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REVIEW

Insurance • Reinsurance • Managed Healthcare

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LETTER FROM WASHINGTON

OPTIONAL FEDERAL CHARTER LEGISLATION IN THE SENATE

By Robert H. Myers Jr.

The National Insurance Act of 2006 was introduced in the U.S. Senate on April 4, 2006. Its principal sponsors are Senators John Sununu and Tim Johnson. Both are members of the Senate Banking Committee. The legislation, if passed, would establish dual federal and state regulation of the business of insurance, similar in concept to the dual regulatory structure for banking.

The legislation would create the Office of National Insurance within the Department of the Treasury. The National Commissioner of Insurance would be appointed by the President. The National

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HASSETT'S OBJECTIONS

INSURER VERSUS INSURER

By Lewis E. Hassett

Policyholder groups and their counsel tend to applaud judicial decisions that expand the scope of coverage. Similarly, the insurance industry tends to applaud judicial decisions that restrict coverage. These truisms are not surprising, since they are based upon predictable self interests.

As an insurance practitioner, decisions that split the business community and the insurance industry, or that split the insurance industry itself, catch my attention. The decision of Pennsylvania's Court of Common Pleas of Philadelphia County in *Aetna, Inc. v. Lexington Insurance Co. et al*, case number 03076 (May 3, 2006), does both. It splits health insurers and business interests on one side and property and casualty insurers on the other.

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PLAYER'S POINT

THE ARMSTRONG COMMITTEE, IT WAS NOT

By Thomas A. Player

It was 1974, and I had just opened my law firm in Atlanta. One of my first clients was the Georgia Life Underwriters Association. They were a terrific group of life insurance professionals. During the next several years, there came on the scene a plague to end all plagues. It was "buy term and invest" the difference. I was told "This will be the end of the life insurance business as we know it." One of the main proponents of that product was A.L. Williams, who finished his career at Primerica.

My job: Stop A.L. Williams. I tried every

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Announcements

The firm is pleased to announce that **Natalie Suhl** has joined the firm's Insurance and Reinsurance Disputes Resolution group. Prior to joining the firm, Natalie was an associate at the New York office of Hughes Hubbard & Reed LLP, where she practiced commercial litigation. Natalie received her B.A. from Wesleyan University and her J.D. from Fordham University School of Law.

Reactions magazine's 2006 survey of the captive insurance industry names **Morris, Manning & Martin** as one of the top captive insurance law firms. Of the six law firms that were mentioned, only three are in the US. Reactions is published in the UK and covers the global insurance and reinsurance market. **Skip Myers** in the DC office is the head of our captive practice.

Skip Myers will be speaking on risk retention group regulation at the annual meeting of the Captive Insurance Association of the District of Columbia in Washington, D.C. on September 26.

Skip Myers will be speaking on risk retention group governance and reform at the annual meeting of the National Risk Retention Association in Chicago on September 19, 2006.

On Sunday June 11 at the NAIC meeting in Washington, DC, **Morris , Manning & Martin** will be sponsoring with Johnson & Lambert a reception to honor our clients and friends in the insurance industry. The reception will be from 5:30 p.m. to 7:00 p.m. in the Virginia B Room at the Marriott Wardman Park Hotel.

Skip Myers spoke at the Arizona Captive Insurance Association annual conference in Phoenix on May 17 and 18. He presented a discussion of current risk retention group issues on the 17th and then appeared on a panel on the future of captive insurance on the 18th.

Joe Cregan attended the Annual Meeting of the Georgia Affordable Housing Coalition held at the new Georgia Aquarium on Tuesday, May 16. Joe was also a participant in a panel discussion on recent developments affecting the low and moderate income housing tax credit under Georgia's insurance premium tax statute.

Joe Cregan and **Dick Dorsey** attended the Annual Issues Symposium focusing on the latest trends statistical results in the workers' compensation and property and casualty insurance markets. The Symposium is sponsored by MMM client, the National Council on Compensation Insurance (NCCI), and was held in Orlando, Florida on May 11 and 12.

Morris, Manning & Martin and Johnson Lambert & Co. Invite You to a Reception to Honor Our Clients and Friends in the Insurance Industry.

At

Summer National Meeting, Washington D.C.

Sunday, June 11

5:30 PM - 7:00 PM

Marriott Wardman Park Hotel • Virginia B Room

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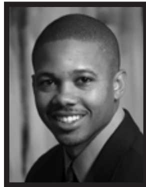
FEDERAL ELECTRONIC DISCOVERY RULES APPROVED BY U.S. SUPREME COURT

By Steven J. Pritchett



On April 12, 2006, the United States Supreme Court unanimously approved amendments to the Federal Rules of Civil Procedure concerning the discovery of digital data. These amendments, originally proposed by the Advisory Committee on Federal Rules, will take effect automatically on December 1, 2006, unless rejected by Congress. The approved changes, which amend Rules 16, 24, 26, 33, 34, and 37, create a new category subject to production, "electronically stored information" ("ESI"). The Advisory Committee created this new category because it believed that digitally stored data has key differences from traditional, hard-copy documents – including: (1) the fact that ESI is generally retained in much greater volume than hard-copy documents and (2) the specific ESI retained by parties is constantly changing due to computer programs that automatically overwrite and delete information that has not been accessed for certain periods. The Advisory Committee sought to address the unique discovery problems created by ESI.

The approved amendments will serve five primary purposes: (1) requiring parties to discuss electronic discovery issues early on during litigation; (2) allowing parties initially to refuse to produce ESI that is not reasonably accessible; (3) allowing "claw-back" privilege and work-product doctrine claims after the disclosure of ESI; (4) specifying the normative form in which ESI is required to be produced; and (5) creating a "safe-harbor" provision for the unintentional loss of ESI.

Rule 26(f) has been amended to require parties, at the initial discovery conference, to consider "any issues relating to disclosure of discovery of electronically stored information, including the form or forms in which it should be produced." Similarly, Rule 16(b) has been revised to note that scheduling orders may include provisions for the discovery of ESI.

Rule 26(b)(2)(B), as amended, will create a category of ESI that need not be produced unless required by court order. The revised Rule 26(b)(2) will provide

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Announcements

Morris, Manning & Martin, LLP, co-sponsored a luncheon in honor of South Carolina Insurance Director, Eleanor Kitzman, held in Charleston on May 8th. **Tom Player** represented the firm.

Tom Player attended the May 3rd hearing of the Life Insurance and Annuities "A" Committee of the NAIC in New York (see, Player's Point).

Joe Cregan and **Dick Dorsey** attended the Annual Meeting of the Georgia Property and Casualty Insurer's Council, held at Chateau Elan in Braselton, Georgia on May 2 and 3. The Council meets annually to discuss issues of concern to insurers, agents and trade groups doing business in Georgia, as well as focusing on recent developments from the recently concluded 2006 session of the Georgia General Assembly.

Lew Hassett's article on issues between insurers and program managers has been posted to the Target Market Program Administrators Association's Website.

Representing a national health insurer, **Lew Hassett**, **Kate Helm** and **Natalie Suhl** have settled a dispute on favorable terms with a national hospital operator regarding reimbursement rates.

Lew Hassett, **Jessica Pardi** and **Bill Megna**, representing a managing general agency, have filed motions to dismiss the claims of a receiver for an insolvent insurer in federal court in New Jersey.

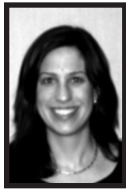
Lew Hassett and **Jessica Pardi** have filed suit in Missouri on behalf of a utility cooperative in conjunction with fuel cost insurance coverage.

Tom Player was a guest lecturer on Reinsurance at Georgia State School of Law in the classroom of **Tony Roehl**. Tony is an adjunct professor of insurance law at the law school.

Students listen attentively during Tom Player's guest lecture at Georgia State University School of Law.

PARTICIPATION IN A CONSOLIDATED ARBITRATION IS A QUESTION FOR AN ARBITRATOR, NOT THE COURT

By Natalie C. Suhl



The Seventh Circuit Court of Appeals has affirmed that whether a party to an arbitration clause could be required to participate in a consolidated arbitration was a question for the arbitrator, not the court. *Employers Insurance Co. of Wausau v. Century Indemnity Co.*, No. 05-3437, (7th Cir. April 4, 2006). Century Insurance Company ("Century") entered into reinsurance agreements with a number of reinsurers, including two agreements with Plaintiff-Appellant Employers Insurance Company of Wausau ("Wausau"). The dispute surrounds Century's demand that Wausau participate in a consolidated arbitration with the other reinsurers to determine liability. While Wausau acknowledged that the reinsurance agreements require it to arbitrate, it argued that it could not be required to participate in a consolidated arbitration. Wausau brought suit in federal district court seeking a declaratory judgment, urging the district court to find that it was entitled to two separate arbitrations for the two reinsurance agreements with Century. The district court found for Century, holding that the question of whether Wausau could be required to participate in a consolidated arbitration was a question for the arbitrator not the court.

The central question of the appeal was who should decide whether the agreements forbid consolidated arbitration: the district court or the arbitrator. Wausau argued that the consolidated arbitration question was one of arbitrability. In *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 944 (1995), the Supreme Court held that unless the arbitration agreement is clear and unmistakable that the issue of arbitrability is for the arbitrator, it should be resolved by the court. Cases since First Options clarify which questions qualify as "arbitrability." The Supreme Court in *Howsam v. Dean Witter Reynolds, Inc.*, 537 U.S. 79 (2002), found that questions or arbitrability are those "dispositive gateway questions" dealing with whether the underlying controversy will proceed to arbitration on the merits. The *Howsam* court gave two examples of a "gateway dispute": (1) a dispute regarding whether parties are bound by a given arbitration clause and (2) a disagreement about whether an arbitration clause is a concededly binding contract applicable to a

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SUPREME COURT ALLOWS ERISA PLAN REIMBURSEMENT UNDER "ACTS OF THIRD PARTIES" PROVISION

By Orlando P. Ojeda, Jr.

In Sereboff v. Mid Atlantic Medical Services, Inc., No. 05-260 (May 15, 2006), the Supreme Court of the United States resolved the disagreement among the federal circuits on whether section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA) authorizes recovery by health insurance plan administrator under an "Acts of third Parties" provisions. A unanimous Supreme Court held that a fiduciary of a plan covered by ERISA can obtain equitable relief under section 502(a)(3)(B) and recover the medical expenses paid by the plan from the proceeds recovered by the plan beneficiary from a third party. The Court explained that a fiduciary must still establish that its claim is equitable and that under the case law from the "days of the divided bench," Mid Atlantic's claim is equitable.

The Sereboffs were beneficiaries of a health insurance plan administered by Mid Atlantic, which was governed by ERISA. The plan contained an "Acts of Third Parties" provision, which required a beneficiary who recovers damages for injuries caused by an act or omission of a third party to reimburse Mid Atlantic for any benefits Mid Atlantic has paid for those same injuries. The Sereboffs were injured in an automobile accident, and Mid Atlantic paid the couples' medical expenses, which totaled $74,869.37. The Sereboffs filed suit in state court against the third parties involved in the accident and eventually settled for $750,000. During the Sereboffs suit, Mid Atlantic sent the Sereboffs' attorney several letters detailing the medical expenses as they accrued and were paid by the plan, and Mid Atlantic asserted a lien on the anticipated proceeds from the suit. After the settlement, Mid Atlantic filed suit under section 502(a)(3) for benefits Mid Atlantic had paid on behalf of the Sereboffs. The District Court found for Mid Atlantic, and the Fourth Circuit affirmed in part noting that the Courts of Appeal were divided on this issue.

The Supreme Court had addressed the scope of the remedial power of section 502(a)(3)(B) before. Section 502(a)(3)(B) only authorizes "those categories of

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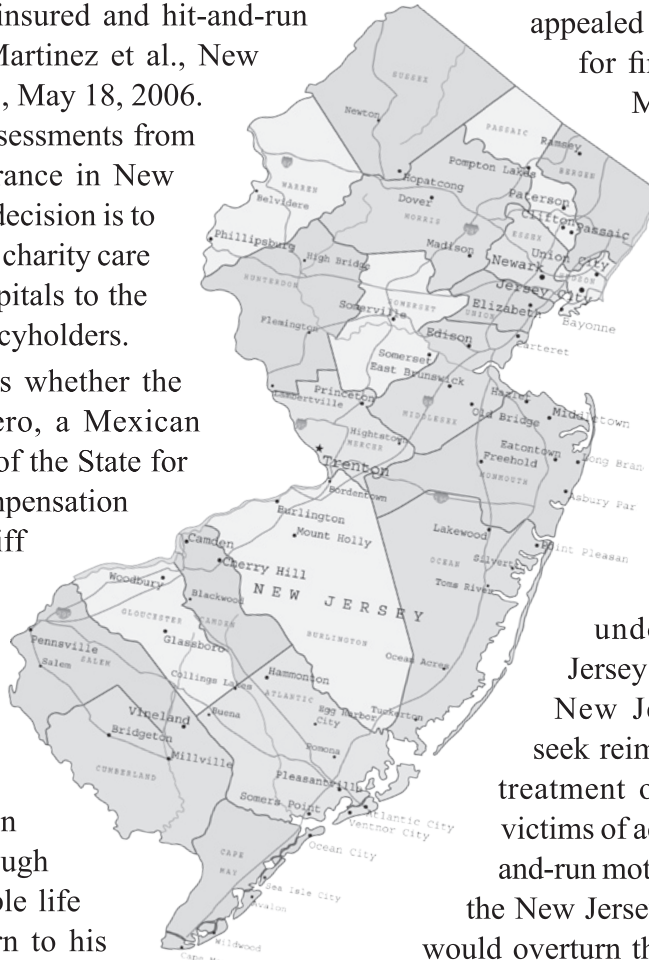
ILLEGAL IMMIGRATION DEBATE DRIVES THROUGH NEW JERSEY

By William F. Megna

The New Jersey Supreme Court has unanimously held that any illegal immigrant injured in a motor vehicle accident is eligible to seek compensation from the State's Unsatisfied Claim and Judgment Fund (UCJF), which compensates victims of accidents involving uninsured and hit-and-run motorists. Caballero v. Martinez et al., New Jersey Supreme Court, A-8, May 18, 2006. The UCJF is funded by assessments from insurers selling auto insurance in New Jersey. The impact of this decision is to shift a portion of the cost of charity care from the State and the hospitals to the auto insurers and their policyholders.



The issue in this case was whether the plaintiff, Manuel Caballero, a Mexican national, was a "resident" of the State for purposes of receiving compensation from the UCJF. The plaintiff was seventeen years old when he illegally came to New Jersey to live with family members who were also undocumented aliens. His intent was to work at least five years in the United States, save enough money to live a comfortable life in Mexico, and then return to his homeland. After living in New Jersey for less than five months, he was injured in an automobile accident while a passenger in an uninsured, unregistered vehicle. Mr. Caballero did not have a driver's license, did not own a car, and was not covered by health or auto liability insurance. On the day of the accident, Mr. Caballero was a passenger in the car of Ricardo Martinez, a co-worker, who was driving the pair to work. Mr. Martinez fell asleep while driving and hit a parked tractor-trailer.

Under New Jersey law, to receive benefits from the UCJF, the claimant must be a "resident" of the state or the owner of a motor vehicle registered in the state. N.J.S.A. 39:6-62. The trial court, in an unpublished opinion, held that without the legal right to remain in New Jersey, Mr. Caballero was incapable of forming the requisite intent to remain for any length of time in New Jersey and therefore could not be a "resident."

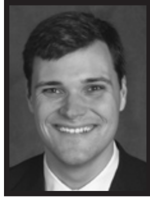
Mr. Caballero appealed arguing that his Equal Protection Rights were violated. A majority of the Appellate Division affirmed the lower court ruling; however, a dissenting member of the panel sided with Mr. Caballero. Mr. Caballero then appealed to the New Jersey Supreme Court for final adjudication. In deciding for Mr. Caballero, the Supreme Court viewed the UCJF's residency requirement as a subjective test based on a person's intent at the time of the accident. In this case, Mr. Caballero's intent was to reside in New Jersey for at least five years before returning to Mexico. This relaxed test also recognizes that an individual may have only one domicile, but several residences.

In addition to the numerous undocumented individuals in New Jersey who could benefit from this case, New Jersey hospitals may be able to seek reimbursement from the UCJF for the treatment of undocumented aliens who are victims of accidents involving uninsured or hit-and-run motorists. A bill has been introduced in the New Jersey General Assembly, A-1410, that would overturn the Caballero decision by requiring proof of "lawful presence" in the United States in order to be eligible for certain state and local benefits.❑

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 at bmegna@mmmlaw.com to receive for future client alerts.

GEORGIA DEPARTMENT OF INSURANCE WITHDRAWS DIRECTIVE RESTRICTING CLAIMS FOR AFFORDABLE HOUSING PREMIUM TAX CREDIT

By Anthony C. Roehl



In what is undoubtedly a positive development for those affiliated with affordable housing and affordable housing tax credits in Georgia, on February 27, 2006, the Georgia Department of Insurance ("DOI") issued a bulletin withdrawing its prior directive that restricted how insurance companies claimed premium tax credit for affordable housing investments.

The DOI's earlier pronouncement, Directive 04-EX-2, was issued on October 19, 2004, and required insurers claiming the housing tax credit to have complete documentation available at the time of filing. Complete documentation was required to include properly executed Form IT-HC, a Georgia K-1, a schedule for each property with a building-by-building allocation of the credit and, most onerously, an issued federal Low-Income Housing Credit Allocation and Certification Form 8609. The DOI had expressly stated that the use of estimates in lieu of the final Form 8609 would not be sufficient.

The recently issued DOI pronouncement, Bulletin 06-EX-1, clarifies the status for insurers claiming the housing tax credit. It withdraws Directive 04-EX-2 and imposes a new requirement that "all required documentation related to the Georgia Housing Tax Credit must be received by the Premium Tax Division of the DOI prior to the scheduled audit of the applicable premium tax return." (Italics in original).

The 2006 Bulletin is very brief and, while withdrawing the 2004 Directive, creates some additional questions. For example:

1. What specific documentation falls within the definition of "all required documentation" that must be received by the Premium Tax Division before the "scheduled audit;" and

2. When is the "scheduled audit?"

The DOI has responded to these questions and clarified that "all required documentation" means a Georgia Form IT-HC signed by the Georgia Department of Community Affairs, a Georgia K-1 or equivalent for each partnership indicating the amount of state credit allocated to the taxpayer, and a schedule that includes each property for which a credit is claimed with a building-by-building allocation.

Thus, the information required to support the credit remains essentially the same as would have been required under Directive 04-EX-2. However, the DOI's more recent statements indicate that the scheduled audit period applicable to a premium tax return will not be less than 24 months from the due date of the return claiming the credit. This additional time should allow insurers claiming the housing tax credit the opportunity to collect all required documentation before the audit period commences.

There are still some open issues. Insurers are required to remit quarterly tax payments that are equal to the tax liability from the previous year or equal to 80 percent of the amount ultimately shown to be due. Failure to comply with these safe harbors results in a 10 percent penalty and an interest charge of 1 percent per month that the taxes are outstanding. The Bulletin does not address how an insurer that uses estimates will be treated if the estimates cannot be supported at the scheduled audit. Since the safe harbor builds on prior years returns, there is a potential for multi-year penalties and interest due if a tax credit is disallowed two years after it was initially claimed.

While there are still open issues regarding the Bulletin and the Department's procedure, by rescinding its earlier directive, the DOI has created a much more favorable environment for affordable housing and affordable housing tax credits in Georgia. The immediate effect should be a strengthening in the market and a renewed insurer interest in the Georgia affordable housing tax credits.❑

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.

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that a party need not produce ESI that it deems not "reasonably accessible" due to undue burden or cost from producing such ESI. ESI that may be considered not reasonably accessible could be data located on recovery tapes or historic ("legacy") data stored on obsolete systems. On a motion to compel (or for a protective order), the responding party has the burden of showing that the sources are not reasonably accessible. Even if the responding party carries its burden, however, a court may still order production of the not reasonably accessible ESI for good cause. A court will expressly be permitted to specify conditions for the production of such ESI, including the substantial cost allocating costs of discovery to the requesting party.

The drafting Committee sought to mitigate the expense and delay necessary for large-scale privilege review. The Committee also believed that privilege review is made even more difficult when it involves ESI, because of potentially massive amounts of ESI responsive to requests for production. Rule 26(b)(5) addresses these concerns by allowing post-production assertions of privilege and work-product protection.

Rule 26(b)(5) will now include a subsection (B) which will allow a party that inadvertently produces any protected information (not limited to ESI) to assert the attorney-client privilege or work-product doctrine at any time following such inadvertent production. Under this provision, the responding party must notify the requesting party that certain disclosed information is privileged or protected under the work-product doctrine. After responding parties are notified that information disclosed to them is privileged or protected, such parties may return, sequester, or destroy such information. If a responding party has disclosed the information to a third party, the responding party must take reasonable steps to obtain the return of the information. A responding party, however, has the option of presenting the information to the court for a ruling of whether the information is protected. It should be noted, however, that Rule 26(b)(5)(B) does not address whether a party which inadvertently discloses protected information has waived a privilege or work-product protection. Thus, a court may continue to rule that a responding party has waived or forfeited a privilege.

Rule 34 governs the production of documents, things, and, as now amended, ESI. The amended Rule 34 provides that a requesting party may specify the forms in which ESI should be produced. The amendment also allows a responding party to object to the requested form of ESI – any objection here must be accompanied by the reasons for the objection to the requested form of ESI production. Rule 34(b)(ii) provides that a responding party may produce ESI in the form in which it is ordinarily maintained or in a form that is "reasonably usable," if the requesting party does not specify the form of production and a court order or stipulation does not prevent otherwise. Additionally, Rule 33(d) has been amended to clarify how a party may respond to an interrogatory with ESI when the "burden of deriving or ascertaining the answer" is substantially the same for either party. The Note to Rule 33(d) states that parties that respond to an interrogatory by making ESI available for inspection, audit, or examination may be required to provide technical support or other assistance to enable the interrogating party to ascertain the answer from the ESI.

Finally, Rule 37(f) has been rewritten to provide that, absent exceptional circumstances, a court may not impose sanctions on a party for failing to produce ESI that was lost as part of a routine, good-faith operation of its electronic information system. The new Rule 37 creates a "good-faith" culpability standard that will require parties, among other things, to take reasonable steps to preserve ESI once it knows or should know that such ESI is discoverable and comply with any agreements or court order regarding the preservation of ESI,. The "safe harbor" provision is a nod to the routine deletions that often occur in computer back-up systems.

In closing, these amendments, are steps to ensure that parties (1) discuss electronic discovery early during litigation (2) avoid undue burdens related to accessing ESI unless necessary and (3) are able to assert a privilege or work-product doctrine following inadvertent production.❑

Steven J. Pritchett is an associate in the firm's commercial litigation group. Steve's practice focuses on commercial litigation, insurance and class actions. Steven graduated with a bachelor's degree from Florida State University and earned his law degree, magna cum laude, from Duke University.

HASSETT'S OBJECTIONS

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In *Aetna*, Aetna sought insurance coverage for losses related to the settlement of consolidated class actions first brought in 1999. The class actions generally alleged that Aetna had embarked on a course of conduct to squeeze health care providers ("HCPs") economically. According to the class plaintiffs, Aetna had denied coverage and refused to pay HCPs based upon economic grounds, rather than medical necessity; had delayed payments for significant periods; had reduced amounts otherwise to be reimbursed; had blacklisted certain HCPs; had refused to negotiate unilateral change to contract terms; had actuarially manipulated the System through various means; and had concealed the foregoing.

Aetna denied the allegations and demanded coverage under various claims-made insurance policies issued in 1999 and 2000. The insurers (the "E&O Insurers") denied coverage. The 1999 and 2000 class actions were consolidated into a multidistrict litigation, which Aetna later settled. Aetna then brought suit seeking reimbursement from the insurers.

On May 3, 2006, the court granted summary judgment to the E&O Insurers on the grounds that the 1999 and 2000 class actions were based upon the same acts and series of acts as various prior lawsuits from and after 1996. Like most errors and omissions policies, the policies at issue provided that "all claims of all persons arising out of the same act, error or omission or series of related acts, errors or omissions shall be deemed to have been made at the time the first of those claims is made against any insured."

The court found that a 1996 action alleged that Aetna had made coverage decisions based upon economic reasons and that Aetna had improperly reduced reimbursements. The court also determined that, although allegations that Aetna had unilaterally dictated terms to the HCPs were not made until 1999, those allegations necessarily formed "part of a series of related acts which Aetna allegedly willed with its overbearing market influence improperly to limit its obligations and the HCPs' rights under the contracts between them." The court concluded that the alleged unilateral setting of terms "was a means to an end . . . and must be viewed as part of an alleged course of conduct in limiting the amounts that Aetna had to pay out on claims submitted by the HCPs."

The court found that its decision, not only was supported by the policy language, but by societal and business considerations as well. "Once an insured becomes aware that it is engaging in behavior that may result in a loss, it should adjust its behavior to avoid the loss. In other words, once Aetna became aware, through the filing of [the law suits in 1996 and 1998] that some of its Managed Care activities were actionable, it should have objectively assessed its exposure and modified its behavior to avoid such potential liability. It should not have waited to get caught in the [1999 and 2000 class actions] and then try to make its insurers share in its (by then) foreseeable and preventable loss." Interestingly, although the court recognized that Aetna actually prevailed in one of the 1996 actions, the court added that "even an unsuccessful law suit should give an insurer pause and cause it to scrutinize the behavior complained of more closely."

Not surprisingly, persons in the property and casualty industry applaud the court's decision. Conversely, others in the health insurance industry condemn it. Practitioners similarly are split.

Aetna and its supporters contend that the court overreached. As a legal matter, they argue that the acts at issue are not related because they involve different patients, different services and different providers. Given the breadth of the allegations of economic misconduct in the prior actions, it is difficult to see how any claim of conduct for the purpose of enhancing Aetna's economic benefits would be covered. The court stated that Aetna's alleged unilateral dictation of terms "was a means to an end, [i.e.] limiting the amounts that Aetna had to pay out on claims submitted by HCPs." However, under this approach, virtually any claim would be excluded against any business that had been sued before or similar allegations.

Aetna is expected to appeal, so this case may be far from over.❑

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.

SUPREME COURT ALLOWS ERISA

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relief that were typically available in equity." *Mertens v. Hewitt Associates*, 508 U.S. 248, 255-56 (1993). In *Mertens*, the claim under section 502(a)(3)(B) was rejected by the Court as being merely compensatory in nature. In *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), the Supreme Court again addressed a claim under section 502(a)(3)(B) in facts similar to *Sereboff*. The Court examined prior cases and secondary legal materials to determine what relief would be considered equitable. In *Knudson*, the beneficiary was also injured in an auto accident, and Great-West paid the beneficiary's medical expenses under a plan subject to a similar "Acts of Third Parties" provision. Great-West sought to recover the medical expenses from the beneficiary after the beneficiary recovered from the third party. The Court distinguished the facts of *Knudson* from those in the instant case by noting that the funds in *Knudson* that Great-West sought were not in Knudson's possession, but had been placed in a "Special Needs Trust" under California law. The Court noted that not all relief considered restitution would be available under equitable principles. The Supreme Court held that the relief sought by Great-West was not equitable in the form of a constructive trust or equitable lien on particular property, but were instead legal remedies not covered by section 502(a)(3)(B).

The ability to specifically identify the funds in the possession of the beneficiary is an important requirement to recover under section 502(a)(3)(B). Although the Sereboffs argued that the funds Mid Atlantic sought did not exist at the time the plan was executed, the Court looked to cases from the "days of the divided bench" and found "the familiar rule of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." *Barnes v. Alexander*, 232 U.S. 117, 121 (1914). The Court noted that the Sereboffs' plan identified a particular fund in the form of all recoveries from a third party whether by law suit, settlement or otherwise. The "Acts of Third Parties" provision created an equitable lien by agreement and not an equitable lien as a matter of restitution. The Court citing *Barnes* explained that the rule allows Mid Atlantic to follow a portion of the Sereboff's recovery as soon as the settlement fund is identified and impose a constructive trust or equitable lien upon that portion of the settlement. The Court also dismissed the Sereboffs' argument that a plaintiff must be able to "trace" the assets it seeks to recover as a requirement limited to equitable liens imposed as a form of restitution. The Court clarified that a claim under an "Acts of Third Parties" provision is an equitable lien by agreement.

The Supreme Court explained that though the fund sought under a section 502(a)(3)(B) claim must be identifiable with particularity, it need not exist at the time the plan is executed. A plan covered by ERISA that contains a properly worded "Acts of Third Parties" provision creates an equitable lien on any potential recovery a beneficiary may receive. If a plan covered by ERISA pays expenses relating to injuries sustained by a beneficiary from the acts of third parties and the beneficiary latter recovers, then the plan administrator could recover the outlaid expenses relating to those same injuries. The facts of Mid Atlantic demonstrate a plan administrator that had a properly worded provision and notified the beneficiary and asserted a lien on any potential recovery. Mid Atlantic demonstrated the Supreme Court's threshold of how a plan administrator must respond in order to recover under section 502(a)(3)(B).❑

Orlando Ojeda is an associate in the firm's litigation group and focuses his practice on insurance and commercial matters. He received his bachelor's degree from George Washington University and his law degree, magna cum laude, from the University of Florida.

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possible way legally to block his company's efforts. However, they almost always accurately completed life insurance replacement forms and for the most part, did not misrepresent the replacement process. The result was virtually no consumer complaints.

At the third annual association meeting, I reported bad news and good news. The bad news was that I did not think we could stop A.L. Williams. The good news, at least in my opinion, was that there was a fine future in the business of life insurance companies selling insurance and investment products, side-by-side. Not long after, we went our separate ways. It was an emotionally charged issue.

Fast forward to 2006. In early May in New York at a meeting of the Life Insurance and Annuities "A" Committee of the NAIC, as chaired by North Dakota Commissioner Jim Poolman, I again experienced an emotionally charged issue facing the life insurance industry. Again, I heard the phrase, "This will be the end of the life insurance business as we know it."

This time, the life insurance industry is talking about investor-initiated life insurance (IILI), where investors – including many hedge funds – provide financing for the purchase of life insurance products purportedly solely for investment purposes, rather than "traditional" reasons for purchasing life insurance coverage. During the course of the hearing, I came to understand that life insurance companies oppose IILI because of three valid reasons, which are:

- Their underwriting is being arbitraged;
- IILI business makes the company's lapse assumptions faulty, actually causing lapse rates to be lower than anticipated on some life insurance policies; and
- Congress will gain evidence that life insurance is an investment asset (which it already is for some life insurance products such as variable life insurance) and will tax life insurance products like other investment assets.

I think the insurers are mostly right. The problem is, with all the attention and protests, the life insurance companies and agents are handing the playbook to Congress.

However, the more life insurance companies try to create fuzzy lines as to where policyowners can sell or pledge what they own, the more companies risk making the very asset that they sell less valuable.

Companies are starting to fashion life insurance applications with many questions concerning the intent of the applicant. A proposal by the ACLI to change the model Life Settlement Act also would try to establish the intent of the applicant at the time of buying the policy. Thus, actions by policyholders would be called into question by companies second-guessing policyholder intention as disclosed or undisclosed in the application. I question whether insurers should want this. Yes, these efforts might put a damper on the investment funds arbitraging the underwriting of some policies. But in the long run, what will be the effect on the value of the asset itself?

During the NAIC hearing, several company executives agreed with Commissioner Poolman's "trial balloon" that the Life Settlement Act should be amended to extend the prohibition on resales of life insurance policies from two to five years. This would severely limit flexibility for policyholders. Moreover, as I am finalizing this article, I learned that the ACLI supports this five year rule and supports an excise tax on the resale of any policy within the first five years. I cannot recall a time during my thirty plus years involvement in the insurance business when life insurance companies asked Congress to impose a tax on their products. However, missing from all of the testimony, in addition to the life reinsurers, was any thoughtful response from those who buy the policies. This is probably because those who buy the policies have no complaint with the current system and just hope the life insurance and the finance industries can reach some sort of Safe Harbor, which will allow the insurance industry to keep selling policies without unnecessary restrictions and restrict the finance industry from blatantly arbitraging insurance company products.

At the commencement of the May hearing, several witnesses made reference to the Armstrong Committee Hearings, which were held not far from the hearing site nearly 100 years ago. My curiosity prompted me to look into the activities of the Armstrong Committee. Its mention was probably ill advised because that 1905 Committee examined life insurance company fraud, mismanagement, unwarranted expenses, unlawful lobbying activity, and encouragement of policy lapses. Let's just say the Armstrong Committee Hearings, this was not.❑

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Commissioner would have the authority to charter and regulate both "National Insurers" and "National Agencies."

The National Commissioner would have broad rulemaking power coupled with federal preemptive authority of conflicting state law. National Insurers and National Producers would both be exclusively regulated under federal law. Moreover, federal regulatory jurisdiction would extend to state-licensed producers placing coverage for National Insurers and to National Producers placing coverage with state-licensed insurers.

Some current aspects of state insurance regulation would continue to apply to National Insurers, however. National Insurers would still have to pay state premium taxes. They would also have to participate in residual market plans and state insurance guaranty associations, but subject to significant restrictions. The Act does not provide for a surplus lines marketplace.

The National Insurance Act marks a significant departure from the State Modernization and Regulatory Transparency Act ("SMART Act"), which also is an act intended to diminish the regulatory burden on the industry and create better market efficiency. The SMART Act's approach was to facilitate interstate cooperation without creating a federal regulator or agency. It essentially imposed insurance reform and the duty to cooperate on to the existing state regulatory system.

The SMART Act is being redrafted and is likely to be introduced in a more streamlined form within the next several months. One of the interesting aspects of the new SMART Act is that it is likely to encourage national regulation by providing more authority to the chartering state, and less authority to the non-chartering states, regarding solvency and market conduct regulation. This "lead state" regulatory approach is the approach utilized in the European Community among its member countries, as well as in the Liability Risk Retention Act of 1986 among the states.

The National Insurance Act is the opening salvo in the battle to streamline and modernize insurance regulation. However, the insurance industry is not uniformly in favor of this legislation. Those entities that are most likely to feel pressure in the marketplace from global competition, *i.e.*, the large national life as well as property casualty insurers, tend to support this approach. In addition, the large brokers tend to favor it. By contrast, the groups representing regional insurers and independent insurance agents tend to oppose this national approach.

To date, there is no counterpart legislation in the U.S. House of Representatives. At most, a hearing or two will be held on the Act. Congress has a very full schedule and limited time left before the midterm elections in November.❑

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PARTICIPATION IN A CONSOLIDATED ARBITRATION

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particular type of controversy. *Howsam*, 537 U.S. at 84. Furthermore, the *Howsam* court held that "procedural" questions which grow out of the dispute and affect the final disposition are questions for the arbitrator. The Seventh Circuit, in light of these decisions, found that Wausau incorrectly characterized the consolidation question as one of arbitrability. The consolidation question did not involve whether Wausau and Century were bound by an arbitration clause or whether the arbitration clause covered the two policies, rather it concerned the kind of arbitration proceeding the parties agreed to. Therefore, the Seventh Circuit held that the consolidated arbitration question is not one of arbitrability, but is one of procedure.

Therefore, under *Howsam* Wausau would have to show that the Agreements require the court rather than the arbitrator to address the consolidation issue. Here, the Seventh Circuit found that the Agreements did not discuss who decides disputes regarding consolidation and, therefore, presumed that the arbitrator decides.❑

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