MORRIS, MANNING & MARTIN, LLP
ATTORNEYS AT LAW

REVIEW

Insurance • Reinsurance • Managed Healthcare

A Publication of Morris, Manning & Martin, LLP Winter 2005

LETTER FROM WASHINGTON

NAIC TO BE TESTED BY GAO REPORT

By Robert H. Myers Jr.

The Government Accountability Office ("GAO") has issued a report entitled "Risk Retention Groups: Common Regulatory Standards and Greater Member Protections Are Needed" ("GAO Report"). Although the GAO Report is from a federal research agency to the Chair of the House of Financial Services Committee, Rep. Michael Oxley, the Report will have a serious effect on the ongoing efforts of the NAIC regarding the regulation of Risk Retention Groups ("RRGs").

This Report will prompt yet another in the series of responses by the NAIC to the mandates of Congress. In response to the passage of the Gramm-Leach-Bliley Act ("GLBA"), the NAIC undertook a major

Continued on page 10

HASSETT'S OBJECTIONS

DUE PROCESS VERSUS ARBITRATOR DISCRETION

By Lewis E. Hassett

A recent decision from the Appellate Division of the New York Supreme Court has stirred controversy among advocates of arbitration. *See Sawtelle v. Waddell & Reed Inc.*, Case No. 115056/01 (N.Y. App. Div., Sept. 22, 2005). In *Sawtelle*, the court was reviewing an arbitration award arising from a dispute between a broker and his former employer. The arbitration panel had awarded the employee approximately $1 million in compensatory damages and $25 million in punitive damages, citing the employer's allegedly "horrible campaign of deception, defamation and persecution."

The employer argued that the punitive award should be set aside as violative of due process, citing *State Farm Mutual Auto Ins. Co. v. Campbell*, 538 U.S. 408, 418 (2003). In *State Farm*, the Supreme Court

Continued on page 8

PLAYER'S POINT

DUAL REGULATION

AND I DON'T MEAN FEDERAL VERSUS STATE[1]

By Thomas A. Player

Hurricane Katrina has already taken its place as one of the costliest (in terms of destruction of property and loss of life) natural disasters in the history of the United States. Before the tarps were spread, Jim Hood, Attorney General for the State of Mississippi, filed a legal action on behalf of the State of Mississippi urging the courts to disregard filed and approved policy language differentiating between wind loss and flood loss, and to cover all losses under wind loss. Mr. Hood urged the niceties, such as issuance of a flood policy, payment of premium for a flood policy and establishing

Continued on page 10

Inside this issue

Announcements

The September 2005 edition of *The Insurance Coverage Law Bulletin* includes an article by **Lew Hassett** and **Kristin Zimmerman** on the McCarran Ferguson Act's pre-emption of the Federal Arbitration Act where state statute bars the forced arbitration of insurance claims.

Skip Myers will be speaking on Risk Retention Groups and the GAO Report at the South Carolina Captive Insurance Association Annual Conference on December 9 in Charleston, SC.

Tom Player participated in the Annual Meeting of the ACLI held in Washington, DC in October.

Chris Petersen spoke at the National Alliance of Life Companies' Fall Conference. Mr. Petersen discussed the ramification that pending federal proposals, such as the SMART Act, would have on the life and health insurance industry.

Participating in Fasano Associates Second Annual Life Settlement Conference held in Washington, DC in November were **Ward Bondurant** and **Tom Player**.

Lew Hassett was quoted on insurance issues arising from Hurricane Katrina in the September 2005 issue of *Bulls Eye.*

Tom Player was quoted in the October 7-13, 2005 issue of the Atlanta Business Chronicle on the subject of the Terrorism Risk Insurance Act of 2002 (TRIA). The article discusses the differing opinions between the government and insurers as to the necessity of reauthorizing TRIA, which expires at the end of this year.

A special Insurance section in the October 18 New York Times included a quote from **Tom Player** about TRIA.

Chris Petersen was invited to Saudi Arabia to brief the Minister of Health on emerging health insurance issues. Mr. Petersen has been reviewing the Saudi health insurance market and regulatory enviroment as a representative to a World Bank mission that is examining healthcare delivery systems.

THE ALLURE OF THE ALTERNATIVE INSURANCE MARKET FOR MEDICAL PROFESSIONALS

By Kristin B. Zimmerman

Significant concerns have arisen over the past few years regarding the cost and availability of medical malpractice insurance. The reason for the increase in cost and decrease in availability has been an item of much debate. While some argue that insurers are taking advantage of medical professionals by overcharging for liability insurance[1], others argue that the medical liability crisis is caused by excessive litigation and huge verdicts.[2] Whatever the true reason, these concerns have been exacerbated as several traditional insurers have left the medical malpractice market or reduced their writings. St. Paul's exit from the market a couple of years ago was probably the most notable carrier exit as it was one of the largest medical malpractice providers at the time of its market withdrawal.

In the wake of the shift in the marketplace and ever-increasing medical malpractice premiums, health care providers, including hospitals, HMOs, long-term care facilities and physician practice groups, among others, have sought alternative insurance sources. This shift towards the alternative insurance market has received limited attention as the debate over medical malpractice rates has focused to a large extent on tort reform and high jury awards. However, despite the public's limited attention, physicians and other medical professionals have been steadily turning their attention to the alternative insurance market.

Estimates regarding the size of the alternative insurance market vary substantially.[3] However, as of 2003 the alternative market for malpractice insurance was approximately twice as large as the traditional market.[4]

The growing interest in the alternative insurance market is illustrated by the rising number of medical liability risk retention groups ("RRGs"). RRGs insuring healthcare providers accounted for half or $1.1 billion of total 2004 RRG premium of $2.2 billion.[5] Of the healthcare RRGs, those providing liability coverages for hospitals and physicians account for almost ninety percent of premium, with RRGs insuring dentists, nursing homes, HMOs, and other healthcare providers, accounting for the remainder of healthcare RRGs.[6]

Medical malpractice captive insurers have also increased dramatically in number over the last couple of years. For example, in the Cayman Islands, the number of captive insurers licensed to write medical malpractice insurance has climbed to 269 in 2005 from 178 in 2001.[7]

The alternative risk insurance market may be enticing as it provides several advantages over traditional insurers. For example, because the owners are also the insureds there is no profit motive to worry about which can help keep premiums lower as compared to traditional insurers. In addition, these new captives, RRGs, and other alternative market insurance mechanisms do not have old claims with which to contend. However, the lack of experience could also be a significant

Continued on page 6

IS THERE A FUTURE FOR FINITE RISK REINSURANCE?

By Anthony C. Roehl

The future of finite risk reinsurance continues to be a hot topic in the regulatory community. There are a number of on-going investigations, including a major investigation in Georgia, and there have been more indictments and plea agreements regarding executives charged with misstating their companies' financial statements through the operation of improperly accounted for reinsurance transactions.

A case has been made convincingly in other publications that the finite risk reinsurance investigations, and subsequent convictions and plea agreements, affect a few bad actors and do not accurately reflect the vast majority of insurers that have handled these transactions lawfully in accordance with the proper accounting procedures. The net effect of the various regulatory actions has been to tear SSAP 62 apart and to create an aura of uncertainty in the industry regarding the proper methodologies for accounting for finite risk transactions.

As a result, what are companies to do going forward to ensure that they comply with all applicable accounting and regulatory requirements for finite risk reinsurance when such standards are in a state of flux? While the accounting for finite risk reinsurance has recently come under scrutiny, the reinsurance industry does not appear to have the risk tolerance or capacity to write any other type of reinsurance (e.g., the unlimited covers that were in place prior to the 1980s when asbestos litigation and other mass tort actions shocked the reinsurance market into changing the way it did business). As a result, insurers and reinsurers are already facing the difficult task of ensuring that they are adequately and properly documenting that their finite risk transactions to meet all the necessary elements of risk transfer. Implicit in this evaluation is the assumption that there is a set formula to measure risk transfer. Presently, this does not appear to be the case.

A rule-a-thumb exists that there is an adequate transfer of risk if there exists a 10 percent chance of a 10 percent loss to the reinsurer (the so-called "10/10 Rule"). The 10/10 Rule is certainly imprecise and, at any rate, has never been codified. Nonetheless, it is assumed to satisfy the risk transfer requirements of SSAP 62.

As a result, there is no one generally accepted definition of what constitutes a risk transfer. Furthermore, since under SSAP 62 the question of the proper accounting treatment is viewed from the reinsurer's standpoint, it is possible that the cedant and the reinsurer have a different evaluation of the probability of loss in the same transaction. Because of this, it certainly seems possible and appropriate that two

Continued on page 9

Announcements

On October 13, 2005, **Joe Holahan** addressed the Credit Insurers' Association at their biannual meeting in Atlanta, Georgia. Mr. Holahan spoke on federal insurance legislative issues, including the SMART Act, optional federal charter and the Liability Risk Retention Act. For a copy of Mr. Holahan's presentation, please contact him at 202-408-0705 or jholahan@mmmlaw.com.

Chris Petersen will moderate a panel discussion "H.S.A's: The Consumer Friendly Health Account" at the Consumer-Driven Health Care Institute's Annual Forum. The forum will be held in Washington, DC, December 7-9, 2005.

On December 9, 2005, **Joe Holahan** will speak at the South Carolina Captive Associations Sixth Annual Executive Educational Conference in Charleston, South Carolina on the topic of Captives and the Terrorism Risk Insurance Act. Please contact Mr. Holahan at 202-408-0705 or jholahan@mmmlaw.com if you would like a copy of his presentation.

On November 10, 2005, **Lew Hassett** attended the quarterly meeting of ARIAS-US in New York City.

In December, **Tom Player** will make a presentation at CSC's Future Focus Conference with former South Carolina Insurance Commissioner John Richards on the changing regulatory environment resulting from the contingent commission investigations, and at the South Carolina Captive Insurance Association meeting in Charleston on the use of captives in light of proposed changes in TRIA (see, Player's Point, page 1).

Joe Cregan served as an expert witness on Georgia insurance law and regulations in an arbitration proceeding held in London, England on November 17, 2005. The case involved a dispute between ceding and assuming insurers on the effect of Georgia law on their contractual obligations.

Tony Roehl has been selected as an Adjunct Professor at the Georgia State University College of Law and will be teaching a class on insurance law during the Spring 2006 semester.

ATTORNEY AUDIT REPORTS AND THE WORK PRODUCT DOCTRINE

By Matthew A. Barrett

Attorneys are continually asked to provide information to clients' outside auditors concerning pending or threatened litigation. Are these audit reports, which often contain attorneys' thoughts and conclusions, discoverable in civil lawsuits? The attorney-client privilege typically does not apply to audit reports, since by definition the report is provided to someone other than the client. This does not necessarily mean, however, that audit reports must be produced. The attorney work product doctrine, codified in the Federal Rules of Civil Procedure and present in some form in most states, may prevent disclosure of the audit letter in litigation.

The Work Product Shield. Under the work product doctrine, the discovery of certain documents is restricted. Fed. R. Civ. P. 26(b)(3). The doctrine applies only to (1) documents and other tangible things (2) prepared in anticipation of litigation or for trial (3) by or for another party or by or for that other party's representative. *Id.*

Many courts have concluded that the work product doctrine precludes the discovery of audit reports. *E.g., Tronitech, Inc. v. NCR Corp*., 108 F.R.D. 655, 656 (S.D.Ind. 1985); *Southern Scrap Material Co. v. Fleming*, 2003 WL 21474516, * 9 (E.D.La. 2003); *Honeywell Intern'l. Sec. Lit.*, 230 F.R.D. 293, 300 (S.D.N.Y. 2003); *Merrill Lynch & Co. v. Allegheny Energy, Inc.*, 2004 WL 2389822, * 4 (S.D.N.Y. 2004); *Laguna Beach Co. Water Dist. v. Superior Court*, 22 Cal. Rptr. 3d 387, 391 (2004). According to these courts, audit reports are not prepared in the ordinary course of business, but are prepared only because of the litigation. *Tronitech, Inc. v. NCR Corp.*, 108 F.R.D. 655, 656 (S.D.Ind. 1985); *Southern Scrap Material Co. v. Fleming*, 2003 WL 21474516, *9 (E.D.La. 2003). The work product doctrine thus restricts their discovery.

A few courts have found that audit reports are not attorney work product. *E.g., U.S. v. Gulf Oil Corp.*, 760 F.2d 292, 296-97 (Temp. Emer. Ct. App. 1985); *U.S. v. El Paso Co.*, 682 F.2d 530, 543-44 (1982). Such courts typically follow the minority rule that the attorney work product does not apply if "the primary motivating purpose behind the creation of the document is not to assist in pending or impending litigation. . . ." *Gulf Oil*, 760 F.2d at 296.

In determining the applicability of the work product doctrine, at least one court has looked to the ultimate use of the documents. In *Raytheon Sec. Lit.*, the court concluded that if the information "must be disclosed in the [company's] public financial statements," it is not entitled to work product protection. 218 F.R.D. 354, 359 (D.Mass. 2003) (declining to determine this issue without a "better record"); *see also Merrill Lynch, supra*. ("The only public revelation could have been, in the worst case scenario, a general statement by Deloitte & Touch regarding its inability to accurately evaluate Merrill Lynch's financial statements due to internal control deficiencies."). Even if a court undertaking this analysis finds that certain information contained in the report must be publicly disclosed, this should not mean that the entire audit report must be produced. Rather, the "non-public" information likely would still be protected work product.

The work product doctrine is not always a complete shield. With regard to "ordinary work product," it permits the discovery of attorney work product where the party seeking discovery has "substantial need of the materials" and is "unable without undue hardship to obtain the substantial equivalent . . . by other means." Fed. R. Civ. P. 26(b)(3). Attorneys' mental impressions, conclusions, opinions and legal theories regarding pending or anticipated litigation – likely much of the information in audit reports – is absolutely protected from disclosure. *Id.* However, audit reports likely will not be protected from disclosure on work product grounds if they are prepared after the conclusion of all litigation. *Dawson v. New York Life Ins. Co.*, 901 F.Supp. 1362, 1369 (N.D.Ill. 1995) (rejecting work product argument because "there was no pending litigation nor identifiable prospect for future litigation at the time the disputed documents were prepared.").

Waiver of the Work Product Doctrine. Most courts that accord audit reports work product protection do not find that the supplying of the information to a company's outside auditors waives that protection. *E.g., Tronitech*, 108 F.R.D. at 657; *Raytheon*, 218 F.R.D. at 359; *Merrill Lynch*, 2004 WL 2389833, *7; *Laguna Beach*, 22 Cal.Rptr.3d at 392. In *Laguna Beach*, for example, the court found that disclosure of the attorney's thoughts and conclusions to the outside auditor was not inconsistent with the purpose of the work product privilege – "to safeguard the attorney's work product and trial preparation." 22 Cal. Rptr. 3d at 391. Several courts find a waiver only if disclosure "substantially increase[s] the opportunities for potential adversaries to obtain the information." *Merrill Lynch*, 2004 WL 2389822, *6 (stating the "critical inquiry" as whether the auditor "should be conceived of as an adversary or a conduit to a potential adversary."); *Raytheon*, 218 F.R.D. at 359 (finding record inadequate to determine whether disclosure was inconsistent with the doctrine). The court in *Merrill Lynch* recognized that, particularly in today's regulatory climate, there can be tension between companies and their auditors. 2004 WL 2389822, * 6. That court, however, found that waiver of the privilege requires a "tangible adversarial relationship," which it did not find in that case between the business and its auditor. *Id.*

Waiver need not occur after the fact. That is, rather than waiving the work product privilege by disseminating the privileged materials, a party can waive the privilege by not timely asserting it in a privilege log. In *Honeywell*, the defendant amended its privilege log to assert work product assertions only after the plaintiffs filed a motion to compel. 230 F.R.D. at 299-300. The court found that this "gamesmanship" resulted in waiver of any work product privilege that might have existed. *Id.* ❑

Matthew Barrett is an associate in the firm's litigation group. He focuses principally on insurance litigation and business litigation. Matt received his bachelor's degree from Berry College and his law degree from the University of Georgia, J.D.

DISCOUNT CARD PROGRAMS UNDER ATTACK

By Chris Petersen

Discount card programs, and the businesses that provide these programs, are receiving increasing attention at both the state and NAIC level. At least twelve states have recently enacted laws regulating these programs. State laws range from information filing to full-fledged licensing schemes, as required in Florida. In addition, the National Association of Insurance Commissioners ("NAIC") is drafting a model law that would impose significant requirements on discount card programs.

An examination of the proposed NAIC model provides insight into the various regulatory requirements that are popping up in the states. The proposed NAIC model defines a "discount medical plan" as any business arrangement in which a person in exchange for fees offers access to providers of "medical services" at a discount. Medical services are defined as any care, service, or treatment of illness or dysfunction of the human body, including physician care, dental care services, vision care services and chiropractic services among other medical services. Prescription drug services are given separate treatment under the model.

The main thrust of the NAIC model is to regulate entities that sell access to discounted medical services through discounted medical plans. These entities are defined as discount medical plan organizations ("DMPOs"). Under the proposed NAIC model, DMPOs are required to have a license from the state insurance department. The only exception is when the discount plan is offered by an entity, such as an insurance company, that is already licensed under state insurance laws. This exception does not apply to non-licensed affiliates of insurance companies.

The proposed model sets forth fourteen items that must be included with an application to be licensed as a discount medical plan organization. These requirements include: 1) the names, biographical statements and fingerprints of all Board members and officers of the organization; 2) audited financial statements; 3) a description of the organization's proposed marketing methods; and 4) copies of the forms of all contracts. There is also a required licensing fee, and licenses must be renewed annually. An entity must have its licensed approved before it may offer discount plans.

The proposed NAIC model also imposes the following, as well as additional, requirements upon DMPOs:1) all forms used by DMPOs must be filed with the insurance department; 2) DMPOs must meet certain financial requirements including minimum net worth and the posting of surety bonds; 3) DMPOs must file annual statements with the insurance department; and 4) DMPOs must maintain an up to date listing of all of their contracted providers on an Internet Website.

Continued on page 7

FOLLOW-THE-FORTUNES DOCTRINE EXTENDED TO SETTLEMENT ALLOCATIONS

By Jessica F. Pardi

In a recent ruling, the Second Circuit Court of Appeals held that the follow-the-fortunes doctrine, long applied to the settlement decisions of underlying insurers, applies also to the *post-settlement allocations* of underlying insurers. *Travelers Cas. & Sur. Co. v. Gerling Global Reins. Corp. of Am.*, Case No. 03-9220-CV (2nd Cir., August 18, 2005).

Between 1952 and 1979, Travelers Casualty & Surety Co. ("Travelers") insured Owens-Corning Fiberglas Corporation ("OCF") for bodily injury and property damage through a series of annual primary policies *and* a number of excess policies. Travelers then obtained reinsurance on its excess policies from various reinsurers, including Gerling Global Reinsurance Corp. of America ("Gerling").

At issue in the *Travelers v. Gerling* litigation were five facultative reinsurance certificates issued by Gerling between 1975 and 1977 (the "Certificates"). The Certificates contained follow-the-fortunes provisions wherein Gerling agreed to be bound by loss settlements entered into by Travelers with the underlying insureds, as long as the settlements fell within the terms and conditions of the original policies and the Certificates.

During the 1970s, asbestos manufacturers, like OCF, were embroiled in constant litigation regarding asbestos-related injuries and claims. Until the early 1990s, OCF, when submitting the claims to Travelers, categorized them as falling within the products category and arising from a single occurrence. By the early 1990s, however, Travelers had paid OCF in excess of $400 million, and OCF's products coverage was exhausted. OCF then began to submit its asbestos claims as non-products claims. Travelers disputed liability for such claims, and the parties ended up in arbitration.

Travelers and OCF settled prior to a final arbitral determination, and, as part of the settlement, Travelers agreed to pay OCF $273.5 million. Travelers explicitly disclaimed any particular theory of coverage, and the parties never agreed as to whether the claims arose from a single occurrence or multiple occurrences. Travelers did, however, have to choose an occurrence position in order to allocate the settlement among its primary and excess policies issued to OCF.

Travelers chose to allocate most of the $273.5 million as a single, additional occurrence of non-products claims and allocated such amount evenly among policy years. Because the primary policies had $1 million per occurrence limits,

Continued on page 9

PRINCIPLES OF EQUITY IN NEW JERSEY TRUMP STATUTE OF LIMITATIONS

By William F. Megna

The New Jersey Supreme Court recently held against an insurance company that raised the statute of limitations as a defense to its insured's uninsured motorists ("UM") claim, on the grounds that the company violated the implied covenant of good faith and fair dealing by lulling the insured into a false sense of security regarding the statue of limitations. *Price v. New Jersey Manufacturers Insurance Company*, 867 A.2d 1181 (N.J. 2005).

The plaintiff, Theodore Price, was insured by New Jersey Manufacturers ("NJM"). As a pedestrian in the course of his employment, Mr. Price was struck by a vehicle driven by an uninsured driver on August 30, 1995. After learning that the driver's insurance company had denied coverage for the accident, the plaintiff's attorney wrote to NJM in February, 1998 to alert the company that the plaintiff would be presenting a UM claim. In March 1998, NJM responded and requested information on the plaintiff's injuries and the amount of a worker's compensation lien as the accident occurred in the course of the plaintiff's employment. Between May 1998 and August 2001, the plaintiff's counsel and NJM exchanged correspondence, medical records were provided, the plaintiff appeared for a medical examination scheduled by NJM, and NJM authorized the plaintiff's counsel to dismiss the action against the tortfeasor as it would not be pursuing its subrogation rights.

Finally on August 21, 2001, nine days before the expiration date of the statute of limitations, NJM requested additional information, much of which had already been provided or was already in the possession of NJM. [In *Green v. Selective Insurance Company of America*, 676 A.2d 1074 (N.J. 1996), the New Jersey Supreme Court previously determined that the six-year statute of limitations applicable to UM claims begins to run from the date of the accident.] On September 20, 2001, the plaintiff's attorney forwarded most of the requested documents and continued to send additional information to NJM in numerous letters dated from October 1, 2001 through March 20, 2002. NJM did not reply to any of those letters. Finally, on November 22, 2002, the plaintiff filed a complaint seeking to compel NJM to participate in arbitration. At that point, NJM first asserted a statute of limitations defense.

The trial court found that NJM's course of conduct had lulled the plaintiff's counsel into the false belief that the UM claim had been made in a timely manner. The Appellate Division affirmed. The Supreme Court also held that NJM's conduct supported an equitable tolling of the statute of limitations because every insurance contract in New Jersey contains an implied covenant of good faith and fair dealing. The Supreme Court stated that NJM was required to act in a fair manner and to inform the plaintiff of (1) any deficiencies in his claim or (2) if he needed to file a request for arbitration by a certain date. The Court held that is was not reasonable for NJM to request and receive various documents over a three and a half year period and then deny plaintiff's claim because he failed to file a complaint or to request arbitration prior to running of the statute of limitations.

The Court further observed that the policy reasons for upholding a strict statute of limitations recede when the defendant has notice of the claim and no significant prejudice results from the claim going forward. This decision is consistent with other New Jersey Supreme Court holdings, which have recognized that the tolling of the statute of limitations is fair when a mechanical application of the statute would inflict obvious and unnecessary harm upon individual plaintiffs without advancing the legislative purpose,(providing defendants a fair opportunity to defend and to prevent plaintiffs from litigating stale claims).

The Court concluded by holding that the insurer is not required to provide notice in all cases where it intends to raise a statute of limitations defense. Nonetheless, a valid statute of limitations defense requires a carrier to engage in fair dealing and exchange of information with its insured.❑

Bill Megna is Of Counsel and the Managing Attorney of the firm's Princeton Office. For updates on new developments regarding this article please forward your contact information to Bill for future client alerts.

ALLURE OF THE ALTERNATIVE INSURANCE

Continued from page 2

disadvantage because there is no claims history. Claims history provides a basis by which to price premiums, and without such history premium pricing may be a bit uncertain, at least until they get a few more years of experience behind them. Either way, it appears that the alternative insurance market is becoming a more attractive source of coverage for many medical professionals who can not find adequate coverage or have been priced out of the traditional marketplace.❑

Endnotes

[1] See Jay Angoff, Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry, July 2005 at www.centerjd.org/ANGOFFReport.pdf.

[2] See Robert E. Hoyt & Lawrence S. Powell, Profitability in Medical Professional Liability Insurance, October 13, 2005 at www.hcla.org/studies/Hoyt-Powell-stidy.pdf.

[3] Shefali Anand, Doctors' Creed: Insure Thyself—Health-Care Providers Create Alternative Market as Firms Abandon Malpractice Coverage, Wall Street Journal, Aug. 17, 2005, at C1.

[4] Id.

[5] Healthcare RRGs Account for Half of Total 2004 RRG Premium, The Risk Retention Reporter, September 2005.

[6] Id.

[7] Shefali Anand, Doctors' Creed: Insure Thyself—Health-Care Providers Create Alternative Market as Firms Abandon Malpractice Coverage, Wall Street Journal, Aug. 17, 2005, at C1.

Kristin Zimmerman is an associate in the firm's insurance and healthcare groups. Kristin received her bachelor's degree from Emory University, her master's degree from Rollins School of Public Health, and her law degree from Emory University School of Law.

GEORGIA ADOPTS LIFE SETTLEMENTS REGULATION

By Anthony C. Roehl

The Georgia Department of Insurance (the "Department") recently adopted regulations to implement the Georgia Life Settlements Act (the "Act"). The Act is fully effective November 5, 2005. After that date, persons effecting life settlement transactions in Georgia or with Georgia residents will need to comply with the Act and the applicable regulations.

The new regulations will impose new obligations on Life Settlement Providers (defined as a person effectuating life settlement transactions) (the "Provider") and clarify licensing requirements. Some of the more notable provisions include:

(1) a requirement that the Provider supply (a) the names, addresses, official positions and professional qualifications of the individuals who are responsible for the conduct of the Provider, including all stockholders, partners, officers, members and employees, with the exception for those persons owning less than 5% of the Provider, and (b) audited financial statements certified by an officer of the company for the two most recent years;

(2) a requirement that the Commissioner not issue a license if he determines that the Provider or any principal thereof is not "competent, trustworthy, financially responsible; has had an insurance license refused, revoked or suspended by any state…"; and

(3) a requirement to deposit a minimum of $100,000 in eligible securities with the Commissioner rather than an errors and omissions insurance policy. The Commissioner also has the authority to increase this amount as he deems appropriate. Georgia and only two other states (Florida and New Jersey) require a cash deposit.

The provisions for renewing a license also have been codified by the regulation. All licensed Providers are required to file an annual license renewal by March 1 of each year. The annual renewal must include:

(1) a report of the life settlement transactions of Georgia resident sellers, including the age of the insured and estimated life expectancy;

(2) a report of the individual mortality of Georgia resident sellers, including the total net death benefit and the amount paid to the seller;

(3) an audited financial statement as of the last year; and

(4) a verification of the $100,000 security deposit.

The Department released the license application forms on November 7, 2005. All Providers operating in Georgia have 30 days after November 7 2005, to submit an application. While the application is pending, they may continue to operate their business. Thus, it will be very important to submit that initial application within 30 days after November 7, 2005, to allow Providers to continue their business uninterrupted. ❑

DISCOUNT CARD PROGRAMS UNDER ATTACK

Continued from page 5

In addition, there are limitations and restrictions on the marketing and disclosures of DMPOs. For example, a DMPO's marketing materials must avoid the use of "insurance terms." The proposed model also mandates that certain disclosures, such as a requirement that all materials must state that the program is not health insurance, are included on all discount plan materials. Many states have adopted similar requirements regarding marketing and mandated disclosures.

The NAIC model also regulates the marketers of discount medical plans. The rules regarding marketers are much less stringent than the requirements imposed on DMPOs. Marketers of DMPOs might include insurance agents and associations or other affinity groups that make discount cards available to their members. The NAIC model provides that certain contractual requirements between the marketer and the DMPO be met before the marketer begins conducting business in the state. Some states have imposed additional requirements on the marketers of discount plans. For instance, some states require marketers, including some association groups, to register with the state before marketing discount plans in the state.

Many states have taken a less intrusive approach toward DMPOs. Most states simply required that a DMPO register with the state. In most cases the registration requires sufficient information to allow the state to track down a DMPO if the state believes that the DMPO is not complying with state law. Generally, a DMPO may begin business operations as soon as it files its registration.

Enforcement actions in the discount card arena are starting to appear. Regulators are reportedly seeking fines of up $65,000 against DMPOs that have failed to register in a state. The next most likely area of enforcement will be against false or misleading advertising. As regulatory action increases in this area, DMPOs will be well served to have established compliance programs that will hopefully avoid enforcement action or, at least, can be used to document good faith efforts towards compliance. ❑

Chris Petersen is a partner in the firm's insurance group. He concentrates in legal and compliance services relating to the Health Insurance Portability and Accountability Act (HIPAA), privacy, state small-group and individual insurance reform regulation and the interaction between state and federal law. Chris received his bachelor's degree from Washington University (St. Louis, Mo.) and his law degree from Georgetown University.

of the United States held that due process generally barred punitive awards in excess of nine times the compensatory award. This is the so-called "single digit rule." The issue in *Sawtelle* was whether due process limitations on punitive awards apply to arbitration awards.

The court vacated the award of punitive damages, finding that the award was arbitrary and in manifest disregard of the law. Essentially, the court held that the due process limitations of *State Farm* constituted established law and that the arbitration panel's decision was irreconcilable with that law.

More recently, the Supreme Court of the United States refused to hear an appeal from a decision that reached the opposite conclusion. *Ventrue, Inc. v. MedValUSA Health Programs, Inc.*, Case No. 05-117 (Oct. 17, 2005) (denying certiorari). The Supreme Court of Connecticut had upheld a punitive award of $5 million where no compensatory damages had been awarded. *MedValUSA Health Programs, Inc. v. Memberworks, Inc.*, Case Nos. 17116, 17117 (Conn., May 17, 2005).

Two issues bear analysis. The first is whether due process even applies to arbitration proceedings and awards. A long line of cases holds that due process applies only to actions by the state (i.e., the government). For example, due process applies to judicial garnishment proceedings, but not to private sales under the Uniform Commercial Code. *See Davis v. Prudential Securities, Inc.*, 59 F.3d 1186 (11th Cir. 1995). Courts are split as to whether arbitrations involve the requisite state action. Some hold that, because the arbitration process itself is extra-judicial, the requisite state action is absent. *See Davis*, 59 F.3d at 1190-1192 (due process inapplicable because private arbitration does not trigger the requisite state action). *MedValUSA* reached the same conclusion. Other courts have held that the judicial confirmation and enforcement process supply the requisite state action. *See Birmingham News Co. v. Horn*, 901 So. 2d 27, 66-67 (Ala. 2004).

The second issue for analysis is whether an excessive punitive award may be rejected as "in manifest disregard of law." *See First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 942 (1995). This is a difficult argument to carry because the objector must show (a) that the panel knew of a governing legal principle, (b) that the panel refused to apply the principle or ignored it altogether and (c) that the principle at issue is well-defined and clearly applicable to the case. *See Hoeft v. MVL Group, Inc.*, 343 F.3d 57, 69 (2nd Cir. 2003).

The *Sawtelle* court avoided the state action issue by holding that the single digit rule was established law and that the panel had manifestly disregarded applicable law (i.e., the due process standard). Conversely, the *MedValUSA* court refused to circumvent the state action test under the guise of a manifest disregard of law analysis. *MedValUSA*, at fn. 16. The court reasoned that, if substantive due process rules are applied to arbitrations, procedural due process rules also must be applied, and that compliance with procedural due process would eviscerate the purposes of arbitration.

In my view, the New York court has it right, and the Connecticut court has it wrong. Whatever procedural shortcuts apply to arbitration do not justify the violation of substantive Constitutional rights. Under the Connecticut court's reasoning, statutory and common law rights could not be manifestly disregarded, but substantive Constitutional rights could be ignored completely. That would turn the priority of rights on its head – substantive Constitutional rights are the most fundamental.

Although vocally opposed to the New York decision, advocates of arbitration should reconsider their position. As a threshold matter, compliance with substantive due process is not an onerous burden. The sanctity of arbitration will survive the reduction of a punitive award to that which could be awarded by a court. Few businesses choose arbitration because they want unfettered punitive awards.

I have detected a shift away from arbitration – not because of dissatisfaction with too much court interference, but because of dissatisfaction with too little. Businesses fear radical decisions, regardless of whether the decision is from a court or an arbitrator. Indeed, the radical decision of a court is preferable, since it is subject to plenary appeal. The more radical discretion accorded to an arbitrator, the less attractive arbitration will be. ❑

Lewis Hassett is a partner in the firm's litigation group and chairs the firm's insurance and reinsurance dispute resolution group. His practice concentrates in the areas of complex civil litigation, including insurance and reinsurance matters, business torts and insurer insolvencies. Lew received his bachelor's degree from the University of Miami and his law degree from the University of Virginia.

FOLLOW-THE-FORTUNES DOCTRINE

Continued from page 5

they were quickly exhausted. The remaining amount was then distributed among the excess policies, including a $4.4 million allocation to those reinsured by Gerling pursuant to the Certificates.

Because there was no aggregate limit on liability for non-products coverage, Gerling argued that the settlement allocation was unfair because Travelers was allowed to allocate on a single occurrence basis. This allocation distributed a larger portion of the settlement funds to the excess policies reinsured by Gerling and a smaller portion to the underlying policies with $1 million per occurrence limits. In refusing to pay the reinsurance benefits demanded by Travelers, Gerling claimed that Travelers had, in the process of settling, relinquished its position that there was a single occurrence and could not, therefore, allocate the settlement as a single occurrence.

The Second Circuit, in deciding the reinsurance dispute between Travelers and Gerling, held in relevant part as follows:

In short, we decline to authorize an inquiry into the propriety of a cedent's method of allocating a settlement if the settlement itself was in good faith, reasonable, and within the terms of the policies. . . . Given that Travelers and OCF expressly declined to resolve the occurrence issue, there is no cause for us to do so now. Indeed were we to undertake such an analysis, we would be engaging in precisely the kind of "intrusive factual inquiry" that the follow-the-fortunes doctrine is meant to avoid.

Travelers, 419 F.3d 181 at 189, quoting, in part, *North River Ins. Co. v. Ace Am. Reins. Co.,* 361 F.3d 134, 141 (C.A.2 N.Y. 2004).

The Court's deference to the cedant's allocations is important. We expect the issue to continue to be the subject of future disputes. ❑

Jessica Pardi is a partner the firm's insurance group. 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.

IS THERE A FUTURE FOR FINITE RISK REINSURANCE?

Continued from page 3

parties could account for the same transaction differently because each has a different assessment of the risk being transferred and assumed.

It appears that the focus of the finite risk reinsurance probes will soon turn towards evaluating the proper documentation of risk transfer. This will be accomplished at two levels. First, by an expanded use of interrogatories and sworn statements in companies' annual financial statements and, second, in the internal documentation used to support these attestations. Any proper analysis of risk should include not only an analysis of the risk transfer using the 10/10 Rule but also other actuarial methods to evaluate risks, including measuring the severity of the underwriting loss at and beyond the 90th percentile of loss[1] (this level of risk of loss is normally ignored under a 10/10 Rule analysis) and an analysis of the expected reinsurer deficit,[2] which is defined as the probability of an underwriting loss times the average severity. These other methods may be preferred to the 10/10 Rule because they reflect the full tail risk in the severity of loss and can integrate the frequency of loss and severity of loss analyses into a single measure of risk.

At any rate, it is clear that insurers and reinsurers are facing a heightened scrutiny that will look toward the work papers used to support their assumptions. Insurers and reinsurers are well advised to create well documented and actuarially valid risk transfer assessment for each reinsurance transaction regardless of the methodology used. Such heightened internal controls will go a long way towards supporting risk transfer and the integrity of insurers and reinsurers' balance sheets. Insurers and reinsurers may also want to have their internal compliance program reviewed by outside counsel in conjunction with outside actuaries to ensure that their internal controls are adequate.

While the near term future of finite risk reinsurance is clouded, the long term future appears bright, provided that insurers undertake a proactive response to the current regulatory environment and learn from the failures of current accounting practices to create a system with more certainty and sophistication regarding risk transfer. ❑

Endnotes

[1] Suggested in 2002 by the Casualty Actuarial Society Valuation, Finance and Investments Committee.

[2] Suggested in 2005 by the Casualty Actuarial Society Risk Transfer Working Party.

Tony Roehl is an associate in the firm's insurance and corporate groups. His principle areas of concentration are insurance regulation and insurance company financial matters. Tony received his bachelor's degree from the University of Florida and his law degree from the University of Michigan.

PLAYER'S POINT

Continued from page 1

reserves for flood coverage under wind only policies, be swept under the legal rug. In recent remarks to a conference on Katrina losses, Mr. Hood minced no words in setting out his view on the likely outcome of his lawsuit. Hood is reported to have said he expects a favorable outcome if the case is heard at the chancery court, and even if the case is appealed to the state Supreme Court. "We've got some judges who live down on the coast and who have to be elected," Hood said. "Guess who's going to be sitting up in that jury box? A jury of their peers who knows someone whose had a loss."

In short, the Mississippi Attorney General argues that the water damage exclusion is void as against public policy under Mississippi common law. The suit requests that courts mandate full coverage be provided if the proximate cause of the damage (wind) is covered under the policy even if other non-covered causes (flood) contributed to the loss. The AG further argues that the water damage exclusion is ambiguous on its face.

When I read the standard ISO water damage exclusion, it doesn't strike me as ambiguous. It excludes coverage for "flood, surface water, waves, tidal water, overflow of a body of water, or spray from any of these, *whether or not driven by wind*."

Both the AG and the Insurance Commissioner, George Dale, are elected officials in Mississippi. Commissioner Dale is a very experienced regulator and has seen Mississippi through numerous storm losses, albeit, none as overwhelming as this one. Like many states, Mr. Dale relies on the AG to be his lawyer when it comes to going to court. In essence, Commissioner Dale is the client and the Office of the AG is his public law firm. As diplomatically as possible, Commissioner Dale has told the public that he disagrees with Jim Hood on this matter. He believes the approved policy language is not void and is not uniformly ambiguous. Then why does the AG get out front of his client and file an action in a well-settled but complex area of insurance law when the primary regulator, his client, disagrees?

The answer seems to be in the trend started by the New York AG, Eliot Spitzer, and followed by other AGs, for example, in Connecticut and Illinois. There is a difference, however, between the actions of Spitzer and Hood. While Spitzer was indeed out front, the primary regulators for insurance matters were in agreement with his actions. Nonetheless, in my opinion, the actions of Spitzer and other AGs have emboldened politically savvy state attorneys general to independently review and act on issues that yesterday they may have seen as in the exclusive purview of their state insurance commissioner.

In my view this trend will continue. And, it will cause more confusion and perhaps lead to some bad law. As all of us in the insurance industry know, if Jim Hood is successful in the lawsuit described herein, the result could be worse for many insurers than the initial losses from Katrina. ❑

Endnotes

[1] My appreciation to Tony Roehl of our Atlanta office for his invaluable assistance in the preparation of this article.

Thomas Player is a partner and chairman of the insurance and reinsurance group. His areas of expertise include insurance and reinsurance, mergers and acquisitions, complex regulatory issues and dispute resolution. Tom received his bachelor's degree from Furman University and his law degree from the University of Virginia.

LETTER FROM WASHINGTON

Continued from page 1

privacy initiative, which resulted in the development of privacy rules to be adopted in all of the states. In response to GLBA's mandate regarding the licensing of agents and brokers and the establishment of the National Association of Registered Agents and Brokers ("NARAB"), the NAIC directed the passage of uniform and/or substantially similar laws and regulations regarding the licensing of producers. The NAIC responded to the passage of the Terrorism Risk Insurance Act ("TRIA") by Congress with both the development of the regulations complimentary to TRIA as well as a highly successful consulting arrangement with the U.S. Treasury.

The NAIC will now have to deal with the GAO Report. The NAIC's response will affect how the NAIC is perceived on Capitol Hill.

NAIC v. RRGs

The Liability Risk Retention Act ("LRRA") is a federal law that permits the creation in any state of a liability insurance company ("risk retention group" or "RRG") that can then operate in other states without the requirement that it be licensed in that other state. The federally created alternative to licensing in non-domiciliary states consists of a notice filing of specified information. In addition, the non-domiciliary states have limited authority over the RRG and are subject to federal preemption if they overstep the bounds of those limitations. The LRRA does not in any way restrict the RRG's state of domicile.

Some state regulators have chafed at this limitation on their authority. Congress believed that this alternative form of "lead state" regulation was necessary to permit RRGs to provide commercial liability insurance where the traditional market had failed.

The results have been good. In 2004, $2.2 billion in premium was paid to RRGs. Almost half of that related to healthcare professional liability insurance, which has enabled numerous hospitals and doctors to continue to provide medical services.

Continued on page 11

Continued from page 10

The NAIC has two groups working on RRG issues. The NAIC Risk Retention Working Group has been exploring issues relating to the insolvency of the National Warranty Risk Retention Group, consumer disclosure, and automobile service contracts. The NAIC Risk Retention Group Task Force is examining the accreditation standards to be required of any state that charters RRGs.

The NAIC charge to both committees is reasonable: to examine problems and develop standards that will prevent market misconduct and insolvency. The focus of the groups has been problematic, however. The insolvency of National Warranty, for example, is unique because it was essentially unregulated. It was chartered in the Cayman Islands and then permitted to operate through the "grandfather" provisions of the 1986 LRRA amendments. The Reciprocal of America insolvency was another hard case because it involved three RRGs chartered in Tennessee (regulated as traditional companies) that had faulty reinsurance. The management of these companies has been subject to criminal investigation. Finally, the issue of automobile service contracts/warranties is, and has been, a difficult matter. Inadequate regulation of the warrantor as well as the problems of the reimbursement insurers, which are both traditional carriers and RRGs, have been at fault. The concern in that "hard cases make bad law," i.e., analyzing unusual circumstances will produce regulatory overreaction.

The GAO Report

The GAO spent almost two years researching the operation and regulation of risk retention groups. It surveyed state regulators and spent time with the industry representatives, as well.

The GAO's central conclusion is that, because regulatory standards differ among the states of domicile, and RRGs are domiciled in one state but operate in many states, there is a need for increased uniformity among the regulatory capability of the various states. More specifically, the GAO Report recommends that states, acting through the NAIC, adopt a uniform accounting system. Of course, even statutory accounting among the states is not entirely consistent due to "permitted practices." Nonetheless, the GAO's conclusion is based upon the premise that non-domiciliary states need to be able to understand the financial statements of RRGs and, apparently, cannot do so without a uniform system.

The GAO Report has two other principal recommendations. First, the state of domicile must tighten the requirements to ensure that RRGs are controlled by their insureds. This can be effected, the GAO believes, by the elimination of any voting authority by non-insureds, "independent directors" (i.e., directors not affiliated with any management company or other vendor), mandatory capital contributions by members, and imposing a fiduciary duty on managers (supplementary to existing fiduciary duties). Second, prospective RRG members should receive greater disclosure regarding the limitations of RRGs, including the lack of guaranty fund protection, than is required under current federal law.

It should be remembered that the recommendations of the GAO are not binding on anyone. The recipient of the Report is the Chairman of the House Financial Services Committee, and he is under no obligation to adhere to the recommendations. Nonetheless, the GAO Report is significant because it is the most recent third party examination of the RRG industry since the Department of Commerce Report in the early '90s.

Problems

Congress' intent in passing the Products Liability Risk Retention Act in 1981, and then the Liability Risk Retention Act in 1986, was to permit medical professionals, colleges, charities, builders and others to create their own liability insurance companies because the standard market had failed to provide insurance at a reasonable cost. Congress expressly contemplated that new liability companies would have to be formed for this purpose.

Over time, certain practices have evolved to facilitate the creation and operation of RRGs. These include the utilization of GAAP accounting (GAAP is utilized by every public corporation in America), permitting letters of credit to be "admitted" assets, and modified rules regarding credit for reinsurance. These issues (and a few others) are crucial to the continuing viability of the RRG marketplace.

Conclusion

The task for the NAIC will be to resist the temptation to take a "one size fits all" approach to establishing a uniform system of accounting. The imposition of a strict statutory accounting regime would choke off the creation of new RRGs. This, in turn, would run the risk of provoking substantial interests in Congress, where federal/state tensions continue and the future of state insurance regulation is an uncertainty. ❑

Robert "Skip" Myers is a partner in the firm's insurance group and practices in the areas of insurance regulation, antitrust, and trade association law. Skip received his bachelor's degree from Princeton University and his law degree from the University of Virginia.

MMM Insurance & Healthcare Attorneys

Paul H. Arne	404.504.7784	parne@mmmlaw.com
Matthew A. Barrett	404.504.7688	mbarrett@mmmlaw.com
Brooks W. Binder	404.504.7626	bbinder@mmmlaw.com
Ward S. Bondurant	404.504.7606	wbondurant@mmmlaw.com
Joseph L. Cregan	404.504.7782	jcregan@mmmlaw.com
Dick Dorsey	404.495.3660	ddorsey@mmmlaw.com
Jason Eakes	404.504.7603	jeakes@mmmlaw.com
Amanda S. McHugh	404.504.7629	amchugh@mmmlaw.com
Lewis E. Hassett	404.504.7762	lhassett@mmmlaw.com
Richard L. Haury Jr.	404.504.7713	rhaury@mmmlaw.com
Joseph T. Holahan	202.408.0705	jholahan@mmmlaw.com
Simon R. Malko	404-495-3646	smalko@mmmlaw.com
William F. Megna	609.430.1414	wmegna@mmmlaw.com
Daniel J. Mohan	404.504.7610	dmohan@mmmlaw.com
Robert H. Myers Jr.	202.898.0011	rmyers@mmmlaw.com
Jessica F. Pardi	404.504.7662	jpardi@mmmlaw.com
L. Chris Petersen	202.408.5147	cpetersen@mmmlaw.com
Thomas A. Player	404.504.7623	tplayer@mmmlaw.com
Anthony C. Roehl	404.495.8477	troehl@mmmlaw.com
Bruce H. Wynn	404.504.7694	bwynn@mmmlaw.com
Kristin B. Zimmerman	404.504.7611	kzimmerman@mmmlaw.com

MORRIS, MANNING & MARTIN, LLP
ATTORNEYS AT LAW

REVIEW

Insurance • Reinsurance • Managed Healthcare