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LETTER FROM WASHINGTON

FEDERAL REFORM NEEDED TO PROTECT RRGS

By Robert H. Myers, Jr.

The carefully crafted balance between state and federal regulatory authority over risk retention groups has recently been tipped heavily in the favor of the states as a result of the recent settlement of the Auto Dealers Risk Retention Group ("AD-RRG") case in California. This continues a trend of increasing state infringement upon the system of regulation of risk retention groups ("RRGs") imposed on the states through the Liability Risk Retention Act ("LRRA"). Congressional action is needed.

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HASSETT'S OBJECTIONS

IMPLIED FOLLOW THE SETTLEMENTS AND RESTRICTIONS ON SETOFF

By Lewis E. Hassett

A federal court in Missouri recently addressed two issues of importance to reinsurance practitioners. *Employers Reinsurance Corp. v. Massachusetts Mut. Life Insurance Co.*, Case No. 06-0188-CV-W-FJG (W.D. Mo. Aug. 19, 2008). First, the court addressed whether a cedant's claim for reimbursement was subject to the follow the settlements doctrine. Second, the court addressed whether a disputed claim could be used to setoff an adverse claim pending the court's judgment. In both cases, the court decided that the result was implied by the language of the agreements rather than expressly stated.

The case involved a reinsurance treaty covering excess disability insurance. Under the treaty, the cedant retained liability for 100 percent of losses incurred in the first 24 months of a covered claim. The reinsurer became liable for 90 percent of covered losses after the two-year retention period. During the course of the treaty, the reinsurer expressed its concern about the cedant's investigation of claims, and the cedant subsequently terminated the treaty.

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PLAYER'S POINT

THE PERFECT STORM

By Thomas A. Player

With apologies to Sebastian Junger[1], who wrote a book about the convergence of two awesome forces, and to George Clooney, who piloted his boat, the *Andrea Gail*, to the bottom in the movie version of the same tale, I write this as two awesome forces are building to converge.

1 Sebastian Junger, *The Perfect Storm: A True Story of Men Against the Sea* (1997)

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Inside this issue

Announcements

Lew Hassett's and **Cindy Chang's** article, "Public Access vs. Arbitration Confidentiality: A Balancing Act that Tilts Towards Access" has been published in the June 20, 2008, edition of *Mealey's Litigation Reports: Reinsurance.*

The firm is pleased to announce that our friend and colleague **Joe Cregan** has accepted a position as counsel for longtime client MAG Mutual Insurance Company, based in Atlanta. While we are sad to see him leave, we congratulate him on his continuing success.

Skip Myers will be speaking on federal and state regulatory issues at the National Risk Retention Association meeting in Washington, DC on September 22 - 24, 2008

The firm is pleased to announce that **James "Jim" Maxson,** a leading practitioner in the life settlement industry, has joined the Atlanta office of Morris, Manning & Martin, LLP. Maxson teams with MMM partner **Ward Bondurant** to co-chair a newly formed Life Settlements Group. The new group will advise domestic and international clients on critical legal, insurance regulatory, tax and financial issues. Maxson was formerly Executive Vice President and General Counsel of Habersham Funding, LLC, a leading life settlement provider.

We are delighted to welcome **Tony Roehl** back to the firm. Tony spent a year with Nationwide Insurance as Assistant General Counsel in the office of the General Counsel supporting the commercial insurance group. He rejoins the firm with this additional experience and will continue to pursue his specialty practice in insurance regulatory, mergers and acquisitions and complex multi-state projects Tony received his law degree from the University of Michigan and has five years experience in the Insurance Group at the firm.

Skip Myers will again be an instructor for the ICCIE course on Risk Retention Groups starting on October 29, 2008.

LAMBS LYING WITH LIONS SB 276 SHOWS COOPERATION ACROSS THE AISLE

By Stacey D. Kalberman

During the current Presidential campaign, the public has heard its share of rhetoric regarding the need for Republicans and Democrats to reach across the aisle. In the 2008 session of the Georgia General Assembly, it appears that the trial lawyers and the insurance industry actually did. SB 276 addressed changes in the Uninsured Motorist law which resulted in something for both sides.

SB 276, which was signed into law by Governor Purdue on May 15, 2008, amended two sections of O.C.G.A 33-7-11: first, the legislation clarified the issue of whether the uninsured motorist statute applies to umbrella policies with underlying personal passenger auto coverage; second, SB 276 provided an option permitting policyholders to purchase uninsured motorist coverage limits equal to their limits of liability and without offset of recoveries from other sources.

OCGA § 33-7-11 requires uninsured motorist coverage to be offered on all automobile liability policies sold in Georgia. In 2006, the Georgia Court of Appeals in *Abrohams v. Atl. Mut. Ins.* Agency, 282 Ga. App. 176, maintained that the requirement under OCGA § 33-7-11, applied not only to primary auto policies, but also to umbrella policies with underlying primary automobile coverage. Overturning the lower court ruling, the Court of Appeals stated that "absent express direction from the legislature," there was no exemption for umbrella or excess policies under the uninsured motorist statute. SB 276 provided the "express direction" needed to exclude umbrella policies from the requirements of the uninsured motorist law by affirmatively stating that the UM coverage required under section (1) of OCGA § 33-7-11 excluded umbrella or excess liability policies unless specifically provided for in the policy at the request of the insured.

SB 276 also provided Georgia consumers the option to purchase uninsured motorist coverage providing full policy limits without an offset from other available coverage. Under the prior version of OCGA § 33-7-11, recovery for an uninsured motorist claim through the policy of the not at-fault party was reduced by available coverage from the at-fault party, regardless of the available limits under the not at-fault party's own policy.

SB 276 added an option to section (b) of OCGA § 33-7-11 which permits policyholders to purchase full limits UM coverage. Recoveries for UM coverage under this option are not offset by recoveries from available at-fault coverage.

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Section (b) of OCGA § 33-7-11 requires all insurers to provide notice to private passenger auto policyholders of the new UM option. The notice is required to be sent to all insureds who have policies in effect after January 1 of 2009 and who have not rejected UM coverage in a previous policy. In a Bulletin to all P&C companies issued by the Georgia Commissioner on August 18, the Department provided a sample notice for personal automobile policyholders informing them of the new UM option and giving numeric examples of the application of coverage.

If SB 276 appeared to demonstrate harmony in the passage of amendments to the UM law, its additions to the personal passenger auto rating law were somewhat more acrimonious. SB 276 amended O.C.G.A. 33-9-21(b) by eliminating the prior approval of auto rates in the range above the statutorily mandated minimum liability limits. As of January 1, 2009, insurers will continue to be required to file for prior approval of rates within minimum liability coverages ($25,000 for per person, $50,000 per occurrence, $25,000 property damage). However, rates above the minimum liability limits will become "file and use", permitting insurers to place the auto rates into effect prior to the approval of the Commissioner. Interestingly, the Department has advised in its August 18 Bulletin that the law as written "is mutually exclusive" necessitating two separate filings: one rate filing for minimum limits and one rate filing for limits above the minimum.

Commissioner Oxendine has predicted that the change in the rating law will result in millions of dollars in auto insurance increases for Georgia citizens. Others, including several consumer advocacy groups, disagree. Those in favor of the change to a "file and use" rating scheme believe that premiums will be reduced because insurers will have the ability to respond more quickly to changes in the marketplace without the additional waiting period imposed by prior approval. An additional fact for consideration is that a majority of the states have already moved away from prior approval to either a "file and use" or a flex rating scheme. Whatever the result, the proof will be in 2009 and beyond. ❑

Stacey D. Kalberman is Of Counsel in the firm's Insurance Practice. Stacey concentrates her practice in regulatory matters for alternative risk programs, including insurance captives, risk retention and purchasing groups. Stacey received her bachelor's degree from George Washington University and her law degree from Emory University School of Law.

Announcements

Lew Hassett will serve as a group leader at the Reinsurance Association of America's upcoming seminar "Reinsurance Claims Management For Claims Professionals by Claims Professionals," to be held September 17-18, 2008 at the Helmsley Hotel in New York City.

Jim Maxson spoke on regulatory issues at the Life Insurance Settlement Association's Industry Services Forum on August 6th-7th.

Jim Maxson will speak on litigation issues impacting the life settlement industry on September 23rd - 25th at the 2008 Life Settlements Conference taking place at the Venetian in Las Vegas, Nevada.

Skip Myers will be speaking on regulatory issues affecting captives at the Nevada Captive Insurance Association meeting in Las Vegas on October 25, 2008.

Jim Maxson will be on reporting and regulatory issues at the 2008 LISA (Life Insurance Settlement Association) Regulatory and Compliance Conference taking place at the Westin in Las Vegas, Nevada on September 25th - 26th.

Jason Cummings joins the Insurance Practice after graduation from Mercer University where he received the highest academic achievement award in three areas of study. He received his undergraduate degree from Wake Forest University.

Chris Petersen moderated a panel presentation at the recent "Health Reform & the 2008 Elections: What's Ahead for Health Care Access, Delivery and Financing" symposium held in Washington, DC. Mr. Petersen's panel examined reform perspectives from the states.

I'M NOT SAYING THE VP OF TAXES SHOULD BE THE HIGHEST PAID OFFICER, BUT….

By Bill Winter

Before attending law school, I was an agent for *Northwestern Mutual Life*. I understand too well the esteemed status given to insurance producers: the hunter-gatherers of the insurance food chain, they are responsible for generating every dollar of insurance company revenue. Without producers, an insurance company has nothing. With this prestigious status, my friends were surprised that I voluntarily chose a career with the analytical side of the business: managing taxes. For every phenomenal group of producers, someone needs to ensure the insurance company, its operations, and its programs do not give away 35% (or more) of its revenue to the IRS.

Recently, the IRS has renewed its focus on the insurance industry. In the last twelve months, the IRS has issued rulings or announcements affecting domestic insurers, foreign insurers, and captives.[1] The IRS has not issued this much guidance in the insurance industry since its trio of rulings in 2002 (Revenue Rulings 2002-89, 2002-90, and 2002-91). In October, the IRS is even hosting a two-day seminar on the financial services industry, with sessions for its Chief Counsel focused on assessing and auditing tax issues for life settlement transactions, P&C carriers, and captives. Now more than ever, a good Vice President of Taxes may lower your tax costs and ensure you retain a larger percentage of each dollar earned by forcing your company to consider the tax implications of its insurance programs, keeping up to date with insurance tax developments, and strictly adhering to compliance guidelines established by the IRS. I have outlined below one of the three recent IRS rulings to illustrate this point.

Revenue Ruling 2008-15

In Revenue Ruling 2008-15, the IRS kindly reminded every foreign insurer who insures or reinsures U.S. risks that it may be taxable in the U.S. Section 4371 of the Internal Revenue Code ("Code") imposes a federal tax of 4% on every premium dollar earned by a foreign insurer on casualty insurance or indemnity bonds and 1% on every premium dollar earned by a foreign insurer on life, sickness, accident, and reinsurance policies where the underlying risks are located in the U.S. While this Foreign Insurer Excise Tax (the "Excise Tax") has been around for years, the IRS outlines four situations where an unsuspecting foreign insurer might trigger this tax.

In the first scenario, a U.S. corporation purchased a casualty policy from a foreign insurer, and paid the required 4% Excise Tax (note a good VP of Taxes would recognize the insured U.S. corporation, and not the foreign insurer, is actually responsible for paying the tax). The foreign insurer decided to cede a portion of the risk to a foreign reinsurer. To the reinsurer's surprise, the reinsurance premium was subject to the 1% Excise Tax in the U.S. (because the *original* insured and the risks were both located in the U.S.). In the second scenario, Foreign Reinsurer A agreed to reinsure risks of a U.S. domestic insurance company. To help manage this risk, Foreign Reinsurer A ceded a portion of the risk to Foreign Reinsurer B, an unrelated foreign reinsurance company incorporated in a different jurisdiction from Foreign Reinsurer A. The IRS held that under Sections 4371(3) and 4372, the 1% Excise Tax on reinsurance applied not only to the initial reinsurance transaction with Foreign Insurer A, but also on the second reinsurance transaction. The IRS relied on Treasury Regulations issued in 1970 for their rationale, stating that "[s]ection 4371(3) imposes a tax upon each policy of reinsurance...if issued —(1) [b]y a nonresident alien individual, a foreign partnership, or a foreign corporation, as reinsurer...; and (2) [t]o any person against, or with respect to, any of the hazards, risks, losses, or liabilities covered by contracts described in Section 4371(1) or (2)." Since the original casualty risks were located in the U.S., any subsequent reinsurance transaction had become subject to the U.S. Excise Tax.

Both situations show the IRS is aggressively applying the Excise Tax, and if any policy issued can be connected with "hazards, risks, losses, or liabilities wholly or partly within the United States" the Excise Tax may be due and payable. Moreover, the question of exactly who has liability to pay the tax – the secondary foreign reinsurer or perhaps the original domestic insured – remains unanswered. Revenue Ruling 2008-15 lists as one of its authorities Section 4374 of the Code, which provides that an Excise Tax shall be paid by any person "for whose use or benefit the same are made, signed, issued, or sold." Could the IRS assert the original domestic insured is liable for the 1% Excise Tax on any foreign reinsurance transaction? It's certainly possible.

The remaining two scenarios in Revenue Ruling 2008-15 discuss application of U.S. Tax Treaties with respect to the Excise Tax (using facts similar to those outlined in scenario one and two above). In several U.S. Tax Treaties, the Tax Treaty will provide an exemption from the Excise Tax (*e.g.*, the Tax Treaty between the U.S. and Barbados exempts Barbados insurers from the Excise Tax). Not all Treaties have such an exemption. As stated in Revenue Ruling 2008-15, the

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1 For example, the IRS has issued proposed Treasury Regulation 1.1502-13 (addressing treatment of transactions involving the provision of insurance between members of a consolidated group), Revenue Ruling 2008-8 (addressing tax considerations for cell captives), and Revenue Ruling 2008-15 and Announcement 2008-15 (addressing application of the federal excise tax to non-U.S. insurers).

IRS plans look at each insurance or reinsurance transaction separately to determine whether a Tax Treaty exemption from the Excise Tax might apply. Thus, a U.S. corporation could obtain casualty insurance through a foreign insurer in a favorable Treaty jurisdiction, and under the Tax Treaty, such transaction may be completely exempt from the Excise Tax. If, however, the foreign insurer reinsures a portion of the risk with a reinsurer in another country that does not have a Treaty-based Excise Tax exemption, then suddenly both transactions – the initial casualty policy and the reinsurance policy – become subject to the Excise Tax. The actions of the foreign casualty insurer may have made the U.S. insured suddenly – and unexpectedly – liable for an aggregate 5% Excise Tax (4% on the initial casualty policy premiums and 1% on the reinsurance premiums). Obviously an onerous result.

So what can we learn from this ruling? By allowing a VP of Taxes to approve, or at the very least participate in, insurance transactions from the beginning, the VP of Taxes (working with outside tax counsel) could have saved your company 4% or more from needlessly going out the door to the IRS. First, the VP of Taxes would ensure the transaction qualifies for benefits under a U.S. Tax Treaty, eliminating any potential Excise Tax (and, as an aside, if the foreign insurer happens to be a captive owned by your U.S. corporation, the VP of Taxes may have just gained both a premium deduction in the U.S. and an exemption from the Excise Tax – a significant double benefit). Second, the VP of Taxes would have insisted on notice and consent provisions prior to any reinsurance transaction, giving them the opportunity to confirm whether the reinsurance transaction might violate applicable Tax Treaties and suddenly subject the parties to Excise Tax. Finally, if an Excise Tax was in fact due, the VP of Taxes and his staff would dutifully file and report amounts to the IRS, keeping both the insured and the insurer from losing money to audit expenses and penalties.

Yes, insurance producers are the key to an insurance company's survival. Without producers, insurance companies would not exist. However, do not overlook the importance of tax and tax compliance. Without it, insurance producers may have to work harder – as much as 35% harder at current U.S. federal income tax rates – to generate bottom line profits. By having someone on hand who will force your company to consider tax implications of its insurance programs, remain abreast of new U.S. tax developments, and undertake the thankless job of tax compliance, you will have more money remaining at the end of the day. Money that very likely will be paid as bonuses to the producers. ❑

William M. Winter is a partner in the firm's Tax and Insurance Practices. His practice focuses on addressing U.S. tax matters for growing businesses, with an emphasis on helping U.S. and foreign companies successfully expand their business overseas. Mr. Winter received his bachelor's degree from University of Illinois and law degree from Emory University School of Law.

COMING TO A FINANCIAL STATEMENT NEAR YOU: CHANGE – IT'S NOT JUST FOR POLITICIANS ANYMORE

By Brooks W. Binder

As if the 2008 presidential race is not exciting enough, we now also have change and drama in the opaque world of accounting policies. On August 27, 2008, the Securities and Exchange Commission voted unanimously to adopt a proposed Roadmap that could lead to abandonment of GAAP in favor of International Financial Reporting Standards by 2014. GAAP is such an integral part of American business that it is hard to believe that we may face a future when GAAP is referred to only in the past tense. Under the Roadmap, the SEC would not finally decide to abandon GAAP in favor of IFRS until 2011 and, theoretically, the switch would only apply to public companies. Nonetheless, the pendency of the change and the debate over the pros and cons should have an impact on American commerce for a long time to come.

Of more immediate concern, the implementation of SFAS 141R later this year will result in significant changes to the accounting policies and procedures applicable to business combinations. As explained below, SFAS 141R will have a substantive impact on accounting for mergers and acquisitions and other business combinations.

In December of 2007, the FASB issued Statement of Financial Accounting Standard No. 141 (revised 2007) ("SFAS 141R"), which will supersede SFAS 141 (Accounting for Business Combinations) for fiscal years beginning after December 15, 2008. The current purchase method accounting guidelines under SFAS 141 measure the purchase price of the target at the announcement date, but measures the assets and liabilities of the combined entity as of the acquisition date. In contrast, SFAS 141R mandates that the acquirer must determine the entire fair value of the target's business as of the acquisition date, which is defined as "the date on which [the acquirer] obtains control of the [target]." Note that this will not be the same date as the closing date if the acquirer obtains control either before or after closing.

The major changes included in SFAS 141R can be divided into five categories:

1) accounting for transaction costs;

2) contingent considerations ("earn-outs");

3) in-process research and development ("IPR&D");

4) pre-acquisition contingencies; and

5) partial or step acquisitions.

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First, SFAS 141R will resolve inconsistencies in accounting for transaction costs. Under SFAS 141 certain direct costs are considered a component of the purchase price, while other indirect costs are expensed as incurred. However, under the revisions, transaction costs such as legal fees, consulting fees, accounting fees, and banking fees will no longer be included in purchase price when accounting for a business combination. Since these acquisition-related costs do not add value to the acquired assets, they will be recognized as expenses of the period in which they were incurred. So, for example, when an acquiring company incurs a multi-million investment banking fee, 100% of that fee will impact earnings in the year in which the transaction is recognized, rather than having the expense spread over several accounting periods. For highly acquisitive companies, transaction costs are a normal and recurring expense and the immediacy of the expense under SFAS 141R will not likely pose a challenge to the financial reporting of those companies. However, for companies that only occasionally play the role of acquirer, immediate expensing of transaction costs could result in significant volatility in earnings.

The second major change under SFAS 141R affects earn-outs. Earn-outs generally include payments to the target's shareholders that are contingent upon achievement of certain financial goals or performance goals that will occur after the acquisition date. SFAS 141R requires that an acquirer include the fair value of any contingent consideration in the consideration for the target at the acquisition date. This is in stark contrast to SFAS 141, which generally prohibited recognition of any contingent consideration until the contingency was resolved and the consideration was issued.

A third change will alter the method of capitalization of in process research and development ("IPR&D"). Currently, the acquirer must immediately expense acquired IPR&D assets. SFAS 141R requires IPR&D to be capitalized as indefinite-lived intangible assets at fair market value, even before IPR&D reaches the point of feasibility. When the research and development project is either completed or abandoned, then the useful life will be reconsidered. If the project reaches completion, it will be accounted for as an intangible asset with an assumed finite life and amortized over the related product's estimated useful life. However, if the project is abandoned and has no feasible alternative use, it must be expensed.

Fourth, SFAS 141R will solidify the measurement date for pre-acquisition contingencies, such as obligations related to product warranties and product defects, guarantees of the indebtedness of others and pending or threatened litigation. Currently, acquirers do not recognize pre-acquisition contingencies until recognition criteria are met, and as a result pre-acquisition contingencies may be measured and accounted for at different times. However, under SFAS 141R contractual pre-acquisition contingencies must be recognized at fair value on the acquisition date. Moreover, non-contractual pre-acquisition contingencies will be recognized at fair value if they will "more likely than not" meet the definition of an asset or a liability. If the "more likely than not" threshold is not met, then the non-contractual contingency is not recognized in the accounting of the business combination.

Finally, the revisions of SFAS 141 will alter the method of measurement for partial acquisitions and step acquisitions. Under SFAS 141R, if an acquirer obtains less than 100 percent of a target or achieves control in stages, the acquirer must record 100 percent of the fair values of all of the target's assets and liabilities at the acquisition date. This means that the acquirer must recognize full fair value of any non-controlling interests, so that the goodwill attributable to the non-controlling interest is represented. This is in contrast with the purchase method where each purchase is accounted for separately, and the historical costs are intermingled. For example, in a step acquisition under SFAS 141R, if a company acquires 30 percent of the target's stock at $100 million, and subsequently purchases an additional 30 percent for $150 million, the acquirer must revalue its original 30 percent position at $150 million and report a $50 million gain on its original 30 percent position, causing the entire 60 percent position to be carried on its books at $300 million. Under SFAS 141, there is no step up in the value of the original 30 percent position as a result of the subsequent transaction and the aggregate 60 percent position would be carried at $250 million.

Most of us do not live in the arcane world of accounting policies and procedures. Even so, the significant changes in policy represented in the near term by SFAS 141R and in the longer term by the move to International Financial Reporting Standards will have wide-ranging impacts on American commerce for generations to come. ❑

[Attribution: The author wishes to acknowledge the assistance of Ms. Jennifer Stutte in the preparation of this Article]

Brooks Binder is a partner in the firm's Corporate and Securities Practices. He concentrates in the areas of mergers and acquisitions, strategic investments, recapitalizations, venture capital financings, leveraged buyouts, debt offerings including mezzanine loans, equipment leasing and other commercial lending transactions. Brooks received his bachelor's degree from the University of North Carolina at Chapel Hill and his law degree from Emory University.

COURTS CONSISTENTLY RULE IN FAVOR OF DISCLOSURE BY ARBITRATORS

By Jessica F. Pardi

Once again, a court has raised the bar on required arbitrator disclosures necessary to avoid an appearance of bias. *Advantage Med. Svcs., LLC v. Hoffman*, 72 Cal. Rptr. 3d 935 (Cal. App. 4th 2008). In *Advantage Medical*, an arbitrator failed to disclose to Hoffman, a founding member of Advantage Medical, that he also served as an attorney for marine entities which procured reinsurance from the London market association to which Advantage Medical's insurer belonged. Further, when an unidentified representative of Advantage Medical's insurer showed up at the arbitration, and Hoffman discovered this connection herself, the arbitrator refused to disqualify himself and subsequently issued an interim award in favor of Advantage Medical. Thereafter, Hoffman moved to disqualify the arbitrator and to vacate the interim award.

While the arbitrator's obstinance in refusing to disclose both his connection to the insurer and to require the insurer's representative present at the arbitration to identify himself certainly cast a suspicion of bias, it is important to note the connection at issue here is not one of an arbitrator to a party or a party's counsel but that of an arbitrator to an affiliate of a party's insurer. This is arguably a remote connection.

Interestingly, it was expert testimony that carried the day for Hoffman and her petition to disqualify and vacate. She hired an expert in the insurance and reinsurance industry who provided a detailed description of the relationship between and among Advantage Medical, its insurer and the marine entities represented by the arbitrator.

The court, which received this matter on appeal from the American Arbitration Association, held the arbitrator was required to disclose his connection to the marine entities because such affiliation "could cause a person aware of the facts to reasonably entertain a doubt that the proposed neutral arbitrator would be able to be neutral" within the meaning of the California Arbitration Act. *See* Cal. Code Civ. Pro. § 1281.9(a). The court also noted that an arbitrator's duty of disclosure is an ongoing obligation and applies from notice of an arbitrator's proposed appointment until the conclusion of the arbitration.

Although California's Arbitration Act does not provide for disqualification of an arbitrator after he has ruled on an issue of contested fact, the court here allowed such a disqualification because the arbitrator issued the interim award before Hoffman discovered the arbitrator's failure to disclose his relationship to an affiliate of Advantage Medical's insurer.

This and other recent cases continue to underscore the importance of vetting party-appointed arbitrators, neutral arbitrators and umpires to avoid the time and expense of a procedure that is subject to appeal and possibly an award that is vacated. ❑

Jessica Pardi is a partner the firm's Insurance Practice. She practices in the areas of insurance litigation, reinsurance dispute resolution, complex coverage disputes, and insurer insolvency. Jessica received her bachelor's degree from Boston University and her law degree from University of Virginia.

ELEVENTH CIRCUIT HOLDS THAT POLLUTION EXCLUSION APPLIES EVEN WHERE INSURED DID NOT CAUSE POLLUTION

By Stacey Turner

The United States Court of Appeals for the Eleventh Circuit has ruled that James River Insurance Company, an excess and surplus lines carrier headquartered in Richmond, Va., was not required to defend Ground Down Engineering, Inc., its insured is a professional negligence action. *James River Ins. Co. v. Ground Down Eng'g, Inc.*, Case No. 07-13207 (11th Cir. Aug. 20, 2008). Ground Down, an environmental inspector, was alleged to have failed to discover fuel tanks and other contaminating debris in a site assessment for Ground Down's developer client. The Court reversed a decision from the U.S. District Court for the Middle District of Florida.

Priority Development, L.P. hired Ground Down to conduct a Phase I Environmental Site Assessment of property it intended to redevelop. A Phase I Assessment conducted in accordance with industry standards may be used to satisfy the "innocent landowner defense" under the Comprehensive Environmental Response, Compensation and Liability Act. *See* 42 U.S.C. § 9601, et seq. Under the industry standard for Phase I Assessments, the Assessment should identify "Recognized Environmental Conditions." The American Society for Testing and Material's standard for a Phase I defines a "Recognized Environmental Condition" as "the presence or likely presence of any Hazardous Substances or Petroleum Products on a property under conditions that indicate an existing release, a past release, or a material threat of a release of any Hazardous Substances or Petroleum Products." Ground Down's Phase I did not identify any Recognized Environmental Conditions with respect to Priority's property. *Id.* at *1.

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In the course of redevelopment, Priority discovered construction debris at the site, including 55-gallon drums and a portion of an underground storage tank, which had contained petroleum. The drums, tank and surrounding soil were impacted by petroleum and had to be disposed of at a special waste facility. The construction debris elevated the level of methane gas at the site. Priority incurred costs to monitor both the groundwater at the site for contamination and the levels of methane gas. Priority sought damages for lost profits, lost property value and costs for environmental clean-up from Ground Down (and an individual engineer and employee) under claims of beach of contract, negligent misrepresentation, and negligence. *Id.*

Ground Down's professional liability policy provided coverage for wrongful acts in Ground Down's performance of, or failure to perform, professional services. *Id.* at *4. "Professional services" were services that Ground Down was qualified to perform in its "capacity as an architect, engineer, landscape architect, land surveyor or planner." *Id.* James River defended the suit under a reservation of rights but also sought declaratory judgment that it was not required to cover Ground Down due to the pollution exclusion in Ground Down's policy. *Id.*

The district court dismissed James River's declaratory judgment claim and denied its summary judgment motion. *James River Ins. Co. v. Ground Down Eng'g, Inc.*, Case No. 8:06-CV-1690-T-17-MAP (M.D. Fla. June 14, 2007). The court found that Priority's claim arose out of a failure to satisfy professional responsibilities, not from pollution itself. The court also held that it would be "unconscionable at best" to interpret the policy to exclude coverage for claims relating to "*any* form of pollution, regardless of causation" and went on to hold that because Ground Down did not cause the pollution, the exclusion should not apply. *Id.* at *4. On appeal, Ground Down and Priority argued that the negligence at issue related to the improper performance of a Phase I, instead of to negligently causing pollution. Under Florida law, insurance contracts are construed according to their plain meaning and ambiguities are construed against the insurer. The Florida Supreme Court has interpreted the phase "arising out of" to be broader in meaning than "caused by" or "originating from." *Garcia v. Federal Ins. Co.*, 969 So.2d 288, 293 (Fla. 2007).

The appellate court found that Priority's claims for damages "arise directly out of the alleged discovered pollution and are covered explicitly by the exclusion… Priority's claim depends upon the existence of the environmental contamination." *James River Ins. Co. v. Ground Down Eng'g, Inc.*, Case No. 07-13207, at *4 (11th Cir. Aug. 20, 2008). The "pollution exclusion" excluded from coverage all "liability and expense arising out of or related to any form of pollution, whether intentional or otherwise." *Id.* at *2. In addition, the exclusion barred from coverage "any damages, claim, or suit arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants.'" *Id.* Finally, the exclusion applied "regardless of whether . . . an alleged cause for the injury or damage is the Insured's negligent hiring, placement, training, supervision, retention, or wrongful act." *Id.*

The appellate court noted that the exclusion contemplated that negligence would be the basis of a claim against the insured and clearly stated that such claims would be excluded. The appellate court distinguished the facts from those in *Evanston v. Treister,* a district court case from the U.S. Virgin Islands. 794 F. Supp. 560 (D. V.I. 1992). In *Evanston*, the insurer was an architect, who designed and supervised the construction of sewer and water pipes. The pipes were improperly placed together, and the water line was incorrectly placed below the sewer line. The improper and incorrect placement led to contamination of sewage into the water supply, which caused a typhoid outbreak. The government sued the architect for the cost to replace the water and sewer lines (i.e., the work done negligently by the architect). The cost was not related to the contamination. *Id.* at 572. The costs for which Priority sought recovery arose from contamination and the resulting clean-up. *James River Ins. Co. v. Ground Down Eng'g, Inc.*, Case No. 07-13207, at *5 (11th Cir. Aug. 20, 2008).

The appellate court gave little weight to the district court's conclusion that it would be unconscionable to exclude coverage given that the contamination was not caused by Ground Down. The circuit court found that fault was not relevant and dismissed the district court's concern that the policy would fail of its essential purpose if the claim were excluded by finding numerous professional services that would still be covered. *Id.*

The appellate court vacated the dismissal and remanded with instructions for the district court to enter an order granting summary judgment to James River. *Id.* at *6. ❑

Stacey Turner is the Senior Associate in the firm's Environmental Practice and a member of the firm's Green Business Practice. Her primary focus is the redevelopment of environmentally impacted properties. She received her bachelor's degree from the University of Florida, her law degree from the University of Michigan and master's degree from Columbia University.

SYNTHETIC STRUCTURES TO HEDGE LONGEVITY RISK IN LIFE SETTLEMENTS

By James W. Maxson

A. Overview of Life Settlement Market

A life settlement is the purchase of an insurance policy from the policy owner at a discount to the policy's face value. Unlike viatical transactions, which involve the purchase of a life insurance policy where

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the insured suffers from a life-threatening, terminal or chronic illness or condition, life settlements relate to the purchase of a policy where the insured is usually sixty-five years or older and has medical impairments that allow a professional medical underwriter to project the insured's life expectancy.

The past decade has seen an explosion in the growth of investment in life settlements. Due to the fact that virtually all participants in the life settlement market are privately owned and are generally unwilling to share their purchase experience data, definitive numbers are difficult to obtain. However, it is believed that the size of the market has grown from approximately $1 billion in face value transacted in 1999 to over $25 billion in face value transacted in 2007. This rapid growth was fueled in large measure by institutional investors, such as German closed-end funds, hedge funds and Wall Street investment banks. Even Warren Buffet's Berkshire Hathaway has invested in life settlements. Bernstein C. Sanford & Co., LLC, in its March 4, 2005 "Research Call", predicted that the secondary market for life insurance policies could grow to as large as $160 billion in the next decade.

B. Economics of Life Settlements

The economics of a life settlement transaction are straightforward. The policy owner is able to realize the present value of an insurance policy that is no longer wanted or needed, rather than surrender the policy for its cash value (often a fraction of its current market value). The policy owner is also freed from the burden of having to pay on-going premiums.

The purchase price life settlement investors are willing to pay for a policy is typically the policy's net present value. Net present value is equal to projected future cash flows over the insured's estimated life expectancy discounted at the investor's desired yield. Projected cash flows include the death benefit less administrative costs and future premiums to maturity. From the investor's perspective, they are investing in an asset that has little or no market correlation (that is, if the Dow Jones average drops 1000 points in one day, it will not impact the value of the underlying asset) and should return steady cash flows over time. The investor is, in essence, assuming the insured's longevity risk with the potential of greater yield if the policy experiences an earlier than projected maturity.

C. The "Cash" Market Versus the "Synthetic" Market for Longevity Risk

The purchase of a life settlement is an investment in longevity. The investor bets that the insured will live for a certain period of time and that the policy will mature as predicted, giving the investor the predicted yield. If the insured outlives his or her life expectancy, the investor will not realize the desired yield. Longevity risk is distinct from the mortality risk borne by issuers of life insurance policies. The longer that premiums are paid for a life insurance policy, the more profit a carrier realizes. If an insured dies earlier than predicted, or before the owner decides to lapse the policy, the carrier will not realize the anticipated profit; thus, carriers are exposed to mortality rather than longevity risk.

Historically, the only way to invest in longevity was to directly purchase life insurance policies in life settlements transactions. The direct purchase of life insurance policies is referred to as the "cash" market. In the past two years a new class of "synthetic" longevity products have arisen that allow investors exposure to longevity risk without the risks associated with owning the underlying asset.

1. The Cash Market

The cash market is the traditional life settlement market in which an investor, utilizing intermediaries such as life settlements brokers and providers, invests directly in life insurance policies. In the cash market, the investor becomes the record owner and beneficiary of the policy. The cash market presents certain advantages and disadvantages. The advantages include: control of risk by direct underwriting; legal transfer of title to the asset; full visibility to the maintenance of the underlying asset; and, because the underlying asset is directly owned, there is no basis risk. The risks associated with the cash market include: legal and reputational risk; ramp-up risk; insurable interest risk; on-going servicing and maintenance requirements; a finite supply of policies that fit target parameters for purchase; and, high costs associated with the intermediaries typically involved in settlement transactions.

2. The Synthetic Market

Unlike the cash market, the synthetic market for longevity is not predicated on direct ownership of an underlying asset. Instead, synthetic transactions "reference" either life insurance policies or indices that can be based on targeted lives or broad populations. The synthetic market allows an investor to deploy capital into a longevity-linked asset without many of the risks associated with the cash market. For instance, because the investor does not own an underlying asset, legal and reputational risk, ramp-up risk, insurable interest risk, servicing and maintenance risks and finite supply risks are virtually eliminated.

D. Synthetic Longevity Investment Structures

The structures utilized for synthetic longevity investments take different forms, but the two main instruments currently utilized are swaps and notes.

1. Swaps

Private parties, one owning a portfolio of previously purchased policies, and the other interested in investing in longevity

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without the risk exposure of owning the underlying asset, will come together and structure a longevity "swap". In a typical transaction, the owner of the pool of policies will, in essence, "sell" the economics of the portfolio to the new investor for a defined period of time by issuing a swap, the value of which can either be derived from the value of the underlying portfolio, or agreed upon between the counterparties without reference to the portfolio.

In one structure, an investor can purchase a synthetic portfolio that duplicates an existing portfolio. The investor will pay a sum to the portfolio owner that is equivalent to a purchase price for the portfolio. Thereafter, the investor will make scheduled payments to the portfolio owner that are similar to the premium amounts paid to a carrier to keep the policies in force. As maturities occur in the underlying pool, the investor receives the equivalent face value of the underlying policies. Thus, the investor is able to invest in longevity via a synthetic portfolio without having to assume the origination and direct ownership risks associated with the underlying asset

In an alternative structure, the reference individuals in the pool are assigned notional amounts that do not relate to the actual amount of coverage in force on their lives. In fact, it is not necessary for any coverage to be in force on the individual reference lives if they have agreed to allow their mortality to be tracked. In essence, the notional amount is the same as a life insurance policy's face value, but the parties can set the notional amount at whatever level they see fit to achieve their risk/return goals. As with the structure described above, scheduled payments are made and when a maturity occurs the investor is paid the notional amount, just as an investor in the cash market receives a policy's death benefit upon a maturity.

The overall return on investment experienced by an investor in a synthetic portfolio can be higher or lower than the expected return depending on the mortality experience of the underlying reference pool.

2. Notes

Similar to the structure used for synthetic longevity swaps, a pool of reference lives is used as the basis for tracking payments. Each reference life is assigned the same fixed notional amount or face value, and a stream of scheduled payments is assigned to each reference individual. Unlike synthetic swaps, in which the investor receives the notional amount as maturities occur, an index is used to track the value of the notes. Scheduled payments are debited to the index for the individuals alive at the end of each quarter, and notional amounts are credited to the index as reference lives pass away. Thus, the value of the notes at redemption are linked to the performance of the index, subject to a cap and a floor. The overall return on investment in the notes will depend on the mortality experience of the reference pool.

E. Conclusion

Although synthetic trading in longevity risk is still in its nascency, its growth has been rapid as the number of investors interested in participating in this alternative asset class has increased. Both Goldman Sachs and J.P. Morgan have created indices used to track longevity/mortality of targeted groups of individuals. Goldman Sachs has created the QxX index, which tracks a pool of U.S. insured individuals age 65 and older, underwritten by AVS, LLC. Goldman Sachs makes daily two-way markets in 5 year and 10 year swaps referencing the QxX index. J.P. Morgan, through its Life Metrics division, has created indices that track longevity/mortality in the Netherlands, Germany, England and the United States.

Given that synthetic longevity products have only existed for a brief period of time, their potential to revolutionize both longevity and mortality risk is extraordinary. Any investor in the life settlement space, as well as anyone who deals with longevity or mortality risk as part of their daily business, should consider whether utilizing synthetic longevity structures is an appropriate tool to manage their overall risk portfolio. ❑

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SUPREME COURT OF ARIZONA DEFINES SCOPE OF COMMON TITLE INSURANCE EXCLUSIONS

By J. Ben Vitale

In *First American Title Insurance Company v. Action Acquisitions, LLC*, Case No. CV-07-0412-PR (July 25, 2008) ("*Action Acquisitions II*"), the Supreme Court of Arizona defined the scope of two common exclusions to coverage found in most title insurance policies: (1) the "failure to pay value" exclusion and (2) exclusion for losses "created, allowed, or agreed to by" the insured. The Supreme Court of Arizona held that the term "value" in the "failure to pay value" exclusion is synonymous with the "valuable consideration" required for protection as a bona fide purchaser under the recording statutes. Further, the Court held that a purchaser need only have intended to commit the act that caused a title defect, not the creation of the defect, for the "created by" exclusion to prohibit recovery under a title insurance policy. In so holding, the Supreme Court of Arizona vacated a prior opinion of the Court of Appeals and affirmed the judgment of the trial court.

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The case involved the purchase of a home at a sheriff's sale for $3,500.00. *Id.* at ¶ 2. At the time, the property was estimated to be worth between $300,000 and $400,000 and was subject to a $162,000 deed of trust. *Id.* After the six month redemption period, the purchasers bought a $400,000 owner's title insurance policy from First American Title Insurance Company ("First American"). *Id.* at ¶ 3. The policy excluded coverage for certain losses, including those resulting from the insured's "failure to pay value" for the title and from risks "created" by the insured. *Id.*

The prior homeowner successfully moved to set aside the sheriff's sale on the ground that the $3,500 purchase price was grossly inadequate. *Action Acquisitions II*, ¶ 4. Rather than appeal the court's judgment setting aside the sale, the purchasers made a claim against the title insurance policy, and First American sought a declaratory judgment that it was not liable. *Id.* at ¶ 4.

The trial court agreed with the First American and found that coverage was properly denied under the "created" risk exclusion but did not address the "failure to pay value" exclusion. *Id.* The Court of Appeals affirmed the trial court's judgment but relied instead upon the "failure to pay value" exclusion and did not address the "created" risk exception. *First Am. Title Ins. Co. v. Action Acquisitions, LLC*, 216 Ariz. 537, 539-40 ¶ 8, 169 P.3d 127, 129-30 (Ariz. App. 2007) ("*Action Acquisitions I*"). In so holding, the Court of Appeals concluded that the "failure to pay value" exclusion applies if the insured is not a bona fide purchaser for value under the recording statutes and that a purchaser whose sale is set aside for a grossly inadequate price is not a bona fide purchaser. *Action Acquisitions I*, 216 Ariz. at 540-41 ¶¶ 12-13, 169 P.3d at 130-31.

On appeal to the Supreme Court of Arizona, the purchasers argued that neither the "failure to pay value" exclusions relied upon by the Court of Appeals nor the "created by" exclusion relied upon by the trial court applied and that, even if one of the exclusions did apply, coverage should not be denied because they had a reasonable expectation of coverage. *Action Acquisitions II*, ¶ 7.

The purchasers presented two arguments regarding the "failure to pay value" exclusion: (1) because the property was subject to a substantial first mortgage and a statutory right to redeem the foreclosure, the payment of $3,500 was a payment of value for the property and, (2) alternatively, that the Court of Appeals erred in equating the term "value" with the "valuable consideration" required for protection by the recording statutes. *Id.* at ¶ 9.

Although the Court agreed with the purchasers that the term "value," "when considered alone, is somewhat unclear," the Court found guidance in the general nature of title insurance and the general provisions found in title insurance policies. *Id.* at ¶ 10. Specifically, the Court observed that "[t]itle insurance exists against the backdrop of the recording statutes" and the "circumstances in which a purchaser will not be protected by the recording statutes have evident counterparts in the policy exclusions." *Id.* at ¶¶ 12 and 14. Guided by these observations, the Court held that "[g]iven the policy language and the nature of title insurance, the exclusion for 'failure to pay value' is most reasonably understood as applying when an insured is not a bona fide purchaser protected by the recording statutes." *Id.* at ¶ 15.

Rejecting the purchasers' arguments, the Court agreed with the Court of Appeals and held that "the policy's exclusion for loss resulting from the insured's 'failure to pay value' for the title means a loss resulting because the insured has not paid 'valuable consideration' and therefore is not protected under the recording statutes." *Id.* at ¶ 16. Nevertheless, although the Supreme Court agreed that the exclusion applies when an insured does not pay valuable consideration, the Supreme Court disagreed with the Court of Appeals' finding that the purchasers had not paid valuable consideration. *Id.* at ¶ 17.

Under the recording statutes, "valuable consideration" does not require fair market value or even a fair or adequate price; valuable consideration "exists if the purchaser surrenders a right or detrimentally changes a legal position 'so that if the claim of title fails the purchaser is left in a worse position than he was before.'" *Id.* at ¶ 18, *quoting Alexander v. O'Neil*, 77 Ariz. 91, 99, 267 P.2d 730, 735 (1954). The recording statutes only require consideration sufficient to distinguish transactions in which the purchaser has surrendered a significant right or incurred some legal detriment from the transactions in which the person has received a gift. *Id.* at ¶ 19. Thus, a nominal payment would not qualify as "valuable consideration" because it does not demonstrate that a purchase ever occurred. *Id.*

First American argued that, as the Court of Appeals had held, "one whose purchase is later set aside for a grossly inadequate price has, by definition, not paid valuable consideration." *Id.* at ¶ 21. However, the Supreme Court found First American's argument unpersuasive in light of the decision in *Krohn v. Sweetheart Props., Ltd.*, 203 Ariz. 205, 52 P.3d 774 (2002), where the Court "acknowledged that the purchaser was a bona fide purchaser for value, but concluded that this status did not insulate the sale from being set aside for a grossly inadequate price." *Action Acquisitions II*, ¶ 22.

Because $3,500 was more than a nominal amount and, although it was a bargain, the property was purchased at arm's length at a sheriff's sale, thus minimizing the danger of bad

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faith, the Court found that the purchasers had paid valuable consideration for the property. *Id.* at ¶ 20. Therefore, "although the 'failure to pay value' exclusion applies if the purchaser's loss is caused by failure to pay valuable consideration under the recording statutes, . . . the $3,500 payment here was sufficient to secure recording act protection" and, as a result, the "failure to pay value" exclusion does not preclude recovery. *Id.* at ¶ 24.

The Court then turned its attention to the trial court's finding that the coverage exclusion for loss resulting from risks "created, allowed, or agreed to by" the purchasers precluded recovery. The purchasers argued that this exclusion could not apply because First American knew of the $3,500 bid prior to issuing the policy and First American argued that the exclusion applied because the bid was an intentional, affirmative act by the purchasers. *Id.* at ¶ 25.

Noting a split of opinion as to the intent required to trigger the exclusion, the Court held that "[c]onsidering the nature of title insurance, we conclude that the exclusion is not ambiguous and that it applies whenever the insured intended the act causing the defect, not only when the insured intended the defect or when the insured engaged in misconduct." *Id.* at ¶ 28. Thus, "by bidding $3,500, the purchasers created the risk that resulted in the loss. Their bid was an intentional, affirmative act that resulted in the sale being set aside." *Id.* at ¶ 29. Therefore, the "created" risk exclusion precluded recovery under the policy.

Finally, the purchasers argued that, even if the exclusions applied, they are entitled to coverage under the "reasonable expectations doctrine" under Arizona law. *Id.* at ¶ 31. Despite the evidence of First American's investigation into the foreclosure, its suggestion that they purchase a premium policy, its knowledge that the purchasers bought the property at a foreclosure sale, and its knowledge that doing so was part of their business, the Court rejected the purchasers' contention that they had a reasonable expectation of coverage. *Id.* at ¶ 35. The Court stated that, although the purchasers might have subjectively expected coverage, "this expectation is simply the 'fervent hope usually engendered by loss.'" *Id.*

Although the "failure to pay value" exclusion did not preclude recovery, having rejected the purchasers' reasonable expectations claim, the Court held that the "created" risk exclusion was enforceable and First American properly denied coverage. ❑

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LETTER FROM WASHINGTON

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A Brief History

In 1981, Congress passed the Product Liability Risk Retention Act ("PLRRA") in response to the absence of affordable product liability insurance. The PLRRA was amended in 1986 in response to the "liability crisis" of that year in which commercial liability insurance was so unavailable or unaffordable that community parks and swimming pools were being closed to avoid the potential liability for which there was no insurance. The 1986 amendments – the LRRA - expanded the authority of RRGs to offer any kind of commercial liability insurance, except workers compensation. The amendments also fleshed out the skeletal regulatory provisions of the 1981 Act and established the concept of "lead state regulation" in which the state of domicile of the RRG is not preempted by federal law, but non-domiciliary states in which the RRG may operate have restricted authority as specified in section 3902 of the Act.

The Congressional intent was abundantly clear and well documented: RRGs, as liability insurance companies chartered in one of the states, could be free to operate on a multi-state basis after providing a "notice filing" in any such non-domiciliary state.

Needless to say, this preemption of regulatory authority by the states was not well received by many of the states. Nonetheless, through the auspices of the National Association of Insurance Commissioners ("NAIC"), a model law was developed and then enacted into state law that empowered the states to exercise those authorities which the states were permitted under federal law. The NAIC also sponsored a working group which ultimately produced the *Risk Retention and Purchasing Group Handbook*, which, on balance, accurately describes the federal law and the states role in regulation.

Gradual Encroachment

As is typical with any federal law that preempts state law, disputes arose regarding the lines of demarcation between state and federal authority. Over the years, litigation has addressed issues such as the definition of a risk retention group, the definition of "liability insurance", assessment of fees and taxes, "discrimination" against RRGs, and other matters. While the outcome of these disputes has been mixed (from the perspective of RRGs), at least a modest body of legal precedent has been established.

However, the strength of the LRRA (federal preemption of state law) is also its weakness. It's weak because its enforcement depends upon (1) the scrupulous adherence to the terms of the federal law by state regulators and (2) the ability of an abused RRG to enforce the federal law.

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Over time, many states have learned that they can push the regulatory envelope and get away with it. For example, the LRRA allows the assessment of "premium and other taxes" but does not allow the assessment of "fees". While there are two federal cases that deal directly with this issue (*NRRA v. Brown* and *ALAS v. Fitzgerald*), the majority of states charge filing fees. These fees are generally not excessive, and the risk retention group community has, for the most part, decided that it is either (1) reasonable to charge modest filing fees to pay for the cost of administration or (2) not worth the effort to fight.

More significantly, many states require as part of the "notice filing" information in addition to that which is defined in the federal law. While this provision of additional information can become quite burdensome, most RRG filers have again taken the approach that it is not worth a fight.

Even more burdensome is the position taken by a number of states that an RRG filing is not bona fide until it is "approved" or "acknowledged" by the state. Some states, *e.g.*, California and New Jersey, have even enacted these "approval" provisions into state law. This clearly violates the letter and the intent of federal law.

Auto Dealers Risk Retention Group

AD-RRG is a risk retention group chartered in Montana that filed its notice of intent to do business in California. It was authorized by its domiciliary state (Montana) to offer stop loss coverage to members of the RRG who were the plan sponsors for self funded employee health plans. The California Department of Insurance took the position that such coverage was not "liability" coverage as defined in the LRRA. After some discussions between AD-RRG and California, California issued a cease and desist order. AD-RRG then went to the U.S. District Court in Sacramento and obtained a temporary restraining order against California. The issues were then fully briefed by both sides and argued before the U.S. District Court resulting in a preliminary injunction against California. The National Risk Retention Association ("NRRA") filed an *amicus* brief in the case.

The opinion of the court was quite favorable to AD-RRG. The Court held that California had exceeded its authority by issuing a cease and desist order and chided California for not seeking an order from federal court. The case was then set for trial on the merits, even though AD-RRG argued that the issue was totally a matter of law and therefore should be decided via summary judgment without any opportunity for discovery. California, however, was able to convince the court it needed some discovery and, as a result, the final hearing on the matter was set for a year later.

AD-RRG, a start up insurer like most RRGs, just could not afford the expense of discovery and a full hearing on the matter. As a result, AD-RRG gave up its fight and entered into a settlement agreement with California. California quite simply used its economic power to grind down AD-RRG, even though a federal court had twice issued favorable rulings.

This abuse of a state's economic power is only the latest iteration of what has been going on for many years regarding filings and subsequent document requests and other inquiries. In these cases, the state, if it wishes to fight either administratively or in court, has an unlimited budget. As a consequence, the fact that the RRG has the better legal case may not matter.

Congressional Action

Legislation has been introduced in the House of Representatives (H.R. 5792), which, if enacted, would impose upon RRGs certain corporate governance requirements along with allowing qualifying RRGs to offer commercial property coverage in addition to commercial liability coverage. The bill would also order the Government Accountability Office (GAO) to investigate abuses of state authority in the regulation of RRGs.

Although this is worthy legislation, it does not go far enough. The expense of litigating against a state government in federal court is just too great for almost any RRG. Those cases that have gone through the federal legal system (briefly mentioned above) have been brought by either the NRRA or those few RRGs that have achieved substantial growth over the years.

A further problem is that, even after a case has been fully litigated, it may only be enforceable in one of the eleven federal circuits. As a result, it may stand as a guideline, but may not be enforceable as precedent.

The answer to this problem is for Congress to acknowledge that its intent has been thwarted by some of the states and that a different dispute resolution process should be adopted. While the normal venue for the resolution of issues regarding federal law is the federal court system, most federal laws are subject to the supervision of a federal agency.

Of course, insurance does not have a federal agency. However, the Treasury, with the cooperation of the NAIC, has served the oversight and rulemaking function for the Terrorism Risk Insurance Act.

Congress should look to that model and establish in the Treasury a binding arbitration or dispute resolution process for LRRA issues. This would finally address both of the most exasperating aspects of the current regime: the unenforceability of federal law in a variety of states and the imbalance of economic power between state governments and RRGs. ❑

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HASSETT'S OBJECTIONS

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The reinsurer later claimed the cedant had not been entitled to payment for twelve claims and demanded reimbursement. The cedant refused, citing the follow the settlements doctrine. The reinsurer then unilaterally setoff the amount in dispute.

The treaty did not contain an express follow the settlement's clause, but the cedant argued that such a provision could be inferred from other language in the treaty and that, at any rate, industry custom implied such a provision. Courts have been split on whether follow the settlements is implied in reinsurance treaties. Some courts have held in the affirmative. *See ReliaStar Ins. Co. v. IOA Re, Inc.,* 303 F.3d 874 (8th Cir. 2002); *International Surplus Lines Ins. Co. v. Certain Underwriters at Lloyds of London,* 868 F. Supp. 917 (S.D. Ohio 1994). Some have held in the negative. *See American Motorists Ins. Co. v. American Reinsurance Co.,* 2007 WL 1557848, *5 (N.D. Cal., May 29, 2007); *Employer Reins. Corp. v. Laurier Indemn. Co.,* 2007 WL 1831775, *4 (M.D. Fla. 2007); *Village of Thompsonville v. Fed. Ins. Co.*, 592 N.W.2d 760, 765 (Mich. App. 1999). Others have categorized the issue as a question of fact for resolution by the jury. *See Nat'l Am. Ins. Co. of Cal. v. Certain Underwriters at Lloyd's of London,* 93 F.3d 529, 537 (9th Cir. 1996); *North River Ins. Co. v. Employers Reins. Corp.,* 197 F. Supp. 2d 972, 986 (S.D. Ohio 2002); *American Ins. Co. v. American Re-Ins. Co.,* 2006 WL 3412079 (N.D. Cal. 2006).

In this case, the court did not decide whether follow the settlements should be implied. Rather, the court inferred a follow the settlements clause from the interplay of several other clauses. Specifically, the court cited a provision of the treaty under which the reinsurer was required to reimburse the cedant "promptly for loss against for which indemnity is herein provided …." *Id. at 2.* A different article of the treaty provided that the reinsurer "will indemnify the [cedant] against the part of such loss indicated in Schedule Item 6." *Id. at 7.*

It is debatable whether the foregoing language is equivalent to a follow the settlements clause. An indemnification clause does not imply follow the settlements. The essence of indemnity reinsurance is that that cedant is reimbursed for certain losses. The issue is the extent to which the reinsurer is bound by the cedant's settlements in measuring the reinsurer's indemnity obligations.

More troubling is the court's citation of the absence of an "anti-follow the settlements" clause. "Nowhere in the treaty does it state that [the reinsurer] may question claims once those losses are incurred or paid." *Id. at 7.*

Essentially, the court implies a follow the settlement clause while declining to reach the question. This is not to say that such a clause should not be implied in some cases. Indeed, perhaps the *Employers Reinsurance* case was appropriate for implying the doctrine. But the Court should not obfuscate its reasoning by equating an indemnity obligation with follow the settlements or by shifting the burden to the reinsurer to identify an "anti-follow the settlements" provision.

With respect to the setoff issue, the reinsurer contended that the cedant had erroneously paid claims for which the reinsurer was entitled to reimbursement and unilaterally declared a setoff against reinsurance benefits claimed by the cedant. The court focused on a contractual setoff provision that allowed the reinsurer to setoff "any balance, whether on account of premiums, commissions, loss or claim expenses due to one party to the other…." *Id. at 9.* The court ruled in favor of the cedant holding that the setoff clause did not allow a setoff for disputed claims. While the setoff provisions provides some support for the court's decision, parties in litigation often assert claims and counterclaims that are ultimately resolved by the court. If a reinsurer's refusal to pay lacks a reasonable basis, the court may award attorneys' fees or, perhaps, penalties.

But the essence of setoff often is that the debts are disputed, and litigation sorts it out. Disallowing a setoff essentially requires a party to pay the disputed amount first, with the adjudication to follow. Of course, the paying party has no guarantee that it will be able to collect the disputed amount if it ultimately prevails.

The court's decision on setoff may not have substantial practical value. Because the court did not include language confirming its setoff decision as a final judgment, the cedant should not be able to levy or otherwise collect on the amount setoff until the final disposition of the case. ❑

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PLAYER'S POINT

Continued from page 1

Second, there are the forces of politics. Two political parties locked in a close race for the Presidency, in which Florida and other coastal states play a pivotal role in this election.

This season, it is not the *Andrea Gail* which is the object of these mighty forces, but the National Cat Fund.

For the first time in history, both political parties have embraced the concept of a National Catastrophic Insurance

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Fund. As expected, the platforms within each Party differ.

The Democratic Party Platform provides, "We will also work to prevent future catastrophic response failures, whether the emergency comes from *hurricanes, earthquakes, floods, tornadoes, wild fires, drought, bridge collapses, or any other natural or man-made disaster.* Maintaining our levees and dams is not pork barrel spending - it is an urgent priority. We will fix governmental agencies like the Federal Emergency Management Agency, ensure that they are staffed with professionals, and create integrated communication and response plans. We will reform the Small Business Administration bureaucracy, and develop a real National Response Plan. We will develop a National Catastrophic Insurance Fund to offer an affordable insurance mechanism for high-risk catastrophes that no single private insurer can cover by itself for fear of bankruptcy. This will allow states and territories to deal comprehensively with the economic dislocation of natural disasters." (Emphasis added.)

The Republican Party Platform provides, "Americans hit by disaster must never again feel abandoned by their government. The Katrina disaster taught a painful lesson: The federal government's system for responding to a natural calamity needs a radical overhaul. We recognize the need for *a natural disaster insurance policy.* State and local cooperation is crucial, as are private relief efforts, but Washington must take the lead in forging a partnership with America's best run businesses to ensure that FEMA's Emergency Operations Centers run as well as any Fortune 500 company. We must make it easier for both businesses and nonprofits to act as force-multipliers in relief situations. We believe it is critical to support those impacted by natural disasters and to complete the rebuilding of devastated areas, including the Gulf Coast." (Emphasis added.)

Senator Obama is in synch with his party's platform when he favors "a national catastrophic insurance fund to offer an affordable insurance mechanism for high-risk catastrophes that no single private insurer can cover by itself for fear of bankruptcy."

Senator McCain, however, on August 19, 2008, said that he was not prepared to endorse a national risk pool but, instead, favors some form of regional alliance. This was certainly disappointing news to Florida Governor Charlie Crist, a strong McCain supporter.

The stage appears to be set for The Perfect Storm. As the pressure builds during this hurricane season and political season, it will be fascinating to learn how this issue evolves.

As I reported in my Winter 2007 Player's Point, the U.S. House of Representatives passed H.R. 3355[1], the Homeowners Defense Act, calling for a system of Treasury loans and reinsurance to state cat funds and residual markets. The measure has failed to gain traction in the Senate.

As we lawyers are prone to say: "The devil is in the details." Nowhere is this more applicable than in a discussion of a National Cat Fund.

Here are some areas where the details are sure to get sticky:

- Coverage

  What constitutes a catastrophe? Is it a natural disaster only? The Democratic Platform is the most inclusive of types of coverage. However, the Terrorism Act[2] is a form of Cat Fund. Where do we draw the line?

- Level of "Back-Stop"

  Our Citizens have come to expect government assistance for incidental losses following a natural disaster. What is a reasonable expectation for personal responsibility, including private sector insurance? Where should the government "back-stop" begin?

- Form of Assistance

  We should be clear on whether government assistance is a loan, a subsidy or a combination, as the Terrorism Act contemplates. There, a portion of the loss is intended to be recouped by future insurance premiums.

- Catastrophic Coverage versus Emergency Relief

  How will Congress discipline itself not to double dip? By that I mean, what if Congress devises a well thought-out plan to provide high level coverage in the event of catastrophe only to rush billions of dollars in similar funds under the auspices of emergency relief?

Stay tuned. Will George Clooney be found floating in a life boat? Will John McCain come to understand the wisdom of a National Cat Fund? Will Congress apply a Band-Aid or seriously look at a serious problem? ❑

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1 H.R. 3355--110th Congress (2007): Homeowners' Defense Act of 2007

2 Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297 (as amended by Terrorism Risk Insurance Extension Act of 2005, Pub. L. No. 109-144, and Terrorism Risk Insurance Program Reauthorization Act of 2007, Pub. L. No. 110-160).

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