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## *In this issue…*



**Wisconsin Governor Jim Doyle Names Sean Dilweg Commissioner of Insurance**

On Friday, December 29, 2006, Governor Doyle named Sean Dilweg Commissioner of Insurance, effective January 1, 2007. Dilweg replaces Jorge Gomez, who announced his resignation last November. Dilweg was the Executive Assistant at the Department of Administration where he advised the Secretary and Governor Doyle on legislative and policy matters.

For more information or to read the entire press release, please visit the Wisconsin Office of the Governor on the at **www.wisgov.state.wi.us**.

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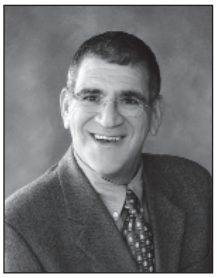
# *Florida Property Insurance: Elections Bring a Sea of Change*



*By Thomas J. Maida and Leonard E. Schulte*

In the decade and a half since Hurricane Andrew, the Florida property insurance market has been in a state of almost constant crisis. Legislative and regulatory efforts to address the crisis have focused primarily on five areas: creating incentives to draw new insurance capital to the state; creating a state fund to provide a stable and inexpensive supply of catastrophic reinsurance for residential property insurers; creating a property insurer of last resort to assure availability of residential coverage throughout the state; providing increased regulatory control over property insurance rates, coverages, and claims practices; and providing incentives for more hurricane-resistant construction.

Legislation enacted in 2006 concentrated on efforts to reduce the potential for assessments on property insurance premiums by bolstering the financial soundness of the residual market and efforts to increase the commitment of private capital to Florida.[1]

However, within a matter of months after enactment of the 2006 legislation, affordability of property insurance became the dominant issue in the campaigns for governor and other statewide offices, and in many legislative campaigns. Premiums had increased dramatically for many homeowners because of the volatile mix of rapidly rising property values and rate increases attributable to the sharply higher reinsurance costs that followed the 2004 and 2005 hurricane seasons. Floridians elected a self-described populist governor and a Florida Legislature that made property insurance rate relief its top priority.

The Legislature moved quickly after the new governor was sworn in. The presiding officers called a special session for January 16 – 22 to address property insurance rates and related issues. The result of the special session was HB 1A, a 167-page bill[2] that shifted the state's emphasis away from rebuilding a competitive private market and toward rate relief for property owners. The Governor signed the act on January 25, and it took effect immediately. Five days later, the Governor and Cabinet, sitting as the Financial Services Commission, adopted an emergency rule[3] freezing personal lines residential rates and prohibiting nonrenewals and cancellations. Further actions are expected during the 60-day regular session of the Legislature, which begins on March 6.

HB 1A should have its greatest impact on the Florida property insurance marketplace because of major changes in four areas: the Florida Hurricane Catastrophe Fund, rate rollbacks, the residual market, and the regulatory process.

### Florida Hurricane Catastrophe Fund ("Cat Fund")

The Cat Fund was established in 1993 to provide a layer of reinsurance coverage for all Florida residential property insurers. As constituted prior to the new law, the fund provided up to $16 billion in coverage for residential losses above an aggregate industry retention of $6 billion. All residential property insurers must participate in the fund. Companies pay premiums to the fund based on their exposures; Cat Fund premiums are generally considered to be roughly 20 percent to 30 percent of the price that the insurer would otherwise pay for comparable privately procured reinsurance.

The fund is exempt from federal taxation and has the power to issue tax-free bonds. In the event of a deficit, the fund issues bonds and levies assessments on all Florida property and casualty premiums

except for workers' compensation premiums to provide a revenue stream to pay off the bonds. Assessments are capped at 6 percent with respect to a deficit attributable to a single contract year and 10 percent with respect to all deficits combined.

HB 1A adds several new layers of Cat Fund coverage, as follows:

1. Certain small insurers will be able to purchase up to $10 million of coverage with retention equal to 30 percent of the insurer's surplus, with pricing set at 50 percent. This authorization applies only to the 2007 contract year.

2. Optional coverage below the standard Cat Fund retention: The standard Cat Fund retention for the 2007 contract year will be the insurer's share of $6 billion. An insurer will have the option of lowering its retention to its share of $3 billion, $4 billion, or $5 billion, with pricing set at 85 percent for the $3 billion option, 80 percent for the $4 billion option, and 75 percent for the $5 billion option. These optional coverages will be available for the 2007, 2008, and 2009 contract years.

3. Optional coverage in excess of the standard Cat Fund cap: An insurer will have the option of purchasing additional coverage in excess of the maximum standard Cat Fund payout, up to the insurer's share of an additional $12 billion (or the insurer's share of an additional $16 billion if the additional coverage is authorized).[4] The pricing for these additional layers of coverage will be based on the average annual loss for the layers. Current Cat Fund estimates are that the $12-billion layer will be priced at a rate on line of 2.32 percent and the additional $4 billion layer if authorized will be priced at a rate on line of 1.6 percent. As with the optional lower retention coverage, these optional coverages will be available for the 2007, 2008, and 2009 contract years.

**Rate Rollback**

During the conference committee deliberations on HB 1A, frequent reference was made to the fact that the actual premium savings to consumers would vary depending on their location and their insurer; legislative negotiators recognized that each insurer will realize a different level of savings when the new, optional Cat Fund coverage replaces private reinsurance. As an example, a document released by the House majority whip's office on the day of the final vote on HB 1A showed expected average savings of seven percent on the total premium (19 percent on the windstorm portion of the premium) for State Farm policyholders and expected average savings of 21.8 percent (43.1 percent on the windstorm portion) for policyholders of other insurers.

As enacted, HB 1A calls for the insurance regulator to calculate a "presumed factor" that all insurers must apply to their rates to reflect the Cat Fund changes, regardless of whether or not they actually purchase the optional Cat Fund coverage and regardless of how the cost of the new Cat Fund coverage compares to what the insurer would have paid for the reinsurance the new Cat Fund coverage replaces.

**Citizens Property Insurance Corp.**

Citizens Property Insurance Corp. is Florida's property insurer of last resort. It was formed in 2002 by the merger of two state-created insurers, one of which had written windstorm-only coverage in certain high-risk areas starting in the early 1970s, and the other of which was formed in the wake of Hurricane Andrew to provide residential property insurance coverage throughout the state. Citizens and its predecessors had been subject to strict eligibility requirements that limited eligibility to property owners who were not able to procure coverage from licensed insurance companies at any price. Citizens was also subject to ratemaking standards that required it to charge non-competitive rates pegged to the highest rates in the market.

The thrust of HB 1A was to move toward lower rates for Citizens and to establish it as a competitor with the private sector, rather than an insurer of last resort. In addition, all property and casualty premiums except for workers' compensation and medical malpractice will now be subject to Citizens' deficit assessments; prior law applied assessments only to personal lines and commercial property premiums.

More specifically:

Citizens' rates will be set by the Office of Insurance Regulation without any avenue of appeal from the regulator's decision. Citizens' rates must be actuarially sound, but will no longer be subject to other statutory rate standards, including the requirements that rates be non-competitive, that rates be at least as high as the highest rates of leading voluntary market insurers on a county-by-county basis, and that rates be based on specified probable maximum losses.

Eligibility standards related to Citizens' status as an insurer of last resort have been rescinded, except that an applicant for new Citizens coverage will be ineligible if he receives an offer of coverage from a private sector company at a rate no higher than 125 percent of the Citizens rate. Citizens will also be able to write full homeowners' policies in areas where it now writes windstorm-only policies. These changes will enable Citizens to compete for business currently in the private sector.

**Regulatory Changes**

HB 1A substantially increases the regulatory burden on insurers. Among other things, the new law:

- Suspends through year-end 2008 an insurer's ability to use arbitration as an alternative to an administrative challenge of the regulator's action on a rate filing
- Requires an insurer to refund excess profits, based on a 10-year average of actual profits vs. profit levels in approved rate filings
- Requires the CEO or CFO of a property insurer and the chief actuary to swear under oath to the truthfulness of material information in a rate filing
- Requires property insurers to pay or deny a claim within 90 days after receiving notice of the claim
- Increases the notice period for property insurance nonrenewals and cancellations, and requires that if the nonrenewal or cancellation is to take effect between June 1 and November 30, the notice must be sent by the earlier of June 1 or 100 days prior to the effective date of the nonrenewal or cancellation
- Requires an insurer that writes private passenger auto in Florida and residential property insurance in any other state to also write residential property insurance in Florida. This requirement will take effect on January 1, 2008
- Increases the minimum surplus required to form a new property insurer to $50 million if the new insurer is a subsidiary of another insurer

**Self-Insurance, Deductibles, and Coverage Waivers**

The new law contains several options for self-insurance. Local governments, hospitals, condominiums, and corporations not for profit will be able to form self-insurance funds for property insurance coverage. In the case of public hospitals, the self-insurance fund may also have bonding authority.

Individual property owners will be able to assume more of a loss through higher deductibles and through coverage waivers. Prior law capped residential property deductibles at 10 percent of the insured value; the new law has repealed this cap. However, with respect to properties insured for $500,000 or less, the insured may assume a deductible in excess of 10 percent only with a personally written waiver and with the consent of the lienholder.

A property owner may also reject windstorm coverage entirely. As with the high deductibles, the rejection of windstorm coverage is available only with the property owner's personally written waiver and the consent of the lienholder. A property owner may also reject coverage for personal property.

**Emergency Rule**

On January 30, the Governor and Cabinet, sitting as the Financial Services Commission, adopted Emergency Rule 69OER07-1 for the stated purpose of preventing certain insurer actions prior to the effective date of rolled-back rates. Emergency rules remain in effect for 90 days.

The emergency rule requires that rates for residential property coverage must remain at the rates that were in effect on January 25 until the insurer makes, and the regulator approves, a rate filing reflecting the presumed factor (see "Rate Rollback," above). The emergency rule also prohibits any nonrenewal or cancellation[5] of a personal lines residential property policy until the insurer makes a rate filing reflecting the presumed factor. Although this portion of the rule refers only to the making of the rolled-back filing, and not to its approval, it should be assumed that the prohibition, like the rate freeze language, applies until the rolled-back rate is approved.

**Potential Issues for the Regular Legislative Session**

The 60-day regular legislative session began on March 6. Property insurance is likely to remain a dominant issue. These are some of the issues that may attract further legislative attention:

- Linkage of auto and property writings. The linkage language in HB 1A takes effect in 2008, and many observers view it as a mere placeholder. During the special session, the governor circulated language that would have set a required ratio of auto writings to property writings for auto insurers who write any property coverage anywhere. This issue, which he referred to as "cherry picking," was a centerpiece of the governor's 2006 campaign.
- Moratorium on nonrenewals. The Governor has advocated a four-year moratorium on residential property nonrenewals, with extremely limited exceptions. The House had proposed a complete moratorium on nonrenewals taking effect during the hurricane season. It is reasonable to expect some further action on nonrenewals.
- Subsidiary companies. Another key campaign issue for the governor was his proposal to prohibit insurers from creating or maintaining Florida-only subsidiaries. As with "cherry picking," the public and many in the media believe that this practice drains profits from Florida and results in higher rates.
- Ratemaking. Further action on ratemaking is possible if elected officials or the public are dissatisfied with the size or pace of the rate reductions mandated by HB 1A.

No one can predict with certainty the future of Florida's property insurance market. Further legislative action later this year is likely. Insurers and reinsurers will evaluate state

government's response to the property insurance situation, and each will adjust its business plan according to its view of the future. Of course Mother Nature will have her say, as well. A few unexpectedly quiet hurricane seasons could help stabilize private insurance markets. A single catastrophic windstorm could lay waste to the best-laid plans of the Governor and Legislature. And Florida's governmental leaders will ride out the 2007 hurricane season with one eye glued to the Weather Channel and the other eye fixed on CNBC, hoping they've made good choices for Florida's ailing property insurance market.

[1] See "Florida Legislature Passes Massive Property Insurance Bill," *FOCUS on the Insurance Industry*, Summer 2006.

[2] HB 1A as enacted is available online at http://www.flsenate.gov/data/session/2007A/House/bills/billtext/pdf/h0001A03er.pdf .

[3] Emergency Rule 69OER07-1 is available online at http://www.floir.com/pdf/69OER7-1_ER.pdf.

[4] The extra $4 billion in coverage may be offered only if authorized by the State Board of Administration (governor, Chief Financial Officer, and attorney general) and approved by the Legislative Budget Commission (a joint legislative committee).

[5] Except for cancellations based on fraud, material misrepresentation, or nonpayment of premium.

## *Federal Court Expands Participant Rights to Sue Insurer-Administrators of Health Care Plans*

*By John N. Gavin*

A recent federal court decision has concluded that a participant in a self-insured ERISA health plan has standing to sue the plan's insurer-administrator for breach of fiduciary duty and for monetary relief on behalf of the plan, regardless of whether the plaintiff can show that he personally suffered or will suffer a concrete injury as a result of the administrator's alleged misconduct. This holding, if upheld and followed, arguably expands the rights of participants to seek redress on behalf of the ERISA plan and could result in a substantial increase in the number of actions brought against ERISA plan fiduciaries.

In *Deluca v. Blue Cross & Blue Shield of Michigan*[1], the plaintiff filed a class action lawsuit against Blue Cross and Blue Shield of Michigan ("Michigan Blue Cross"). In this case, Michigan Blue Cross administered a self-funded health benefit plan sponsored by a bank that employed the plaintiff's spouse. Plaintiff alleged that Michigan Blue Cross obtained the agreement of certain hospitals to accept lower payments from an HMO operated by Michigan Blue Cross in exchange for higher payments from self-funded ERISA plans administered by Michigan Blue Cross. Plaintiff claimed that the self-funded plan of which he was a participant accordingly paid excessive reimbursement rates and that the participants and beneficiaries of his plan paid excessive contributions, deductibles and/or co-payments.

It was unquestioned that plaintiff (as a participant in the plan) had a statutory right under ERISA to bring the action against Michigan Blue Cross. Michigan Blue Cross, however, argued on the basis of prior court decisions that the plaintiff lacked the requisite standing under Article III of the U.S. Constitution to pursue the claim. The U.S. Supreme Court has held that Article III requires, as a minimum, (1) that the plaintiff has suffered an "injury in fact," i.e., the invasion of a legally protected interest that is (a) concrete and particularized and (b) actual or imminent, (2) a causal connection between the alleged misconduct and the injury and (3) a likelihood that the injury can be redressed by a favorable decision.[2] Michigan Blue Cross argued that plaintiff could not meet these requirements because (1) plaintiff had not incurred any greater costs on account of the alleged fiduciary violations (particularly since he enrolled as a beneficiary only seven days before the lawsuit), and (2) plaintiff could not establish a casual connection between the alleged misconduct and any alleged increase in monthly benefit contributions, coinsurance payments or deductibles.

Other federal courts, in prior decisions, have been unwilling to allow a plaintiff to proceed under such circumstances. They have noted that it is uncertain whether either the harm suffered by the plan or the relief obtained by the plan would affect the individual participant or beneficiary personally. In *Central States Southeast v. Merck-Medco*[3], the 2nd Circuit stated that the financial impact of an over-costly drug plan "would in all probability" not affect individual plan participants unless they had purchased drugs based on percentage coinsurance payments. And in *Glanton v. AdvancePCS*[4], the 9th Circuit stated that plan participants in an allegedly over-costly drug plan could not show a likelihood that a favorable outcome would provide relief for them, because nothing would force the plans to reduce the participants' contributions or co-payments, "nor would any one-time award to the plans for past overpayments inure to the benefit of participants."

In *Glanton*, the 9th Circuit rejected the plaintiff participants' contention that they had standing on the ground that they could not show a likelihood that a recovery by the plan would result in a benefit to them[5]. In *DeLuca*, the district court similarly noted that the plaintiff participant could not show that a financial injury to the plan had caused any injury to himself and noted that the plaintiff accordingly could not have sued if he were seeking a monetary recovery on behalf of himself.[6]

The 9th Circuit in *Glanton*, however, also rejected the plaintiffs' contention that they had standing solely as representatives of

the plan.[7] On this question, the district court in *DeLuca* expressly declined to follow *Glanton*. The court allowed the plaintiff to seek full ERISA remedies on behalf of a plan, "regardless of whether he can show that he personally suffered or will suffer a concrete injury" as a result of the alleged misconduct.[8] In so doing, the court relied on (among other things) a Supreme Court decision holding that Congress can grant standing to sue for generalized harm where the courts otherwise would deny standing under Article III (while recognizing that Article III standing requirements remain)[9] and on ERISA statutory provisions allowing a plaintiff to seek recourse on behalf of a plan. The courts thus seem divided on the question of whether a plan's participant or beneficiary may sue to recover monetary relief on behalf of a plan, where the participant or beneficiary cannot show that he or she has suffered a concrete injury. Further litigation (perhaps up to the Supreme Court) may be necessary to fully resolve this question.

If the *DeLuca* approach is upheld and followed, plan fiduciaries may face more claims of plan participants who no longer need to show an "injury in fact" to themselves. The courts in such situations must then resolve the substantive issues presented — which in *DeLuca* includes an interesting and yet unresolved issue regarding the fiduciary obligations of an insurer–administrator providing services to ERISA plans. The courts may also have to face other issues which they have thus far sought to avoid — such as the measure of the harm to the plan and its beneficiaries.

[1] 2007 U.S. Dist. LEXIS 5698 (E.D. Mich. January 25, 2007).
[2] *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).
[3] 433 F.3d 181, 202-03 (2d Cir. 2005).
[4] 465 F.3d 1123, 1125 (9th Cir. 2006).
[5] Id. at 1125.
[6] 2007 U.S. Dist. LEXIS 5698, supra, at *15.
[7] 465 F.3d at 1125-27.
[8] 2007 U.S. Dist. LEXIS 5698, supra, at *12-16.
[9] *Warth v. Seldin*, 422 U.S. 490, 499-501 (1975).

## *Non-Profit Health Care System Captives: Is Your Captive an "Insurance Company" and Do You Want It to Be?*

*By Kevin G. Fitzgerald*[1]

A captive insurance company is, for larger organizations, one of many "alternative risk transfer" vehicles.[2] It can provide a variety of benefits if structured and operated properly. The basic premise for a single parent captive is that it is a form of self–insurance. Thus, it is certainly not for everyone. Only those organizations that have the requisite financial where-with-all as well as the skill to manage a self–insurance program should consider the use of such a captive.

The strategic reasons behind the use of a captive include: better financial management, improved claims management, more effective loss prevention and risk management, and customized insurance programs. Before establishing a captive, an organization should conduct a thorough review of the fundamental underpinnings of a captive. The factors to be considered include: predictable and controllable losses, available and cost effective reinsurance, effective risk control, adequate capitalization, a long-term commitment, and a method to exit the captive structure when desired.

One of the potential advantages to utilizing a captive insurance company over a traditional self-insurance program is the possibility to accelerate certain tax deductions. In a typical self-insurance program, money that is set aside, or "reserved," for a future claim payment is not deductible until the loss is paid.[3] This is true even for known claims that have already been incurred. On the other hand, premiums paid for "insurance" are deductible when paid. Section 1.162-1(a) of the Income Tax Regulations provides that certain insurance premiums are included as deductible "ordinary and necessary" business expenses.[4] However, the terms "insurance" and "insurance contract" are not defined by the Internal Revenue Code, but rather have been defined by the U.S. Supreme Court to include the presence of both risk shifting and risk distribution.[5] Over the years, the IRS has had different ideas of what constitutes risk shifting and risk distribution.

Under the definition set forth by the Supreme Court in 1941, risk shifting and risk distribution are the primary requirements for insurance.[6] Beginning in 1977, the IRS adopted the "economic family" theory, under which a parent corporation and its subsidiaries do not shift risk or distribute risk to an affiliated captive if the ultimate burden of loss is retained by the same economic family that may suffer a loss.[7] As a consequence, the IRS concluded that "when there is no economic shift or distribution of the risk 'insured,' the contract is not one of insurance, and the premiums therefore are not deductible under section 1.162-1(a) of the regulations."[8] The premium payments were not treated as payments for insurance, but rather as capital contributions under Section 118. Moreover, the related captive insurer was not treated as an insurance company if its primary and predominant business activity was insuring or reinsuring the risks of related parties. In sum, the IRS maintained the position that there can be no risk shifting or risk distribution unless the economic burden of loss is transferred outside the economic family.[9] The IRS's economic family theory was never adopted by the courts,[10] and the IRS finally abandoned it on June 5, 2001.[11]

On December 11, 2002, the IRS issued three new revenue rulings on the qualification of captives as insurance companies for federal tax purposes: Revenue Rulings 2002-89, 2002-90, and 2002-91.[12] The rulings focus on risk shifting and risk

distribution under parent-subsidiary, brother-sister arrangements, and group captive insurer arrangements.

- Revenue Ruling 2002-89 addressed the deductibility of premiums in the parent-subsidiary captive arrangement by describing two scenarios. In one scenario the parent's premium is 90 percent of total premium and the parent's risk is 90 percent of total risk. Because the vast majority of the risk falls on the parent, this is not deemed insurance. In the second scenario, both the risk and the premium of the parent is less than 50 percent of the total risk, with the remainder of the risk coming from unaffiliated insureds. Here, because the parent risk and premium is less than 50 percent of total risk, it is insurance.[13]

- Revenue Ruling 2002-90 addresses the deductibility of premiums in the brother-sister affiliate captive arrangement. The IRS approved insurance company status where the risk insured of any one affiliate is no more than 5 to 15 percent of the total risk insured by the captive.[14]

- Revenue Ruling 2002-91 addresses the group captive arrangement. The ruling described a situation in which a relatively small group of unrelated businesses formed a captive to compensate for the unavailability of commercially available coverage. None of the group members had greater than 15-percent voting control of the captive or more than a 15-percent capital interest in the captive. No member's risk exceeded 15 percent of the total risk insured by the captive. The ruling also states that none of the owner/insureds was subject to additional premium assessments if losses exceed premium, no member was entitled to a refund if losses are less than premium, and premiums paid by any insured were available to cover losses of other insureds.[15]

Under the Internal Revenue Code, a corporation qualifies as an "insurance company" for a particular year if more than half of the corporation's business during that year consists of activities that, for federal tax purposes, constitute "insurance" (which, for this purpose, also includes reinsurance).[16] Thus, with the abandonment of the economic family theory and the guidance set forth in the new Revenue Rulings, as well as existing case law, the issue of what constitutes "insurance" for tax purposes has probably never been clearer.

Accordingly, most "for-profit" organizations with captive insurance companies work diligently to structure their captive insurance arrangements to satisfy the requirements outlined above in order for the transaction to constitute "insurance" and for the captive to be an "insurance company" under the Internal Revenue Code. For some, the tax advantages of the accelerated deductibility of losses may make the difference between the captive being an economically viable model or not.

But while having a captive meet the requirements for an "insurance company" can have tax advantages (i.e., the accelerated deductibility in the form of "premium" for an ultimate loss payment), there are tax costs associated with such a structure as well. These "costs" can include state premium taxes (owed by the captive insurance company, or more likely a licensed "fronting" company utilized as part of the captive program) and/or independent procurement taxes owed by the insured on the premium paid to the captive. For example, in California an "insured" that independently procures insurance is responsible for a "Nonadmitted Insurance Tax" of 3 percent of gross premium;[17] in Florida, this "independent procurement tax" is at a rate of 5.3 percent.[18] In addition to the state taxes, if the captive is established "off shore" in a jurisdiction without a tax treaty with the United States, and has chosen not to make a Section 953(d) election,[19] then the premium paid to the captive is also subject to a Federal Excise tax of 1 percent for reinsurance premium and 4 percent for direct insurance premium.[20] Thus, if the "insured" is headquartered in California and independently procures insurance from its off shore subsidiary, the insurance premium is taxed at 7 percent, and if in Florida, 9.3 percent.

If the captive is part of an organization that is not-for-profit, the tax costs associated with the captive being an insurance company (i.e., the 7 percent to 9 percent "sales tax") can greatly exceed any tax benefit (since there may very well be no tax benefit for a non-profit). In such a situation, it may be advantageous to establish the captive insurance program in such a way that it fails to meet the definitions for insurance under the Internal Revenue Code so that the captive is not an insurance company. Since the IRS no longer follows the economic family theory, the analysis of whether the captive insurance program satisfies the requirements of insurance must be based on the more recent revenue rulings and case law. Factors that can be utilized to take the captive program out of the insurance realm for tax purposes include: (1) using a thinly capitalized captive, (2) putting in place a parental guarantee behind the captive, (3) including no unaffiliated risk in the program,[21] and (4) using an insurance policy form that is 100-percent assessable (meaning there is no risk transfer).

One such non-profit health care system took this approach and others, following this lead, are restructuring their captive insurance arrangements in a manner to minimize the tax costs.[22] So back to the title, is your captive an insurance company, and do you want it to be?

[1] The author would like to thank Jamshed J. Patel and Ben S. Thomas for their assistance in preparing this article.

[2] Other alternative risk transfer options include self–insurance, high deductible programs, retrospectively rated programs, along with a variety of "captive" programs, such as group captives, rent-a-captives (including segregated portfolio companies), and risk retention groups. The discussion in this article will focus on single parent captives, the most common type of captive insurance company.

[3] 26 C.F.R. § 1.461-1 (2006).
[4] 26 C.F.R. § 1.162-1 (2006).
[5] *Helvering v. Le Gierse*, 312 U.S. 531 (1941).
[6] Id.
[7] Rev. Rule 77-316, 1977-2 C.B. 53.
[8] Id.
[9] Id.
[10] See, e.g., *Humana, Inc. v. Comm'r*, 881 F.2d 247 (6th Cir. 1989).
[11] Rev. Rul. 2001-31, 2001-1 C.B. 1348.
[12] Rev. Rul. 2002-89, 2002-2 C.B. 984; Rev. Rul. 2002-90, 2002-2 C.B. 985; Rev. Rul. 2002-91, 2002-2 C.B. 991.
[11] Rev. Rul. 2002-89, 2002-2 C.B. 984.
[12] Rev. Rul. 2002-89, 2002-2 C.B. 984; Rev. Rul. 2002-90, 2002-2 C.B. 985; Rev. Rul. 2002-91, 2002-2 C.B. 991.
[13] Rev. Rul. 2002-89, 2002-2 C.B. 984.
[14] Rev. Rul. 2002-90, 2002-2 C.B. 985.
[15] Rev. Rul. 2002-91, 2002-2 C.B. 991.
[16] I.R.C. §§ 831(c), 816(a) (2006).
[17] Section 13210, Cal. Rev. & T. Code (2006).
[18] Fla. Stat. § 626.938(3) (2006).
[19] A 953(d) election is an election made by the off shore captive to be taxed as a US taxpayer. There are many situations in which this can be an advantageous election.
[20] I.R.C. § 4371 (2006).
[21] The addition of unaffiliated risk is something quite commonly done to ensure that a captive satisfies the requirements of being an insurance company.
[22] I.R.S. Priv. Ltr. Rul. 2005-18-010 (May 6, 2005).

# *D&O Insurance: The Stand-Alone "Side A" Dilemma What Is It (And Do We Need It)?*

*By Ethan D. Lenz*

**Background**

The typical directors and officers (D&O) insurance program for a publicly traded company contains three types of coverage, or "insuring agreements," in one policy. These coverages are often referred to as Side A, Side B and Side C (or Entity) coverage. In recent years, there has been a trend for directors to demand, and companies to also purchase, additional stand-alone, Side A Coverage for their directors and officers.

Based on our experience, coverage provided under Side A is often misunderstood, or at least not clearly understood, by directors, officers and the risk managers or other persons charged with insurance purchasing decisions at the company. This article attempts to provide some insight as well as specific questions that can be used as a starting point to determine if additional Side A Coverage is appropriate for your circumstances.

**Structure of a Typical D&O Insurance Program**

As noted, the typical D&O insurance program contains three coverages (including Side A) under one policy. In short, these coverages are:

1. Side A — Coverage for both defense expenses and payments of settlements/judgments that arise from claims brought against directors and officers, when those costs cannot be indemnified by the company. Usually, no retention (deductible) applies to Side A coverage. Therefore, it affords protection against individual directors and officers having to use their own resources to pay the costs of any claims for which they are not indemnified by the company. In essence, Side A coverage provides the final layer of protection for an individual director's or officer's personal assets from the plaintiff(s) in a claim.

2. Side B — This is also often referred to as "company reimbursement" coverage. It reimburses the company for the costs of paying claims against individual directors and officers when the company is permitted, or required, to indemnify them. Because the majority of claims against directors and officers are eligible for indemnification, Side B typically is the primary coverage under which payments are made under a D&O insurance policy.

3. Side C/Entity Coverage — This provides coverage for claims when the company itself is a defendant in the claim. For publicly traded companies, it typically only provides coverage for securities-related claims. For example, if a securities-related lawsuit names both the company and individual directors/officers as separate defendants, Side C coverage will come into play for any defense costs and/or judgments or settlements that are attributable to the company's separate alleged liability. Conversely, if a policy does not include Side C coverage, any amounts allocated to the company's defense or ultimate liability in that claim would not be covered by the policy.

**Typical Claims Situations Triggering Side A Coverage**

As discussed in the preceding section, "traditional" Side A Coverage is only triggered if the company cannot indemnify the directors and officers for a claim. Usually, this involves one of the following circumstances:

1. The claim is in the form of a derivative action, brought on behalf of the company, and state law prohibits the company from indemnifying defense costs or settlements/judgments arising from derivative actions.

2. The company is insolvent and, therefore, cannot indemnify the directors and officers.

In addition to these situations, a number of insurers offer stand-alone Side A policies, often referred to as "Side A DIC" or "Difference in Conditions" policies which profess to offer coverage in other situations, such as where the primary D&O insurers wrongfully refuse to provide coverage, where exclusions in the primary D&O insurance program preclude coverage or where the primary D&O insurance program has either been exhausted or rescinded. These types of policies vary widely with respect to the scope of coverage that they provide, and they should be carefully reviewed by a specialist in D&O coverage to ensure that they offer the coverage they purport to offer.

**Questions to Determine If Stand-Alone Side A Is Appropriate**

As is the case with all D&O insurance, one size never fits all. Therefore, while additional Side A coverage may be highly desirable in some situations, it may be less desirable in others. To help determine whether additional Side A coverage is appropriate for your company's individual directors and officers, you can start by asking the following questions:

1. **How do the limits of the company's primary (Side A, B and C) D&O insurance program compare to others in its peer group?**

   A number of reputable organizations publish studies showing the limits of D&O insurance carried by publicly traded companies. These are typically broken down by several different demographic factors, including industry, market cap and revenues. Your company's insurance broker should have this information readily available. This "benchmarking data" is a useful starting point, as it shows where the company's limits stand in comparison to other companies in its peer group. If the company's limits are significantly below those of other companies in its peer group, additional Side A limits (or additional Side A, B and C limits) may be appropriate.

2. **Does the company's primary D&O insurance program contain an "Order of Payments" provision?**

   One of the traditional selling points of stand-alone Side A coverage is that it provides dedicated limits for the individual directors and officers. As discussed previously, most primary D&O insurance programs include Side A, B and C coverage in one policy. Therefore, directors and officers share the limits of the policy with the company. If the company's indemnification obligations, or its separate liability, deplete the limits of insurance under the Side B and C coverage, this can leave the individual directors and officers "bare."

   Despite the preceding, the problem of individual directors and officers being left bare by depletion of the policy's limits under Sides B and C can be significantly reduced if the primary D&O insurance program contains an appropriate "Order of Payments" provision. In general, such a provision will provide that, in all claims situations, any payments due under Side A must be made before the company is reimbursed or otherwise receives any coverage under Sides B and C. Thus, the "Order of Payments" provision can largely have the effect of dedicating the primary D&O insurance program limits to the individual directors and officers, at least as they relate to any particular claim.

3. **Is the Side A coverage in the company's primary D&O insurance program fully non-rescindable and/or does the coverage have strong severability language for application misrepresentations?**

   Another selling point of many stand-alone Side A insurance policies is that they are non-rescindable. That is, once they are written, the insurer cannot later look for misrepresentations in the application to void the coverage. This can be an important feature, as it avoids the situation where the coverage is seemingly in place, but "disappears" when a claim arises and the insurer discovers an alleged misrepresentation in the policy application. However, many insurers have recently begun to alleviate this potential problem in primary D&O insurance coverage by offering Side A, B and C policies that include non-rescindable Side A coverage.

   In addition to the preceding, if the company's primary D&O insurance program includes a favorable "severability" provision relative to application misrepresentations, this can alleviate much of the potential for rescission of the individual directors' and officers' coverage at the time of a claim. Such a provision should essentially provide that, in the event the application contains any misrepresentations, the policy can only be rescinded as to those individual directors and officers who knew the misrepresentation existed in the application. In this regard, it should be noted that the provisions relative to application misrepresentations and severability vary widely among insurers, and seemingly small differences in language can lead to significantly different coverage consequences. Accordingly, these provisions should be carefully reviewed by a professional who is well-versed in D&O insurance coverage.

4. **Does state law allow the company to indemnify you for costs arising from derivative actions?**

   Both the number of derivative actions and the costs of resolving those actions have risen in recent years. For this reason, it is important to know whether state law in the company's state of domicile allows the company to

indemnify individual directors and officers for both defense costs and settlements/judgments related to derivative actions. If state law does not allow such indemnification, or places burdensome restrictions on such indemnification, it increases the likelihood that individual directors and officers will need Side A coverage for costs that are not indemnified. In turn, this increases the desirability of additional Side A coverage.

5. **Does the company have a strong and stable balance sheet?**

   Because insolvency is one of the primary instances where Side A coverage might be triggered, it is important to understand the current strength, and the likely ongoing stability, of the company's balance sheet when evaluating the need for additional stand-alone Side A coverage. Of course it is always difficult to predict what the balance sheet will look like at the time a claim is actually filed, but the more volatile the balance sheet, typically the more attractive Side A coverage becomes for the individual directors and officers.

**Conclusion**

The preceding questions and their potential answers are not meant to be an exhaustive list of all considerations that should go into the decision-making process regarding stand-alone Side A insurance coverage. However, they provide a good starting point for evaluating whether or not your company should further explore the purchase of stand-alone Side A coverage. Other considerations that should be kept in mind include the fact that stand-alone Side A coverage typically commands premiums in the range of 70 percent to 80 percent of the premium for the same limits of Side A, B and C coverage, despite the more limited circumstances in which it typically responds. Additionally, if the decision is made to purchase stand-alone Side A coverage, it should always be kept in mind that these policies vary widely in the coverage that they provide. The policies should be carefully reviewed and heavily negotiated to ensure that they provide the broadest protection for the personal assets of individual directors and officers.

# *Preserving Privilege in Reinsurance Audits*

*By Brett H. Ludwig and Eric L. Maassen*

Virtually every reinsurance treaty includes an audit clause, granting the reinsurer access to the ceding company's records. Reinsurers routinely invoke the clause to conduct periodic audits and to monitor claims that are likely to cause significant losses to the reinsurer.

Allowing access to claims files, in particular, raises important issues of attorney client privilege and work product. A ceding company's claims file will almost always contain privileged materials. The application of the age-old rules of privilege to a reinsurer's audit rights is not always considered. But privilege issues warrant caution. This article discusses the applicability of privilege to reinsurer audits, the danger of waiving privilege, and a potential solution to satisfy both reinsurer and ceding company.

1. A reinsurer generally does not have the right to access privileged documents.

   In an audit, the reinsurer typically will want to review claims files to assess the cedent's claims handling, evaluate its exposure, and decide whether to invoke its right to associate in the defense of particular claims. The claims file will almost always contain correspondence between the insurer and defense counsel. The attorney client privilege and work product doctrine ordinarily protect this correspondence and similar documents from disclosure to third parties.

   These standard privilege principles apply equally to documents reviewed in a reinsurance audit. Courts have expressly held that a basic audit clause does not trump the longstanding rules of privilege. Accordingly, ceding companies can (and perhaps should) deny reinsurers access to privileged materials. See *Gulf Ins. Co. v. Transatlantic Reinsurance Co.*, 788 N.Y.S.2d 44 (N.Y. App. Div. 2004); *North River Insurance Co. v. Philadelphia Reinsurance Corp.*, 797 F. Supp. 363 (D.N.J. 1992); see also Modern Reinsurance Law and Practice § 6.04 (citing

*North River Insurance Co. v. Philadelphia Reinsurance Corp.*, 797 F. Supp. 363 (D.N.J. 1992); *United States Fire Ins. Co. v. Phoenix Assurance Co.*, No. 7712/91 (N.Y. Sup. Ct. N.Y. County Aug. 18, 1992), aff'd, 598 N.Y.S.2d 938 (App. Div. 1st Dep't 1993).

In *Gulf Ins. Co. v. Transatlantic Reinsurance Co.*, 788 N.Y.S.2d 44, 45 (N.Y. App. Div. 2004), the New York appellate division confirmed that a standard access-to-records clause does not affect the cedent's privilege rights. There, the ceding company, Gulf Insurance Company (Gulf), had purchased quota share coverage from Transatlantic Reinsurance Company (Transatlantic) and other reinsurers. *Id.* The treaties contained a boilerplate, and seemingly broad, access-to-records clause. *Id.* ("the Reinsurers ... will have the right to inspect ... all records of the [cedent] that pertain in any way to this Agreement.") When Gulf asked for contribution from Transatlantic on a significant settlement, the reinsurer asked to see Gulf's files, including its communications with counsel. *Id.* When Gulf asserted privilege, Transatlantic refused to pay and litigation ensued. *Id.*

During the subsequent lawsuit, the trial court ruled that the reinsurer was entitled to access, regardless of privilege. *Id.* The appellate court reversed, ruling that "[a]ccess to records provisions in standard reinsurance agreements, no matter how broadly phrased, are not intended to act as a per se waiver of the attorney-client or attorney work product privileges." *Id.* at 45-46.

A similar result was reached in a prominent federal court decision on this issue. In *North River Insurance Co. v. Philadelphia Reinsurance Corp.*, 797 F. Supp. 363, 368 (D.N.J. 1992), the parties fought over access to privileged documents under a broad access-to-records clause that required the ceding company to provide the reinsurer with "any of its records relating to this reinsurance or claims in connection therewith." When the ceding company refused to disclose communications with its underling claims counsel from an underlying arbitration, the reinsurer sought court relief. *Id.* at 366.

The court upheld the assertion of privilege. *Id.* at 369. According to the court, so long as the cedent has been "forthright in making available to its reinsurer all factual knowledge or documentation in its possession relevant to the underlying claim or the handling of that claim, it has satisfied its obligations." In addition, the court rejected the reinsurer's argument that reinsurance industry custom was to allow access, calling industry practice "irrelevant." *Id.*

2. The failure to assert privilege risks waiver.

   Under Gulf and North River, the legal framework would seem to be clear. A ceding company has the right to deny access to privileged materials. But, having a right and exercising it are two different things. What if the reinsurer refuses to pay unless and until it gains access? And given the time, effort, and costs associated with combing through a claims file to remove privileged documents, shouldn't the ceding company simply allow access? A ceding company that fails to assert privilege faces a potentially larger problem.

   Consistent with the ordinary rules of privilege, courts have held that, by allowing a third party, like a reinsurer, access to files that contain privileged documents, a party waives its right to assert privilege. See *Massachusetts Bay Ins. Co. v. Stamm*, 700 N.Y.S.2d 707 (N.Y. App. Div. 2000) (affirming determination based on transmission of documents to reinsurers); but see *Employer Reinsurance Corp. v. Laurier Indemnity Co.*, No. 8:03CV1650T266MSS, 2006 WL 532113 (M.D. Fla. March 3, 2006) (finding no waiver).

   This is a significant risk. The waiver can extend not only to the reinsurer, but also to all other third parties — including parties in litigation with the ceding company. This can be especially troublesome where a reinsurer demands access while the underlying claim is still active. By allowing the reinsurer access, the ceding company risks opening up its defense counsel's thoughts on the strengths and weaknesses of its case and his communications with the company on strategy to the underlying claimant. A clever plaintiff's lawyer could succeed in obtaining a gold mine in discovery, — increasing the likely payout on the claim. This is something both the reinsurer and ceding company would want to avoid.

   A finding of waiver is not a certainty, however. Reinsurers and ceding companies often assert the "common interest" doctrine. At its narrowest, the doctrine provides that parties represented by the same counsel can share information in their "common interest" without risking waiver of privilege. See *North River Ins. Co. v. Columbia Cas. Co.*, 1995 WL 5792 at *2-3 (S.D. N.Y. Jan. 5, 1995). At its broadest, the doctrine can apply to parties with separate counsel so long as it is limited to communications in regard to which they share a joint legal interest. *Id.*

   In *Durham Indus. Inc. v. North River Ins. Corp.*, No. 79 Civ. 1705, 1980 U.S. Dist. LEXIS 15154, 1980 WL 112701 (S.D.N.Y. Nov. 21, 1980), the court held that an insurer and reinsurer shared a common interest in a dispute over a surety bond. According to the court, a "community of

interest exists among different persons or separate corporations where they have an identical legal interest with respect to the subject matter of a communication between an attorney and a client concerning legal advice." *Id.* Because the parties both had liability with regard to the bond, their interests were identical. *Id.* The fact that the parties were not represented by the same counsel did not affect the result. *Id*; see also *Aetna Cas. & Surety Co. v. Certain Underwriters at Lloyds*, 176 Misc. 2d 605, 676 N.Y.S.2d 727 (N.Y. App. Div. 1998) (upholding common interest doctrine between reinsurers and ceding company).

But not all courts agree that this doctrine applies to reinsurers and ceding companies. In *Allendale Mutual Ins. Co. v. Bull Data Systems, Inc.*, 152 F.R.D. 132, 134 (N.D. Ill. 1993), for example, the court declined to apply the work-product privilege to documents exchanged between Allendale and its reinsurers concerning an underlying claim for a destroyed warehouse. The court viewed the information exchange as an ordinary business practice. *Id.* at 139-40. The "mere contractual relationship" between the insurer and its reinsurers was not, in the court's view, sufficient to invoke the common interest doctrine. *Id.* at 141.

Similarly, in yet another case involving North River, the court in *North River Ins. Co. v. Columbia Cas. Co.*, No. 90 Civ 2518, 1995 WL 5792 at *2-5 (S.D.N.Y. Jan. 5, 1995), rejected application of the common interest doctrine where a reinsurer tried to invoke common interest to compel access to privileged materials. The court ruled that the reinsurer's "only argument for finding a common interest is that the two parties stand in the relation of reinsurer to ceding insurer, and that is insufficient."

The North River court went on to embrace a very fact-specific approach (which is thus hard to generalize to other situations). "What is important is not whether the parties theoretically share similar interests but rather whether they demonstrate actual cooperation toward a common legal goal." *Id.* "This rationale applies with even greater force in the reinsurance context. While a direct insurer may have a duty to defend its insured, thus implying some level of cooperation in litigation, no such duty is imposed on a reinsurer. And, as in the direct insurance context, the interests of the ceding insurer and the reinsurer may be antagonistic in some respects and compatible in others. Thus, a common interest cannot be assumed merely on the basis of the status of the parties." *Id.*

3. A Recommended Approach

The rule on whether allowing access to a reinsurer waives privilege is far from clear. A very good argument can be made that reinsurers and ceding companies have common interests in defending claims in which they will both share a portion of the loss. But, depending on your jurisdiction, judge, and factual circumstance, a different result could follow.

Without doubt, the safest legal approach is for the cedent to raise its privilege objection and deny the reinsurer access to privileged documents. This eliminates the risk of a waiver finding and of the disclosure of key legal strategies to aggressive plaintiff's counsel.

Of course, business considerations may counsel a different approach. A business person could reasonably think it foolish to deny access to the legal analysis of the merits of claims the reinsurer is being asked to indemnify.

If a ceding company decides to allow access, it would be wise to take all precautions possible to preserve privilege and to assert the common interest doctrine. A simple way to accomplish this is to require the reinsurer, prior to obtaining access, to sign what is commonly called a joint defense or common interest agreement. We have many samples of these on file and they can be easily and inexpensively drafted to fit particular audit circumstances.

A carefully drafted joint defense agreement will lay out in advance the bases for asserting that a common interest between ceding company and reinsurer exists. This better positions the parties to support their claims later should a waiver issue emerge. A well-drafted agreement can also help convince a court that the parties are not acting in hindsight to cover up an unintended waiver, but have previously and conscientiously considered the issue with the intent to protect against further disclosure.

## *Announcements*

### Successes

Partner **John Gavin's** article, "Irma Will Transform the Relationships Between Reinsurers and Receivers," was published in the Winter 2007 issue of the *Journal of Reinsurance*, Vol. 14, No. 1.

Partner **Wm. Carlisle Herbert** authored, "Seeking Equity in a Reinsurer's Obligations to an Insolvent Life Insurer: The Role of the Market Value Adjustment" which appeared in *Mealey's Litigation Report: Reinsurance* on December 7, 2006.

Mr. Herbert also authored, "FASB Proposes Bifurcation of Insurance Contracts," which appeared in the December 15, 2006 issue of *Insurance Finance & Investment*.

### Upcoming Presentations

Foley Partner **Brett Ludwig** will be moderating a session called "Structuring Claims Provisions on Right to Associate, Access to Records and Confidentiality" at the American Conference Institute's Third National Forum on Reinsurance Agreements. The conference will take place March 13 and 14, 2007 at the Flatotel Hotel in New York City.

Partners **Brett Ludwig**, **Eric Maassen**, and Senior Counsel **Brian Kaas** will be speaking at the 2007 Committee Rendezvous sponsored by the Brokers & Reinsurance Markets Association to be held March 25 – 27, 2007.

### Recent Speaking Engagements

On January 19, 2007, Partner **Richard Bromley** chaired a panel on the topic of "Risk Transfer Developments and Their Tax Implications," at the ABA Tax Section meeting in Hollywood, Florida.

Foley Partner and Chair of the Insurance Industry Team **Kevin Fitzgerald** and Robert D, O'Keefe, Vice President, Treasury Services & Chief Compliance Officer for Aurora Health Care, Inc. presented, "A Primer and Case Study on Alternative Risk Transfer Vehicles for Medical Professional Liability," at AMGA's 2007 Annual Conference on Saturday, March 3, 2007 at the Westin Kierland Resort & Spa in Scottsdale, Arizona.

Foley Partners, **Gordon (Chip) Davenport, III** and **Ethan Lenz** presented a session called, "D&O Insurance – Advanced Issues," at the firm's Sixth Annual National Director's Institute on March 8, 2007.



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