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## New Jersey Judge Finds Insurers Have No Obligation To Pay Global Asbestos Settlement in Prepackaged Bankruptcy

An issue creating significant controversy in recent years has related to the obligations of insurers with respect to “prepackaged” bankruptcies filed by policyholders facing asbestos claims. Outside of the asbestos context, “prepacks” are a common means for debtors and creditors to resolve their differences and agree on a plan of reorganization before making a bankruptcy filing. The debtor then files for bankruptcy and simultaneously submits its “prepackaged” plan to the court, allowing the debtor to quickly emerge from bankruptcy.

In recent years, however, insurers have expressed concerns about abuse of the process, where policyholders collude with asbestos plaintiffs’ attorneys at the expense of insurers. Prior to filing for bankruptcy, the policyholder negotiates a “global” settlement of asbestos liabilities with certain of the plaintiffs’ attorneys. The agreements can require literally hundreds of millions of dollars in payments, which would be funded by insurance. The insurers are not a part of the negotiation. The “prepack” is then presented to the insurers as a *fait accompli* and the insurers are expected to fund the settlement. In a recent decision, however, a trial court in New Jersey found that an insured’s global settlement agreement coupled with a prepackaged bankruptcy agreement was not made in good faith and that the insurers’ objections to the settlement agreement and prepackaged bankruptcy agreement were well-founded and precluded the insurers’ coverage obligations.

*Congoleum Corporation v. Ace American Ins. Co., et. al.*, Superior Court of New Jersey, Law Division, Middlesex County, Docket No. MID-L-8908-01 (May 18, 2007)

Congoleum is a manufacturer of flooring products, and certain of its products manufactured through the early 1980s contained asbestos. As a result, numerous claims for asbestos-related injuries were brought against Congoleum. Once Congoleum's primary carriers alleged that their limits of liability were exhausted, Congoleum looked to its excess carriers for coverage for these claims. The excess carriers declined arguing that Congoleum had not exhausted its primary policies. One of the excess carriers then filed a declaratory judgment action against Congoleum and its other insurers seeking a declaration that the policies did not provide coverage for the asbestos claims.

In Phase I of the trial of the declaratory judgment action, the Court was asked to determine whether a global settlement, entered into by Congoleum with the claimants along with a negotiated prepackaged bankruptcy agreement, was proper and whether the excess carriers had an obligation to provide coverage for the global settlement agreement. In opposition to coverage, the excess carriers gave three reasons why coverage should be denied: (1) that the global settlement agreement was not made in good faith and was unreasonable; (2) that the insurers had a good faith, reasonable basis to withhold consent to the global settlement agreement; and (3) that the global settlement agreement resulted in Congoleum being released from any obligation relating to the settlement monies.

The Court found that the reasons relied upon by the excess carriers were proper and found that the excess carriers have no coverage obligations for the global settlement agreement. The Court specifically held that the excess carriers reasonably denied coverage and reasonably refused to consent to the global settlement agreement. In making this decision, the Court relied on several factors surrounding the global settlement agreement:

- The excess carriers were excluded from negotiations for the global

settlement agreement, despite their request to participate in the negotiations;

- Congoleum entered into the global settlement agreement without consent and over the objections of the excess carriers;
- The global settlement agreement was negotiated by conflicted counsel that jointly represented Congoleum and several of the claimants against it which enabled counsel to liquidate their claims first, leading to unfair priority in relation to other claimants;
- The global settlement agreement was entered in collusion to provide Congoleum with both insurance proceeds and protection from liability for the asbestos claims, leaving the insurers to bear the cost for all periods, including periods that Congoleum was uninsured or for which an insurer was insolvent;
- The agreement took away defenses to the asbestos claims otherwise available in the court system, including causation, product identification, and statute of limitations; and
- The agreement did not allow for any protection from fraudulent claims.

The Court found that based on these factors, the excess insurers reasonably and in good faith withheld any consent to the global settlement agreement. The Court also rejected Congoleum's argument that the insurers would have objected to any agreement proposed in connection with a prepackaged bankruptcy plan. The Court stated that Congoleum did not prove this as it relied only on the fact that insurers have a general concern against prepackaged bankruptcy plans.

The Court also briefly addressed whether the global settlement agreement constituted a legal obligation to pay on behalf of

Congoleum that could trigger coverage under the carriers' policies, which included language providing coverage where the insured was "legally obligated to pay." The Court was not persuaded that the language contained in the global settlement agreement conferred any legal obligation to pay on Congoleum. The language contained in the agreement specifically provided that the claimants that signed the agreement would have no recourse against Congoleum.

Although this is only one decision by a trial court in one state, it will

likely have a significant impact on the controversy over insurance coverage for "prepackaged" asbestos settlements. The decision received extensive coverage in the popular and business press and has been widely circulated on the internet. The arguments are likely to be repeated in many other cases. In addition, the decision focused on the alleged collusion between policyholders and the asbestos plaintiffs' bar in reaching these settlements. The *Congoleum* decision will provide important ammunition to other insurers faced with demands for payment resulting from "prepacks."

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## Stranger Originated Life Insurance - A Review of the Law on Insurable Interest

Life insurance has been traditionally viewed as a vehicle for providing peace of mind, financial liquidity, investment diversification or an inheritance for loved ones of the insured. Imbued within these social benefits conferred by the life insurance product is the concept that the beneficiary of the policy has to have an insurable interest in the life of the insured. This insurable interest can be generally described as a substantial economic interest in having the life, health or bodily safety of the insured continue. The doctrine of insurable interest has been part of the common law governing life insurance contracts for well over 150 years.

In recent years, however, with the advent of viatical settlements in the late 1980s, the life insurance policy is often being viewed as a property right with a market value that can be traded as any security. While viatical settlements were initially pursued from those individuals suffering from terminal illness to allow for the payment of medical treatment, the market place for life settlements has transformed over the last several years. Today a market has arisen that is referred to as stranger originated life insurance or "STOLI." Also known as investor originated life insurance ("IOLI") or speculator initiated life insurance ("SPIN LIFE"), STOLI has developed into

a separate financial vehicle used by third parties as an investment device.

STOLI transactions often involve premium finance arrangements where the insured agrees to sell her property interest in the life insurance policy to the investor after a prescribed period of time (often two years). At the end of this period, the investor owns the contract and would make all necessary premium payments, ultimately receiving the death benefit upon the death of the insured.

While there are many criticisms of the STOLI transaction the primary issue raised in opposition to such transactions is that the investor, who becomes the ultimate beneficiary of the life contract, has no insurable interest in the life of the insured. This article will discuss the historical development of the doctrine of insurable interests in the life insurance arena and more recent case law addressing the doctrine in the general case law governing the treatment of insurable interest and the various doctrines that have developed to address questions involving insurable interest in life contracts. Finally, we will also discuss recent legislative actions by state insurance commissioners to create a regular framework that would allow legitimate uses of life settlements.

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## General Structure of the Stoli Arrangement

Before embarking on the discussion of insurable interest, we should first discuss the general structure of the STOLI arrangement. While the variety and complexity of STOLI arrangements increases daily, the overall structure of the transaction is simple. Generally, the investors seek out older insureds with the ability to obtain high levels of insurance to participate in the transaction. The investor will often finance the premiums on the policy during the initial contestability period, which is typically two years. At the end of this period, the assignment of ownership of the contract will either be automatically enacted or the insured will have the option to repay the financed premiums or assign the ownership of the contract to the investor. In any case, the ultimate goal of the transaction is the same- the investor obtains ownership of the life contract and upon the death of the insured, the investor obtains the death benefit of the policy.

Unlike other situations involving third party ownership of life insurance (corporate owned life (“COLI”), bank owned life (“BOLI”) or viatical settlements), the life insurance industry has strenuously opposed STOLI arrangements. One reason given by the industry is that the investors have the ability to “underwrite” such life contracts based on inappropriate or illegal criteria (e.g., race, gender, etc.). Another reason for the opposition is that the parties to the transaction, particularly insureds, are unaware of the risks posed by the transaction

itself. Admittedly, STOLI arrangements in and of themselves pose a number of risks, even if enforced or allowed under the law, to the insured. These risks include the taxability of proceeds, waiver of premium benefits under the policy and potential adverse effect on the insured’s eligibility for Medicaid or other government benefits.

Less concern is voiced over the risk assumed by the investor. The central risk to this party to the transaction is that the insured will outlive the mortality predictions of the insurer or the investor. The investor by necessity must assume it can underwrite the risks much more accurately than the life insurer; if the life underwriter is more accurate, the investor would likely lose money on the arrangement.

The risk to the insurer would involve a risk that the assignment of the policy would negatively affect the lapse rate. Many insureds let their life insurance lapse. Under these circumstances, the insurer faces no future liability on the contract. However, in the STOLI arrangement, the lapse rate would likely be zero, thereby exposing the insurer to claims on policies that may otherwise have lapsed. Under this circumstance, the insurer would likely prefer to avoid the policy. For these reasons, a number of lawsuits have been filed recently seeking to rescind the coverage in question under a theory that the contract is void because of a lack of insurable interest on the part of the STOLI investor.

## The Historical Treatment of Insurable Interests

For well over 150 years, courts in the United States have required that a beneficiary of a life insurance policy have an insurable interest in the life of the insured in order to receive the benefits paid under the insurance contract. This requirement is necessary to create the life insurance contract in the first instance. In the absence of an insurable

interest in the life of the insured, the life contract cannot exist. From this simple proposition flow a number of different positions that have been historically developed by the courts on the right of the insured to assign the life insurance policy to a third person.

## A. The Minority View

In a minority of jurisdictions, the assignment of a life policy by the insured or the beneficiary to one having no insurable interest in the life of the insured is void as a matter of law. Five jurisdictions follow this view including Alabama, Kansas, Kentucky, Texas and Virginia. Historically three general rationales, all ultimately concerned with preventing the untimely death of the insured, are offered by the courts to support this view. The first rationale is that there is no distinction between the assignment of a policy to a person without insurable interest and the procurement of a policy by such person in the first instance. *Warnock v. Davis*, 104 U.S. 775, 26 L. Ed. 924 (1882); *Milliken v. Haner*, 184 Ky. 694, 212 S.W. 605 (1919).

The second rationale for disallowing the assignment of a life contract to one with no insurable interest is that such assignments constitute mere wagering contracts which are against public policy. *Helmetag v. Miller*, 76 Ala. 183, 52 Am. Rep. 316 (1884); *Smith v. Agnew*, 137 Ky. 83, 122 S.W. 231 (1909). The third and oldest rationale for disallowing the assignment of life insurance contracts to third persons without insurable interests is to avoid the temptation for the assignee to bring about the death of the insured. *Price v. Supreme Lodge, K. of H.*, 68 Tex. 361, 4 S.W. 633 (1887). Under all of these rationales, the assignment of the life contract would be void. In these circumstances, the STOLI arrangement would be void.

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## New York Court Rejects Cedent's Change In Position

*Allstate Insurance Co. v. American Home Assurance Co.*, No. 9335, 2007 N.Y. slip op. 05170, 2007 N.Y. App. Div. LEXIS 7284 (Sup. Ct. Ny. 1st App. Div. June 12, 2007)

In *Allstate Insurance Co. v. American Home Assurance Co.*, No. 9335, 2007 N.Y. slip op. 05170, 2007 N.Y. App. Div. LEXIS 7284 (Sup. Ct. Ny. 1st App. Div. June 12, 2007) the New York intermediate appeals court rejected an insurer's attempt to maximize its reinsurance benefits by limiting the number of occurrences, after it had previously attempted to minimize its liability to the insured by arguing that there were multiple occurrences.

Before this case arose, the primary insured sued AIG to indemnify it for environmental claims at several sites. In its defense of that suit, AIG argued that multiple occurrences took place at each site. The parties disagreed as to exactly how many occurrences there were. The jury determined that there were seven occurrences and AIG moved for a new trial. Before the motion was decided, the parties settled without agreeing on the number of occurrences at each site.

Throughout the entirety of its suit with the primary insured, AIG "vigorously pursued the maximum number of occurrences per site," which would minimize its liability. Later, in a post-settlement analysis to allocate costs between AIG and Allstate, its reinsurer, AIG's attorneys maintained that there was only one occurrence per site. Under this analysis, Allstate would have owed AIG in excess of \$2.5 million for reinsurance. Under Allstate's analysis, based on the number of occurrences consistent with AIG's pre-settlement claims, reinsurance would not have even been triggered for the claim.

The trial court held that AIG's one-occurrence-per-site allocation for the Allstate claim was reasonable. The appellate court reversed, holding that the trial court's decision effectively would allow AIG to play by "two sets of rules." The court justified its decision under the follow-

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the-fortunes doctrine, which states that a reinsurer must reimburse the reinsured for reasonable settlement payments made in good faith. The doctrine's goal is to "foster consistency in the treatment of losses at both levels." Allowing AIG to claim a one-occurrence-per-site allocation would be inconsistent because it would permit it to "minimize the amount of [its] exposure and loss while "[m]aximiz[ing] its recovery against the reinsurer."

Cases holding that the doctrine still applies when there is an inconsistency between an allocation and pre-settlement risk assessments do not apply because this case

dealt with an inconsistency between pre-settlement and post-settlement allocations. See *North River Insurance Co. v. ACE American Reinsurance Co.*, 361 F.3d 134 (2d Cir. 2005); *Travelers Casualty & Surety Co. v. Gerling Reinsurance Corp.*, 419 F.3d 181 (2d Cir. 2005).

Furthermore, the court held that the follow-the-fortunes doctrine does not require reinsurance when "the reinsured's settlement allocation, at odds with its allocation of the loss with its insured, designed to minimize its loss, reflects an effort to maximize unreasonably the amount of collectible reinsurance."

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## Seventh Circuit Holds Two Year Statute of Limitations of Illinois Insurance Producers Limitations Act Does Not Govern Claims Against Reinsurance Intermediaries

*BCS v. Guy Carpenter & Co., Inc.*, No. 06-1050, 2007 U.S. App. LEXIS 14300 (7th Cir. June 18, 2007)

The United States Court of Appeals for the Seventh Circuit rejected the argument that the two year statute of limitations set forth in the Illinois Producers Limitations Act governs claims against reinsurance intermediaries. *BCS v. Guy Carpenter & Co., Inc.*, No. 06-1050, 2007 U.S. App. LEXIS 14300 (7th Cir. June 18, 2007). This case arose out of reinsurance agreements negotiated by reinsurance intermediary, Guy Carpenter & Company, Inc. ("Guy Carpenter") for BCS Insurance Company ("BCS"). BCS alleged that Guy Carpenter failed to obtain adequate reinsurance for BCS resulting in an arbitration award against BCS in favor of its reinsurers. Guy Carpenter was responsible for procuring reinsurance for BCS with respect to a "fronting" program in which BCS issued insurance policies to customers through another company. The reinsurers sent Guy Carpenter a reservation of rights letter without the knowledge of BCS. After reimbursing BCS for its claims for several years, the reinsurers refused to make any additional payments and demanded arbitration to rescind the reinsurance agreements or obtain compensation from BCS for various losses. BCS and Guy Carpenter entered into

a tolling agreement on February 15, 2001, to toll the statute of limitations on any claims BCS had against Guy Carpenter. In arbitration, the reinsurers prevailed on their claim that BCS was responsible for losses it had incurred and were awarded a sum of money from BCS.

BCS filed suit against Guy Carpenter claiming breach of contract, breach of implied contract, professional negligence, implied indemnity, breach of fiduciary duty, and negligent misrepresentation. The district court found that reinsurance intermediaries should be considered insurance producers for the purpose of the statute of limitations and therefore, the Insurance Producers Limitations Act, 735 ILCS 5/13-214.4 ("IPLA") two-year statute of limitations applies to reinsurance intermediaries. Based on that finding, the district court granted summary judgment in favor of Guy Carpenter on five of the six counts because they were time barred. Although the implied indemnity claim was not time barred, the district court granted summary judgment on that claim because BCS did not establish that its liability was based solely on its legal relationship with Guy Carpenter.

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In reversing the district court's ruling, the Seventh Circuit concluded that the IPLA does not apply to reinsurance intermediaries. In reaching its decision, the Court gave some deference to an *amicus curiae* brief filed by the Illinois Attorney General. The Attorney General concluded that the reinsurance agreement between BCS and Guy Carpenter was not a "policy of insurance" within the meaning of the IPLA and that the IPLA does not apply to parties acting as reinsurance intermediaries. The Court noted the Attorney General's assertions that the terms "insurance" and "reinsurance" have distinct and separate

meanings, and that a reinsurance intermediary is not considered an insurance producer under the IPLA. It recognized that the IPLA applies only to insurance producers, limited insurance representatives, or registered firms. The Court reversed the district court's grant of summary judgment in favor of Guy Carpenter and remanded the case to the district court to determine the applicable statutes of limitations for the five counts that had been declared time barred. The Court affirmed the district court's judgment dismissing the implied indemnity claim.

## Stranger Originated Life Insurance - A Review of the Law on Insurable Interest continued...

### B. The Majority View

In a majority of jurisdictions, the assignment of a life policy by the insured to a person who has no insurable interest in the life of the insured is not necessarily void as a matter of law. Such assignments may be upheld if it appears that the transaction was in good faith and that the assignment was not created to evade the law against wagering contracts. Few jurisdictions allow for the free assignment of life insurance policies.

Historically, Minnesota and New York have been among the jurisdictions that allow for such unfettered assignment. One justification for this position is that the free assignability of the policies tends to increase the commercial value of life insurance as an investment vehicle. See, *Rahders, Merritt & Hagler v. People's Bank*, 113 Minn. 496, 130 N.W. 16, (1911) (holding that it is a species of property, and the value of life insurance as an asset would unnecessarily be lost if not made assignable as other choses in action). Under New York law, courts consider the life policy a mere chose in action and should therefore be assignable absolutely or by way of security the same as any other chattel. *St. John v. American Mut. L. Ins. Co.*, 13 N.Y. 31, 64 Am. Dec. 529 (holding life insurance policies are choses in action; they are governed by the

same principles applicable to other agreements involving pecuniary obligation . . . If the policies were valid in their inception, the assignment of them to the plaintiff did not change the liability of the company).

Where life policies are freely assignable, the question of whether a STOLI arrangement will run afoul of state insurable interest doctrines is moot. It would seem that the STOLI arrangements in these limited jurisdictions would be upheld and enforced. Most other jurisdictions, however, while allowing for the assignment of life insurance, are more restrictive.

More generally, if the transaction from its inception was a mere cover for a wager contract or speculation in the life of the insured in favor of one having little or no actual insurable interest, an assignment gives the assignee no right of recovery. The courts in those jurisdictions look to a number of factors to determine whether the assignment was valid, including, whether the insured paid the premiums on the policy, the length of time the policy was in force prior to the assignment and the intention of the parties.

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For example, in *Harrison v. Northwestern Mut. L. Ins. Co.*, 78 Vt. 473, 63 A. 321 (1906), an applicant procured a policy for the purpose of immediately assigning it without consideration; the policy was assigned as soon as the insured procured it; and the notice thereof was immediately given to the insurer. Critically, the insured paid all renewal premiums during his life, while the assignee paid the last renewal premium. The court held that the assignment of the policy was not a wager but was valid as a gift. Similarly, in *Davis v. Brown*, 159 Ind. 644, 65 N.E. 908 (1903), the court held that there can be no objection to a third person's taking an assignment of a life insurance policy that another has taken out upon his own life, where the insured has covenanted with the insurance company to pay the premiums, and where it is not contemplated that such third person will pay them.

In *Midland Nat. Bank v. Dakota L. Ins. Co.*, 277 U.S. 346, 48 S. Ct. 532 (1928), an assignment to a creditor was made about three years after the policy was issued. The court by way of dictum stated that it was plain that the assignment would not render the policy void, whatever the lack of insurable interest on the part of the assignee. In *Rylander v. Allen*, 125 Ga. 206, 53 S.E. 1032 (1906), an assignment of an insurance policy a few months after it was taken out, to one having no insurable interest, who paid the first and all subsequent premiums, was held not to be void unless it was done by way of cover for a wager policy. The court added that the mere fact that insured was at the time of the assignment of a very advanced age and had a large amount of other insurance on his life and that he was financially unable to keep in force all the insurance on his life to the knowledge of the assignee, was insufficient to show that the transaction was a wagering or gambling one.

In *Volunteer State Life Ins. Co. v. Buchanan*, 10 Ga. App. 255, 73 S.E. 602 (1912), it appeared that an assignment was made about two weeks after the policy was issued and before the first premium had been paid. Upholding the validity of the assignment, the court stated that in Georgia, the rule was well-settled that a person had a right to procure an insurance policy on his own life, and to assign it to one who had insurable interest in his life, provided it was not done by way of cover

for a wager policy, adding that the intention of the insured in taking out the policy and in making the assignment, and of the assignee in accepting the assignment, were questions of fact for determination by a jury.

In *Prudential Ins. Co. v. Liersch*, 122 Mich. 436, 81 N.W. 258 (1899), an insured obtained a policy on his life payable to his executors, administrators, or assigns, and paid the premiums thereon for several years, when he assigned his interest in the policy to a person without an insurable interest in his life. The assignment was made on the advice of the insurer's agent, and with the insurer's consent, because the insured was unable to keep up with the premiums. After the assignment, the premiums were paid by the assignee, and the insurer was willing to pay whatever was due upon the policy. The court held that the assignee was entitled to recover, upon the ground that there was no statute which prohibited the assignment.

Finally, in *Hawley v. Aetna Life Ins. Co.*, 291 Ill. 28, 125 N.E. 707 (1919), it was held that the holder of a life insurance policy payable to his estate and having a surrender value of \$2,000 could validly assign it by an absolute sale for \$2,500 cash to one having no insurable interest in his life. Rejecting the contention that public policy required that the policy could not be legally assigned, the court stated that it could see no reasonable basis for public policy forbidding the owner of an insurance policy to sell it and assign it to anyone who would pay more than the cash surrender value which the insurer was willing to pay. The court reasoned that to sustain the doctrine forbidding assignment would be, in effect, to hold that a valid policy cannot be sold in the best market but must be either surrendered to the company or sold to a person having an insurable interest, and this would in most cases result in compelling the policy-holder to surrender his policy to the insuring company at its own figure. This, the court concluded was contrary to sound public policy.

The question of assignability of a life policy may also be influenced by the existence of statutory provisions or bylaws of benevolent associations either expressly permitting or expressly prohibiting such assignments or affecting the question by indirection. In *Cook*

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*v. Cook*, 17 Cal.2d 639, 11 P.2d 322 (1941), the court stated that the object of a statute making life insurance transferable without notice to the insurer, unless expressly required, to any person, regardless of whether or not he has an insurable interest, was to make insurance policies freely alienable, although the transferee or legatee has no insurable interest.

Looking to the factors considered by the courts in determining whether the assignment of the ownership of a life insurance policy is permissible, it would appear that STOLI arrangements as they are currently structured would fail to satisfy many states' insurable interest doctrines. In order to overcome the difficulties posed by the restrictions on assignment, many of the features that make STOLI arrangements attractive to potential insureds would fall, including the notion of premium finance and quick return. As discussed above, many STOLI transactions provide that the investors will finance the premiums paid by the insured during the two year "wet ink" period. However, in order to avoid running afoul of the insurable interest laws, the potential insured would no longer be able to benefit from premium finance offers and would need to shoulder the burden of paying premiums.

Furthermore, STOLI arrangements would be found unenforceable where the intent of the parties at the beginning of the transaction was to assign the ownership of the life contract. Most STOLI arrangements contemplate assignment of the life policy as a condition for entering into the transaction. The intention of the parties in entering into the transaction and purchasing life insurance is an important distinction in the life settlement market. Many life settlements involve situations where an insured faces the decision to terminate the policy and accept the cash value of the contract or allow the policy to lapse. Assigning the ownership of the policy under these circumstances is much different than the typical STOLI arrangement and does not appear to be subject to the same criticism of the life insurance industry.

Finally, the STOLI arrangement would be frustrated if the insured were required to hold the policy for a long period of time prior to assignment. In many STOLI transactions, the insured is elderly and seeking payment on the policy as consideration for the assignment. By delaying the time period for providing payment to an insured, the incentive for entering the transaction in the first instance is reduced.

## Legislative Activities

In response to the advent of STOLI arrangements and concerns over the transactions raised by the life insurance industry, the National Association of Insurance Commissioners has proposed, and a number of states have enacted,

legislative amendments designed to address STOLI transactions. As discussed below, a number of the proposed amendments and legislative enactments address concerns over existence of an insurable interest.

## NAIC Model Act

The National Association of Insurance Commissioners (NAIC) has proposed amendments to the Viatical Settlements Model Act ("Model Act"), the most recent version of which was issued on April 2, 2007. There has been some opposition to the Model Act by the Life Insurance Settlement Association (LISA) and the Life Settlement Institute (LSI) which proposed amendments to the NAIC Viatical Settlements Model Act including a proposed amendment which would decrease the moratorium from five years back to two years. See, *LISA and LSI Proposed Amendments to*

*NAIC Viatical Settlements Model Act*, p. 16.

The Model Act regulates all elements of viatical settlements including, licensing of brokers, reporting requirements, investigations, disclosure, advertising, fraud prevention, and unfair trade practices. The proposed changes addressing STOLI arrangements require disclosures of potential risks to the insured, as well as regulation of brokers involved in the STOLI transactions.

The largest proposed change to the Model Act  
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was made to section 11, which delineates viatical settlement contracts' prohibited practices. The amended Model Act extends the two year period during which anyone is prohibited from entering into a viatical settlement contract to

five years. It also contains requirements that the potential insured fund the premiums with unencumbered assets and that no agreement to enter into a life settlement exist prior to the issuance of the insurance policy.

## State Legislation

A number of states have enacted or are considering enacting legislation addressing the amendments proposed by NAIC to the Model Act. Most recently, in June 2007, Mississippi adopted regulations and procedures for licensing investors in life settlements, including STOLI arrangements. Miss. Reg. 200-1. There are a number of differences between the NAIC Model Act and the Mississippi Act that appear to tend to favor the STOLI arrangement at this time. The Mississippi regulations are interesting in that they define all life settlements to be no different in treatment than viatical settlements governed by Mississippi statute. Miss. Code Ann. §83-7-201, *et. seq.* (2007).

North Dakota recently passed Senate Bill No. 2268 which was signed into law by the Governor. The bill created and enacted Chapter 26.1-33.3 of the North Dakota Century Code which takes effect on August 1, 2007. The Chapter is nearly identical to the NAIC Model Viatical Settlements Act and also prohibits any person from entering into a viatical settlement contract prior to the application for or issuance of a policy which is the subject of a viatical settlement contract or within a five-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies that one or more of four specified conditions have been met within the five year period. N.D. CENT CODE § 26.1-33.3-10 (2007).

In addition to these legislative enactments, a number of state directives have issued from state insurance commissioners. On March 28, 2005, the Arkansas Insurance Department issued Directive 1-2005, Directive on Investor-Owned Life Insurance With Charitable Organizations. The directive explained that while a charity has a lawful and substantial economic interest in the lives of those whom it may rely upon for financial support, the trust or business organization establishing "investor-owned" life insurance, even when charitable organizations are partial beneficiaries, have a

lesser interest in having the life of the insured individual continue.

On July 10, 2006, the Utah Insurance Commissioner released Bulletin 2006-3 regarding Insurable Interest and Life Insurance. In the bulletin, the commissioner explained that the Utah Insurance Department had received several inquiries regarding the legality of a life insurance transaction that involves the purchase of a life insurance policy, premium financing through a non-recourse loan, the sale of the policy in the secondary market, and a payment to the applicant. The Commissioner explained that the Department's position regarding such life insurance transactions is that they are not compliant with the insurable interest requirement of the State. He further explained that in transactions where a third party initiates, arranges the transaction, and ultimately expects to receive the proceeds of the insurance policy, the third party has no insurable interest in the person insured because a lawful and substantial interest does not exist in having the life of the insured continue.

More recently, on April 2, 2007, the Director of the Department of Insurance of the State of Idaho issued Bulletin No. 07-03 regarding Stranger or Investor Owned Life Insurance Arrangements. In its Bulletin, the Director warned that arrangements entered into with the intent of assigning policy benefits to investors may be illegal under Idaho law. He explained that the arrangements may violate Idaho laws that require an insurable interest in the life of an insured and that prohibit rebates or other inducements to purchase insurance unless the inducement is set forth in the policy.

It is clear that many state regulators have concern over STOLI arrangements and are taking steps to address those concerns. It is likely that a number of legislative enactments related to STOLI arrangements will be raised in the near future.

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## Conclusion

The future viability of STOLI arrangements remains to be determined. While such arrangements may violate insurable interest laws, there are a number of states where STOLI arrangements may be upheld. The question of whether the STOLI transaction would violate a particular state's insurable interest laws will become increasingly important to determining whether the transactions will be upheld or rescinded by the courts.

Other than the few limited jurisdictions that allow for the free assignment of life insurance contracts, most states will likely disallow

STOLI transactions under existing state insurable interest laws. As a practical matter, in many states, the very factors that make a STOLI arrangement attractive to a potential insured would likely be found to be the factors that render the transaction as violative of state insurable interest law. With the advent of the amendments to the NAIC Model Viatical Settlement Act and recent legislative activities, concerns over consumer protection and fraud are being addressed. What seems certain though is that investors will continue to seek to use life insurance products for gain so long as a market exists.

## Senate To Consider Legislation Leading To The Creation of National Insurance Regulatory System

On May 24, 2007, Senator John Sununu of New Hampshire introduced S. 40, the National Insurance Act of 2007 (the "Act"), on behalf of himself and co-sponsor Senator Tim Johnson of South Dakota. 110th Congress S. 40 "National Insurance Act of 2007." The bill builds on the proposal National Insurance Act of 2006, previously introduced by the Senators. It was referred to the Senate Committee on Banking, Housing, and Urban Affairs.

The Act seeks to create a uniform regulatory environment for the insurance industry by establishing a comprehensive system of Federal chartering, licensing, regulation, and supervision for insurers and insurance producers independent of the State system. It creates an Office of National Insurance within the Department of the Treasury, to be headed by the Commissioner of National Insurance (the "Commissioner") and funded by assessments imposed upon federally chartered and licensed insurers and insurance producers. The Commissioner's powers include: conducting examinations of National Insurers, National Agencies, and federally licensed producers; revoking or suspending a charter or license; issuing a cease and desist order; removing or suspending individuals; and imposing civil

finances. The Commissioner may consult with State insurance regulators regarding regulatory and supervisory matters of common interest.

Under the Act insurers and producers are free to elect either federal or state regulation, charters and licenses. State insurers may convert to National Insurers and National Insurers may convert to State Insurers. Unless authorized by the Act or other Federal law, national insurers, agencies, and federally licensed producers are only subject to certain State laws including: 1) State tax laws; 2) State unclaimed property and escheat laws; 3) State laws related to participation in assigned risk plans and other mandatory residual market mechanisms that are designed to make insurance available to those unable to obtain insurance in the voluntary market; and 4) State laws that provide for compulsory coverage of workers' compensation or motor vehicle insurance.

The Act also provides for the regulation of product, sales, and marketing of National Insurers, National Agencies and federally licensed insurance producers to prevent unfair competition and unfair and deceptive practices. In addition the Act provides for

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insolvency protection by requiring National Insurers to belong to the State guaranty associations in each State in which they

offer insurance or to the National Insurance Guaranty Corporation created by the Act.

## Illinois Appellate Courts Reject Argument That Insurers Should Reimburse Defense Costs Until No Duty To Defend Is Adjudged By Court

The Illinois Appellate Courts have rejected two recent attempts by policyholders to obligate an insurer to pay defense costs incurred in an underlying action until the insurer secures a ruling that it has no duty to defend. *Steadfast Insurance Co. v. Caremark Rx Inc.*, 2007 Ill. App. LEXIS 550 (Ill. Ct. App. May 22, 2007); *Allstate Insurance Co. v. Amato*, 372 Ill. App. 3d 139 (Ill. Ct. App. 2007). In both cases, the policyholders relied on the decision issued in *General Agents Insurance Co. of America, Inc. v. Midwest Sporting Goods Co.*, 215 Ill.2d 146 (2005). In *General Agents*, the Illinois Supreme

Court held that where an insurer agrees to defend its insured under a reservation of rights, it cannot seek reimbursement of defense costs, even if it is determined that the insurer had no duty to defend, unless the terms of the insurance policy provide for such reimbursement. In that case, an insurer agreed to defend its insured under a reservation of rights which provided that the insurer could recoup defense costs if it was later determined that the insurer had no duty to defend. The court held that an insurer cannot unilaterally alter its policy with its insured through a reservation of rights letter.

*Allstate Insurance Co. v. Amato*, 372 Ill. App. 3d 139 (Ill. Ct. App. 2007)

In *Allstate Insurance Co. v. Amato*, the court held that an insurer who declines coverage and seeks a declaratory action has no retroactive duty to reimburse defense costs if it is determined that the insurer had no duty to defend. In this case, a couple sued Allstate's insured, Joe Amato, for allegedly fraudulently inducing them to invest \$375,000 in his business and failing to deliver them an ownership interest in the business. Amato tendered the lawsuit to Allstate, which denied coverage and filed a declaratory judgment complaint seeking a ruling that it was not obligated to defend or indemnify Amato. The Second District determined that Allstate had no duty to indemnify or defend Amato based on the language of the personal umbrella policy. Despite the no duty to defend determination,

Amato contended that Allstate did have a duty to defend him for the period before the court determined that no duty existed. If Allstate had the duty to defend Amato during this period, it would be liable to reimburse him for fees and costs incurred during the period. Amato relied on *General Agents Insurance Co. of America, Inc.*, 215 Ill.2d 146 (2005). The court, however, distinguished *General Agents* from the case at hand because Allstate sought a declaratory judgment rather than agreeing to defend and "explicitly told Amato that his conduct was not covered." The Appellate Court found that Allstate was not obligated to reimburse Amato for his defense costs during the period in which it was uncertain whether Allstate would be required to defend him.

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In *Steadfast Insurance Co. v. Caremark Rx Inc.*, Steadfast filed a declaratory judgment action seeking a ruling that it had no duty to defend or indemnify Caremark in connection with two lawsuits filed in federal court by Caremark's health plan members. The underlying actions alleged that in managing certain health plans, Caremark breached fiduciary duties under ERISA (29 U.S.C. §1001 et seq. (2000)) by conspiring with drug manufacturers to favor higher priced prescription drugs. In doing so, Caremark obtained for its own benefit undisclosed discounts, rebates and kickbacks. Caremark filed a counterclaim seeking a declaration that Steadfast was obligated to defend and indemnify it and also sought attorney fees pursuant to Section 155 of the Illinois Insurance Code (215 ILCS 5/155(1) (West 2002)), claiming that Steadfast's denial of coverage was vexatious and unreasonable.

On summary judgment motions, the trial court held that Steadfast was required to defend Caremark. The circuit court granted Steadfast's motion for a finding of appealability but refused to stay enforcement of the order pending the outcome of an appeal. In order to comply with the circuit court's order, Steadfast paid nearly \$1 million for Caremark's defense in the federal actions. On appeal, the court reversed the trial court's ruling, finding that Steadfast had no duty to defend or indemnify Caremark. Because Caremark's claim for attorneys' fees under Section 155 was still pending in the circuit court, the appellate court remanded the matter for resolution of that claim. On remand, the trial court denied Caremark's claim for attorneys' fees.

As a result of the subsequent rulings, Steadfast filed a "motion for restitution" seeking to recover the defense costs it expended in the two underlying federal actions. Relying on *General Agents Insurance Co. of America, Inc.*, 215 Ill.2d 146 (2005), the trial court held that Steadfast could not recover litigation costs because its filing of a declaratory judgment action "was the 'functional equivalent' of an agreement to defend Caremark under a reservation of rights" and the policy at issue did not contain any provision that allowed for the recovery of defense costs.

On appeal, the appellate court distinguished *General Agents* based on the fact that Steadfast did not agree to defend Caremark under a reservation of rights. Rather, it refused to defend and filed a declaratory judgment action. Therefore, Steadfast, unlike the insurer in *General Agents*, did not seek to unilaterally alter its policy with Caremark through a reservation of rights letter. Consequently, the court found that the lack of a "reimbursement of defense costs" provision had no effect on the disposition of the case. The appellate court held that Steadfast was not required to pay defense costs. The court further held that "[i]f a party has received a benefit from an erroneous decree or judgment, it must, after reversal, make restitution." However, because Steadfast's complaint did not include a cause of action for unjust enrichment, the basis for the restitution claim, the court could only rule that Steadfast be allowed to amend its complaint to include a cause of action for unjust enrichment.

*Steadfast  
Insurance Co.  
v. Caremark Rx  
Inc.*, No. 03-L-  
001363, 2007  
Ill. App. LEXIS  
550 (Ill. Ct.  
App. May 22,  
2007)

# About SmithAmundsen

SmithAmundsen LLC is a law firm that provides services to clients on a wide range of legal and business issues. Our goal is to become our clients' primary source for legal services and business advice. The Insurance Services Group at SmithAmundsen offers experienced attorneys that have a comprehensive understanding of the business environment in which insurers operate. We represent insurers and reinsurers in the property and casualty, life and health, excess and surplus lines fields. Our attorneys have extensive experience representing the interests of insurers in all aspects of their business, including claims counseling, litigation, dispute resolution, reinsurance and policy drafting. A number of our attorneys have held positions in insurance companies, which provides us with a unique perspective on our clients' concerns. We maintain a perspective beyond the individual case and look for solutions consistent with the long term interests of the company. Whether the issue involves policy coverage, avoidance of bad faith, representation in arbitration or litigation, reinsurance disputes or drafting policy language, we have the expertise to provide reliable and cost effective solutions.

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