateral requirements that apply to the new rating band for all existing as well as new contracts.²¹

Last, the REO proposal provides that “an appropriate appeals process” will be available to review rating decisions made by the REO.²²

Reinsurer Eligibility Requirements

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The REO requirements must be satisfied by a reinsurer seeking to be rated by the REO. To be rated, a reinsurer must submit a variety of information to the REO, including, inter alia: an application and fee; audited financial statements for the past three years filed with the reinsurer's domiciliary regulator, including, when applicable, a reconciliation to U.S. accounting procedures, unless waived by the REO,²³ certification of all current NRSRO ratings issued for the reinsurer; an AR-1 Form; biographical information for the reinsurer's directors and officers; NAIC Annual Filing Blanks; a list of all disputed and overdue²⁴ recoverables; signed consent to obtain financial and operational information from the reinsurer's domiciliary regulator; a certificate of good standing; a description of the domiciliary regulatory structure; and "any other information that the REO may reasonably require."²⁵

Responses to the Proposal

Parties engaged in the debate over the REO proposal (domestic and non-authorized reinsurers, life insurers, regulators, and other interested parties) agree that both domestic and foreign domiciled reinsurers are necessary to provide the requisite capacity to meet the U.S. demand for reinsurance, and that the financial ability of the assuming reinsurance companies to meet the reinsurance obligations ceded is of vital importance. This consensus falters, however, when the parties comment on the adequacy of the new collateral requirements to improve the condition of the reinsurance marketplace.

The REO proposal has been criticized by interested parties and domestic reinsurers alike as catering to non-U.S. reinsurers by easing the collateral requirements currently applicable to these entities, while increasing the burdens and imposing collateral requirements on U.S. licensed reinsurers who already comply with stringent state regulatory requirements. Domestic insurers, reinsurers and industry associations voiced objections to the proposal and provided comments including, inter alia, that the proposal:

- is unnecessary and imposes excessive new collateral requirements;
- is under-inclusive, fails to address alternatives other than the ratings proposal, and ignores other relevant risk factors;
- weakens critical solvency protections by relaxing collateral requirements of reinsurers over which the U.S. regulators have no oversight;
- devalues a U.S. license by removing incentives and protections formerly available as a result of a domestic license;
- involves an unconstitutional delegation of authority to a non-governmental body;
- is too imprecise and lacks the necessary specificity;
- reduces overall reinsurance capacity and harms the market;
- is unnecessary as the current regulatory system is not in need of fixing; and
- fails to address withdrawal of a rated reinsurer and what collateral requirements would remain upon a reinsurer's refusal to be re-rated.²⁶

Non-U.S. reinsurance companies and certain industry associations, on the other hand, expressed support for the collateral proposal, stating in comment letters that, inter alia, the proposal:

- regulates all reinsurers based on their financial strength, rather than merely by state or country of domicile;
- provides options to either be rated or to comply with the 100% collateral rule; and
- provides a single regulator for assessing credit risk of reinsurers.²⁷

The non-U.S. reinsurance companies and industry associations further suggested improvements to the proposal, including, inter alia, changes to the:

- rating band and collateral requirements applicable to each band; and

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- financial reporting requirements to accept suitable financial reports prepared under non-U.S. accounting standards.²⁸

Comments received from the NRSROs provide suggestions for restating the REO rating bands to more accurately track the credit ratings listed by the NRSROs, with support expressed by both domestic and non-U.S. reinsurers as well.²⁹

Most interesting was the strong consensus among state regulators that the credit for reinsurance regulatory scheme needs revision. Up until the time that the Task Force was charged to study the current reinsurance collateral requirements, state regulators almost unanimously supported the requirements for at least 100% collateral from non-U.S. reinsurers.

With increasing pressure from U.S. domiciled insurance companies with non-U.S. affiliates, the handling of reinsurance under the new E.U. rules and the need to be a player in the global markets, the NAIC and state regulators had no choice but to consider and recommend changes to the credit for reinsurance requirements. Without pressure from these outside sources, the NAIC might not have moved as quickly as it has.

Status of the Proposal

The Task Force received the REO proposal at the Winter National Meeting along with the variety of comments posited by the industry and interested parties. The Task Force, after testimony by interested parties, adopted the recommendation that the NAIC regulation of reinsurance procedures be amended to focus on broad-based risk and credit criteria, rather than focusing solely on U.S. licensure status. The Task Force adopted the further recommendation that the REO proposal be the basis of a risk-based evaluation process to be further refined by the E-Committee by September 2007. A revised proposal is expected to be adopted during the current calendar year.

Once adopted, those in favor and against the REO proposal, as adopted by the NAIC, will have ample opportunity to support, oppose, and recommend changes before each state legislature. The problem, however, is going to be when some states adopt a new regulatory scheme for collateralization, while others do not.

Endnotes

1. For example, reinsurance agreements must provide an actual transfer of risk, contain an insolvency clause, and reinsurers must provide an agent for service of process and submit to U.S. choice of law and court.
2. NAIC Reinsurance (E) Task Force, U.S. Reinsurance Collateral White Paper (March 5, 2006).
3. V NAIC Model Laws, Regulations and Guidelines §2(A), 785-1, Credit for Reinsurance Model Law (1996).
4. Id. at §2(B)(1). An accredited reinsurer is one that:
files an AR-1 Form evidencing the reinsurer's submission to the state's jurisdiction and authority; is licensed to transact reinsurance in at least one state; files a copy of its annual statement and its most recent audited financial statement in cedent's state of domicile; and maintains an adequate policyholder surplus. V NAIC Model Laws, Regulations and Guidelines §5, 786-1, Credit for Reinsurance Model Regulation (2006).
5. Id. at § 6. The assuming reinsurer must also maintain a policyholder surplus of \$20,000,000 and must file an AR-1.

FEDERATION OF REGULATORY COUNSEL, INC.

6. NAIC Reinsurance (E) Task Force, U.S. Reinsurance Collateral White Paper (March 5, 2006).
7. Id.
8. § 2, NAIC Reinsurance Evaluation Office Proposal to Grant Credit for Ceded Reinsurance, NAIC, Dec. 10, 2006.
9. Id. at § 3(B)(II).
10. Id. at § 3(B)(III).
11. Id. at § 3(B)(IV). Section 3(B)(IV) provides that the analysis of the reinsurer's reputation for prompt payment of valid claims may include:
...the proportion of the reinsurer's obligations that are more than 90 days past due or are in dispute, including receivables payable to companies that are in Administrative Supervision or Receivership.
12. Id. at § 3(B)(V). Section 3(B)(V) provides:
For U.S. authorized reinsurers collateral will not be required for unaffiliated assumptions if the U.S. authorized reinsurer is rated REO 1, 2 or 3, is in compliance with applicable U.S. capital requirements, and has a minimum financial strength which may include selected financial leverage ratios (e.g. net liabilities to surplus) as established in these regulations and has a history of promptly paying claims...
13. Id. at § 3(B)(VII).
14. Id. at § 4(B)(I).
15. Section 3(B)(VI)(ii) of the REO proposal provides that groups of reinsurers (including both affiliated groups and Lloyd's) maintaining multi-beneficiary trusts shall receive a rating based on the overall financial strength of the group. The proposal, however, provides that each member or Lloyd's syndicate must submit a separate application to the REO.
16. Id. at § 4(C)(I).
17. Id. at § 4(D).
18. Id. at § 4(C)(II).
19. Id. at § 4(D)(I).
20. Id. at § 4(E)(I).
21. Id. at § 4(E)(III). Despite the downgrading of the reinsurer's REO rating, U.S. ceding companies may continue to take previously allowed credit for reinsurance obligations ceded to such reinsurer for a period of three months, unless the reinsurance is deemed uncollectible.
22. Id. at § 4(E)(IV).
23. Id. at § 3(A). A reinsurer must submit audited financial statements for the past three years:
...pursuant to or including a reconciliation to U.S. GAAP or U.S. Statutory Accounting Principles. Id.
24. Recoverables more than ninety days past due are considered overdue.

FEDERATION OF REGULATORY COUNSEL, INC.

25. Id. at § 3(A).
26. Various comment letters contained in the Minutes of the NAIC Reinsurance "E" Task Force Dec. 9 and Dec. 11, 2006.
27. Id.
28. Id.
29. Id.

TEXAS BUSINESS ORGANIZATIONS CODE AND INSURANCE COMPANIES

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In Texas, insurance companies have always been organized under various provisions of the Texas Insurance Code. Property and casualty insurance companies are organized under what used to be called "Chapter 2" of the Insurance Code, but which has now been re-codified under Chapter 822 of the Texas Insurance Code. Life insurance companies were incorporated under "Chapter 3" of the Insurance Code, which has now been re-codified under Chapter 841 of the Insurance Code.

Chapter 822 of the Insurance Code, which applies to property and casualty insurers, provides that "[a]n insurance company organized in this state is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act, and any other law of this state that governs corporations in general to the extent those laws are not inconsistent with this code."² Chapter 841, which governs the organization of life insurance companies, has a similar provision: "An insurance company operating under this chapter is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act, and any other law of this state that governs corporations in general to the extent those laws are not inconsistent with this chapter or another law described by Section 841.002."³

Mutual life insurers were organized under the old Chapter 11, which has now been recodified in Chapter 882 of the Insurance Code. Chapter 882 provides: "[e]xcept to the extent of any conflict with this chapter, a law governing a company organized under Chapter 841 applies to a mutual life insurance company organized under this chapter."⁴ Mutual property and casualty insurers, which were organized under Chapter 15 of the Insurance Code, are now subject to new Chapter 883 of the Insurance Code, which provides: "[e]xcept to the extent of any conflict with this code, the Texas Non-Profit Corporation Act [citation] applies to a domestic mutual insurance company. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to mutual insurance companies."⁵

On January 1, 2006, the new Texas Business Organizations Code ("BOC" or the "Code") became effective for domestic corporations formed in Texas on and after that date. The BOC combines and re-codifies the Texas

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Business Corporation Act, the Texas Non-Profit Corporation Act, the Texas Miscellaneous Corporation Laws Act and other business related statutes (such as the Texas Limited Liability Company Act and the Texas Revised Partnership Act) into one code, in a "hub-and-spoke" configuration.⁶ This means that the "hub" provisions (Title 1 of the BOC, or Chapters 1-12), are generally applicable across all entity forms, while the "spoke" provisions are applicable to only the specific type or types of entities being considered.⁷ The stated purpose of the re-codification is: "(1) rearranging the statutes into a more logical order; (2) employing a format and numbering system designed to facilitate citation of the law and to accommodate future expansion of the law; (3) eliminating repealed, duplicative, expired, executed, and other ineffective provisions; and (4) restating the law in modern American English to the greatest extent possible."⁸ There are transitional provisions that provide that a domestic entity formed prior to January 1, 2006 may voluntarily elect to adopt and become subject to the BOC by following certain procedures set forth in the Code.⁹ Foreign entities "registered with the secretary of state to transact business" in Texas may also adopt the BOC.¹⁰ By January 1, 2010, whether they have agreed to adopt the Code or not, all domestic and foreign corporations doing business in Texas will be subject to the Code.¹¹

Since January 1, 2006, business and corporate lawyers in Texas have had to become accustomed to filing "certificates of formation" signed by the "organizers" of the "organization" with the Texas Secretary of State, rather than "articles of incorporation." They have had to learn to deal with concepts such as "governing authority," in place of "board of directors," and "governing person" instead of a "director."¹² While the Texas Legislature, which directed the codification process, mandated that there be no substantive revisions to the statutes being codified, drafters of the BOC have acknowledged that the Code contains a number of substantive changes in the law.

Chapter 23 of the BOC is a "spoke" provision applicable to special purpose corporations, such as business development corporations and grand lodges. Under Chapter 23, a corporation created under a special statute outside the BOC (e.g., the Insurance Code), "to the extent not inconsistent with a special statute regarding a particular corporation, is governed by: (1) Title 1 and Chapter 21, if the corporation is organized for profit; and (2) Title 1 and Chapter 22, if the corporation is organized not for profit."¹³ "A corporation organized under a special statute other than this code is not considered a 'domestic corporation' formed under this code, although this code may apply to the corporation."¹⁴ The BOC becomes effective for such corporations on and after January 1, 2010; however, the transition clause governing such "non-code organizations"¹⁵ provides that a corporation formed under another statute "may elect for this code to apply to the corporation at any time on or after January 1, 2006, and prior to January 1, 2010, to the extent provided in Subchapter A, Chapter 23, by filing a statement and taking other actions in a manner similar to a domestic filing entity under Section 402.003."¹⁶ Under Section 402.003, a domestic entity may "voluntarily elect to adopt and become subject to this code by: (1) complying with the procedures to amend its governing documents to comply with this code; and . . . filing with the secretary of state in accordance with Chapter 4: (A) a statement that the filing entity is electing to adopt this code; and (B) if necessary, a certificate of amendment that would cause its certificate of formation to comply with this code."¹⁷ It would appear, then, that an insurance company could adopt the BOC by making a filing with the Secretary of State, and not with the Insurance Commissioner. However, it is not clear how the "non-code organization" would amend its "certificate of formation to comply with this code," if its articles of incorporation are governed by the provisions of the Insurance Code. The Texas Secretary of State's website provides forms for common transactions, including early adoption statements.¹⁸ However, the website only includes forms for early adoption of the BOC by domestic entities and foreign filing entities previously registered. There is no form for a non-code organization's early adoption of the BOC as contemplated by Chapter 23, Subsection A of the BOC. Further, if an insurance company did choose to adopt the BOC prior to January 1, 2010, only such provisions in Title 1 and Chapters 21 or 22 of the BOC as are not addressed by or that do not conflict with the Insurance Code would apply to the insurance company after adoption of the BOC.

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This article addresses the question: what is the impact of the adoption of the new BOC on insurance companies organized under the Texas Insurance Code and their holding companies?

1. Formation of Insurers under the Texas Insurance Code. Because insurers are incorporated in Texas under the Insurance Code, changes in the laws applicable to corporations in general have not always been applied to the organization of insurance corporations, and the Insurance Code has, to some extent, become something of an anachronism. For example, the articles of incorporation of insurers organized under the Insurance Code must still recite the "amount of the company's capital stock" and the "amount of the company's surplus," which is no longer required of general business corporations organized under the old Texas Business Corporation Act. The Insurance Code also retains such concepts as "earned surplus," and allows insurers to pay dividends only out of "surplus profits arising from its business,"¹⁹ a concept that was long ago abandoned in the Texas Business Corporation Act, which allows dividends to be paid out of "surplus," without regard to whether the surplus was the result of earnings, paid-in or contributed surplus, capital reduction surplus, or other sources.²⁰ Because laws that govern corporations in general apply to insurance companies only when "not inconsistent with" the Insurance Code, these old rubrics will still apply when organizing an insurance company in Texas. "Incorporators" will still file and amend "articles of incorporation" with the Texas Department of Insurance. However, insurers organized under Texas law might want to consider some amendments to their articles of incorporation or bylaws to allow them to take advantage of certain substantive changes in the law brought about by the BOC.²¹

2. Insurance Companies and the BOC. The BOC creates a new "vocabulary" for business organizations operating in Texas. For example, a "non-code organization" is defined as "an organization other than a domestic entity."²² One commentator has stated that this would include foreign entities or organizations formed under a Texas law other than the Code, such as banks or insurance companies.²³ While the definition of "domestic entity" in the BOC includes "an organization formed under *or the internal affairs of which are governed by* this code,"²⁴ a "domestic entity" may not "operate as . . . an insurance company" under the BOC.²⁵ For purposes of the BOC, "internal affairs" of an entity include: "(1) the rights, powers, and duties of its governing authority, governing persons, officers, owners, and members; and (2) matters relating to its membership or ownership interests."²⁶ While the internal affairs of insurance companies are, to the extent not governed by the Insurance Code, subject to the laws of the state governing corporations in general, an insurance company is not considered to be a "domestic corporation," and is, therefore, a "non-code organization."²⁷

There do not appear to be any implications or special obligations for being a non-code organization, other than as found in Chapter 10, which describes mergers, interest exchanges, conversions and sales of assets. Most of the provisions found in Chapter 10 were simply re-codifications of the merger provisions found in the Texas Business Corporation Act. Very few specific references are made to non-code organizations in the BOC and thus, most provisions of the Code, if applicable to insurance companies, will be applicable as "gap fillers" in such instances where the BOC does not conflict with the Insurance Code.

To adopt the BOC early, in addition to the statement that the non-code organization voluntarily elects to adopt the BOC prior to January 1, 2010, a non-code organization would also have to amend its articles of incorporation to conform to the BOC. By way of example, a property and casualty insurance company, under Chapter 822 of the Insurance Code, must include the following in its articles of incorporation to incorporate with the Texas Department of Insurance: (1) the name of the company; (2) the location of the company's principal business office; (3) the kind of insurance business in which the company proposes to engage; (4) the amount of the company's capital stock; and (5) the amount of the company's surplus.²⁸ In order to conform to the BOC, assuming that a non-code organization could adopt the BOC in this manner, a property and casualty insurance company organized as a for-profit corporation would have to change the name of its articles of incorporation to a "certificate of formation" and add the following: (1) the type of filing entity; (2) the purpose for which the entity was formed, which can be any lawful purpose; (3) the period of duration, if not perpetual;

FEDERATION OF REGULATORY COUNSEL, INC.

(4) the street address of the initial registered office and the name of the initial registered agent; (5) the name and address of each organizer; (6) the aggregate number of shares the corporation is authorized to issue; (7) the par value of each share or a statement that each share is without par value; (8) the number of directors and the name and address of each director; and (9) if the shareholders are to have preemptive rights or cumulative voting rights, the certificate of formation must so state.²⁹ Therefore, there is a significant number of items that would have to be added to the articles of incorporation in order to adopt the BOC; however, none of the items is particularly burdensome. Whether the insurance regulators would have any issue with them, however, is another question.³⁰

3. Substantive Changes in the Law. The BOC effected some substantive changes in the law governing corporations and other business entities. Most notable are changes in requirements for meetings of shareholders and the board of directors ("governing authority") of corporations; changes regarding the indemnification of officers and directors; and changes standardizing the rules for mergers, interest exchanges, conversions and sales of assets ("fundamental business transactions").

First, the BOC modernized provisions regarding notice of and voting lists for shareholders and board of directors meetings. The Code added a definition of "electronic transmission"³¹ and now permits notice of meetings and voting lists to be transmitted by electronic mail or posted on reasonably accessible electronic networks so long as the notice includes the means of accessing the electronic communications system.³² Meetings may also be held by conference telephone, videoconferencing equipment or the Internet.³³

Second, Chapter 8 (Indemnification and Insurance) of the BOC effected some changes with respect to director and officer indemnification. Two provisions which were previously only implied in existing law were explicitly added. One provides that a unanimous vote of the shareholders of a corporation can approve a permissive indemnification of a director or former director.³⁴ Another provides that the shareholders may by resolution approve indemnification of and advancement of expenses to any officer, employee, agent or delegate who is not also a director.³⁵ The BOC also now allows a determination that the standard for indemnification has been met to be made by a committee of one rather than two disinterested directors.³⁶ These provisions apply to "domestic entities" after the mandatory application date³⁷ regardless of whether the events giving rise to indemnification occurred before or after such date, and it is therefore unclear how, or even if, this provision would affect non-code organizations.³⁸

Finally, the BOC includes a number of substantive changes to the law governing mergers, interest exchanges, conversions, and sales of assets.³⁹ The BOC generally standardizes the rules for these "fundamental business transactions" for most entities and simplifies conversions from one form of entity to another. Although prior statutes did, in some cases, provide for the conversions of entities from one form to another, many of these laws were of recent vintage, and it was often easier to dissolve the original entity, form a new entity, and transfer the assets and liabilities of the original entity to the new entity.⁴⁰ The Code consolidates the previously fragmented conversion provisions into one location. Chapter 10 of the BOC provides for the conversion of a domestic entity into a different type of domestic entity or a non-code organization.⁴¹ Because the definition of a "non-code organization" could include a foreign corporation, this provision may act both as a redomestication provision, as well as a means of converting a general business corporation into an insurance company. Chapter 10 also provides for the conversion of a non-code organization into a domestic entity.⁴² The implications of this are most interesting: perhaps there are insurance companies that would rather not continue in business as insurance companies, but could be converted into general business corporations.

With respect to statutory mergers, Chapter 10 of the BOC provides that if one or more non-code organizations is a party to a merger, each non-code organization must take all action required by the BOC and its own governing documents, the merger must be permitted by the law under which the non-code organization is incorporated (or its governing documents)⁴³ and each non-code organization must comply with the applicable laws under which it is organized (and its governing documents). The Code further provides that if the

FEDERATION OF REGULATORY COUNSEL, INC.

surviving organization in a merger is not a domestic entity, it is considered to have appointed the Texas Secretary of State for service of process, and it shall promptly pay to the dissenting owners of each domestic entity that is a party to the merger who have perfected their rights of dissent and appraisal the amount, if any, to which they are entitled.⁴⁴ The BOC also supplies a definition of "fair value" for dealing with dissenters.⁴⁵ However, it is not clear that dissenters' rights provisions would apply to non-code organizations, because the Code states that it "applies only to a 'domestic entity subject to dissenters' rights,' as defined in Section 1.002."⁴⁶ A "domestic entity subject to dissenters' rights" means a domestic entity the owners of which have rights of dissent and appraisal under the BOC or the governing documents of the entity.⁴⁷

4. Implications for Insurance Holding Companies. Most stock insurers are members of "holding company systems" in which all of the outstanding shares of stock of the insurer are owned by another entity. In most cases, the "holding company" is a general business corporation; however, other forms of organization, such as limited partnerships and limited liability companies, are sometimes found as "insurance holding companies." If the insurance holding company is a domestic entity, it can choose to adopt the BOC early or it can choose to wait until January 1, 2010, when the BOC will become applicable as a matter of law. As a domestic entity, no provisions of the BOC would mandate early adoption and/or a penalty for failure to timely adopt the BOC. In fact, on or after January 1, 2010, a domestic entity formed prior to January 1, 2006 does not even have to conform its articles of incorporation to the BOC until it next amends them.⁴⁸

Chapter 9 of the Code applies to foreign entities and describes when a foreign entity would or would not be required to register under the BOC. If the insurance holding company is a foreign filing entity formed prior to January 1, 2006 and previously registered to transact business in Texas, it may voluntarily elect to adopt the BOC prior to January 1, 2010 by filing the application for registration described in Chapter 9.⁴⁹ If the insurance holding company is a foreign filing entity formed on or after January 1, 2006 and/or had not previously registered to transact business in Texas, then it must register to transact business in Texas⁵⁰ unless other state law authorizes the entity to transact business in Texas.⁵¹

The BOC contains a non-exclusive list of activities that do not constitute the transaction of business in Texas, including maintaining or defending an action or suit or an administrative or arbitration proceeding; holding a meeting of its owners or board of directors, or carrying on another activity relating to its internal affairs; maintaining a bank account; securing or collecting a debt; and transacting business in interstate commerce.⁵² A foreign filing entity that is required, but fails to, register under the BOC may be liable to the state for a civil penalty and late filing fees.⁵³

5. What Are the Advantages and Disadvantages to "Opting In" to the BOC? Why would an insurance company or its holding company choose to opt in to the BOC prior to its "mandatory application date" of January 1, 2010? One obvious reason would be that the BOC will apply on January 1, 2010 whether or not an insurance company agrees to adopt it, and companies should not delay in acclimating themselves to this new law. However, there may be reasons to delay adoption until the last minute.

One advantage to the early adoption of the BOC is the modernization of the law allowing for the use of the Internet or electronic mail for meetings, notice of meetings and voting lists. Although these electronic meetings and notice provisions were not previously available under the Texas Business Corporation Act (the "TBCA"), similar language was added to the TBCA in 2003.⁵⁴ Therefore, these provisions are available whether or not a non-code organization opts in early; however, the BOC does flesh out the definition of "electronic transmission" and "similar communications equipment."⁵⁵ Where the TBCA allowed for meetings by telephone or similar communications equipment⁵⁶ and notices by electronic transmission,⁵⁷ the BOC makes clear that communications equipment can include the Internet⁵⁸ and that electronic transmission can include a facsimile, an electronic mail transmission, or a posting on an electronic network.⁵⁹

FEDERATION OF REGULATORY COUNSEL, INC.

Another advantage, as discussed above, is that some of the indemnification provisions have been amended to provide for simplified determinations that standards for indemnification have been met. These amendments were made only to the BOC, and thus are not available unless a non-code organization opts in early.⁶⁰ The BOC also simplifies merger procedures, especially for non-code organizations. The BOC updated many of the provisions with respect to the creation of holding companies⁶¹ as well as clarifying the provisions with respect to conversions of or into non-code organizations.⁶²

Most provisions of the BOC that would appear to make early adoption a disadvantage for a non-code organization were merely transferred from prior law and result in no substantive change in the law. The main disadvantage to early adoption is the administrative burden of amending the organization's articles of incorporation to comply with the BOC and filing an early adoption statement. And the main uncertainty for insurance companies is how the Texas Department of Insurance will view amendments to an insurance company's organizational documents to comply with the BOC.

Endnotes

1. The authors would like to express their gratitude and acknowledge the contribution of Paige Ingram Castañeda, an associate in Winstead's Austin office, for her assistance in providing research and source checking for this article.
2. Tex. Ins. Code Ann. § 822.002 (Vernon 2006).
3. Section 841.002 provides that "[e]xcept as otherwise expressly provided by this code, each insurance company incorporated or engaging in business in this state as a life insurance company, an accident insurance company, a life and accident insurance company, a health and accident insurance company, or a life, health and accident insurance company is subject to: (1) this chapter; (2) chapter 3; and (3) Title 7." Chapter 3 is the remaining uncodified remnants of the old insurance code; Title 7 regulates life insurance and annuities.
4. Tex. Ins. Code Ann. § 882.001 (Vernon 2006).
5. *Id.* § 883.003. There does not seem to be a similar reference to the Texas Non-Profit Corporation Act in Chapter 882, which governs mutual life insurance companies.
6. See Daryl B. Robertson et. al., *Introduction to Texas Business Organizations Code*, 38 Tex. J. Bus. L. 57 (Fall 2002).
7. *Id.* at 64.
8. Tex. Bus. Orgs. Code Ann. § 1.001 (Vernon 2006).
9. *Id.* § 402.003.
10. *Id.* § 402.004.
11. *Id.* § 401.001(1)(c).
12. All of these terms are defined in Tex. Bus. Orgs. Code Ann. § 1.001 (Vernon 2006).
13. *Id.* § 23.001(a).

FEDERATION OF REGULATORY COUNSEL, INC.

14. *Id.* § 23.003.
15. *Id.* § 1.002(56).
16. *Id.* § 402.005(b).
17. *Id.* § 402.003(a).
18. http://www.sos.state.tx.us/corp/forms_boc.shtml (Last visited January 27, 2007).
19. Tex. Ins. Code Ann. arts. 21.31, 21.32, 21.32A (Vernon 1981). A life insurance company may declare or pay dividends to its shareholders only "from the company's earned surplus, as defined by the commissioner." Tex. Ins. Code Ann. § 841.253(a)(2) (Vernon 2006).
20. See Tex. Bus. Corp. Act Ann. art. 2.38 (Vernon 2003).
21. Perhaps subject to "opting in" to the BOC, and resolving the uncertainties as to how a "non-code organization" actually can do this.
22. Tex. Bus. Orgs. Code Ann. § 1.002(56) (Vernon 2006).
23. Daryl B. Robertson, "The New Texas Business Organizations Code," presented at "Understanding and Working with the new Business Organizations Code," sponsored by the University of Texas School of Law and the Business Law Section of the State Bar of Texas, January 25, 2006.
24. Tex. Bus. Orgs. Code Ann. § 1.002(18) (Vernon 2006) (emphasis added).
25. *Id.* § 2.003(2)(D).
26. *Id.* § 1.105.
27. *Id.* § 23.003.
28. Tex. Ins. Code Ann. § 822.052 (Vernon 2006).
29. Tex. Bus. Orgs. Code Ann. §§ 3.005, 3.007 (Vernon 2006).
30. For example, we are not sure how insurance regulators would react to calling the document a "certificate of formation," because the words "articles of incorporation" are specifically used in the Insurance Code.
31. Tex. Bus. Orgs. Code Ann. § 1.002(20-a) (Vernon 2006).
32. *Id.* §§ 6.002, 6.051, 21.3531, 21.354, 21.372, 21.411.
33. *Id.* § 6.002.
34. *Id.* § 8.103(a)(5).
35. *Id.* § 8.105(a)(3).
36. *Id.* § 8.103(a)(2)(B).

FEDERATION OF REGULATORY COUNSEL, INC.

37. The "mandatory application date" means: (a) the date a "domestic entity" is formed or the date a "foreign entity" registers with the Secretary of State if on or after January 1, 2006; (b) the date a "domestic entity" or a "foreign filing entity" voluntarily adopts the BOC if the entity was formed prior to January 1, 2006; and (c) January 1, 2010 in all other instances. *See id.* § 401.001(1). Note that an insurance company formed after January 1, 2006 is not a "domestic entity," but a "non-code organization."
38. Tex. Bus. Orgs. Code Ann. §402.007 (Vernon 2006).
39. *See id.*, Chapter 10.
40. *See* Daryl B. Robertson et. al., *Introduction to Texas Business Organizations Code*, 38 Tex. J. Bus. L. 57, 69 n.19 (Fall 2002).
41. Tex. Bus. Orgs. Code Ann. § 10.101 (Vernon 2006).
42. *Id.* § 10.102.
43. *Id.* § 10.001(d). "Governing documents" would appear to include both the articles of incorporation and bylaws of a non-code organization. *See* Tex. Bus. Orgs. Code Ann. §1.002(36) (Vernon 2006).
44. *Id.* § 10.008(c).
45. *Id.* § 10.362.
46. *Id.* § 10.351(b).
47. *Id.* § 1.002(19).
48. *Id.* § 402.005(a)(3).
49. *Id.* § 402.004.
50. *Id.* § 9.001.
51. *Id.* § 9.002(c); e.g., the Insurance Code.
52. *Id.* § 9.251.
53. *Id.* §§ 9.052, 9.054.
54. Tex. Bus. Corp. Act Ann. arts. 2.25A, 2.25-1, 9.10C (Vernon 2003 & Supp. 2006).
55. Tex. Bus. Orgs. Code Ann. §§ 6.002(a), 21.3531(b) (Vernon 2006).
56. Tex. Bus. Corp. Act Ann. art. 9.10C (Vernon 2003 & Supp. 2006).
57. *Id.* art. 2.25A, 2.25-1.
58. Tex. Bus. Orgs. Code Ann. § 6.002(a) (Vernon 2006).
59. *Id.* § 21.3531(b).

FEDERATION OF REGULATORY COUNSEL, INC.

60. The TBCA and the BOC provide minimum standards for indemnification of current and former officers, directors and "delegates." Through its governing documents, an entity may provide for indemnification and advancement of expenses *greater* than the minimum standards, but may not limit indemnification and advancement of expenses to be *less* than provided in the applicable law. Therefore, the new Code indemnification standards are technically "available" if an entity provides for them in its governing documents, whether or not the entity has opted in early to the BOC. However, if no provision for indemnification or advancement of expenses is contained in its governing documents, or if the indemnification standards are less than those provided for in the BOC, and the entity has not yet adopted the Code, then the statement that these indemnification standards are "not available unless a non-code organization opts in early" would be applicable. The minimum standards provided for in the TBCA, however, would still be applicable.

61. *See id.* § 10.005.

62. *See id.* §§ 10.101, 10.102.

ANNUITIES: WHAT ARE THEY AND HOW ARE THEY USED

¹ An annuity is a contract under which the owner of the contract pays money or transfers assets to the obligor in exchange for the obligor's promise to make periodic payments to an annuitant.²

The three basic types of annuities are (i) commercial annuities issued by insurance companies in exchange for premiums, (ii) charitable annuities issued by qualified charitable organizations³ in exchange for charitable gifts⁴, and (iii) private annuities created by an agreement between a transferor and a non-life insurance company which provide for the transferor to transfer property to the transferee in exchange for the transferee's promise to make scheduled payments to the transferor.

Commercial Annuities

The three principal types of commercial annuities are (i) fixed annuities, (ii) variable annuities, and (iii) equity-indexed annuities. The period during which premiums are paid for an annuity is called the "accumulation period," and the period during which periodic payments are made to the annuitant is called the "payout period."

Fixed Annuities. Fixed annuities guarantee the payment of both interest and principal.⁵ Premiums paid on an annuity contract are invested by the insurer in its general account.⁶ Therefore, the value of a fixed annuity is dependent on the financial health of the insurer that issues the annuity.

The amount of each periodic payment is dependent on the amount of accumulated principal, the rate of interest applied to the principal amount, and the length of the payout period.⁷ The rate of interest paid by the insurer on a particular annuity contract may be reset from time to time, but it can never be less than the minimum rate specified in the annuity contract. The payout period may be for the life of the annuitant or for a specified number of years, whichever is longer. It may also be for joint lives and for the life of the survivor.

Immediate annuities provide for a single (lump sum) premium, with the payout period commencing shortly after the payment of the premium.⁸ Deferred annuities provide for the premiums to be paid in installments

FEDERATION OF REGULATORY COUNSEL, INC.

which may be flexible in amount and timing with the payout period being deferred until the end of the accumulation period.

Depending on how a particular annuity is structured, the premium may include fees to cover various charges, such as charges for mortality and expenses, and for riders and any special features included in the annuity contract.

Annuities are not suitable for short-term goals. They are designed to supply funds to meet long-term goals, such as retirement, and may be used to supplement social security and as a substitute for or to supplement pension plans offered by employers.⁹ When tax qualified plans such as IRAs and 401Ks have been fully funded, annuities offer an additional vehicle in which to invest retirement assets. Fixed annuities may also be used as structured settlements to compensate individuals for injury.

Fixed annuities are regulated by state insurance regulators, and are sold by licensed insurance producers who may be independent or captive agents, or employees or associates of banks, brokerage firms and investment advisors.

Fixed annuities are tax-deferred. No taxes are paid by the annuitant on the interest earned on the principal until periodic payments are received unless the annuitant makes an early withdrawal. When periodic payments are made to the annuitant, the portion of the payments representing the interest earned on the principal amount paid by the annuitant with after-tax dollars is taxed as ordinary income.

Monies withdrawn from an annuity prior to the annuitant reaching the age of 59 and ½ years may be subject to a penalty tax if the withdrawal is not caused by the death or disability of the annuitant. If the monies are withdrawn during the accumulation period, they will be subject to immediate taxation and may also be subject to a surrender charge.¹⁰

If the annuitant of a deferred annuity dies during the accumulation period, the annuitant's beneficiary may elect to receive the entire principal and accrued interest in lump-sum¹¹ or in periodic payments over the life expectancy of the beneficiary.¹² If the beneficiary is a spouse, the spouse may continue the annuity contract in the spouse's name.¹³ If the annuitant dies during the payout period, the beneficiary must receive the remaining portion of the annuity at least as rapidly as the method of distribution in effect at the annuitant's death.¹⁴

For estate tax purposes, death benefits payable on an annuity are included in the annuitant's estate to the same extent death benefits payable on a life insurance policy are included. Also, an annuitant's gross estate includes the value of the annuity or other payments receivable by a beneficiary to the extent the payments were payable to the annuitant.¹⁵

Variable and Equity Indexed Annuities. Variable annuities are essentially mutual funds wrapped in an annuity contract. Neither variable nor equity-indexed annuities guarantee the amount of periodic payments. Variable annuity periodic payments are based on the investment performance of the underlying mutual funds, and equity-indexed annuity payments are based on the performance of the equity index (e.g., Standard and Poor's 500 or the Wilshire 4500, etc.) chosen by the annuitant.

Variable annuities claim to combine the best aspects of fixed annuities (tax deferral, insurance protection for beneficiaries, tax-timing controlled income options) with the benefits of traditional mutual fund portfolios (flexibility in selecting how to invest funds and the potential for higher investment returns).¹⁶

Variable annuities may be immediate or deferred. Variable annuitants direct the investment of the accumulated principal amount in sub-account portfolios of stocks, bonds or money market funds. These investments may be managed by the insurer or a mutual fund company. However, unlike a mutual fund, a

FEDERATION OF REGULATORY COUNSEL, INC.

variable annuity does not pay out earnings or distribute capital gains. Instead, they are compounded on a tax-deferred basis.¹⁷

Most insurers that sell variable annuities offer 5 to 35 sub-account investment options, and an annuitant may make exchanges within those sub-accounts without sales or transfer charges.¹⁸

Variable and equity-index annuities are taxed in the same manner that fixed annuities are taxed for both income and estate tax purposes. When periodic payments are made on variable and equity-indexed annuities, only the portion of the payments that represent investment or index gains are taxed as ordinary income.

Fees included in the premiums for variable annuities include the costs incurred by the insurer in investing the premiums in the mutual fund or funds selected by the annuitant.¹⁹

Section 3 (a) (8) of the Securities Act of 1933 (the "Act") exempts from the registration provisions of the Act, "Any insurance or endowment policy or annuity contract or optional annuity contract issued by a corporation subject to the supervision of the insurance commissioner, bank commissioner, or an agency or officer performing like functions, or any state or territory of the United States or the District of Columbia." However, Rule 151²⁰ under the Act provides that Section 3 (a) (8) does not apply to an annuity or optional annuity contract if the contract is marketed primarily as an investment, and the insurer does not assume the investment risk under the contract. For Section 3(a) (8) to apply, the value of the contract cannot vary according to the investment risk of a separate account.

Because variable annuities are a combination of insurance and securities and their value varies with the investment experience of a separate account, they are regulated by state insurance regulators, by the Securities and Exchange Commission, and by some, but not all, state securities regulators.²¹ Equity-index annuities are hybrid fixed-variable annuities, and depending on how they are structured and sold they may or may not be deemed to be securities subject to the regulation of federal and state securities regulators.

Variable annuities are sold by persons who are licensed both as insurance producers and security salesmen. Such persons may be independent or captive agents or persons who are employees of or are associated with banks, brokerage firms and investment advisors.

Charitable Annuities

Charitable gifts made in exchange for annuities may be made directly to the charity or indirectly through a charitable annuity trust.

Charitable Gift Annuities. A charitable gift annuity is a contract between a donor and a qualified charitable organization (a "charity") in which the donor transfers assets to the charity in exchange for a fixed annuity usually payable for the donor's lifetime. The donor is entitled to a charitable deduction in an amount equal to the difference between the value of the gifted assets and the value of the annuity. If the value of the gifted assets exceeds the donor's tax basis in the assets, the gain is taxable to the annuitant, pro rata, over the annuitant's life expectancy. Thus, each periodic payment received by the donor will be partly a non-taxable return of capital, partly taxable income, and possibly partly capital gain.

Charitable Remainder Annuity Trusts. A charitable remainder annuity trust issues a fixed annuity to the grantor, or to the grantor's beneficiary, in exchange for assets placed in the trust, and a charity named in the trust receives a remainder interest in the gifted assets. The trust grantor is entitled to a charitable tax deduction equal in amount to the value of the remainder interest. The annuity paid to the grantor or to the grantor's beneficiary is taxed in the same manner as annuitants of charitable gift annuities are taxed.²²

FEDERATION OF REGULATORY COUNSEL, INC.

Private Annuities

A private annuity occurs when a transferor (the "annuitant") transfers assets to a person who is not an insurance company (the "obligor") in exchange for the obligor's agreement to make periodic unsecured payments (an "annuity") for the annuitant's life. A private annuity has many advantages, and is often used as an estate planning tool. If the value of the annuity is more than the value of the transferred assets, the annuitant will realize a capital gain which will be taxed to the annuitant pro rata over the annuitant's lifetime. If the value of the annuity is less than the value of the transferred assets, the difference will be subject to gift taxes. Upon the death of the annuitant, neither the transferred assets nor the value of the annuity will be included in the annuitant's taxable estate. However, the obligor's tax basis in the transferred assets will only be equal to the value of the periodic payments that are made prior to the annuitant's death. Each periodic payment received by the annuitant will be partly a non-taxable return of capital, partly taxable income, and possibly partly capital gain.

Conclusion

Annuities are very useful products. They come in many forms, can be structured to serve many purposes, and provide numerous tax benefits to the parties involved. Life insurance companies annually write millions of dollars of fixed and variable annuity premiums. Charities rely on the use of charitable annuities to induce wealthy donors to make charitable gifts, and estate planners utilize private annuities to reduce estate taxes.

Endnotes

1. This article is limited in scope because a thorough discussion of annuities would require a book-long treatise.
2. The owner may be the annuitant or the owner may designate another person or persons as annuitants. For the purpose of this article, the annuitant is deemed to be the owner.
3. A qualified charitable organization is a charity that is eligible to receive tax deductible gifts from donors.
4. The insurance codes of all or substantially all of the states authorize qualified charitable organizations to issue annuities in exchange for the transfer of assets to the charity.
5. The principal is the sum of the premiums paid on the annuity contract net of the charges and fees imposed by the insurer.
6. In special circumstances the premiums may be invested by an insurer in a separate account created for such purpose.
7. At least for the number of years required for the annuitant to reach the age of 59 and ½.
8. Usually within 30 days.
9. Some major life insurers offer annuities designed to serve personal pension plans and have designed various features, such as inflation protection and interest rate protection, to make the annuities more attractive to purchasers.
10. Surrender charges usually start at around 6-8% and gradually decline over a period of years.

FEDERATION OF REGULATORY COUNSEL, INC.

11. IRC Sec. 72 (s) (1) (B).
12. IRC Sec. 72 (s) (2) (B).
13. IRC Sec. 72 (s) (3).
14. IRC Sec. 72 (s) (1) (A).
15. IRC Sec. 2039 (a).
16. M. Lane, *Guaranteed Income for Life*, Mc Graw Hill (1999).
17. *Id* at 4.
18. *Id* at 9.
19. Such costs may include administrative fees, advisory fees, distribution fees, and front and back end commission loads.
20. Rule 151 under the Securities Act of 1933 provides in part:
 1. "Any annuity contract or optional annuity contract (a "contract") shall be deemed to be within the provisions of section 3(a)(8) of the Securities Act of 1933, Provided, That
 1. The annuity or optional contract is issued by a corporation (the "insurer") subject to the supervision of the insurance commissioner, bank commissioner, or any agency or officer performing like functions, of any State or Territory of the United States or the District of Columbia;
 2. The insurer assumes the investment risk under the contract as prescribed in paragraph (b) of this rule; and
 3. The contract is not marketed primarily as an investment.
 2. The insurer shall be deemed to assume the investment risk under the contract if:
 1. The value of the contract does not vary according to the investment experience of a separate account;
 2. The insurer for the life of the contract
 1. Guarantees the principal amount of purchase payments and interest credited thereto, less any deduction (without regard to its timing) for sales, administrative or other expenses or charges; and
 2. Credits a specified rate of interest (as defined in paragraph (c) of this rule) to net purchase payments and interest credited thereto; and
 3. The insurer guarantees that the rate of any interest to be credited in excess of that described in paragraph (b) (2) (ii) will not be modified more frequently than once per year."
21. The National Conference of Commissioners on Uniform State Law adopted the Model Uniform Securities Act of 2002, but very few jurisdictions have adopted it. One of the reasons that more jurisdictions have not adopted the 2002 Model Securities Act is the uncertainty of whether its definition of a security should or should not include fixed and/or variable annuities.

FEDERATION OF REGULATORY COUNSEL, INC.

22. IRC Sec. 664.

AN AMERICAN CRISIS

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Sometime during 2006, the population of the United States surpassed 300 million.¹ Of that 300 million, it is estimated that approximately 16%, or 48 million, are uninsured.² Setting aside for the moment that some estimate that 8.7 million Americans are uninsured because they choose to be,³ many experts believe that the rising cost of health care coverage will be the number one problem facing Americans in the very near future.

In 2004, health care costs exceeded \$1.9 trillion, or \$6,280 per person.⁴ The total cost of health care has risen approximately 7.9% annually, which is three times the rate of inflation.⁵ Total health care spending represents approximately 16% of the gross domestic product.⁶ In 2006, employer health insurance premiums increased by 7.7 percent.⁷ Studies have shown that "premiums for employer-sponsored health insurance in the United States have been rising four times faster on average than workers' earnings since 2000."⁸ Moreover, there are additional costs to cover the uninsured population's health services. The United States spends "nearly \$100 billion per year to provide uninsured residents with health services."⁹ Health care spending by the national government is 4.3 times the amount spent on national defense.¹⁰ Also, hospitals provide about \$34 billion worth of uncompensated care a year.¹¹

Most Americans look to insurance to cover their medical expenses. Insurance coverage in the United States is provided through public and private sources. It is estimated that approximately 174.8 million Americans (59.5%) have health insurance through their place of employment.¹² Another 40.1 million (13.7%) are on Medicare.¹³ Still another 38.1 million (13%) are on Medicaid and 8.3 million (11.2%) are on children's health plans through State sponsored programs.¹⁴

Even so, a large segment of the population remains uninsured. Of that group, an increasing number are considered "uninsurable." These are individuals who, because of certain health conditions, are unable to obtain health insurance from the private market at any price. Additionally, they are not eligible for Medicare or Medicaid. If they are working, and many are, there is no health insurance provided through their place of employment or their spouse's. Because of their health condition, they cannot obtain insurance coverage in the individual market.

Unfortunately, Americans have come to see health care as an entitlement, or right. Inseparably connected with that entitlement or right is the fact that Americans want the absolute best health care, to be provided by the best doctors, they choose, and for the absolute minimum in cost. Americans have wrestled for decades with affordability, accessibility, and quality of care issues. They want complete freedom of choice to see any doctor for any type of procedure, which inevitably causes the cost to be higher. Additionally, Americans want every procedure and treatment to be covered. If steps are taken to reduce the cost, then accessibility to certain doctors may be eliminated, or the scope of coverage reduced, and the quality of care overall may suffer. Most Americans have not been able to come to grips with these issues; however, if they do not soon, the decision will be made for them.

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In 2006, Americans spent approximately \$2 trillion on health care.¹⁵ If medical costs continue to rise at the same level of increase they have over the last decade, it is easy to see why some experts believe this is the number one problem Americans are facing. This problem is not new. In his 1979 State of the Union Address, President Carter stated: "We must act now to protect all Americans from health care costs that are rising \$1 million per hour, 24 hours a day, doubling every 5 years."¹⁶ The average cost of an employer-provided family health insurance plan has increased from \$6,000 per year in 1999 to around \$11,000 per year in 2005.¹⁷

As previously mentioned, the number of uninsurables has continued to grow, particularly as small employers drop health coverage for their employees. One way states have attempted to deal with the uninsurable problem is the creation of risk pools to provide coverage for those individuals who are unable to obtain health insurance in either the public or private sector. In general, applicants must demonstrate their eligibility to participate in the program. Once in, the premiums paid by these individuals are clearly insufficient to cover the cost of their medical expenses. The balance of the funds to pay for the claims incurred by these individuals is subsidized by the various states in a variety of fashions. Many of the pools have evolved over time, due to a number of factors. The Comprehensive Risk Pool in Utah, for example, was started in 1991. At that time, it not only covered eligible individuals who were unable to obtain insurance through either the public or private sector, but it also allowed small employers who were in danger of losing their coverage as a result of one or two employees who were bad health risks, to place those employees in the risk pool. The employers could require an employee with certain health conditions to apply for coverage with the risk pool in Utah, thereby allowing the other employees to keep their coverage and reduce the premiums for the remaining employees, or at least incur smaller increases in premiums for covered employees.

However, with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), states were required to provide a mechanism to cover the uninsurable population within their respective states. Several states, including Utah, had to modify their risk pools in order to comply with the conditions established by HIPAA. At that time, if an individual could obtain health insurance coverage through his or her place of employment or his or her spouse's place of employment, they were no longer eligible for risk pool coverage and had to be covered by the employer's health plan. Small employers could no longer "dump" unhealthy employees into a risk pool if they provided a health insurance plan for their employees.

Prior to the passage of HIPAA, some states, such as Kentucky, South Dakota, Washington, Utah, and others, passed guaranteed issue laws for individual health insurance policies. While it was assumed this would be a benefit for individuals attempting to obtain and maintain health insurance coverage, it actually resulted in health insurers leaving those markets, thereby reducing competition, which obviously decreased availability and increased the cost of the insurance for those who could find it.

Risk pools have helped to reduce this problem. Even though risk pools provide coverage for a relatively small portion of the U.S. population, they are an integral part of maintaining the viability of the current system. Because of the stability provided by risk pools, they give an incentive to health insurance companies to come back into the market. Through 2006, there were 33 risk pools.¹⁸ Tennessee is commencing operation this year. One of the major problems facing these pools is funding. The total claims for these risk pools in 2006 reached \$1.49 billion.¹⁹ Though enrollee premiums constitute a significant contribution toward the cost of the claims, they clearly are insufficient. Each year, those states with risk pools must find monies to make up the shortfall in the funding of the pools. For example, Utah's Comprehensive Health Insurance Pool (HIPUtah) is funded through enrollee premiums, the State's general fund, as well as interest and dividends earned from the fund's assets.²⁰ Since the risk pool's inception in 1991, the Utah State Legislature has appropriated \$68 million for operational funding, with a total of \$16.2 million contributed in 2006.²¹ However, claims and expenses from 1991 through 2006 have exceeded \$139,000,000.00.²² As enrollment continues to increase, funding becomes a more pressing issue. This is particularly true in lean budget years.

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Several ideas or plans have been proposed in an attempt to solve the health care dilemma. In 1993, President Clinton announced the formation of the "President's Task Force on National Health Care Reform."²³ The task force was chaired by the First Lady, Hillary Clinton. In essence the plan "guaranteed health insurance for all Americans through the 'employer mandate,' a provision requiring that employers purchase insurance for their employees."²⁴ However, the plan lacked public support and never made it out of a congressional sub-committee.²⁵

Recently, the State of Massachusetts implemented a plan in an attempt to cover all of its citizens. Its new law requires all residents to obtain a health insurance policy by July 1, 2007. Massachusetts was told by the federal government that it had to adopt measures to substantially reduce the uninsured population in its state, or risk losing \$385,000,000.00 in federal funds. Those funds, along with \$320,000,000.00 in assessments, which were being used to subsidize hospitals for uncompensated care, were used to help jump start the Massachusetts plan. In essence, employers with ten or more employees who make no contribution toward employee health coverage are required to make a contribution of approximately \$295.00 per year. Additionally, those employers are subject to a surcharge if their employees receive free care. The surcharge can be anywhere between 10% and 100% of the cost, subject to certain rules and regulations.

Under the Massachusetts law, the individual and small group health insurance markets are merged. A new entity will be developed called the "Connector." It will act as a clearinghouse for individuals and small groups to purchase coverage and to oversee subsidies which will be provided to those who are entitled. It is expected that funding will come from current assessments, the federal Medicaid grants that the State of Massachusetts was about to lose, the surcharges and assessments under the new law, additional federal safety net revenues, and money generated from the State general fund. Even so, many are concerned that the amount of money the plan has projected it will need for the program is inadequate.²⁶

More recently, in his January 2007 State of the Union address, President Bush further refined his health care plan. President Bush proposed a tax deduction for those who purchase health insurance on their own.²⁷ Because those who purchase health insurance on their own must do it with taxed dollars, President Bush's proposal would have a "flat, standard deduction for anybody who purchases any kind of health insurance, no matter how much the health insurance costs and no matter where they get it."²⁸ The deduction would be \$15,000.00 for a family policy or \$7,500.00 for a single policy.²⁹

Additionally, there are others who are espousing a single payor plan. One type of single payor plan would set up a governmental agency which would collect all health care fees and pay out all the health care costs.³⁰ Some argue this system would eliminate the vast amounts of administrative waste created by many different health care organizations and billing agencies.³¹ The plan would be federally funded and has been estimated to reduce overall health costs more than \$225 billion.³² The administrative savings could be passed on to patients.

Still, many want to use the approach found in countries with socialized programs. They point to Canada and Europe as having very successful socialized medicine plans. However, those plans are not without problems. They still must deal with the same issues; namely accessibility, affordability and quality of care. Reports vary as to the actual success of those programs. Because of the direction America appears to be headed, it may be spiraling towards this result, making it inevitable.

However, regardless of the approach that is eventually settled on, there are some actions which if taken can help to minimize the rising costs of health care. First, preventative health care must have a larger role in a health care plan. A system of check ups and exams can help ensure early detection of larger health problems. Healthier lifestyles, including exercise and eating habits, would greatly reduce health care needs and problems resulting in a reduction in cost for all Americans. It is estimated that more than 61% of Americans are overweight or obese.³³ In 1999, there were 300,000 U.S. deaths associated with obesity and being overweight,

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compared to 400,000 deaths that year associated with cigarette smoking.³⁴ From all of the medical journals, it is obvious that being overweight leads to numerous other health problems, thereby increasing medical costs which could be avoided.

Moreover, smoking continues to be responsible for 1 in 5 deaths in the United States.³⁵ Because smoking is an acquired behavior or choice, it is viewed as the most preventable cause of premature death.³⁶ Cigarettes cause more death in America than alcohol, car accidents, suicide, AIDS, homicide, and illegal drugs combined.³⁷ Smoking also accounts for an estimated 30% of all cancer deaths and accounts for 87% of lung cancer deaths.³⁸ Also, secondhand smoke continues to play a devastating role in our society. The 2006 U.S. Surgeon General's report reached many important conclusions such as: secondhand smoke causes premature death and disease, increases risk of SIDS for children and other respiratory problems, has adverse effects on the cardiovascular system, and increases the risk of coronary heart disease and lung cancer. The report further stated that proper ventilation and a separation of smokers and nonsmokers fails to eliminate exposure.³⁹ The increased health risks from smoking only increases the health care needs and cost. Continued legislative initiatives and personal awareness can help prevent many diseases caused by smoking.

Second, legislatures must stop mandating types of coverage. While most mandates in and of themselves may not be expensive, collectively, mandates are responsible for a substantial portion of the cost of health care. Each year, state legislatures and even Congress consider a variety of mandates, with many of them passing.

Third, drug companies should not be allowed to advertise on radio and television. Since the beginning of consumer-directed advertising in 1997, cost and usage of prescription drugs have risen dramatically.⁴⁰ Doctors seemed perfectly capable of prescribing medications prior to drug companies telling everyone what they absolutely need. Fourth, tort reform should be revisited. Finally, licensing enforcement must ensure better doctors and encourage better practices.

In conclusion, the problem of health care and its attendant cost should be the concern of everyone. Many believe these problems have already reached crisis stage. The health care debate should be on every political platform, both nationally and locally. Unfortunately, at the present time there are more questions than answers.

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