INTERNATIONAL ASSOCIATION OF INSURANCE RECEIVERS
PROMOTING PROFESSIONALISM AND ETHICS

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PRESIDENT'S MESSAGE

Donna Wilson –CIR-MIL

It's been a busy and exciting time for IAIR!

At the NAIC Fall National Meeting in Miami, several committees met and furthered their work, the Receivers and Guaranty Fund Relations committee meeting was well attended (See Lynda Loomis' wrap up later in this issue), Kathleen McCain conducted an educational and thought provoking Issues Forum, the Annual Meeting resulted in four directors continuing on the Board and the election of Don Roof to his first term. The Annual Meeting was capped off with a great celebration of IAIR's 25th Anniversary where Joe DeVito captivated us with a rendition of Unchained Melody.

James Kennedy and Pat Hughes successfully co-chaired the 2017 Insurance Resolution Workshop February 1-3 (See Summary in this issue). With over 160 attendees, excellent topics and panels, warm Austin weather and great food and locale, it was an event that will not soon be forgotten. Great work gentlemen!

During the Workshop, James Mills was awarded the Accredited Insurance Receiver (AIR) designation for legal experience and awarded a plaque and lapel pin. Congratulations James!

But now is not the time to sit back and rest on our accolades! There are opportunities to further our mission!

And that is one of the items your Board is contemplating – what is IAIR's mission? Bernie Heinze of Accolade Management Services LLC began guiding the Board in developing a strategic plan during the Board meeting in Miami and we quickly realized our current mission statement is more about what we do than why we do it. As we proceed, the Board will be seeking your input on revising the mission statement and other elements of the strategic plan.

IAIR's committees have begun 2017 with very full agendas. Thank you to all the committee chairs and the committee members. Without you, the Board would not be able to fulfill our obligations.

The Audit, Finance, Governance, and Membership & Promotions Committees are working to improve our organizational processes and fulfill our duties to the association and to you.

The Ethics Committee has worked diligently to develop outlines and processes to improve our professional designation program. The development, review and discussions have been thorough and collaborative. The Board has reviewed their work, made a few tweaks and will soon be ready to seek your feedback and begin soliciting support for further program development.

A blog is being developed by the Website Committee where we can share our thoughts on various issues and topics as well as our individual triumphs. My hope is that this will be a venue to seek other's input similar to the roundtable meetings held during NAIC in the past.

The Ad-hoc Response Committee is preparing comments to various requests and consultations. IAIR provided comments to the NAIC Receivership Model

Law Working Group on issues and implications of long-term care insurance (available on-line and in this issue). Also, as an interested stakeholder of the International Association of Insurance Supervisors (IAIS), IAIR will be providing comments in response to a formal consultation by the Resolution Working Group expected in March 2017.

There is no time to rest after the Insurance Resolution Workshop for the Education Committee. IAIR is again participating in the UConn Insurance Solvency Law and Regulation course – Thank you to Bill Goddard, Partner at Day Pitney, LLP and Adjunct Faculty for UConn School of Law, for this opportunity. The committee is busy preparing for events in Denver including the Issues Forum and a joint SOFE/IAIR breakfast sponsored by Risk & Regulatory Consulting during which there will be a presentation on Long Term Care Insurance. The Education Committee continues its work on a webinar series focusing on the basics of the resolution process. As if that's not enough to keep the Education Committee busy, there are other opportunities to provide state training, presentations to guaranty fund zones and other joint events. And work begins now for the 2018 Insurance Resolution Workshop – Mark your calendars to be in Scottsdale February 7-9, 2018!

It is indeed a busy and exciting time for IAIR! I encourage you to participate – serve on a committee, provide articles or review support for the newsletter, co-chair a workshop, speak on a topic, post to the blog – There's something for everyone and I look forward to hearing from you all.

RECEIVERS & GUARANTY FUND RELATIONS COMMITTEE NAIC FALL 2016 RECAP

IAIR's Receivers & Guaranty Fund (R&GF) Relations Committee met at the NAIC Fall 2016 National Meeting in Miami, Florida. The R&GF Committee welcomed Frank O'Loughlin, of Lewis Roca Rothgerber Christie, LLP, who provided an update on the many developments in health insolvencies and an update on issues and litigation between health insurer estates and the Federal government.

Frank noted that as of December 10th, there are 25 pending lawsuits between receivers and the Federal government regarding the Affordable Care Act ("ACA"). Many of the lawsuits involve CO-OPs that have failed. Some of the cases reviewed included Land of Lincoln (failed IL CO-OP), where the U.S.'s motion to dismiss was granted by the court deferring to the federal agency's interpretation of the ACA, and lawsuits filed by solvent health insurers, including Blue Cross & Blue Shield of North Carolina and Moda Health Plan (Oregon) involving the risk corridors. Frank noted that there are many different judges overseeing related suits demanding risk-corridor payments, both in federal courts and in domestic jurisdictions.

The claims filed in U.S. Federal Claims Court involve the Tucker Act (28 U.S.C. § 1491), which is a federal statute pursuant to which the U.S. government has waived its sovereign immunity with respect to certain lawsuits. Other cases filed in federal district courts seek declaratory & injunctive relief.

Frank noted that a couple months ago CMS had sent a letter to various CO-OPs about settling the risk corridor issues. Consequently, there are two Bills that have been introduced to block any settlement by CMS. In the House, the Bill provides that CMS cannot use the federal Judgment Fund. In the Senate, the Bill provides that CMS cannot use the Judgment Fund to settle cases, nor can CMS use the Judgment Fund to settle litigation. Some commented it might be a delay tactic by those who would like to see a repeal of the ACA.

Doug Schmidt, of Husch Blackwell, provided an update on the insolvency of CoOportunity Health, Inc. ("CoOportunity"). In that matter, the Liquidator sought to enjoin the United State from effecting any setoffs. After briefing, the federal district court denied the Liquidator's request for an injunction.

Those in attendance discussed other developments that they were aware of, recent political events and the potential impact on resolving issues such as the priority of payment of claims in CO-OP insolvencies, and the Federal government position on priority regarding repayment of HHS loans.

Upon the suggestion of James Kennedy, R&GF will try to reach out to the receivers of the other state CO-OP insolvencies not already discussed to seek their input and participation in the ongoing conversation.

SELECTED ISSUES AND DEVELOPMENTS IN FEDERAL INCOME TAXES

By Michael C. Warren and Lori J. Jones

This article focuses on certain federal income tax issues that can arise when an insurance company is in receivership and particularly when the insurance company is a member of a consolidated group. It discusses the importance of federal income tax considerations for the receiver (even in a situation where the insurer has significant loss carryforwards) and certain recent developments at the IRS. The article also addresses the considerations in two fairly common scenarios involving the filing (or lack thereof) of the respective federal income tax returns and describes a variety of options and tools to obtain IRS assistance and resolve the insurer's tax situation.

Why Taxes Matter to Receivers

When a receiver is appointed by a court to operate an insurance company that is either in rehabilitation or liquidation, the Internal Revenue Code (IRC) generally imposes an obligation on the receiver personally for the filing of tax returns and potentially for the payment of tax liability. In general, the post-receivership tax liabilities of the company are classified as Class 1 administrative expenses. Tax liabilities incurred during periods prior to the receivership date generally will fall into a liquidating distribution class payable only after policyholder claims have been paid in full. In general, an insurance company in receivership must file a tax return with the IRS (Form 1120-PC if a nonlife insurance company or Form 1120-L if it qualifies as a life insurance company for tax purposes) using the same tax year after receivership as before. Receivers should be aware that the definition of what qualifies as a life insurance company for tax purposes is a complex and tricky quantitative computation and does not depend upon the company's state license classification or which type of Annual Statement it files.

The receiver is required to continue filing tax returns even if the company has large NOLs (net operating losses if a nonlife insurance company) or OLDs (operations loss deductions if a life insurance company) carrying forward into receivership. In addition, an insurer could incur an AMT (alternative minimum tax) in post-receivership years even if existing losses exceed taxable income. This occurs because, in general, only 90% of any pre-NOL taxable income can be offset by the AMT NOL carryforward so that the remaining 10% could cause a 20% AMT to be payable. There is a notable exemption to the AMT for small companies as defined in IRC Section 55(e). Receivers of companies that have previously qualified as life insurance companies for tax purposes also should be aware of the potential for a tax ("Phase III trigger") on any accumulated Policyholder Surplus Account balance. The timing of this tax can be a minefield for unsuspecting receivers, although if a timely election was made for 2005 or 2006 the possibility of a Phase III trigger may have been eliminated.

In general, a three-year statute-of-limitations prevents the IRS from assessing additional tax, such time beginning to run on the date the tax return is filed or the due date of the return, whichever is later. If no tax return has been filed for a particular year, the statute-of-limitations does not begin to run until the return is filed. Further, if there is a 25% or more understatement of gross income in any filed return, a six-year statute-of-limitations applies. Also, if any filed return is later deemed fraudulent by the IRS, the statute-of-limitations never begins to run. Even in cases where the IRS assesses additional tax on a receivership estate, there are significant limitations on the IRS's ability to actually levy or seize receivership assets to satisfy an assessment. The fact that the receivership Court Order prevents any party from obtaining control over its assets is a powerful deterrent to keep the tax collector in check.

In general, the post-receivership tax liabilities of the company are classified as Class 1 administrative expenses.

What Is New at the IRS

Since 2010, the IRS's budget has been severely curtailed. Most recently, a freeze on federal hiring was imposed via an Executive Order signed by President Trump on January 23, 2017. In addition, the term of current IRS Commissioner John Koskinen ends on November 12, 2017, and it is not clear whether he will stay given the change in the administration and controversy over his actions as Commissioner. Consequently, there have been many administrative changes at the IRS including longer response times to inquiries, a reduction in the number of audits, additional limitations on issues for which the IRS will consider advance rulings, and significantly higher user fees for private letter ruling requests

and pre-filing agreements, and more changes are likely.

One major change that could affect insurance companies is the recent reorganization of the Large Business & International (LB&I) Division of the IRS. LB&I is the principal group handling the examinations for large corporations (those with assets greater than $10 million), so as a practical matter, it is the primary IRS contact for many insurance companies that have outstanding audits. The most recent reorganization announced late in 2015 aligned LB&I's approximately 4,500 employees into four regional practice areas (Western, Central, Eastern, and Northeastern) and five subject matter practice areas (Pass-Through Entities, Enterprise Activities, Cross-border Activities, Withholding and International Individual Compliance, and Treaty and Transfer Pricing Operations). Enterprise Activities is the area generally relevant to insurance companies and the current Director is Kathy J. Robbins. In order to better identify the issues that should be audited, LB&I has instituted a number of changes, including changes to Information Document Requests issued by the IRS which must now be more issue-focused (which focus requires taxpayer input). Also, under a new Campaign Approach, the IRS has identified potential areas of noncompliance, such as the "micro-captive transactions" in the insurance industry, and designed "campaigns" to specifically address them.

Another group relevant to insurers at the IRS is the "Insurance Branch." This is a specific branch in the Financial Institutions and Products Division of the Office of Chief Counsel of the IRS located in Washington, DC. The IRS Office of Chief Counsel has many responsibilities including the issuance of regulations, revenue rulings, revenue procedures, private letter rulings (these rulings are issued to a particular taxpayer and can provide comfort on the tax treatment of particular items such as a type of reorganization) and other general guidance. The Insurance Branch focuses specifically on issues arising under subchapter L for insurance companies and items affecting the taxation of policyholders and can be a good resource to provide answers to technical tax questions in their jurisdiction.

The most troublesome tax issues for insurance companies in receivership seem to arise when they are or have been members of a consolidated group for federal income tax purposes.

Common Issues with the Filing of Tax Returns

The most troublesome tax issues for insurance companies in receivership seem to arise when they are or have been members of a consolidated group for federal income tax purposes. In general, the common parent is the sole agent for the group for all matters (except those specifically excepted under the regulations) and, as a result, members of the group have no ability to discuss their outstanding federal tax liability directly with the IRS. Therefore, the lack of common parent cooperation creates all kind of issues addressed in more detail below. On the other hand, if the common parent cooperates, it is possible for a subsidiary (acting through the receiver) to become the agent for the consolidated group so that it can become the voice of the group as far as the IRS is concerned, although this may not always be the desired outcome if there are other members of the consolidated group or for non-tax liability reasons. Alternatively, there are provisions which allow a subsidiary to request that the IRS "break agency" and deal directly with the subsidiary. These options can be helpful when trying to resolve issues described below that can arise within a consolidated group setting.

As a general matter, under IRC Section 1504, a subsidiary is a member if its stock is held by another domestic corporation and that stock represents at least 80% of the voting power and 80% of the value of the outstanding subsidiary stock (although in some cases there might be a waiting period for a new life insurance subsidiary). Once a consolidated return has been filed by the common parent, a consolidated return must continue to be filed (absent the Commissioner's consent to deconsolidate which is rarely given) as long as the 80% affiliation standard is met. Receivership, rehabilitation, or liquidation (assuming there is no transfer of the stock) does not generally result in the subsidiary being deconsolidated from the group. Once a consolidated return is filed, all members of the group share several liability for the tax liability determined on a consolidated basis, even if the member generated no taxable income in the year in question, and without regard to contrary provisions in a tax sharing agreement.

Common parents often fail in their tax filing obligations, causing problems for the receivers of subsidiary insurance companies in the group. Two common failures are as follows: (1) the common parent fails to file a consolidated return even though it is required to file the returns on behalf of the group; and (2) the common parent timely files a consolidated return, but fails to include the receivership subsidiary at all or fails to include complete and accurate information regarding the insurance subsidiary even though the insurer is still listed as a member. A common issue in the second scenario is that the common parent does not share the filed consolidated return with all members of the consolidated group, leaving them in the dark and creating significant uncertainty regarding potential federal tax liability or potential tax refunds allocable to the insurer and further uncertainty regarding whether the receiver's fiduciary obligations with respect to filing returns have been satisfied.

There are many variables that must be considered to determine the best approach in these situations, but some possible approaches are suggested below. In the first scenario, as indicated earlier, if no return has been filed, the statute-of-limitations on assessment has not yet begun to run and, therefore, it is impossible to definitively assess whether there is any federal income tax liability for members of the

group, including the receivership subsidiary. In general, in that case, because the common parent is the sole agent, no member has the ability to file the consolidated return. Some companies in this situation have taken a two-fold approach in that they first ask the IRS to "break agency" so that they can act as their own agent and secondly they file either a separate return reflecting only their tax information or a consolidated return on behalf of the group. Either situation likely results in the need to include disclosures in the return (typically on IRS Form 8275 "Disclosure Statement") to explain the reason for the inconsistent filings and any other significant issues. It is important that any separate return include a specific disclosure referenced in the consolidated return regulations so that the return can be treated as starting the statute of limitations on assessment at least with respect to the receivership subsidiary's tax liability. In addition, if a separate return is filed after the due date (with extensions), for example, because the common parent failed to file the return on time, the IRS is likely to automatically assess tax penalties if there is tax shown as due on the return. If the tax is not paid because it is not considered a Class 1 administrative expense or is paid late, for example, the receiver can seek a waiver of some of the penalties by filing Form 843 as described below.

In the second scenario, a consolidated return has been filed, but it either does not list the subsidiary as a member or does not include the subsidiary's complete and accurate tax information, even though the subsidiary is still a member of the group. The tax regulations generally provide that if a consolidated return is required, the group's tax liability must be computed on a consolidated basis, even if separate returns were filed or the income of one member was not included in the consolidated return. The initial challenge here is to try and get a copy of the filed tax return or at least the IRS transcript which covers the year(s) for which the consolidated returns were reportedly filed. This can be very difficult to do without the common parent's assistance. The second challenge is to decide what, if any, actions to take with respect to the filing of tax returns for the year(s) in question. Depending on the content of the filed consolidated return, there might be support for the position that the filed return was in substantial compliance with the requirements for filing and, therefore, there is no requirement to file a separate return reflecting only the subsidiary's tax information. In addition, as a general matter, a taxpayer is under no obligation to file an amended return if it is later determined that the earlier-filed return is incorrect. Alternatively, particularly if a copy of the consolidated return is not available, the receiver may decide to file a separate return to ensure that his/her fiduciary obligations are satisfied. And similar to the separate returns mentioned above, it is important to include a disclosure statement which describes the unique situation for the return filing.

Important IRS Forms

This section provides a list of various forms that can be important to receivers in numerical order.

FORM 56—Notice Concerning Fiduciary Relationship—This Form must be filed with the IRS by the receiver upon being named as the fiduciary for the receivership estate. A "closing" Form 56 should be filed with the IRS when the receivership is closed. IMPORTANT: The Receiver should file Form 56 as soon as appointed. Under IRC Section 6872, failure to file the Form can result in a suspension of the otherwise applicable statute of limitations on assessment for a period of up to two years.

FORM 843—Claim for Refund and Request for Abatement—This Form can be used to request abatement (on the basis of reasonable cause) of late filing and late payment penalties (except for estimated tax penalties) that have been erroneously assessed by the IRS.

FORM 911—Request for Taxpayer Advocate Service Assistance—This Form can be used when the IRS is being recalcitrant about an issue. Hardship cases take priority with the Taxpayer Advocate's office, so the receiver should make a case for hardship based on claims going unpaid while the IRS fiddles around, i.e., is unresponsive.

FORM 982—Reduction of Tax Attributes Due to Discharge of Indebtedness—This Form must be included in the tax return when the receivership has experienced decreases in unpaid claims liabilities (unless from actual payment of claims) that qualify for exclusion from gross income under IRC Section 108 described below.

FORM 2848—Power of Attorney and Declaration of Representative—This Form should be filed with the IRS in order to facilitate dialogue and problem resolution between the IRS and the tax practitioner/advisor. Tax practitioners, designated in a Form 2848, have a special hotline that they can access to speak directly with IRS representatives about outstanding issues. Recently, the IRS has been very particular if the exact name of the taxpayer contained on the Form 2848 differs from the name used in the tax return.

FORM 4506—Request for Copy of Tax Return—This Form has been used with mixed success since the IRS often does not recognize receivers as authorized requesters. Some success has been had with the tax practitioner making this request using powers granted by the receiver under Form 2848.

FORM 4506-T—Request for Transcript of Tax Return—An expedited request is available, but still with mixed success as with Form 4506 above. The transcript contains less information than the actual tax returns, but it is particularly helpful in showing the history of tax payments and any refunds issued to the taxpayer.

FORM 4810 —Request for Prompt Assessment Under Internal Revenue Code Section 6501(d)—This Form should be filed for each tax year immediately after the tax return has been filed. If the IRS grants the request, the usual three-year statute-of-limitations is reduced to 18 months, providing additional protection to the receiver. If there is no immediate time concern and there are potential significant audit issues in the filed return, it may not be beneficial to file the Form

4810 because it could generate an IRS audit of the return. A possible alternative to Form 4810 is a Request for Prompt Determination of Tax Liability pursuant to Rev. Proc. 2006-24, 2006-1 C.B. 943. This procedure can be used to request that the IRS make a choice to either examine already-filed returns, or "accept as filed" the returns already filed. (Technically, this procedure only applies to companies in a title 11 case, but in the past the IRS has extended it to insurers in receivership.) Under this procedure, the IRS has 60 days to decide to either examine the filed returns or issue an "accepted as filed" letter to the receivership. This is different from the Form 4810 procedure described above in that it does not alter the usual three-year statute-of-limitations, but provides, as a practical matter, assurance that the IRS has no issues with the filed returns and would generally not pursue any issues with the filed returns. However, these two procedures are the only avenues for obtaining an IRS "release" of tax returns that have been filed for the receivership. In short, there is no way to achieve an exact "cutoff" of future tax liability that is coincidental with the closing of the receivership. The final tax return for the receivership will still have to be filed after the receivership is closed and before any statute-of-limitations has expired.

FORM 8275—Disclosure Statement—This Form (including a detailed supporting statement) should accompany each year's tax return in order to inform the IRS of the existence of a State Court receivership, especially when the tax return is being filed without being accompanied by an Annual Statement as required by IRS Regulations. The detailed statement should also disclose the basis of accounting used in the tax return as well as the existence of any estimates of material items being used.

FORM 8822—Change of Address—This Form should always be filed at the beginning of each receivership in order to make certain that the receiver is notified of all IRS correspondence being issued, such as assessments and tax adjustments.

Important Code Sections

As a final note, this section highlights some Code sections that are often applicable or arise in connection with receiverships. It by no means covers all potentially applicable Code sections.

IRC SECTION 108—Discharge of Indebtedness Income – Gross income does not include discharge of indebtedness income if the company is either in a title 11 case or insolvent. Insurers can take advantage of the insolvency exclusion in certain cases, although if such income is excluded, IRC Section 108(b) also requires the reduction of certain tax attributes so they might not be available going forward. See Form 982 discussed above.

IRC SECTION 111—Recovery of Tax Benefit Items—"Gross income does not include income attributable to the recovery during the taxable year of any amount deducted in any prior taxable year to the extent such amount did not reduce the amount of tax imposed by this chapter." For this purpose, NOL carryforwards are treated as reducing the amount of tax imposed; however, receivers should be aware of expiring or expired NOL carryforwards that might make this provision useful.

IRC SECTION 831(b) ELECTION--This is a permanent election to be taxed on "Net Investment Income" instead of overall taxable income. This is useful in the case of large litigation and reinsurance recoveries. But, this election is irrevocable without approval of the IRS Commissioner, and likely generates some level of taxable income each tax year. Receiverships can use Early Access Distributions with "claw back" provisions to control the level of assets in the receivership estate earning investment income.

IRC Section 832(c)(5) and Schedule G of FORM 1120-PC—Insurance companies in receiverships can get an ordinary deduction (unlimited) for Capital Losses (which are usually not deductible unless they offset Capital Gains) for "Capital assets sold or exchanged to meet abnormal insurance losses and to pay dividends and similar distributions to policyholders." In other words, if the receiver is forced to sell assets at a loss in order to pay policyholder claims, that loss may be deductible without limitation from ordinary taxable income.

Finally, we are frequently asked whether an insurer in receivership can obtain a release letter from the Federal Government. The answer is yes, but not with respect to federal income taxes. The release letter can be issued by the U.S. Department of Justice. This letter, when received, can assure the receiver that no other department of the Federal Government has an outstanding claim against the receivership. However, this letter will state explicitly that it covers all government departments EXCEPT the department of the Treasury and the Internal Revenue Service. Again, in short, there is no way to achieve an exact "cutoff" of tax liability that is coincidental with the closing of the receivership.

In short, there is no way to achieve an exact "cutoff" of future tax liability that is coincidental with the closing of the receivership.

Conclusion

Different issues can arise depending on the underlying facts and circumstances such as the type of business and whether the insurer is a member of a consolidated group. This article highlights only some of the federal income tax issues that can arise in an insurer receivership. Consequently, dealing with the potential federal tax issues of an insurance company in receivership can be tricky and the possibility of the receiver having personal liability (even if the risk is remote) is an important consideration.

WHOSE PRIVILEGE IS IT? - ATTORNEY-CLIENT PRIVILEGE ISSUES IN INSURANCE RECEIVERSHIPS

By John Murphy and Louie Jorczak

Introduction

When an insurance company is placed into rehabilitation, and then liquidation, litigation often ensues regarding the performance or conduct of officers and directors that led to the circumstances that put the company into liquidation. Often, situations arise relating to the attorney-client privilege of the insolvent company, especially when the insolvent company is a subsidiary or parent of another company. In these instances, the officers and directors of the two companies are often the same individuals. Generally, two types of attorney-client privilege issues arise in these situations. The first is when a former director attempts to assert the insolvent company's attorney-client privilege, to protect the interests of himself and the other former officers and directors of the company, in opposition to state insurance Commissioner or another receiver in charge of winding down the insolvent company. The second is when a former director attempts to assert the privilege on behalf of one entity against another during a time in which both entities were jointly operated.

Generally, in both situations, the answer to the attorney-client privilege question is that former officers and directors are unable to successfully assert the company's privilege. In an insurance receivership, the company is effectively under new management. The courts have generally held that the former officers or directors no longer control the entity's affairs, and thus only the receiver, as the new controlling management, can assert or waive the attorney-client privilege on behalf of the entity. In situations where parent and subsidiary companies were formerly jointly represented, communications are not privileged in a subsequent action between the two parties. Absent facts establishing that one of the insurers took measures to prevent its parent or subsidiary from gaining access to the claimed privileged information, the communications are discoverable.

The following discussion and analysis will help insurance rehabilitators and liquidators navigate the thorny issues that often arise when the conduct of former officers and directors, and their communications with counsel, are implicated after an insurer is placed into receivership.

1. Controlling the Insolvent Insurer's Attorney-Client Privilege

A. A Trustee, Receiver or Liquidator May Waive an Insolvent Insurer's Attorney-Client Privilege for Pre-Liquidation Communications.

The U.S. Supreme Court provides significant guidance to state courts on these questions in the bankruptcy context, analogous to insurance receiverships. *Commodity Futures Trading Comm'n v. Weintraub*, 471 U.S. 343 (1985) is a seminal case regarding the ability of a receiver to waive the attorney-client privilege with respect to communications occurring on or before the initial appointment of the receiver. In *Weintraub*, the Commodity Futures Trading Commission filed a complaint alleging violations of the Commodity Exchange Act by the Chicago Discount Commodity Brokers (the "Company"). *Id.* at 345. The sole director of the Company entered into a consent decree that resulted in the appointment of a receiver who was ultimately appointed trustee in bankruptcy on behalf of the Company. *Id.* at 345-46. Weintraub, the Company's former counsel, appeared for a deposition, but refused to answer certain questions, asserting the Company's attorney-client privilege. *Id.* at 346. Ultimately, the Court agreed with the trial court, reversing the Seventh Circuit, and ruled that the trustee of a bankrupt corporation has the power to waive the corporation's attorney-client privilege with respect to communications that occurred before the filing of the bankruptcy petition. *Id.* at 347.

This is because the power of a corporation to waive its attorney-client privilege rests with its management, and is normally exercised by its officers and directors. *Id.* at 348. Upon transfer of control from prior officers and directors to a receiver as new management, the authority to assert and waive the privilege also transfers to the receiver in the role of new management. *Id.* The receiver may waive the attorney-client privilege with respect to communications made by former officers and directors, and displaced managers "may not assert the privilege over the wishes of current managers, even as to statements that the former manager might have made to counsel concerning matters within the scope of their corporate duties." *Id.* at 349. The dispute in *Weintraub* centered around which party has the ability to waive the company's attorney-client privilege when the company is in a bankruptcy receivership – the bankruptcy trustee or the debtor's directors? *Id.*

The Court noted that in situations outside of bankruptcy, the attorney-client privilege is controlled by the management of the company. *Id.* at 351. It follows that the actor whose duties

most closely resemble those of management should control the privilege in bankruptcy – namely the trustee. *Id.* at 351-52. This is so because the powers and duties of a bankruptcy trustee with respect to managing the insolvent corporations business are extensive. *Id.* at 352. The trustee is accountable for all the property received, has the duty to maximize the value of the estate, is directed to investigate the debtor's financial affairs, is empowered to sue on the debtor's behalf, and has substantial power to operate the debtor's business. *Id.* Even in liquidation, the court may authorize the trustee to operate the business for a limited period of time. *Id.*

"[d]isplaced managers may not assert the privilege ***over the wishes of current managers****, even as to statements that the former might have made to counsel concerning matters within the scope of their corporate duties."*

In contrast to the broad and wide-ranging powers given to the trustee in bankruptcy, the powers of the debtor's directors are severely limited. *Id.* Their role is to turn over the property and provide certain information to the trustee and creditors. Id. Indeed, when a trustee is appointed, "the trustee assumes control of the business and the debtor's directors are 'completely ousted.'" *Id.* at 352-53. The Court concluded that because the trustee plays the role most closely analogous to that of a solvent corporation's management, the debtor's directors "should not exercise the traditional management function of controlling the corporation's attorney-client privilege, unless a contrary arrangement would be inconsistent with policies of the bankruptcy laws." *Id.* at 353.

The Court found no such policies, and, in fact, concluded that allowing the officers and directors to assert the corporation's privilege would frustrate an important goal of the bankruptcy laws – that being the trustee's duty to "investigate the conduct of prior management to uncover and assert causes of action against the debtor's officers and directors." *Id.* This inquiry would become virtually impossible to conduct if the former management were allowed to control the privilege. *Id.* "To the extent that management had wrongfully diverted or appropriated corporate assets, it could use the privilege as a shield against the trustee's efforts to identify those assets." *Id.* Again, for these reasons, the Court concluded that the trustee of a corporation in bankruptcy has the power to waive the attorney-client privilege with respect to pre-bankruptcy communications. *Id.* at 358.

Two states have followed the Supreme Court's lead on this issue, and, both citing *Weintraub,* have held that a State's Commissioner of Insurance, as liquidator of an insurance company, has the power to waive the insurance company's attorney-client privilege with respect to pre-liquidation communications.

In *Hon. James H. Brown, Comm'r of Ins. for the State of Louisiana v. Car Ins. Co.*, 634 So.2d 1163 (La. 1994), the Louisiana Supreme Court held that the State's insurance commissioner was authorized to waive the attorney-client privilege on behalf of a corporation for pre-liquidation activity. The court also held that a law firm could not assert the work-product privilege against the Commissioner who was acting as the legal representative of the corporation for whom the legal work was performed. *Id.* The case arose out of the rehabilitation and liquidation of Automotive Casualty Insurance Company. *Id.* at 1164. Under Louisiana law, the Commissioner was empowered to conduct the business of the insurer and take the necessary steps to remove the causes and conditions that led to the insurer's problems. *Id.* Once the Commissioner determined that further rehabilitative efforts would be futile, he applied to the court for an order directing the liquidation of the insurer. *Id.* at 1164-65.

Shortly thereafter, the Commissioner requested that the law firm that rendered legal advice to the insurer regarding regulatory matters prior to liquidation turn over files and documents related to the services performed for the insurer. *Id.* at 1165. The firm refused to turn over the files after a former executive officer of the insurer declined to waive the attorney-client privilege. The Louisiana Supreme Court granted certiorari to answer the question of whether the Commissioner had the power to waive the privilege with respect to communications that occurred before the filing of the liquidation petition. *Id.*

The court first reviewed the statute creating the privilege, the Louisiana Code of Evidence, which states that the privilege may be claimed by "the client, the client's agent or legal representative, or the successor, trustee, or similar representative of a client that is a corporation, partnership, unincorporated association, or other organization, whether or not in existence." *Id.* (quoting La. Code Evid. Art. 506(D)). Under the Louisiana Code of Civil Procedure, a "legal representative" includes, among others, receivers, trustees, and liquidators. *Id.* Based on the definitions of these terms under Louisiana law, the Court concluded that the Commissioner had the power to waive the privilege with respect to the confidential communications of the company's former officer. *Id.* Since the insurer was the entity to which legal services were rendered, the insurer held the privilege, and, since the Commissioner was the liquidator and "legal representative" of the insurer, he had the power to claim the privilege held by the company. *Id.* "By the same token, the Commissioner as the company's legal representative may act for the company in waiving the privilege or in consenting to the disclosure of privileged matter." *Id.* at 1165-66.

Relying heavily on *Weintraub*, the court rejected the former officer's arguments that he may continue to claim the privilege on behalf of the company. *Id.* at 1166. New managers of a corporation, regardless of the manner in which they are installed (takeover, merger, loss of confidence by shareholders, or normal succession) "may waive the attorney-

client privilege with respect to communications made by former officers and directors." *Id.* In addition,

"[d]isplaced managers may not assert the privilege ***over the wishes of current managers***, even as to statements that the former might have made to counsel concerning matters within the scope of their corporate duties." *Id.* (emphasis added) (citing *Weintraub*, 471 U.S. at 349; *In re O.P.M Leasing Servs., Inc.*, 670 F.2d 383 (2d Cir.1982); *Citibank, N.A. v. Andros,* 666 F.2d 1192 (8th Cir.1981); *In re Grand Jury Investigation,* 599 F.2d 1224, 1236 (3rd Cir.1979); *Diversified Indus., Inc. v. Meredith*, 572 F.2d 596, 611, n.5 (8th Cir.1978)).

The court also rejected the former officer's contention that the liquidator's control over the privilege would have a "chilling" effect on attorney-client communications. *Id.* The court rejected this contention, noting, like the Weintraub Court, that the chilling effect is no greater in this situation than in the situation of a solvent corporation whose directors always run the risk that successor management may waive the privilege with respect to prior management's communications with counsel. *Id.* (citing *Weintraub*, 471 U.S. at 357). Indeed, the only party that would really be stifled or "chilled" in exercising its duties, would be the Commissioner, who would be frustrated in his duty to "maximize the value of corporate assets, investigate the conduct of prior management, and uncover causes of action against the former officers and directors." *Id.*

In addition to holding that former officers may not claim the corporation's attorney-client privilege to stifle the Commissioner's efforts to obtain information leading to the possible injurious actions of such former officers, the court also rejected the former officer's contentions that the work-product privilege applied. *Id.* at 1166-67. Any work was prepared in connection with professional legal services rendered to the insurance corporation, not the former officer, thus he could not personally invoke the work-product privilege in his individual capacity. *Id.* at 1167. In addition, because he was no longer in the employ of the company, the former officer could not invoke the work product shield on behalf of the corporation. Nor could the law firm unilaterally withhold the information because, despite the fact that a lawyer may claim the work-product privilege in opposition to third persons, he cannot invoke the privilege against his own client – in this case, the Commissioner as liquidator. *Id.*

Pennsylvania held similarly in *Cynthia M. Maleski, Ins. Comm'r of the Commonwealth of Pa. v. Corporate Life Ins. Co.*, 641 A.2d 1 (Pa. 1994), discussed further below. This case also concluded that the Commissioner of Insurance, as liquidator of an insurance company, has the power to waive the insurance company's attorney-client privilege with respect to communications that took place before the insurance company was placed into liquidation.

B. A Very Limited Exception May Allow a Former Officer and Director to Invoke the Privilege on His or Her Own Behalf.

Only in very limited circumstances may a former officer and director successfully invoke the privilege for actions undertaken when the former officer or director was still with the now-insolvent insurer. The exception is illustrated in *Cynthia M. Maleski, Ins. Comm'r of the Commonwealth of Pa. v. Corporate Life Ins. Co., supra*, where the Commonwealth Court of Pennsylvania held that the State's Insurance Commissioner could waive any attorney-client privilege held by a company in liquidation. The facts of this case are very similar to the facts of *Brown*, and the Commonwealth Court also relied heavily on *Weintraub* in holding that the privilege belonged to the Commissioner and not the former officers. *Id.* at 3. Like *Weintraub* and *Brown*, the court held that the Liquidator-Commissioner performed a function most analogous to that of the management of a corporation winding up affairs, and was, therefore, the "management successor to the former directors and officers" and thus could waive the attorney-client privilege with respect to confidential pre-liquidation communications. *Id.* at 4.

Although holding that the former officers and directors could not assert the company's attorney-client privilege, the court did address a wrinkle not at issue in either *Weintraub* or *Brown*; namely, the issue of whether there were any circumstances under which the former officers held a privilege individually, separate and distinct from the company. *Id.* at 4. The court held that the former directors and officers may have a privilege separate and distinct from the corporation in extremely limited circumstances. In order to assert the privilege, the former officers would be required to meet a five-part test to establish the privilege. *Id.* The former officer or director must show (1) that they approached counsel for legal advice; (2) that they made it clear at that time that they were seeking advice in their individual and not corporate capacities; (3) that counsel saw fit to communicate with them in that capacity despite potential conflicts; (4) that the conversations were confidential; and (5) that the substance of the communications with counsel did not contain matters within the company or the general affairs of the company. *Id.* at 4-5.

The court held that the former directors and officers may have a privilege separate and distinct from the corporation in extremely limited circumstances.

2. Privilege Issues Regarding Formerly Jointly Represented Clients

Generally, when companies are subsidiaries or parent companies of other insurance companies, these companies will often share common officers and directors. Privilege issues arise when a former director attempts to assert the attorney-client privilege on behalf of one entity against another during a time in which both entities were jointly

operated. Generally, communications between jointly represented clients are not privileged in a subsequent action between the two parties and are discoverable.

Indiana state and federal courts have recognized that the attorney-client privilege cannot be used to prevent disclosure of privileged communications against presently adverse, but formerly commonly-represented parties. *Woodruff v. Am. Family Mut. Ins. Co.*, 291 F.R.D. 239, 244 (S.D. Ind. 2013); see also *Simpson v. Motorist Mut. Ins. Co.*, 494 F.2d 850, 855 (7th Cir. 1974) (applying Ohio law, the Seventh Circuit observed that "where the same attorney represents two parties having a common interest, and each party communicates with the attorney, the communications are privileged from disclosure at the instance of a third person. Those communications are not privileged, however, in a subsequent controversy between the two original parties."); *Hanlon v. Doherty*, 9 N.E. 782, 785 (Ind. 1887) (where attorney acts for two parties, communications made to attorney are not confidential in action between the two parties).

Courts around the country have reached a similar conclusion. *Janousek v. Slotky*, 980 N.E.2d 641, 651-52 (Ill. App. Ct. 2012) (concluding that where the same attorney represented an LLC and its individual members, the majority members could not assert attorney-client privilege as to communications related to the LLC's business while minority member was still a member of the LLC); *Anten v. Superior Ct.*, 233 Cal. App. 4th 1254, (Cal. Ct. App. 2014) ("[C]ommunications made by parties united in a common interest to their joint or common counsel, while privileged against strangers, are not privileged as between such parties nor as between their counsel and any of them, when later they assume adverse positions."). Furthermore, courts have recognized that where the same attorneys acted on behalf of a parent corporation and its subsidiary, the former parent could not assert the attorney-client privilege against the subsidiary as to communications with the legal department that represented both entities prior to the sale of the subsidiary. *In re Santa Fe Trail Transp. Co. v. Santa Fe Indus.*, 121 B.R. 794, 798-800 (Bankr. N.D. Ill. 1990).

In *Transmark, USA, Inc. v. Florida Dept. of Ins.*, 631 So.2d 1112 (Fla. Ct. App. 1994), the Florida Department of Insurance placed Guarantee Security Life Insurance Company ("GSL") into receivership. *Id.* at 1113. GSL was a wholly-owned subsidiary of Transmark USA. *Id.* The Receiver then brought a lawsuit against Transmark, as well as the former directors and officers of both Transmark and GSL, alleging that the defendants had concealed the insolvency of GSL from regulators. *Id.*

Transmark and GSL, while legally distinct entities, were essentially operated by the same employees and had, for the most part, interlocking directors and officers. *Id.* at 1114. Transmark maintained its legal files together with those of its subsidiaries, and employed the same in-house and outside counsel with respect to various matters. *Id.* Multiple attorneys (both in-house and outside counsel) testified that "there was no expectation or mandate that communications" with the entities' lawyers would be treated as confidential between any of the entities themselves. *Id.*

The Receiver sought production of documents from Transmark and one of its directors/officers related to GSL. *Id.* at 1115. Transmark and the director resisted production, asserting that the attorney-client privilege protected the documents from disclosure, and the Receiver moved to compel. *Id.* Relying on the Florida statutory scheme governing the attorney-client privilege and exceptions thereto, the Florida Court of Appeals affirmed the trial court's order compelling production of the documents. *Id.* at 1116-17. The court noted that there was evidence to support the trial court's conclusion that the attorneys jointly represented both companies "in matters pertinent to the transactions at issue in the complaint" and that there was never any expectation of confidentiality in attorney communications between the parent and subsidiary during the time that they were operated together. *Id.* at 1117. Accordingly, the court confirmed that the attorney-client privilege did not apply to the documents and communications that the Receiver sought. *Id.*

Conclusion

It is important that an insurance receiver or liquidator be aware of the attorney-client privilege issues that will arise when the conduct of the former officers and directors of an insolvent insurer are at issue. The liquidator or receiver of such an insurer needs to be aware that pre-liquidation communications may be discoverable. In addition, a liquidator or receiver must be aware of the possibility that the privilege can be, or has already been, waived with respect to pre-liquidation communications. Finally, a liquidator or receiver must be aware of the privilege issues that arise when entities that were formerly jointly operated and represented are no longer so operated and one entity seeks to assert the privilege.

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U.S. CAPTIVES – WHAT YOU MAY NOT KNOW

By Don Roof

Today, no matter your source of industry news it is rare not to find daily articles on the growing captive market. Whether it is a new type of captive, a new risk transferred to the captive market or a new captive domicile, the news is plentiful and overwhelmingly paints a picture of a successful and thriving market.

If success is measured by growth, then certainly promoters of the captive market can claim victory as the number of captives in the U.S. grew 133% from 1,415 in 2007 to 3,304 in 2015 . This growth is at least in part attributable to increased captive domiciles, now at 30, and efforts of such domiciles, through legislative and marketing initiatives, to attract captives to their jurisdictions.

While pure captives still comprise a large segment of the market and generally pose limited risk to the public, there are other less known forms of captives that write compulsory lines of insurance on a direct basis often without the safety net of guaranty fund coverage. As a former regulator responsible for solvency regulation, troubled company administration and receiverships, I have experienced firsthand the impact failures these types of captives have on claimants, employers and the insurance buying public, as well as the challenges they present to insurance regulators.

In my home state of Georgia, captive legislation was first enacted in 1988. Like most captive statutes in existence today, Georgia's captive law authorizes the formation of several types of captives including pure captives, association captives, and industrial insured captives.

Prior to the enactment of the captive law in Georgia, several trade and professional associations formed group self-insured workers' compensation funds to afford workers' compensation coverage to their members during the hard market of the mid-1980s. Following the liquidation of one of these group self-insured funds, wherein member employers had statutory joint and several liability which was successfully enforced by the Liquidator, Georgia quickly experienced the formation of a number of association captives as employers sought to limit their liability, or so they thought.

When the workers' compensation market turned and pricing became soft, the association captives began to lose employers with more favorable risk profiles to the traditional market. Although they may have recognized the precarious situation that was evolving, managers and third-party administrators of the majority of these association captives took no action to discontinue operations.

In recognition of the potential consequences that could result from changing market conditions, the Georgia Department of Insurance proactively took measures to increase its regulatory oversight by requiring captives to file on the same basis as traditional insurers including filing NAIC Financial Statement Blanks, Risk-Based Capital reports, actuarial opinions, management discussion and analysis, CPA audit reports and to comply with Georgia's Holding Company Statute. Furthermore, as an additional measure to protect injured workers, the Department worked with the Georgia Legislature to amend the captive law to require association captives and industrial insured captives issuing workers' compensation coverage to become members, on a prospective basis, of the Georgia Insurers Insolvency Pool.

With this enhanced regulatory oversight, the Department was able to take timely regulatory action to address the majority of association captives demonstrating solvency concerns. Of the seven association captives that have been placed into receivership, claims have been paid in full in two estates and four estates are expected to conclude with significant distribution percentages. However, the remaining estate illustrates the significant impact association captives that write on a direct basis can have on a variety of parties.

Prior to liquidation and before the legislative amendment previously discussed requiring association captives issuing workers' compensation coverage to become members of the Insolvency Pool, this association captive converted to a traditional property and casualty insurance company thereby becoming a member of the Insolvency Pool at the date of conversion. As a result of a case reserve analysis initiated by the Department, it was subsequently determined that the captive was stair-stepping reserves on multiple catastrophic workers' compensation claims. The identified reserve deficiency rendered the company insolvent and a liquidation proceeding was initiated.

The largest catastrophic claim was incurred just days before the association captive had converted to a traditional insurer. As a result, the claim was not covered by the Insolvency Pool and the employer, like other impacted employers, was not financially capable of assuming direct responsibility for the claim as required by law.

Facing significant liability, a number of insured employers contacted their state representatives seeking assistance. As a result of the magnitude of the insolvency and the prospect of severely injured employees not obtaining benefits, the Legislature took an unprecedented action. To protect injured employees and their employers, some of which were governmental agencies, the Legislature enacted a law that allowed insured employers with a net worth of less than $25 million to pay $10,000 per claim and insured employers with a net worth of $25 million or greater to pay $50,000 per claim to the Insolvency Pool and receive retroactive coverage for

their claims. While employers that elected this option incurred expense to be relieved of liability, the insurance buying public that ultimately pays the costs of Insolvency Pool assessments became responsible, at least in part, for satisfying the claims of this previously organized association captive.

Additionally, while the legislative amendment sought to account for injured workers whose employer was no longer in business, the enacted legislation only affords coverage to claimants whose employer had, by a court of competent jurisdiction, been declared bankrupt or insolvent. As such, if the employer went out of business for reasons other than a judicially declared bankruptcy or insolvency, the injured employee has no recourse for benefit payments that he or she is entitled to by law other than a claim against the general assets of the insolvent captive.

As of the date of this article, only a few states have statutes that permit captives to write compulsory lines of insurance on a direct basis. Considering the fact that most of these states do not require captives to file financial statements with the NAIC, there is no efficient way to determine how many captives are writing these lines of business. Nevertheless, given the number and types of promoters of this currently popular industry, concerns exists that states may permit this activity in the future without a complete understanding of the associated risks. If this should occur, the outcomes experienced in Georgia will most likely be repeated in other jurisdictions.

1. Source: Business Insurance

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WHERE ARE THE CO-OPS TODAY?

By Amy Yurish

As the Consumer Operated and Oriented Plans ("CO-OPs") created out of the Affordable Care Act ("ACA") have been established now for several years, there have been many developments with these unique insurers. Some have failed, many have become insolvent, and one is converting to a for-profit entity. Unsurprisingly, litigation has ensued and many questions remain unanswered as to how these cases will progress and what effect they will have on both the insolvent CO-OPs and those trying to stay afloat. How did we get here – and what is to come?

What is a CO-OP?

The ACA authorized the award of federal loans to establish new CO-OPs as an alternative to a public option for health insurance coverage. Each CO-OP is an independent, non-profit entity operated by its members. The intent of CO-OPs was to provide another insurance option for individuals and small businesses with fewer than 100 employees that could not qualify for government insurance (i.e., Medicare and Medicaid) or had limited existing private insurance options.

Section 1322 of the ACA provides for the Department of Health and Human Services ("HHS") to establish the CO-OP program in order "…to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States..."

Similar to a credit union in banking, the main selling point of a CO-OP is that the CO-OP is owned and controlled solely by its members who, in theory, are better positioned and incentivized to provide better care at a lower cost compared to a private insurer or the government. The Centers for Medicare and Medicaid Services ("CMS") described CO-OPs as being "…designed to offer individuals and small businesses additional affordable, consumer-friendly and high quality health insurance options."

Health insurance CO-OPs are not a new invention created by the ACA. CO-OPs have existed since the late 1920s when the government made loans available for creating health associations to help care for needy individuals and families impacted by the Great Depression. Today, some CO-OPs created since the Great Depression continue to exist in some form or another such as HealthPartners and Group Health which together cover more than two million individuals. Beyond management structure and non-profit status, CO-OPs operate much the same as traditional health insurance plans. CO-OPs perform the same administrative functions such as collecting member premiums, contracting with providers, and paying claims.

How were the CO-OPs funded?

Each ACA CO-OP initially started in a single state with a handful of CO-OPs later expanding to a nearby state having met the specific insurer requirements to operate in the expansion state.

Because of the significant investment required to start a new CO-OP, CMS partially funded each CO-OP with low interest federal loans to encourage the creation of new CO-OPs. The loans were only available to new CO-OPs started by individuals and organizations who were not already associated with a traditional health insurance plan, rather than existing insurers wishing to expand. Specifically, an entity was ineligible for CO-OP loans if it received more than 25% of its total funding (excluding any CO-OP loans) from pre-existing issuers / traditional health insurers and their agents.

In 2012, CMS awarded 23 CO-OPs with over $358 million in start-up loans and over $2 billion in solvency loans with start-up loans due within five years and solvency loans within 15 years after disbursement. Start-up loans were, as the name implies, used to assist with the start-up activities associated with developing a CO-OP. CO-OPs were able to draw down on start-up loans by meeting certain developmental milestones detailed in the CO-OP's business plan and approved by CMS. Solvency loans were requested by the CO-OP on an as needed basis via written request specifying the amount needed to meet state-mandated risk-based reserve capital requirements ("RBC").

Where are the CO-OPs today?

As of February 2017, 17 of the 23 original CO-OPs are insolvent and, of these, 13 (as highlighted) have already been liquidated or are in the process of liquidation. The remaining insolvent CO-OPs are either in rehabilitation or the process of winding down. One of the CO-OPs, Evergreen Health Cooperative, Inc., is converting to a for-profit, private issuer and will no longer retain its CO-OP status. Just five of the original CO-OPs offered coverage for 2017.

The table on page 15 provides an overview of the 23 CO-OPs, awarded federal loans thereto, and the state(s) of domicile, as well as the current status of each.

What were the issues?

From an operational perspective, the CO-OPs' failures have been tied to various issues including inadequate pricing of premiums, over- and under-enrollment, and mismanagement. Three programs established under the ACA were designed to mitigate some of the potential risks with adverse selection and premium pricing in the individual and small business insurance markets. These programs are commonly referred to as the "3Rs": reinsurance, risk corridors, and risk adjustment.

However, beyond the operational issues referred to above, the CO-OPs' demise has been largely blamed on greater than anticipated risk adjustment charges and CMS's failure to pay the risk corridor amounts due to the CO-OPs. CMS's failure to

remit the risk corridor payments on an annual basis, along with its requirement that the risk adjustment charges due to CMS be paid as scheduled, has resulted in severe cash flow issues for the CO-OPs. Details of the enrollment and the 3Rs are discussed more fully below.

Enrollment

Variances between projections and actual enrollment have been a key issue for the CO-OPs, both under-enrollment and over-enrollment. In April 2015, the Government Accountability Office ("GAO") issued a report (the "GAO Report") finding that of the 22 CO-OPs that participated in the first round of open enrollment between October 2013 and March 2014, the CO-OPs collectively fell short of projections by 559,000 members. Only eight of the 22 CO-OPs met or exceeded projections. Of the 16 CO-OPs that did not meet projections, 10 did not even reach half of the number of members originally projected in their business plans. The CO-OPs cited various challenges meeting projections including technical difficulties, navigators being unaware of CO-OP plans, and competitive pricing from existing issuers.

A similar report issued in July 2015 by the HHS Office of Inspector General ("OIG") also pointed to low enrollment negatively affecting CO-OP financial performance (the "OIG Report"). The OIG Report noted, "Claims' expense exceeding premium income can be attributed to higher-than-estimated enrollment of members with more expensive health conditions, enrolling fewer-than-expected young and healthy members, or inaccurate pricing of health insurance premiums."

Over-enrollment was also a negative factor as described in the March 2016 Majority Staff Report by the Senate Permanent Subcommittee on Investigations ("Senate Report"). Specifically, premiums purportedly priced too low multiplied by more members than expected exacerbated the net outflow of funds for two CO-OPs. The Staff Report stated that, "By March 2014, two CO-OPs (CoOportunity and the New York CO-OP) had already exceeded their high enrollment projections for the year… Because both fast growing CO-OPs had mispriced their plans, that dramatic enrollment growth multiplied the CO-OPs' losses rather than gains." CoOportunity exceeded 800% of projections and Health Republic Insurance of New York reached 500% of projections.

The Three Rs

As mentioned earlier, the ACA established three programs with the goal to "provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets." The programs, the "3Rs", included:

- Reinsurance: transitional three-year program from 2014 through 2016. The program was developed to provide funding to issuers that incur high claims costs for enrollees. Issuers pay contributions to HHS based on a national per-capita rate. HHS then pays issuers a coinsurance rate if the total annual medical cost for an enrollee is incurred above a defined threshold, subject to a cap.
- Risk Corridors: temporary three year program from 2014 through 2016. The program was designed to share risk – both gains and losses – between insurers to protect against inaccurate rate setting. The delta between a plan's allowable costs and target amount is used to calculate risk corridor charges or payments. If allowable costs are less than 97% of target amount, an issuer is supposed to pay HHS. If allowable costs are more than 103% of the target amount, HHS is supposed to pay an issuer.
- Risk Adjustment: the permanent program that allows for payments to issuers with disproportionately higher-risk populations enrolled. The program essentially reallocates dollars from plans with lower-risk enrollees to plans with higher risk enrollees within a given state.

The reinsurance and risk adjustment programs were designed to be budget neutral – meaning that net payments to or from HHS and the qualified health insurers as a whole would be equal to zero. The risk corridors program was not required by the legislation to be budget neutral; however, HHS later indicated that this program would be implemented as budget neutral. The application of budget neutrality to this program has been a source of debate and litigation. Questions emerged early on regarding whether these programs would operate as intended and how effective they would be in stabilizing the markets.

For the risk corridors program, analysts began to raise concerns as early as 2014 regarding whether collections by HHS from the risk corridor program would be sufficient to cover the sizable receivables for risk corridor payments that insurers were recording. While CO-OPs booked "massive risk corridor" receivables, questions loomed as to whether HHS would ultimately pay these receivables.

In October 2015, HHS announced proration results for the 2014 risk corridors payments. The announcement reiterated a prior statement that "if risk corridor collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall." The announcement continued "Based on current data from [qualified health plan] issuers' risk corridor submissions, issuers will pay $362 million in risk corridors charges [to HHS], and have submitted for $2.87 billion in [receivables for] risk corridors payments [from HHS] for 2014. At this time, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent."

This shortfall further contributed to the destabilization of the CO-OPs. In September 2016, HHS announced that it would use collections received for 2015 to continue to pay a portion of the amounts due to insurers for 2014 risk corridor payments. The announcement indicated that "HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments… Collections from the 2016 benefit year will be used first for remaining 2014 benefit year risk corridors payments, then for 2015 benefit year risk corridors payments, then for 2016 benefit year risk corridors payments."

It is likely that there will continue to be a significant shortfall in collections received for the 2016 benefit year compared to the amount needed to pay the remaining amounts due to insurers.

OVERVIEW OF THE 23 ORIGINAL CO-OPS

#	Status	CO-OP Name	Area	Startup Loan	Solvency Loan*	Total Awarded
1	Insolvent	Arches Mutual Insurance Company	UT	$10.1	$79.5	$89.7
2	Insolvent	Colorado HealthOp	CO	15.2	57.1	72.3
3	Insolvent	Community Health Alliance Mutual Insurance Company	TN	18.5	54.8	73.3
4	Insolvent	Consumers' Choice Health Insurance Company	SC	18.7	68.9	87.6
5	Insolvent	Michigan Consumer's Healthcare CO-OP	MI	18.7	52.8	71.5
6	Insolvent	CoOportunity Health	IA, NE	14.7	130.6	145.3
7	Insolvent	Health Republic Insurance of New Jersey	NJ	14.8	94.3	109.1
8	Insolvent	Health Republic Insurance of New York	NY	23.8	241.4	265.1
9	Insolvent	Health Republic Insurance of Oregon	OR	10.3	50.4	60.6
10	Insolvent	HealthyCT	CT	21.0	107.0	128.0
11	Insolvent	InHealth Mutual	OH	16.0	113.2	129.2
12	Insolvent	Kentucky Health Care Cooperative, Inc.	KY	22.0	124.5	146.5
13	Insolvent	Land of Lincoln Health	IL	15.9	144.2	160.2
14	Insolvent	Louisiana Health Cooperative, Inc.	LA	13.2	52.6	65.8
15	Insolvent	Meritus Health Partners	AZ	20.9	72.4	93.3
16	Insolvent	Nevada Health Cooperative	NV	17.1	48.8	65.9
17	Insolvent	Oregon's Health CO-OP	OR	7.2	49.5	56.7
18	Solvent	Common Ground Healthcare Cooperative	WI	7.6	100.1	107.7
19	Solvent	Community Health Options	ME	12.5	119.8	132.3
20	Solvent	Minuteman Health, Inc.	MA, NH	25.1	131.4	156.4
21	Solvent	Montana Health Cooperative	MT, ID	8.6	76.5	85.0
22	Solvent	New Mexico Health Connections	NM	13.1	64.3	77.3
23	**	Evergreen Health Cooperative, Inc.	MD	13.3	52.1	65.5
				$358.1	$2,086.3	$2,444.4

* Loan amounts include the initial awards and additional emergency solvency loans provided by CMS.
** Evergreen is transitioning to a for-profit entity and is no longer operating as a CO-OP.

Questions remain as to whether, to what extent, and when remaining risk corridor payments will be made by HHS to issuers.

Litigation

Multiple CO-OPs and other qualified health issuers have filed lawsuits over the risk corridor program. Three of these cases have had recent opinions by the U.S. Court of Federal Claims; however, the Courts reached two different conclusions on the same fundamental issues. In these cases, the issues centered on whether the plaintiffs had a statutory and regulatory entitlement to the full amount of payments due under the risk corridor program and whether the full amount was due on an annual basis.

In November 2016, the U.S. Court of Federal Claims dismissed claims brought by Land of Lincoln Health ("Lincoln"), an insolvent CO-OP, against the United States related to the risk corridors program. The decision was grounded on two conclusions – that the program was a three-year program, so payments were not yet due and that the program could be implemented in a budget-neutral manner.

The judge in that case found that "Section 1342 [of the ACA] directs HHS to establish the risk-corridors program and sets forth the amounts that HHS must receive and pay under the payment methodology subsection, but it does not obligate HHS to make annual payments or authorize the use of any appropriated funds.… HHS's three-year, budget-neutral interpretation reasonably reflects these circumstances."

The Court also indicated that "…Section 1342 and the implementing regulations do not provide any express or explicit intent on behalf of the government to enter into a contract with qualified health plan issuers." And further found that "Alternatively, even assuming Lincoln could show that Section 1342 and the implementing HHS regulations constituted a contractual offer

relating to risk-corridor payments that Lincoln accepted, thus giving rise to an implied-in-fact contract, Lincoln cannot establish that HHS breached a contractual obligation. … Lincoln cannot establish that HHS breached any implied contract because the three-year, budget-neutral risk-corridors program has not ended."

Conversely, in an opinion filed on January 10, 2017, another U.S. Court of Federal Claims judge reached a different conclusion in a matter involving Health Republic, another insolvent CO-OP. In this case, the U.S. Court of Federal Claims denied a motion by the United States to dismiss claims brought by Health Republic Insurance Company ("Health Republic") against the United States related to the risk corridors program.

The United States argued that Health Republic had not "established that its damages are presently due." The argument was based on the premise that "In the absence of an explicit deadline, [neither in Section 1342 of the ACA nor the implementing regulations] … HHS may defer payments to insurers until the conclusion of the three-year risk corridors program, or to whenever it has the funds available to make full payment." However, in this case, the judge concluded that "HHS is required to make annual risk corridors payments to eligible qualified health plans."

In the most recent related decision filed February 9, 2017, another U.S. Court of Federal Claims judge embraced the opinion in Health Republic and found in favor of Moda Health Plan, Inc. ("Moda") for summary judgment on the issue of liability against the United States. The Court found that annual payments for the risk corridors program were required and that the program was not designed by Congress to be budget-neutral.

The decision, which included references to the Court's opinion in Health Republic, indicated "Section 1342 requires full annual payments to insurers, and the Government has not made these payments. Furthermore, Congress has not modified the risk corridors program to make it budget-neutral. As a result, there is no genuine dispute that the Government is liable to Moda under Section 1342."

The ruling went further to state "Though the Court could rest on its statutory entitlement ruling [discussed above], the facts just as strongly indicate that the Government breached an implied-in-fact contract when it failed to pay Moda. Therefore, the Court finds in the alternative that Moda is entitled to summary judgment on that basis."

It is not clear yet how these differing decisions will be interpreted, and weighed, by the courts in subsequent cases. However, the most recent two cases are extremely favorable for the CO-OPs and other insurers.

Although the payments and amounts due to insurers under the risk corridor program are, arguably, the hottest issue right now with the 3Rs, other challenges remain. Calculations under the risk adjustment program resulted in multiple CO-OPs facing significant, unanticipated payments to meet their risk adjustment obligations. As these CO-OPs were already confronting financial difficulties and crippling losses, many simply lacked the funds to make payments and remain solvent. Another question under great debate is the treatment by insurers of amounts due as payments to HHS and amounts due as receivables from HHS under the 3Rs and whether, and how, these are netted against each other. Challenges related to timing differences, the potential impairment of receivables, and the accounting treatment of current payables vs. long-term receivables remain to be addressed.

CMS Updated Guidance

In order to address some of the challenges faced by CO-OPs, in May 2016, CMS issued revisions to certain rules governing CO-OPs. Among other things, these revised rules recognize that a CO-OP may enter into financial transactions to convert to or sell to a for-profit or non-consumer operated entity when faced with winding down or insolvency in order to preserve coverage for enrollees. Since the updated guidance, Evergreen Health Cooperative, Inc. ("Evergreen") announced it would be acquired by private investors and converted to a for-profit, private insurer thus dropping its CO-OP status. Evergreen was once one of the more successful CO-OPs, however, significant payments required to HHS under the risk adjustment calculations contributed to financial instability for the CO-OP. And ultimately, the CO-OP determined it was unable to continue as an independent non-profit entity.

It is too early to tell whether the updated guidance will have a considerable effect on the financial stability of the remaining CO-OPs.

Questions Remain

The outcome of litigation surrounding the 3Rs remains the biggest question, and the industry is watching these developments closely. As noted above, Lincoln, Health Republic, and Moda have been heard by the U.S. Court of Federal Claims with differing results. These rulings will significantly impact the ultimate outcome of the insolvent CO-OPs and their ability to pay policyholder benefits. And, therefore, the State Guaranty Funds are closely monitoring the court proceedings as well as how the outcomes eventually impact the individual State Guaranty Fund's obligations. Stay tuned…

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SIMPLE WAYS TO KEEP YOUR MOBILE DEVICE MORE SECURE

By Scott Greene

Easy Security for your Cell Phone

Our cell phones have become one with us. Keeping the data contained in these mobile devices should be a priority for all users. Here are some cell phone security hazards:

1) Failing to Secure Your Device Digitally

Securing your device with a passcode, pattern or even a fingerprint can help keep prying eyes from looking at the content of your phone. This first line of defense can protect the content of your phone from the casual viewer at the bar or restaurant to the person who finds your phone on the street. This step keeps your lost, misplaced or stolen phone secure long enough to track it down or kill the phone by wiping it remotely.

2) Storing Sensitive, Personal or Work-Related Data on An Unauthorized Device

Storing your sensitive personal data or on your phone is an egregious sin. Phones disappear. Phones can be hacked or merely accessed by a casual user. Storing personally identifiable information (PII) such as social security numbers or bank account information on a mobile device increases the risk of the data theft. Don't do it!

3) Skipping Operating System and Application Updates

Keeping your software up to date by installing updates as soon as they are available reduces the security risk of hacking and malware. Updates often address vulnerabilities discovered after the last software release. Android, iOS as well as Windows Mobile apps can be vulnerable to attack. Having the most up to date, and hopefully, the most secure versions of your apps is an easy fix. Set apps to update automatically. If you are concerned about how this impacts your data plan, most phones also allow the user to update apps only when connected to Wi-Fi.

4) Using Public or Unsecured Wi-Fi

Using unsecured Wi-Fi is dangerous. Data transmitted over on open (password-free) Wi-Fi can be intercepted and read by a hacker in the area. Only connect to secure networks with WPA2 encryption. Especially if you must carry sensitive company data on a cell phone or tablet, or when connecting to business or eCommerce sites. In addition to letting others read your data, hackers may be able to hijack your cell phone to install malware on your phone or to use your phone to send malicious data to others.

5) Opening Questionable Content

Mobile devices are just as vulnerable to malware as computers. Malware links are sent by email as well as text messages (SMS). Messaging poses significant threats, as these tend to be missed by security applications. Text message spam often contains links to malware and may initiate more dangerous spam. Avoid opening links from any source you do not recognize. Read hyperlinks carefully. One letter off in an internet address spells danger.

6) Apps From Third Parties.

While Apple, Google, and Microsoft (the Big Three) do their best to scan and test mobile device apps for vulnerabilities, they aren't perfect. Downloading apps from third-party app stores is always risky. When you get apps from untrusted vendors or amateur developers, there's no telling what kind of malicious software you may be installing.

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CMS ORDERED TO AMEND ONEROUS REIMBURSEMENT PRACTICES

By John Blatt

On January 5, 2017, the United States District Court for the Central District of California issued a landmark decision in a case between the California Insurance Guarantee Association ("CIGA") and the United States' Center for Medicare & Medicaid Services ("CMS"). CIGA v. Burwell, 2:15-cv-01113, Doc. 94 (C.D. Cal. 2017). The court held that CMS shall not seek reimbursement from CIGA for charges unrelated to an injury covered by policies being administered by CIGA. The court's ruling may appear to state the obvious to the casual observer; however, it cuts against CMS's standard operating procedure and ends a costly and pernicious process, if only in California's Central District.

According to the Medicare Secondary Payer statute ("MSP"), if CMS pays for health benefits for people that are covered under another insurance plan, CMS is required to seek reimbursement from the primary insurer for those covered claims. See, 42 U.S.C. § 1395y(b)(2)(A)(ii), (B)(ii). In this case, three injured workers received treatment for their work place injuries, while also receiving treatment for medical conditions that were unrelated to those injuries. CMS paid for all of the treatments of these three people and sought reimbursement for those charges from the primary insurer, a workers' compensation carrier. Unfortunately, the primary insurer was insolvent at the time and the relevant policies were being administered by CIGA.

Pursuant to the MSP, CMS issued a demand for reimbursement from CIGA. CMS's demand provided a single charge, which listed a series of diagnosis codes under that charge. Many of the diagnosis codes under each charge were not covered under the relevant workers' compensation policy. Thus, CIGA disputed CMS's demand, stating that it would only reimburse CMS for the portions of the charges that were covered by CIGA under the related workers' compensation policies. CMS renewed its demand for reimbursement for the full charges. CIGA filed suit.

After several rounds of pleadings, the parties essentially agreed on the underlying facts. CIGA agreed that the charges for which CMS was seeking reimbursement included at least one diagnosis code that was covered by the policies being administered by CIGA. In turn, CMS agreed that each charge also included diagnosis codes that were not covered by the CIGA policies. Given that there were no factual disputes, the only issues for the court to decide were matters of law and the parties filed competing motions for summary judgment.

Before proceeding on the motions, the court mandated the parties mediate the claims. During mediation, CMS reanalyzed its requests for reimbursement and indicated that the recalculated amounts would then be sought by CMS, and CIGA could challenge those amounts through the newly adopted and applicable administrative appeals process rather than in its court proceeding. CIGA insisted that the matters were still cognizable in the pending litigation and demanded that CMS permanently cease its costly over-inclusive billing practice. CMS was unwilling to make this concession and the court proceeded to judgment.

Anticipating defeat based on the court's remarks at oral argument, CMS withdrew its original demands for reimbursement and asked the court to dismiss CIGA's lawsuit as moot. A case becomes moot when the issues presented are no longer alive, that is to say that the reason for the lawsuit is rendered inert. However, the U.S. Supreme Court has stated that:

[A] defendant cannot automatically moot a case simply by ending its unlawful conduct once sued. Otherwise, a defendant could engage in unlawful conduct, stop when sued to have the case declared moot, then pick up where he left off, repeating this cycle until he achieves all his unlawful ends.

Already, LLC v. Nike, Inc., 133 S. Ct. 721, 727 (2013). CIGA argued this exact point, stating that CMS's current withdrawal of the demands in no way precluded CMS from renewing its request at a later time. The court agreed with CIGA, noting that CMS's withdrawal was "simply a strategic maneuver designed to head off an adverse decision so that CMS [could] continue its practice in the future." Thus, CMS's motion to dismiss was denied.

The court then turned its attention to the parties' motions for summary judgment, breaking the arguments into two parts: 1) whether CIGA properly proved that the CMS reimbursement requests were erroneous; and 2) whether the MSP allows CMS to seek reimbursement for a complete charge even though only one diagnosis code was covered by the CIGA policy. It is axiomatic that when a party disputes a Medicare reimbursement charge, the disputing party has the burden to show that the charge was over-inclusive. As discussed above, the parties agreed that the charges included diagnosis codes not covered by the underlying workers' compensation policies. The court found that CIGA through its dispute letters properly notified CMS that several of the diagnosis codes were not covered and, thus, met its initial burden.

Because CIGA presented a prima facie case that the CMS charges were over-inclusive, the burden then shifted to CMS to justify its reimbursement requests. CMS argued, among other things, that the MSP allowed it to seek reimbursement "for any payment made… with respect to an item or service if it is demonstrated that such primary plan has or had responsibility to make payment with respect to such item or service." CMS tried

to persuade the court that it should ignore the MSP's use of the singular "item or service" and instead include whatever and however many medical treatments the doctor lumps into a single charge. In other words, CMS argued that CIGA had a responsibility to pay for all of the "item or service" within the charge. The court was not convinced. CMS's glaring grammatical incongruity was obvious not only in its presentation, but also when examined against the MSP, which carefully constrained its text to the singular or plural form when appropriate.

The court also looked to the MSP Manual—which provides additional detail on MSP provisions and their relationship to other laws—and found that it provides for CMS to pay for the portion of services that are not compensable by a primary insurer. It was nevertheless CMS's practice to always seek full reimbursement for both covered and uncovered charges when lumped together by a medical provider. This practice was addressed in the deposition of Ian Frasier, a health insurance specialist employed by CMS. Mr. Frasier admitted under oath that CMS's all-or-nothing billing practice was instituted because CMS did not have a method of apportioning charges by diagnosis code. Without any statutory, regulatory or policy justification for CMS's all-or-nothing billing practice, the court had no choice but to grant CIGA's motion for summary judgment.

Under the ruling, CMS is only allowed to seek reimbursement for claims that can reasonably be apportioned to the relevant primary insurer. However, it was left to CMS to determine if the charge can be apportioned and, if so, to decide upon the best method for apportioning the charges. The ruling, while certainly a win for primary payers in reimbursement disputes, will likely need to be given color and breadth through subsequent court opinions.

The lesson for primary payers is to continue to closely examine all CMS reimbursement claims to ensure that they are paying on claims for which they are responsible. If the bill seeks reimbursement for medical or health care costs that are not covered by the policy, or for which the primary payer is not statutorily obligated to pay, the primary payer should timely dispute the amounts for which it is not responsible. If CMS remains inflexible and litigation is the only option, at least now there exists some persuasive legal authority condemning CMS's all-or-nothing billing practice.

John Blatt is Senior Counsel for the National Conference of Insurance Guaranty Funds (NCIGF).

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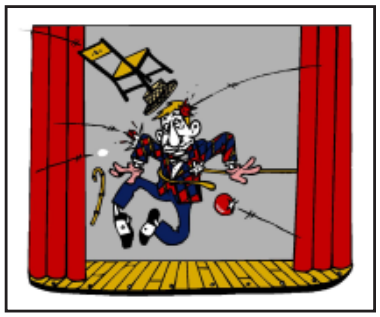
THE PERFECT RECEIVER: NUMBER 14 - ACTUARIES

Why, it's someone without the personality to be an accountant!" explained Jack to Jill in response to her inquiry as to what is an actuary. Happy to be so informed, off she went up the hill, followed by Jack, to fetch the infamous pail of water. But members of our community may need a bit more of an explanation. The 8th installment of this column, ostentatiously named "The Numbers," emphasized the need to know many components of a troubled insurer's financial profile. Here we delve into why actuaries may become the most important contributors to attaining that goal. "Why in the heck is this lawyer boring me with stories about actuaries?" you ask justifiably. The truth is that this stuff is important. Also, if I had asked a good actuary to provide it you wouldn't understand it. So tighten your belt, strap on your chute, and here we go!



Fundamentally, the business of insurance is the business of risk management. Insurers earn a living by helping their customers manage risk, principally over time and/or over a large number of comparable exposures. For this service they charge a premium. Actuaries are the individuals who specialize in developing (and to some degree implementing) methodologies for predicting the probable frequency and severity of losses that will be generated by a defined set of exposures and for pricing risk management, including risk assumption, spreading, shifting, and pooling.

In a less theoretical sense, in our world actuaries are the individuals who will assist us in understanding the losses that are likely to be generated by the insurance policies sold by the troubled insurer that has been placed in our charge. This information will enable us, in turn and with their assistance, to understand how much money will be needed to manage these losses and, therefore, also the degree to which premiums charged by the company may be inadequate. It will also assist us in structuring and maintaining adequate reinsurance and other risk-shifting programs. Even an incomplete explanation of everything actuaries do, and how one becomes an actuary, is far beyond the scope of this brief column. Depending on how you act, I may inflict some of that on you in future columns. For today, I will confine my comments to the role of actuaries in a receivership or workout.

The first question you might ask yourself is "Given that the company is broke and no longer selling new business, do I really need an actuary?" The short answer is "YES!" The longer answer, on the other hand, is also "YES." I will tell you why briefly. Each of these reasons can itself be the subject of its own article. An actuary may be indispensable in: 1) understanding the future losses that constitute the company's largest liability component, 2) understanding how much money you will need and when in order to pay those losses, 3) understanding how the expected returns from the company's invested assets will compare to the company's cash needs, 4) understanding the value of the company's reinsurance, 5) developing valuations of the company, 6) understanding (at least in part) how the company got into trouble, 7) understanding (at least in part) who is responsible for the company having gotten into trouble, 8) holding those people accountable by explaining to a court or jury what they did wrong, 9) developing a workable rehabilitation plan, 10) developing a satisfactory liquidation plan, and 11) allocating value in complex transactions like demutualizations.

So now you ask, who should I engage? Many people divide actuaries into two categories: a) life and health, and b) "non-life" (in the rest of the world) or property and casualty ("P&C" - in the U.S.). In reality, there are many sub-specialties within these broad categories and even some overlap between the two. Nonetheless, they are a useful starting point. More precisely, you will need an actuary who has experience with the specific type of insurance your company had in place. While many actuarial principles and techniques apply to many types of insurance, the more familiar your actuary is with your specific type of policies (i.e., workers' compensation, health, life and annuity, long term care, environmental exposures, automobile, home, commercial liability, fidelity and guaranty, and so on), the less on the job training for which you will have to pay and the quicker you will get satisfactory results.

Assuming that you have a list of actuaries knowledgeable about the particular insurance involved, what else should you consider? Obviously, credentials are very important. Just as important is the type of help you will need. If you intend to use this actuary as an expert witness, verify up front that the individual or firm you are considering is willing and able to provide adverse expert testimony against other actuaries, perhaps even from well-recognized firms. Too many actuaries will not do that. A similar point arises if you

will need a fairness opinion. Make sure your candidate is willing to provide an acceptable one without so many caveats and disclaimers as to make it about as useful as one provided by your cat.

Cost is important too. Actuaries, like certain German cars, can be very impressive and just as expensive. Know your budget and discuss total expected costs as soon as possible. Also material will be the support available to the actuary. In the main, that support takes two forms: people and systems. Make sure that your candidate will have the necessary support at his or her firm, including the necessary peer review. In addition, inquire into whether they have the right software for modeling the liabilities involved in your case, and the right systems for managing the associated data.

What else should you consider? The good actuaries, like the President's lawyers, tend to be very busy. Make sure that the candidates you are considering will actually have enough time to manage your project on your schedule. Spend time on potential conflicts of interest. The actuarial community is small (they won't give us the code to their school door so no one can get in), and conflicts are very common. Check into past opinions and testimony. It could be embarrassing to learn during cross-examination at trial that your actuary expressed precisely the opposite opinion five years before in another case.

Thoroughly bored to tears, yet knowing it is important, you look at me with great pain in your eyes and ask finally "how do I use my newly acquired actuary?" Excellent question Grasshopper! First, make sure the seal on the box has not been broken previously. If intact, gently remove the outer wrapping without shaking the box violently (actuaries too have feelings you know!), then gently pull the entire actuary out of the box in one continuous motion. Plug the power cord into a 120v outlet and the data cord into IBM's Blue Gene/P or some other supercomputer and you are ready to go. Just kidding! All seriousness aside, you will save time and money by having your actuary only do actuarial work. Data gathering and management and simple number crunching should be handled by your company staff when possible. Also, actuaries are required by divine law to enforce the GIGO principle. Make every effort to arm your actuary with complete and reliable data. Finally, and in many respects most importantly, communicate your needs and expectations clearly. Understand what you need from your actuary and explain it carefully.

Now I am going to tell you an important secret. But please keep it quiet. If the *International Brotherhood of Actuaries and Other Soothsayers* finds out I told you this, they will call another brotherhood friend of theirs and I will be sleeping with the fishes. Here goes: Most of what actuaries do is common sense. In fact, anyone can be an actuary. Why do I risk it all so recklessly to tell you this? Because it is very important that you understand exactly what your actuary is telling you and why. Take the time to get from her or him a step-by-step explanation of what they have concluded. You will be amazed at how smart this will make you feel!

I have managed here to barely scratch the surface of this important topic. Nonetheless, I hope that I have provided some useful guidance. If not, remember my grandmother's words, "You get what you pay for!"

1. If I were an actuary, this list would have at least 100 items.

2. The other major way of dividing actuaries is: a) the ones I cannot afford, and b) my son-in-law.

3. Garbage In - Garbage Out - 'nuff said.

4. Provided that anyone happens to be brilliant, loves numbers, derives inexplicable pleasure from spending long hours looking at columns of them, and has a keen sense for discerning patterns in those numbers. Oh yeah, and has black horn-rimmed glasses an inch thick perched at the very end of the nose.

IAIR RESPONSE TO RMLWG REQUEST ON LTC ISSUES

By Jonathan Bing, Esq.

February 7, 2017

James Kennedy (TX)
Chair, Receivership Model Law Working Group ("RMLWG")

RE:: Request for Comment on LTCI Issues and Implications

On behalf of the International Association of Insurance Receivers ("IAIR"), this letter responds to your request for comments on issues and implications of long-term care insurance ("LTCI") insolvencies on receivership practices and processes, the guaranty fund system, the applicability of provisions within Life and Health Insurance Guaranty Association Model Act (#520) on long-term care insurance and any other receivership laws/regulations.

IAIR was founded in 1991 as an association of professionals involved with insurance receiverships and financially stressed or troubled insurers. IAIR's mission includes facilitating the exchange of information concerning the administration and restructuring of such insurers. IAIR's members include experienced insurance receivers (including rehabilitators and liquidators), insurance regulators, life and health and property and casualty insurance guaranty associations, and other professionals (attorneys, accountants, actuaries, information technology experts, etc.) that provide consulting services in rehabilitation and liquidation proceedings.

When LTCI products were introduced in the late 1970's and early 1980's, there was no insured experience data available. LTCI is a lapse supported product. As there is usually no value to the policyholder upon lapse, the reserves on lapsing policies help fund the benefits for those remaining inforce. The lapse rate has developed significantly lower than priced. This is due to changes in policyholder behavior. The result has been inadequate premiums on legacy blocks of LTCI. Additionally, socioeconomic factors influencing the long-term care market have significantly changed. There are more options available to those unable to perform routine activities of daily living and the cost of such care has risen. These factors among others resulted in adverse development of many legacy LTCI products that were underpriced and under reserved.

Rate increases are often sought to remediate adverse development. However, rate increases for LTCI products could likely have a significant adverse effect as policyholders who had paid premiums for possibly decades may be unable to afford the increased premiums at this time in their lives and may lose their prior investment in this guaranteed renewable protection. Due to the nature of LTCI and public policy concerns, rate increase requests have had varying experience in being approved.

The long exposure period of LTCI and the guaranteed renewable provision further complicate resolution in receivership actions. Life and annuity blocks of business are typically assumed by another company with funding provided from the company assets and by guaranty association assessments. However, due to the issues discussed above, there is limited or no market for LTCI blocks.

From a guaranty association perspective, LTCI is treated as health insurance and assessments for its coverage fall upon the member insurers that write health insurance, many of which do not write LTCI. LTCI is often written by life insurers or monoline insurers who specialize in that product. In addition, over the last few years, health markets within a state may be dominated by one insurer, or a small number of insurers, resulting in only a few member insurers to bear a large portion of the assessments for an extended period of years. Industry is calling for a change in the assessment process to ensure those companies writing LTCI pay a proportionate share of assessments for LTCI products and that LTCI assessment obligations do not create significant and disproportionate financial burdens on a small group of health insurers in a state.

Additionally, while most states have adopted $300,000 or more of guaranty association coverage for LTCI policies, a few states remain at the older $100,000 limit. While even the lower limit is not expected to be an issue for some LTCI policyholders, there are likely to be exceptions where the benefits due under the LTCI policy exceed the guaranty association coverage.

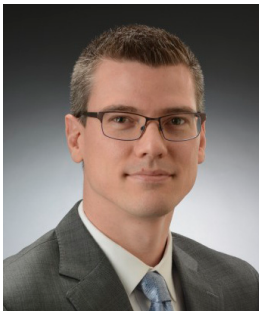
Finally, the introduction of hybrid life and annuity LTCI products create some confusion regarding how these products would be covered by a guaranty association should the insurer fail. Clarification regarding under which line of business these products would be viewed in an insolvency might be advantageous in furthering the consumer protection intent of the guaranty associations.

We thank you for the opportunity to opine in this matter. IAIR would be pleased to respond to any questions on the foregoing and welcomes the opportunity to assist and participate in further discussions.

Respectfully submitted,

Jonathan Bing, Esq.
First Vice President
International Association of Insurance Receivers

WELCOME IAIR'S NEWEST MEMBERS



John Blatt

John is the most recent addition to the National Conference of Insurance Guaranty Funds (NCIGF), joining the team in January of 2017 as Senior Counsel. Throughout his tenure, John will be working alongside guaranty fund managers and state regulators to facilitate multi-state insolvencies. He will also concentrate his efforts on educating various entities on the importance of model legislation, while managing day-to-day legal affairs of the NCIGF.

John is a transplant from Chicago, Illinois, where he worked as a litigation attorney for a mid-sized creditors rights firm. He earned a BS in economics from DePaul University and his law degree from The John Marshall Law School.

Mary Linzee Branham

Mary Linzee earned her Bachelor of Arts degree in History with a minor in Criminology from The University of Florida in 2002 and her Juris Doctorate from Florida State University in 2006. Mary Linzee is a licensed attorney in Florida and joined the Florida Department of Financial Services, Division of Rehabilitation and Liquidation, as Assistant Director in April 2016. Mary Linzee directly oversees the Division's estate management team, legal department, and administration services section.

Prior to joining the Division, Mary Linzee was an associate in private practice handling all aspects of creditor rights, bankruptcy, civil litigation, insurance defense and worked as in-house claims counsel for a large national title insurance company.

Kirsten Byrd

Kirsten is a Partner at Husch Blackwell and represents business clients and professionals in complex regulatory issues and disputes as a member of the firm's Financial Services & Capital Markets industry team. A significant focus of Kirsten's practice is on insurance regulatory law and insurance disputes, including issues of compliance with state and federal insurance laws, coverage and insurer extra contractual liability. In addition, Kirsten has extensive experience prosecuting and defending business disputes, consumer disputes and malpractice claims.

In the civic arena, Kirsten has served on the boards of directors for the Kansas City Ballet and KCPT Public Television since 2010.

Kirsten received her Juris Doctorate from the University of Iowa College of Law and her B.A. from University of Iowa.

Elena Byron

Elena is a Senior Consultant with Risk & Regulatory Consulting, LLC, and is a Chartered Property Casualty Underwriter as well as an Associate in Claims. Elena began her career with National Insurance Company before joining the Florida Department of Financial Services where she gained over 14 years of experience in the Division of Rehabilitation and Liquidation.

Moses Chao

Moses Chao is a Receivership Oversight Analyst with the Texas Department of Insurance. Moses graduated from Oklahoma State University with a BA in Accounting and MS in Quantitative Financial Economics and holds CFE and AFE designations from the Society of Financial Examiners.

Karen Heburn

Karen is a Manager of Troubled Companies and Receiverships with Risk & Regulatory Consulting LLC and has over 20 years of experience in the insurance industry, both as a regulator and as staff of an insurance company. While at the Florida Department of Insurance, her duties included solvency monitoring and regulation. She also worked as the Director of Accounting for the Florida Division of Rehabilitation and Liquidation and was responsible for the accounting functions of over 50 companies in receivership. Additionally, Karen has separate accounts, mutual funds, banking and healthcare experience. Prior to RRC, Karen was a Quality Assurance Analyst at Citibank where she was part of an international team that reviewed federal banking filings to enhance the reporting accuracy on reports such as the Call Report, Treasury International Capital Report, the Report of Bank Holding Company Intercompany Transactions and Balances and various other reports. She was also the Quality Reviewer at a Big 4 firm where she assisted in the review of year end audit processes.

WELCOME IAIR'S NEWEST MEMBERS

Frank Knighton, Jr.

Frank became an employee with the Marchman Steele Agency, Inc. (MSA) in 2002 and currently holds the position of Claims Manager for all claims handled by the Georgia Insurers Insolvency Pool. His tenure with MSA has involved working with the Special Deputy Liquidator in the capacity of Claims Manager in the administration of five receiverships for the Georgia Department of Insurance, including reinsurance contract interpretation, reinsurance billing and negotiation of reinsurance commutations.

Frank started his claims career with Liberty Mutual Insurance Company and worked many years in a managerial capacity for the Home Insurance Company and CNA Insurance Company. Prior to joining the MSA/Pool, Frank was also the Operations Manager for a startup workers' compensation TPA and manager of the Georgia Independent Medical Examinations Division for Concentra Health Care. Frank earned his BS Degree in Business Administration from Clark Atlanta University, formerly Clark College in Atlanta, Georgia and his BS in Information Technology from DeVry University, Summa Cum Lade. Frank also holds the designation of Workers' Compensation Claims Law Associate from the American Insurance Institute (WCCLA), Workers' Compensation Certified Professional from the Risk Management Institute (CWCP), State of Georgia Adjuster's License and Certified Auto Appraiser, Vale Tech. Frank is also the developer of Benefit Buddy, a Workers' Compensation software program that is used on a daily basis by MSA/Pool, the Georgia Subsequent Injury Trust Fund and other TPA's and Law Firms in the State of Georgia in the determination of claims exposures, reserving, settlement evaluations and payments.

Allan Patek

Allan is the Executive Director of the Wisconsin Insurance Security Fund. After receiving a BA in history and Political Science from the University of Wisconsin at Eau Claire, Allan was a Legislative Analyst and Research Analyst for the Wisconsin State Senate. Subsequently, he became State Legislative Affairs Manager and Assistant Vice President of State Government Relations with Employers Health Insurance Company. Before joining the Wisconsin Insurance Security Fund, Allan worked for Humana in the Green Bay area as Director of State Government Relations, Corporate Director of State Government Relations and Director of Public Affairs Strategy.

Stuart Phillips

Stuart ("Stu") Phillips has worked for the Office of Financial Counsel at the Texas Department of Insurance since 2014. Beginning in 1991, Stu worked at the Texas Attorney General's Office. Prior to working with the AG's office, Stu worked in private practice. She also spent four years working for American General (now AIG). Stu holds a Juris Doctorate from the University of Texas.

Valerie Reglat

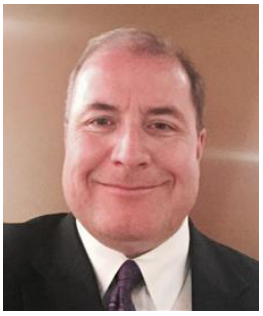
Since July 2015, Valerie has served as Director of Estate Management at the Florida Division of Rehabilitation and Liquidation. Previously, she worked for over almost two decades in insurance, including 13 years at the Florida Office of Insurance. Prior to working at the OIR, she worked for several years in a variety of state government positions relating to insurance regulation and Workers' Compensation. Valerie's first experience in insurance began on the private side of the industry in 1991, when she worked for an insurance agency. Later, she joined Fidelity Security Life Insurance Company in Kansas City, MO, where she worked as a Contract Analyst and, later, as an Actuarial Technician.

Valerie earned her Bachelor's degree from Fort Hays State University in Kansas before moving to Tallahassee to launch her career. She also studied French Language and Culture at Michael de Montaigne University in Bordeaux, France for one year in 1996. Valerie holds the titles of Fellow, Life Office Management (FLMI) and Associate, Insurance Compliance & Regulation (AIRC) with the Life Office Management Association. She also earned the Professional, Insurance Regulation (PIR) designation from the National Association of Insurance Commissioners. Currently, she is finishing the Project Management Graduate Certification at Florida State University.

Rachelle Robles

Rachelle Robles is an attorney with the Texas Department of Insurance. She has represented the receiver in property & casualty, life and fraternal receiverships. Rachelle obtained her Juris Doctorate from Hastings College of Law, Berkeley.

WELCOME IAIR'S NEWEST MEMBERS



Nestor Romero

Nestor is CEO and owner of Regulatory Consultants Inc., performing statutory financial and market conduct examinations and is the Assistant Receiver of Red Rock Insurance Company.

Nestor graduated from the University of New Mexico with a MBA and is a Certified Public Accountant as well as Certified Financial Examiner, Fellow Life Management Institute and Market Conduct Management.

Nestor's past activities include SOFE's National Board of Governors, SOFE National Vice President of Programs, Director of University of New Mexico Foundation as well as the Lobo Club and Popejoy Society and Director of the Special Olympics of New Mexico.

Steven Sigler

Steve is the Director of I.T. Examination Services with Examination Resources LLC. Steve has 18 years of experience in Insurance; 7 years involving IT support, IT management, executive management and regulatory reporting in the Insurance industry, followed by 11 years involving financial examinations, market conduct examinations and IT evaluations for Insurance regulation. His prior career experience includes over 20 years in Information Technology involving strategic planning, systems analysis & design, implementations, operations, business continuity planning, management and auditing for a number of industries. Mr. Sigler holds professional designations for Certified Financial Examiner (CFE), Advanced Market Conduct Manager (AMCM), Automated Examination Specialist (AES) and Certified Information Systems Auditor (CISA).

Thomas Streukens

Tom is a graduate of Michigan State University in East Lansing, Michigan and began his insurance career in the regulatory sector with the Michigan Insurance Bureau in 1991. After relocating to Florida in 2001, he served in several positions with the Florida Office of Insurance Regulation beginning as the Bureau Chief for Life and Health Insurer Solvency and ending as the Deputy Commissioner of Property and Casualty.

Tom moved to the quasi-government sector in October 2006, and is currently serving as the Chief Operating Officer of the American Guaranty Fund Group, Inc. (AGFG), the management company that oversees the two Florida property and casualty guaranty associations, Florida Insurance Guaranty Association (FIGA) and Florida Workers' Compensation Insurance Guaranty Association (FWCIGA). His duties at AGFG include the oversight of Accounting, Claims and IT functions for the group. Tom serves as the Secretary/Treasurer for AGFG and the Treasurer for FWCIGA.

Tom works closely with receivers and regulators in Florida as well as throughout the country in the handling of insolvent insurance companies and ensuring the guaranty association safety net is in place for Florida residents.

Amy Jeanne Welton

Amy has represented the court-appointed Receiver both as staff attorney and managing attorney of the Texas Department of Insurance, Liquidation Division and as general counsel. Currently, Amy represents the SDR's of a number of estates and assists the SDR's working with guaranty associations, insurance departments, attorney generals, other receivers, regulators on claim coordination, special/statutory deposit collection, solvent/insolvent subsidiaries and receivers agreements. Amy obtained her Juris Doctorate from the University of Houston Law Center.

Salma Zacur

Salma is an Estate Manager and Deputy Receiver with the Rehabilitation & Liquidation division of the Florida Department of Financial Services. Salma is experienced in Takeover and Estate Management, Litigation Support and Rehabilitation.

Salma is a graduate of University of North Texas with a BS in Computer Science.

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2017 IAIR

INSURANCE RESOLUTION WORKSHOP
RISKS, REGULATION AND RESOLUTION

OMNI AUSTIN DOWNTOWN | FEB 1-3 2017

IAIR held its 2017 Resolution Workshop, Risks, Regulation and Resolution, in Austin, Texas February 1 -3. Over 160 attendees, including regulators, receivers, guaranty fund managers and industry representatives participated. The conference focused on emerging risks in the insurance industry, regulatory responses and resolution strategies.

We started global with a panel addressing International Standard Setting and Resolution Policy. This panel presented the regulator, industry and guaranty system perspectives on the ongoing deliberations on international standard setting. With resolution policy on the agenda in 2017, and resolution planning as a potential regulatory outcome, our panel reminded us that the international standard setting across the globe will continue to influence our work in the resolution space.

Leaders of the guaranty system, moderated by former NAIC CEO and now Dean Terri Vaughan, then addressed The Guaranty System Post-Dodd Frank. The NOLHGA and NCIGF Presidents dove into the Dodd-Frank orderly liquidation authority, what congressional proposals might portend, and the importance of the guaranty system response to ongoing discussions about responding to larger insolvencies.

Climate Change Impact to the Insurance and Reinsurance Industry included an overview of how climate change risk is showing up on the radar screen of the industry from an expert and the perspective of the RAA. Oklahoma's Commissioner Doak provided a regulatory perspective on the topic, as well as his real world perspective of the impact of weather events from his service to his own state.

Wisconsin Commissioner Ted Nickel, the 2017 NAIC President, generously shared his time as our Keynote Speaker. Commissioner Nickel brought us up to date on developments around international standard setting, covered agreements and other topics of interest – even the fate of his beloved Packers! Welcoming the NAIC President has become something of a workshop tradition that we hope to continue.

A panel that lived, and is living, the Penn Treaty rehabilitation and eventual liquidation, told us A Tail of Too Pities – Lessons from Penn Treaty. We received an in-depth summary of the path to that estate's current status, as well as a flavor of the issues that were discussed, and sometimes litigated, among the receiver, guaranty system, policyholders' counsel and other interested parties.

Transformation of Health Care Financing: Where Do We Stand Today and What's Next? The Affordable Care Act—Obamacare—took the stage next, with experts zeroing in on what the new Congress and Administration might and might not do to make changes.

Long-Term Care: Capital, Trends and the Way Forward. With the baby boomers reaching retirement and long term care looming large as a public policy issue, a panel of experts on long term care laid out the options going forward as we deal with legacy blocks like Penn Treaty but the newer products that might meet the need for retirement security.

After the breadth and depth of our Day One, we took a well-justified overnight break, and started Day Two with an overview of The 10 Most Important Legal Developments from 2016. Highlights from the General Counsel of NOLHGA and the NCIGF included what's in store on Dodd-Frank, Lincoln Memorial developments, and an update on large deductible issues.

A panel of senior regulators explained the New Tools for the Toolkit – the ABCs of Regulatory Coordination. We were privileged to receive perspectives on supervisory colleges, crisis management groups, the new (and new new) Holding Company Act, and other cutting edge developments in how insurance companies (and increasingly groups) are supervised.

Co(opted): The ACA and Resolution. The Obamacare co-ops have had significant problems, and the Workshop next considered the legal challenges that the new co-ops have had, and the fallout from so many of them failing.

Ethics in Insolvency. Failing insurance companies can be risky for legal practitioners, and three highly respected Texas lawyers laid out a pathway out of what can be an ethical morass.

So after getting ourselves up to date, reminding ourselves of where our energies will be needed in the coming year, celebrating births and, yes, honoring the lives of lost friends, we adjourned with an eye toward regathering in Scottsdale in 2018 to see how our forecast held up, and what new and evolving challenges are in store for 2018.

LIST OF BOARD MEMBERS/OFFICERS

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