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LETTER FROM WASHINGTON

CAPTIVES CHALLENGED BY MASSACHUSETTS RULING

By Robert H. Myers, Jr.

Captive insurance has been a great benefit to risk managers and businesses that want to structure an efficient insurance program. Captive insurance regulation, however, has been a thorn in the side of some states and the NAIC because it deviates from the norm. A captive insurer is licensed in only one state, its state of domicile, and accordingly, does "the business of insurance" in only that state. Nonetheless, the risks of the captive's parent may be located in other states.

In the case of risk retention groups ("RRGs"), another alternative risk transfer structure, the states and the NAIC have worked hard to develop a regulatory structure which deals with this issue. This effort is enhanced by the Liability Risk Retention Act, 15 U.S.C. § 3901 et seq.,

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HASSETT'S OBJECTIONS

HEALTHCARE REFORM: IT'S THE FUNDING...

By Lewis E. Hassett

Few legislative enactments have generated the strong reactions of the Patient Protection and Affordable Care Act. In a nutshell, the Act seeks to expand care by: (a) requiring citizens to obtain private health insurance, (b) requiring insurers to provide coverage notwithstanding pre-existing conditions and without lifetime caps and with some limitations on the allocation of financial responsibility to insureds through deductibles and co-pays, (c) having the government subsidize the cost of insurance for those with income under a certain threshold and (d) reducing some Medicare reimbursements to providers as a means to offset the cost of the governmental subsidy.

The primary legal issue is whether the Commerce Clause authorizes the federal government to require individuals to purchase health insurance from private insurers. Because the issue is the *federal government's* power to mandate individual purchases of health insurance, the

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CAN YOU TRUST THE TRUSTEE?

By James W. Maxson

The majority of life insurance policies sold into the secondary market are owned by an irrevocable life insurance trust ("ILIT"). An ILIT is an irrevocable trust specifically designed to hold and own life insurance policies. Once the ILIT has been set up, ownership of the policy or policies is transferred to the trustee of the ILIT. The utility of an ILIT is that it will keep the proceeds of the life insurance out of the trust grantor's estate upon his or her death.

In the typical life settlement transaction, the trust agreement is reviewed to confirm the trustee possesses the authority to sell the policy out of the trust to a third party. Typically, that is the end of the inquiry, although some purchasers of policies demand the trustee execute a resolution or certificate affirming the trustee's authority to act

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Inside this Issue

HEALTHCARE REFORM REGULATORY ENVIRONMENT CONTINUES TO EVOLVE

By Chris Petersen and Joseph T. Holahan

Recent state actions concerning the Affordable Care Act ("ACA") highlight the tension between state and federal authority inherent in ACA's regulatory structure and bring into sharp relief the complex regulatory environment ACA has created for health insurers.

ACA gives the states a key role in implementing and enforcing its reforms, but states are free to opt out of this role if they so choose. Recently, uncertainty over ACA's constitutionality, along with concerns in some states about the goals and effects of reform, have cast doubt on just how much of a role the states will assume.

On February 1, 2011, the Florida Office of Insurance Regulation announced it would suspend implementation of ACA following a decision by the U.S. District Court for the Northern District of Florida striking down the law as unconstitutional. Officials in two other states have suggested they too may suspend implementation of ACA. The Florida lawsuit, brought by 26 states, and three similar lawsuits are now on a fast track to appeal.

On February 7, 2011, twenty-one Republican governors sent a letter to Health and Human Services ("HHS") Secretary Kathleen Sebelius stating they believe ACA "is seriously flawed." ACA, the governors stated, "threatens to destroy our budgets and perpetuate and magnify the most costly aspects of our healthcare system." For these reasons, the governors said, "we do not wish to be the federal government's agents in this policy in its present form." The governors stated that unless the Secretary would endorse a number of fundamental changes to ACA, they would not implement the state-based health benefit exchanges that are a key component of the law.

The rift between state and federal authorities over ACA illustrates the fragmented regulatory structure ACA embraces and highlights the potential for conflict among the various authorities tasked with implementing the law. Under ACA, health insurers have at least four regulators: state insurance departments, state and federal exchanges, HHS and the Internal Revenue Service ("IRS").

State Insurance Departments

Under ACA, state insurance departments retain their traditional authority over regulation of market conduct and solvency. States may enforce their own market reforms so long as they do not prevent the application of ACA requirements. In addition, subject to limited exceptions, the states are given primary authority to enforce ACA's insurance market reforms. Generally speaking, HHS may enforce ACA in a state only if the state notifies HHS it is not enforcing the law's requirements or if HHS makes an independent determination that the state is not substantially enforcing the law. This is the same structure that has been in place for years under the market reforms enacted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and similar federal

Announcements

Lew Hassett has been named a "Client Service All-Star" by BTI Consulting of Wellesley, Massachusetts. The designation is given to 318 attorneys nationwide and is based upon interviews with more than 2,800 in-house counsel. Lew also was recently selected as a 2011 Georgia Super Lawyer, as noted in *Atlanta* magazine.

Chris Petersen will be the next recipient of the Professional Insurance Marketing Association's ("PIMA's") President's Distinguished Service Award. The announcement was made during PIMA's 37th Annual Meeting in Aventura, Florida. Chris has been a long time member of PIMA and its Legislative & Regulatory Committee.

Skip Myers spoke on "The Regulation of Risk Retention Groups" on March 15, 2011, at the International Conference of the Captive Insurance Companies Association meeting in Tucson, Arizona.

Joe Holahan will speak on "The Future of Reinsurance Regulation" at the Reinsurance Basics: Demystifying Reinsurance Conference on May 9-11, 2011, in Chicago, Illinois.

Jim Maxson will speak on "Legal Risks in Life Settlement Portfolios" at the International Life Settlements Conference on May 11-12, in London.

Lew Hassett's and **Cindy Chang's** article titled "Bad Faith Allegations Versus an Insurer's Attorney-Client Privilege" was published in the December 2010 issue of the *Insurance Coverage Law Bulletin.*

Joe Holahan spoke on "Developments in Healthcare Reform" at the International Conference of the Captive Insurance Companies Association on March 14, 2011, in Tucson, Arizona.

Ward Bondurant, **Jim Maxson** and **Margaret Paradis** will present a webinar on March 29, 2011, entitled "Private Placement of Life Settlements and Variable Universal Life Products - the Challenges and Pitfalls." The webinar is from 12 pm - 1 pm (eastern time). To register, please visit: https://www1.gotomeeting.com/register/260394400

Chris Petersen is speaking at the Captive Insurance Council of the District of Columbia's upcoming conference on Healthcare, ACOs and ART Programs. Chris will discuss the interaction among the NAIC, state insurance regulators and the federal government and the evolving regulatory framework resulting from healthcare reform. The program will be held June 21, 2011, at the ASAE Center in Washington, DC.

legislation such as the Mental Health Parity Act of 1996.

Although the Republican governors' letter to Secretary Sebelius focused on state exchanges, the strong objections to ACA expressed by the governors extend to many of ACA's fundamental reforms. Given these deep reservations, it is conceivable that some states may elect to not enforce substantial aspects of ACA, preferring instead to leave enforcement to HHS. Indeed, this has happened before. After HIPAA was enacted, several states failed to enact legislation to enforce its provisions, causing HHS to assume direct responsibility for enforcing the law in those states. It also is possible that differences in interpretation of ACA's requirements between state and federal regulators could cause HHS to find that a state is not substantially enforcing the law and seek to take control of enforcement in that state.

At this point, it is not clear whether the notice given to HHS by the Florida Office of Insurance Regulation that it was suspending implementation of ACA constitutes the type of notice necessary for HHS to take on direct authority for enforcing ACA in Florida.

State and Federal Exchanges

The health benefit exchanges contemplated by ACA, whether state-based or federal, will play a critical role in implementing ACA which calls on states to implement exchanges for their residents no later than January 1, 2014. If a state elects not to establish an exchange, or if HHS determines that the state will not have an exchange operational by 2014 or has failed to take the actions necessary to implement ACA's requirements with respect to exchanges or market reform, HHS is directed to provide an exchange for residents of that state.

The exchanges have a number of important functions. In general, they are intended to assist individual and small employers in obtaining health coverage. Eventually, they can be opened to large employers as well. States may establish exchanges as a governmental entity or as a nonprofit entity.

Only "qualified health plans" and "qualified dental plans" certified by an exchange may participate in the exchange. Significantly, the federal premium subsidies available under ACA will be provided only to persons enrolled in a qualified plan. Thus, insurers have a strong incentive to participate in the exchanges.

Exchanges will be required to certify qualified plans in accordance with regulations developed by HHS. Among other things, exchanges must require health plans seeking to maintain certification to justify any premium increase. If an exchange deems an increase unjustified, it may, at least in theory, deny certification. It is unclear how the exchanges' authority to review rates will interact with existing rate regulation by state insurance departments. Rate review by state exchanges and state insurance regulators may or may not be well coordinated, depending on the state. In states that provide no exchange, there is a clear potential for conflict between state regulators and the federal exchange operating in that state.

Another point of uncertainty is just how much control HHS will seek to exercise over state exchanges. State exchanges could operate relatively independently if HHS limits itself to establishing broad guidelines for them. On the other hand, it is possible HHS will take a more active approach toward the exchanges — for example, by establishing prescriptive criteria for certifying qualified plans.

The Department of Health and Human Services

HHS plays a central role in implementing ACA. It is the agency charged with developing regulations and guidance to implement ACA's insurance market reforms and, as discussed above, oversight of state exchanges. HHS also will operate a federal exchange in states that fail to implement a state-based exchange. In coordination with the Department of Labor and the IRS, HHS already has engaged in nine rulemakings to implement ACA. As noted above, if a state does not substantially enforce ACA's provisions, HHS will enforce ACA under the guidance provided in these interim rules.

The Internal Revenue Service

ACA establishes several new provisions applicable to health insurers that will be enforced by the Department of the Treasury through the IRS.

Among other things, the IRS is charged with collecting two new assessments intended to help fund healthcare reform: (1) a health insurance provider fee that applies to any entity engaged in the business of providing health insurance (with some important exceptions) and (2) a "fee" that will be imposed on each specified health insurance policy. The issuer of the policy is responsible for the payment of the fee. A specified health insurance policy is defined as any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States, but excluding any insurance if substantially all of its coverage is of excepted benefits.

The IRS will be under pressure to maximize revenue and might be under pressure to minimize the impact of the new assessments on major medical writers by broadening the products and entities affected by the assessments. If so, it might apply tighter scrutiny to products which have been traditionally regulated as excepted benefits.

Conclusion

The regulatory structure adopted by ACA is complex, including overlapping lines of authority among state insurance regulators, exchanges, HHS and the IRS. Recent events highlight the potential for conflict among the various regulators, which could spell unwelcome regulatory uncertainty for insurers.

Over the longer term, assuming ACA survives constitutional and legislative challenges, conflicts between state and federal authorities could cause some states to cede authority over implementation of health benefit exchanges and enforcement of ACA's market reforms to HHS. This, too, could have unwelcome consequences for insurers as they will continue to be subject to regulation at the state level but will also have to contend with direct regulation by federal authorities.❑

Chris Petersen is a Partner in the firm's Insurance and Reinsurance Practice where he concentrates on legal and compliance services relating to the Health Insurance Portability and Accountability Act (HIPAA), privacy, state small group and individual insurance reform regulation and the interaction between state and federal law. Mr. Petersen received his bachelor's degree from Washington University in St. Louis, Mo. and his law degree from Georgetown University School of Law.

Joseph T. Holahan is Of Counsel in the firm's Insurance Practice and a member of the firm's Privacy Practice. Mr. Holahan advises insurers and reinsurers on a variety of legal matters, including all aspects of regulatory compliance. Mr. Holahan received his undergraduate degree from the University of Virginia and his law degree from the Catholic University of America.

NAIC ADOPTS REVISED HOLDING COMPANY SYSTEM MODEL ACT REQUIRING ENTERPRISE RISK DISCLOSURE

By Tony Roehl

In December 2010, the Plenary Committee of the NAIC adopted a significant revision to the Insurance Holding Company System Regulatory Act (Model 440) and the Insurance Holding Company System Model Regulation (Model 450) ("Model Act and Regulation"). The Model Act and Regulation were modified by the NAIC in response to the perceived risk to insurance company entities from non-regulated entities within their holding company structure. Specifically, the revisions were a response to the contagion within the AIG holding company system which for a time appeared to be a threat to AIG's insurers.

The revisions resulted from two years of efforts by regulators to determine the best methods to better understand the risks and activities of non-insurance entities within a holding company system. Given this backdrop, it is not surprising that the main focus of the revisions has been to put into the Model Act and Regulation the concept of enterprise risk and to enact provisions designed to provide regulators with additional information and authority to manage this new concept.

"Enterprise Risk" is defined as "any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurers Risk-Based Capital to fall into company action level … or would cause the insurer to be in a hazardous financial condition." Holding companies will be required to report their Enterprise Risk at least annually on a newly created "Form F."

Form F requires the holding company to disclose information regarding ten different areas of its operations which could potentially pose Enterprise Risk to a regulated insurer, including the business plans of the insurance holding company system for the next 12 months, information on corporate or parental guarantees and identification of any material activity of the insurance holding company system that could adversely affect the insurance holding company system. Insurance holding company systems that are filing similar information with the Securities and Exchange Commission ("SEC") may attach the appropriate form in lieu of completing a new response. Foreign holding company systems may attach their most recent public audited financial statement filed in their country of domicile. The Form F filing will be exempt from open records requests and is not subject to subpoena.

In addition to the new requirement for Enterprise Risk reports, the revisions include the following significant changes:

- Requiring controlling persons of an insurance company seeking to divest their controlling interest to provide notice of divestiture at least 30 days before their cessation of control.
- Permitting consolidated public hearings on an application to acquire control of an insurance holding company system with insurers domiciled in multiple states.
- Requiring insurers to provide, if requested by the Commissioner, financial statements for all affiliates of the insurer. This requirement may be satisfied by providing the most recently filed parent corporation financial statements if filed with the SEC.
- Including a statement in the annual holding company registration that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures or, alternatively, include a statement that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures.
- Requiring prior approval to amendments or modifications to previously approved agreements between an insurer and its affiliates as well as all reinsurance pooling agreements regardless of materiality. In addition, the revised Model Regulation mandates

specific provisions that must be included in cost-sharing and management service contracts.

- Expanding the Commissioner's examination authority to include the insurer's affiliates when examined to ascertain the insurer's financial condition including the Enterprise Risk to the insurer. The examination authority includes the power to issue subpoenas, administer oaths and examine any person to determine compliance with examination requirements. Insurers are also required to produce information not in their possession if they can obtain access to such information through a contractual relationship, statutory obligation or other method.

Finally, the Model Act's privacy provision has been expanded to apply to all information filed with the NAIC. It is now up to the states to adopt the amended Model Act and Regulation. The NAIC is considering making the amendments part of the new accreditation standards which will create pressure for states to act quickly in revising their statutes and promulgating a new regulation. Legislation will have to be closely tracked to determine if states are modifying the NAIC Model Act and Regulation. ❑

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which is the federal law governing the authority permitted or denied to non-domiciliary states. Such a regulatory structure does not exist in the world of single-parent or association captives, which do not benefit from a federal law. As a result, there are occasional cases that call into question the existing regulatory structure.

A decision by the Appeals Court of Massachusetts recently held that a captive insurer is liable under state claims settlement practice provisions. In *Lemos v. Electrolux North America, Inc.,* 2010 Mass. App. LEXIS 1534 (Dec. 2, 2010), a lawnmower user obtained a jury verdict against the manufacturer for $550,000 due to injuries sustained as a result of a defective lawnmower and then brought a lawsuit against the manufacturer and its captive insurer, alleging violations of state claim settlement practice provisions (Mass. Gen. Laws ch. 176D § 3). The trial court granted summary judgment in favor of the manufacturer and its captive insurer because neither party engaged in the business of insurance, and therefore, could not be subject to the state's claims settlement practices act. The Appeals Court affirmed as to the manufacturer and reversed as to the captive insurer.

The manufacturer in *Lemos* was the parent and sole shareholder of the captive insurer, domiciled in Vermont. The captive provided commercial general liability coverage, including indemnification for sums the manufacturer became obligated to pay due to "bodily injury" or "property damage." Moreover, the manufacturer had a right and duty to defend any lawsuit seeking damages, but the captive could investigate and settle any claim at its discretion. However, the captive had only a board of directors and no employees. Accordingly, the captive was not actually involved in the investigation, negotiation or litigation of claims. The president of the captive averred that the captive's role was "purely that of a funding vehicle for the reimbursement of [the manufacturer] for claims that are paid by [the manufacturer]."

The Appeals Court held the captive insurer was indeed in the business of insurance and therefore subject to the claims settlement practices act even though the manufacturer was not. The court rejected the captive's argument that because the manufacturer used a captive insurer, the manufacturer was effectively a self-insurer, and therefore neither party could be subject to the insurance regulatory requirements, including the claims settlement practice provisions. The captive relied upon *Morrison v. Toys "R" Us, Inc.,* 806 N.E.2d 388 (Mass. 2008), which held that insurance regulations could not be applied to self-insurers who have no contractual obligation to settle claims and are not otherwise regulated by state insurance regulators.

In its opinion, the Appeals Court emphasized the captive insurer's distinct corporate identity and its engagement in the regulated business of issuing insurance policies. To support its holding that the manufacturer was not a *de facto* self-insurer and to distinguish *Morrison*, the court reasoned that the manufacturer purposefully chose a captive arrangement over a self-insurer structure due to financial benefits of the former. Additionally, the court noted that the Massachusetts insurance code identified captive insurers as "insurance companies" and did not exempt captive insurers from application of the state's unfair trade practices act, including claims settlement provisions. In contrast, under *Morrison*, the self-insured manufacturer was not in the business of insurance, and its duty to defend under the insurance policy was insufficient to subject it to the claims settlement provisions.

A possible conclusion from *Lemos* could be that single-parent captives with multi-state risks should be prepared to have the unfair claims settlement laws of non-domiciliary states imposed upon them. If this is the case, then these captives should be prepared for bad faith or other extra-contractual claims, which could substantially increase potential liability. A prudent captive manager therefore should make certain that any reinsurance will provide coverage for extra-contractual liability.

The broader conclusion may be that even though a captive is not transacting "the business of insurance" in a non-domiciliary state as defined by various state laws, it may be subject to some of the provisions of state law affecting claims settlement or trade practices. The Court in *Lemos* appears to have concluded that because the captive was providing "insurance" to its parent, it was subject to these laws regardless of whether or not it was a licensed insurer in the state.❑

Robert "Skip" Myers is Co-Chairman of the firm's Insurance and Reinsurance Practice and focuses in the areas of insurance regulation, antitrust and trade association law. Skip received his bachelor's degree from Princeton University and his law degree from the University of Virginia.

Massachusetts Court of Appeals' unpublished decision upholding the constitutionality of Massachusetts' individual mandate does not provide guidance. *See Fountas v. Comm'er of Revenue*, Case No. 2009-P-0526 (Mass. App. 2009) (unpublished), *review denied*, 925 N.E.2d 865 (Mass. 2010).

Five federal courts have addressed the constitutionality of the individual mandate. Three courts have found the Act constitutional. *See Mead v. Holder*, Case No. 10-950 (D.D.C. Feb. 22, 2011); *Thomas More Law Center v. Obama*, 720 F.Supp.2d 882 (E.D. Mich., Oct. 7, 2010); *Liberty University, Inc. v. Geithner, Case No. 6:10-CV-00015, (W.D.Va. Nov 30, 2010)*. Two other courts have held that the Commerce Clause does not authorize the individual mandate. *See Virginia, ex rel. Cuccinelli v. Sebelius*, 728 F.Supp.2d 768 (E.D. Va., Dec. 13, 2010); *Florida v. U.S. Dept. of H.H.S.,* ____ F.Supp.2d ____, Case No. 3:10-cv-91-RV/EMT (N.D. Fla., Jan. 31, 2011). One of those courts severed the mandate and upheld the remainder. *See Cuccinelli*, 728 F.Supp.2d at 789-790. The other found the mandate to be an integral part of the statute and struck the entire Act. *Florida, supra* at 36-39.

While the Commerce Clause issue is interesting, it does not address the ultimate policy questions arising from continuing advances in health science. People are living longer and, as a result, consume more care, with most expenditures coming at the end of life. The good news is that we can live longer, notwithstanding chronic illnesses; the bad news is that someone has to cover the cost.

Therefore, as a society, we face two economic and moral issues. The first is the extent to which government should subsidize healthcare costs. The second is the extent to which that cost should be covered through borrowing and, therefore, passed to future generations.

My own view on the second issue is that it is shameful to fund our generation's healthcare on the backs of our descendants. The aging of our population, as well as its increased longevity, and the enactment of an unfunded Medicare prescription program has contributed to the deficit. Deficits matter.

Politicians recently have said that it is time for an "adult conversation." I still wait. The reality is that we cannot afford first dollar unlimited care for everyone, certainly not without regard to long term prognosis — not just length of survival but quality of life. While the Congressional Budget Office concludes the Act will save money over the next ten years, that projection assumes cuts to Medicare and the actuarial timing of inflows and outflows raises fears of what happens after ten years. The unfunded Medicare prescription act understandably triggers skepticism of governmental accounting. Remember when the Iraq war was going to pay for itself?

Politicians decry the rationing of care. But we already do so in several ways. One is through market forces whereby the wealthy can afford more and better care. While the poor can obtain emergency room care without insurance, that care (and the governmental subsidiary for that care) is limited to stabilization, unless they are "lucky" enough to be admitted. *See* 42 U.S.C. § 1395dd(b). First dollar, long term and unlimited care are something else altogether.

Co-pays, deductibles and annual and lifetime caps are other forms of market-generated rationing. The Act precludes lifetime caps, which necessarily carries an increased cost.

Another form of rationing is managed care. As the United States Supreme Court noted in *Pegram v. Herdich*, 530 U.S. 211, 221 (2000), under any HMO, "there must be rationing and an inducement to ration. [The] inducement to ration care goes to the very point of any HMO..., and rationing necessarily raises some risks and reduces others (ruptured appendices are more likely; unnecessary appendectomies less so) ...." The criteria for rationing necessarily embodies "a judgment about socially acceptable medical risk." *Id.*

When the managed care is through an ERISA plan, federal law protects the decisions of the plan administrator. *See Pregram*, 530 U.S. at 225-229 (HMO is no fiduciary under ERISA plan). While some would say that protection allows the administrator to make knowledgeable decisions without fear of liability, others say that it encourages restrictions of care. Regardless, it has the effect of rationing care.

But this rationing is nothing new. Before the prevalence of employer-sponsored plans separated patients from pricing decisions, patients and their parents weighed the cost of treatment against the expected benefits. Because insureds now often feel little direct financial impact from treatment decisions, someone else must weigh these factors.

Decisions of life and death through rationing have been made for years by transplant committees. They consider the age, health and prognosis of potential recipients before allocating precious transplantable organs. Because, unlike money, organs cannot be printed or borrowed, our society accepts this type of rationing. After all, even the most egalitarian among us understands that not everyone who needs a new liver gets one and that giving a liver to an otherwise healthy 30 year old makes more sense than donating it to the 60 year old recidivist alcoholic. [Full Disclosure: As I get older, my perception of the age at which care becomes wasteful has increased].

My point is that our national health policy should treat our nation's current and future wealth with circumspection. If we make the moral choice that we want to ensure care for all, then we need to pay for it and not bequeath an insolvent nation to our children and grandchildren.

Any "adult" implementation of this policy necessarily will require the rationing of treatment. Fiscal and monetary policy cannot fund unlimited treatment without extensive deficit financing. Further, if the government is funding the care, then it must implement the rationing through bureaucratic regulation. The payor is the only party with the incentive to limit cost, except to the extent that the payor shares "savings" with providers. *See Pregram*, 530 U.S. at 220 (payor reimbursement scheme with year-end distribution to providers did not violate duty to patients).

In other countries, care is rationed by committees reviewing quality of life benefits versus costs. Some countries, such as the Netherlands, even allow active euthanasia. In Christopher Buckley's 2007 novel, *Boomsday*, the younger generation proposes financial incentives to the

elderly (actually, to their families) for euthanasia.

Our society is not ready to accept active euthanasia. We envision the young saying, "Grandma, I love you so much that it hurts me so much to see you in pain...and, by the way, where do you bank?" The Act's provisions for end of life counseling have been decried as "killing grandma."

The conclusion that saddling our descendants with the tab for our own healthcare is economically unwise and morally wrong leads to two other conclusions. First, the decision in *Cuccinelli*, 728 F.Supp 2d at 789-790, striking the individual mandate but upholding the remainder of the Act is difficult to justify economically. Requiring insurers to cover pre-existing conditions without a corresponding duty on citizens to obtain insurance necessarily would trigger substantial premium increases and higher governmental subsidies.

Second, any healthcare reform must address how much care we can afford now and how we allocate that care. Historically, and apart from Medicare, Medicaid and related programs, we have allocated that care based upon market forces. Medicare and Medicaid affected that allocation by providing subsidies to the old, the poor and the disabled, although that care is limited.

Not surprisingly, those unable to afford adequate coverage or care are dissatisfied with a pure market allocation. As the gap between rich and poor grows and the purchasing power of the middle class decreases, those disfavoring a market allocation of healthcare naturally increase. If some level of healthcare is to be guaranteed to all citizens without exploding the national debt, by definition it will be heavily rationed. Ultimate authority for treatment, and the criteria for treatment, necessarily would be made by the payor (perhaps with independent opinions). For a government program, the payor by definition is the government. Some would prefer governmental oversight over insurer or HMO oversight, and that societal split probably mirrors the split over the Act. The bottom line is that the days of making unfettered treatment decisions with your doctor are over, and have been for a while. The sooner we face that reality, the quicker we can begin the adult conversation. ❑

Lew Hassett is Co-Chairman of the firm's Insurance and Reinsurance Practice. His practice concentrates in the areas of complex civil litigation, including insurance and reinsurance matters, business torts and insurer insolvencies. Mr. Hassett received his bachelor's degree from the University of Miami and his law degree from the University of Virginia.

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under the terms of the trust.

A recent case, *Paradee v. Paradee*, 2010 WL 3959604, decided by the Delaware Court of Chancery in October 2010, may give participants in the secondary market for life insurance reason to re-think this position and undertake additional diligence when purchasing a policy from an ILIT.

The facts of *Paradee* could serve as the basis for a day-time soap opera. There is a wealthy but ailing family patriarch, a younger, avaricious stepmother who married the patriarch shortly after his first wife died, an estranged son and a beloved grandson, who, upon the patriarch's passing, falls out of favor with his step-grandmother.

Prior to passing, the patriarch and the stepmother set up an ILIT for the benefit of the patriarch's grandson. The trust was funded with approximately $370,000, which was used to purchase a second-to-die life insurance policy on the lives of the grantors. On multiple occasions thereafter, the stepmother attempted to access the policy's cash value by revoking the trust. When advised that she could not gain access due to the trust's irrevocability, the stepmother convinced the trustee (a long-time financial advisor to the patriarch and the stepmother) to make a loan on the policy's cash value in the amount of $150,000. The loan from the trust was unsecured and did not pay a rate of interest equal to the rate charged by the insurance company for the policy loan.

The grandson, the trust's sole beneficiary, was not told of the existence of the trust, the policy or the loan until after the policy lapsed due to failure to pay interest on the loan. Upon learning of the existence of these previously unknown assets, the grandson sued, alleging among other things a breach of the trustee's fiduciary duties as trustee of the trust.

The court agreed, holding that the trustee had breached his fiduciary duty of loyalty because his actions in making the loan were undertaken to please the stepmother rather than to act in the best interests of the trust. The court considered and dismissed the defense that the trustee had the legal authority to make the loan, noting that trustees' actions are reviewed twice under Delaware law, once for legal authority and again for inequitable conduct. Thus, the court concluded that while the trustee undoubtedly had the authority to make the loan, by doing so he nevertheless breached his fiduciary obligation to the trust because the loan was not in the best interest of the trust or its beneficiary.

It is often the case in the sale of life insurance policies from an ILIT into the secondary market that the grantor and insured life under the policy appear to be the motivating force behind the sale of the policy. In fact, providers are occasionally asked to wire the funds from the proceeds of the sale of the policy to a party other than the trustee, and they should deny any request to do so. While the policy purchaser is engaging in no wrongdoing if additional inquiries are not made into the circumstances of the policy sale, the *Paradee* case is a strong argument for obtaining the written consent of the beneficiaries of the trust itself (rather than just the policy). Failure to do so runs the risk that an unhappy beneficiary could later challenge the sale and unwind the transaction. ❑

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