

CAPTIVE MANAGERS

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Captive Managers

Most state laws authorizing the formation of captive insurers require the captive insurer to engage and utilize a Captive Manager. This article will discuss the reasons for this requirement, the role and responsibilities of the Captive Manager, qualifications and approval of Captive Managers, and conflict of interest and dual agent issues inherent in the role of Captive Manager.

Captive insurers are not permitted to market and provide insurance at large, but are restricted to providing insurance to their affiliates and certain other parties who have a relation to the captive insurer that fosters an incentive for the insured to actively manage risk and control loss. Thus, most regulators regard most captive insurance programs as a form of self-insurance. Licensing and regulation of captives is therefore not motivated by the same primary consumer protection concerns that underlie the regulation of "traditional" insurers. The primary public interests in regulating captive insurers are usually the generation of public revenue, the economic development of the captive insurance service industry within the state, and enabling business enterprises to address their own insurance needs through alternatives to commercially available insurance from third party insurers. Captive insurer owners, directors and officers commonly lack experience and expertise in operating an insurance company. The Captive Manager is a private sector insurance consultant and service provider the regulator relies upon to: (i) serve as a knowledgeable intermediary between the regulator and the captive insurer's owners (whose expertise lies in some other industry); (ii) monitor the affairs of the captive insurer on behalf of the regulator; (iii) educate and orient the captive insurer's owners, directors and officers with respect to owning and operating an insurance company; (iv) justify a more relaxed and flexible regulatory regime for captive insurers; and (v) promote the development of the state's captive insurance industry.

Role

Most captive laws provide only a very general description of the responsibilities of a Captive Manager. To the extent addressed at all in the law itself, most captive laws specify that the Captive Manager is required to maintain the captive insurer's books and records at a location in the state of domicile and is required to promptly notify the Commissioner of any failure of the captive insurer to comply with the applicable captive law. Regulators' more specific expectations of the Captive Manager are often expressed in general reference materials, websites, application forms and instructions, and bulletins or even more informal statements of policy.¹ South Carolina and Washington, D.C. have issued regulatory bulletins that describe a Captive Manager's responsibilities in some detail, summarized as follows:

- Maintain a place of business for the captive insurer in the state
- Maintain and make available for inspection by the Commissioner copies of the books and records of the captive insurer
- File statutorily required reports on behalf of the captive insurer
- Obtain prior approval from the regulator prior to implementing material changes to the captive insurer's plan of operations
- Notify the regulator promptly if the captive insurer is out of compliance with financial requirements or evidences another adverse financial condition

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See Government of the District of Columbia, Department of Insurance and Securities Regulation, Captive Insurance Bulletin 2002-01; South Carolina Department of Insurance, Bulletin 2008-03.

Additionally, some states require the Captive Manager to approve material expenditures by the captive insurer, or even be a signatory on the captive insurer's checking account.²

Beyond these "formal" responsibilities, Captive Managers commonly fulfill the following functions:

- To actively promote the captive domicile and attract captive insurer applicants
- To consult with prospective captive owners in the development of their business plans
- To serve as broker for the purpose of obtaining fronting and reinsuring carriers
- To formulate and shepherd the captive insurer's application for certificate of authority
- To recommend other professional service providers, such as attorneys, auditors/accountants, actuaries, underwriters/administrators, risk managers, adjusters, investment managers, bankers and others
- To coordinate the captive insurer's use of professional service providers
- To provide administrative support to the captive's board of directors or other governing body
- To actively monitor the captive insurer's ongoing regulatory compliance

It is not unusual for captive managers to be affiliated with substantial insurers, reinsurers or insurance brokers and to offer "bundled" services that include basic captive management together with some of the other above-described professional services that captive insurers may require.

Qualifications

Most state captive insurance laws commonly describe the required qualifications to serve as Captive Manager in broad terms of possessing sufficient "competence," "experience," "character," and "reputation." Some states specifically require or request that Captive Managers have applicable E&O coverage. *See e.g.*, Arizona Captive Insurance Division Reference Guide, p.11 (5/09).³ *See, e.g.*, S.C. Code Ann. § 38-90-60, 8 V.S.A. § 6002, A.R.S. § 20-1098.01, U.C.A. § 31A-37-202, N.R.S. §§ 694C.180, 694C.210 and 694C.310, and DC ST §§ 31-3931.09 and 31-3931.11. Though some states provide additional guidance amplifying upon one or more of these standards, they are usually not specifically defined. Thus, consistent with general principles of statutory construction, these qualification standards should be afforded their ordinary meanings. Presumably, the regulator's assessment of a proposed Captive Manager's qualifications will be made in the context of the duties the Captive Manager is obligated to perform after approval.

The International Center for Captive Insurance Education (ICCIE) is a 501(c)(3) organization with the purpose of developing and certifying qualified captive insurance professionals. It provides a comprehensive education program leading to the certification of Associate in Captive Insurance (ACI), and also allows course enrollment on a modular basis. The ACI designation requires the completion of five "core" courses, two elective courses, participation in three topic-specific teleconferences, and twelve continuing education credits within three years after obtaining the ACI designation. This is a credible program supported by many reputable participants in the captive insurance industry. However, this author is unaware of any state insurance regulatory agency that relies upon the ACI designation to approve a Captive Manager.

Some domestic captive domiciles "pre-approve" Captive Managers through a quasi-licensing process.⁴ Typically, these domiciles require a prospective Captive Manager to submit a prescribed application form and supporting materials with the objective to be added to that regulator's published list of pre-approved Captive Managers. An applicant for a captive insurer certificate of authority in that domicile must then indicate in its application that it has engaged, or will engage, a Captive Manager from the regulator's pre-approved list. Other domiciles do not publish a list of pre-approved Captive Managers but instead require each applicant for a captive insurer certificate of authority to indicate its choice for Captive Manager, which the regulator must

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then find acceptable in the context of that particular application.⁵ In such case, the captive insurer's application must include certain information about the proposed Captive Manager, often on a prescribed form. The content of the prescribed Captive Manager application forms, under either approval system, effectively constitutes the regulator's articulation of the information it considers relevant for purposes of assessing whether a proposed Captive Manager is sufficiently "competent," "experienced," "reputable," etc.

Any process for approval of Captive Managers creates the possibility of denial and termination of approved status. In fact, the captive insurance laws of many domiciles grant the regulator express authority to withdraw or terminate the approval of a Captive Manager. For example, Arizona law provides that "[t]he director may require a captive insurer to discharge a captive manager for failure to substantively fulfill the captive manager's duties under this article." A.R.S. § 20-1098.16. The South Carolina bulletin provides that the regulator may withdraw or suspend approval of a Captive Manager if:

- "The captive manager knew or should have known the officers or directors of the company were engaged in any conduct that...violated state or federal laws or engaged in any conduct that would otherwise threaten the solvency of the captive insurer and failed to report such conduct to the Department in a timely manner."
- "The captive manager knew or should have known and failed to inform in a timely manner, the captive board of directors and the director of insurance of actions...leading to revocation or suspension of the certificate of authority..."
- "The manager failed to perform the basic manager responsibilities or reporting requirements..."
- "The captive manager engaged in conduct detrimental to the interests of the captive insurer, including but not limited to, conduct that constitutes a breach of the fiduciary duty owed to the captive insurer or a conflict of interest."

South Carolina Department of Insurance, Bulletin 2008-03, pp. 6-7.

Under general principles of administrative law, codified in the Administrative Procedures Acts of most states, the disapproval of a Captive Manager's, or captive insurer's, application for approval of a Captive Manager, and the subsequent withdrawal or termination of approval, constitute agency actions that should be subject to appeal on the grounds of being unauthorized, arbitrary, capricious, or an abuse of discretion.

In determining whether to disapprove a proposed Captive Manager, the regulator obviously enjoys great subjectivity and latitude. In fact, the regulator is likely not to even make any affirmative findings regarding disapproval of a proposed Captive Manager. From both a practical and legal perspective, it would be difficult for either the applying Captive Manager or the applying captive insurer to successfully challenge the regulator's decision that a proposed Captive Manager is not sufficiently "competent," "experienced," "reputable," etc. However, after the regulator has approved a Captive Manager, or licensed a captive insurer without rejecting its proposed Captive Manager, the regulator's withdrawal or termination of that approval should be more susceptible to administrative challenge.⁶ The regulator may be acting arbitrarily and capriciously if it takes the position that a Captive Manager it previously approved or declined to disapprove is now not sufficiently "competent," "experienced," "reputable," etc., unless there is some new evidence that would justify a different conclusion as to the qualifications of the same manager. Thus, it appears that the most likely scenario for the regulator to withdraw or terminate its prior approval of a Captive Manager is the allegation that in its conduct as Captive Manager after initial approval, the Captive Manager failed to perform in accordance with the requirements set forth in the applicable captive insurance law or other guidance.

Dual Agency

A Captive Manager is obviously an agent of its principal, the captive insurer, to the extent it acts on the captive insurer's behalf in dealing with the regulator and other third parties. Generally, an agent has a duty of

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loyalty to its principal to act solely for the benefit of the principal in all matters connected with the agency. Restatement (Second) of Agency § 387 (1958-2009). This duty of loyalty encompasses duties not to act or speak disloyally in matters connected with the agency and not to use or communicate, for its own benefit or that of a third party, confidential information acquired by the agent in the course of its agency. *Id.*; Restatement (Second) of Agency § 395 (1958-2009). However, these general principles of agency do not fully describe the relation of a Captive Manager to a captive insurer because, as discussed above, captive insurance laws generally require the Captive Manager to serve as agent to both the captive insurer and the regulator. In other words, the function of a Captive Manager under most captive insurance laws is one of dual agency.⁷

As in the case of any agency, the exact nature and scope of the duties and authority of an agent as to dual principals must be determined from the particular facts and circumstances. Restatement (Second) of Agency § 376 (2009). However, there are guiding principles. The dual agent must make full disclosure to the principals of all relevant facts regarding its position so that they have full knowledge of the agent's position as dual agent, and the principals must assent to or acquiesce in the dual agency. Restatement (Second) of Agency § 237 (2009). The dual agent has a duty to act with fairness to each principal. *Id.* The dual agent must act with consideration for the interests of each principal and must provide impartial advice to each. Restatement (Second) of Agency § 392 (2009). Unless otherwise agreed, a dual agent has a duty not to disclose to one principal confidential information given to it by the other. *Id.* However, an agent is privileged to reveal information confidentially acquired by it in the course of its agency to protect a superior interest, such as the public interest in preventing the commission of a crime. Restatement (Second) of Agency § 395 (2009).

Suffice it to say, a Captive Manager's legal relations with the captive insurer that employs it and the regulator is a complex dual agency. It is a consultant and service provider to the captive insurer, and at the same time it is a quasi-regulator for the benefit of the regulator.⁸ To properly effectuate this dual agency the Captive Manager must (i) make full disclosure of all relevant facts regarding its position with respect to both principals; (ii) obtain the consent or acquiescence of the principals to the dual agency; and (iii) carry out the dual agency with consideration for the interests of each principal.⁹ It is therefore important that a Captive Manager's service agreement with a captive insurer adequately makes the required disclosures and obtains the insurer's express assent to the dual role. To the extent the Captive Manager fails to make full disclosure to the insurer and to obtain its consent, it may be exposed to liability to the insurer should the performance of its duties for the benefit of the regulator allegedly result in some damage to the insurer.

Conflicts of Interest

The inherent conflict of interest in the Captive Manager's responsibilities to the captive insurer and the regulator is not nearly the only potential conflict of interest scenario for the Captive Manager.

It is not uncommon for a representative of the Captive Manager to serve as an officer and/or director of the captive insurer. Most state's captive insurance laws require that the governing board of a captive insurer have at least one member who is a resident of the state of domicile. Because a captive insurer's owners, and the situs of the activity it insures, often reside outside the state of the captive insurer's domicile, Captive Managers are commonly requested to provide a representative who resides in the state of domicile to serve on the captive insurer's board, either for a full term or until a state resident without such affiliations can be secured to serve as director. Further, representatives of Captive Managers are commonly requested to serve as Secretary and/or Treasurer of a captive insurer. The role of the Captive Manager under the captive law is often functionally similar to the role of a Secretary (i.e., maintaining records) or Treasurer (i.e., approving expenditures) of a company, and it may seem redundant to the captive owners and affiliated directors to put a different person in those offices. Because the captive owners and affiliated directors often lack insurance industry experience and expertise, they may be comforted by having a representative of the Captive Manager in a formal director or officer role with the company.

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Another conflict of interest scenario for a Captive Manager may arise from its role as a provider of services other than services technically associated with the Captive Manager role. As discussed above, a captive management firm may offer its captive insurer clients bundled services that combine services such as brokerage, actuarial consulting, underwriting, policy or claim administration, risk management, and investment management, with the services technically regarded as Captive Manager services. In such cases, the Captive Manager may have a conflict of interest within its own service obligations to the captive insurer. For example, a Captive Manager affiliated with a fronting or reinsuring carrier must be sensitive to the potential to be perceived as "steering" the captive insurer's business toward its affiliates. Or, the Captive Manager may have duties to the captive insurer and/or regulator to report and/or recommend discharge of a service provider not properly performing critical services, such as policy administration. If the same firm is providing captive management and policy administration services, a conflict of interest is likely present. Even if the Captive Manager is not engaged to provide any such additional services to the captive insurer, it may have a conflict of interest arising out of the fact that it is a competitor of the firm that is engaged to provide such services to the captive insurer. This article is not to be regarded as an exhaustive listing of the various scenarios under which a Captive Manager may have an actual or potential conflict of interest as to its client captive insurer.

The general principles of managing conflicts of interest are full disclosure, express consent, and formal recusal from certain deliberations and actions that implicate the conflict of interest. To avoid undue liability exposure to other outside directors/officers of the captive insurer, insureds, claimants, and creditors, among others, a Captive Manager is well advised to be highly informed and sensitive as to conflict of interest issues and expert in their management.

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Endnotes

1. For example, much of the Arizona Department of Insurance regulatory policy with respect to Captive Managers is set forth in its informational "Arizona Captive Insurance Division Reference Guide."
2. Arizona is an example of a state that requires the Captive Manager to approve all disbursements by the captive insurer.
3. Some states specifically require or request that Captive Managers have applicable E&O coverage. See e.g., Arizona Captive Insurance Division Reference Guide, p.11 (5/09).
4. Such domiciles include Washington D.C., Nevada, South Carolina, Delaware, Utah and Vermont.
5. Such domiciles include Arizona, Hawaii, Montana and Kentucky.
6. There may be an issue whether the appropriate appellant is the terminated Captive Manager or the affected captive insurer. The determination may rest upon whether that particular state has a pre- approval process for Captive Managers separate and apart from the certificate of authority application process for captive insurers.
7. Though a Captive Manager is required to function as the agent of both the regulator and the captive insurer, the manager is employed and compensated only by the captive insurer.

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8. One must assume that a court would regard the duties of the Captive Manager to the regulator under the applicable enabling captive insurance law as legally superior to the duties of the captive manager to the captive insurer under its private contract with the captive insurer, to the extent of any conflict.

9. As a practical matter, the requirement of full disclosure and consent concerns the Captive Manager's contractual relationship with the captive insurer rather than its relationship with the regulator. The Captive Manager's duties to the regulator are set forth in the applicable captive law and in the guidance provided by the regulator pursuant thereto. Its dual role is known and understood by the regulator as a given for any captive insurer to which the regulator issues a certificate of authority. However, if not expressly disclosed by the Captive Manager in connection with its written service agreement, the owners, directors or officers of a captive insurer may not be aware of the Captive Manager's various roles and relations under the captive law.

MEDICARE SECONDARY PAYER REPORTING: EXTRATERRITORIAL APPLICABILITY OF REQUIREMENTS TO FOREIGN INSURERS

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Background. Section 111 added new mandatory reporting requirements for group health plans (“GHPs”) (42 U.S.C. 1395y(b)(7)) and for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers’ Compensation plans, collectively referred to as “non-group health plans” (“NGHPs”) (42 U.S.C. 1395y(b)(8)), pertaining to when claims involving Medicare beneficiaries need to be reported to CMS. Section 111’s purpose is to reinforce Medicare’s status as a secondary payer for coordination of benefits purposes and to prevent Medicare from paying for the same services for which reimbursement is available under other plans. The original Secondary Payer Statute, 42 U.S.C. Sec. 1395y, already applied to workers’ compensation claims since the inception of the Medicare program in 1965, and to liability, automobile and no-fault insurance claims since the statute was amended in 1980.

Many policy, procedural and technical issues relating to Section 111 have had to be resolved, and CMS has been accepting emailed comments and questions and holding frequent “Town Hall Teleconferences” in its effort to identify and eliminate gaps and ambiguities in its published guidelines. Some of the more important issues have been addressed by CMS in a series of published Alerts.

Section 111 reporting became effective on July 1, 2009, and most GHP “responsible reporting entities” (RREs) were required to begin reporting electronically by October 1, 2009. NGHP RREs are currently in a testing period that has been extended to December 31, 2010, due to the lingering confusion, as well as technical difficulties. All NGHP RREs will be required to begin reporting between January 1, 2011 and March 31, 2011, based on a schedule determined by CMS’s Coordination of Benefits Contractor.

Applicability to Foreign Insurers. Perhaps the most interesting unresolved legal issue involving Section 111 is whether it gives CMS the legal right to assert extraterritorial jurisdiction on foreign liability insurance companies who make direct claims payments to U.S. residents. Although Section 111 itself is silent regarding its potential applicability to foreign carriers, CMS has stated informally that Section 111 does apply

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to them. CMS's December 29, 2009 Alert ("Registration Guidelines for Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation Responsible Reporting Entities (RREs) Who Are Foreign Entities") stated:

Foreign entities will follow the same registration and reporting procedures, and have the same responsibility and accountability for data as domestic RREs. The delay in registration for foreign entities does not change the July 1, 2009 reporting date requirements associated with "Ongoing Responsibility for Medicals" (ORM) or the January 1, 2010 reporting date requirements associated with "Total Payment Obligation to Claimant" (TPOC) amounts.

The effective date for ORM reporting has since been delayed but remains retroactive to January 1, 2010, while TPOC reporting obligations will now be effective October 1, 2010.

CMS's December 29, 2009 Alert further "encourage[d] foreign entities that do not have a U.S. TIN [Tax Identification Number] or EIN [Employer Identification Number] to apply at this time for a U.S. EIN" in order to be ready to register for reporting. CMS's revised Section 111 implementation timeline now provides for foreign RREs to register beginning April 5, 2010, but no specific deadline for their registration has been imposed as of April 30, 2010. In a subsequent Alert dated February 24, 2010, CMS promised to issue additional guidance regarding reporting by foreign insurers; however, such guidance had not yet been issued by April 30, 2010. Despite the continuing uncertainty as to their obligations, foreign RREs will still be required to begin reporting in the first quarter of 2011.

Analysis. There is a long-standing presumption in the U.S. against extraterritorial jurisdiction, which has its roots in the Foreign Commerce Clause of the Constitution. The presumption was strengthened in *Foley Bros., Inc. v. Filardo*, 336 U.S. 281 (1949), in which the Supreme Court held that the Eight Hour Law, requiring overtime payments to contractors in contracts to which the U.S. is a party, is inapplicable in foreign countries "over which the United States has no direct legislative control." Federal courts have consistently followed *Foley* in denying extraterritorial application of statutes without a clear congressional expression of intent to the contrary.

Notwithstanding CMS's understandable financial interest in having Section 111 apply to all insurers, wherever they are located, it is doubtful that CMS will have sufficient manpower to devote to attempting to enforce Section 111 overseas. From a practical standpoint, it is not clear how the law could be enforced against a foreign insurer that pays claims to U.S. residents but that has no official U.S. presence. Importantly in this era of data breaches, the requirements of Section 111 directly conflict with the privacy laws of a number of other countries, so CMS should not expect to receive any assistance in its enforcement efforts. If an insurer that elects not to comply with Section 111 does not market its products within the U.S. or to U.S. residents overseas, even being publicly identified in the U.S. as a scofflaw would likely have little effect on its business. The issue would become even more complicated, however, and the range of potential consequences successively more difficult to predict, in the following scenarios:

- A Section 111 violator domiciled in another country could have a U.S. branch or a related legal entity that is domiciled or does business in the U.S. In such event, the branch or affiliate might be directly vulnerable to an enforcement action by CMS.
- The noncompliant foreign insurer might have a business relationship with a broker or agent that conducts business in the U.S. While brokers and agents do not have primary responsibility for Section 111 reporting, it is easy to imagine new regulations being promulgated that would forbid them to market insurance policies of non-compliant foreign insurers to U.S. residents.

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- The noncompliant foreign insurer might have, under the same corporate umbrella, a technically unrelated sister entity that conducts business in the U.S. Despite the absence of potential legal liability in the U.S., in the event of noncompliance with Section 111 by the foreign insurer, the public relations cost to its similarly named affiliate would be difficult to quantify.
- The noncompliant foreign insurer might contract with a U.S.-based third-party administrator to process its claims. While Section 111 provides that TPAs are RREs only for GHPs, and not for NGHPs, expanding Section 111's reporting requirements to U.S.-based TPAs of foreign insurers that violate Section 111 does not seem implausible.

In any of the foregoing fact situations (and undoubtedly others), even if the courts were to deny extraterritorial application of Section 111, it remains to be seen whether a foreign insurer might be subject to indirect enforcement of Section 111 through an affiliate or agent. In addition, a foreign insurer that markets its products in the U.S., which might otherwise be inclined to ignore its Section 111 reporting responsibilities, might be justifiably concerned that a technical violation of Section 111 would result in its name appearing on a list of violators and tarnish its reputation.

Conclusion. The possible extraterritorial application of Section 111 is but one of the difficult legal questions related to Section 111 that will need to be addressed by CMS, and perhaps the courts, in the months and years ahead. All foreign insurers who pay claims to U.S. residents would be well advised to monitor CMS's forthcoming public releases for further guidance on these complex issues.

THERE'S A NEW SHERIFF IN TOWN

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There is a buzz in the world of corporate law in North Carolina. A state with a dearth of case law in the officer and director liability realm has been given a weighty, seventy page, four appendix opinion (the "Opinion") full of detailed analysis and answers to previously unanswered questions of North Carolina corporate law. The case involves officers and directors of an insurance company, so for those of us who practice insurance regulatory law in North Carolina, it is the new guideline for advising our clients.¹

The lawsuit was filed March 31, 2006, by the Commissioner of Insurance (the "Commissioner") as liquidator of Commercial Casualty Insurance Company of North Carolina ("CCIC" or the "Company") against defendants A. Richard Custard ("Mr. Custard"), Wendy J. Custard ("Mrs. Custard"), E. Nimocks Haigh ("Mr. Haigh")(the "Individual Defendants") and Delta Insurance Services, Inc. ("Delta")(collectively, the "Defendants"). The action was designated a mandatory complex business case by Order of the Chief Justice of the Supreme Court of North Carolina dated May 3, 2006, and assigned to Judge Ben F. Tennille, Chief Special Superior Court Judge for Complex Business Cases. The matter was before the Court on the Defendants' motion for summary judgment.

Delta was a Georgia holding company controlled by Mr. Custard. Mrs. Custard and Mr. Haigh also owned stock in Delta. Delta owned all of the stock of CCIC.

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CCIC was a Georgia property and casualty insurer organized in 1988. The Company's daily operations were run by Mr. Haigh with the assistance of an experienced and qualified group of advisors, all of whom were integrally involved in the decision-making process which gave rise to the lawsuit. Mr. Haigh, however, was the only member of CCIC's management team named as a defendant.

Mr. and Mrs. Custard also owned Custard Insurance Adjusters ("CIA"). CIA is a well-known national property and casualty insurance claims adjuster. In addition to adjusting claims for other companies, CIA handled most of the claims of CCIC.

The Individual Defendants were directors and/or officers of both Delta and CCIC. Mr. Custard was the chief executive officer of CCIC and president of CIA and Delta. Mrs. Custard was secretary of CCIC and Delta. Mr. Haigh served as president and chief operating officer of CCIC from 1992 until March of 2003.

At the center of the lawsuit was the selection and volume of a particular line of business written by the Company. Initially, CCIC wrote primarily professional liability policies for environmental consultants in Florida. After a few short years, and a foray into the non-standard automobile insurance market in North Carolina, the Company shifted its focus to take advantage of the housing and construction boom on the west coast. During the late 1990s and early 2000s, CCIC experienced substantial premium growth by writing insurance policies for small tradesmen and contractors, or artisans, in California. "CCIC's growth outperformed the Company's ability to generate policyholder surplus."²

Company management began taking action to increase surplus as early as the spring of 2001. One of its initial steps was the filing of a Petition for Redomestication from Georgia to North Carolina in June of 2001. The Petition was approved in December of that year. Because North Carolina's premium tax rate was lower than that of Georgia, CCIC saved \$1.5 million in out-of-state premium taxes the year following its redomestication.

The month of approval of its redomestication, CCIC filed a request for a rate increase of 20% for its artisan business with the California Department of Insurance ("CADOI"). Pending approval of the rate filing, CCIC's vice president of marketing assigned a 15% bad risk surcharge on all new and renewal business. In February, the CADOI approved a rate increase of only 16.2%.

Central to the case against the Defendants were the management decisions regarding loss ratio estimate selections used in filings with the North Carolina Department of Insurance ("NCDOI"). CCIC's internal actuary completed a reserve analysis in February of 2002, based on the Company's losses for the year ending 2001. The Company's actuary utilized the loss data from both California and non-California business and found that the losses on the California artisan business outpaced those of the non-California business.

CCIC's annual statement filed with the NCDOI reported lower loss ratio estimates than those estimated by the Company's internal actuary. The differences between the reported estimates and those of the Company actuary were significant: approximately 25% for accident year 2000 and 14% for accident year 2001. Management believed that as the California artisan business matured, the losses would fall in line with the non-California business. Furthermore, the Company's outside accounting firm, Ernst & Young ("E&Y"), had provided a preliminary actuarial analysis which supported management's decision.

E&Y delivered to the Company a 2001 reserve study in April of 2002 (the "Reserve Study"). The Reserve Study was consistent with E&Y's preliminary reserve analysis and concluded that the Company's loss ratio estimates for 2001 were approximately 14% lower than the findings of CCIC's internal actuary. Again, the conclusion was rooted in the losses of the non-California business. The Company's first quarter filing showed no change in its California loss experience. An actuary for the NCDOI reviewed the Reserve Study and found no issue with its methodology, findings and conclusions.

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The Company sought another rate increase in California in June, 2002. CADOI approved an increase of 8.45% in response to CCIC's requested increase of 43.3%. During the same month, AM Best downgraded the Company from A- to B++ and blamed the California risk for the downgrade. Efforts were being made by management to raise capital through various investment brokers. In fact, a purchase agreement was signed which would have resulted in a \$6 million capital infusion into CCIC. The transaction was never consummated.

By the end of 2002, CCIC had drastically reduced the premium volume of its artisan business in California. It continued to pursue outside financing. E&Y issued a statement of actuarial opinion on February 29, 2003 (the "February Opinion") and concluded that CCIC had not made a "reasonable provision in the aggregate for all unpaid losses and loss adjustment expenses."³ At the time of the filing of CCIC's 2002 annual statement, E&Y believed management's reserve estimates were "several million dollars lower" than appropriate levels. "E&Y relied on CCIC's California loss experience in calculating their reserve estimates for 2002 - a fundamental change in their approach."⁴

CCIC was placed under administrative supervision by the NCDOJ on March 7, 2003. One week later, Mr. Custard invested \$1 million of surplus into the Company and continued efforts to raise outside capital. In April, E&Y reissued its 2002 Reserve Study, basing it entirely upon CCIC's California losses. As a result, the loss estimates were much higher than those of the 2001 Reserve Study. CCIC was placed into rehabilitation On November 17, 2003.

Theories of Recovery

The initial theory of recovery by the Commissioner was based on allegations of improper conduct by the Individual Defendants perpetrated for the purpose of benefitting CIA. In short, the DOJ alleged that those defendants breached their fiduciary duty by selling insurance through CCIC to provide a source of claims for CIA to adjust and the insurance was sold without regard to the solvency of CCIC. "Not surprisingly," Judge Tennille writes, "there does not appear to be any evidence to support what is, on its face, an irrational theory."⁵

A new theory was put forth at summary judgment. "For the first time, the NCDOJ based its theory of liability on allegations that the Individual Defendants showed a lack of good faith in (1) filing CCIC's monthly reports with the NCDOJ and (2) continuing to sell a high volume of artisan insurance policies in California after seeing that losses on those policies were coming in at higher than expected rates."⁶

The Decision

The Opinion begins with an explanation of the differences between the standard of conduct and the standard of review. A standard of conduct indicates how an actor should conduct a given activity while a standard of review is the test a court utilizes in reviewing an actor's conduct to determine whether it is appropriate under the circumstances. Although in many circumstances the lines between these two principles are blurred, in the world of corporate governance, they have diverged because fairness and efficiency require it. "In order to attract competent directors it is only fair that we judge their conduct according to the circumstances in which they must make decisions."⁷ They often have to act without being fully informed. Efficiency is driven by the creation of corporate value. "In order for the corporation to increase in value...it must take risks."⁸

The Court's task was to determine the proper standard of review in two contexts: "(1) the operation of the business and the application of the corporate charter's exculpatory provisions and (2) the director's duty to monitor."⁹ Because North Carolina case law on the subject is sparse, the Court looked to Delaware for guidance in the analysis of good faith and bad faith. The indemnity clause of CCIC's charter exculpates officer and director action taken in good faith. Duty to monitor also invokes good faith. "[W]hether there was an

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absence of good faith or the existence of bad faith is virtually the same."¹⁰

"There is no duty of good faith separate and apart from the duties of care and loyalty under either Delaware or North Carolina law."¹¹ When fiduciary conduct is reviewed, it must be reviewed in context. "Directors' obligations will be judged in the context in which they occur, and thus conduct by directors of an insurance company may be judged differently from conduct by directors of a textile company depending on the actions in question."¹²

The duty of loyalty and the duty of care are the two fiduciary duties of directors. Duty of loyalty is usually implicated when a conflict of interest arises. There are, however, circumstances when no such conflict exists but director action is required and a failure to act may result in a breach of that duty. An example is the director's failure to monitor corporate activities. Although there are circumstances where a director's state of mind is at issue in this context, the existence of such an issue does not bar an award of summary judgment. "The Court has a significant gatekeeper role in determining which factual circumstances warrant submission of bad faith issues to a jury."¹³

North Carolina has codified the business judgment rule in section 55-8-30(a) of the General Statutes. A director shall discharge his duties as a director, including his duties as a member of a committee: (1) in good faith; (2) with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and (3) in a manner he reasonably believes to be in the best interests of the corporation. There is a strong presumption in North Carolina that "a decision by a loyal and informed board will not be overturned by a court unless it cannot be attributed to any rational business purpose." Russell M. Robinson, II, *Robinson on North Carolina Corporation Law* §14.06 (7th ed. 2009).¹⁴

In order to succeed on its breach of fiduciary duty claim (and avoid the exculpatory clause of CCIC's charter), the Commissioner had to prove that the officers and directors acted in bad faith (a violation of NCGS 58-8-30(a)). The claim of breach of fiduciary duty was based upon decisions made by management concerning the volume of California artisan business written. "In order to establish a lack of good faith in business decisions in the context of an insurance company, a plaintiff...must show that the officers and/or directors displayed a conscious indifference to risks in the face of clear signals of the existence of problems likely to lead to insolvency."¹⁵

Judge Tennille found no evidence of conscious indifference to risk or irrational process. The Company used both in-house and outside actuaries, made efforts to increase rates, attempted to raise outside capital, reinsured risk and ceased selling unprofitable lines of business. The Custards had millions of dollars at risk. Mr. Haigh's job was at risk, as was his investment in *Delta*. "The actors were not indifferent; they made judgments."¹⁶ Although the judgments turned out to be wrong, there was no evidence that the actors did not believe that their actions were in the Company's best interests.

The Court cites *In re Caremark Int'l Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996) in addressing failure to monitor as a breach of fiduciary duty. Only a "sustained or systemic failure of the board to exercise oversight...will establish the lack of good faith that is a necessary condition of liability." *In re Caremark*, 698 A.2d. ¹⁷ A showing of bad faith is necessary to support the theory of liability.

"There is no evidence that the directors of CCIC acted in bad faith in monitoring the business risks."¹⁸ Losses were reviewed by both in-house and outside actuaries. Even though the Company's in-house actuary assigned higher loss estimates to the artisan business than E&Y, the directors were entitled to rely on outside actuaries. In fact, the NCDI explicitly approved of the methodology utilized by E&Y. Although there was evidence that the premium volume was too high relative to surplus, management was actively engaged in efforts to raise outside capital and implementing other measures to improve profitability. "In this context, the Commissioner has failed to establish that any director had the illicit state of mind sufficient to support a

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finding of bad faith in the monitoring context."¹⁹

The Court gives short shrift to the Commissioner's argument, based on one sentence from *State ex rel. Long v. ILA Corp.*, 132 N.C. App. 587, 513 S.E.2d 812 (1999), that there exists an independent cause of action for negligent mismanagement of an insurance company. That case involved a breach of fiduciary duty that abrogated the business judgment rule because of self-dealing. Noting no showing of a conflict of interest by the Commissioner, the Court held that there is no stand-alone cause of action for negligent mismanagement. "The [*State ex rel. Long*] decision simply held that a director who is not entitled to the protection of the business judgment rule can be liable for negligent conduct which harms the corporation."²⁰

Reliance on E&Y as an outside advisor was justified under the circumstances. Although CCIC's in-house actuary predicted higher losses for the artisan business, E&Y considered, and rejected, those findings. It concluded that it was more reasonable to utilize mature loss data that included non-California business. E&Y was competent to render its opinions and the NCDOJ agreed with its methodology. A director is "entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, if prepared or presented by one or more officers or employees of the corporation whom the director reasonably believes to be reliable and competent in the matters presented." N.C. Gen. Stat. § 55-8-30(b)(1).²¹ The advice received must be followed and a director cannot rely on information she knows to be inaccurate.

Finally, the Court addressed the Commissioner's claim that the Individual Defendants breached their fiduciary duties by filing misleading financial reports with the NCDOJ in 2002. "Directors of insurance companies have a fiduciary duty - under both a duty of care and a duty of loyalty - to exercise good faith in the supervision of the regulatory filings which protect policyholders as well as the owners of the company."²² The only filings at issue were those in the latter part of 2002 estimating losses for the Company's California business.

The Commissioner alleged that the June 30, 2002, and September 20, 2002, reports were false and misleading because the loss ratios were not revised to reflect the 2002 developments prior to the filing of the 2003 annual statement. After reviewing several factors that impacted CCIC's loss reserve estimates during the period, the Court points to E&Y's methodology change as having the most dramatic impact. Its decision to forgo use of nationwide historical data in 2003 (which it had used in 2002) and use solely California data to determine ultimate losses on the California artisan business resulted in a 106.5% increase for accident year 2000 and a 119.9% increase for accident year 2001. "The decision on what data to use was a judgment call."²³ In 2003, E&Y changed its judgment because historical data on California was more mature. "The NCDOJ does not fault E&Y for its methodology in 2002 or 2003. Yet it asks the Court to impose liability for breach of fiduciary duty on CCIC's officers and directors for employing the same methodologies."²⁴

Summary judgment was granted in favor of Defendants. The case was not appealed by the Commissioner. "History teaches us at least three things. First, our knowledge is vulnerable. What we think we know with certainty can and probably will be proven wrong. Second, things change. Third, bad things will happen, randomly."²⁵

Endnotes

1. *State ex rel. Comm'r Ins. v. Custard*, No. 06CVS4622, 2010 WL 1035809, 2010 NCBC 6 (N.C. Super.Bus.Ct. March 19, 2010).
2. *Id.* at 2010 WL 1035809 at *6, 2010 NCBC at 10.
3. *Id.* at 2010 WL 1035809 at *13, 2010 NCBC at 20.

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4. *Id.* at 2010 WL 1035809 at *13, 2010 NCBC at 21.
 5. *Id.* at 2010 WL 1035809 at *2, 2010 NCBC at 3.
 6. *Id.*
 7. *Id.* at 2010 WL 1035809 at *15, 2010 NCBC at 25.
 8. *Id.* at 2010 WL 1035809 at *16, 2010 NCBC at 25.
 9. *Id.* at 2010 WL 1035809 at *17, 2010 NCBC at 27.
 10. *Id.*
 11. *Id.* at 2010 WL 1035809 at *18, 2010 NCBC at 29.
 12. *Id.* at 2010 WL 1035809 at *19, 2010 NCBC at 29.
 13. *Id.* at 2010 WL 1035809 at *19, 2010 NCBC at 30.
 14. *Id.* at 2010 WL 1035809 at *20, 2010 NCBC at 32.
 15. *Id.* at 2010 WL 1035809 at *22, 2010 NCBC at 34.
 16. *Id.* at 2010 WL 1035809 at *23, 2010 NCBC at 36.
 17. *Id.*
 18. *Id.* at 2010 WL 1035809 at *25, 2010 NCBC at 38.
 19. *Id.* at 2010 WL 1035809 at *25, 2010 NCBC at 39.
 20. *Id.* at 2010 WL 1035809 at *26, 2010 NCBC at 41.
 21. *Id.* at 2010 WL 1035809 at *27, 2010 NCBC at 42.
 22. *Id.* at 2010 WL 1035809 at *29, 2010 NCBC at 44.
 23. *Id.* at 2010 WL 1035809 at *35, 2010 NCBC at 54.
 24. *Id.* at 2010 WL 1035809 at *41, 2010 NCBC at 64.
 25. *Id.* at 2010 WL 1035809 at *36, 2010 NCBC at 54.
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LIABILITY OF A SURETY UNDER NEBRASKA LAW

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Surety is a unique arrangement as far as insurance is concerned. The typical insurance contract has two parties: the insurer and the policyholder. The surety contract is a three-party relationship among a principal, an obligee and an insurer. Surety is a secondary as opposed to a primary obligation. The surety agrees with the obligee that if the principal does not pay or perform as per its contract with or for the benefit of the obligee, the surety will pay or perform. Performance, release or settlement between the principal and the obligee typically releases the surety, and the surety typically retains indemnity rights against the principal or separate indemnitors. Surety has been described as a credit relationship as opposed to an insurance arrangement, and there are other mechanisms, such as bank letters of credit, which often substitute for surety. Because of the differences between surety and other types of property and casualty insurance, the question often arises whether and to what extent the legal doctrines applicable to other types of insurance apply to surety. The Nebraska Supreme Court recently answered some of these questions.

Amwest Surety Insurance Company, and its subsidiary, Far West Insurance Company, two Nebraska-domiciled insurance companies whose principal business was surety, were both declared insolvent in 2001 and ordered into liquidation under the Nebraska Insurers Supervision, Rehabilitation and Liquidation Act, Neb. Rev. Stat. §44-4801 *et seq.*

Prior to their insolvency, Amwest and Far West combined were about the tenth largest writer of surety bonds in the United States, specializing in substandard surety and bail. They wrote bonds in nearly every state. As with most insurance company liquidations, a major part of the proceedings have involved the adjudication of policyholder claims. Because only eight state property and casualty guaranty funds cover surety, the domiciliary Liquidator has adjudicated the great majority of claims without guaranty fund participation.

As with virtually all insurance company liquidation acts¹, Nebraska's Liquidation Act provides that the court overseeing the liquidation proceedings has exclusive jurisdiction to hear all matters brought thereunder. Neb. Rev. Stat. §44-4804. That provision is generally accepted by courts in states with model act provisions, which generally require that the courts of other states give full faith and credit to the insurance liquidation laws of the domiciliary state, and this has been interpreted to provide for the domiciliary liquidation state as the only forum in which claims against the insolvent insurer may be brought. Neb. Rev. Stat. §44-4824(1). While the federal courts are not per se bound by those provisions, the great body of federal cases abstain in favor of the domiciliary liquidation court's jurisdiction over claims against the insolvent insurer. *See Burford v. Sun Oil Co.*, 319 U.S. 315 (1943). In addition, the McCarran-Ferguson Act, 15 U.S.C. §1012(b), reverse pre-empts non-insurance federal law in favor of state law enacted for the purpose of regulating the business of insurance. *United States Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993). In the absence of ancillary receiverships, guaranty fund participation, or other special circumstances (such as a valid pre-existing arbitration agreement in some states), attempts to adjudicate claims against an insolvent insurer in a forum other than the domiciliary liquidation court are the exception rather than the rule.

The Nebraska Liquidation Act provides for the disposition of disputed claims. Neb. Rev. Stat. §44-4839. The Liquidation Act contemplates that an administrative adjudication procedure will resolve the great majority of claims one way or the other, with Liquidation Court participation largely limited to ultimate approval of claims, Neb. Rev. Stat. §44-4843, and distributions thereon. Neb. Rev. Stat. §44-4844. Whenever a claim is denied in whole or in part, the claimant initially has sixty days to file objections with the Liquidator. If no objection is filed within that period, the claimant may not object further. Neb. Rev. Stat. §44-4839. If the claimant objects and the Liquidator does not change his or her position on the claim objection, the Liquidator

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must refer the disputed claim to the Liquidation Court, which may either hear the matter or refer it to a court-appointed referee. *Id.* After the Liquidation Court decides the disputed claim, the losing party has appeal rights.

As a result of this process, Nebraska's appellate courts have decided a number of surety cases. One of the most significant cases, *State ex rel. Wagner v. Amwest Surety Ins. Co.*, 274 Neb. 110 (2007), commonly known as *Strategic Capital Resources*, was decided in 2007 by the Nebraska Supreme Court. Saxton, Inc., the bond principal, entered into four lease agreements with Strategic Capital Resources (Strategic). Saxton contracted with Amwest to issue four corresponding lease bonds under which Amwest agreed to provide payment to Strategic if Saxton defaulted. Subsequent to the issuance of the bonds, on June 7, 2001, Amwest became subject to an order of liquidation, pursuant to which, on July 6, 2001, all of its surety bonds, including the lease bonds, were cancelled by operation of law under the Liquidation Act. Neb. Rev. Stat. §44-4819.

Following termination of the lease bonds, on July 9, 2001, Strategic provided Amwest with written notice of Saxton's default. Each of the Amwest bonds specified that in order to recover against the surety, 30 days' written notice of the principal's default was required. In finding that the Liquidation Court properly disallowed Strategic's claims against Amwest because it had not given written notice while the lease bonds were in effect, the Nebraska Supreme Court found as follows:

Strategic's claims were correctly denied because Strategic failed to comply with the express conditions set forth in each of the lease bonds before the lease bonds were canceled.

Nebraska adheres to the rule of strict construction of guaranty contracts. A guaranty is interpreted using the same general rules as are used for other contracts. When the meaning of the contract is ascertained, or its terms are clearly defined, the liability of the guarantor is controlled absolutely by such meaning and limited to the precise terms. We have further explained that

[A] surety cannot be held beyond the precise terms of his contract. Any intention on the part of the surety to assume a further and continued liability must be found in the words of the contract made. It is not a matter of inference but of express statement. The liability of a surety, therefore, is measured by, and will not be extended beyond, the strict terms of his contract.

274 Neb. at 116 (footnotes omitted). The Court observed that "[c]ourts in other jurisdictions have similarly concluded that when a guaranty contract contains express conditions, those conditions must be strictly complied with before the guarantor is liable," specifically mentioning Arkansas, Colorado and Wisconsin. *Id.* at 118.

In response to the claimant's arguments that the bond defaults in question took place prior to the cancellation of Amwest's bonds, the Nebraska Supreme Court made another important observation concerning the nature of a surety contract:

Strategic claims that notwithstanding the fact that the lease bonds have now been terminated, the alleged defaults took place before the lease bonds were canceled and that therefore, Amwest remains liable to pay. In support of this argument, Strategic relies on cases dealing with occurrence-based insurance policies. Strategic contends that under occurrence policies, if the event insured against -- i.e., the occurrence -- takes place within the policy period, regardless of when a claim is made, the policy provides coverage.

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However, Strategic's reliance on cases relating to occurrence policies is misplaced. The contracts at issue in this case are guaranty contracts, not insurance liability policies. As a guaranty contract, the liability of the guarantor is limited to the precise terms used in the contract. Before Amwest's liability under the bonds arose, certain conditions had to be satisfied. Strategic did not comply with those provisions while the lease bonds were in force.

274 Neb. at 119 (footnotes omitted).

The Nebraska Supreme Court in *Strategic Capital Resources* made important findings that are applicable to solvent, operating sureties. The surety contract -- the bond -- forms the legal relationship between the parties and sets forth the conditions and extent under which the surety will be called upon to perform the principal's contract.

Courts in other states have also considered how to construe surety contracts. The decisions fall into three major categories: states like Nebraska which strictly construe surety contracts in favor of the guarantor, states which construe surety contracts against the guarantor, and other states. A majority of states, such as Arkansas², Colorado³, Illinois⁴, and California⁵, follow the same rule as Nebraska, applying strict construction to the interpretation of guaranty contracts in favor of the guarantor. Other states, such as Alabama⁶, Florida⁷, Oklahoma⁸, and Tennessee⁹, take the opposite approach, employing a strict rule of construction against the guarantor. Other states have either not considered these issues or apply more general doctrines of contract interpretation.¹⁰

Commercial banks, in their form guaranties, tend to throw in the kitchen sink in drafting their form guaranties to best assure that any suretyship defense is waived. Sureties do not generally have the same luxury. Oftentimes the form and substance of a surety bond is dictated by statute, by the owner, or by course of dealing. So it is in both the surety's and the obligee's interest to pay more attention to the specific wordings of the bond as well as controlling law to avoid unwanted or unanticipated consequences.

The author would like to thank John H. Binning, Jane F. Langan and Tara L. Tesmer for their invaluable assistance in preparing this article.â€”

Endnotes

1. See National Association of Insurance Commissioners, Insurers Rehabilitation and Liquidation Model Act (NAIC 555-103).
2. See, e.g., *National Bank of Eastern Ark. v. Collins*, 236 Ark. 822, 370 S.W.2d 91 (1963) (Guarantor is entitled to strict construction of his undertaking and cannot be held liable beyond strict terms of the contract).
3. *Walter E. Heller & Co., Inc. v. Wilkerson*, 627 P.2d 773 (Colo. App. 1980) (Guarantee agreements are to be strictly construed in favor of the guarantor).
4. *McClellan County Bank v. Brokaw*, 119 Ill.2d 405, 519 N.E.2d 453 (1988) (A guarantor is to be accorded benefit of any doubt which may arise from language of contract, and its liability is not to be varied or extended by construction or implication beyond its precise terms).
5. *Bank of America Nat. Trust & Savings Ass'n v. Kelsey*, 6 Cal.App.2d 346, 44 P.2d 617 (1935) (Contracts of guaranty are to be construed under the same rules employed in construing other contracts and should receive a fair and liberal interpretation according to the true import of their language, and the guarantor's liability should not be extended by implication beyond the express terms of the instrument in which the guaranty is contained).

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6. *Dill v. Blakeney*, 568 So.2d 774 (Ala. 1990) (Generally, the rules governing the construction and interpretation of contracts are applicable in interpreting or construing a guaranty contract. Where language in a guaranty contract is ambiguous and susceptible of more than one meaning, the contract should be construed more strongly against the guarantor).
 7. *LEA Industries, Inc. v. Raelyn Intern., Inc.*, 363 So.2d 49 (Fla. App. 3 Dist. 1978) (A contract of guaranty is generally construed against a guarantor, particularly where it has been prepared by him).
 8. *Rucker v. Republic Supply Co.*, 415 P.2d 951 (Okla. 1966) (In construing a guaranty to determine the intent of the parties, it should be taken most strongly against the guarantor and in favor of the creditor).
 9. *Farmers-Peoples Bank v. Clemmer*, 519 S.W.2d 801 (Tenn. 1975) (Guarantor in a commercial transaction will be held to the full extent of his engagements; in construing the guaranty instrument, the words of guaranty are taken as strongly against the guarantor as the sense will admit).
 10. *Ferrell v. South Central Bell Tel. Co.*, 403 So.2d 698 (La. 1981) (Contracts of guaranty or suretyship are subject to the same rules of interpretation as contracts in general).
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QUESTIONS A POTENTIAL INDEPENDENT DIRECTOR SHOULD ASK ABOUT THE COMPANY'S DIRECTORS & OFFICERS LIABILITY INSURANCE BEFORE JOINING THE BOARD OF DIRECTORS

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INTRODUCTION

Directors and Officers Liability Insurance policies offer unique insurance coverages and present a variety of unusual issues. While many people know that defense costs are charged against the liability coverage limits, there are many potential concerns that can be surprises to the uninitiated. Since the company purchases the D&O insurance, many directors do not realize what the gaps may be in the protections they expect. This article discusses questions a potential director should be asking about the D&O insurance policy.

In contrast to most liability insurance policies, a Directors and Officers liability policy does not require the insurance carrier to provide a “defense,” even if the claims are covered by the policy. Instead, if a claim is covered, the carrier will reimburse (or advance) defense fees and costs and if it agrees, fund a settlement. That means insureds must arrange for their own defense, although usually the selection of counsel does require the consent of the carrier.

1. What is Covered - Key Definitions.

D&O insurance policies typically provide that the insurance company will pay all loss for which the insureds become legally obligated to pay on account of a claim for a wrongful act. The following definitions are key to gaining an understanding of what is covered by the policy, as well as what is

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not covered.

a. Claim

A claim is commonly defined as a demand for money from an insured or a lawsuit which has been filed against an insured. For a company in a regulatory environment, it is important to check and make sure that a claim also covers a criminal proceeding as well as an administrative or regulatory proceeding.

b. Loss

A loss is often defined as the amount which the insured or the company becomes legally obligated to pay on account of a claim. It includes damages, judgments, settlements and defense costs.

c. Defense Costs

A common definition of defense costs includes reasonable and necessary costs including attorneys' fees and expenses incurred in defending or investigating the claims against the insureds.

d. Wrongful Act

A wrongful act is often defined as any error, misstatement, act, omission or breach of duty, actually or allegedly committed by any of the insureds in his or her insured capacity, i.e., as a Director or Officer, etc.

2. Is There Side A, B and C Coverage?

The primary concern of potential Directors is whether the company D&O insurance will cover their liability, if any, and defense costs in the event a claim is made against them. This type of coverage is referred to as Side A Coverage.

Side B coverage refers to amounts the carrier would pay to the company as reimbursement for indemnification paid by the company to insureds.

Side C coverage protects the company for liability the company itself may have due to a claim. These coverages generally work together, depending upon the factual circumstances. It is important that the Directors know that not only are they covered, that the company is also properly protected if a claim is made by having coverage for both (1) reimbursement to the directors and (2) the company's own liability.

3. What are the Limits?

In contrast to most insurance policies, defense fees and other costs that are covered by a D&O policy are charged against the policy limits. Thus, legal fees often seriously erode the policy protections. Legal expenses, in fact, may exceed the policy limits, leaving the insureds with the predicament that they must fund their own defense fees and costs as well as come up with their own money for settlement.

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What is the amount of the coverage? Is there a single limit for each claim and all claims in the aggregate? Are there separate sub-limits for some coverages? How likely is it that potential liability and defense costs could exceed that amount?

4. What is the Retention?

The self-insured retention or deductible in a Directors and Officers liability policy is often a significant sum such as, for example, fifty thousand dollars or a hundred thousand dollars. If a claim is made, will the corporation pay that retention before the D&O coverage kicks in?

5. Who pays the Defense Costs and Expenses in the first instance?

Does the D&O carrier advance the defense costs and expenses, or is it only at the carrier's option? In other words, must the company and/or Director incur defense fees and costs initially and then get reimbursed under the policy? Similarly, if the corporate bylaws provide for indemnification, do they require the corporation to advance defense fees and costs, or do the bylaws only provide for reimbursement?

6. How broad are the claims made provisions?

a. Claims that occurred before the policy inception

A D&O policy generally only covers those claims made during the policy period unless expressly agreed otherwise. Does the policy cover claims made during the policy period when the events giving rise to the claim occurred before the policy inception? If so, and there is such a claim, will there be enough coverage left once that claim is resolved?

b. Claims made after the policy is terminated

Are you covered for claims made after the policy expires? If so, for how long? Is there additional cost? Is it paid for in advance?

7. Who is Covered by the Policy? Does the policy cover the directors and officers of the named insured's parent corporation, its subsidiaries and affiliates? Are only Directors and Officers who are formally elected or appointed as such covered, or does the policy cover employees in a managerial capacity or otherwise? What is the impact, if any, on your protections under the policy once you leave the Board of Directors?

8. What are the Exclusions? As with almost any insurance policy, D&O policies contain a long list of exclusions. Some key exclusions include any deliberately fraudulent act or omission or any willful violation of any statute or regulation. Also, claims based upon an insured gaining any personal profit or financial advantage to which the insured was not legally entitled are commonly excluded. *See also* the discussions of the *Insured vs. Insured* exclusion and the Regulatory Exclusion below.

9. What is the methodology for Allocations Among Insureds? D&O policies often contain one coverage limit that applies to all claims against any insureds, although there may be sub-limits for specific types of claims.

a. Defense costs

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What does the policy provide regarding how defense costs are allocated among various insureds and/or sets of insureds? If there is a Side C coverage and the company itself is insured for direct liability to a third party, is there any methodology specified for allocation of defense costs between the company and individual insureds?

b. Settlement costs

Similar questions arise in connection with a potential settlement – for example, can all of the funds remaining in the policy, up to the unused limits, be utilized to settle a claim against one insured or one set of insureds to the exclusion of the others, leaving some insureds “uninsured?”

10. Is There a Separation of Insureds Clause?

If there are misrepresentations in the application for the policy, does the insurance company have the right to rescind the policy against all of the insureds or only against the person who made the misrepresentations and/or the company itself? For example, a company employee falsely answers a question as to whether the applicant has knowledge about the potential for a claim that has not yet been made. Similarly, if the financial statements were in error and need to be restated, can coverage for all insureds be denied? If there is a misrepresentation in the application and the other insureds had knowledge that the representation was false, is there coverage for those insureds with knowledge of the misrepresentation?

11. Who Must Consent to a Settlement?

These policies generally provide that the D&O carrier must consent to a settlement. Does the policy also require all of the insureds to consent to a settlement? Can consent by the carrier or the other insureds be withheld under any circumstances or is it limited to situations where consent cannot be unreasonably withheld?

12. How financially strong is the carrier(s)?

Is all the coverage with one carrier or in layers with two or more carriers? What are the A.M. Best ratings of the carrier(s)? Insurance guaranty funds generally do not cover claims under Directors and Officers liability insurance if the carrier becomes insolvent. If the primary carrier does become insolvent, will the other carrier(s) pick up that coverage?

13. What Indemnification is provided?

How are the indemnification provisions in the policy tied in with applicable law and the corporation’s bylaws? What does the applicable state law provide for indemnification, and if the bylaws are different, do they provide for maximum indemnification? If so, is it mandatory or discretionary?

14. Is the Insured v. Insured Exclusion Limited?

D&O policies generally contain an *Insured v. Insured* exclusion which is intended to prevent collusion among insureds, such as where the corporation sues its Directors and Officers in an attempt to recover insurance proceeds from the D&O carrier despite the lack of merit to the claims. Does the *Insured v. Insured* exclusion carve-out claims brought by the receiver or trustee of the corporation if

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the corporation is placed into receivership or bankruptcy? Carriers have often taken the position that since a receiver stands in the shoes of the company, the *Insured v. Insured* exclusion prevents coverage of the lawsuit. This position has been rejected by a number of courts, but the policy should contain a carve-out for this type of litigation so that there is coverage if a claim is brought by a receiver of the company.

15. Is There a Regulatory Exclusion That Would Deny Coverage for Claims Brought By a Governmental Agency?

Does the policy contain a regulatory exclusion which excludes coverage for claims brought by a governmental, quasi-governmental, or regulatory agency? These exclusions go back to the savings and loan crises in the 1980's, and are not necessarily included in policies any longer.

16. Does the company have any experience with the insurance carrier on previous claims?

Have there been any previous claims with this insurance carrier? Have any of the policy limits been used up already? How did the carrier handle the claim and the defense? Were they cooperative and helpful?

17. What are the Additional Insured Rights?

The company purchases the policy and is the named insured. Are the directors additional insureds? What rights does an additional insured have compared to all of the rights of the named insured(s)? For example, can the policy be canceled by the named insured a) without the director's consent, b) without the director's knowledge, or c) over the director's objection?

CONCLUSION

The time to look at these issues and ask questions is before joining a Board of Directors. Once a claim is made, the policy controls and directors may not be protected as they expected.

NARAB II â€œ THE DEVIL'S IN THE DETAILS â€œ THE PRACTICAL EFFECTS OF HB 2554 ON INSURANCE REGULATORS AND THE INDUSTRY

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Eleven years after the passage of the Gramm-Leach-Bliley Act (15 U.S.C. 6751 *et seq.*), as states struggle to achieve full reciprocity and uniformity in producer licensing, the U.S. House of Representatives passed the National Association of Registered Agents and Brokers Reform Act of 2010. HR 2554 would amend the

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Gramm-Leach-Bliley Act (GLBA) and establish the National Association of Registered Agents and Brokers (NARAB) to serve as a clearinghouse for producers who wish to do business in multiple states. Since the threat of the original NARAB proposed in the GLBA still exists, HR 2554's version is sometimes referred to as "NARAB II." (In this article, references to NARAB mean the association that would be created under HR 2554.) HR 2554 attempts to preserve the consumer protection and enforcement powers of states while simplifying multistate licensing for producers. This article explores the practical effects of the bill.

How it Will Work

HR 2554 applies to all lines of insurance (other than title insurance) that are defined or regulated by state insurance regulators. If created pursuant to HR 2554, NARAB would be a non-governmental association with the power to adopt and apply non-resident insurance producer qualification requirements on a multistate basis. NARAB would be managed by a board of directors consisting of six state insurance commissioners and five representatives of the insurance industry. NARAB would have the power to adopt bylaws, rules and establish membership criteria. Membership in NARAB would permit producers to bypass states' nonresident licensing procedures but states' ability to regulate resident producers would not be affected.

Section 322, the purpose clause, expresses a clear intent to preserve the rights of states to "license, supervise, discipline" and establish fees for producers and to prescribe and enforce consumer protection and unfair trade practices laws. Section 322 also expressly provides that NARAB's activities are not intended to have any effect on state laws for resident producers or to produce a net loss of revenues. State laws and actions that are inconsistent with the bill would be subject to preemption under Section 331.

Under HR 2554, once a producer is licensed in the producer's home state, the producer could become a member of NARAB subject to certain eligibility requirements that include a national criminal background check and no recent revocation of a state insurance license. NARAB may establish additional membership criteria so long as the criteria do not unfairly limit access or discriminate against smaller producers or agencies. NARAB will also have the power to deny, suspend, not renew or revoke a producer's membership and to place members on probation.

Any producer who operates in multiple states is likely to want to be a member of NARAB as Section 323(e)(B) states that NARAB membership shall "be the equivalent of a nonresident insurance producer license issued in any State in which the producer pays the licensing fee." Membership in NARAB will authorize a producer to sell, solicit, negotiate, effect, procure, deliver, renew, continue, or bind insurance and exercise "all such incidental powers" as shall be necessary to carry out such activities. Incidental powers include claim adjustment and settlement, risk management, employee benefits advice, retirement planning and "any other insurance-related consulting activities." (Section 323(e)). States will *not* issue nonresident licenses to NARAB members. To avoid a detrimental effect on state revenues, NARAB members will, however, be required to pay state nonresident license fees.

HR 2554 contemplates information sharing among NARAB, state insurance regulators, and the National Association of Insurance Commissioners (NAIC), perhaps through systems already established by the National Insurance Producer Registry (NIPR). In fact, the bill requires NARAB to notify the National Association of Insurance Commissioners (or its designee, presumably NIPR) when a producer becomes a NARAB member and to provide ongoing updates about the states in which NARAB members are entitled to operate. Nonresident license fees will be payable to NARAB which will distribute them to the respective states. For life insurance agents, NARAB would be required to coordinate its activities with the Financial Industry Regulatory Authority (FINRA).

Preemption of State Laws

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Obviously, for NARAB to be effective there must be preemption of state laws that would interfere with the objective of the legislation and the rights of NARAB members. Section 331 prohibits states from impeding the activities of or applying any law arbitrarily or discriminatorily to a producer who is a NARAB member or who plans to become a NARAB member. States may not impose different fees upon NARAB members than those imposed on nonmembers.

All nonresident licensing laws except those imposing licensing fees are likely to be preempted. Licensing requirements for nonresident business entities are preempted. It is also conceivable that appointment requirements may be preempted.

The states of California and Florida have not been reciprocal under the GLBA largely due to long-standing practices of requiring fingerprints and criminal background checks for nonresident producers. Those requirements would be preempted with respect to NARAB members. Section 331(b)(2)(C) specifically prohibits states, other than a NARAB member's home state, from requiring a NARAB member to submit to a criminal background check as a condition of doing business.

The Devil is in the Details

On the face of it, HR 2554 streamlines and eliminates many headaches from the current nonresident producer licensing process. It purports to maintain the rights of states to regulate the conduct of producers, discipline those who do not follow the rules and preserve state revenues. However, as the title of this article implies, the devil is in the details. Revenues may not be preserved and the ability of states to discipline a producer who does not have a license may be limited.

The first erosion of state power will be the inability of states to deny a nonresident NARAB member the ability to do business on the same grounds on which a state might deny a license to a nonresident who is not a NARAB member. Section 12 of the NAIC Producer Licensing Model Act (PLMA), adopted by almost all states, provides various grounds for which a state may deny a license to a nonresident producer even if the producer is licensed in the home state. For example, Section 12 permits a state to deny a nonresident license to a convicted felon. But, under HR 2554, if a felon is a member of NARAB, he or she would have the right to engage in the business of insurance in any state pursuant to Section 331(b)(2)(A). If a producer meets NARAB's standards, a nonresident state will not be able to prohibit the producer from doing business in that state, at least initially.

For misconduct that occurs after a producer joins NARAB, a nonresident state's disciplinary powers may be limited. At the very least, the interplay between HR 2554 and state insurance and administrative procedure laws raise interesting questions. Presumably states will be able to impose fines against nonresident NARAB members. But because nonresident licenses will not be issued to NARAB members, there will be no license to suspend or revoke in the event of egregious conduct. Yet Section 323(e) states that membership in NARAB subjects producers to "all laws, regulations, provisions or other action of any State *concerning revocation or suspension of a member's ability to engage in any activity* within the scope of authority granted under this subsection..." (*emphasis added*). The ability to engage in the business of insurance is granted through membership in NARAB and not by the states. It is unclear what a state would have to do in order to revoke or suspend that "ability." Perhaps a cease and desist order could be issued by a state. It remains to be seen whether such an order would be sufficient for NARAB to revoke a membership, but Section 323(h)(1) does permit NARAB to suspend or revoke membership when a producer has been disciplined pursuant to a final adjudicatory order of a state insurance regulator. NARAB members will be entitled to certain procedural rights before a membership may be revoked. So, in some cases, a producer may have two administrative hearings.

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HR 2554 is noticeably silent about appointments, yet most states require appointments and some place severe limits on what a producer can do without an appointment. Under Section 331(b)(1)(D), a state will be prohibited from requiring appointments for a nonresident NARAB member who places commercial property and casualty risks for insureds with multistate risks. That section does not, however, prohibit states from imposing appointment requirements on NARAB members in other circumstances nor does it permit the practice. However, if a state restricts the ability of a nonresident NARAB member to sell, solicit or engage in the business of insurance unless the producer has an appointment, the appointment requirement might be considered an additional and impermissible licensing requirement. Section 322 specifically states that the bill is not intended to affect laws concerning appointments and other matters for *resident* producers, which suggests appointments for nonresident NARAB members might be affected. This is an issue that will require clarification. If states cannot require appointments for nonresident NARAB members, it will mean a significant loss of appointment fee revenue in many states.

State revenues will also take a hit from the loss of business entity licensing and appointment fees. Under section 323(e)(2), states will no longer be permitted to force the licensure of a business entity with which a nonresident producer is affiliated so as long as the individual is a member of NARAB. Nor will states be able to prohibit the payment of compensation to any employer, employee or affiliate of a member for the member's performance of permitted activities. Traditionally, states have insisted that nonresident business entity licensing is necessary for enforcement purposes, and HR 2554 will test that rationale. The elimination of nonresident business entity licensing is likely to result in significant cost savings for agencies that do business in multiple states and for the insurance companies with which they do business.

Potential Areas of Regulatory Confusion and Change

Finally, there are additional issues that may arise if NARAB is created under HR 2554. Since no licenses are being issued to NARAB members, state insurance departments will need to make significant modifications to their systems to track NARAB membership or they will need to designate NARAB members as licensed. The latter practice may cause confusion as there will be some nonresident producers, particularly those in bordering states, who do not join NARAB and who will obtain a nonresident license the old-fashioned way.

Market conduct examiners may be forced to modify testing of producer licenses and appointments. Currently, examiners often compare the insurance department's licensing and appointment records to a list of commission payments or a list of new business. Depending upon how a state identifies NARAB members in its records and whether appointments can be required, these tests may need to be modified or eliminated.

Consumers may be confused, as both NARAB and individual state insurance departments will have the power to receive and investigate complaints. It does not appear NARAB will have any authority to order corrective actions, and it is questionable whether NARAB would be staffed sufficiently to handle consumer complaints. NARAB would be required to forward appropriate complaints to the respective state insurance departments.

A few states have retained separate broker and producer licenses and have different rules governing the conduct of brokers and producers. It is not clear which set of rules will apply to a nonresident NARAB member.

States will have to deem membership to be the equivalent of a nonresident producer licensing when considering certain laws. For example, most states restrict the payment of commissions to licensed producers - states will have to permit payments to NARAB members who pay the requisite license fees.

The Act includes "insurance-related consulting activities" as one of the activities authorized by membership in NARAB. A few states license consultants separately and the bill may affect those licensing programs.

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HR 2554 contains many promising provisions that indicate an intent for NARAB, state insurance regulators and the NAIC to share information readily and perhaps share access to databases. What is less clear is whether states will have the authority to share producer licensing and enforcement information with NARAB. States have information sharing laws that permit them to share confidential information with the NAIC, state and federal regulators and law enforcement agencies. But NARAB will not be a governmental agency that is included within the scope of those information sharing laws. Licensing records include sensitive information such as social security numbers and birthdates. As drafted, HR 2554 does not mandate states to share information with NARAB, and many states may be prohibited from doing so under current state law.

None of these issues seem insurmountable and some are merely technical in nature. They are outweighed by the potential benefits to the insurance industry and especially multistate agents and brokers. State insurance regulators may have to adjust their thinking, processes and systems but they should retain the substantive powers necessary to protect their consumers and insurance markets.

DEFINING MENTAL HEALTH PARITY AND ADDICTION EQUITY

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The Mental Health Parity and Addiction Equity Act 1 sketched out the idea that there should be parity between medical and surgical benefits on the one hand, and mental health and substance use disorder benefits on the other hand. On February 2, 2010, the federal agencies charged with implementing this Act filled in the details on how exactly parity can be measured.²

As you might expect, the rules begin by taking a stab at dividing benefits among "medical-surgical," "mental health," and "substance use disorder," which they do by deferring to the definition "under the terms of the plan and in accordance with applicable Federal and State law."³ Thus, if neither federal nor state law has anything to say about whether a particular service is in a particular category, it is up to the plan to categorize the service; however, that must be done "consistent with generally recognized independent standards of current medical practice," with examples of such standards being "State guidelines" and the most current version of the International Classification of Diseases (ICD) and, for mental health and substance use disorders, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).⁴ For example, if the current DSM categorizes a benefit as a mental health condition, then a plan must define it as such absent contrary state guidelines. Even then, the rules would not prevent a plan from excluding coverage for a particular benefit altogether;⁵ if a mental health condition is covered, however, it must be covered on par with medical and surgical benefits.

Once benefits are categorized, the interim final rules issued in February take separate approaches to evaluating parity for:

- aggregate lifetime and annual dollar limits;

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- financial requirements (such as deductibles, copays, coinsurance, and out-of-pocket maximums⁶) and quantitative treatment limitations (such as visit and day limits⁷);
- nonquantitative treatment limitations (such as medical management⁸); and
- multi-tiered prescription drug plans.

These separate approaches are described in order below.

Aggregate Lifetime and Annual Dollar Limits

This part of the rule has not changed much, except to expand it to substance use disorders (though it will be mitigated by restrictions on lifetime and annual limits in the federal health care reform legislation). Thus, a plan may not impose aggregate lifetime or annual dollar limits on mental health-substance use disorder benefits unless at least one-third of all medical-surgical benefits have such limits.⁹ The one-third calculation is determined by the dollar amount of benefits paid for benefits subject to aggregate lifetime or annual dollar limits vs. the dollar amount of benefits paid for all other medical-surgical benefits.¹⁰

If a plan imposes aggregate lifetime or annual dollar limits on more than one-third but less than two-thirds of all medical-surgical benefits (with the two-thirds determined like the "dollar amount" calculation described above), then the plan must either impose no such limits on mental health-substance use disorder benefits or limits that are no less than the average limit for medical-surgical benefits.¹¹ Finally, if the plan imposes aggregate lifetime or annual dollar limits on at least two-thirds of all medical-surgical benefits, then the plan must either also apply the limits to mental health-substance use disorder benefits (in a manner that does not distinguish them from the medical-surgical benefits), or apply the same or lesser limits separately to mental health-substance use disorder benefits.¹²

Financial Requirements and Quantitative Treatment Limitations

The rules provide a very complex, fact-intensive, slice-and-dice, plan-by-plan process for determining parity in financial requirements and quantitative treatment limitations. This process basically involves determining which such requirements and limitations are "predominant" and apply to "substantially all" medical-surgical benefits - those financial requirements and quantitative treatment limitations are then the most restrictive ones that can be applied to mental health-substance use disorder benefits.¹³

The first step in this process is to determine which of six classifications apply to a particular plan design, that is, (1) inpatient network, (2) inpatient out-of-network, (3) outpatient network, (4) outpatient out-of-network, (5) emergency, and (6) prescription drugs.¹⁴ Note that if a plan "provides mental health or substance use disorder benefits in any classification of benefits ..., mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided."¹⁵

The second step is to allocate the benefits in the non-emergency or prescription drug classifications between medical-surgical benefits on the one hand and mental health-substance use disorder benefits on the other.

The third step is to determine which financial requirements and quantitative treatment limitations apply to each benefit in each category of benefits in each classification.

The fourth step is to look at each financial requirement and quantitative treatment limitation that is used in the plan to determine which ones apply to "substantially all" medical-surgical benefits in each classification, where "substantially all" means two-thirds¹⁶ (with the two-thirds determined like the dollar amount calculation described above¹⁷). A financial requirement or quantitative treatment limitation that does not apply to two-thirds of the medical-surgical benefits in a classification cannot be applied to mental health-substance use disorder benefits in that classification.¹⁸

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The fifth step, for each financial requirement and quantitative treatment limitation that meets the "substantially all" standard of the fourth step, is to determine which level is the "predominant" one in each classification, where "predominant" means more than half (with the one-half determined like the dollar amount calculation described above).¹⁹ The level of financial requirement or quantitative treatment limitation that applies to more than half of the medical-surgical benefits, in a classification that is subject to the requirement or limitation, is the most restrictive one that can be applied to mental health-substance use disorder benefits in that classification.²⁰ If a plan also imposes different financial requirements and quantitative treatment limitations based on the "coverage unit" (*e.g.*, self-only, family, or employee-plus-spouse²¹), then the plan must determine which one is predominant after dividing the classification into coverage units.²²

It is clear that evaluating parity for financial requirement and quantitative treatment limitations could take a substantial amount of time. Just gathering the dollar amount data could be a substantial job, as the insurer would potentially have to figure out how much it spends for each benefit (*e.g.*, physician visits, maternity, transplants, inpatient) in each applicable classification (*e.g.*, inpatient network, outpatient network, inpatient out-of-network and outpatient out-of-network).

Then evaluating just one plan design could take another substantial amount of time, since the plan must be broken down into all its parts and then comparisons and calculations must be made. Obviously, the more financial requirements and quantitative treatment limitations the plan uses, and the more levels of those requirements and limitations it uses, the longer the evaluation would take. This might create an incentive to simplify plans. It also may be more cost-effective to "reverse engineer" a plan; that is, to design medical-surgical benefits in a way that will produce a certain result for mental health-substance use disorder benefits.

On the other hand, marketplace demands may make it difficult for plans to impose enough restrictions on medical-surgical benefits to allow imposition of restrictions on mental health-substance use disorder benefits. For example, a plan would have to impose a lot of day and visit limitations on medical-surgical benefits in order to satisfy the "substantially all" standard (two-thirds of such benefits) so that such limits could be imposed on mental health-substance use disorder benefits.

Nonquantitative Treatment Limitations

Nonquantitative treatment limitations are "limits on the scope or duration of treatment" under a plan that are not "expressed numerically."²³ The breadth of this definition will make it difficult to determine whether certain plan limits qualify,²⁴ unless those limits are described in or analogous to the examples provided by the rule:

- "Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- "Formulary design for prescription drugs;
- "Standards for provider admission to participate in a network, including reimbursement rates;
- "Plan methods for determining usual, customary, and reasonable charges;
- "Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
- "Exclusions based on failure to complete a course of treatment."²⁵

While the rule literally subjects nonquantitative treatment limitations to the same "predominant" standard as quantitative treatment limitations,²⁶ the rule also states that application of the predominant standard to nonquantitative treatment limitations is addressed by a separate "comparable to and not more stringent than" standard.²⁷ Under that standard, a plan "may not impose a nonquantitative treatment limitation with respect to

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mental health or substance use disorder benefits in any classification unless, under the terms of the plan ... as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference."²⁸

This standard is fairly easily applied to a limitation, like medical necessity, that applies across all benefits in a classification - that is, the limitation must be applied similarly to medical-surgical benefits on the one hand and mental health-substance use disorder benefits on the other - and that is the subject of most of the examples in the rule.²⁹ That leaves the question as to whether a plan can single out certain mental health-substance use disorder benefits for a nonquantitative treatment limitation, and the remaining example discussed below seems to answer that question in the negative:

In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.³⁰

The rule goes on to state that, in this example, the plan violates the "comparable to and not more stringent than" standard: "Although the same nonquantitative treatment limitation -- medical appropriateness -- is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning."³¹

Multi-Tiered Prescription Drug Plans

The special rule for multi-tiered drug plans states that a plan may apply "different levels of financial requirements to different tiers of prescription drug benefits" if such application is (1) "based on reasonable factors determined in accordance with the rules ... relating to requirements for nonquantitative treatment limitations" (the "comparable to and not more stringent than" standard discussed above) and (2) "without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits."³² In this context, "reasonable factors" include "cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up."³³

Conclusion

It may have been inevitable that applying abstract concepts like parity and equity to complex and manifold health plans would result in an extraordinarily convoluted and difficult testing regimen. At least in the short term, until health plans can digest and explore this regimen, the counterintuitive result may be more simplicity in health plans. Since it is so difficult to apply requirements and limitations to mental health-substance use disorder benefits without applying them to medical-surgical benefits, and since the market will make it difficult to apply requirements and limitations to medical-surgical benefits, the main response may well be to eliminate many such requirements and limitations altogether.

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Endnotes

1. 42 USC § 300gg-5 (while the Act appears in the tax code, ERISA, and the Public Health Service Act, with implementing rules coming from the three corresponding federal agencies, this summary will cite only the Public Health Service Act and Department of Health and Human Services rules). Generally, the Act applies only to employers with more than 50 employees. § 300gg-5(c)(1).
2. 75 FR 5410. The rules "generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010." *Id.*
3. 45 CFR § 146.136(a).
4. 45 CFR § 146.136(a).
5. 45 CFR § 146.136(a) (only annual or lifetime dollar limits, financial requirements, and treatment limitations are regulated by the rules, and a total exclusion does not fall within the definitions of the first two and is specifically excluded from the last one).
6. *See* 45 CFR § 146.136(a).
7. *See* 45 CFR § 146.136(a).
8. *See* 45 CFR § 146.136(c)(4)(ii).
9. 45 CFR § 146.136(b)(2).
10. 45 CFR § 146.136(b)(5) (the determination "is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year Any reasonable method may be used" to make the determination).
11. 45 CFR § 146.136(b)(6). Per § 146.136(b)(6)(i)(B), "The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits." Per § 146.136(b)(6)(ii), the weighting for any category is determined in the same manner as the "dollar amount" calculations.
12. 45 CFR § 146.136(b)(3).
13. In addition, 45 CFR § 146.136(c)(3)(v)(A) prohibits use of a cumulative financial requirement or cumulative quantitative treatment limitation for mental health-substance use disorder benefits that accumulates separately from such a requirement or limitation for medical-surgical benefits in any classification, where § 146.136(a) defines "cumulative" financial requirements and quantitative treatment limitations as those "that determine whether or to what extent benefits are provided based on accumulated amounts." While this prohibition is easy to apply for a financial requirement like a deductible - which is a dollar amount that applies across all types of benefits (so that the prohibition would prevent using a deductible that applies separately to mental health-substance use disorder benefits on the one hand and medical-surgical benefits on the other) - it is more difficult to apply to quantitative treatment limitations like day and visit limits. (Indeed, all the examples for this prohibition deal with deductibles, § 146.136(c)(3)(v)(B).) Presumably, the prohibition means that similar benefits with visit limitations would have to accumulate visits together to be applied to the limitation. For example, a plan would probably have to limit outpatient visits for medical-surgical treatment in order to limit outpatient visits for mental health-substance use disorder

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treatment (for the reasons described above), so all outpatient visits - regardless of whether they are mental health, substance use disorder, or medical-surgical - would have to count toward satisfaction of the visit limit for all benefits.

14. 45 CFR § 146.136(c)(2)(ii)(A).
15. 45 CFR § 146.136(c)(2)(ii)(A).
16. 45 CFR § 146.136(c)(3)(i)(A).
17. 45 CFR § 146.136(c)(3)(i)(C) and (E). *See* § 146.136(c)(3)(i)(D) for calculations involving threshold requirements such as deductibles and § 146.136(c)(3)(iv) for examples of this calculation.
18. 45 CFR § 146.136(c)(3)(i)(A).
19. 45 CFR § 146.136(c)(3)(i)(B). If no level of financial requirement or quantitative treatment limitation is predominant, then levels are combined until the combination is predominant, and then the least restrictive level in that combination is deemed to be the predominant one. § 146.136(c)(3)(i)(B)(2). *See* § 146.136(c)(3)(iv) for examples of this calculation.
20. 45 CFR § 146.136(c)(2)(i).
21. 45 CFR § 146.136(c)(1)(iv)
22. 45 CFR § 146.136(c)(3)(ii).
23. 45 CFR § 146.136(a).
24. For example, may coverage for mental health services be limited to providers or programs certified by a certain government or other body? May a plan automatically request certain information from a mental health care provider to determine medical necessity? Would such differences be permitted by "recognized clinically appropriate standards of care" under 45 CFR § 146.136(c)(4)?
25. 45 CFR § 146.136(c)(4)(ii).
26. 45 CFR § 146.136(c)(2)(i).
27. *See* 45 CFR § 146.136(c)(4). It might have made more sense simply to acknowledge that nonquantitative treatment limitations are subject to a different standard - instead of stating that one standard is applied using a different standard - but the rule's roundabout approach still leaves it fairly clear that parity for nonquantitative treatment limitations is governed by the "comparable to and not more stringent than" standard.
28. 45 CFR § 146.136(c)(4)(i).
29. 45 CFR § 146.136(c)(4)(iii), Examples 1, 2, 3, and 5.
30. 45 CFR § 146.136(c)(4)(iii), Example 4.
31. 45 CFR § 146.136(c)(4)(iii), Example 4.

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32. 45 CFR § 146.136(c)(3)(iii). The one example for multi-tiered drug plans in § 146.136(c)(3)(iv), Example 4, basically just repeats this rule in the context of a 4 tier plan (90% coverage for generic, 80% coverage for preferred brand name, 60% coverage for nonpreferred brand name, and 50% coverage for specialty).

33. 45 CFR § 146.136(c)(3)(iii).

SPECIAL PURPOSE FINANCIAL CAPTIVES SOUTH CAROLINA’S SUCCESS STORY

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Special Purpose Financial Captives South Carolina's Success Story

Over the years, many jurisdictions have developed and utilized captives in a traditional form. South Carolina has distinguished itself by allowing a captive to be used not only as an innovative and useful insurance mechanism, but for a variety of purposes, most specifically in accessing the capital markets.

Background

Initially, South Carolina passed a special purpose reinsurance vehicle act in 2002. This non-captive entity was the first attempt by the state to view the capital markets through the prism of an insurance entity. The idea developed into a Special Purpose Captive (*see* S.C. Code §38-90-10 (26)), which in 2003 was the captive structure first utilized as a vehicle to access the capital markets.

Thereafter, South Carolina developed the first and most comprehensive statutory framework for accessing the capital markets through its unique Special Purpose Financial Captive ("SPFC"), found in Article 3, Chapter 90 of Title 38 of the South Carolina Code. Since its promulgation, more than \$20 billion has been accessed by insurers through their captive platforms, primarily from the capital markets. South Carolina successfully licensed over 25 SPFCs, each of which contributes sizeable deposit infusions into South Carolina banks, annual substantial premium taxes, as well as indirect economic benefits, such as travel and room nights in South Carolina, annual and quarterly Board Meetings and fees to service providers.

This article addresses some of the reasons for the success of SPFCs in South Carolina and how the state continues monitoring the activities of existing SPFCs, as well as future prospects for SPFCs.

What is an SPFC?

An SPFC is a captive insurance company formed specifically to reinsure the risk of an affiliate or parent, usually a life insurance company, to facilitate the securitization of the risk as a means of accessing alternate sources of capital addressing the burden of a reserving requirement. For Term Life products, the acronym "XXX" is used to denote these reserves, and for Universal Life products, the acronym "A XXX" is used. The required reserves are substantial and generally exceed expected benefits payable for term and universal life products. To date, South Carolina has successfully securitized term, universal life contracts and disability claims through a variety of different SPFCs for some of the major life and disability insurers in the U.S.

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South Carolina has been successful because it has always viewed the SPFC as a true "insurance company," not simply a financial transaction. Under South Carolina's statutory framework, the SPFC is subject to careful ongoing scrutiny and reporting requirements, as the general life of the SPFC often exceeds twenty and sometimes thirty years. Once licensed, the SPFC is essentially put on autopilot, subject to a variety of control mechanisms described in this article.

Why Use An SPFC?

This fundamental question was posed by many interested parties during the early phases of the program. The answer is that SPFCs provide simple and cost effective solutions to address reserve strains by isolating blocks of business for reinsurance purposes. This becomes more apparent when comparing SPFC solutions with other more temporary solutions for reserve relief.

First, there is the traditional reinsurance market. Reinsurance for XXX and A XXX reserves is expensive and extracts many of the economic benefits of the block. Further, buying reinsurance for the "excess reserves" exacerbates the problem of inefficient use of capital created by reserve redundancy. Also, reinsurance is more traditionally viewed as protecting term life blocks of business from adverse mortality and other aberrations in the block's performance. With some exceptions, it is generally not viewed as a cost effective or economically viable alternative for financing XXX or A XXX Reserves.

Another option has been the use of a letter of credit ("LOC") to finance XXX and A XXX Reserves. Though currently in vogue, this financial product is problematic in that LOCs are generally issued for short terms and generally expose the parent company to rollover, re-pricing, liquidity, credit and possible other risks. Until the recent implosion of the capital markets and because of the dangers that exist in counterparty exposure (using one bank's balance sheet to issue a letter of credit), there had been a reluctance to use LOCs to finance reserves. LOCs are also expensive, lock the insurer in with one financial institution for a lengthy period of time and are difficult to tailor to a XXX transaction.

The final method commonly used to finance XXX Reserves is internal funding. This is generally viewed as a very inefficient use of internal capital, since the invested funds are essentially idle and not directly related to selling life products, the core business of a life insurance company. Many term and universal life writers have been very successful in estimating their "economic reserves" (the reserves required to meet expected benefit payments). This has enabled these companies to avoid tapping their XXX and A XXX reserves. Internal funding proposals also presume the existence of an affiliate or parent that has sufficient cash to invest to meet the reserve requirements of the XXX or A XXX regulations.

For these reasons, and the simple desire to control one's own destiny, the SPFC came into existence. The capital markets contain trillions of dollars available for access through the SPFC mechanism. The aforementioned alternative solutions are limited not only in terms of size of the available market, but also in the number of participants, particularly in the LOC realm.

How Does it Work?

The principal component of the SPFC is isolation of segregated blocks of business, usually on a yearly basis, to finance the reserve requirements of that block. Through a reinsurance agreement with the SPFC, there can be a true separation of the reserves from the ceding company. This enables the parent company to achieve the operating leverage needed and treat the funds accessed in the capital markets as surplus, not debt. The capital markets transaction involves a number of protections to ensure that the market risk from issuance of the notes or securities used to finance XXX and A XXX reserves does not pass back to the captive. In other words, one of the strengths of South Carolina's program is that all of the reserves to date have been primarily financed through high quality assets, cash or other marketable securities, which are controlled by strict investment

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guidelines and placed in a specific trust arrangement to provide credit for reinsurance for the ceding company and protect the assets of the captive. To pay annual interest or periodic principal on the note, each SPFC license is accompanied by an Administrative Order, which utilizes a specific formula to allow the SPFC to apply for interest and/or dividend payments based on its annual performance. These formulas are a function of Risk Based Capital ("RBC") ratios developed by the NAIC. To date, no captive in South Carolina has ever missed an interest or dividend payment. In fact, most of the annual applications for dividend or interest payments far exceed the minimum RBC ratios set forth in their Administrative Orders.

Historically, the SPFC issued surplus notes to a purchaser who, in turn, utilized an investment bank to repackage those notes and sell them in the capital markets to sophisticated "Regulation 144A" Investors. Most early transactions were "wrapped" (guaranteed by financial guarantors such as MBIA, Ambac and others). These financial guarantors provided a "AAA" credit rating that many money market managers needed to ensure high quality investments in their portfolios. With the demise of these financial guarantors, greater emphasis has been placed on traditional rating agencies. In the current environment, many of the surplus notes issued by the SPFCs exceed the rating of the financial guarantors. This provides a unique opportunity in the XXX/A XXX world for "unwrapped" offerings.

The minimum capital, economic and excess reserves are also rigorously tested through a variety of actuarial stress scenarios involving mortality, interest rate fluctuations, and lapsation of insurance policies. This actuarial modeling provides confidence to the domiciliary regulator, the insurer, and investors that the captive will perform as expected. In some cases, these projections are now approaching 9 years, and with each passing year, experience shows them to be very precise and in line with actuarial modeling predictions. There is thorough ongoing regulation to ensure the proper performance of all of the insurance entities involved, with extensive annual reporting to South Carolina and domiciliary state regulators. The SPFC is generally subject to annual GAAP and statutory filings as well as an annual actuarial assessment of the performance of the block that has been ceded to the captive. This regulatory framework has worked extremely well and has provided comfort to knowledgeable investors who view these entities as safe and prudent investments. Finally, there are ongoing surveillance reviews by rating agencies, as well as careful monitoring by the insurance companies themselves.

Why The Success Story?

As stated above, South Carolina is by far the leader and recognized expert in the SPFC field. The controlling South Carolina statutes contain a variety of unique provisions protecting the investor and captive, some of which do not exist in jurisdictions that have replicated South Carolina's statutory framework. For example, South Carolina has a comprehensive Administrative Procedures Act to provide long term stability to the operations of the SPFC over its expected useful life. To implement this Act, South Carolina has a dedicated Administrative Law Court, with an agency and business focus, which provides a forum to expeditiously resolve any disputes that might develop and cannot be resolved with the Department of Insurance. Additionally, South Carolina, unlike most other states, has unique internal processes and resources to review applications, continually monitor the SPFC, and craft unique provisions in flexible Administrative Orders that are necessary to ensure the successful operation of the captive. Every South Carolina license is preceded by months of careful, detailed analysis and actuarial modeling. The ceding life insurance company's domiciliary state is also required to sign off on the SPFC reinsurance transaction. Domiciliary states have expressed their satisfaction with the careful regulatory environment in South Carolina. This has allowed some SPFCs to be deemed accredited reinsurers, which provides for even more financial flexibility for the affiliate/parent ceding company, especially in terms of valuation of assets held in trust. This view of SPFCs as true "insurance companies," and not simply financial transactions, is extremely important, particularly given the environment that currently exists in the regulatory and investment world.

The Future

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In the wake of the capital markets downturn, some have misconceived the function and protection inherent in life insurance reserve securitizations. They are very different from most asset-backed securitizations. The misconceptions appear to be the result of a simplistic tendency to lump life insurance securitizations with other asset-backed securities. That, and the failure to take into account (much less explain) the significant differences between the regulatory and capital market aspects of these products contributes to this false perception. The risks involved for investors in asset-backed securitizations utilizing life insurance blocks of business are principally mortality, interest rate fluctuation and lapsation. With rigorous testing, long experience, and a wealth of intellectual capital within the Department of Insurance, South Carolina's SPFCs have performed extremely well to date. This experience leads to the expectation that investors will view life insurance as a unique asset-backed security, since mortality risk is de-linked from the economy, and the reserve trust assets are carefully regulated by the Department of Insurance. Neither of these protections existed in the mortgage world, which one could say was one of the principal reasons for the collapse of the asset-backed securities market. Given this current unique investment environment, several new options are being considered by the Department for use of the SPFC. Specifically, there has been a great deal of discussion that the SPFC market needs to be "jump started" through some mechanism, either at the state or private level, to reinvigorate the interest of investors and term life providers in providing capital market based solutions. This could involve a variety of ideas, such as creation of an infrastructure bank or investment of state retirement funds in the program¹. Further, considerations have been given to securitizing other types of insurance projects, such as variable annuities and even property and casualty risks.

Conclusion

As stated above, the real success story in South Carolina relates to innovative thinking, dedication, and a continued commitment to the captive program, as evidenced by the SPFCs that have been licensed to date. This reputation has enabled South Carolina to be a true success story in protecting term and universal life consumers by providing benefits through efficient use of capital, which transfers into safe, low cost products. It also gives insurers the comfort of knowing that the SPFC has completely segregated itself from the balance sheet of the parent, thereby enabling the parent to use its capital more efficiently to provide reserves for term and universal life products. The SCCIA will be featuring several panels discussing many of the above referenced topics at its annual meeting September 13th-15th in Charleston, SC. Please mark your calendars to attend. You won't want to miss what is happening in South Carolina.

Endnotes

1. Retirement funds have a unique interest in that the state retirement system views assets on a long term basis, which is one of the unique features of surplus notes issued by the SPFC.