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THE DIRECTION OF ANNUITY SUITABILITY REGULATION

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The future of annuity regulation is uncertain. Amidst suggestions that the state regulatory framework is not sufficient to protect consumers in annuity transactions, the Securities and Exchange Commission (SEC) published proposed Rules 151A and 12h-7, categorizing fixed indexed annuities as federal securities. Although no one has a crystal ball to predict the future of the SEC proposal, state regulators across the country are working on their own track to enforce existing laws and consider whether additional regulations are necessary. Wisconsin regulators are only one example of the type of activity occurring across the country, but they also play a major role in national reform efforts. It may be helpful, therefore, to consider actions Wisconsin regulators have taken as indications of where state regulation may be headed.

Wisconsin Commissioner Sean Dilweg is Vice Chair of the NAIC's A Committee and Deputy Commissioner Kimberly Shaul is Chair of the A Committee's Suitability of Annuity Sales Working Group. The Working Group is charged with determining whether to revise the standards in the NAIC Suitability in Annuity Transactions Model Regulation. To gain insight into where Commissioner Dilweg and Deputy Commissioner Shaul may steer these efforts, it is helpful to consider Wisconsin's annuity enforcement actions, as well as the work of Wisconsin's own Annuity Sales Supervision Advisory Committee.

ANNUITY ENFORCEMENT ACTIONS

Historically in Wisconsin, annuity enforcement actions focused on agents and unsuitable recommendations. That is no longer true. On June 16, 2008, the Wisconsin Office of the Commissioner of Insurance ("OCI") announced a settlement with Pennsylvania Life Insurance Company ("Penn Life") that was unique in several respects. First, the $925,000 forfeiture set a record for the agency. Second, the action appeared to be focused on the company's failure to supervise annuity sales. Third, the absence in the order of specific allegations against the company is inconsistent with the normal format of a Wisconsin stipulation and order.

For companies writing annuities, the questions are: What did Penn Life do to warrant the largest forfeiture ever ordered by OCI? What can my company do to avoid a similar enforcement action? These questions are especially important because, although Penn Life is the first large forfeiture against an insurer based on failure to supervise annuity sales, indications are that it will not be the last. An analysis of the Stipulation and Order[1] and the underlying administrative actions against Penn Life agents provides some insight.

Background

In 2003, OCI began its investigation of agents associated with the Premier Marketing Group, a Penn Life affiliate that acts as Penn Life's general agent in Wisconsin. Ultimately, OCI took administrative action against seven of these agents. Based on OCI records, the investigation was initiated over the sale of annuity products. It is clear that OCI became concerned with cross-selling and sales tactics of other products, as well, including long-term care insurance policies, Medicare Advantage, Medicare Part D Plans, and Medicare supplemental policies.

Actions of Penn Life and Penn Life Agents

Because the action against Penn Life settled prior to the issuance of an OCI Notice of Hearing, it was not necessary for OCI to publicly identify the allegations against the company. Therefore, the degree of knowledge of the agents' behavior and complicity by the company is not clear from the public record. However, OCI maintains that the question is not whether the company knowingly permitted the illegal acts of its agents, but rather, whether the company had taken proactive steps to prevent violations.

The agents' actions were contested through the administrative hearing process with appeal to Wisconsin circuit court. Penn Life agents were found to have violated Wisconsin laws related to annuity suitability, misrepresentation and home solicitation. Examples of agent behavior include the following:

- Over a one-and-one-half year period beginning October 3, 2003, Penn Life agents sold a 75 year-old woman a nursing home policy; two level premium whole life policies; six flexible premium deferred annuities; and three single premium interest sensitive whole life policies. The majority of these policies were either canceled by the insured or lapsed. In March of 2004, the customer requested that Penn Life cancel all pending policies, complaining about the negative financial impact of the sales and requested that Penn Life agents not contact her again. Instead of honoring this request, Penn Life requested that an agent contact the customer in an attempt to conserve the business. Agents sold five policies to the customer after this date. Ultimately, the transactions resulted in surrender penalties of more than $30,000 and significant tax consequences to the insured.[2]
- OCI alleged unsuitable sales and misrepresentation in each of the agent actions, with allegations of agents' misleading or unfounded assertions, purporting to have knowledge they lacked, failing to exercise reasonable care and recommending products that did not meet the consumer's objectives. Many of the recommendations resulted in customers incurring significant surrender fees.[3]
- In another case, the OCI alleged that the agent visited an elderly woman, telling her that he was responding to a prepaid mailer card requesting information about Medicare changes. The agent indicated that he was there to discuss Medicare changes, but once inside the home, he began to ask about her financial status. Contrary to Wisconsin law on home sales,[4] he did not identify himself as an agent until after he obtained her signature on annuity application documents.[5]According to OCI, agents were trained to use a "one call close method" to obtain a sale on the first visit.[6]
- In other cases, the OCI alleged that the agents ignored consumers' decisions to provide power of attorney to a family member. In one instance, the customer was living in an assisted living facility. He and his father indicated to the agent that he was not mentally capable of making financial decisions and requested that all business inquires be directed to his father. Ignoring these wishes, the agent had the customer sign documents disbursing funds from his annuity and attempted to transfer a certificate of deposit into a Penn Life annuity.[7] Similarly, OCI alleged two Penn Life agents were informed by a customer, who was legally blind and could not read documents, that she wished to consult her nephews about any financial decisions. One of her nephews had power of attorney. OCI further alleged that the agents, ignoring her expressed wishes, convinced the customer to let them drive her to the bank. One agent accompanied her inside to assist her in withdrawing her CD's and obtaining a check made out to Pennsylvania Life.[8]

Penn Life Settlement

In addition to the record-setting forfeiture, the settlement order requires Penn Life and its affiliates to maintain a compliance program from July 1, 2008 through 2012. A review of some of the required components of the compliance program is helpful to understand the Wisconsin regulator's perception of what should be included in a supervision system. The order provides that Penn Life's compliance program must include:

- a compliance officer;
- measures and controls that are reasonably designed to ensure that violations of Wisconsin law are promptly identified;

- guidelines and processes for punishing agents for violations of Wisconsin laws;
- biennial evaluations of the compliance program by a qualified, and nationally recognized, outside auditor;
- creation of an operating budget and administrative plan for operation of the compliance program.[9]

In addition, OCI required Penn Life to implement supervision, monitoring and training measures including the following:

- written compliance procedures and controls;
- compliance training of marketing personnel and agents and annual testing of agents;
- management control and approval of lead cards and marketing material including sales scripts or presentations;
- measures to monitor cross-selling;
- appropriate suitability standards, appropriate standards for inquiry relating to suitability;
- management reports;
- periodic reviews of records reasonably designed to detect violations;
- customer contacts to review transactions reasonably designed to detect violations;
- annual on-site audits of agents and agencies including interviews with agents, review of sales files, etc.;
- contact with selected customers to determine product understanding and agent compliance with regulations;
- written and disseminated standards for personnel and agent discipline; and
- annual Compliance Plans filed with OCI.[10]

Components of the order target specific practices OCI identified as problematic. For example, the order specifically addresses advertising that offers information regarding federal Medicare or other government programs, "including but not limited to 'lead cards.'" The order indicates such cards must "state that it is an advertisement for insurance or that it is intended to obtain insurance prospects and prominently state that any material or information offered will be delivered in person by a representative of the insurer, if such is the case." [11]

An original review of the order would suggest that one of the more draconian provisions was the requirement that Penn Life cease the sale of annuities in Wisconsin for the period from July 1, 2008 through December 31, 2012. According to OCI, however, annuity products have not been a major line for Penn Life, with most of the annuity sales generated from the one sales office that was the subject of the agent investigations and related enforcement actions.

ANNUITY SALES SUPERVISION ADVISORY COMMITTEE

The Penn Life settlement demonstrates Wisconsin regulators' expectation that companies take proactive steps to prevent agent violations of the annuity suitability regulations. The types of company actions that are expected may be further reflected in the OCI's proposals to the Annuity Sales Supervision Advisory Committee (a Wisconsin regulator/industry committee established by the OCI) created slightly over a year ago.

The Wisconsin Committee was created to consider an administrative rule establishing the minimum supervisory requirements that annuity writers must meet in order to sell annuity products in Wisconsin. Parrett and O'Connell, LLP represents the Wisconsin Council of Life Insurers, and Connie O'Connell serves on this Committee representing the trade association.

The role of this Committee has changed to provide guidance to the NAIC Working Group as it considers changes to the Model Act. Over the course of the past year, the Wisconsin Committee has heard from regulators regarding their suitability supervision concerns, company presentations describing their supervision systems and presentations from the Financial Industry Regulatory Authority (FINRA), the Iowa Insurance Department and the Insurance Marketplace Standards Association (IMSA).

The Committee is now discussing the appropriate work product to offer to the NAIC Working Group. WCLI, on behalf of the Wisconsin insurance industry, has suggested that the existing NAIC model should serve as the starting point and that supervision regulation should be based on identifying broad principles rather than mandating a particular supervision system. This recommendation was based on the determination that flexibility is critical given the continued evolution in the market place related to more effective monitoring approaches, changes to product design or changes to distribution systems. Further, this approach would avoid bright line rules that tie regulators' hands and, instead, give regulators more flexibility in addressing issues in the market place.

OCI's original draft, offered at the July 22, 2008 meeting, included a laundry list of very specific supervision, monitoring and training techniques. The standards appeared to reflect the most rigorous elements of the various supervision systems that were presented to the Committee in addition to prescriptive proposals from other forums. The industry expressed concern that the standards inserted regulatory judgment into corporate governance, severely limited the ability to delegate responsibility to third parties, created an unworkable training proposal and required an overly prescriptive and resource-intensive supervision and monitoring system. The following are a few examples of OCI's initial proposal:

- The supervision staff must be a dedicated organization with staffing and budget independent from sale or marketing functions.
- The supervision system must annually report to the audit committee/top management and that the Board of Directors annually review reports related to suitability.
- Staff must interview customers to verify suitability information and understanding of the product. The interviews must include at least all customers over 70.
- If responsibilities are delegated to an unaffiliated insurance agency, the insurer must assure that the agency "has the financial and system capacity to maintain the delegated elements of the Supervision System."
- Insurers must offer mandatory training on every annuity product and that the agent be tested for product knowledge following the training. An agent may not be present at a solicitation prior to completing the training.[12]

WCLI Proposal

The industry, through WCLI, offered a counter proposal for consideration at the August 25th meeting of the Committee. WCLI proposed that the model be updated in the areas of training, disclosure, supervision and monitoring as discussed below. The additions to the model primarily establish principles rather than prescribing particular practices. WCLI also recommended that the NAIC encourage adoption of the model in all states for all ages, adoption of the annuity disclosure model and adoption of the existing replacement model. Further, publication of best practices by regulators would provide guidance to the industry.

In the area of training, WCLI recommended that producers receive two credits of state-approved continuing education regarding the general features and mechanics of annuity products and related suitability considerations. In addition, insurers would be required to make available to producers detailed product information regarding the annuities sold by the producers, and producers would be required to have a comprehensive understanding of the products prior to recommending the purchase or exchange of an annuity. The proposal adds consideration of current and anticipated liquidity needs to the information that must be

obtained prior to execution of a purchase or exchange of an annuity. It also requires that the insurer conduct periodic reviews to detect unusual sales patterns and to take corrective action to address such practices.[13]

OCI was responsive to recommendations that the Advisory Committee produce a consensus document identifying principles updating the NAIC model. The principles are described below under the heading "Consensus Document." However, OCI also determined to refine and submit the more prescriptive concepts for consideration by the NAIC. Although some of the more objectionable provisions were modified, the industry continues to oppose many of the requirements as overly prescriptive, inflexible and inefficient. OCI has agreed to include these objections, and comments from other Committee members, in the document submitted to the NAIC Working Group. Although the work product did not receive endorsement from the Committee, it provides insight into OCI's expected components of a company supervision system.

Consensus Document

The following principles were supported by the Committee:

1. An insurer, general agency or third party shall have written guidelines to reasonably ensure the suitability of annuity sales.
2. Guidance for a suitable sale shall include a liquidity analysis reasonably designed to determine the consumer's current and future need for liquidity.
3. A recommendation of an annuity product shall include a written disclosure to assist in the consumer's understanding of the product being sold.
4. An insurer, general agency or a third party shall have processes and written procedures to identify potentially unsuitable annuity sales.
5. An insurer, general agency or a third party shall have procedures to follow when an unsuitable sale is suspected, including procedures for corrective action.
6. An insurer, general agency or third party shall monitor to prevent, identify and address suitability issues.
   An insurer, general agency, or third party shall take corrective action, as appropriate, to address sales practices or patterns resulting in unsuitable sales.
7. NAIC should work to develop uniform continuing education training requirements relating to annuities.
8. Agents recommending annuities must complete state required continuing education training relating to annuities.
9. An insurer, general agency or third party shall make available to producers detailed product information regarding the annuities it sells.[14]

CONCLUSION

As some proponents of the SEC fixed annuity proposal allege failure of state insurance regulators to protect consumers in annuity transactions, the reality in states is very different. Wisconsin is only an example of the serious efforts in states to assure consumer protection in the sales of annuities. Wisconsin was the first state to adopt the NAIC model, has taken significant enforcement actions against companies and agents and is committed to strengthening the regulatory framework.

If you would like to receive copies of the referenced documents, please contact either Noreen Parrett (nparrett@parrettoconnell.com) or Connie O'Connell (coconnell@parrettoconnell.com).

Endnotes

1. *In the Matter of Pennsylvania Life Insurance Company*, Stipulation and Order, Case No. 08-C31326

2. *In the Matter of Shawn P. Henderson*, Petition For and Summary Suspension Order and Cease and Desist Order, Case No. 05-C29711

3. *In the Matter of Kenneth R. Brown*, Stipulation and Order, Case No. 05-C29450; *In the Matter of Lucas J. Brunmeier*, Final Decision, Case No. 05-C29612; *In the Matter of John L. Hammer*, Final Decision, Case No. 05-C29611; *In the Matter of Shawn P. Henderson*, Final Decision, Case No. 06-C30049; *In the Matter of Stephen K. Love*, Final Decision, Case No. 05-C30510; *In the Matter of Richard T. Paetz*, Final Decision, Case No. 04-C29032; *In the Matter of Timothy J. Petrie*, Final Decision, Case No. 05-C29438

4. It is evident from the Penn Life Order and the actions against the agents that a significant OCI concern was the systematic violation of Wisconsin's home solicitation requirements. Wisconsin regulations require that certain disclosures be made at the time of initial contact of a home solicitation, including the agent's name, name of business, fact that insurance is being sold, identity of the insurer and type of insurance being solicited. Wis. Adm. Code § Ins 20.01(4)(a)

5. *In the Matter of Richard T. Paetz, Kenneth R. Brown*, Notice of Hearing, Case Nos. 04-C29032 and 05-C29450, page 2

6. *In the Matter of John L. Hammer*, Final Decision, Case No. 05-C29611 page 6

7. *In the Matter of Richard T. Paetz*, Final Decision, Case No. 04-C29032

8. *In the Matter of Richard T. Paetz*, Final Decision, Case No. 04-C29032

9. *In the Matter of Pennsylvania Life Insurance Company*, Stipulation and Order, Case No. 08-C31326

10. *In the Matter of Pennsylvania Life Insurance Company*, Stipulation and Order, Case No. 08-C31326

11. *In the Matter of Pennsylvania Life Insurance Company*, Stipulation and Order, Case No. 08-C31326

12. Letter from Kim Shaul, Wisconsin Deputy Insurance Commissioner, to Annuity Sales Suitability Committee Members (July 18, 2008)

13. Letter from Connie L. O'Connell, Wisconsin Council of Life Insurers, to Kim Shaul, Wisconsin Deputy Insurance Commissioner (August 13, 2008)

14. "Principle Based Guidelines for consideration in modification of the NAIC Suitability in Annuity Transactions Model Regulation," Wisconsin Annuity Sales Supervision Committee (August 25, 2008).

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ANTI-STOLI LEGISLATION: A STATUS REPORT

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Do you remember where you were when you first learned that "STOLI" isn't always an adult beverage? For many involved in the life insurance industry, it was a moment to remember. And life hasn't been the same since.

Some life insurance companies see their business and pricing models being undermined, and the federal tax preferences of the products threatened by STOLI. Some life settlement companies see STOLI as undermining the credibility of their business and undermining a stable statutory and regulatory climate. Elected officials, regulators, and representatives of the settlement and insurance industries have faced enormous challenges during recent debates about STOLI. Those debates have occurred at the National Association of Insurance Commissioners ("NAIC"), the National Conference of Insurance Legislators ("NCOIL"), and in many state legislatures. State activity related to STOLI is expected to continue in 2009. This article provides an overview of state anti-STOLI laws enacted to date.

Background. While there is discussion about the best, most accurate, most legally defensible definition of STOLI, there is general agreement about the concept. A STOLI transaction involves a person who intends, at the time of original purchase of a life insurance policy, that the policy will benefit a third person who has no interest in the continued life of the insured. STOLI is a technique or design that involves these elements. STOLI isn't a type of insurance product. STOLI transactions can take many different forms and, to avoid detection by insurance companies, STOLI often involves complex arrangements designed to conceal the true nature and purpose of the transaction. Some insurers tell of instances where STOLI involves simple misrepresentation, but they also report about sophisticated STOLI transactions using trusts and other business entities that conceal the identity of parties with ownership or beneficial interest.[1]

When the growth of STOLI activity was first identified 3 or so years ago, questions arose about what effects STOLI would have on the life insurance and life settlement markets. While there's not much that life insurers and life settlement companies agree on in this debate, it may be accurate to say that both industries would be better off if no one had cooked up STOLI!

But we know that the concept that underlies STOLI has been tried before--at least as far back as the 1880s. *Warnock v. Davis*, 104 U.S. 775 (1881), involved a contract between an individual and the Scioto Trust Association. The contract provided that the individual, who was himself a partner in the Association, would apply for an insurance policy on his own life, and then unconditionally assigned the policy to the Association. In exchange, the Association paid all premiums, and agreed to pay the insured's wife one-tenth of the policy proceeds upon the death of the insured. There is no suggestion that the insured's death would create a pecuniary loss for the Association. If that had been the case, this might have been a forerunner of today's key-man insurance. This case is referenced here not because of the significance of the holding,[2] but to illustrate that there is nothing new about the concept of an individual and a disinterested third party agreeing that the individual -- for a fee -- will buy insurance on his own life, with the intent of benefitting a third party. By owning the policy at issuance, the insured and intended third-party beneficiary circumvent insurable interest laws.

NAIC and NCOIL Respond. At the urging of the life insurance industry, both the NAIC and NCOIL recently appproved new model laws intended in part to help eliminate STOLI. The NAIC acted first, adopting a new version of its Viatical Settlement Model Act (the "NAIC Model Act") in December 2006.[3] NCOIL followed by adopting its Life Settlements Model Act (the "NCOIL Model Act") in December 2007.[4]

There are many similarities between the Model Acts approved by the NAIC and NCOIL. While the specifics differ, the two Models have the following major provisions in common:[5]

- Settlement Providers (investors who purchase life insurance policies in the initial settlement transaction) and Settlement Brokers (intermediaries who arrange the sale of a life insurance policy from an individual to investors/Settlement Providers) must be licensed by the state insurance regulator.
- A policy owner must give written consent to the settlement contract and have a "full and complete" understanding of the contract.
- A policy owner must receive disclosures regarding possible tax issues, possible effect on eligibility for certain public assistance programs, and exposure of settlement proceeds to claims of creditors.
- Contacts with the insured to determine health status, subsequent to the settlement, are limited to once every three months when life expectancy is one year or more, and limited to once each month when life expectancy is less than one year.
- Settlement Providers must report certain data regarding their settlement activity to the state insurance regulator.
- Settlement Providers and Brokers must adopt and implement anti-fraud programs.
- Advertising by Settlement Providers is subject to state regulation; the use of certain phrases, such as those stating or implying that insurance is "free," are prohibited.

The NAIC and NCOIL Model Acts take very different approaches to address STOLI. The NCOIL Model Act uses a very direct approach to STOLI. Under the NCOIL Model Act, it is a "fraudulent life settlement act" to enter into any practice or plan which involves STOLI. STOLI is defined as "a practice or a plan to initiate a life insurance policy for the benefit of a third party investor who, at the time the life insurance policy is originated, has no insurable interest in the insured."[6] The NCOIL Model Act also provides that it is unlawful for any person to "issue, solicit, market or otherwise promote" the purchase of a life insurance policy "for the purpose of or with an emphasis on settling the policy."[7] The NCOIL Model includes a two-year moratorium on the settlement of life insurance policies.

In contrast, the NAIC Model Act has as the centerpiece of its anti-STOLI provisions a five-year moratorium -- or waiting period -- on the settlement of a policy.[8] Sometimes referred to as a "catch and release" approach, the NAIC Model Act prohibits the settlement of all life insurance policies until five years after original issuance by the insurer, then identifies categories of policies that are carved out of the five-year moratorium. Most importantly, the NAIC Model Act provides that policies that do not have any of the characteristics of a STOLI transaction are subject to only a two-year waiting period prior to being eligible for settlement. A policy may be settled after two years when: policy premiums have been funded exclusively by the insured; there is no agreement or understanding that a policy would be settled at the inception of the contract; and neither the insured nor the policy has been evaluated for settlement.

Finally, if any of several specified hardship situations occur, a life insurance policy can be settled at any time. A policy may be settled at any time if the policy owner experiences any of the following: retirement from

full-time employment; divorce or death of a spouse; physical or mental disability that prevents full-time employment; bankruptcy or insolvency; or the terminal or chronic illness of either the policy owner or the insured.

One of the challenges facing state legislatures and regulators is that neither Model Act is unconditionally supported in unaltered form by either the settlement companies or the life insurance companies.[9] The life settlement industry generally opposes key elements of the NAIC Model, particularly the 5-year moratorium on settlement. The life insurance industry supports the NAIC Model.

The approach taken in the NCOIL Model is generally supported by both the settlement and insurance industries and has been endorsed by the two major trade associations representing those industries.[10] But during debate on state legislation, both industries have sought modifications of key provisions of the NCOIL Model -- such as the definition of "STOLI." As a result, very few of the state anti-STOLI laws enacted so far faithfully track either Model Act.

State Activity To Date. Although many state legislators have never heard of a viatical or life settlement, in about half the states they've been thrust into the complex and sometimes fractious debate on Stranger-Originated Life Insurance. And in twelve states, they've approved anti-STOLI legislation that was then signed by their governors.[11]

In most states, either the NAIC Model Act or the NCOIL Model Act was used as a basis for drafting legislation. However, most state legislatures have developed their own variations on a Model, rather than enact it as approved by either the NAIC or NCOIL. Some of the state variations are minor, while others are substantively significant.

In 2008, laws generally based on the NCOIL Model Act were enacted in Connecticut, Hawaii, Kansas, and Oklahoma. In Arizona, Indiana, Kentucky, and Maine, "slimmed down" versions of the NCOIL Model Act were enacted. The NAIC Model Act was the basis for statutes enacted in Nebraska and North Dakota.

Three states -- Iowa, Ohio, and West Virginia -- enacted "hybrid" laws that combine the anti-STOLI features of both the NAIC and NCOIL Models. These hybrid laws define and prohibit STOLI transactions and impose a 5-year moratorium on settlement of policies with STOLI characteristics.

During 2008, several other states considered anti-STOLI legislation. The Rhode Island legislature passed anti-STOLI legislation, but it was vetoed by the Governor. Notably, bills are pending in both California and New York.

Several state insurance regulators have issued bulletins and less formal "alerts" to consumers and producers regarding STOLI.[12]

Ohio Law includes Unique Provisions. The most recent anti-STOLI bill was enacted in Ohio.[13] In addition to including most of the major elements of the NCOIL and NAIC Model Acts, the Ohio law includes some unique provisions. First, rather than using the NAIC Model Act's language describing the STOLI

characteristics that trigger imposition of the 5-year moratorium, the Ohio law re-words the triggers. Ohio legislators were concerned that the NAIC Model Act would require a policy owner to "prove a negative" before being allowed to settle a policy after two years. For example, the NAIC Model Act requires that to avoid the 5-year moratorium, a policy owner must certify that the insured has not been evaluated for settlement. To address this concern, the Ohio law requires that at the time of application, the policy owner truthfully respond to the insurer's inquiry about whether a life expectancy evaluation was obtained and, if one was obtained, a copy of it must have been provided to the insurer.[14] Similar changes were made to related provisions.

Ohio law also imposes new requirements on insurers. Each insurer issuing life insurance policies in Ohio must annually provide to the Ohio Department of Insurance a description of its anti-STOLI measures.[15] The information must be provided electronically in a format prescribed by the Department.[16] It is likely that the first report will be due some time in 2009. Perhaps more importantly, insurers issuing life insurance policies in Ohio will be required to include on their applications questions "reasonably structured to identify and prevent" STOLI.[17] The Department of Insurance is charged with adopting rules to implement this requirement. Compliance by insurers will be required 12 months after the rules are adopted. At this writing, the rules remain under development by the Ohio Department of Insurance.

The Ohio law also includes unique provisions designed to facilitate an insurer's detection of STOLI transactions. To motivate compliance with these "transparency" requirements, the Ohio law states that contracts and agreements related to STOLI, including premium financing agreements that are not disclosed to the insurer, are unenforceable as a matter of law. Specifically,

- If a premium finance company fails to provide notice to the insurer within 30 days of entering into an agreement, the agreement is unenforceable.
- A contract, agreement, arrangement or transaction entered into "for the furtherance or aid of a STOLI act, practice, arrangement, or agreement" is void and unenforceable.
- Trusts, LLCs, LLPs or other entities created as part of a STOLI transaction violate Ohio's insurable interest laws and the prohibition against wagering on life.[18]

Case Law. A discussion of case law and pending litigation related to STOLI is beyond the scope of this article. Among the cases of interest are: *American General Life Ins. Co. v. Schoenthal Family, LLC*, 248 F.R.D. 298 (N.D. Ga. 2008); *Life Product Clearing LLC v. Angel*, 530 F.Supp. 2d 646 (S.D.N.Y. 2008); *Kramer v. Lockwood Pension*, No 98-2499 (S.D.N.Y. 2008); *Sun Life Assurance Co. of Canada v. Paulson*, 2008 U.S. Dist. LEXIS 11719 (D. Minn. Feb. 15, 2008); and *Wuliger v. Manufacturers Life Ins. Co*., 2008 U.S. Dist. LEXIS 9809 (N.D. Oh 2008). To our knowledge, no litigation has yet ensued under the new state anti-STOLI laws. But this is sure to come.

What's Ahead? On the legislative front, it's likely that additional states will consider anti-STOLI initiatives in 2009. States to watch -- as always -- include California and New York, where bills are pending.

It seems inevitable that litigation related to STOLI will continue. It may result from insurance company rescission actions, or from an insurer's refusal to honor requests for change of ownership -- pursuant to the insurer's understanding of a new state anti-STOLI statute, or on other grounds. And certainly we can expect that actions will continue to be brought by survivors and estates of individuals insured under policies subsequently sold to third party investors.

It's unclear how investors who fund the life settlement industry will respond to state anti-STOLI laws. If we assume that these investors have every reason to avoid being involved in STOLI transactions, we must assume that they will demand an increasingly high level of due diligence by settlement providers. But will laws like the new Ohio statute that voids any contract related to STOLI make investors unwilling to fund settlements in Ohio? And, of course, economic developments unrelated to the laws and regulations governing STOLI will affect investors.

Finally, insurers are likely to continue to look for innovative ways to compete against the life settlement industry. In the 1980s, insurers developed accelerated death benefits in response to the viatical settlement industry. Similarly, the life settlement industry may prompt the next wave of innovation by life insurers.

One major question remains: will there continue to be sufficient investor funding for STOLI? Many observers of the settlement marketplace suggest that investors have tightened their standards for this market. It's too early to know what effect, if any, the 12 new state anti-STOLI laws will have on those who fund the settlement industry generally, and STOLI transactions in particular. Will these laws give investors more confidence in policies sold in the secondary life insurance market? Or will these new laws create further uncertainty -- at least in the near term?

We make no predictions, other than to say that this will continue to be an interesting and important area of the life insurance marketplace.

Endnotes

1. For background on STOLI, see "Stranger-Owned Life Insurance: A Point/Counterpoint Discussion," Jensen and Leimberg, ACTEC Journal, Fall, 2007.

2. After the death of the insured, the administrator of his estate sued to recover all proceeds paid by the insurer. The Court ruled that the Association was entitled only to recover the amounts it had advanced to the insured to pay policy premiums; the estate was entitled to all remaining policy proceeds. The Court effectively held that a policy could be assigned to one without insurable interest only as security for the loan made by the Association. *Warnock v. Davis*, 104 U.S. 775 (1881). This holding effectively has been overturned: today most states permit a life insurance policy, if legitimately purchased, to be assigned to one without an insurable interest. E.g., *Grigsby v. Russell*, 222 U.S. 149 (1911) (holding that life insurance policies may be assigned to persons without an insurable interest in the insured, but not in a situation where a person with an insurable interest "lends himself" to one without any insurable interest "as a cloak to what is in its inception a wager."

3. Earlier versions of the NAIC Viatical Settlement Model Act were prepared in response to the development of viatical settlements (the sale of a life insurance policy by a policy owner who has a chronic or terminal illness).

4. The NAIC Model Act uses the term "viatical settlement," while the NCOIL Model Act uses "life settlement." Throughout this article, the term "settlement" is used to refer to the sale of a life insurance policy on the secondary market.

5. Some of these provisions were included in versions of the NAIC Model Act approved prior to 2007.

6. The NCOIL Model Act, Sec. 2.Y.

7. *Id*., at Sec. 13.A.4.

8. NAIC Model Act, Sec. 11.

9. This article does not attempt to articulate the positions of either the life settlement industry or the life insurance industry. There are often different views among the companies within each industry. This article reflects the positions expressed by some settlement and insurance companies and their trade associations that have been actively involved in state legislative debates.

10. The Life Insurance Settlement Association (LISA) and the American Counsel of Life Insurers (ACLI) both endorsed the NCOIL Model shortly after its adoption.

11. The following states have enacted legislation to address STOLI: Arizona, Connecticut, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, North Dakota, Ohio, Oklahoma, and West Virginia. The Rhode Island legislature also approved anti-STOLI legislation, but the legislation was vetoed by Governor Carcieri on July 3, 2008.

12. Bulletins and other advisories are available on the websites of insurance regulators in Arkansas, California, Idaho, Illinois, Kansas, Louisiana, North Carolina, Ohio, Pennsylvania, and Utah.

13. Ohio House Bill 404 was signed into law in June and is effective September 11, 2008.

14. Ohio Revised Code Sec. 3916.16(B)(4)(c).

15. Ohio Revised Code Sec. 3911.021.

16. The Ohio Department of Insurance has not yet released information regarding the format to be used by insurers.

17. Ohio Revised Code Sec. 3916.05(B).

18. Ohio Rev. Code Secs. 3916.172 and 3916.173. There is no "prohibition against wagering on life" elsewhere in Ohio statutes.

TREATMENT OF INSURANCE CLAIMS UNDER TENNESSEE'S CONSUMER PROTECTION ACT

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Tennessee's General Assembly enacted the Tennessee Consumer Protection Act[1] in 1977 and has amended it frequently in the interim. This Act declares a number of "unfair or deceptive acts" to be unlawful and in violation of the Act, and, when any of these is found to have been a willful and knowing violation, the Act permits an award that may be as much as three times[2] actual damages and for the non-prevailing party to be

charged for the prevailing party's attorneys fees.[3]

The Supreme Court of Tennessee in 1998 affirmed a decision of the Tennessee Court of Appeals to the effect that the Act applied to insurance.[4] While, the *Myint* case opened up the Act to claims for wrongful actions by insurers, the Court specifically found based on the trial record that the carrier's conduct in handling the claim in that case was neither unfair nor deceptive[5] so that no award of damages under the Act was made.

In *Myint*, the Tennessee Supreme Court was not persuaded of inapplicability of the Act to insurance due to other Tennessee statutes that provided remedies for essentially the same conduct.[6] It was persuaded on this by the broad declaration of acts declared to be violations,[7] a scope provision in the Act that declared it was to be liberally applied,[8] and an absence of any statutory exclusion for insurance in the Act.[9] Immediately after and as the result of *Myint*, the Act was opened up for suits against insurers, but that case did not affirm or declare any award against an insurer or remand the case for further proceedings about liability under the Act.

Sparks v. Allstate Ins. Co.[10] held that the Act applied to claim handling under, as well as to the sale of, an insurance policy. *Sparks* involved denial of the insurer's motion to dismiss, but there is no published information as to outcome at the trial if in fact the case proceeded to trial. *Soloman v. Hager*[11] was an action against a builder and the insurer which had issued a builder's risk policy to the builder and involved a wall that fell following heavy rains and caused the roof to sag and the house to bow in the middle; the carrier denied liability on the ground that damage had been caused by a flood. Evidence at trial differed as to cause of the damage; the jury found for the plaintiff under the contract, under the Act and under Tennessee's penalty statute. The Court of Appeals affirmed, rejecting arguments that motions for directed verdict or new trial should have been granted or that requested charges should have been given to the jury. The case also held that the one-year statute of limitations did not bar additions of a claim under the Act in an amended complaint since the claim asserted in the amended complaint arose out of the conduct, transaction or occurrence set forth in the original complaint and was related back to that date for purposes of that one-year statute.[12]

Gaston v. Tennessee Farmers Mut. Ins. Co.[13] reached the Tennessee Supreme Court, which found that principles under the Act would permit a jury to conclude that the carrier's conduct in not telling an insured (unrepresented by counsel) that her third party settlement would prevent her from collecting under her own policy, due to her failure to secure carrier consent under the policy's subrogation provision, violated the Act. The directed verdict for the insurer was reversed and the case was remanded for trial.[14] On remand, a bench trial resulted in judgment for the insured, effectively finding a waiver of the subrogation provision by the carrier, making an award under the Act, and including plaintiff's attorney's fees (which the trial court had cut back from those sought). The trial court found that the 25% penalty statute did not apply because the trial court had no proof that the carrier's refusal to pay the claim was not in good faith and the trial court did not award treble damages as it found no deceptive conduct, all of which was affirmed by the Tennessee Court of Appeals.[15]

The recent case of *Farris v. Standard Fire Ins. Co*.[16] was an appeal from a trial court judgment on a case involving a claim under a homeowner's policy. Plaintiffs sought damages based on contractual liability and additional damages under the Act for costs they incurred which were not thought to be covered by the policy, e.g., loss of use, interest on home equity loan, along with attorney's fees incurred at trial and on appeal. The jury found for plaintiffs on contract and under the Act, and the trial court, concerned about double recovery, forced plaintiff to elect between remedies. The appellate court made it clear that a claim under the Act was to be treated as a separate cause of action, reduced the award under the Act to eliminate duplication, left undisturbed the portion of the award under the Act for damages not covered by contract, and awarded attorney's fees for the trial and the appeal.

Case law under the Act and the Act itself make Tennessee a potentially dangerous place for defendant insurers in litigation. As yet, no judgment amount in reported cases involving insurance under the Act has been

outrageous, which we believe is attributable to several factors, none easily demonstrable. First, carriers are aware of the Act and we think they have taken it into account in resolving claims, have borne in mind that appearances are a separate reality, and have both paid the claims they owe and largely avoided creating unfortunate records in the claims process on claims they believe they did not owe. Second, we think insurers have improved their trial advocacy. Third, and finally, we think that alternative dispute resolution by mediation, which many trial courts require, and by mandatory arbitration provisions in policies, have reduced exposure at trial by providing attractive means other than litigation by which parties may resolve insurance disagreements. In summary, this may be a situation where legislation has worked to achieve its aim of improving lives of consumers and done so without undue cost, but it may simply be a situation where the worst is yet to come.

Endnotes

1. Tenn. Pub. Acts 1977, Ch. 438, now codified at Tenn. Code Ann. Sec. 47-18-101, et seq., and sometimes referred to as the Act.

2. Tenn. Code Ann. Sec. 47-18-109(a)(3).

3. Tenn. Code Ann. Secs. 47-18-109(e)(1) permits recovery by prevailing plaintiffs and 47-18-109(e)(2) for defendants if the action in found to be frivolous, or with legal or factual merit or brought to harass.

4. *Myint v. Allstate Ins. Co*., 970 S.W.2d 920 (Tenn. 1998).

5. *Id*. at 927.

6. Specifically, Tenn. Code Ann. Sec. 56-7-105 (Provides for a penalty of up to an additional 25% of a contract award in a private action for refusal to pay an insurance claim if not made in good faith) and Tenn. Code Ann. Sec. 56-8-101, et seq. (Tennessee's Unfair Trade Practices Act in the business of insurance, which provides no private cause of action).

7. Tenn. Code Ann. Sec. 47-18-104.

8. Tenn. Code Ann. Sec. 47-18-102 and remedially interpreted, Tenn. Code Ann. Sec. 47-18-115.

9. Tenn. Code Ann. Sec. 47-18-111.

10. 98 F. Supp. 2d 933 (W.D. Tenn. 2000).

11. 2001 Tenn. App. LEXIS 929.

12. Tenn. Code Ann. Sec. 47-18-110. The one-year period runs from date of discovery and there is a five-year maximum.

13. 120 S.W. 3d 815 (Tenn. 2003).

14. *Id.* at 822-23.

15. 2007 Tenn. App. LEXIS 388. The Court of Appeals reversed the trial court only on its denial of pre-judgment interest.

16. 2008 U.S. App. LEXIS 12068, 2008 FED. App. 0315N (6th Cir.), not recommended for full publication.

PUNITIVE DAMAGES COVERAGE IN TEXAS-WHERE ARE WE NOW AND WHERE ARE WE GOING

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Whether punitive damages are covered under liability policies has long plagued the Texas insurance coverage lawyer and his or her clients, and two recent decisions suggest that the outcome, at least from a public policy standpoint, may remain a question without a definitive answer. Applying Texas law, the opinions in *Fairfield Insurance Company v. Stephens Martin Paving, LP* and *American International Specialty Lines Insurance Company v. Res-Care, Inc.,* analyze coverage for punitive damages under two different types of liability coverage.**1** The opinions suggest, however, that the answer is only certain under one type of policy, with other types of liability coverage being fact-dependent.

The Texas Supreme Court's opinion in *Fairfield* was decided first. In that case, the insurer argued that punitive damages awarded against the insured employer were not covered under the employer's liability coverage as a matter of Texas public policy. On appeal at the Fifth Circuit, however, the panel certified a much broader question to the Texas Supreme Court: Does Texas public policy prohibit a liability insurance provider from indemnifying an award for punitive damages imposed on its insured because of gross negligence? The Texas Supreme Court narrowly held that Texas public policy does not prohibit coverage under the workers' compensation and employer's liability insurance policy at issue, avoiding the Fifth Circuit's broader question and leaving open the question of whether punitive damages are covered under other types of liability policies.

The Texas Supreme Court enunciated a two-step process necessary to answer the issue based upon a public policy analysis: 1) determine whether the plain language of the policy covers the exemplary damages sought in the underlying suit against the insured; and 2) if the policy affords coverage, whether public policy allows or prohibits coverage under the circumstances of the underlying suit. Given this two-step framework, the *Fairfield* decision makes sense in light of the coverage at issue.

The employer's liability policy covered all sums the insured legally must pay as damages because of bodily injury to an employee. Because the certified question was limited to public policy, the court presumed that the policy afforded coverage for the damages. Moving to the second step, to answer the public policy issue, the court determined it must first decide whether the Legislature had addressed public policy on the issue by its enactments.

The court concluded that the following facts indicated the Legislature had spoken on public policy in this context: 1) the worker's compensation system in Texas is optional; 2) if an employer and employee subscribe, the only policy available is the Texas Department of Insurance (TDI)-approved form; and 3) if the employee dies, the statutory beneficiaries may sue the employer for gross negligence only. Accordingly, the court concluded if the worker's compensation system is the exclusive remedy for an injured employee, the only

reason the Texas Department of Insurance (TDI) must provide additional liability insurance to employers is to harmonize the statutory scheme allowing claims for gross negligence against the employer with the policy coverage.

Notably, the court did not end its opinion with its decision, but rather went on to opine on the suggested public policy analysis for other cases. The court started its discussion by noting the various outcomes of the issue in other jurisdictions, noting that other states' courts or legislatures have reached differing conclusions, both finding and prohibiting coverage, and also noting exceptions to punitive damages coverage in the context of UIM coverage and vicarious liability situations. The court then summarized the issue as one of weighing the interest in enforcing a contract, considering the freedom to contract, versus the public policy against such enforcement.

Important to the court was the current punitive damages statutory scheme in Texas. Recent statutory amendments addressing punitive damages make clear that their purpose is to punish the wrongdoer and downplay the role of deterrence, by deleting the language "as an example to others." Additionally, the statutory scheme provides that an award of punitive damages must be specific as to each defendant, and a defendant is liable only for the punitive damage award against it. The Legislature has provided only a limited exception to liability to a third-party for punitive damages based on the criminal conduct of another.

Further looking to the Legislature's intent, the court suggested that the six statutory considerations in awarding punitive damages may play a key role in answering the public policy question, three raising objective concerns (the nature of the wrong; the character of the conduct involved and the extent to which the conduct offends a public sense of justice and propriety), and three raising subjective concerns (the degree of culpability of the wrongdoer; the situation and sensibilities of the parties concerned; and the net worth of the defendant). The court reasoned that spreading the risk of and obligation for exemplary damages through insurance does not affect the objective factors, while the subjective factors are relevant only if the defendant must pay the plaintiff. In other words, if exemplary damages are to be paid by insurance, it is less relevant to set the amount based upon whether the plaintiff was trusting or the defendant was calculating or wealthy.

The court also suggested that considerations may weigh differently when the insured is a corporation or business that must pay punitive damages for the conduct of one or more of its employees. When employees or management are not involved in or aware of an employee's conduct, the court indicated that the purpose of exemplary damages may be achieved by permitting coverage so as not to penalize many for the acts of one, encouraging courts to consider valid arguments that businesses be permitted to insure against punitive damages in this circumstance. What the court failed to address, however, is that, in most instances, an employer's "vicarious" liability for the punitive damages of its employee is based on the employer's conduct. For instance, an employer can be vicariously liable when the employer authorized the doing and manner of the employee's act or the employer ratified or approved the act. In only one situation is the employer's conduct not considered: when the employee was employed in a managerial capacity and was acting in the scope of employment.**2** Thus, it appears under the supreme court's rationale that public policy currently would allow coverage for an employer's vicarious liability for punitive damages awarded against its employee only when the employee was in a managerial capacity and acted in the scope of his employment.

The Fifth Circuit applied the *Fairfield* rationale to a troubling case, *American International Specialty Lines Insurance Company v. Res-Care, Inc.,* concluding that public policy prohibited coverage for punitive damages under a CGL policy.**3** The court's opinion is fact-specific, however, and cannot necessarily be read as a blanket prohibition on coverage of punitive damages under a CGL policy. Thus, understanding the facts is key to understanding the court's decision.

Trenia Wright, a 37-year-old woman with cerebral palsy and mental disabilities, resided at Res-Care's facility. Wright fell in a hallway at the facility, and defecated on the floor. Vicki Kennerly, an employee at the home,

found the woman and poured a mixture of undiluted bleach and another cleaner onto the floor around the woman, and possibly directly onto the woman. She then escorted the other residents outside, leaving Wright lying on the floor in the home. After spending over an hour outside eating pizza with the other residents, Kennerly returned inside and dragged Wright into a bathroom and finished cleaning the hallway floor. She did not, however, wash the bleach off of Wright. Kennerly left the facility soon afterward when her shift ended.

Two other attendants later found Wright on the floor of the bathroom and put her to bed in clean clothes, but again, did not wash the bleach off of the woman. A staff doctor observed Wright 17 hours later, but diagnosed her only with superficial burns. Two days later, Wright fell out of bed and was found unresponsive, at which point she was taken to a nearby hospital. At the hospital, she was diagnosed with extensive chemical burns on 40% of her body, and four days after the original incident, died from complications due to the severe burns and chemical poisoning. The attendant who first poured the bleach on the woman was later convicted in state court of recklessly causing bodily injury to a disabled individual.

The patient's family filed a wrongful death and survival lawsuit against Res-Care, the hospital, treating physicians, and four of Res-Care's employees. Given the egregious facts of the case, the settlement demands from the plaintiffs, and the coverage issues involving potential exemplary damages, AISLIC and Res-Care entered into a non-waiver agreement that authorized AISLIC to seek settlement of the lawsuit, while reserving the right to bring a claim for recoupment against Res-Care for all sums paid by AISLIC attributable to claims that were not covered under the insurance policies.

In the coverage action, the court followed the *Fairfield* guidelines in its analysis of whether punitive damages were insurable under the applicable CGL policy. Under the facts before it, this court also "presumed" the CGL insuring language encompassed punitive damages. Next, the court examined whether any statutes specifically addressed the insurability of punitive damages for an entity such as Res-Care. Res-Care was classified as an Intermediate Care Facility for the Mentally Retarded. Certain "healthcare providers" are precluded from obtaining insurance for punitive damages (or are required to do so through an approved endorsement). Res-Care's classification, however, did not fall into any of those specific statutes. Because no statute addressed Res-Care's ability to obtain such insurance, the court then considered general public policy, specifically, whether the freedom of contract was outweighed by the primary purpose of punitive damages - to punish the wrongdoer.

The Fifth Circuit noted the *Fairfield* court's suggestion that circumstances may exist when insurance coverage for punitive damage may be allowed, such as when the insured is a corporation responsible for damages due to the conduct of its employees. The Fifth Circuit, however, heeded the *Fairfield* court's reservations about "extreme circumstances" that may warrant different considerations. The Fifth Circuit concluded such "extreme circumstances" existed for Res-Care, such as allegations of gross negligence by *all* defendants, not only for direct participation in the bleach incident, but also for failure to take steps to prevent the situation from occurring, and documented, systemic problems of care. These allegations, according to the court, "were so extreme that the purposes of punishment and deterrence of conscious indifference outweigh the normally strong public policy of permitting the right to contract."**4** Notably, the court did not discuss any of the statutory requirements for awarding punitive damages, either generally, or specifically those situations involving liability based on the criminal acts of another.

The Fifth Circuit's holding illustrates the fact-intensive analysis courts likely will undertake in the wake of *Fairfield* to determine the public policy prohibition or allowance of insurance for punitive damages. It remains to be seen, however, what courts may do when faced with less-extreme fact scenarios. More important, however, is that neither of these opinions answers the contract question of whether punitive damages are covered. The "pure coverage" issue is one that needs to be addressed and could eliminate much of the litigation on this issue.

In Texas, the Legislature's definitions of gross negligence and malice provide the guidance needed on the contract question. Punitive damages in Texas are awarded for conduct constituting malice or gross negligence, the former requiring a specific intent to cause substantial injury or harm to the claimant, the latter requiring an act or omission, which when viewed objectively from the standpoint of the actor, involves an extreme degree of risk, considering the probability and magnitude of potential harm to others, and of which the actor has actual, subjective awareness of the risk involved, but nevertheless proceeds with conscious indifference to the rights, safety or welfare of others. Initially, as pointed out above, the Texas Legislature has indicated that punitive damages are awarded to punish. Thus, at least in a general liability context, those damages are not awarded "because of" bodily injury or property damage. Moreover, the conduct required for gross negligence and malice findings includes "intentional" conduct. Under most types of liability policies, the insuring agreement requires some type of accidental or other unintentional conduct. Accordingly, a finding of malice or gross negligence should not meet the terms of the typical insuring agreement. Additionally, many liability policies exclude damages awarded as a result of an insured's intentional conduct or that are expected by the insured. Thus, in most cases -- particularly in cases involving an award of punitive damages directly against the actor -- public policy arguments simply should not come into play, because punitive damages should not be covered by the policy. It seems the best position for an insurer in Texas is to exhaust all pure coverage arguments, before relying upon a public policy argument, which undoubtedly will require a fact-intensive analysis.

Endnotes

1. *See Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653 (Tex. 2008) (analyzing coverage for punitive damages under a Texas workers' compensation/employer's liability policy); *American Int'l Specialty Lines Ins. Co. v. Res-Care, Inc.,* 529 F.3d 649 (5th Cir. 2008) (analyzing coverage for punitive damages under a CGL policy).

2. *Hammerly Oaks, Inc. v. Edwards*, 958 S.W.2d 387 (Tex. 1997); *Purvis v. Prattco, Inc.,* 595 S.W.2d 103 (Tex. 1980).

3. *American Int'l Specialty Lines Ins. Co. v. Res-Care, Inc.,* 529 F.3d 649 (5th Cir. 2008).

4. *Res-Care*, 529 F.3d at 664.

HEALTH CARE: TO MANDATE OR NOT TO MANDATE?

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In the 1960s, when health care was not such a national issue, there were only a handful of state mandates in existence related to health insurance. However, as of this year, the Council for Affordable Health Insurance ("CAHI")[1] has indentified 1,961 health insurance mandates nationwide. There are arguments for and against health insurance mandates. It has been estimated that approximately 46 million Americans are uninsured.[2]

This fact has sparked a national debate over whether to expand coverage through employer mandates or individual mandates, with the purpose of getting to the goal of universal coverage, where every American would have some form of health insurance. On the other hand, mandating health insurance coverage, while popular, carries with it a cumulative price tag which makes health insurance less affordable for individuals, small employers and increasingly even large employers. So, what is the answer?

The answer may in large part depend upon which side of the political coin one happens to occupy: generally speaking, Democrats support mandates, while Republicans typically oppose mandates primarily because of the cost associated with such forced coverage. Regardless, one thing is certain: health insurance mandates are a topic currently being debated in every state and on a national level and will be a relevant topic for years to come. And regulators, primarily insurance departments, are also wrestling with mandates. Regulators have testified before Legislative Committees both in support of and against mandates and are charged with enforcement of legislation once passed. This article will define health care mandates, identify types of health care mandates, provide an analysis of the arguments for and against such mandates in a health care context and then identify current trends.

What Are Health Care Mandates?

Simply put, a mandate is a requirement that an insurance company, a health maintenance organization or other entity that sponsors health plans (such as a self-insured employer) offer specified providers, procedures or benefits, or provide coverage to certain classes of individuals. On the insured side, in order for a health insurer or health maintenance organization to do business in a state, it must comply with state-legislated health insurance mandates. Accordingly, the vast majority of health mandates come from state legislatures. However, the federal government, in the last two decades, has been increasingly willing to impose mandates nationwide that impact both insured and self-funded plans. Most state mandates affect small and large employers and occasionally, individual policyholders, which can mean the self-employed. Employers can escape state mandates by self-funding and sponsoring a qualified health plan under the Employee Retirement Income and Security Act ("ERISA").[3]

While mandated benefits may in fact make health insurance broader, in that more people may obtain more coverage, there is no doubt that health mandates in turn make coverage more expensive. But one thing is certain. Once a state mandate is enacted, it is almost impossible to get it repealed.

Types Of Health Care Mandates.

Essentially, there are three types of mandates in health insurance coverage. The first and most commonly known mandate has to do with benefits. Identification of a specific medical benefit or treatment and a government requirement that such medical benefit or treatment be covered by a regulated health plan is the most popular of all health mandates. A few examples would include mandates to require coverage of treatment for mental illness, alcoholism, diabetes, autism or mammograms. In a report issued this year, the CAHI identified sixty-five benefit mandates that have gained acceptance in the fifty states, such that they are not considered anomalies or outliers in coverage any longer. One example would be mammograms, which are currently mandated in every state.[4] Benefit mandates easily represent the fastest way that mandates as a whole may grow in the future, as arguments are put forth regarding the need for coverage of different conditions and medical procedures.[5]

The second type of health care mandate, one that is becoming increasingly common, requires plans to cover the services of certain types of providers. Again, according to the 2008 report issued by the CAHI, there are

apparently thirty-three different provider groups that enjoy mandates which require health plans to pay for their services in certain coverage situations. Providers enjoying the benefits of such mandates include chiropractors, dentists and podiatrists, who are usually represented by large lobbying groups, as well as lesser known providers such as lay midwives, naturopaths, pastoral counselors and various types of social workers. Mandates in this area generally find their genesis in the legislative lobbying power of the providers who are affected, as opposed to patient activism.

The final type of health care mandate is in the area of eligibility, otherwise referred to as "covered persons." Mandates in this area tend to require coverage that is linked to the age or status of the individual. Examples would be coverage for adopted children, newborns and non-custodial children, as well as dependent students. Another example would be where employees and dependents move from primary coverage to continuation coverage, or to conversion coverage for non-group individuals. The person's eligibility for the additional coverage is based upon his or her status as a person who has lost primary coverage usually due to a life-changing event. Continuation/conversion coverage is found in virtually every state and certainly, we have the federal mandate under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), which gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. The status or age of an individual is the determining factor in the area of eligibility mandates.

Arguments For And Against Health Care Mandates.

The arguments in favor of health care mandates generally depend upon the type of mandate involved. In the area of benefit or coverage mandates, there are many reasons legislatures desire to enact and introduce mandates, including the desire to guarantee coverage for individuals with a particular disease or condition. But, as mandates now expand beyond benefits and include mandates requiring usage of certain providers, coverage of certain treatments and coverage of certain classes of individuals, the arguments can be more complex.

The base argument in favor of employer or individual mandates has already been mentioned -- the fact that a sizeable portion of America's population is currently uninsured. This argument is closely followed by the conclusion that without mandates, America will not achieve universal coverage. Studies have found that even if we experience insurance market reforms, more managed care, administrative streamlining and health alliances, nonetheless, a system without mandates would still leave 20 million to 28 million Americans without insurance. The chief reason for this is money. Small employers, individuals and families, if given a choice, would weigh economic risk and benefits and not purchase coverage if they don't have to. In the private sector, decisions regarding non-mandatory items usually come down to whether the decision-maker has money to support the purchase.

Another argument in favor of mandates is in the area of access to health care and access to better health. Supporters see mandates as producing better health outcomes. It is argued, for example, that people will receive more preventive care if they are covered by insurance. Another argument also advanced in favor of mandates has to do with those in the system who are getting a free ride at the expense of taxpayers. When an individual does not have health insurance, he or she still receives medical treatment and indeed, hospitals are legally required to provide care regardless of the ability of the patient to pay. In fact, uncompensated care costs an estimated $40.7 billion per year, with 85% of that cost being borne by federal, state and local governments.[6] Therefore, advocates of a mandate will argue that if government can mandate automobile insurance in order to protect society from costs imposed by uninsured drivers, then government should also be able to do the same for health insurance.

The arguments against mandates are many. The first and most immediate is that mandates have been proven to increase the cost of health care coverage.[7] The amount of the cost increase will depend upon the nature of the legislation, the geographic location and the usage patterns of the particular population affected. For example, mandates requiring treatment of drug abuse may result in higher utilization in inner cities as opposed to in largely rural areas. However, it should be noted that not all mandates are equal in this respect. Some mandates have a marginal cost and others, a significant impact on the cost of health insurance. For instance, the overall increase in health care premiums has been well documented as a result of the passage of the Mental Health Parity Act nationwide. Compare this to mandates involving hair prostheses, given that there may not be that many hair prostheses needed across the United States at any given time.

A second argument against employer and individual mandates is ideological in nature: the government should not tell private business or individuals what to do. After all, the American way is entrepreneurship and free enterprise, as opposed to government intervention, although that has certainly begun to diminish over time. However, as an example that Americans still favor private health insurance options over mandates, a recent Gallup Survey asked Americans their views on twelve different reform options for health care, from tax breaks and deregulation to mandates in a national health care system (similar to that of Canada and Europe). The most favored policy and one receiving near universal support (94%) was tax breaks to small businesses for providing insurance to employees. The policy most opposed (44%) was a mandate for every American to have health insurance.[8]

Other problems created by mandates that have been put forth are that they increase health insurance utilization, create health insurance dependency, cause employers and individuals to cancel their policies and thus, actually cause more Americans to become uninsured. A mandate may encourage individuals to use their health insurance for therapies not previously covered, thus increasing utilization which supports higher health care prices and perhaps minimizes competition. Mandates create health insurance dependency, as the consumer increasingly depends upon the health insurer to pay the cost of the medical treatment or procedure, as opposed to paying first dollar for that treatment or procedure, as was done long ago. Finally, the idea that employers and individuals are canceling their policies and will cancel their policies is also well founded.

Trends For The Future.

One of the phenomena seen in the industry is what can be termed as "catch on" mandates. That is where one or two (or a handful of) states pass a mandate and then legislators in other states hear about it -- often through special interest groups or lobbying groups -- and then introduce a version of the legislation in their own states. An example of such a mandate is one related to the treatment of autism and its various complications. In 2008 alone, several states have either considered or passed legislation related to autism.[9]

Another trend is in the area of eligibility mandates that can be termed "slacker" mandates. Slacker mandates are those in which health insurance coverage is extended to unmarried dependents or students up to the age of thirty, or at least over the age of twenty-four to some cutoff age. In addition to this type of mandate, new categories of health insurance coverage eligibility have recently emerged, such as coverage for illegal aliens or elderly parents. As an example, Maine has extended eligibility for health insurance coverage to include an individual who is not yet a United States citizen, but who is residing legally in the United States. Oregon has added elderly parents who meet certain criteria.

Another trend associated with mandates is in the area of mandated benefit studies. There are now at least

thirty states requiring mandated costs to be assessed before the mandate is implemented.[10] Independent advisory commissions, both at the state and federal levels, are being established to proactively evaluate the impact of mandates and to ensure that they will result in improved care and value. Increasingly, legislators are recognizing that mandates must promote evidence based medicine, which in turn promotes high quality care.

Individual Mandate For Health Insurance.

A final note on individual health care mandates, or a watered down proposal for achieving universal health insurance. Individual health care mandates are laws that require individuals to purchase health insurance and threaten punishment for those individuals who do not. Individuals would be required to receive such coverage through their employers or some other group to which they have membership or would be required to purchase their own individual coverage. Those who fail to do so would be subject to fines or other penalties. Massachusetts is one state that has already created a health care policy with an individual mandate. A similar plan has been proposed by Governor Schwarzenegger for California. Proposals for an individual mandate respond to a legitimate concern about those uninsured who nonetheless receive treatment and pass the cost along to taxpayers or individuals with private health insurance. Some observers see an individual mandate as an achievable step on the road to universal coverage. As mentioned above, having long equated insurance coverage with access to health care and access to better health, they see an individual mandate as producing better health outcomes.[11]

The problem with individual mandates is that such a requirement may not be workable in the real world as part of health care reform. First, individual coverage can be mandated but it does not mean much unless the coverage is affordable. How does the low income sector of society find the funds to purchase required insurance coverage? Moreover, what benefits should the individual coverage mandate? And what about enforceability? What sort of penalties would be assessed for violation of the mandate and will the punishments be punitive or adversely impact certain segments of society, such as those with a low income? Finally, how should individual mandated coverage be rated? These are practical problems of an individual mandate, but are nonetheless important problems that need to be addressed. Perhaps the Great Massachusetts Experiment will give us valuable insight on these issues.

Conclusion.

Health care mandates have been part of the landscape for the last few decades and will occupy the health care debate for years to come. An understanding of the arguments, both in favor of and against mandates, is critical for consumers, employers, regulators and legislatures as the debate increases from state-to-state and on a national level.

Endnotes

1. The Council for Affordable Health Insurance ("CAHI") is a research and advocacy association of insurance carriers active in the individual, small group, HSA and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance producers. *See*, http://www.cahi.org/index.asp.

2. Carmen DeNavas-Walter W. Alt, Bernadette Proctor, and Cheryl Hill Lee, "Income, Poverty and Health Insurance Coverage in the United States, 2004," U.S. Census Bureau, August 2005.

3. When employees incur health care expenses under a self-funded plan, the employer, rather than an insurance company, pays the medical bills.

4. "Health Insurance Mandates in the States 2008" by Victoria Craig Bunce and J.P. Wieske. *See* http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf.

5. Additionally, the CAHI identifies twenty other benefit mandates that appear in very few states but which may have wider acceptance in the future. *See*, "Health Insurance Mandates in the States 2008" by Victoria Craig Bunce and J.P. Wieske.

6. Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.

7. For instance, a long awaited report issued on July 7, 2008 by the Division of Health Care Finance and Policy in Massachusetts concludes that 12¢ of every one dollar paid for health insurance in Massachusetts goes toward twenty-six state mandated benefits, from maternity and mental health care to infertility and diabetes services. Statewide, the price tag is $1.3 billion a year. *See*, Boston Globe, Kay Lazar, July 8, 2008.

8. Source: Gallup Telephone Survey of 1,006 national adults aged 18 and older, conducted September 24,-27, 2007, "*any health care reform plan will do for Americans: broadest support for plans that expand access to private health insurance*," October 25, 2007: www.gallup.com/poll/102349/any-healthcare-reform-plan-will-americans.aspx.

9. Autism mandates were passed in Pennsylvania, West Virginia and Louisiana in 2008, and are under consideration in Florida, Michigan and Washington.

10. *See*, "Trends & Ends," CAHI, Council for Affordable Health Insurance, Victoria Craig Bunce, Director of Research and Policy, May 2008.

11. *See*, "Individual Mandates for Health Insurance," Cato Institute Policy Analysis, Michael Tanner, April 5, 2006.

PROTECTING FLORIDAâS CORPORATE OFFICERS AS D&O SUITS INCREASE

Florida Corporate Officers are not Statutorily Protected to the Same Extent as Corporate Directors by the Business Judgment Rule

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In 2007, the Florida Legislature passed a law requiring the CEO or CFO of a property insurer to certify the company's annual rate filing.[1] Similar to CEOs and CFOs who certify financial statements to the SEC that

they rely on other qualified personnel to prepare, most CEOs and CFOs of property insurers are not experts in actuarial science. As a result, the certifying officer is caught having to rely on actuary staff to prepare the filing while certifying that based on his or her personal "knowledge," the filing is accurate. Certifying officers are justifiably concerned regarding the potential liability to corporate shareholders and regulators in certifying a filing, whether it is an insurance rate filing or financial filing with the SEC, wherein the officer must rely on the expertise of others. But what, exactly, is the standard of knowledge an officer must have to certify a filing and what is the potential liability in relying on others preparing the filing?

Officers, Directors and the Business Judgment Rule in Florida

In researching the standard of "knowledge" a CEO or CFO must have to certify a filing, it was discovered that there is a disparity in the law in Florida with respect to officers and directors. Directors are statutorily protected by the Business Judgment Rule. Officers, however, are not.

The Business Judgment Rule applies to directors who use due care in the exercise of business judgment and protects them from liability, unless they act fraudulently, illegally, oppressively or in bad faith. The Florida Statutes codify the Business Judgment Rule and provide that a director is not liable for any action taken as a director, or any failure to take any action, if he or she performed the duties of his or her office in compliance with the statute.

The Business Judgment Rule provides that a director is entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, if prepared or presented by: (a) one or more officers or employees of the corporation whom the director reasonably believes to be reliable and competent in the matters presented; (b) legal counsel, public accountants, or other persons as to matters the director reasonably believes are within the persons' professional or expert competence; or (c) a committee of the board of directors of which he or she is not a member if the director reasonably believes the committee merits confidence. A director is not protected, however, if he or she had knowledge concerning the matter that makes reliance on others unwarranted.[2]

Notwithstanding this limitation on director liability, directors are required to educate themselves prior to making business decisions of all material information that is reasonably available to them and having become so informed to act with requisite care in discharge of their duties in order to avail themselves of the protections of the rule.[3]

There is no provision in the Florida Statutes applying the protection of the Business Judgment Rule to officers. Instead, the Florida Statutes merely provide that each officer has the authority and shall perform the duties set forth in the bylaws or, to the extent consistent with the bylaws, the duties prescribed by the board of directors or by direction of any officer authorized by the bylaws or the board of directors to prescribe the duties of other officers.[4]

Because officers are not afforded the same protection from liability under the Business Judgment Rule that directors are, all Florida corporations should include language from the Business Judgment Rule in their bylaws. Although language in the bylaws may not provide as much protection to officers as it would if contained in a statute, it is better than leaving the issue completely unaddressed.

FEDERATION OF REGULATORY COUNSEL, INC.

Recommendations for CEOs and CFOs in Certifying Filings

The following recommendations are for CEOs and CFOs certifying filings, either in compliance with Sarbanes-Oxley or for insurance companies certifying rate filings in Florida. These recommendations also should be adopted for any annual or quarterly reports that require certification.

- The CEO/CFO should act with utmost good faith.
- The corporation's bylaws should include language that officers are entitled to rely upon information, documents, etc. prepared by those people whom the officer reasonably believes to be reliable and competent in the matter presented.
- Filings to be certified should be prepared by competent, credentialed professionals with active licenses. The CEO/CFO should be confident in, and able to articulate, the qualifications of his or her professional staff to support the argument that the CEO/CFO is reasonable in his or her reliance on the professional staff.
- The CEO/CFO and professional staff should meet to discuss the filing, including the basis for the filing. These do not have to be lengthy tutorial sessions; rather, they should be more along the lines of a narrative summary explanation.
- The CEO/CFO should review the filing and thoroughly review any explanatory memoranda and other supporting narrative documentation filed in support of the filing.
- The professional staff should send drafts of the filing documents well in advance of when they are filed in order to allow the CEO/CFO ample time to review them. CEOs/CFOs should not accept receipt of a filing at the last minute; a CEO/CFO who is forced to certify the filing without adequate time to review it will have difficulty establishing that he or she was able to give critical thought to its contents.
- CEOs/CFOs should ask questions about any uncertainties or concerns and keep a record of the fact that they asked questions and commented on the documents.

If these recommendations are followed, the CEO/CFO will be in a better position to argue that he or she (1) reasonably relied on professional staff that has the appropriate experience and credentials to justify the reliance; and (2) took necessary and reasonable steps to familiarize themselves with the filing, such that the certification is made in good faith.

Endnotes

1. The rate filing certification in Section 627.062, Florida Statutes, requires the CEO or CFO to certify under oath and subject to penalty of perjury, that (i) the signing officer reviewed the rate filing; (ii) based on the signing officer's knowledge, the rate filing does not contain any untrue statements, any omissions, or misleading statements; (iii) based on the signing officer's knowledge, the rate filing fairly represents the basis of the rate filing; and (iv) also based on the signing officer's knowledge, the rate filing reflects all premium savings reasonably expected to result from legislative enactments and is in accordance with generally accepted and reasonable actuarial techniques.

2. Section 607.0830, Fla. Stat.

3. Section 285, Business Relationships, Vol. 8A Florida Jurisprudence, 2d Ed.

4. Section 607.0841, Fla. Stat.

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