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REVIEW

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LETTER FROM WASHINGTON

CLASH OF CULTURES - CAPTIVE EDITION

By Robert H. Myers Jr.

The phrase "clash of cultures" has gained popularity in referring to the struggle between the West (Europe and United States) and portions of the Middle and Far East. Much of the brutality and virulence of this fight can be explained by the inability of each opponent to understand the other, or even to agree upon a way to deal with the other's grievances, other than through conflict.

A sociological definition of "culture" is "the sum total of ways of living built up by a group of human beings and transmitted from one generation to another." "Culture" both describes and dictates behavior and thought. When cultures collide, there is at a minimum friction and often much worse.

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HASSETT'S OBJECTIONS

THE CONTINUING CONFLICT: RESERVATIONS OF RIGHTS AND CHOICE OF COUNSEL

By Lewis E. Hassett*

The United States Court of Appeals for the Fourth Circuit recently addressed whether an insurer defending under a reservation of rights loses the right to choose counsel. *Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C.*, Case No. 04-2048 (4th Cir., December 27, 2005). The insured was sued for sexual harassment and related claims. The insurer, under a general commercial liability policy, agreed to provide a defense for all claims, but reserved its right to refuse indemnification on claims other than for defamation and false imprisonment.

Contending that the insurer's reservation of rights triggered a conflict of interest, the insured eschewed the insurer's appointed counsel and retained its own counsel. The insured then demanded reimbursement

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PLAYER'S POINT

CONNECTING THE DOTS

By Thomas A. Player

As a young boy growing up in the Low Country of South Carolina, I was fascinated by the stars. I once wrote off for a star map which presented unimagined heavenly images of Leo, Taurus and Orion. Try as I might, I never saw the images. I only saw the three stars that when connected formed the basis for the magical images.

I'm having a bit of the same problem now with the different insurance initiatives. Starting with the extension of TRIA and migrating to proposals for an overhaul of the Federal Flood Program to the creation of a National Catastrophe Fund, on one hand, to the actions of Mississippi Attorney General Jim Hood and

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Inside this issue

Announcements

Bill Megna has been included in the 2007 edition of The Best Lawyers in America, as well as in the listing of the 2006 New Jersey Super Lawyers. Best Lawyers is based on nearly two million confidential evaluations by the top attorneys in the country.

Skip Myers will be speaking at the Arizona Captive Insurance Conference on May 17 on regulatory issues affecting risk retention groups.

On May 2, **Joe Holahan** will speak at the Medicare Supplement Conference in New Orleans sponsored by the American Insurance Education Institute on the topic of Recent Security and Privacy Laws Affecting Insurers.

Lew Hassett will lead a workshop at the mid-year meeting of the Target Markets Program Administrators Association in Baltimore on April 11 and 12. The workshop will cover negotiating contracts and handling disputes between insurers and program managers. For more information, please visit www.targetmkts.com.

Lew Hassett is co-chairing a Mealey's sponsored seminar on "Fundamentals of Reinsurance Litigation and Arbitration" at the Ritz Carlton Hotel in Boston March 23 and 24. During the seminar, Lew will lead a Practitioners and Industry Roundtable on ways to improve the arbitration process. **Jessica Pardi** will speak at the seminar on the key phases of the arbitration process. For more information, please visit www.mealeys.com/con_agendas/Rei0306.html.

On March 17, **Joe Holahan** will speak at the CPCU Society Reinsurance Section Symposium in Philadelphia on the topic of Terrorism Risk Insurance.

Skip Myers will be speaking on terrorism insurance at the Captive Insurance Company Association's annual conference in Orlando, Florida on March 9.

PENNSYLVANIA SUPREME COURT LIMITS INSURANCE DEPARTMENT'S RIGHT TO MANDATE ARBITRATION IN POLICY FORMS

By Kristin B. Zimmerman

In *Insurance Federation of Pennsylvania, Inc. v. Pennsylvania Department of Insurance*, No. 207 MAP 2003 (Pa., Dec. 30, 2005), the Supreme Court of Pennsylvania held that the Pennsylvania Insurance Department (the "Department") lacked the requisite authority to require insurers to include arbitration clauses in uninsured ("UM")/underinsured ("UIM") motorist coverage. This is a significant curtailment of implied regulatory authority.

In 1996, Liberty Mutual Insurance Company filed a revision to its private passenger insurance policy form for UM and UIM coverage with the Department. The proposed revision would have eliminated the policy's arbitration provision. The Department rejected the proposed revision, stating that removal of the arbitration provision violated the requirements of 31 Pa. Code § 63.2 (extent of coverage to be offered) as to UM coverage. Liberty Mutual did not challenge the decision of the Department; however, the Insurance Federation of Pennsylvania, Inc. (the "Federation") filed a petition for declaratory judgment before the Department and sought an order declaring that the Department did not have the authority to require mandatory arbitration of UM and UIM coverage disputes.

In response, the Insurance Commissioner issued a declaratory opinion and order, holding that the Department could disapprove automobile insurance policies which did not require binding arbitration of UM and UIM disputes. The Federation appealed to the Commonwealth Court, which affirmed the Insurance Commissioner's decision. The Supreme Court of Pennsylvania granted leave to appeal certain questions, including whether the Department possessed the authority to require that all UM and UIM coverage forms provide for mandatory, binding arbitration.

The court initially noted that the Pennsylvania Legislature did not grant the Department the express authority in either of the two applicable motor vehicle statutes, the UM Act and the Motor Vehicle Financial Responsibility Law (the "MVFRL"), to require mandatory binding arbitration for UM and UIM claims. Thus, the court was left to determine whether the Department had the implied authority to promulgate a regulation requiring insurance contracts to contain an arbitration provision.

Upon review, the court stated that "the public policy underlying the enactment of the MVFRL does not create an implied legislative mandate allowing the Insurance Department to change the normal course of judicial proceedings simply because arbitration is less costly and less time-consuming than traditional litigation." Insurance Federation at *4. Further, the court stated "that authority may be given to a government official or administrative agency to make rules and regulations

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LOSS OF A PRODUCER'S RIGHTS TO EXPIRATIONS

By Anthony C. Roehl

A producer's ownership of the expirations related to his or her book of business is one of the cornerstones of the law relating to insurance producers. Courts have noted that "expiration in the field of insurance has a definite and well-recognized meaning and embodies the records of an insurance agency by which the agent has available a copy of the policy issued to the insured or records containing the date of the insurance policy, the name of the insured, the date of its expiration, the amount of insurance, premiums, property covered and terms of insurance." *Blake v. Aetna & Cas. Ins. Co.*, 681 N.Y.S.2d 73 (App. Div. 1998). Having the information necessary to know when to contact insureds when they are most in need of insurance is extremely important.

However, an agency's rights to the expirations are not absolute. For example, a number of agency and managing general agency agreements invest the insurer with ownership of the expirations if the agency or MGA violates certain terms of the agreement, most commonly the requirement to timely pay all premiums over to the insurer.

The ownership of expirations can also be contracted away through the use of company computer systems. In Costanzo v. Nationwide Mutual Ins. Co., the Ohio Court of Appeals held that the insurer, not its exclusive agent, had an exclusive property right in the expirations where the insurer had provided and maintained a computer network for its agent's use. 832 N.E.2d 71 (Ohio App. 2005). The court held that the expirations were vested in the insurer for at least two reasons. First, under the common law of agency, insurance agents represent only one principal, and the principal is the owner of the expirations not the agent. Second, the terms of use agreement related to the computer network stated that all information entered into the network was vested with Nationwide. Additionally, Nationwide required all of its agents to use its computer system so, effectively, the agents had no choice but to transfer ownership of the expirations to Nationwide.

Agents and agencies are well advised to verify how expirations are treated both in their agency agreements and in the terms of use related to accessing insurers' computer systems or web-based portals. Expirations are perhaps the most valuable asset an insurance agency has. It is important to ensure that any contract terms relating to the expirations are clear and fully respected.❑

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.

Announcements

Brooks Binder and **Tom Player** represented the publicly owned Bahamian insurance holding company, Family Guardian, in its strategic alliance with Sagicor, a Barbados-based financial services company listed on the stock exchanges of Barbados, Trinidad and Tabagos.

On February 2, **Joe Holahan** addressed the Oklahoma State and Oklahoma City Associations of Insurance and Financial Advisors on the subject of preparing for and Responding to an Information Security Breach.

Skip Myers' article "State Regulators Already Have Adequate Authority to Address GAO Concerns" is featured in the February 2006 issue of the Risk Retention Reporter.

The January 2006 edition of The Insurance Coverage Law Bulletin includes an article by **Lew Hassett** and **Katherine Lahnstein** entitled "Attorney-Client Privilege as Between the Insured, the Insurer and Their Attorney."

Tom Player made a presentation in January at the 2006 PCI Executive Roundtable Seminar in Naples, Florida. His topic was "The Expanding Role of Attorneys General."

Lew Hassett's article on the California Supreme Court's decision in Boghos v. Certain Underwriters at Lloyd's of London was published in the January 2006 edition of *The Insurance Coverage Law Bulletin*. The case addressed the potential conflict between an arbitration clause and a service of suit clause in an insurance policy.

Lew Hassett and **Skip Myers** have been named to the Guide to the World's Leading Insurance & Reinsurance Lawyers. Attorneys are eligible for inclusion based upon nominations from in-house counsel and peers.

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

LETTER TO THE EDITOR

Dear Lew,

I read with interest your article in the Winter 2005 edition of the MMM Review. In that article you criticized the decision of the Connecticut Supreme Court in *MedValUSA Health Programs v. Memberworks, Inc.*, 872 A.2d 423 (Conn. 2005), [Editor's Note: In that case, the court affirmed an arbitration panel's award of $5 million in punitive damages without awarding any compensatory damages.] I was the claimant's counsel in the MedVal case, and thought I'd share with you some information about that matter, and why I disagree with your argument that courts should entertain a due process challenge to arbitration awards (at least those which are entered pursuant to unrestricted and consensually bargained for arbitration provisions).

The respondent in MedVal made a strategic decision (reminiscent of the Texaco/Pennzoil case) to avoid addressing the issue of punitive damages altogether. Thus, respondent presented the arbitrators with no authority, argument or evidence that there should be any linkage of the amount of punitive damages to the compensatory award. Having made that decision, respondent could not argue that the arbitrators manifestly disregarded the law of punitive damages (although respondent unsuccessfully raised the argument at the trial court on the motion to vacate; respondent did not pursue the argument before the Connecticut Supreme Court). Thus, Sawtelle and MedVal are perfectly consistent on the manifest disregard point.

Having been hoisted by its own petard, respondent tried to circumvent its strategic decision by arguing that, whether presented to the arbitrators or not, the court should set aside the award as violative of due process.

Setting aside the ramifications of respondent's strategic decisions, the issue of due process calls into question the fundamental right of parties to contract. This was not a consumer contract case, where the arbitration provision was arguably part of an adhesion contract. Rather, the provision was negotiated and inserted by two commercially sophisticated parties, both represented by counsel. They made a deliberate decision that all issues would be submitted to arbitrators. A fundamental component of due process is the right to contract, and the right for parties to determine the forum for adjudicating disputes: e.g., jury waiver provisions, forum selection clauses.

There is always a risk of legal or factual error in arbitration matters, and yet the law permits parties to choose that forum, subject to very narrow grounds of review. Under Connecticut law, the parties could have opted for provisions that would have permitted heightened judicial scrutiny of the award, but they opted not to do so.

Permitting "due process" review would be nothing more than an invitation to have a court revisit the wisdom of the arbitration award, a process that is fundamentally at odds with the goals and purposes of arbitration.

Under State Farm and related cases, there is no "black line" test that decrees precisely when a punitive damage award is excessive. If parties want to entrust that ultimate decision to three arbitrators who they selected, rather than to a judge, due process and the right to contract should permit that.

Regards,
Robert A. Harris
General Counsel
OpHedge Investment Services, LLC

Letters and commentary on articles featured in the MMM Review are welcome. They will be edited for clarity and brevity.

SUPREME COURT HOLDS THAT ARBITRATOR DECIDES WHETHER ENTIRE CONTRACT VOID

By Lewis E. Hassett

The Supreme Court of the United States has just addressed the allocation of authority between a court and an arbitrator to determine whether a contract is void for illegality. *Buckeye Check Cashing, Inc. v. Cardegna*, Case No. 04-1264 (February 21, 2006). In that case, the plaintiffs alleged that a check cashing company's charges were criminally usurious under Florida law. Although the consumer agreements contained an arbitration clause, the plaintiffs argued that whether a contract is void for illegality is a question for the court, not for the arbitrator.

The Supreme Court rejected the plaintiffs' argument, holding that whether a contract is void for illegality is a question for the arbitrator. Only where the challenge is to the arbitration clause itself is legality a question for the court. The Court's decision is consistent with its own precedent and decisions from other courts.❑

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.

NAIC MOVES FORWARD ON APPLYING SARBANES-OXLEY TO ALL INSURERS

By Chris Petersen

The NAIC/AICPA Working Group has agreed to a framework for applying Sarbanes-Oxley ("SOX") requirements to insurance licensees including non-public insurance companies. As reported earlier, the NAIC is attempting to amend its Model Regulation Requiring Annual Audited Financial Regulations ("Model Regulation") to apply SOX requirements regarding audit committees, independent auditors and financial controls to all insurers. To accomplish this task, the Working Group appointed three subgroups to examine applying SOX "Title II," "Title III" and "Title IV" to insurance companies. The Title II subgroup examined issues regarding audit committees. The Title III subgroup studied independent auditors and the Title IV subgroup was charged with reviewing internal management controls.

The Title II subgroup recommended, and the Working Group adopted, language mandating that all insurers establish audit committees. In addition, the required audit committees must be comprised of independent boards members, i.e., audit committee members may not receive, other than in their capacity as board members, compensatory fees from the Plan. A provision, however, was added to the model that states that if domiciliary law requires board participation by otherwise non-independent board members such members may participate on the audit committee as independent members. The number of independent audit committee members varies based on the insurance-based revenue of the entity.

The Working Group also adopted the Title III subgroup's recommendations regarding independent auditor provisions. The proposal contains additional new standards for qualified independent certified public accountants ("QICPA"). Under the proposal, a Plan's QICPA may not provide insurers with non-audit services such as book keeping, consulting, financial information system design, etc. Under limited circumstances, the audit committee may grant approval for the QICPA to provide certain non-audit related services, but even the use of these limited services is capped. Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from the Department of Insurance.

Finally, the Title IV subgroup adopted some significant amendments to its section of the Model Audit rule relating to internal management controls. Insurers will be required to file a "Management Report of Internal Control over Financial Reporting." This report must include 1) a statement that management is responsible for establishing and maintaining adequate internal control over financial

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SECOND CIRCUIT ADDRESSES NON-PARTY DISCOVERY IN ARBITRATIONS

By Jessica F. Pardi

Several courts have wrestled with an arbitrator's authority to order pre-hearing depositions from a non-party. Most courts have disallowed such discovery. *See e.g. Hay Group, Inc. v. EBS Acquisition Corp.*, 360 F.3d 404 (3rdCir. 2004). A few have allowed third party discovery. *See e.g. Amgen Inc. v. Kidney Ctr. of Del. County*, 879 F.Supp. 878 (N.D.Ill. 1995).

The Second Circuit recently allowed an arbitration panel to avoid the discovery issue by holding the deposition before the panel. In *Stolt-Nielson SA v. Celanese AG*, 430 F.3d 567 (2ndCir. 2005), the Court, relying on Section 7 of the Federal Arbitration Act (the "FAA"), allowed the arbitration panel to subpoena documents from third parties and to order the third parties to testify before the panel in a "preliminary evidentiary hearing" purportedly designed to resolve evidentiary issues prior to the final hearing.

Section 7 of the FAA provides that arbitrators "may summon in writing any person to attend before them ... as a witness and in a proper case to bring with him or them any book, record, document, or paper which may be deemed material as evidence in this case." 9 U.S.C. § 7. Previously, the Second Circuit left open the question of whether Section 7 allows arbitrators to compel pre-hearing depositions and/or pre-hearing discovery of documents "especially where such evidence is sought from non-parties." *National Broadcasting Co., Inc. v. Bear Stearns & Co.*, 165 F.3d 184, 188 (2ndCir. 1999).

In *Stolt-Nielsen*, the Court purported to leave this same question unanswered. The Court claimed the Stolt-Nielson subpoenas did not provide an occasion to rule on this issue because the subpoenas in question did not seek pre-hearing depositions or document discovery from non-parties. "Instead, the subpoenas compelled non-parties to appear and provide testimony and documents to the arbitration panel itself at a hearing held in connection with the arbitrators' consideration of the dispute before them." *Stolt-Nielsen*, 430 F.3d at 569 (emphasis added). The fact that the non-parties were compelled to appear before the panel itself was deemed dispositive of the issue, and the non-parties' argument that the subpoenas were a thinly disguised attempt to obtain pre-hearing discovery was rejected.

As further rationale for this distinction between pre-hearing discovery and a "preliminary hearing" before the panel, the Court noted that the compelling party assured the panel that the non-party witness at issue would not be recalled to testify at multiple hearings. Additionally, the

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NEW JERSEY WINTER UPDATE

By William F. Megna

Much has occurred in New Jersey over the last few months. New laws have been enacted, regulations adopted, legislation introduced, a significant decision was rendered by the State Supreme Court, a new Commissioner of Banking and Insurance was nominated, and an advisory letter was issued by the Department of Banking and Insurance that has a potentially significant impact on group disability coverages.

FROM THE LEGISLATURE

Effective May 12, 2006, employees' dependant children will be allowed to keep coverage under their parents' group plans until attaining the age of thirty. P.L.2005,c.375. The definition of a dependant is limited to an employee's child by blood or by law who (1) is less than thirty years of age, (2) is unmarried, (3) has no dependants, (4) is a resident of New Jersey or is enrolled as a full time college student, and (5) is not actually covered under another group or individual health plan. ERISA plans are exempt from this mandate. Regulations to be promulgated for the implementation of this law are anticipated to be modeled after the requirements of COBRA.

Also, signed into law was legislation to amend the State's insurance laws to meet the federal requirements for high deductible health insurance that must accompany federal Health Savings Accounts (HSAs). P.L.2005,c.248. New Jersey, however, did not change its tax laws to conform to the federal treatment of HSA contributions. Under federal law, employees can make tax free contributions to their accounts, but in New Jersey these contributions will be treated on an after-tax basis.

As reported in a previous newsletter, the State's new reporting requirements for lobbying, and what constitutes lobbying, became effective January 1, 2006. The scope of lobbying activity that is now subject to reporting has been expanded significantly to include "governmental process" lobbying, which encompasses a great degree of regulatory activity.

FROM DOBI

During his first month in office, Governor Jon Corzine nominated Mr. Steven Goldman to be Commissioner of the Department of Banking and Insurance. Mr. Goldman was a senior member of the law firm of Sills, Cummis, Epstein and Gross. His practice focused on mergers and acquisitions, banking and finance, joint ventures, and leveraged buy-outs. He earned his Masters of Law in taxation from New York University School of Law and his Juris Doctorate from The George Washington University School of Law.

As recorded in the February 13, 2006 edition of the New Jersey Lawyer, the Department of Banking and Insurance has determined that contract provisions reserving for insurers their full discretion to interrupt all terms of a policy violate State law. In a letter from Acting Commissioner Donald Bryan Jr. to attorney Michael E. Quiat (who requested the opinion regarding discretionary clauses in health and disability insurance policies), the Department says it is drafting proposed regulations to specifically prohibit carriers from using "full-discretion provisions." 15 New Jersey Lawyer 281.

FROM THE BENCH

The New Jersey Supreme Court decided on February 1, 2006 that a policyholder whose insurer becomes insolvent is personally liable for judgments in excess of the $300,000 maximum coverage provided under the New Jersey Property-Liability Insurance Guaranty Act. *Johnson v. Braddy et al*. (DDS No. 14-1-2767). In its decision, the Court strongly recommended to the State Legislature that it consider remedial action as it deems appropriate to cure the potential catastrophic effect this ruling will have on individual insureds.

THE HORIZON

During the course of the next few months, the New Jersey State Legislature's primary focus will be working with the Governor to adopt a budget for the fiscal year that begins July 1. Approximate estimates of the State's deficit range from $3 to $5 billion. Other than a bill recently introduced to allow New Jersey to become a domiciliary state for captive insurance companies (A.2058/S.1444), not much activity regarding property and casualty issues is expected until fall. Health reform, however, will be the hot issue throughout the year. Assemblyman Neil Cohen, who chairs the Assembly Financial Institutions and Insurance Committee, has introduced legislation that will significantly amend the State's individual and small group health insurance laws. A companion bill, S. 503, has been introduced by Senator Nia Gill, who chairs the Senate Commerce Committee. This legislation would change the rating requirements for the individual market from pure community rating to a modified 2 to 1 rating band. Minimum loss ratios also will be increased in the individual market to 80 percent and 77 percent for the small group market.

Please call the firm's New Jersey office at 609.430.1414 for additional updated information.❑

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

COMPLIANCE WITH NEW ANTI-MONEY LAUNDERING RULES REQUIRED BY MAY 2, 2006

INSURERS MUST INTEGRATE AGENTS AND BROKERS INTO THEIR ANTI-MONEY LAUNDERING PROGRAMS

By Jospeh T. Holahan

Under federal anti-money laundering regulations issued last fall by the U.S. Department of the Treasury, insurers offering permanent life and annuity products must have an anti-money laundering program in place no later than May 2, 2006. Insurers offering these products also must be prepared to file Suspicious Activity Reports with federal authorities for suspicious transactions occurring after that date.

The most challenging aspect of the new regulations is a requirement that insurers integrate agents and brokers into their anti-money laundering programs. Many insurers already have an anti-money laundering program in place, but few if any have integrated independent agents and brokers into their programs to the extent required by the new regulations.

The new regulations apply only to the following types of products:

- Individual permanent life policies;
- Individual annuities;
- Any other insurance product with features of cash value or investment.

Group life and annuity contracts are excluded from the new requirements. Term life policies, including credit life, also are excluded. In addition, the rules do not apply to reinsurance or retrocession contracts.

Under the new regulations, insurance companies writing covered products must develop and implement a risk-based anti-money laundering program designed to prevent the company from being used to facilitate money laundering or the financing of terrorist activities. The program must be approved by senior management and must:

- Include policies, procedures and internal controls based on the company's assessment of the money laundering and terrorist financing risks associated with its products;
- Integrate agents and brokers into the program;
- Collect all customer-related information necessary for an effective program;
- Designate a compliance officer responsible for the program;
- Provide for ongoing training of appropriate persons, including agents and brokers; and
- Include independent testing of the program by a third party or by an officer or employee other than the anti-money laundering compliance officer.

An insurer's anti-money laundering program also must include measures for compliance with existing currency transaction reporting requirements and with new requirements regarding Suspicious Activity Reports. Suspicious Activity Reports are discussed below.

A Risk-Based Program

The regulations give insurers considerable discretion in determining the precise policies, procedures and controls they will adopt to combat money laundering. Whatever measures are adopted, however, must be based on a reasonable assessment of the risk that the insurer's products and services may be used for money laundering. Relevant factors to be considered in conducting a risk assessment include the extent to which customers may use cash or cash equivalents to purchase a covered product and whether the insurer underwrites products in any country designated by U.S. or international authorities as a concern for money laundering or terrorist activities.

In conducting their risk assessments, insurers also may consider the extent to which their agents and brokers are required by law to establish their own anti-money laundering programs. Distribution of products through producers who are required to maintain their own anti-money laundering programs—e.g., because they are registered securities broker/dealers selling variable products—may present less of a risk. Nevertheless, insurers should ensure that such producers have extended their anti-money laundering programs to all covered products.

Insurers should document their anti-money laundering risk assessment in writing and update the assessment as necessary so that it may be provided to the independent tester for the anti-money laundering program and to regulators in the event of an examination.

Integrating Agents and Brokers

The regulations do not require agents and brokers to establish their own anti-money laundering programs. Instead, insurers are required to integrate agents and brokers into their programs. This means that insurers must either train the producers with whom they do business or verify that producers have received appropriate training from a commercial service or from another entity that has its own anti-money laundering program, such as another insurer or a bank.

Regardless of how training is obtained, each insurer remains responsible for monitoring the effectiveness of its training program. In guidance on the new rules, Treasury states that "mere certification" of a producer's completion of a training program is not sufficient. Rather, "evaluation

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of its attorneys' fees and expenses and proceeded with the case with its own counsel and settled the claim. The insurer refused to indemnify the insured for the settlement or to reimburse for fees and expenses.

The court agreed with the insurer, holding that under South Carolina law a reservation of rights letter did not trigger a per se conflict of interest, which would allow the insured to choose counsel.

This is an area of law that is quite unsettled in the courts. A leading case in the matter, *San Diego Navy Federal Credit Union v. Cumis Ins. Society, Inc.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (Cal. App. 4th 1984), *superseded by statute* at Cal. Civ. Code § 2860, held that a reservation of rights triggered an automatic conflict of interest, thereby allowing the insured to choose counsel. While *Cumis'* holding later was diluted by case law and statute, other courts have followed *Cumis* to varying degrees. *See, e.g., Golotrade Shipping and Chartering, Inc. v. Travelers Indem. Co.*, 706 F. Supp. 214 (S.D.N.Y. 1989); *CHI of Alaska, Inc. v. Employers Reinsurance Corp.* 844 P.2d 1113 (Alaska 1993).

Other courts have taken the opposite view. *See, e.g., Mutual Service Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365 (Minn. App. 1991) (refusing to adopt the "extreme position" taken by *Cumis*, and instead holding that before an insured may hire independent counsel, an actual conflict of interest, rather than an appearance of a conflict of interest, must be established); *L & S Roofing Supply Co., Inc. v. St. Paul Fire & Marine Ins. Co.*, 521 So.2d 1298 (Ala. 1987) (rejecting *Cumis* as going "too far" and holding instead that a decision to defend under reservation of rights does not raise such a conflict of interest that the insured may hire independent counsel at the expense of insurer, so long as the insurer and defense counsel retained by the insurer meet enhanced obligation of good faith).

This is a difficult area to apply general rules and policies. The reality is that the measure of the conflict is inversely proportional to the strength of the insurer's coverage defenses. An insurer that reserves rights under the view that its coverage defenses are weak has interests generally aligned with the insured. Conversely, an insurer that perceives strong coverage defenses simply is not as invested as the insured in defending and, certainly, settling the case.

A case by case inquiry into the strength of a coverage defense is unworkable. On the other hand, a bright line rule on either side is just as likely to lead to an unfair result as to a fair result. Insureds argue that an insurer is free to avoid the problem by not reserving rights. They conclude that, if the insurer reserves rights, then it seems fair to allow the insured to choose counsel. The insurer must pay for counsel either way, albeit at a reduced rate for its own appointed counsel. So, the potential harm to the insurer is not that great. On the other hand, allowing the insured to choose counsel is an invitation to fraud. *See, e.g., Callahan & Gauntlett v. Dearborn Ins. Co.*, 980 F.2d 736 (9th Cir. 1992) (action arising out of claims that law firm, acting as Cumis counsel for its insureds, engaged in fraudulent billing practices and provision of unnecessary services); *Krasner v. Professionals Prototype I Ins. Co. Ltd.*, 983 F.2d 1076 (9th Cir. 1993) (same).

One solution for the insurer is the "cannibalizing" policy, i.e., where the insured chooses counsel but the cost is deducted from the policy limits. These provisions are common in errors and omissions policies. This solution is far from perfect, particularly with respect to a general commercial liability policy, since the pricing of these competitive policies is driven significantly by allocated loss adjustment expenses.

The industry needs a reasonable way to resolve this problem. Until is does so, the insurer's right to appoint counsel in cases with contested coverage will continue to vary by state.❑

* Lew gratefully acknowledges the assistance of Jeff Douglass in preparing this article.

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.

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to cover mere matters of detail for the implementation of a statute . . . . [However], where the statute itself is lacking in essential substantive provisions the law does not permit a transfer of the power to supply them, for the legislature cannot delegate its power to make a law."

Insurance Federation at *4 citing *Sullivan v. Commonwealth of Pennsylvania, Department of Transportation, Bureau of Driver Licensing*, 708 A.2d 481, 485 (1998).

The court stated that the Pennsylvania Legislature delegated to the Department the authority to approve or reject contracts. However, neither the MVFRL nor the UM Act contained a provision requiring mandatory binding arbitration. Thus, by enacting a regulation which mandated that all UM and UIM coverage disputes be subject to mandatory binding arbitration, the Department exceeded its express and implied authority. The court held that the regulation in question covered more than "mere matters of detail for the implementation of [this] statute" and therefore, the Department overstepped its legislative mandate in requiring mandatory binding arbitration in UM and UIM disputes.❑

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

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of the substance of the training is essential." The guidance acknowledges, however, that an insurer's evaluation of a training program used by producers may be less stringent if the training is provided by another entity that is required to have its own anti-money laundering program, as opposed to a commercial educational service.

Integration of agents and brokers into an insurer's anti-money laundering program also may require that insurers obtain appropriate information from producers when a transaction raises a "red flag" for money laundering. Insurers will need to evaluate how much responsibility for anti-money laundering they want to delegate to producers and under what circumstances they will expect the producer to notify the insurer of suspicious activity so that the insurer may take appropriate action. Insurers will need to notify producers of these expectations and may want to amend their standard producer contract to clarify any new duties.

Finally, the regulations provide that insurers must monitor producers for compliance with their anti-money laundering program. The independent testing required by the rule must include testing of agents and brokers. The appropriate scope and frequency of testing is determined by the insurer's anti-money laundering risk assessment. Insurers should check their standard producer contract to be certain the contract will accommodate this type of testing and amend the contract appropriately if it does not.

Suspicious Activity Reports

At the same time Treasury issued new regulations on anti-money laundering for insurers, it also issued new regulations requiring insurers to file Suspicious Activity Reports under certain circumstances. The regulations on reporting suspicious transactions apply to the same products as the rule for anti-money laundering programs.

After May 2, 2006, an insurer must file a Suspicious Activity Report with Treasury regarding any transaction involving a covered product if the transaction involves or aggregates at least $5,000 in funds or other assets and the company knows, suspects or has reason to suspect that the transaction (or a pattern of transactions of which it is a part):

- Involves funds derived from illegal activity or is intended or conducted to hide or disguise funds or assets derived from illegal activity as part of a plan to violate or evade any federal law or reporting requirement.
- Is designed to evade requirements of the Bank Secrecy Act.
- Has no business or apparent lawful purpose or is not the sort of transaction in which the customer normally would engage, and the company has no reasonable explanation for the transaction.
- Involves use of the company to facilitate criminal activity.

The $5,000 threshold for reporting suspicious activity is triggered by any policy for which the premium or maximum potential payout is $5,000 or more. Treasury has identified certain "red flags" that may indicate suspicious activity, although the list is not intended to be exhaustive.

The regulations place the responsibility for reporting suspicious transactions conducted through an agent or broker on the insurer whose product is involved. Accordingly, insurers must implement policies and procedures reasonably designed to obtain customer-related information necessary to detect suspicious activity from agents and brokers and all other relevant sources.

Generally, an insurer must file a suspicious activity report within 30 days of the date on which the suspicious activity is detected. Companies must maintain a copy of each filed report and a record of any supporting documentation for a period of five years from the date of filing. Certain confidentiality requirements apply to information relating to suspicious activity reports filed with Treasury.

Other Anti-Terror and Financial Crimes Compliance Duties

The new regulations on anti-money laundering and Suspicious Activity Reports do not supplant the existing compliance duties of insurers, agents and brokers relating to anti-terrorism and financial crimes. For example, the federal currency transaction reporting requirements that apply to all insurers, agents and brokers are unaffected, as are the rules enforced by the Treasury Department's Office of Foreign Assets Control that prohibit persons in the U.S. from doing business with certain designated individuals and in certain countries. Finally, insurers that already are subject to anti-money laundering and suspicious activity reporting requirements because they are regulated as securities broker-dealers may comply with the new rules by extending their anti-money laundering programs to the newly covered products. If an existing program is extended in this way, insurers should be certain that it integrates agents and brokers as required by the new regulations.❑

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. He may be contacted at 202.408.0705 or jholahan@mmmlaw.com.

PLAYER'S POINT

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the sympathetic demands of the New Orleans homeless, the refrain is consistent: "We have a Right to Protection."

It is a compelling statement and means different things to different people.

For the New Orleans poor, it means their government let them down in not keeping the water out of the city, and they expect government assistance in rebuilding. For Attorney General Jim Hood, it appears to mean that, notwithstanding clear policy language, he expects the insurance community to be required to provide coverage never contemplated by policy terms, because to do otherwise would be unconscionable to a Right to Protection. Some advocates for a revision of the Federal Flood Program advocate applying flood benefits where no policy or premium exists. Again, relying upon a Right to Protection. Big insurer executives want government backstops to apply at some level to any natural disaster. Real estate markets convinced Congress to extend its Federal backstop for terrorism losses including a mandate to provide a study on how to make the backstop permanent.

In trying to sort out these differing initiatives, I think I have connected the dots. I now see Leo. The image suggests that every constituency is seeking a federal solution to its loss, and the insurance industry is squarely in the middle.

So, is there a "Right to Protection?" Perhaps no right, but certainly an expectation. It also seems the threshold for this expectation is falling lower. We all can understand a right to be protected from our enemies. Thus, the 9-11 response certainly satisfied that Right to Protection. A natural disaster such as Katrina presents difficult gradations of the Right to Protection. Is the Right to Protection different for one who built behind a New Orleans levy which failed, as opposed to one who built on a barrier island which is now gone? But, at some level, most agree that the people of New Orleans have a Right to Protection.

This growing notion that there is a Right to Protection has the industry spooked, and for good reason. Contracts will be bent and broken by juries and judges pressured to accommodate this perceived Right to Protection.

Insurers must be able to define and charge for that portion of the risks they accept. Balancing a public's real or perceived Right to Protection against an insurer's need to limit and underwrite its exposure is certain to produce conflict. Therefore, industry executives are smart to push for a Federal backstop for catastrophes. I suspect they reasoned that if the Right to Protection is to be satisfied, then establish a mechanism to do so prior to a large catastrophe, not piecemeal afterwards. The same rationale was heard in debates concerning the extension of TRIA.

Now that we have seen Leo, where does this lead? It leads to Congress. We need experts advising Congress, not a parade of testimony by current experts who might have been on the job a year or two. Congress will soon be addressing a number of weighty insurance matters with no real pool of dedicated experts. It would be well advised to establish its own think tank.❑

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.

NAIC MOVES FORWARD

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reporting, 2) a statement that management has established effective internal control over financial reporting that provide reasonable assurance regarding the reliability of financial statements, 3) a statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal controls and 4) disclosures of any unremediated material weakness in the internal control over financial reporting.

The Working Group also adopted some important amendments to these requirements. First, companies with less than $500,000,000 in annual premiums are excluded from the Title IV requirements. The Working Group also agreed to eliminate the requirement of for external, independent attestation of an insurer's internal controls thus eliminating the additional costs associated with the independent review. Also adopted were provisions that make it clear that management has the discretion to report either at the enterprise level or at any other level within the holding company framework. Finally the model now includes a more flexible reporting framework and less onerous documentation requirements.

Although approved by the Working Group, the model still must go through several other hurdles at the NAIC. These hurdles combined with the delayed implementation timeframes in model means that it is highly unlikely that compliance will occur before 2009.❑

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

LETTER FROM WASHINGTON

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"Clash of cultures" is at least a useful metaphor to describe the ongoing debate over the regulation of captive insurance companies. Captive insurance has grown from a few offshore entities primarily owned by Fortune 1000 companies to thousands of captives taking various forms domiciled both offshore and onshore.

During the period that the captive movement remained offshore, the only interested governmental authority was the Internal Revenue Service. However, when captives started to spring up onshore in domiciles such as Vermont, United States insurance regulators started to take notice. Because captives are a form of "self insurance," United States regulators adopted a more flexible and, in some cases, lenient form of regulation. After all, insurance provided by the captive was for the benefit of the captive's owner, and a failure should not detrimentally affect third parties. Moreover, any captive was deemed only to be doing business in its state of domicile, which facilitated a more close, "home town" relationship between the regulator and the regulated.

However, the growth of the captive industry produced several interesting results. First, it fostered an increasing number of captive state domiciles. Twenty-four states now have some form of captive law. Second, it stimulated growth in the types of captives, i.e., pure (single parent) captives lead to association captives, which spun off agency captives, which stimulated the creation of "cell" captives. Third, the increase in the number of risk retention groups (now well over two hundred) created the opportunity by federal law for captives domiciled in one state to operate in numerous states without being licensed under the traditional regulatory system.

Some state insurance regulators have been uncomfortable with risk retention groups since 1986 when the Product Liability Risk Retention Act was expanded by Congress to permit risk retention groups to be formed for all lines of commercial liability insurance. The regulatory underpinning of the Liability Risk Retention Act ("LRRA") is the concept of "lead state regulation," which means that the state of domicile of the RRG has unfettered regulatory authority over the RRG, and non-domiciliary states in which it may do business have limited regulatory authority. The LRRA only requires that a RRG make a "notice" filing with another state before doing business in that state, and not be "licensed" in the traditional sense.

This preemption of state law wreaks havoc on a fundamental precept of traditional insurance regulation, which is that each state is sovereign and no insurer can do business in that state without being licensed. The increase in the number of RRGs in recent years has rubbed salt in this wound. Even more problematic to the traditional system is the fact that most RRGs are regulated as captives.

The captive laws of the states vary, although they tend to have many of the same provisions. A common formulation of the captive law is that only the portions of the insurance code referenced in the captive law apply to captives and all others are excluded. This means that many of the requirements imposed upon insurance companies through NAIC Model laws or otherwise do not apply to captives.

Captive regulation tends to be "hands on" by regulators who receive information about their captives through "captive managers," who have the responsibility of informing the regulators if a captive has any regulatory issues. The captive manager is the "eyes and ears" of the insurance regulator and provides more than just financial information on a quarterly basis. This contrasts with conventional insurance regulation, which depends upon the quarterly and annual reports, triennial examinations, and market conduct information to determine the health of an insurer.

Another difference between captive and conventional regulation is that most captives utilize GAAP accounting rather than statutory accounting. While it can be argued that statutory accounting is specifically designed for insurers, GAAP is the form of accounting used by every public corporation in America. Whether one system or the other is preferable is hotly debated.

The NAIC now has a working group and a task force dealing with the regulation of RRGs. Their labors have brought to light the clash of cultures between the captive community and traditional insurers. Every effort is being made to reconcile the two. However, the path has not been smooth. The two cultures approach issues differently, base their conclusions on different premises, and have different visions of the future of insurance regulation.

The outcome is not yet predictable. Stay tuned….❑

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.

SECOND CIRCUIT ADDRESSES PARDI

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Court noted that arbitrators would use this authority to compel testimony and the production of documents at a remote "hearing" sparingly, since it requires the panelists to attend hearings and endure the same inconvenience as the non-party witness. This, of course, is not necessarily true since the panelists are being paid for their time and may not necessarily experience any inconvenience depending upon the forum of the hearing.❑

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.

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
Jessica F. Pardi	404.504.7662	jpardi@mmmlaw.com
L. Chris Petersen	202.408.5147	cpetersen@mmmlaw.com
Thomas A. Player	404.504.7623	tplayer@mmmlaw.com
Anthony C. Roehl	404.495.8477	troehl@mmmlaw.com
Bruce H. Wynn	404.504.7694	bwynn@mmmlaw.com
Kristin B. Zimmerman	404.504.7611	kzimmerman@mmmlaw.com

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