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LETTER FROM WASHINGTON

CAPTIVES SHOW THEIR CLOUT ON TAXATION

By Robert H. Myers, Jr.

The "alternative market" has grown to such an extent that, by some estimates, the premium paid into the "alternative market" exceeds that paid into the standard commercial property/casualty market. Even in the recent soft market, the number of captives, both on-shore and off-shore, has continued to grow. At least half of the states have some form of captive legislation, and new risk transfer concepts, such as securitizations for a wide variety of risks, continue to gain adherents.

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PLAYER'S POINT

SUBPRIME'S IMPACT ON SECURITIZATIONS

By Thomas A. Player

The capacity of the capital markets to fund securitizations is far greater than either the direct insurance market capacity or the worldwide reinsurance capacity (see Figure 1). My estimates of the frictional cost of accessing the capital markets is much less than the frictional costs for either of the other two (see Figure 2). That fact alone should drive more insurance risks into the capital markets than has occurred historically.

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HASSETT'S OBJECTIONS

PUNITIVE DAMAGES – RECENT APPLICATIONS OF DUE PROCESS LIMITATIONS

By Lewis E. Hassett

In *BMW of North America, Inc. v. Gore,* 517 U.S. 559 (1996), the Supreme Court held that Due Process imposes substantive limits on the size of a punitive damage award. Whether a punitive award exceeds the limits provided by Due Process depends upon the reprehensibility of the conduct, the disparity between the awards of compensatory damages and punitive damages, and the difference between the punitive award and the civil penalties imposed in analogous cases. *Id.* at 582. In State *Farm Mut. Auto Ins. Co. v. Campbell*, 538 U.S. 408 (2003), the court stated that in most cases a punitive award should not exceed a single digit multiple of the compensatory damage award. However, the court noted that a greater ratio is permissible when "a particularly egregious act has resulted in only a small amount of economic damages." *Id.* at 424.

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Announcements

Tom Player is participating in the Blue Water Strategy Survey sponsored by the Society of Actuaries' Futurism, Marketing and Distribution and Technology Sections. The survey exams future distribution alternatives for the U.S. life insurance industry.

On February 15, 2008, **Joe Cregan** testified before the House Insurance Committee in opposition to pending HB 378, which was opposed by a number of insurance companies, trade associations and agent groups.

Skip Myers lectured at the RRGs 101 course at the Captive Insurance Companies Association annual conference in Scottsdale, AZ on March 5.

Mac Hunter, a partner in the firm's governmental practice group, engaged in a point/counterpoint with Senator Charles Grassley (R. Iowa) in the January 6, 2008, edition of *The Atlanta Journal-Constitution.* Senator Grassley is the ranking Republican on the Senate Finance Committee and is questioning the tax-exempt status of media-based ministries. Mac represents the New Birth Baptist Church with respect to Senator Grassley's inquiry. His article emphasized the importance of governmental neutrality in applying the Constitution's Free Exercise Clause and questioned whether the investigation was a disguised deprecation of the church's advocacy of personal prosperity.

In November, **Tom Player** participated in the Fasano Life Settlement Conference held in Washington, D.C.

On December 13, 2007, **Joe Cregan** spoke at the annual luncheon meeting of the Georgia Surplus Lines Association in Dunwoody Georgia, addressing the status of pending federal legislation affecting multi-state surplus lines transaction taxation and regulation.

Donna Fuller participated in the Life and Health Compliance Association (LHCA) meeting January 23-25, 2008, held in Panama City, Florida.

Skip Myers will be speaking on the captive aspects of insurance taxation to the Federal Bar Insurance Taxation conference in Washington, DC on May 22.

As a guest of Bill Rabel, who is now a professor at the University of Alabama, **Tom Player** presented a lecture to the Alabama Insurance Society entitled, *"Terrorism: An Insurable Event or a Social Liability."*

WHAT INSURERS MUST DO UNDER THE FACT ACT WHEN THEY RECEIVE A NOTICE OF ADDRESS DISCREPANCY

By Cindy Chang

On November 9, 2007, bank agencies and the Federal Trade Commission ("FTC") issued joint regulations[1] to provide guidance on Sections 114 and 315 of the Fair and Accurate Credit Transactions Act of 2003 ("FACT Act"). Section 114 and the related regulations are not applicable to insurers and are only applicable to "financial institutions," as defined in the Fair Credit Reporting Act, 15 U.S.C. 1681a(t).[2]

Section 315 of the FACT Act provides that a consumer reporting agency ("CRA") must provide a notice of address discrepancy to a consumer report user if the address provided by the user "differs substantially" from the address the CRA has in the consumer's file. Section 605(h)(2) requires federal agencies to issue regulations on the reasonable polices and procedures a user of a consumer report should employ when the user receives a notice of address discrepancy.

Pursuant to the authority granted in Section 605(h)(2), federal bank agencies and the FTC promulgated regulations that require users of consumer reports to develop and implement reasonable policies and procedures for when they receive a notice of address discrepancy. The FTC's regulations which are applicable to insurers are found at 16 CFR 681.

According to 16 CFR 681.1, the policies must address how the user, upon receiving a notice of discrepancy, (1) forms a reasonable belief that the user knows the identity of the person for whom it has obtained a consumer report, regardless of whether it has a continuing relationship with the consumer, and (2) furnishes the CRA with an address for the consumer when three conditions are satisfied. 16 CFR 681.1(c), (d).

1. Reasonable Belief of Identity

Examples of reasonable policies and procedures include comparing the information in the consumer report provided by the CRA with information the user (1) obtains and uses to verify the consumer's

1. Identity Theft Red Flags and Address Discrepancies Under the Fair and Accurate Credit Transactions Act of 2003, 72 Fed. Reg. 217, 63718 (Nov. 9, 2007). The FTC regulations are codified in 16 CFR 681.

2. "The term 'financial institution' means a State or National bank, a State or Federal savings and loan association, a mutual savings bank, a State or Federal credit union, or any other person that, directly or indirectly, holds a transaction account (as defined in section 19(b) of the Federal Reserve Act) belonging to a customer." 15 U.S.C. 1681a(t). According to section 19(b) of the Federal Reserve Act, a "transaction account" is "a deposit or account on which the depositor or account holder is permitted to make withdrawals by negotiable or transferable instrument, payment orders of withdrawal, telephone transfers, or other similar items for the purpose of making payments or transfers to third persons or others."

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identity in accordance with the requirements of the "Customer Information Program" rules pursuant to 31 U.S.C. 5318(l), (2) maintains in its own records, or (3) obtains from third-party sources. 16 CFR 681.1(c)(2)(i). The user may also verify the information in the consumer report provided by the CRA with the consumer. 16 CFR 681.1(c)(2)(ii).

2. Furnish CRA with Consumer's Address

Three conditions must be satisfied before a policy for furnishing the address to the CRA takes effect. The conditions are when the user: (1) can form a reasonable belief that the consumer report relates to the consumer about whom the user requested the report, (2) establishes a continuing relationship with the consumer, and (3) regularly and in the ordinary course of business furnishes information to the CRA from which the notice of address discrepancy relating to the consumer was obtained. 16 CFR 681.1(d)(1).

A user may reasonably confirm that the address is accurate by (1) verifying the address with the consumer about whom it has requested the report, (2) reviewing its own records to verify the address of the consumer, (3) verifying the address through third-party sources, or (4) using "other reasonable means." 16 CFR 681.1(d)(2).

The policies and procedures regarding furnishing the consumer's address to the CRA must provide that the user will furnish the consumer's address as part of the information it regularly furnishes for the reporting period in which it establishes a relationship with the consumer. 16 CFR 681.1(d)(3).

These regulations will become effective November 1, 2008. ❑

Cindy Chang is an associate in the firm's Washington, D.C. office and a member of the insurance and reinsurance and litigation groups. Prior to joining the firm, Ms. Chang completed a clerkship with the Honorable Kathianne Knaup Crane of the Missouri Court of Appeals. She can be reached at 202-842-1081 or cchang@mmmlaw.com.

Announcements

Our friend and colleague **Bill Megna** has started a new insurance management office in Princeton, NJ, which will be known as Definitive Insurance Management Services, Inc. (DIMS). The firm will specialize in government relations, the formation and management of insurance entities, and product development. All of us at MMM wish Bill the very best.

Skip Myers will be one of the instructors in the ICCIE course on Risk Retention Group law and practice. The course will be on-line and will start on April 1.

On March 6, **Joe Holahan** spoke at the 2008 Law Forum sponsored by America's Health Insurance Plans (AHIP). The topic of Mr. Holahan's presentation was "Legal Considerations for Designing an Employee Wellness Program."

On March 7, 2008, a Preliminary Injunction was issued by the U.S. District Court (Sacramento, CA) against the State of California prohibiting the Department of Insurance from enforcing its Cease and Desist Order against Auto Dealers Risk Retention Group. **Skip Myers**, as General Counsel for the National Risk Retention Association, with help from Cindy Chang, filed an amicus curiae brief with the court that was frequently cited in the opinion.

Skip Myers and Lew Hassett to Co-Chair Insurance and Reinsurance Group At Morris, Manning & Martin, LLP

January 14, 2008

Robert H. ("Skip") Myers and Lewis E. Hassett have been named Co-Chairs of the Insurance and Reinsurance Group at Morris, Manning & Martin, LLP. Mr. Myers specializes in insurance regulatory and antitrust matters and is based in the firm's Washington, D.C. office. Mr. Hassett focuses on insurance and reinsurance litigation and arbitrations and is based in the firm's Atlanta office. Tom Player, formerly Chairman of the Group, will continue as a Senior Partner.

"This is a natural evolution of the Group's leadership. Skip and Lew bring a broad scope and focused strength to the direction of the Group," said Player. Player will continue practicing with the Group, concentrating on judging arbitrations and multi-state regulatory matters.

"We have some big shoes to fill," said Hassett, "but are well-positioned for the future." Adds Myers, "We are fortunate that Tom will continue to lend his knowledge and judgment to our Group."

The Group represents insurers, reinsurers, agencies, program managers and administrators in a broad array of matters, including mergers and acquisitions, capital markets, corporate governance issues, corporate reorganizations, litigation and arbitrations, coverage matters, agency liability, regulatory matters, insolvencies, captives, and tax and securities issues. For example, during 2007, attorneys for the Group represented private equity firms, Texas Pacific Group and Calera Capital in securing regulatory approvals for the $635 million acquisition of Direct General; represented Lincoln Financial Group in its comprehensive reorganization of its insurance companies; and represented Goldman Sachs in a major life insurance assumption transaction.

GEORGIA LEGISLATURE MOVES TO TIGHTEN LIFE SETTLEMENT PRACTICES AND INCREASE DEPARTMENT OVERSIGHT

By Joe Cregan

In the 2005 Georgia General Assembly, the Legislature enacted a Life Settlements Act, which was modeled on the NAIC Viatical Settlements Model that was then in existence. Subsequent to passage of that law, the Department of Insurance began to regulate and to license life settlement providers. Now, midway through the 2008 legislative session, a new bill has been introduced which will comprehensively rewrite and update Georgia law regulating life settlements.

Senate Bill 499, which was introduced by Senate Insurance and Labor Chairman, Ralph Hudgens (R-NE Georgia), has the full support of Insurance Commissioner John Oxendine and the staff of the Department of Insurance. The bill makes a number of key changes to existing law. Most notably, the bill:

1. Defines for the first time a "life settlement financing transaction," which is used in connection with the purchase of a settled life insurance policy.
2. Prohibits entering into a practice or plan that involves "Stranger Originated Life Insurance," which is the first time this industry buzzword has been used in the Georgia statute.
3. Requires disclosure to the issuing insurer when the prospective insured has undergone a life expectancy evaluation by a person unaffiliated with the issuing insurer.
4. Makes it improper for any party to solicit an application for a life insurance policy by any scheme that is intended to avoid Georgia's insurable interest laws.
5. Makes it improper to misrepresent the policy owner's state of residence to avoid the policy or life settlement transaction from being subject to Georgia law.
6. Establishes a new registration requirement for life settlement brokers, which are defined as any person who represents a policy owner for a fee or commission in the negotiation of a life settlement transaction between the policy owner and one or more life settlement providers. The bill makes it clear a life settlement broker must represent only the policy owner and that this function can also be undertaken by a resident or a non-resident life insurance producer that is already licensed under Chapter 23 of the Insurance Code.
7. Substitutes the definition "provider" for the old definition of "life settlement provider," which is any person or entity who arranges life settlement contracts.
8. References the individual who enters into a life settlement agreement as the policy "owner" rather than the policy "seller."
9. Requires a provider to submit an antifraud plan with several significant new disclosures and filing requirements.
10. Requires licensed life settlement providers to satisfy a minimum net worth requirement, to be determined by the Commissioner.
11. Changes the licensure renewal date for providers from March of each year to May.
12. Subjects life settlement brokers to a new continuing education requirement involving 15 hours of training on a biennial basis (note that life insurance producers complying with the continuing education requirements under Chapter 23 of the Insurance Code are not subject to this separate requirement).
13. Clarifies that disciplinary proceedings and other administrative hearings conducted in accordance with Chapter 59 of the Insurance Code will be handled according to the Insurance Department's Administrative Procedures (Chapter 2 of the Insurance Code) as opposed to the more general Georgia Administrative Procedures Act (Title 50).
14. Requires an annual financial statement filing, which details the provider's life settlement activity for the prior year, along with aggregate data on all life settlement policies in force for that provider (note that some, but not all, of these disclosures are currently required under Chapter 93 of the Department of Insurance Regulations).
15. Substantially increases penalties for failure to respond to written inquiries from the Department of Insurance.
16. Clarifies that non-public personal information obtained in connection with life settlement contracts is subject to the Gramm-Leach-Bliley Act.
17. Changes the record retention requirement from the current five-year period to a period of three years after the death of the insured party.
18. Changes the Commissioner's examination authority to eliminate reliance on the National Association of Insurance Commissioners Examiner's Handbook and may also limit an examined party's right to challenge an examination report or obtain an administrative hearing (see further comments on the following page).

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19. Deletes a comprehensive life settlement advertising chapter and replaces it with much shorter and simpler advertising guidelines.
20. Changes the potential rescission period to a uniform 15 days after execution of the life settlement contract.
21. Enhances some of the written disclosures that must be made to the insured party regarding changes that may occur as a result of the life settlement contract.
22. Enhances the disclosures on offers, acceptances and rejections concerning a proposed life settlement contract and also requires a reconciliation of the provider's bid to the net proceeds received by the policy owner so that subtractions, commissions and fees can be accurately traced.
23. Clarifies that insurers are within their rights to ask if the applicant or insured has entered into a financing transaction or prearranged a future sale of ownership of the life insurance policy.
24. Retains the requirement that life settlement funds must be transferred to the owner within three business days after the life settlement transaction closes or the entire transaction may be voided.
25. Limits the ability to enter into a life settlement transaction at time of application or issuance or within the first 24 months following issuance unless the owner can demonstrate that he or she is chronically ill, recently divorced, widowed, retired or meets certain other conditions.
26. Clarifies how jurisdiction is determined when there is more than one owner or when the resident state of the provider and owner differ.
27. Allows the Commissioner to pursue violators of the Chapter with a charge of insurance fraud, which carries a penalty of a felony conviction and a prison term of two to 10 years or a fine of $10,000 (or both), or to impose an administrative penalty of up to $1,000 for each violation or $5,000 if the violation is willful.
28. States that Chapter violations are considered Unfair Trade Practices Act under any state law, not just the Insurance Unfair Trade Practices Act (see further comments below).

The Bill was introduced on February 21, 2008 and passed the Georgia Senate by a vote of 52-0 on March 5, 2008. As of March 12, the Georgia General Assembly had reached day 30 of its constitutionally limited 40 business-day schedule. Therefore, the House of Representatives will need to take up and pass SB499 within the next ten legislative days in order for the law to become effective.

Most of the provisions of the Bill appear to be attempts to update and clarify the regulatory provisions contained in the original 2005 law. However, there are concerns about the fact that the newly written examination law may limit or restrict the ability of the examined party to request a hearing to dispute a written examination report and may in fact authorize the Commissioner and Department of Insurance to issue a written report notwithstanding any objection or opposition by the examined party. See proposed O.C.G.A. § 33-59-7(f). There may also be a concern about the fact that this new code section, unlike other provisions of the Insurance Code, could be cross-referenced not only to the Georgia's Insurance Unfair Trade Practices Act (Chapter 6 of the Insurance Code), but also potentially to Georgia's general business Fair Business Trade Practices Act (commonly referred to as the "Mini-FTC Act"), which is contained in Title 10 of the Georgia Code. See proposed O.C.G.A. § 33-59-17. It is unclear whether these potential concerns will be addressed in any House committee version under consideration. It is interesting to note that since Georgia began regulating the life settlement industry in the fall of 2005, it has thus far reviewed approximately 30 applications and issued 20 licenses in this industry. It appears that the licensure of those active in the life settlement industry has become one of the more significant regulatory functions (and some might argue regulatory burdens) of Georgia's insurance regulatory structure.

We will continue to monitor SB 499 as it moves through the Legislature and report on its ultimate outcome in a subsequent newsletter update. ❑

Joe Cregan is a partner in the firm's insurance group. He specializes in the areas of insurance regulation, mergers and acquisitions of insurers, insurance company financial matters and general administrative law. Joe received his bachelor's degree from Youngstown State University, his master's degree from Kent State University and his law degree from Georgia State University.

SEC PROVIDES SAFE HARBOR FOR HOLDERS OF RULE 144 SECURITIES

By Ward S. Bondurant

In February, amendments went into effect for a rule that plays a critical role in U.S. Securities laws. The rule, Rule 144, provides a safe harbor for the public resale of securities without registration under the Securities Act of 1933 (the "Securities Act"). Without Rule 144, holders of securities that were acquired directly from the issuer of the securities in a private (unregistered) transaction (called "restricted shares" in the Rule) and holders of securities who are affiliates of the issuer cannot be certain that their public resale of those securities will not require registration of the sale with the SEC (an expensive and time-consuming process). Rule 144 includes a series of conditions that, if properly met, will give the reselling shareholder a safe harbor from those registration requirements and allow the shareholder to resell the restricted shares. These latest amendments are an attempt by the SEC to liberalize some of the resale restrictions in the Rule. Holders of securities issued by insurance companies have always been subject to slightly different requirements under the Rule, and the new amendments preserve those differences. Anyone issuing securities should be aware of the amendments and plan accordingly in its dealings with its investors and affiliates.

Background on Rule 144

The Securities Act requires that anyone selling securities must register the sale of those securities with the SEC, unless they have a proper exemption from this registration requirement. One such exemption can be found in Section 4(1) of the Securities Act. This section provides for an exemption from registration for sales of securities in "transactions by any person other than an issuer, underwriter, or dealer." The definition of "underwriter" under the Securities Act is, however, broad and includes "any person who has purchased from an issuer with a view to … the distribution of any security…." The difficulty of determining when someone that has acquired shares from an issuer could safely sell those shares without being considered an "underwriter" prompted the SEC to promulgate Rule 144 in 1972 to provide a safe harbor from the definition of underwriter for certain types of sellers engaged in certain types of resale transactions. The types of resellers using Rule 144 to avoid underwriter status are divided into two types: (1) "affiliates" of the issuer that are attempting to sell any securities of the company (restricted or unrestricted), and (2) non-affiliates of the issuer that are attempting to sell restricted securities. The definition of the term "affiliate" in the Rule is vague, but its references to people that "control" the issuer usually leads to a focus on the issuer's insiders and shareholders holding a significant number of the issuer's shares.

Under the provisions of the Rule, affiliates of the issuer must have held the securities for a minimum amount of time and then may only publicly resell them if certain requirements have been satisfied, including the availability of current public information on the issuer, limits on the volume of securities to be sold, prescribed methods for making the sales and the filing of a form with the SEC in certain circumstances. The recent amendments to Rule 144 reduce a number of these restrictions and, in the process, make it easier for a holder to resell securities.

The Conditions of Rule 144 and the 2008 Amendments

Rule 144 sets conditions for sales of restricted securities in order to qualify for its safe harbor. Which specific condition is applicable to a particular sale depends largely on whether the seller is or, during the ninety days before the sale, was an affiliate of the issuer, whether the issuer is a reporting company, and how long the securities have been held by the seller.

Affiliate or Not? The first step in assessing the application of the Rule's safe harbor is to determine whether the seller is affiliated with the issuer or has been an affiliate in the previous ninety days. Affiliates selling under Rule 144 are required to meet a number of requirements that non-affiliated sellers are not required to follow (see *Additional Requirements* below).

Reporting Company or Not? The second step is to determine whether the issuer of the securities is subject to the reporting requirements of the Securities Exchange Act of 1934 (the "Securities Exchange Act") (the requirements to file periodic reports with the SEC) and has been subject to those reporting requirements for at least 90 days. Whether the issuer of the securities proposed to be resold is a reporting company has an impact on the minimum holding period required for restricted securities, as well as certain other requirements.

Holding Period for Restricted Securities: Six Months or One Year? The holding period requirement is the centerpiece of Rule 144. Once an applicable holding period has been met, a seller that is an affiliate of the issuer may sell, subject to certain conditions, and a non-affiliated seller of restricted securities may sell without registration under the Securities Act and the securities received by the purchaser are no longer restricted. The amended Rule 144 calculates those holding periods as follows:

For a non-affiliate of the issuer:

- If the issuer of the restricted securities is a reporting company, then the minimum required holding period is:
  - *six months,* if the issuer is current in its SEC filings; or
  - *one year,* if the issuer is not current in its SEC filings.
- If the issuer of the restricted securities is not a reporting company, then the minimum required holding period is *one year*.

For an affiliate of the issuer:

- If the issuer of the restricted securities is a reporting company,

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then the minimum required holding period is six months and the additional requirements described below apply.

- If the issuer of the restricted securities is not a reporting company, then the minimum required holding period is one year and the additional requirements described below apply.

The recent Rule 144 amendments significantly reduced these holding period requirements from two years in many instances to one year generally and, in certain circumstances, to six months. These reductions should significantly increase the marketability and liquidity of restricted securities issued by a reporting company.

Additional Requirements. In addition to the holding period restrictions described above, Rule 144 includes a number of other requirements that apply to Rule 144 sales made by affiliates. These requirements include limitations on the amount of securities that can be sold in a specific period of time, the manner of the sale, and the filing of a notice of the proposed sale.

Insurance companies have retained their special status as it relates to the disclosure obligations under these additional conditions. Affiliates of companies that are not SEC reporting companies traditionally have had a difficult time selling securities pursuant to Rule 144 because the Rule requires that there must be current public information available at the time of the sale. For a company that is not filing SEC reports, this requirement can be very difficult to meet. For insurance companies, however, there is a special provision in the Rule that states that the current public information requirement can be satisfied by a state regulated insurance company that files periodic reports with the insurance regulator in that state. Therefore, affiliates of insurance companies that do not file periodic reports with the SEC can still sell under Rule 144 if the sale meets the other requirements described above (volume limitations, Form 144 filing obligations, manner of sale requirements and, if the securities are restricted, holding period requirements).

While holders of securities subject to Rule 144 resale restrictions will enjoy the enhanced liquidity arising from the new amendments, issuers of these securities need to be aware of the new holding periods and the shorter delays before securities they issue may enter the public markets. In issuing restricted securities through private offerings, companies may want to consider imposing additional contractual restrictions on transfers if they want to prevent the securities from rapidly hitting the open market. ❑

Ward S. Bondurant is a partner in the firm's corporate practice group. Mr. Bondurant has counseled businesses in general corporate and corporate finance matters for over 20 years, with his primary focus on representing middle market companies. Mr. Bondurant received his bachelor's degree from University of North Carolina and his law degree from University of Georgia.

FOURTH CIRCUIT FINDS RESORT TO OTHER INSURANCE CLAUSE UNNECESSARY IN DISPUTE BETWEEN EXCESS INSURANCE PROVIDER AND PRIMARY PROVIDER

By Benjamin T. Erwin

In *Horace Mann Ins. Co. v. General Star National Ins.* Co., Case No. 06-2156 (January 23, 2008), the Fourth Circuit Court of Appeals held that a conflict between two insurance policies could be resolved without resorting to either policy's other-insurance clause where the respective policies offered different levels of coverage. In reaching its conclusion, the Fourth Circuit predicted that the West Virginia Supreme Court would adopt the general rule that between a true excess policy and a primary liability policy with an other insurance clause, the limits of the policy that provides primary insurance must always be exhausted before coverage under the excess policy is triggered. *Id.* at 8.

The coverage dispute arose after a West Virginia high school student was sexually abused by a teacher. *Id.* at 1. The student brought suit against a number of defendants, including the school board and the school principal. *Id.* The parties settled the case for over $1 million. *Id.* Under West Virginia law, all county school boards and their employees must be covered by a minimum of $1 million of liability insurance procured by the State Board of Risk and Insurance Management. *Id.* The State Board must also provide a minimum of $5 million in excess liability coverage. *Id.*

The State Board procured the $1 million in liability coverage for the West Virginia county school board and its employees through a liability insurance policy provided by National Union Fire Insurance Company. *Id.* The $5 million in excess liability insurance coverage mandated by West Virginia law was provided by General Star National Insurance Company. *Id.* In settling the underlying sexual abuse litigation, National Union contributed $1 million to the settlement, exhausting its limits, while General Star, as the excess insurer, contributed the balance. *Id.*

Following settlement, General Star sought reimbursement from Horace Mann Insurance Company, which had provided a policy to the school's principal. *Id.* Believing that its policy was excess to that of General Star, Horace Mann brought a declaratory judgment action, seeking a declaration that Horace Mann's coverage was excess to that of General Star and that, because General Star's policy limits had not been exhausted, Horace Mann was not liable for any reimbursement. *Id.* General Star counterclaimed, seeking a declaratory judgment in its favor and a money judgment compensating it for its portion of the settlement amount. *Id.* at 14 (Niemeyer, J., dissenting).

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The district court granted summary judgment in favor of Horace Mann after comparing the other insurance clauses contained in each policy. *Id.* at 1. In comparing the clauses, the district court found that the Horace Mann policy was excess to all other insurance policies, while the General Star policy's language indicated that other policies were expected to be excess to General Star's coverage. *Id.* Therefore, the district court found that the General Star's policy limits must be exhausted before Horace Mann could be required to contribute, and granted summary judgment in favor of Horace Mann. *Id.* General Star appealed the decision to the Court of Appeals for the Fourth Circuit. *Id.*

The Fourth Circuit reversed the district court, holding that General Star's policy was a true excess policy, *id.* at 3, while the Horace Mann policy provided primary liability coverage that in some cases will convert to excess coverage by virtue of an other-insurance clause. *Id.* at 7. Sitting in diversity, the Fourth Circuit was bound to apply West Virginia law to the dispute. *Id.* at 2. However, West Virginia's Supreme Court has not addressed the issue, so the Fourth Circuit resorted to generally accepted principals of insurance law in order to resolve the conflict between the policies, believing the West Virginia Supreme Court would adopt such principals as its own. *Id.*

Reviewing the policies, the Fourth Circuit found the General Star policy to be a typical excess policy, *id.* at 3, while the Horace Mann policy was a primary liability policy, which in some instances will convert to excess coverage by virtue of an other-insurance clause. *Id.* at 7. The Fourth Circuit disagreed with the district court's determination that the conflict should be resolved by resorting to the language of each policy's other insurance provision, as those rules do not apply when one of the policies is a true excess policy and the other is a primary liability policy. *Id.* at 8. The characterization of the General Star policy as an excess policy and the Horace Mann policy as a primary policy led the court to apply the general rule that "between a true excess policy and a primary liability policy with an other-insurance clause, the limits of the policy that provides primary insurance must always be exhausted before coverage under the excess policy is triggered." *Id.* (emphasis in original). The court noted the widespread application of this rule:

> Numerous courts in other jurisdictions have addressed the question and have aligned themselves with the position [General Star] takes: a true excess insurance policy is secondary in priority to a primary insurance policy, even with respect to an incident for which the primary policy purports to make itself excess to any other available insurance…. Indeed, it appears that not only is this the majority rule, but *the practically universal rule* in jurisdictions that have addressed the issue. Otherwise stated, the prevailing rule is *that umbrella insurance coverage is true excess over and above any type of primary coverage, excess provisions arising in regular policies in any manner, or escape clauses.*

Id. (emphasis in original) (internal citations omitted). In so characterizing the policies, the Fourth Circuit found review of the other insurance clauses in each policy to be unnecessary, as courts must resort to such clauses only "when two or more policies apply at the same level of coverage. An 'other insurance dispute' . . . cannot arise between excess and primary insurers." *Id.* (quoting *North River Ins. Co .v. American Home Assur.,* 210 Cal.App.3d 108, 257 Cal.Rptr. 129, 132 (1989)). Although the West Virginia Supreme Court had not expressly adopted this position, the Fourth Circuit found that it was likely that West Virginia's highest court would adopt such a position, a prediction previously made by the Fourth Circuit. *Id.* at 9 (citing *Allstate Ins. Co. v. American Hardware Mut. Ins. Co.,* 865 F.2d 592 (4th Cir. 1989)). Accordingly, the Fourth Circuit reversed the district court and remanded the case with a finding that Horace Mann must reimburse General Star for it's contribution to the sexual abuse settlement. *Id.* at 12.

In dissent, Judge Niermeyer took issue with the court's application of general insurance principles to the dispute, agreeing instead with "the district court's common sense reading of the plain language of the two policies and its conclusions that they are not in conflict." *Id.* at 13 (Niermeyer, J., dissenting). Judge Niermeyer noted that West Virginia law requires that when deciding a case concerning the language employed in an insurance policy, the court must "look to the precise words employed in the policy of coverage," giving the language in the policy its "plain, ordinary meaning." *Id.* at 16 (citing *Horace Mann Ins. Co. v. Adkins,* 215 W.Va. 297, 599 S.E.2d 720, 724 (2004)) (internal quotations omitted). In reviewing the plain meaning of the language used in each policy's other insurance provisions, Judge Niermeyer agreed with the district court, believing that the coverage provided by Horace Mann's policy is unambiguously excess to the coverage provided by General Star. *Id.* at 17. ❑

Benjamin T. Erwin is an associate in the firm's litigation group and insurance/reinsurance dispute resolution group. Mr. Erwin received his bachelor's degree from University of Georgia and his law degree from Duke University School of Law.

INSURER TRADE SECRETS AND DEPARTING EMPLOYEES

Lessons from General Reinsurance Corporation v. Arch Capital Group, LTD. et. al.

By R. Jason D'Cruz

Editor's Note: Jason D'Cruz has written this article from the insurance company's prospective. The Summer 2008 edition of the MMM Review will address the scenario of departing executives from the executives' perspective.

You are the CEO of a successful insurance company. Every week is tough, but this last week was especially trying. Imagine that it is Friday afternoon at 4:30 p.m. The weekend is almost here. In fact, you are finally getting away for the weekend. Just as you start to envision your relaxing weekend, one of your company's Senior Vice Presidents walks into your office. He is a thirty year company veteran, and the head of your property facultative (Prop Fac) reinsurance division. He has come to inform you that today is his last day and that he will be leaving the company to take advantage of "other career opportunities." Though you are disappointed that he is leaving, you thank him for his service and wish him luck in his future endeavors. Fortunately, you have a strong bench of other employees to replace him.

By the following Friday, however, thirty of your Prop Fac reinsurance division's key employees, including the people you had in mind to replace your former Senior Vice President, have submitted their resignations effective *immediately*. In other words, your division has been gutted. According to a loyal employee, your former Senior Vice President and several others had been discussing their dissatisfaction with the company for almost a year, and had been looking for opportunities to work together at a competing corporation. Your loyal employee tells you that the others left to join your former Senior Vice President, who is currently employed as the President of the Prop Fac division of an insurance company which previously had no Prop Fac division.

Naturally, you are concerned that these employees have intimate knowledge of your company's customer lists, customer information, trade secrets, business strategies, profit ratios, employee information, salary information, and information on employee productivity. What do you do? Will the employment covenants agreements your former employees signed protect the company's interests?

A recent decision from the Connecticut Superior Court should yield some hope to companies as they continue to operate in a climate in which it is increasingly attractive and easy for employees to leave their employers, to invite thirty of their favorite co-workers to join them, and to take the valuable confidential information/trade secrets of their former employer to a competitor.

The facts of *General Reinsurance Corporation v. Arch Capital Group, LTD. et al.,* Conn. Super. Ct., Case No. X05CV0740116685 (October 17, 2007), are remarkably similar to those recited in the scenario above. It is critical to note that none of the thirty employees had signed an agreement not to compete with Gen Re or not to solicit Gen Re's customers or employees.

The court, however, decided in favor of Gen Re and issued a temporary injunction against the former employees and their current employer. Even though the employees argued that they did not physically take documents containing Gen Re's information, the court determined that much of the business information the employees took to their new employer rose to the level of trade secrets. The court disagreed with the premise that information retained in an employee's memory is not subject to trade secret law protection. The court reached this decision because the information taken gave Gen Re a competitive advantage, had independent economic value, had been adequately preserved as confidential, and was not shared with competitors or otherwise publicly available. Further, Gen Re used passwords and limited the distribution of much of the information.

Gen Re was lucky. The outcome could have been dramatically different had there been a different judge or had the case been in a different state.

So what can your company do to avoid this situation? First, take steps to monitor employee satisfaction. Keep the lines of communication open to address dissatisfaction. Second, make sure that employees who have contact with company customers, customer information, confidential information, and trade secrets have signed *enforceable* employment covenants agreements restricting their ability to solicit company customers, disclose company trade secrets and confidential information, disclose customer information, and recruit company employees. These types of agreements are usually governed by the state law in which the employee lives. Third, the agreements should be reviewed and updated on a regular (annual) basis. Finally, protect information the company intends to keep confidential by:

- limiting disclosure to employees who have a business need to know the information;
- periodically re-evaluating which employees have a business need to know the information;

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- using passwords;
- periodically changing passwords;
- monitoring which employees are accessing the information;
- regularly communicating to employees that the information must remain confidential; and
- imposing penalties on employees who disclose confidential information to unauthorized persons.

As a side note, what really sank the departing employees was email records. All companies should routinely monitor email traffic (in accordance with applicable law and published company policies). In addition, when an employee departs, the Information Technology department should capture all data relating to the departing employee (from hard drives, Blackberrys, servers, phone records, expense reports, etc.), review the activities of the departing employee, and maintain the data in a safe place. As Gen Re found out, you never know when you may need this information. ❑

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IN THROUGH THE BACK DOOR? CONSEQUENTIAL DAMAGES FOR BREACH OF THE DUTY OF GOOD FAITH AND FAIR DEALING

By John Williamson

A divided New York Court of Appeals recently held that an insured could maintain a breach of contract action for consequential damages (even though the policy excluded "consequential loss") because the court found that the insured's consequential damages were reasonably foreseeable and contemplated by the parties at the time of contracting. *See Bi-Economy Market, Inc. v. Harleysville Ins. Co. of NY,* Slip Op. 01418, (N.Y. Feb. 19, 2008). The case is significant because it may signal a change in the law of a major commercial state and because the decision is based on contract principles alone without a finding of bad faith.

It is well-settled that in breach of contract actions the non-breaching party may recover general damages that flow directly from the breach. Special, or consequential, damages that flow indirectly from the breach are usually not recoverable unless the parties could reasonably foresee them at the time of contracting. Proving foreseeability can be difficult. New York has traditionally required a party seeking consequential damages to point to specific contractual provisions demonstrating that such damages were contemplated by the parties. *See, e.g., Globecon Group, LLC v. Hartford Fire Ins. Co.,* 434 F.3d 165, 176 (2d Cir. 2006). Other decisions are in accord. *See, e.g., Blis Day Spa, LLC v. The Hartford Ins. Group,* 427 F. Supp. 2d 621, 638-39 (W.D.N.C. 2006) (federal district court concluded that North Carolina would permit the recovery of consequential damages if they were contemplated by the parties, but granting the insurer's motion for summary judgment on that claim because "not only is there no provision . . . making Hartford liable for consequential damages, but the policy specifically excludes from business interruption coverage 'any other consequential loss.'"); *Essex Builders Group, Inc. v. Amerisure Ins. Co.,* 485 F. Supp. 2d 1302, 1306-08 (M.D. Fla. 2006) (holding that Florida law permits an insured to recover consequential damages where the insurer's breach of contract causes the insured's business to fail, but granting insurer's motion for summary judgment on consequential damages because the insured could not show that the failure of its business as a result of the insurer's failure to pay a claim was a loss contemplated by the parties at the time the policies were issued). Other jurisdictions similarly limit the recovery of consequential damages in contract. *See, e.g., Midamar Corp. v. National-Ben Franklin Ins. Co.,* 898 F.2d 1333, 1339 (8th Cir. 1990) (Iowa permits recovery upon a showing of "special circumstances").

At least one court, however, has affirmed an award of consequential damages for breach of an insurance contract without expressly finding that the parties contemplated such damages at the time of contracting. In *Salamey v. Aetna Casualty & Surety Co.,* the federal Sixth Circuit affirmed a jury award of lost profits arising from the insurer's refusal to pay for fire loss at the insured's business. *See Salamey*, 741 F.2d 874, 877 (6th Cir. 1984) (Michigan follows the rule of *Hadley v. Baxendale* that damages recoverable for breach of contract include those that "arise naturally from the breach" and the jury was entitled to conclude that the insured's inability to rebuild and reopen his business resulted naturally and directly from Aetna's refusal to pay the fire claim).

Some jurisdictions also permit the recovery of consequential damages in tort if the insured can demonstrate that the carrier acted in bad faith or unreasonably in handling a claim. *See, e.g., Univ. Med. Assoc. of the Med. Univ. of S.C. v. UnumProvident Corp.,* 333 F. Supp. 2d 479 (D. S.C. 2004) (South Carolina law). New York, however, does not recognize such bad faith tort claims. *See, e.g., Continental Info. Sys. Corp. v. Federal Ins. Co.,* No. 02 Civ. 4168 (NRB), 2003 U.S. Dist LEXIS 682, at *10 (S.D.N.Y. January 17, 2003).

In Bi-Economy, a retail meat market was insured under a casualty policy that provided replacement cost coverage on the insured's building and business property, as well as business interruption coverage for up to twelve months from the date of loss. The insured

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suffered a major fire, which caused heavy damage to the building and a total loss of its contents. The carrier disputed the insured's claim for actual damages and advanced the insured $163,162. More than a year after the fire, the insured was awarded $407,181 in ADR. During this time, the carrier offered to pay seven months of the insured's claim for twelve months of business interruption losses. The insured never re-opened the market.

Following the ADR award of approximately three times what the carrier had advanced, the insured sued for tortuous interference with business relations, bad faith claims handling, and breach of contract, seeking consequential damages for "the complete demise of its business operation." Bi-Economy, Slip Op. at *3. The carrier moved for partial summary judgment on the breach of contract claim relying on the contractual provisions excluding coverage for "consequential loss." The trial court granted the motion and the intermediate court of appeals affirmed.

The New York Court of Appeals (New York's highest court) reversed, holding that the insured could pursue its contract based claim for consequential damages. The court particularly focused on the business interruption provision of the contract: "The purpose served by business interruption coverage cannot be clearer – to ensure that Bi-Economy had the financial support necessary to sustain its business operation in the event disaster occurred. . . . The insurer certainly knew that failure to perform would (a) undercut the very purpose of the agreement and (b) cause additional damages that the policy was purchased to protect against in the first place." *Id.* at *9-11. The court thus had no trouble finding that the insured's consequential damages attributable to the loss of its business were reasonably contemplated by the parties and therefore were potentially recoverable. *Id.*

While the court did not expressly hold that the insured would be entitled to recover at trial only if it could show that the carrier had acted in bad faith, it came close. The court noted the basic contract principle that "[a]s in all contracts, implicit in contracts of insurance is a covenant of good faith and fair dealing, such that a reasonable insured would understand that the insurer promises to investigate in good faith and pay covered claims." *Id.* at *8 In light of the purpose of the business interruption provision, the implied duty of good faith and fair dealing, and the insured's claim that the carrier had breached that duty, the court found that the insured's contract claim for consequential damages could not be dismissed on summary judgment. *Id.* at *13.

The court spent very little time dismissing the basis for the lower courts' rulings. Consequential "losses," the court ruled "clearly refer to delay caused by third party actors or by the suspension, lapse or cancellation of any license, lease or contract. Consequential 'damages,' on the other hand, are in addition to the losses caused by a calamitous event (i.e., fire or rain), and include those damages caused by the carrier's injurious conduct – in this case, the insurer's failure to timely investigate, adjust and pay the claim." *Id.* at 12.

In dissent, a minority of the court discussed the court's precedents holding that an insurer's bad faith failure to pay a claim could not, without more, justify an award of punitive damages. *Id.* at *13. In the minority's view, the majority decision was less than candid: "the majority abandons this rule, without discussing it and without acknowledging that it has done so. The majority achieves this simply by changing labels: Punitive damages are now called 'consequential' damages, and a bad faith failure to pay a claim is called 'breach of the covenant of good faith and fair dealing.'" *Id.* at *14.

The minority argued that the court's prior refusals to expand liability for punitive damages was sound policy: "Underlying our refusal . . . to open the door to awards of punitive damages was a recognition of the serious harm such awards can do. Punitive damages will sometimes serve to deter insurer wrongdoing and thus protect insureds from injustice, but they will do so at too great a cost" by driving up premiums "and so will inflict a burden on every New Yorker who buys insurance." *Id.* The minority acknowledged that the policy judgment underpinning the court's precedents could be debated, but took the majority to task for not doing so head-on, as a lower appellate court had done. The minority noted that in *Acquista v. New York Life Ins. Co.,* 285 AD2d 73,78 (1st Dept. 2001), the Appellate Division "hardly concealed its disagreement" with the prevailing rule on fairness grounds, and found a way avoid what it believed was an unjust result by adopting the rule in certain other states that an insurer that denies a claim in bad faith becomes liable for consequential damages beyond policy limits. *Id.* at *15. Thus, the minority believes that "[w]ith less frankness than the Acquista court . . . the majority here reaches the same result." *Id.* ❑

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Last term, in *Philip Morris USA v. Williams*, 127 S.Ct. 1057 (2007), the court held that the jury may not consider the harm to non-parties in awarding punitives, but may consider such evidence in assessing the reprehensibility of the conduct. From the business point of view, the court's distinction has little practical value in the context of a jury trial. More distressing is that the court did not reach whether the ratio of compensatory damages ($821,000) to punitive damages ($79.5 million), i.e., 100 to 1, violated Due Process. Judicially-imposed limits on punitive awards splits pro-business Republicans from pro-states' rights Republicans. The court's decision not to address the ratio provides some indication that the two newest members of the court (John Roberts and Samuel Alito), might be unwilling to accept any Due Process limitation on state punitive awards.

Against that backdrop, I reviewed some recent court decisions addressing punitive awards. For example, *Hampton v. State Farm Mut. Auto. Ins. Co.,* Case No. WD-66791 (Mo. App., January 8, 2008), involved a punitive award to two plaintiffs aggregating $8 million compared to a compensatory award totaling approximately $400,000, thereby creating a ratio of approximately 20 to 1. The allegations were ugly, i.e., that State Farm had denied an automobile property damage claim on the grounds that the insured had deliberately set the vehicle on fire, had knowingly relied on questionable conclusions and had induced a prosecutor to bring an action for insurance fraud when the insured would not drop the claim. The insureds were acquitted of the insurance fraud and sued for both the unpaid insurance benefits and for malicious prosecution. The trial judge found that State Farm had misrepresented facts to the insureds, had threatened criminal prosecution and used an expert who rendered an opinion on the vehicle's engine before examining it fully. Accepting the trial court's findings as true, the appellate court upheld the punitive award on the grounds that the court's findings evidenced conduct that was "clearly reprehensible."

In *Gehrett v. Chrysler Corp.,* Case No. 2-06-0507 (Ill. App., January 28, 2008), the plaintiffs sued an automobile dealership for fraud and deceptive business practices, alleging that the dealer had falsely represented that a vehicle carried a "Quadra-Trac" transmission, as opposed to a less desirable "Selec-Trac" transmission. The jury found in favor of the plaintiffs and assessed actual damages of $8,527.97 and punitive damages of $88,168.50, which is slightly under a 10 to 1 ratio. Finding that the defendant's conduct was "reprehensible, but . . . not heinous or shocking to the conscience" the court reduced the punitive award to $59,695.79, which equals a ratio of 7 to 1.

In *Hall v. Farmers Alliance Mut. Ins. Co.,* Case No. 32326 (Idaho, Feb. 13, 2008), the court addressed a compensatory award of $18,650 with a punitive award of $660,000, a ratio of 35 to 1. The plaintiffs' home was damaged when intentionally rammed by a tractor-trailer, and the owners and their homeowner's insurer disagreed on the value of the damages. The plaintiffs introduced disputed circumstantial evidence of bad faith and unnecessary delay.

The court found that the 35 to 1 ratio was presumptively unconstitutional and, applying the Gore factors, determined that a ratio in the mid-range of *State Farm*'s single digit rule was appropriate. The punitive award was reduced to $74,600 for a ratio of 4 to 1.

I laud the *Gehrett* and *Hall* decisions and criticize the *Hampton* court. In *Gehrett,* the court reduced a punitive award to a ratio of 7 to 1, notwithstanding that the defendant's employee had intentionally mislabeled the type of transmission included in the car and had made other misrepresentations. The court found that, while the conduct was reprehensible "it was not heinous or shocking to the conscience." The decision is remarkable because of the court's willingness to distinguish among the nature of the fraud, e.g. lies versus concealment, the number of false statements directed at the plaintiff and whether the fraud represents a pattern. These are important factors, and the court considered all of them.

The *Hall* court accepted that the State Farm single-digit rule may be exceeded only where the actual damages are small or the act is particularly egregious. An act sufficient to exceed the single-digit rule "is not simply 'regretful, naughty, unscrupulous' or the like. . . . While it is true that unsuccessful delay tactics may be highly inconsiderate and perhaps even exploitive, they were not 'particularly egregious.'" As in Gehrett, the court is making analytical distinctions among degrees of wrongful conduct.

The Hampton decision is troubling. The *Campbell* formulation sets a general ceiling of ten times the compensatory award, except where the compensatories are small. That exception makes sense, since applying the single-digit rule to a small compensatory award could promote economically egregious conduct. However, Hampton is not such a case. The compensatory award, $400,000, was substantial, and the trial court did not find a pattern of conduct extending to other cases. In these circumstances, it is difficult to see why $4 million would not be a sufficient punitive award.

The Supreme Court has just heard oral argument regarding an award of punitive damages relating to the *Exxon Valdez*. In that case, a jury awarded punitive damages of $5 billion, which the trial court eventually reduced to $4.5 billion and the Ninth Circuit Court of Appeals reduced to $2.5 billion. The $2.5 billion produced a 5 to 1 ratio of punitive damages to compensatory damages. Because the Supreme Court limited its considerations to whether the award is too high in light of maritime law principles, the case should not affect non-maritime jurisprudence. However, the Court may anticipate a broader ruling. When plaintiffs' counsel noted at oral argument that the Court granted review to clarify the place of punitive damages in maritime law, Justice Scalia interjected, "That, and $2.5 billion." ❑

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PLAYER'S POINT

Continued from page 1

Securitizations have been on the rise, particularly in specialized situations such as CAT risks and redundant life reserves, but securitizations of core insurance risks continue to be slow in implementation. However, just recently, Munich Re announced its first ever mortality bond, shifting $100 million of its pandemic event risk to the capital markets. This is said to be the first of a $1.5 billion program to transfer extreme mortality risk to the capital markets.

That was before the subprime mortgage meltdown.

It is certainly too early to predict the effect of the meltdown on the insurance industry and its ability to access the capital markets in the future. However, three things seem certain.

- There will be investigations. Currently, many state Attorneys General have launched both investigations and lawsuits. In addition to the FBI and the Securities and Exchange Commission, state Attorneys General in Arizona, Texas, Connecticut, Illinois, Massachusetts, Florida, Iowa and Ohio have taken action, just to name a few. Civil actions have been filed by Massachusetts and Ohio. There are inquires into fraud and impropriety in the organization of the mortgages, the sale of the mortgage-backed securities and the suitability of mortgage-backed securities for certain investors.

- There will be legislative fixes (both state and federal). Already the American Securitization Forum (ASF) and the Securities Industry and Financial Markets Association (SIFMA) have emphasized the importance of a sensible regulatory response to the challenges of the subprime mortgage finance market. The organizations note that a measured, reasonable approach at the federal and state level is imperative for liquid, efficient and well-functioning national mortgage securities markets. One focus of legislation certainly will be strengthening consumer disclosure laws. Another potential area of legislation would require more disclosure and structural boundaries in the sales of mortgage-backed securities.

- There will be innovations. We have already seen evidence of innovation in Warren Buffet's sponsoring of a de novo financial guarantee insurer, which enjoyed fast-track licensing by the New York Department of Insurance under the urging of Superintendent Dinallo. The NAIC is helping to expedite licensing for Berkshire Hathaway Assurance Corporation by utilizing its Uniform Certificate of Authority Application.

Just as with hurricanes Katrina and Rita, many lost much in catastrophic losses; however, others gained much in the aftermath of the storms as fresh capital filled the voids. Could we see the same phenomenon in the aftermath of the subprime meltdown where fresh capital will fill the need for financial guarantee writers, and fresh regulations will provide greater stability and predictability in the securitization markets? The ultimate result might be that the insurance industry gains more access to the abundant, efficient capacity available in the capital markets. ❑

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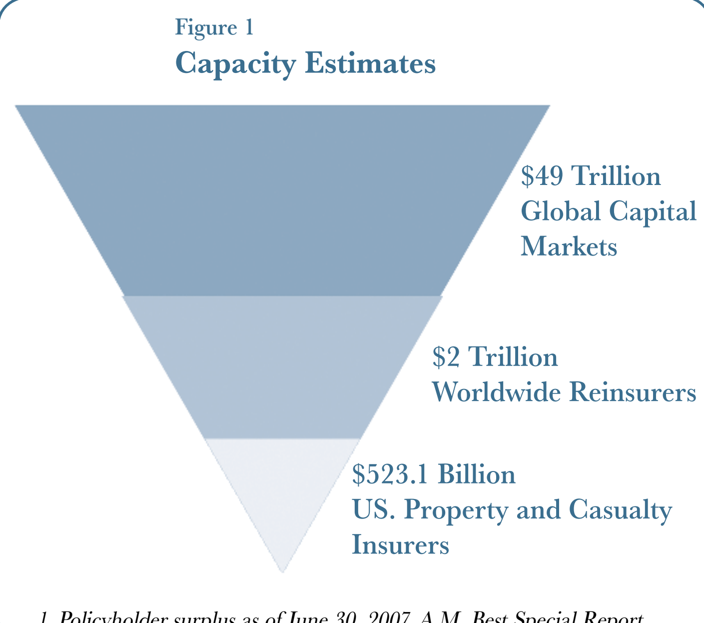
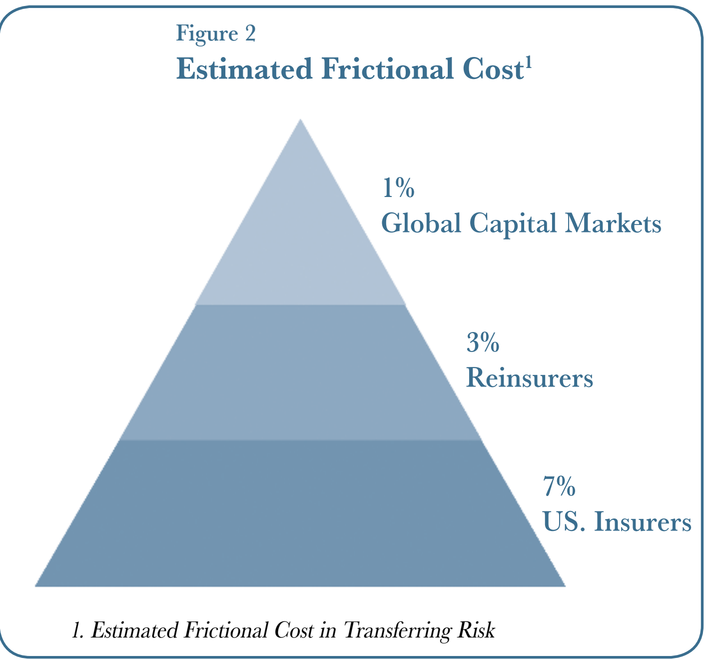
Figure 1
Capacity Estimates



1. Policyholder surplus as of June 30, 2007. A.M. Best Special Report.

Figure 2
Estimated Frictional Cost[1]



1. Estimated Frictional Cost in Transferring Risk

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This increase in economic activity in the "alternative market" brings with it expanded political and regulatory clout, particularly in those states with captive legislation. Recent developments in the federal taxation of captives illustrates this new power and influence.

Treasury's "September Surprise"

On September 27, 2007 the U.S. Treasury issued proposed regulations that would have amended the intercompany transaction rules under I.R.C. § 1502 in a manner that would have essentially rendered almost all single parent captives unable to treat their captive insurance subsidiaries as "insurers". It would have done so by excluding from such favorable tax treatment all captive insurers that insured risks from sister companies in excess of 5% of total risks insured. This would have overruled the Humana case (and succeeding cases), which have been relied upon for decades.

The Internal Revenue Service has never favored captives. In 1977, it advanced its own "economic family" theory, which asserted that affiliated companies had to account for risks as if they were one "economic family" and therefore no "risk shifting" or "risk transfer" could occur (a pre-requisite for "insurance" treatment under the Internal Revenue Code). However, two decades of adverse case law prompted the I.R.S. to acknowledge the demise of the "economic family" theory, and it issued Revenue Ruling 2001 – 31, which expressly so stated. It then followed with Revenue Rulings 2002-89 and 2002-90, which established "safe harbor" guidance for the captive industry. As recently as 2005, it elaborated on those safe harbors in Revenue Ruling 2005-40.

Accordingly, the September 27, 2007 proposed rules came as a complete surprise to the captive industry. However, it did not take long for the industry to recognize the threat and to rally. Under the leadership of the Vermont Captive Insurance Association (VCIA) and the Captive Insurance Companies Association (CICA), a coalition was formed to focus the efforts of the captive industry and captive states (Coalition for Fairness to Captive Insurers (CFCI).

As in most lobbying campaigns, the effort required both technical and political expertise. CFCI assembled a group that was well versed in both respects. After "working the Hill" and petitioning the Treasury, a meeting took place with Treasury representatives that resulted in a further exchange of information on both the economic impact of the proposed regulations on interested persons (including several significant states) and the technical flaws (from a tax perspective) of the rules. The theme was that not only were the proposed rules "bad law," but, after implementation, would both (1) damage important economic interest. and (2) worsen the Tax reporting of the genuine economic effect of the legitimate business activity.

A hearing had been scheduled for February 28. However, in a surprise move, the proposed rules were withdrawn by Treasury.

Protected Cell Company Taxation

Protected cell companies (PCCs) have been in existence for at least fifteen years and have more recently become popular as mechanisms to insure risk without establishing an independent captive insurer. In brief, a segregated "cell" or separate account can be established within a PCC. By the laws of the chartering jurisdictions, the liabilities of one cell cannot be attributed to another cell within the same PCC.

As the use of PCCs has increased, additional domiciles (both on-shore and off-shore) have passed laws which elaborate upon the initial regulatory regime, first established in Bermuda. In all of this time, no case has ever been decided that clearly establishes a precedent that the borders of a cell will be respected in the event of an insolvency.

In Notice 2005-49, the I.R.S. asked for comment regarding the tax treatment to be provided to cells. Should they be treated as "insurers"? Should the boundaries of the cells be respected? Comment was provided by a group of tax practitioners under the auspices of VCIA.

Very recently, the I.R.S. issued Notice 2008-19 along with Revenue Ruling 2008-8. In almost all respects, the I.R.S. adopted the positions taken by the captive industry panel. The I.R.S. concluded that an individual cell could be treated for tax purposes as an "insurer" separate from any other entity (e.g., the PCC itself), but *only* if it legally acted as a separate insurer. The criteria set by the I.R.S. were: (1) the assets and liabilities of the cell were segregated from the assets and liabilities of the PCC, and (2) the law of the domicile and the contractual documentation of the cell supported its independence. In order to establish and implement these requirements, the cell would have to: (1) make any tax elections required of an insurer; (2) apply for a taxpayer identification number (if subject to U.S. tax); (3) segregate its economic activities from that of any other entity including its PCC; (4) file all applicable returns as an insurer; and (5) make certain that the PCC did not include any of the cell's income, deductions, reserves or credits in its income tax filings. In other words, to be treated like an insurer, the cell would have to both appear and act as one.

Captive Clout

Captives are now part of the insurance mainstream and are valued contributors to the insurance industry and the economies of numerous states and off-shore jurisdictions. Nothing shows this more clearly than the recent actions of the U.S. Treasury. ❑

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REPRESENTATIVE INSURANCE TRANSACTIONS

THE WORLD BANK

TECHNICAL ASSISTANCE TO
THE KINGDOM OF SAUDI ARABIA
TO DEVELOP A REGULATORY
STRUCTURE FOR
PRIVATE HEALTH INSURANCE

2007

**GOLDMAN SACHS
AND ITS WHOLLY-OWNED
INSURER**

COMMONWEALTH ANNUITY AND
LIFE INSURANCE COMPANY
IN A MULTI-STATE ASSUMPTION REINSURANCE
TRANSACTION WITH THE FIDELITY MUTUAL
LIFE INSURANCE COMPANY

2007

**TEXAS PACIFIC
GROUP AND
CALERA CAPITAL**

IN THE ACQUISITION OF
DIRECT GENERAL CORPORATION
A PROPERTY/CASUALTY COMPANY
$635 MILLION

2007

**RED VIKING
INSURANCE**

EQUITY FINANCING
FOR ODIN HOLDING CORP.,
PARENT COMPANY OFRED
VIKING INSURANCE

2006

**LINCOLN
FINANCIAL GROUP**

IN ITS MULTI-COMPANY REORGANIZATION
INCLUDING:

- STATUTORY MERGERS
- REDOMESTICATION
- REINSURANCE AGREEMENTS

2007

**BEECHER
CARLSON**

IN THE
ACQUISITION OF
ALLIANCE INSURANCE GROUP

2007

RAYMOND JAMES

Morgan
Keegan

**RAYMOND JAMES
& ASSOCIATES
AND MORGAN KEEGAN
COMPANY, INC.**

IN THE UNDERWRITTEN PUBLIC OFFERING OF
COMMON STOCK BY AMERICAN PHYSICIANS
SERVICE GROUP, INC.
$40,000,000

2007

**FAMILY GUARDIAN
INSURANCE
COMPANY, BAHAMAS**

IN CONNECTION WITH ITS JOINT VENTURE
WITH SAGICOR FINANCIAL GROUP,
BARBADOS

2006

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