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HASSETT'S OBJECTIONS

BAD FAITH ALLEGATIONS VERSUS AN INSURER'S ATTORNEY-CLIENT PRIVILEGE

By Lewis E. Hassett and Cindy Chang

Various courts have addressed the extent to which an insured's allegation of bad faith eviscerates an insurer's right to invoke the attorney-client privilege. While insureds argue that an allegation of bad faith is sufficient to waive the privilege, insurers argue that an insurer's right to invoke the privilege should be revocable only under the same crime/fraud exception applicable to non-insureds.

The latest court to address the issue in the first party context is the Washington Court of Appeals. In *Cedell v. Farmers Ins. Co. of Washington*, Case No. 38921-5-II. (Wash. App. Div. 2 Aug. 3, 2010), the court held bad faith allegations alone, even if supported by some evidence, do not eviscerate an insurer's right to attorney-client privilege. Rather, the insured must establish fraud.

In *Cedell*, the insured filed a bad faith action against his insurer after the insurer had not settled his claim stemming from an accidental fire at his home over a year after the incident. During the course of discovery, the

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AMENDMENT OF FEDERAL SECURITIES LAWS TO ADDRESS LIFE SETTLEMENTS IS UNNECESSARY

By James W. Maxson

On July 22, 2010, the Securities and Exchange Commission's (the "SEC's") Life Settlements Task Force (the "Task Force") issued its Staff Report to the SEC. The most significant recommendation in the Staff Report was that the SEC should consider recommending to Congress that the definition of a "security" under the federal securities laws, including the Securities Act of 1933, as amended (the "Securities Act"), and the Investment Company Act of 1940, as amended (the "Investment Company Act"), be revised specifically to include life settlements.

Because the SEC already possesses the tools to characterize life settlements as securities, it is unnecessary for Congress to amend the securities laws. Furthermore, were Congress to make this amendment per the Task Force recommendation, the most probable consequence is that consumers seeking to sell their policies for more than cash value would have few, if any, options to do so.

The life settlements industry already is regulated in 43 of the 50 states, and life settlements are defined as a security under state law in 48 of the 50 states. While aspects of life settlements regulation remain patchwork in nature, nearly 90% of Americans live in a jurisdiction regulating the sale of life insurance into the secondary market. Mandating an additional layer of federal regulatory scrutiny is unlikely to offer investors

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NAIC ADOPTS MEDICAL LOSS RATIO STANDARDS

By Chris Petersen and Joseph T. Holahan

At its last meeting, the National Association of Insurance Commissioners ("NAIC") adopted standards defining the elements that must be used to calculate and report minimum medical loss ratios ("MLR") under the Patient Protection and Affordable Care Act ("PPACA"). Following approval, the standards were submitted to the Secretary of Health and Human Services ("HHS"). Under PPACA, the Secretary is charged with reviewing the standards developed by the NAIC and, if the Secretary deems appropriate, certifying the standards for use. It is anticipated the Secretary will certify the NAIC's standards since HHS staff assisted the NAIC in developing the standards.

PPACA's MLR requirements provide only two expense items for the numerator when calculating loss ratios: (1) funds spent on reimbursement for clinical services provided to enrollees and (2) funds spent on activities that improve health care quality.

The NAIC's new standards define quality improvement expenses as "expenses for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees." To qualify as a quality improvement expense, the "expenses must be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations." Although the expenses may have cost-reducing benefits, quality improvement expenses may not be designed primarily to control or contain cost. The primary focus of the expenditure must be to improve the quality of health care provided to enrollees.

The NAIC standards include five categories of quality improvement expenditures.

Improvement in health outcomes These are insurer expenses, as well as services performed on the insurer's behalf by business associates, with providers and/or the enrollee or the enrollee's representatives for activities designed to improve health outcomes. The contact may be through face-to-face or telephonic meetings, web-based interactions or other means of communication. This category includes costs for associated activities such as case management, care coordination and chronic disease management, including making/verifying appointments and medication and care compliance initiatives. It would also include programs to support shared decision making with patients, their families and the patient's representatives; activities to identify and encourage evidence-based medicine; the use of the medical homes models; and education and participation in self-management programs.

Activities designed to prevent hospital readmission This category includes expenses such as comprehensive discharge planning, e.g., arranging and managing transitions from one setting to another to help assure appropriate care and avoid readmission to the hospital. It also includes post-discharge counseling, quality reporting and related documentation for activities designed to prevent hospital readmissions as well as health information technology ("HIT") expenses and data extraction, analysis and transmission in support of these activities.

Announcements

On October 1-3, 2010, **Lew Hassett** will attend the Fall meeting of State Law Resources, an international organization of attorneys with regulatory and governmental practices, to be held in Ottawa, Ontario.

On October 4, 2010 **Skip Myers** will speak at the Community 100 Conference in Williamsburg, Virginia, on the utilization of captive insurance for medical care risk management.

On October 4, 2010, **Jim Maxson** will speak at DealFlow Media's Life Settlements Conference in Las Vegas on the topic "Litigation: What are the Legal Trends Affecting the Market?"

On October 6, 2010, **Skip Myers** will speak at the annual conference of the National Risk Retention Association in Washington, DC, on the impact of federal and state regulatory changes on insurance.

On January 26-29, 2011, **Chris Petersen** will speak at the Professional Insurance Marketing Association's annual meeting in Miami. Mr. Petersen will discuss the health insurance reforms under the Patient Protection and Affordable Care Act and their impact on the association marketplace.

Representing the lender under a mortgagee title insurance policy, **Lew Hassett** recently argued before the Georgia Supreme Court in the case of *Gordon, as Bankruptcy Trustee, v. U.S. Bank National Association, Docket No. S10Q1564,* addressing a certified question from federal court. The case involves the extent to which a mortgage with a facially defective attestation provides constructive notice to bona fide purchasers where the mortgage has been actually recorded and accurately indexed.

On August 26, 2010, **Jim Maxson** spoke on a panel tracking current issues at the Life Insurance Settlement Association's Compliance Conference in Atlanta, Georgia.

In the September 12, 2010, issue of *Investment News*, **Jim Maxson** wrote an article with a broker-dealer entitled "Point/Counterpoint: Are Life Settlements Essentially Securities?"

Finally, activities to promote the sharing of medical records and ensure that clinical providers have access to accurate records from all providers participating in a patient's care also are included.

Activities to improve patient safety and reduce medical errors As set forth in the standards, these are expenses for activities to improve patient safety and reduce medical errors, including the identification and use of best clinical practices, activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns and activities to lower risk of facility-acquired infections. These also include utilization review to identify potential adverse drug interactions; quality reporting and related documentation for activities that improve patient safety and reduce medical errors; and data extraction, analysis and transmission in support of these activities. Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care are also included in the standards.

Wellness and health promotion activities This category includes expenses for programs that provide wellness and health promotion activity. These activities may be through face-to-face, telephonic or web-based interactions or other forms of communication. As set forth in the NAIC standards, expenditures for wellness assessment and coaching programs to achieve measurable improvements or to educate individuals about effective means for dealing with a specific chronic disease or condition are qualified expenditures. Public health education campaigns, if performed in conjunction with state or local health departments, are also included. Certain rewards and incentive programs (including reductions in co-pays) also qualify as wellness and health promotion expenditures. To qualify, the expenditures for rewards and incentive programs must not be already reflected in premiums or claims and the programs are only allowed for employer groups. Individual policies may not, for purposes of MLR calculations, take advantage of reward or incentive programs. As with other categories of expenses, any quality reporting and related documentation for wellness and health promotion activities and HIT expenses to support these activities are included.

Health information technology expenses for health care quality improvements The NAIC standards also recognize HIT expenditures that may improve the quality of care or provide technological infrastructure to enhance existing quality improvement activities or make new initiatives possible as expenditures to be included in the MLR numerator. The NAIC standards provide that HIT expenditures used to accomplish activities in the first four categories described above are expenditures that improve quality. It also specifically recognizes expenditures for monitoring, measuring or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation or costs for public reporting of quality of care (both required and/or encouraged by law) as quality expenditures. In addition, the standards recognize that HIT expenditures for advancing the ability to efficiently communicate clinical or medical information to determine patient status, avoid harmful drug interactions or direct appropriate care are expenditures that improve quality.

Other qualifying HIT expenditures are monies spent to track whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes; monies spent to re-format, transmit or report data to government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; and monies spent to provide electronic health records and patient portals. The NAIC standards exclude costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims.

The standards also include a list of activities that do not qualify as quality improvement expenditures. These are "all retrospective and concurrent utilization review; fraud prevention activities; costs associated with developing and executing provider contracts and other fees associated with managing provider networks; provider credentialing; marketing expenses; accreditation fees; and cost associated with administering incentive programs." The list of excluded expenses also includes a catch-all provision that any function or activity not expressly listed as a quality improvement expense is excluded from the quality improvement category. Unfortunately, this means any new quality improvement program that does not fit within one of the existing approved categories of qualified improvement activities will not be allowed as a quality improvement expenditure. The NAIC has indicated it will revisit the list of approved activities as new quality improvement programs are developed, but this will provide relief only after the NAIC and HHS go through what could be a lengthy review process to approve the program.

The NAIC also has developed an MLR schedule that insurers must prepare and submit to each jurisdiction in which the company has written "direct comprehensive major medical health business, or has direct amounts paid, incurred or unpaid for provisions of health care services." Although the NAIC uses the phrase "comprehensive major medical coverage," it appears that PPACA's MLR requirements apply to all types of health insurance coverage other than those coverages that are defined as excepted benefits or that qualify as short-term, limited duration insurance. The schedule also includes columns for insures to report premiums for excepted benefits. The NAIC indicated it included these columns so insurers could not simply shift administrative expenses to supplemental products.

The NAIC standards include three important exceptions to the reporting requirements. First, insurers without any major medical business to report on the schedule are not required to complete the MLR blank supplement. Second, insurers whose reportable major medical business is less than 2% of their total accident and health business are not required to report their excepted benefits premium, but they must complete all other components of the supplement. Finally, insurers in run off (major medical claims incurred with zero major medical premiums) are not required to complete the minimum loss ratio blank supplement.

Insurers will be required to allocate premium and claims in "the jurisdiction in which the contract is issued or delivered as stated in

the contract." For individual business sold through an association, the allocation is based on the issue state of the certificate of coverage. For employer business issued through a group trust, the allocation is based on the location of the employer.

In addition to the various state-based submissions required, the NAIC proposal also includes a separate regulator-only supplemental filing that insurers must complete. In this single, regulator-only filing, insurers must provide a description of the method for allocating quality improvement expenditures on a state-by-state basis and show the insurer's method for allocating expenses among lines of business. Additionally, insurers must include a detailed description of each reported quality improvement expense item, including a narrative explaining why the insurer believes the specific expense qualifies under one of the quality improvement categories described above.

The NAIC standards will not become effective until certified by the Secretary of HHS .❑

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insured sent interrogatories and requested documents, including the case file on the insured's claim. The insurer produced heavily redacted documents, withheld documents and refused to respond to interrogatories on the basis of attorney-client privilege and work product protection.

After finding that the facts of the case were adequate to support a good faith belief the insurer engaged in wrongful conduct, the trial court conducted an *in-camera* review of the redacted documents. The court ordered the insurer to produce the insured's entire claim file including all attorney-client privileged and work product documents.

On appeal, the court rejected the insured's argument that insurers have no attorney-client privilege rights in a first-party bad faith claim simply because information about the insurer's handling of the claim is central to the bad faith allegations. *See also W. Va. ex rel. Allstate Ins. Co. v. Madden,* 601 S.E.2d 25, 34 (W. Va. 2004) (holding filing a first-party bad faith claim action alone does not automatically waive the insurer's attorney-client privilege); *cf. Dion v. Nationwide Mut. Ins. Co.,* 185 F.R.D. 288, 294-95 (D. Mont. 1998) (finding that first-party bad faith allegations do not automatically waive insurer's attorney-client privilege). Instead, the Washington Court of Appeals held that insurers do not lose attorney-client privilege protection unless an otherwise recognized exception, such as fraud, applies.

Importantly, the *Cedell* court distinguished between a prima facie showing of fraud versus a showing of bad faith. Although the trial court had found sufficient facts to support a finding of bad faith, it had not made sufficient findings to support fraud. Accordingly, without a factual basis for finding fraud, the Court of Appeals held that the trial court abused its discretion by ordering an *in-camera* review of the evidence and ordering disclosure and production of the privileged information.

Other courts have been less protective of the privilege. *See, e.g., Hutchinson v. Farm Family Cas. Ins. Co.,* 867 A.2d 1, 6-7 (Conn. 2005) (holding a number of courts have concluded that the civil fraud exception should be extended to claims of bad faith against insurers); *see also Allstate Indem. Co. v. Ruiz,* 899 So.2d 1121, 1131 (Fla. 2005) (an insurance agent's generally protected work product was subject to discovery in a bad faith action); *Adega v. State Farm Fire & Cas. Ins. Co.,* Case No. 07-20796-CIV (S.D. Fla. 2008 Apr. 9, 2008) (applying *Ruiz* decision to attorney-client privilege).

The *Cedell* court has it right. An insurer should be able to adjust a first-party claim with the same protections as when any other business determines its contractual rights and obligations.

While eviscerating the privilege may assist the insureds in pending cases, the long-term effect could be anti-consumer. If the insurer's analyses and considerations are subject to discovery, insurers will not receive the candid views that otherwise might support settlement. ❑

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any significant extra protection but will pose a real risk that regulatory compliance costs (licensure as broker-dealers, FINRA membership, potential Securities Act and Investment Company Act registrations) for industry participants will increase to the point that many of them will be unable to continue as a viable business, thereby depriving consumers of this important option for realizing the true value of their otherwise illiquid asset.

The principal concern with the Task Force's recommendation to amend federal securities laws is that it is unnecessary – the SEC already has the authority, where appropriate, to characterize life settlement investments as securities. Investments not explicitly defined as securities in the

Securities Act or the Investment Company Act are frequently found to be within the jurisdiction of the SEC because they meet the test of being an "investment contract," which is explicitly defined as a security in the federal securities laws.

Over six decades of case law, including the seminal case, *SEC v. W.J. Howey Co.,* have refined the test for determining when an investment constitutes a security. Why the SEC apparently believes the traditional *Howey* analysis is insufficient to police investments in life settlements is unclear. This conclusion is particularly perplexing when reviewed through the lens of the last fifteen years of state and federal case law. With only one notable exception, every case which has considered the issue of whether investments in life settlements are securities has concluded that they are. The one exception, *SEC v. Life Partners,* decided by the D.C. Circuit in 1996, is generally considered to have reached an incorrect conclusion.

In sum, the life settlements industry already is a comprehensively regulated industry. While it may be true that the regulation is not perfect, that does not make the life settlements industry unique. Rather than take the sweeping step of amending federal securities laws to define all life settlements as investments, and potentially significantly reduce a policy owner's ability to exercise their right to sell their policy into the secondary market, the SEC should continue to adhere to its tried and true investment contract analysis to determine whether any particular life settlement investment program involves the issuance or sale of a security. ❑

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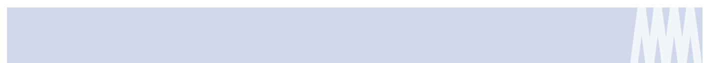


A SIMPLE WAY FOR FOREIGN INSURERS AND REINSURERS TO ELIMINATE U.S. INCOME TAXES

By William M. Winter

I just returned from my first trip to Las Vegas. Keep in mind I have spent my professional life helping others avoid risks, and I am generally risk averse by nature. However, I couldn't help trying to beat the odds and win against the house (I hope the casino owners enjoy my money).

Looking back on my experience, I am reminded that in the tax world the IRS is the "house," and the odds are in their favor. However, for foreign insurers or reinsurers who want to write business in the U.S. without paying high U.S. income taxes, there is one sure-fire way to turn the house odds in your favor: write your U.S. business through an independent U.S. agent.

Foreign insurers or reinsurers with a "permanent establishment" in the U.S. are taxable. As a foreign insurer or reinsurer, if you conduct your insurance business directly within the U.S., then any resulting profit generally may be subject to U.S. income tax. However, for foreign insurers or reinsurers located in a country where the U.S. has an international tax treaty, such insurer or reinsurer is subject to U.S. income tax only if it generates profits through a "permanent establishment" located in the U.S.

Under most U.S. tax treaties, the term "permanent establishment" means a fixed place of business through which the business of an enterprise is carried on (whether in whole or in part). A permanent establishment specifically includes any place of management, branch or office located in the U.S. It also may include any person operating in the U.S., if that person is acting on behalf of the foreign insurer and has and habitually exercises the authority to conclude contracts in the name of such company. Such a person is often referred to as an "agency permanent establishment" and can be a trap for the unwary. In the most extreme case, visits to the U.S. by a single agent of a foreign insurer or reinsurer to approve policies on U.S. risks potentially creates a taxable agency permanent establishment, subjecting any resulting profit to U.S. income taxation. In fact, during the Federal Bar Association's 22nd Annual Insurance Tax Seminar held this past June in Washington, D.C., attorneys with the IRS Office of Chief Counsel reportedly confirmed the IRS strongly believes "there are PEs being created by the activities of agents" that would readily create a taxable permanent establishment, and such arrangements are being evaluated by the IRS.[1]

As a result of the agency permanent establishment concept, many foreign insurers or reinsurers in treaty countries try to avoid all contact with the U.S. -- requiring all underwriting decisions to be made outside the U.S., all policy applications to be signed outside the U.S. and all policies to be issued outside the U.S. However, this approach is impractical if you are trying to reach a broad U.S. market. More importantly, we all know that to get to U.S. business, there must be someone in the U.S. who will shake hands and interact with the insured or potential insured. It is a fact of life.

Fortunately, most U.S. tax treaties provide a solution. Specifically, a foreign insurance company is not deemed to have a permanent establishment if it carries on business in the U.S. through "a broker, general commission agent, or any other agent of an independent status" provided that such person is acting in the ordinary course of their business.[2]

Foreign insurers or reinsurers using an "agent of independent status" avoid U.S. income taxes. Using an agent in the U.S. who is "independent" of the foreign insurer or reinsurer is critical to avoiding U.S. income taxes. The primary source for interpreting whether a foreign insurer or reinsurer carries on business through an "agent of an independent status" is *Taisei Fire & Marine Ins. Co.,*

[1] See Kristen A. Parillo, "Agency Permanent Establishments Do Exist Says IRS Official," *Tax Analysts Tax Notes Today*, June 7, 2010 edition.

[2] See e.g. Article 5 of the U.S.-Barbados Income Tax Treaty; Article 3, paragraph 6 of the U.S.-Bermuda Income Tax Treaty; and Article 5, paragraph 6 of the U.S.-U.K. Income Tax Treaty.

Ltd. et al. v. Commissioner, 104 TC 535 (1995), which involved four Japanese reinsurers and a U.S. reinsurance manager who wrote the U.S. business. Under *Taisei,* so long as the U.S. entity has "legal independence" and "economic independence" from the foreign insurer and otherwise acts in the ordinary course of its business, the agent will be considered an "agent of an independent status" and its business on behalf of the foreign reinsurers will not create a permanent establishment in the U.S. Without a permanent establishment, the foreign insurers and reinsurers are not subject to U.S. income tax on profits related to their U.S. business -- essentially "beating the house" when it comes to paying U.S. income taxes. Although a 1995 decision, *Taisei* remains the leading interpretive authority in this area and confirms that by using an independent agent in the U.S., a foreign insurer or reinsurer may effectively avoid U.S. income taxation. [3]

Practical steps to avoid agency permanent establishments The key to having an independent U.S. agent and avoiding an agency permanent establishment lies in maintaining the U.S. agent's legal and economic independence. To do so, foreign insurers and reinsurers should consider structuring their arrangement with U.S. agents as follows:

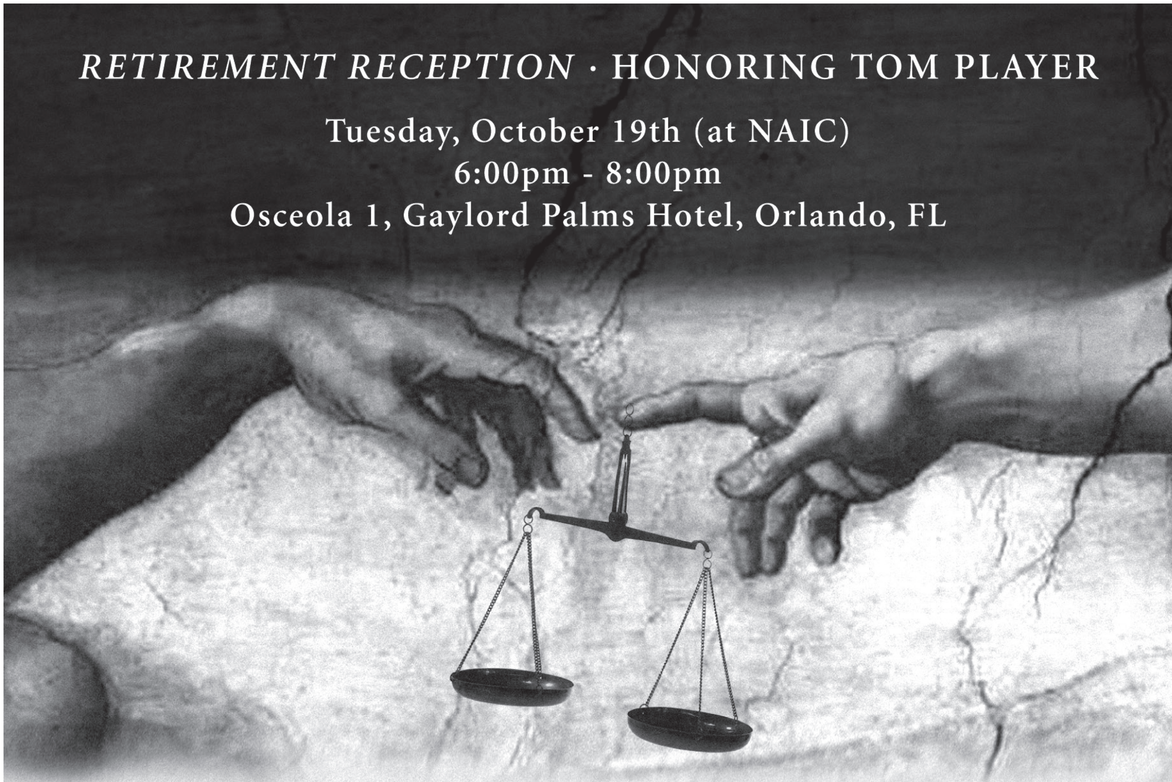
- Enter a written agreement with your U.S. agent clearly specifying the terms and conditions.
- Grant the U.S. agent complete discretion and control to conduct its insurance or reinsurance business in the U.S., subject only to certain objective, clearly specified limitations. Ideally, the limitations should be restricted to: (1) maximum underwriting authority (for example, the U.S. agent has authority to bind coverage up to a maximum net liability on a single policy of $5,000,000) and (2) maximum claims authority (for example, the U.S. agent may handle and dispose of all claims for amounts less $1,000,000 without approval from the foreign insurer or reinsurer).
- The U.S. agent's limitations should be high enough that decisions made by the foreign insurer or reinsurer will be extraordinary and not a substitute for day-to-day management or underwriting decisions.
- Do not impose exclusivity on the U.S. agent. To show independence, the U.S. agent should be allowed to act for other companies. Better yet, it is helpful to choose an agent who already provides services for other insurance companies. Alternatively, the foreign insurer or reinsurer should consider having multiple U.S. agents.
- Under the written agreement with the U.S. agent, allow either party to cancel the arrangement without cause. The cancellation may require some reasonable advance notice. In *Taisei,* the Japanese reinsurers or the U.S. reinsurance agent could cancel for any reason with six months advance notice.
- Be careful to ensure there is no common ownership (either directly or indirectly) between the foreign insurer or reinsurer and the U.S. agent.
- Compensation to the U.S. agent should be clearly defined, readily measurable by a third party and reasonable relative to the market. For example, remuneration might include compensation based on management fees (*i.e.*, a fixed percentage of gross earned premium), contingent commissions (based on the profitability of business underwritten) and override commissions.
- The U.S. agent should have real operations in the U.S. While a specific number of employees is not required, the U.S. agent should have at least one employee, should have all appropriate insurance licenses and generally should follow good business practices, such as maintaining regular accounting records and owning or renting office space, where such agent pays its own rent, property insurance, salaries and other operating expenses.
- The U.S. agent may be required to regularly report results to the foreign insurer or reinsurer. The U.S. reinsurance agent in *Taisei* provided its reinsurers quarterly accounting reports, including unpaid losses, reserves for IBNR losses and a narrative summary of overall underwriting results.
- The U.S. agent should file U.S. federal and state income tax returns, reporting all profit and loss from its operations (and, if applicable, paying its own U.S. income taxes).

In assessing the agent's independence, the IRS will view all the facts together to determine both legal and economic independence of the agent. While no single item above is determinative, exercising too much control over the U.S. agent's operations and decisions, or inconsistent compliance with one's own guidelines, may allow the IRS to successfully challenge the arrangement as a taxable permanent establishment. As a result, careful planning and consistent implementation are critical to the foreign insurer or reinsurer's success.

In a world where the tax authorities often have the odds in their favor, eliminating or avoiding U.S. income tax can be a challenge. However, for foreign insurers or reinsurers located in a tax treaty country, writing your U.S. business through an independent agent in the U.S. is an effective way to eliminate income tax on profits from U.S.-based risk.❑

William "Bill" Winter is a Partner in the firm's Tax Practice. Mr. Winter focuses on minimizing U.S. tax for growing businesses, with an emphasis on acquisitions, restructuring and helping U.S. and foreign companies successfully expand their business overseas. He also routinely advises public and private companies on all aspects of U.S. taxation, including the tax consequences of cross-border acquisitions, reducing U.S. and foreign withholding taxes, effective tax treaty planning, utilizing foreign tax credits, investment in domestic and foreign real estate and captive insurance company planning. Mr. Winter received his undergraduate degree from the University of Illinois and his law degree from Emory University.

[3] Foreign insurers and reinsurers still remain subject to the federal excise tax on premium income under Section 4371 of the U.S. Internal Revenue Code of 1986, as amended. This tax equals approximately 4% of gross premium paid for property and casualty risks located in the U.S., and 1% of gross premium paid for life, health and reinsurance policies covering U.S. risks.



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