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LETTER FROM WASHINGTON

H.R. 5637 OFFERS ROADMAP TO SAVE STATE REGULATION

By Robert H. Myers Jr.

The Non-Admitted and Reinsurance Reform Act (H.R. 5637) (the "Act") is the first of several pieces of legislation that will be introduced to reform state insurance regulation. The need for substantial reform is acknowledged almost universally. During a recent hearing on the proposed National Insurance Act (S. 2509), Treasury Undersecretary Randal Quarles testified that state regulation can be "burdensome" and "inefficient" and that the current system of state regulation creates international trade problems regarding access to U.S. and foreign financial services markets. Such a direct statement by a Republican Administration is a signal to the states that change is going to occur.

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HASSETT'S OBJECTIONS

UGH, JUST WHAT WE NEED - HIGHER DAMAGE AWARDS

By Lewis E. Hassett

For a number of years, plaintiffs' attorneys have sought awards of "hedonic damages" separate from the traditional award of pain and suffering. Hedonic damages refers to "the detrimental alterations of a person's life or lifestyle or a person's inability to participate in the activities or pleasures of life that were formerly enjoyed." *See McGee v. A C and S, Inc.*, Case No. 2005-CC-1036 (La., July 10, 2006). Through the *McGee* decision, the Louisiana Supreme Court became the latest jurisdiction to approve separate awards of hedonic damages. A minority of states agree with the Supreme Court of Louisiana. For example, the Supreme Court of New Hampshire authorizes a separate award for a "loss of enjoyment of life." *Marcotte v. Timberlane/Hampstead Sch. Dist.*, 733 A2d 394, 399 (N.H. 1999). Similarly, Connecticut allows such damages. *See Mather v. Griffin Hosp.*, 540 A2d 666, 678 (Conn. 1988). *See also Boan v. Blackwell*, 541

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PLAYER'S POINT

ERM: NOT JUST ANOTHER INDUSTRY "Y2K"

By Thomas A. Player

ERM, or enterprise risk management, has become a buzz word in the insurance industry. Consultants are gearing up and anointing their own ERM practice leaders and section chiefs.

What is enterprise risk management? If I were flippant, I might say enterprise risk management parallels the identification of pornography espoused by Mr. Justice Stewart when he said, "I know it when I see it." Simply put, ERM is an integrated approach to the major risks facing an enterprise. It seeks to

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Inside this issue

Announcements

MMM Puts Model Audit Rule Resources on Web — MMM has been tracking the developments with the Model Audit Rule and has established a Web site at mmmlaw.com/naic to aggregate information on the MAR and to provide updates to any interested parties. In addition to links to telephone conferences and client alerts, the site will be updated to maintain current information on the NAIC Implementation Guide and other best practices as companies come into compliance with the MAR. For more information please contact Ward Bondurant at 404.504.7606, wbondurant@mmmlaw.com or Chris Petersen at 202.408.5147, cpetersen@mmmlaw.com.

Bill Megna and **Skip Myers** were recently successful in obtaining the approval of the District of Columbia for the formation of an RRG for hole-in-one coverage. The RRG is owned by the New Jersey Coalition of Automotive Retailers (NJCAR).

On September 9, 2006, **Jessica Pardi** will be speaking on Overcoming the Obstacles of Missing Information and Personnel in an Insolvency at the Fall Quarterly Meeting of the International Association of Insurance Receivers, held in conjunction with the Fall NAIC conference in St. Louis.

Tom Player will participate in a panel at the ARIAS winter meeting in New York with representatives from AIG and Swiss Re concerning arbitrator and umpire selection.

Lew Hassett has been named to the Education Committee of the National Association of Insurance Receivers.

Bill Megna has been appointed Chairman of the New Jersey State Bar Association's Insurance Law Section.

Skip Myers will be addressing the Captive Insurance Council of the District of Columbia in Washington, DC on September 26, 2006 on the impact of the NAIC and GAO on the current status of risk retention groups.

GEORGIA SEEKS NEW FOUR YEAR PERIOD TO BRING SUIT ON AN INSURANCE POLICY

By Anthony C. Roehl

On June 9, 2006, the Georgia Department of Insurance promulgated an emergency regulation creating a new unfair trade practice in revising the standard fire insurance policy for Georgia. The fire policy was amended to change the provision that suit on the policy can only be initiated if the insured has complied with all the requirements in the policy and must commence within one year after the inception of the loss. The emergency revision extended the suit period to two years after inception of the loss. The proposed regulation then seeks to extend the suit period to four years.

In a more far reaching move, the Department also promulgated a second regulation that requires all property, casualty, credit, marine and transportation and vehicle insurance policies providing first party insurance coverage to also include the emergency two-year time limitation for filing suit, and if approved, ultimately a four-year period. Liability coverage and workers' compensation coverage are specifically exempted from the second regulation. The emergency regulations are effective for policies written or renewed after June 20, 2006.

The Department took this action because the Commissioner found that a one-year limitation was difficult for even a diligent consumer to comply with. Additionally, the Commissioner has reportedly received a number of consumer complaints indicating that insurers are becoming increasingly strict in requiring policyholders to comply with each and every requirement in the policy. The Commissioner felt that the limited one-year window for filing suit, combined with insurers requiring consumers to comply with the insurance contract, created the potential for an "untenable situation" in which the consumer would be unable to comply with all of the requirements in a policy (presumably providing a proof of loss, completing an appraisal, etc.) for a period beyond the one-year time limitation for suit. The Commissioner was concerned that insurers would then be in the position to legally deny an otherwise valid claim. Based on the information available to the Department, the Commissioner concluded that the situation constituted an imminent peril to the public health, safety or welfare of Georgians and therefore promulgated the emergency regulations.

The emergency regulations are effective on an interim basis on June 9, 2006, for a period of 120 days. The Department has to issue a final regulation following the Georgia Administrative Procedure Act during this period

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DELAWARE COURT ADDRESSES DIRECTOR LIABILITY

By Kelly L. Whitehart

In June, the Court of Chancery of Delaware for New Castle County ruled that the public shareholders of a worldwide holding company that sells insurance products had adequately pled a cause of action for breach of fiduciary duty against several of its Directors. Based upon an allegation that the board of directors relied blindly on a brief presentation by its CEO and did not undertake any "integrity-enhancing device" to advise itself of the relationship between its directors and an insurance agency wholly owned by top members of the board, the decision of the board to continue its relationship with the agency in question was not protected by the business judgment rule. The Court found that the Board was not subject to protection by the business judgment rule, even if its decision was approved by an independent majority. *Teachers' Retirement System of Louisiana v. Aidinoff, et. al.*, Case No. 20106 (Del. Ch., Decided June 21, 2006). The Court denied the defendants' motion to dismiss holding that (a) the complaint stated a claim for breach of a fiduciary duty by the named Directors as the decision to renew the contracts with the agency was not protected by the business judgment rule; and (b) the complaint stated claims against the insurance agency for aiding and abetting breach of fiduciary duty and unjust enrichment.

Teachers' is a retirement fund that owns shares of American International Group, Inc. ("AIG"). *Teachers'* filed a derivative action and sought relief on behalf of AIG against four defendants: Maurice Greenberg, AIG's former Chairman and CEO; Edward Matthews, AIG's former Senior Vice Chairman for Investments and Financial Services and a former Director; Howard Smith, AIG's former Executive Vice President and CFO and former board member; and C.V. Starr & Co., Inc. ("Starr"), a corporation that was owned, controlled and operated by top AIG executives and that operated four general insurance agencies. *Teachers'* claimed that the defendants operated Starr as a sham entity to siphon commissions away from AIG and into the hands of Starr stockholders, Greenberg, Matthews and Smith, among others. *Teachers'* also claimed that AIG made payments in excess of $28.1 million to Starr International Company, Inc., ("SICO"), another entity controlled by Greenberg. In denying the defendants motion to dismiss and allowing the breach of fiduciary duty claim to stand, the Court was persuaded by the lack of effort on the part of AIG's board to inform itself of the relationship among the parties, especially in light of allegedly clear conflicts of interest.

According to the Complaint, in 1967, AIG's current holding company structure was created. At that time, all of AIG's non-U.S. assets were transferred to two privately held companies, Starr and SICO. In 1969, AIG went public and the foreign assets of both Starr and SICO were exchanged for AIG stock. Starr, however, maintained four small domestic insurance agencies: Aviation, Starr Marine, Starr California, and Starr Tech. At the same time that he was a top AIG executive, Defendant Greenberg was also the largest shareholder of Starr, as well its chairman and CEO. Defendants Matthews and Smith, during their tenure with AIG, were Starr's second and third largest shareholders and also directors. In the 1970's, AIG entered into contracts with Starr's various agencies whereby Starr sold AIG's products and procured reinsurance. AIG had the option to cancel each Starr contract on an annual basis. By the 1990's, according to the Complaint, Starr was reaping revenues in excess of several hundred million dollars.

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Announcements

An article by **Lew Hassett** and **Tony Roehl** on the "series of acts" exclusion in commercial liability policies appears in the July 2006 issue of the *Insurance Coverage Law Bulletin*.

An article by **Skip Myers** and **Joe Holahan** will appear in the Fall 2006 edition of the *Quarterly Journal of the Federation of Regulatory Counsel*. The article, which is titled "'Show Me the Money': Anti-Money Laundering Program Requirements," examines some of the ways in which insurers continue to adjust their anti-money laundering programs to comply with federal anti-money laundering regulations that became effective last spring.

An article by **Bill Megna** appeared in the latest edition of the *CIC-DC Bulletin*. The article discussed developments within the NAIC regarding the regulation of RRGs.

On September 19, 2006 **Skip Myers** will be speaking on risk retention group regulation at the Annual Conference of the National Risk Retention Association in Chicago.

Tom Player is scheduled to act as an advisor to the Board of Directors of ERM Institute International, Ltd. at its special meeting to be held in New York this November.

FEDERAL COURT HOLDS THAT REINSURER NOT BOUND TO CEDANT'S SETTLEMENT

By Natalie C. Suhl

On July 14, 2006, a federal judge in New Jersey ruled that a reinsurer was not obligated to pay reinsurance benefits for claims that were not properly investigated by the excess-level insurer and were not covered under the excess-level policies. The dispute stems from a class settlement made by Pfizer in 1992 regarding allegations surrounding the Shiley heart valve. The class alleged malfunction or fear of malfunction of the heart valves. Pfizer's excess insurer, Integrity Insurance Co., paid the limits of its policy and sought payment from its reinsurer, General Accident Insurance Co. However, General Accident refused payment, contending that Integrity failed to act reasonably or in good faith. The Pfizer settlement included claims of anxiety regarding future failures, and General Accident argued that Integrity allowed anxiety claims that did not arise during the policy period.

Suit was brought by Karen Suter, as liquidator of Integrity, to recover more than $3 million under facultative reinsurance certificates. In 2004, Judge William Bassler denied summary judgment. The bench trial lasted from May 5 - July 5, 2005, during which Judge Bassler heard 18 days of trial testimony.

His ruling states that Integrity's payments were outside the scope of coverage and that General Accident therefore is not under an obligation to Integrity under the follow the settlement's doctrine. Integrity's policies were occurrence-based. Pfizer initially paid claims for valve failures occurring before October 1985, based on the date of failure or fracture. However, thereafter Pfizer paid failure and anxiety claims and re-operation claims based on the date of implantation, assuming that injury began when the device was implanted. The date of implantation standard was not well received by the court. Specifically, the court stated that policies were written to cover bodily harm, not defective products, and interpreted the date of implantation standard to imply coverage for a defective product.

In addition, Judge Bassler held that the follow the settlements doctrine could not be enforced in this case. Under this doctrine the reinsured party is under a duty to conduct a reasonable, businesslike investigation. Judge Bassler found that Integrity failed to conduct such an investigation and naively relied upon Pfizer's analogy between this case and asbestos and silicone exposure cases. Specifically, Pfizer asserted that the date of implant should trigger coverage because heart valves most likely deteriorate in a similar fashion as asbestos or silicone harm

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FIFTH CIRCUIT ADDRESSES THE EFFECT OF "SERVICE-OF-SUIT" CLAUSE ON A DOMESTIC INSURER'S RIGHT OF REMOVAL

By Orlando P. Ojeda, Jr.

In *Southland Oil Co. v. Mississippi Ins. Guar. Ass'n*, Case No. 05-60282 (5th Cir., May 30, 2006), the Fifth Circuit held that a "service-of-suit" clause foreclosed the insurer's right to remove an action to federal court. The Court, citing *City of Rose City v. Nutmeg Ins. Co.*, 931 F.2d 13, 16 (5th Cir. 1991), explained "we are persuaded that this clause gives to the policyholder the right to select the forum." At issue in both *Southland* and *Nutmeg* were the insurers' removal of actions to federal court after the insureds had filed in state court. The clauses involved in both cases were nearly identical, stating that at the insured's request the insurer "agree[s or will] submit to the jurisdiction of any court of competent jurisdiction within the United States." *Southland*, Case No. 05-60282 (5th Cir. 2006); *Nutmeg Ins.* Co., 931 F.2d at 14.

In 2003, Southland Oil Company, a manufacturer of asphalt and other related products, brought a declaratory action in Mississippi state court against its insurers for failure to pay claims under general comprehensive, umbrella, and excess liability policies. Southland sought a declaration that the insurers were obligated to pay costs associated with alleged environmental damage, which occurred at one of Southland's refineries. Six of the ten defendant insurers had "service-of-suit" provisions in their policies. The defendants removed the suit, and Southland moved for remand. The district court, relying on *Nutmeg*, held that the "service-of-suit" clauses prevented removal by the insurers under policies with the provisions and that, because the requisite unanimity in effecting removal was missing, the action must be remanded to the state court. The Fifth Circuit accepted the insurers' appeal noting that remands pursuant to contract provisions are reviewable.

The Fifth Circuit began its analysis in both *Southland* and *Nutmeg* by recognizing the maxim "that any ambiguity in an insurance policy is to be construed against its drafter-the insurer." *Southland*, Case No. 05-60282 (5th Cir. 2006); *Nutmeg Ins.* Co., 931 F.2d at 16. *Southland* refused to accept the proposition that a "service-of-suit" provision merely submits an insurer to personal jurisdiction of a court. The Fifth Circuit reasoned that construing the provision to merely confer personal jurisdiction to some court would render the clause superfluous, and the court explained it would "not interpret a policy to leave specific provisions without meaning or effect." *Southland*, Case No. 05-60282 (5th Cir. 2006) (quoting *Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 103 (5th Cir.1993)). The court held that by including the phrase "any court" meant the Insurer waived its right to removal.

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THE FUTILITY OF UTILITY SUBROGATION IN NEW JERSEY

By William F. Megna

The New Jersey Supreme Court, almost 20 years ago, created a rule that bars subrogation claims by insurers against water utilities in service-interruption cases. *Weinberg v. Dinger*, 106 N.J. 469 (1987). The State Supreme Court has now extended this rule to all regulated utilities. *Franklin Mutual Insurance Company v. Jersey Central Power & Light Company* (JCP&L), 2006 N.J. Lexis 1147 (July 27, 2006). This decision may have major implications for the insurance industry when the next catastrophic storm hits New Jersey.

Franklin Mutual paid its insured store owner $6,255.78 for spoiled food resulting from power loss due to Hurricane Floyd. The insurer then sought subrogation against JCP&L. The State trial court dismissed the subrogation action against the electric utility on the basis of the *Weinberg* holding, and the Appellate Division affirmed. The New Jersey Supreme Court granted certification and also affirmed.

The *Weinberg* subrogation carve-out for water utilities is based on a premise that the rate-paying public would ultimately bear the burden of subrogation recoveries through increased water rates. Interestingly, the *Weinberg* court continued to allow uninsured and underinsured property owners to sue a water company for damages resulting from service interruptions. The intent of the *Weinberg* court was to make whole the innocent victim either through a compensatory tort recovery or insurance, but not both. In *Weinberg*, however, the Supreme Court left open the possibility that it would reconsider its holding if it were shown that any resulting increase in water rates would be potentially offset by reductions in insurance premiums.

Upon invitation by the Supreme Court in the *Franklin Mutual* case, an *amici curiae* brief was submitted on behalf of the Insurance Council of New Jersey, Property Casualty Insurers Association of America, and National Association of Mutual Insurance Companies. An important consideration in the *Franklin Mutual* decision was the fact that the Supreme Court believed that it had not been offered adequate proof that would demonstrate a reduction in insurance premiums if subrogation claims were to be allowed against a utility. In fact, the *Franklin Mutual* court specifically noted in its decision that at least one scholar had pointed out that "no decision exists where insurers have even attempted to demonstrate a relationship between subrogation rights and premium rates." James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?*: Text v. Context (24 Ariz. St. L. J. 1995, 1024 n.95) (1992).

Although the *Franklin Mutual* court declined to alter the subrogation rule of *Weinberg*, the Court still left open the possibility of a reconsideration if a showing could be made that the public would not suffer the disadvantage of "paying twice" through insurance premiums and then through increased utility rates reflecting subrogation losses. This Court also noted that the New Jersey State Legislature could have overruled the *Weinberg* holding at anytime over the last 20 years if there was disagreement with the subrogation prohibition.

I do not believe that the Legislature will take this latest decision as a clarion call for legislative change on its own because the insurance industry has yet to show how the initial ruling has had an adverse impact on premiums. In this new age of catastrophic rate modeling, however, I believe that the insurance industry should be able to account for this latest holding in its current rate making factors.❑

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.

DATA THEFT AND THE "DO'S AND DON'TS" OF INFORMATION SECURITY

By Joseph T. Holahan

Insurers, brokers and all businesses that routinely handle personal data can draw a number of important lessons from the recent rash of thefts involving personal data that seems to be plaguing industry and government.

The scenario has become depressingly familiar: A laptop computer or associated storage media, such as a disk, is stolen from an employee's home, car or office. The thief was probably after the hardware, but the device contained thousands of records with individually identifiable data, possibly including names, Social Security numbers and other personal information.

Now the data is out there and could be used for identity theft. What could you have been done to prevent this in the first place, and what should you do after the fact to limit your potential liability and protect your business reputation? Consider a few "do's" and "don'ts," drawn from experience handling this type of situation and many similar ones:

DO address the security risk posed by laptops and portable storage devices. For years, corporate security programs have tended to focus on the risks posed by computer hackers, viruses and other internet-related threats. The risks associated with laptop computers and portable storage media have been widely underappreciated. Yet, as every IT professional knows, laptops and their paraphernalia "walk off" from homes, offices, conference rooms and cars with alarming frequency. In April, an employee of the Department of Veterans Affairs lost 26.5 million personal records when his home was burglarized. Losing that amount of data is extraordinary, but a single stolen laptop can easily involve the loss of tens of thousands (or even hundreds of thousands) of records.

Given the risks posed by laptops and portable storage media of all types, every company should be certain it has reasonable safeguards in place for the use of these devices.

For example, companies should review their controls on the ability of employees to download and store data on portable devices. In addition, companies may want to require that all portable drives and other portable storage media be encrypted. Aside from its obvious security advantages, encryption can help to avoid triggering security breach notification laws now in effect in many states. Many notification laws do not apply to encrypted data. If you experience a security breach, you may decide to notify affected individuals even if their data is encrypted, but at least you will have the option of deciding how best to

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UPDATE ON BAD FAITH

By Jessica Pardi

Recently, significant bad faith actions have been decided which may affect the way insurers proceed in lawsuits and settlement negotiations.

Bad Faith Statute Applied to Insurer's Conduct AFTER Commencement of Litigation

After making a claim for a construction accident against his employer's insurance policy, Lloyd Knotts also filed both a personal injury action against his employer and a bad faith claim against its insurer, Zurich Insurance Company. The bad faith claim alleged violations of Kentucky's Unfair Claims Settlement Practices Act, including some purported violations occurring *after* Knotts filed his personal injury action against his employer.

The trial court denied the bad faith claim against Zurich, because the court found that the Unfair Claims Settlement Practice Act was inapplicable to Zurich's conduct *after* commencement of the personal injury action against the employer. The appeals court affirmed, and Knotts petitioned the Supreme Court of Kentucky. The Supreme Court reversed the lower court. *Knotts v. Zurich Ins. Co.*, Kentucky Supreme Court No. 2004-SC-0400-DG (decided May 18, 2006). The reversal hinged upon whether the word "claim" in the Unfair Claims Settlement Practice Act was limited to a pre-litigation, adjustable claim made against a policy, or whether the term "claim" is broader and therefore encompasses acts or omissions of an insurer after litigation commences. The Supreme Court held that the broader reading applied thus leaving the door open for bad faith claims for an insurer's conduct *after* litigation is instituted.

United Ordered to Pay TIG $2 million for Failure to Settle a Claim

As the primary insurer, United National Insurance Company handled the defense for property owners of a nightclub sued by a patron after the patron was badly injured in an attack in the parking lot. The limit of the United primary policy was $1 million, and TIG insured excess amounts up to $10 million.

The defense rejected an initial settlement offer of $1 million which would have been covered by the primary United policy and cost TIG nothing. After a summary judgment ruling that the property owners were legally responsible for providing security in the nightclub parking lot, plaintiff demanded $11 million to settle, the combined limits of both the United and TIG policies.

Before trial, TIG took over the defense and settled the claim for $6.75 million, of which United paid $1 million. TIG

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DELAWARE COURT ADDRESSES DIRECTOR LIABILITY

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Teacher's pled that Starr did nothing that AIG could not do for itself. Revenues that should have flowed to AIG through its own efforts instead flowed to Starr and were directed to its shareholders rather than AIG's shareholders.

In 1975, SICO created long-term incentive plans for the benefit of AIG executives giving equity in AIG to those who remained with the company until the age of sixty-five. Greenberg controlled the board of directors of SICO, and the board of directors controlled the invitations to participate in the long-term incentive plan. SICO controlled nearly ten percent of AIG's shares and each of the defendants owned roughly eight percent of SICO. *Teachers'* alleged that from 1999-2003, AIG paid SICO $28.1 million for "service" and "rental fees." *Teacher's* claimed that the defendants' breached their fiduciary duty to the shareholders by allowing such payments.

Although AIG's Board of Directors received a brief presentation every year from Greenberg regarding the Starr contracts, the Court in *Teachers'* focused on the allegedly deceitful tactics of the defendants and the Board's alleged failure to employ any "integrity-enhancing device" such as a special review committee. The Court stated,

> "The informed approval of a conflict transaction by an independent board majority remains an important cleansing device under our law and can insulate the resulting decision from fairness review under appropriate circumstances. For that device to be given credit, however, the board majority must have acted in an informed manner. The conflicted insider gets no credit for bending a curve ball past a group of uncurious Georges who fail to take the time to understand the nature of the conflict transactions at issue."

Teachers' Retirement System of Louisiana, Case No. 20106 (Del. Ch., 2006). The Court stated that for the defendants to benefit from the business judgment rule, the Board must have been "fully informed." The Court stated that Greenberg's annual "song and dance," while Matthews and Smith sat quietly knowing that the information was a mere "cursory review," does not stand to the level of full disclosure to receive the benefits of the business judgment rule. Additionally, the Court found that *Teachers'* had stated a cause of action against Starr directly as the knowledge of the individual defendants that controlled Starr was imputed to it.❑

Kelly Whitehart is an associate in the firm's litigation group. She focuses her practice on insurance and intellectual property disputes. Ms. Whitehart received her bachelor's degree from the University of North Carolina at Chapel Hill and her law degree from Emory University.

GEORGIA SEEKS NEW FOUR YEAR PERIOD

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or the emergency regulations will expire. The Georgia Administrative Procedure Act requires that each new regulation go through a notice and comment period followed by a public hearing. As of mid-August, no hearing date has yet been set to formally consider regulation that would permanently extend the suit period to four years.❑

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.

FEDERAL COURT HOLDS THAT REINSURER NOT BOUND

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an individual's body. However, in this case Integrity failed to present any medical evidence to support this claim. Furthermore, Judge Bassler noted that Integrity ignored a California state court decision, *Dairyland Insurance Co. v. Shiley Inc. and Pfizer Inc.* (No. 718166, slip op. [Cal Super. Ct. April 26, 1996]), which distinguished heart valves from bodily harm caused by asbestos exposure.

Therefore, Judge Bassler held that Integrity's payment of all of Pfizer's claims under a variety of circumstances were in bad faith and grossly negligent.❑

Natalie Suhl is an associate in the firm's insurance and reinsurance dispute resolution group and also has several years' experience in commercial law. She received her bachelor's degree from Wesleyan University and her law degree from Fordham University School of Law.

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then sued United for bad faith failure to settle the claim in conjunction with the $1 million original offer. TIG further alleged that United failed to inform TIG and/or the nightclub owners of the settlement offer, and that such offer would have been accepted. A southern District of Florida jury found these arguments compelling and awarded TIG $2 million. (*TIG Ins. v. United Nat'l Ins. Co.*, U.S.D.C. S. Distr. Fla., decided July 31, 2006).❑

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

HASSETT'S OBJECTIONS

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S.E.2d 242, 244 (S.C. 2001) (holding that damages for the loss of enjoyment of life is separate from damages for pain and suffering). Other jurisdictions allow hedonic damages to be awarded, or argued to the jury, as an element of pain and suffering. *See Loth v. Truck-A-way Corp.*, 70 Cal. Rptr. 2d 571 (1998); *Poyzer v. McGraw*, 360 N.W.2d 748 (Iowa. 1985); *Banks v. Sunrise Hospital*, 102 P.3rd 52 Nev. 2004). *Anderson v. Nebraska Dept. of Soc. Serv.*, 538 N.W.2d 732, 739 (Neb. 1995) (damages for a loss of enjoyment of life may be considered as an element of pain and suffering).

Proponents of hedonic damages argue that the goal of the tort system is to make plaintiffs whole and that a loss of enjoyment of life because of an inability to engage in previous activities is real and important. Opponents argue that hedonic damages are often redundant of damages for pain and suffering, so that allowing hedonic damages risks a double recovery.

In my view, the problem is not so much a potential double recovery. That risk probably can be remedied by requiring that all non-economic damages be awarded together. The problem is that it adds another monetary recovery to an already overburdened tort system. No doubt, many plaintiffs suffer a decreased enjoyment of life as a result of their injuries. We all can sympathize with the recreational pianist unable to play again or as well. However, more money is not the cure. Neither life nor our tort system can be perfect. Injured claimants cannot be put into the same position as before the injury, and an award of additional money does not change that. That is, that person will not enjoy playing the piano again no matter how high the financial award, and the sad reality is that a bigger house, a fancier car or more exotic trips flowing from a higher award will not replace the inner happiness of recreational accomplishment. At the end of the day, the claimant either finds an absorbing substitute or has a less fulfilling life. More money does not change that sad reality.

Granted, the jury may feel better, and the plaintiff's attorney may reap a higher fee, but that is not the objective of the tort system. The tort system works best when it addresses economic losses, perhaps with an added gloss for pain and suffering.

The ultimate societal question is the extent to which we want to incur the economic cost of increased monetary awards through increased insurance premiums and product costs. I suggest that we recognize the limits of our ability to compensate for some consequences of an injury. Injecting additional costs and uncertainties into our tort system is not the answer.❑

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.

SERVICE-OF-SUIT" CLAUSE

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Southland recognized that a contractual provision that waives a party's removal right "must give a clear and unequivocal waiver of that right." *Southland*, Case No. 05-60282 (5th Cir. 2006) (quoting *City of New Orleans v. Mun. Admin. Servs., Inc.*, 376 F.3d 501, 503 (5th Cir.2004), *cert. denied*, 543 U.S. 1187 (2005)). The Fifth Circuit then added that "explicit words, such as 'waiver of right to remove'" are unnecessary to waive an insurer's removal right. *Southland*, Case No. 05-60282 (5th Cir. 2006) (quoting *Waters v. Browning-Ferris Indus*., Inc., 252 F.3d 796 (5th Cir.2001)).

In *Southland*, the Fifth Circuit recognized a distinction between domestic and foreign insurers. The Fifth Circuit noted that a "service-of-suit" provision would be interpreted as merely submitting a foreign insurer to personal jurisdiction of the courts of the United States and would not waive a foreign insurer's removal right. *Southland*, Case No. 05-60282 (5th Cir. 2006) (citing *McDermott Int'l, Inc. v. Lloyds Underwriters of London*, 944 F.2d 1199 (5th Cir.1991); *In re Delta Am. Re Ins*. Co., 900 F.2d 890 (6th Cir.) cert. denied, 498 U.S. 890 (1990) (holding a similar policy provision was merely a promise to submit to the personal jurisdiction of a court in the United States where the reinsurer was a foreign entity)). *Southland* noted that the Court in *McDermott* examined why *Nutmeg* rejected a similar interpretation when applied to a domestic insurer and explained that interpreting the provision to concede only personal jurisdiction by a domestic insurer is "wholly untenable because . . . Nutmeg is a domestic corporation with its principal place of business in the United States." *McDermott*, 944 F.2d at 1207. *Southland* reconciles this distinction and explains that, as a domestic corporation, personal jurisdiction is already conceded and a domestic insurer's waiver of removal rights is the only tenable interpretation of its "service-of-suit" provision.

Under *Southland* and *Nutmeg*, a "service-of-suit" provision will be considered a waiver by a domestic insurer of any right to remove a case once filed by its insured. *Southland* maintains the distinction between domestic and foreign insurers' rights under a "service-of-suit" provision, but the holding evidences that if any insurer wishes to maintain its right to removal it should be contractually preserved. In addition, under the unanimity rule for removal, an insurer might find it right of removal conceded by other co-insurers' "service-of-suit" provisions.❑

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.

DATA THEFT AND THE "DO'S AND DON'TS"

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proceed rather than being forced into a particular course of action by legal notification requirements.

DO have an adequate response plan in place. Companies should review their security incident response plans to be certain they are adequate and are being observed in the field. For example, proper reporting and escalation of security incidents is critical to an effective response plan. The VA's response was slowed, leading to political embarrassment, because employees failed to report the theft of data in a timely manner to officials responsible for investigating security incidents.

As private entities, insurers face challenges that are somewhat different from those confronting a large government agency, but the politics of a swift and effective response vis à vis regulators, law enforcement officials and your customers can be just as difficult as anything dealt with by the VA.

DO conduct periodic security training and regular security awareness activities. A good security program is worthless if it is ignored by members of your workforce. Periodic training and regular security awareness activities are the only way to maintain the critical "human element" in your security program. Training and security awareness also are necessary to fulfill your legal duty to maintain an adequate security program. The duty to conduct training and security awareness is explicit in the HIPAA Security Rule. The same duty is couched as a guideline in state and federal laws implementing the Gramm-Leach-Bliley Act, but the duty is no less real for being presented this way. No security program can be adequately implemented without reasonable training and awareness activities.

DO act quickly and deliberately when a breach occurs. When data is compromised, it often takes time to ascertain precisely what happened and whose data was involved. You may find yourself in the situation of knowing that certain personal records could have been stored on a missing laptop but not know for certain which records were there. For example, if a laptop belonging to a regional sales director were stolen, you might know that records for groups within the sales region might have been on the laptop, but not know for certain which groups were involved.

The time involved in determining which records may have been compromised can slow a response greatly, making it all the more important to speed other response activities, such as conducting a legal review, briefing management and making preparations for responding to customer inquiries. Be certain to check any applicable security breach notification laws for deadlines on sending out notices to individuals whose information was involved. Florida, for example, imposes such deadlines.

DON'T panic. Act with due speed, but consider your options carefully. The laws governing information security could give you more options than you might think. By design, the laws generally pertaining to your security program—including your incident response plan—are flexible and risk-based, which should allow you to respond in a flexible manner based on the risk to your customers presented by the situation.

Many states now have laws requiring that companies give notice of a security breach involving personal data to individuals affected by the incident. These laws are more prescriptive than the regulations that generally apply to information security, but they contain significant ambiguities regarding what triggers a duty to notify. For example, say a contractor accidentally gained unauthorized access to certain personal records stored on your company's computer server. Although the access was unauthorized, the incident might not be considered a security "breach" triggering a duty to give notice under the laws of many states. This is especially true if the contractor is subject to security controls under your contract for services.

Keep in mind that whatever you decide to do today in response to a security breach will have consequences for your response to any future incident. Once you have made a particular response to an incident, you have created a record of what you believe is a reasonable and adequate response. For example, you might be faced with an incident involving just a few records. Before you send a notice to each individual involved promising to pay the cost of monitoring credit reports for suspicious activity, consider whether you could make the same response if many thousands of records were involved.

DON'T let legal concerns eclipse more important matters. When you craft a response to a security incident, start with the legal issues. In other words, first determine what you must do. Once that is settled, move on to the more important matter of what you will do to protect your customers and preserve your business reputation. In the long run, the importance of demonstrating to your customers that you will protect the security of the personal information they entrust to you will likely outweigh any legal concerns. Get the legal issues right so that you know the lay of the land. Then decide where you will go based on what is best for your business.❑

Joe Holahan is Of Counsel in Morris, Manning & Martin's Washington, D.C. office and is Director of the firm's Terrorism Insurance Group. His areas of expertise include privacy and data security, compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), state and federal insurance regulation, and managed care. He received his bachelor's degree from University of Virginia and his law degree from Catholic University of America, J.D., 1990.

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identify and measure internal and external risks impacting the enterprise. While the seeds of ERM have been around for a while, its quantification by the rating agencies is new. Rating agencies are wrestling with definitions, models and labels to better quantify ERM. It is a process which is just beginning.

As a law firm, we have had the pleasure of assisting in the birth of the ERM Institute International, Ltd. ("ERM-II"), a worldwide research and educational organization dedicated to refining and designating those experts who are truly schooled in enterprise risk management.

In the recently released research report by the ERM-II (www.ermii.org), Dr. Shaun Wang defines ERM as a new discipline that starts with an analysis of the company's business model, including external and internal forces and their interactions. Among these forces, regulation and rating agencies represent huge factors impacting company behavior.

According to David Ingram,[1] Standard & Poor's will evaluate ERM quality in five areas:

1. Risk Management Culture
2. Risk Controls
3. Emerging Risk Management
4. Risk and Economic Capital Models
5. Strategic Risk Management.

S&P defines excellence in ERM as follows: "[An] insurer has extremely strong capabilities to consistently identify, measure, and manage risk exposures and losses within the company's predetermined tolerance guidelines. There is consistent evidence of the enterprise's practice of optimizing risk-adjusted returns. Risk and risk management are always important considerations in the insurer's corporate decision-making."[2]

Other criteria have been established by other rating agencies, including A.M. Best, Moody's and Fitch. Each is struggling in its own way to quantify ERM. For the insurance industry, which is in the business of taking risk, it is doubly difficult for those assessing risk-taking to both assess the quantification and quality of an insurer's acceptance of third-party risk, while, on the other hand, assessing the ability of the enterprise to identify, correlate and prepare for external risk.

Would the application of ERM have given warning signs in the case of three enterprises which experienced significant losses? Let's look at Marsh, Reliance Insurance Company, and Conseco. Each of these presents a markedly different risk profile. One is a broker, one is a property/casualty insurer, and one is a life insurance holding company.

Marsh

The primary risk that I would attribute to the substantial loss at Marsh is the lack of transparency in its business practice. That is, in many cases, there was no disclosure that Marsh was receiving additional commissions from the insurance companies in the form of contingent commissions, also referred to as profit sharing agreements (PSAs) and market service agreements (MSAs). This additional compensation was generally being paid to Marsh as contingent commissions generated by steering business to favored insurers. An extreme example of ultimate steering of premiums to specific insurance companies was bid-rigging. One might say the enterprise was being operated in a way that withheld compensation information from customers, which in turn, masked the pervasive steering of business to specified insurance companies for higher contingent commissions. It is certainly plausible that with full disclosure of compensation arrangements, placing business with designated carriers would have required justification on merit and, thus, bid-rigging would have been avoided. One lesson here is that the embedded risk of lack of transparency in Marsh's business model could have been isolated and examined using good enterprise risk management techniques. Whether a revised business model requiring transparency would have satisfied Mr. Spitzer is anyone's guess. It is clear, however, that the atmosphere created by the lack of transparency at Marsh was an easy target for Mr. Spitzer.

Reliance Insurance Company

From talking to those who have been deeply involved in the Reliance Insurance Company Liquidation, it appears that the thread running through many of the problems at Reliance was one of a robust appetite for fronting risky program business. The unraveling of one, then another of the risky programs resulted in pressure on reinsurers and their retrocessionaires. This pressure caused a cascade of reinsurance failures. Clearly, ERM could have been invaluable in helping to avoid what happened at Reliance. A focused high level ERM review of the risk profile and cumulative risk profiles of the Reliance insured risk would have alerted management to the acute problem.

Conseco

Generally speaking, the insurance operations at Conseco were adequately managed. There were some issues concerning long term care and reserving, but those issues occurred industry wide. The problems at Conseco were found in its acquisition program. Its acquisition models seemed to accelerate risk in four areas: (a) aggressive pricing; (b) poor consolidation and expense savings; (c) aggressive tax positions; and (d) consolidation positions which were subject to growing concern by the SEC. As usual, it was not a single risk profile that was the problem.

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LETTER FROM WASHINGTON

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What the states need to do now is embrace change so that it can be steered in an acceptable direction. H.R. 5637 provides that opportunity. The Act was approved and reported out of the House Financial Services Committee, but has not yet been sent to the floor of the U.S. House of Representatives for a vote.

Provisions of the Bill

The Act is designed to streamline the regulation of the excess and surplus lines market and reduce redundant state regulation of insurers. H.R. 5637 integrates the concept of "lead state regulation," which is the central regulatory principle of the Liability Risk Retention Act.

The Act would centralize the regulation and collection of premium taxes for surplus lines in the home state of the insured. Under this arrangement, the surplus lines broker would only have to pay premium tax to one state. The other states would be able to cooperate by an interstate compact or other arrangement to obtain their share of the premium tax consistent with the amount of risk in that state. Further, the Act would lighten the burden on surplus lines producers by prohibiting a state from collecting fees for licensing unless that state participated in the NAIC National Producer Registry. It also would eliminate the "diligent search" (also known as the "declination requirement") for the placement of risks of an "exempt commercial purchaser."

In regard to reinsurance, H.R. 5637 would eliminate the extraterritorial reach of any state by preempting the regulatory authority of non-domiciliary states, as long as the home state of the ceding insurer is an NAIC accredited state. Non-domiciliary states would be required to accept the determination by the domicile state regarding all issues relating to credit for reinsurance and financial solvency.

Why is This Important?

The movement toward the optional federal chartering and regulation of insurers is making progress and gathering support. Clearly, a federally chartered and regulated insurer would avoid much, if not all, of the burden of duplicative (and in some cases contradictory) state regulation. It would facilitate multi-state, as well as multinational operation and would avoid the perils of rate regulation. However, the implementation of any such system would require the creation of a new federal agency, and the transition from state regulation to federal optional regulation would be onerous, expensive and difficult.

H.R. 5637, on the other hand, shows the way towards "lead state regulation," which would enable an insurer to operate on a national basis under the aegis of its domiciliary state. In this way, it would avoid the application of the laws, rules, and "desk drawer" practices of the other 49 states. Minimum baseline standards could be imposed by the Congress on all states of domicile and, therefore, avoid a "race to the bottom" among domiciles.

The Act provides insight as to how to avoid the creation of a federal regulator while still having national standards. This is essentially the model followed by the European Union ("E.U.") where an insurer chartered in one E.U. nation can operate in any other E.U. nation. It is also the model followed by the U.S. corporate law, where the internal operations of a corporation are governed by the laws of a single state, its state of domicile.

It is time for the NAIC to embrace this approach.❑

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

PLAYER'S POINT

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The risk profiles were cumulative. Conseco appears to be another excellent candidate where ERM could have made a difference.

In summary, the prudent application of enterprise risk management techniques would have made a difference in all three case studies. Is ERM another Y2K? In my opinion, no. While consultants will certainly be active in the ERM analysis of insurers, management must buy in and adopt a high level internal ERM process.

Moreover, the rating agencies are exercising their influence to encourage companies to implement ERM. This will definitely result in additional "compliance cost" on the part of insurance companies, and thus, run the risk of generating more bureaucratic burdens. Whether companies will reap ERM benefits by changing the way they conduct business still remains to be seen.❑

[1]"Standard & Poor's Enterprise Risk Management Evaluation of Insurers," *Standard & Poor's RISK MANAGEMENT*, March 2006.

[2]*Id*. at 17.

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

MMM Insurance & Healthcare Attorneys

Paul H. Arne	404.504.7784	parne@mmmlaw.com
Brooks W. Binder	404.504.7626	bbinder@mmmlaw.com
Ward S. Bondurant	404.504.7606	wbondurant@mmmlaw.com
Joseph L. Cregan	404.504.7782	jcregan@mmmlaw.com
Dick Dorsey	404.495.3660	ddorsey@mmmlaw.com
Jason Eakes	404.504.7603	jeakes@mmmlaw.com
Amanda S. McHugh	404.504.7629	amchugh@mmmlaw.com
Lewis E. Hassett	404.504.7762	lhassett@mmmlaw.com
Richard L. Haury Jr.	404.504.7713	rhaury@mmmlaw.com
Joseph T. Holahan	202.408.0705	jholahan@mmmlaw.com
Simon R. Malko	404.495.3646	smalko@mmmlaw.com
William F. Megna	609.430.1414	wmegna@mmmlaw.com
Robert H. Myers Jr.	202.898.0011	rmyers@mmmlaw.com
Orlando P. Ojeda Jr.	404.504.7609	oojeda@mmmlaw.com
Jessica F. Pardi	404.504.7662	jpardi@mmmlaw.com
L. Chris Petersen	202.408.5147	cpetersen@mmmlaw.com
Thomas A. Player	404.504.7623	tplayer@mmmlaw.com
Anthony C. Roehl	404.495.8477	troehl@mmmlaw.com
Natalie C. Suhl	404.504.7690	nsuhl@mmmlaw.com
Kelly Whitehart	404.504.7670	kwhitehart@mmmlaw.com
John H. Williamson	404.495.3618	jwilliamson@mmmlaw.com
Bruce H. Wynn	404.504.7694	bwynn@mmmlaw.com
Kristin B. Zimmerman	404.504.7611	kzimmerman@mmmlaw.com

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