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LETTER FROM WASHINGTON

SPITZER LITIGATION UNDERMINES THE STATE REGULATORY SYSTEM

By Robert H. Myers Jr. and Joseph T. Holahan

The litigation brought by New York Attorney General Eliot Spitzer, and his counterparts in other states, has had the beneficial effect of rooting out "bid rigging" among brokers and "steering" of business to favored insurers. As much as $1 billion in fines and compensatory payments have, or will be, paid to remedy this illegal behavior.

Unfortunately, the lack of restraint shown by some attorneys general will produce results that are detrimental to the insurance industry as a whole and some of its participants in particular. The power and expense of litigation brought by a state attorney general does not result in the compromise and

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HASSETT'S OBJECTIONS

ALIEN VERSUS PREDATOR VERSUS ROBOCOP

By Lewis E. Hassett

The Mississippi coast remains a disaster from Hurricane Katrina. Debris sits, and rebuilding proceeds slowly. Efforts are complicated by a lack of sufficient housing. Residents are leaving, and employers are closing. FEMA's response and "Brownie's great job" are well-known and need not be critiqued further here.

Against this backdrop, three protagonists are ready to brawl. In one corner are the policyholders, their attorneys and Mississippi Attorney General Jim Hood. Using adverse publicity, a bully pulpit and litigation, they have attempted to pressure insurers into covering flood damage. Their legal arguments have been that the flood exclusions are void and unenforceable or, alternatively, that a "storm surge" is not a "flood." Their efforts have not succeeded. The

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PLAYER'S POINT

LIFE SETTLEMENT TRAIN ROLLS ON NAIC COMMITTEE UNANIMOUS

By Thomas A. Player

You may recall from my last Player's Point (Winter 2006) that I put forward what I thought was a well-reasoned, cogent plea not to change the NAIC Viatical Settlements Model Act to limit the assignability of life insurance products beyond the incontestable period (**two years**). On December 10, 2006, the NAIC Committee on Life and Health ("A" Committee) unanimously, without discussion, decided to extend the ban to **five years**[1]. At the very least there should have been a whistle or maybe warning lights.

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Announcements

The firm is pleased to announce that **John D. Hadden** has joined the firm's Insurance and Reinsurance Dispute Resolution Group. Prior to joining the firm, John was an associate with the Atlanta firm of Carter & Ansley LLP, focusing on a broad range of insurance matters. John received his B.A. from Emory University and his J.D. from the University of Georgia School of Law, where he served as Notes Editor of the *Georgia Law Review*.

Lew Hassett will co-chair Mealey's "Fundamentals of Reinsurance Conference" in New Orleans on March 15 and 16, 2007. **Jessica Pardi** will be speaking on "Key Phases of the Arbitration Process" and **Larry Kunin** on "Discovery Battles: What Every Reinsurance Practitioner Needs to Know." For more information, please go to www.mealeys.com.

Joe Holahan's article, "Designing A Complaint Wellness Program," was presented February 22, 2007, at a symposium on "Health & Productivity Management" sponsored by Wachovia Insurance Services. The article addresses new standards for complaint wellness programs issued jointly by the Department of Labor and Department of Health and Human Services in December 2006. For a copy of the article, please contact Mr. Holahan at 202-408-0705 or jholahan@mmmlaw.com.

Chris Petersen will be speaking at the Delta Dental Plans Association Public Policy Conference. Mr. Petersen will be discussing NAIC activities relating to dental insurance. Mr. Petersen will also be moderating a panel discussion on state access proposals and the optional federal charter. The panel will explore the impact of these proposals on health insurance generally and their impact specifically on dental insurance.

Lew Hassett, **Natalie Suhl** and **Orlando Ojeda**, representing a non-standard automobile insurance managing general agency and an affiliated third-party administrator, prevailed on the insurer's motion to compel arbitration of disputes relating to claims administration. *Lincoln General Insurance Company v. Access Claims Administrators, Inc., et al.*, Civil Action No. 05-MC-201 (E.D. Pa., February 13, 2007). The court agreed with the MMM team that the arbitration clause in the MGA Agreement did not bind the affiliated third-party administrator and also rejected the insurer's attacks on the affiliate's corporate veils as a basis to force arbitration.

TENTH CIRCUIT EXAMINES THE RELATIONSHIP BETWEEN AN ERISA FIDUCIARY'S GENERAL BUSINESS DUTIES AND DUTIES OWED AS A FIDUCIARY OF A BENEFIT PLAN

By Orlando P. Ojeda, Jr.

In *Holdeman v. Devine*, Case No. 05-4302 (10th Cir., January 17, 2007), the Tenth Circuit held that an officer of an employer that serves both as an ERISA benefit plan's fiduciary and as an operational manager of the company must act in only one role at a time. Although actions taken while in a non-fiduciary role will not subject the officer to liability for breach of the officer's fiduciary duties, an officer's inaction as the plan's fiduciary could result in a breach of those fiduciary duties. Analyzing its holding in *In re Luna*, 406 F.3d 1192 (10th Cir. 2005), the court recognized the sometimes opposing roles an officer faces while making general business and operational decisions compared to the decisions made as an employee benefit plan fiduciary. Holdeman explained that because virtually every business decision made by an officer can have an impact on an employee benefit plan, a court must examine the conduct at issue and determine if it constituted management or administration of the plan or if the conduct was simply a business decision that had an effect on an ERISA plan. The latter is not subject to fiduciary duties. Citing *Pegram v. Herdich*, 530 U.S. 211, 226 (2000), *Holdeman* recognized the threshold question in an action for breach of a fiduciary duty is whether the alleged fiduciary was acting as a fiduciary when taking the action alleged by the complaint. Though *Holdeman* found the affirmative actions taken by the CEO did not breach his fiduciary duties to benefit plan, the court remanded whether actions the CEO allegedly failed to take in his role as plan fiduciary would support an ERISA claim.

In 2002, Terrance D. Holdeman, as a class representative of a group of employees of the State Line Hotel and Silver Smith Casino, filed the underlying action against various officers and directors of State Line, including Michael Devine, and asserted claims under ERISA, including breach of fiduciary duties. At issue was the alleged under-funding of State Line's Employee Benefits Plan (the "Plan"). State Line's eventual bankruptcy left more than $970,000 in unpaid medical claims. The court found that when Devine joined State Line he was aware of funding problems with the Plan and after becoming CEO in 2000, he began focusing on increasing State Line's income to pay all expenses including medical expenses. Under Devine, State Line doubled its cash flow and began paying down the arrearages in unpaid medical claims, but Devine also approved distributions beyond just salaries to State Line's owners, which totaled approximately $1,245,000.

Plaintiff claimed that the Defendants breached their fiduciary duties by making these and other distributions, while the Plan remained under funded. The district court granted summary judgment in favor of all of the defendants except Devine and concluded that the evidence established that Devine was the

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DISCOVERY ALLOWED AGAINST REINSURER ON SIMILAR CLAIMS

By Natalie C. Suhl

In a recent decision in the United States District Court for the Southern District of New York, a federal magistrate ordered a reinsurer to produce documents relating to two allegedly similar lawsuits. *Zurich American Insurance Co. v. Ace American Reinsurance Co.*, No. 05 Civ. 9170 (Dec. 22, 2006) Zurich, the cedant, contended that R&Q breached its obligation to pay its share of a settlement reached by Zurich with its insured. Whether R&Q breached its contractual obligations to Zurich turned upon whether R&Q failed to "follow the fortunes" or "follow the settlements" of its cedant. Zurich moved the Court to compel R&Q to produce documents relating to two similar lawsuits, as well as documents relating to any claims denied by R&Q based upon a cedant's allocations. R&Q argued that it was burdensome to meet such a request because its computer system could not segregate in that manner.

The Court held that R&Q's handling of similar claims may reveal the meanings the parties ascribed to terms in the policies at issue. Specifically, the court stated that inconsistencies in the defendant's interpretation of contract terms would be relevant to a determination of the actual meaning of those terms. The court also noted "R&Q's handling of other claims where the allocation of limits was at issue can provide evidence of how it has interpreted its' obligation to follow the settlements of its cedent in similar circumstances."

The Court held that a "sophisticated reinsurer that operates a multimillion dollar business is entitled to little sympathy for utilizing an opaque data storage system." The court directed that the parties propose a protocol for sampling the R&Q's claim files to obtain examples of claims files in which issues of the allocation of policy limits has been addressed. If R&Q objects to any of Zurich's proposals it must provide specific evidence of cost and burden to support its objections. ❑

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

Announcements

Skip Myers will be teaching Risk Retention Groups 101 at the Captive Insurance Companies Association (CICA) conference in Tucson, Arizona on March 11.

Tom Player is to participate in the **Fifth Annual Hill Country Charity Classic & Regulatory Roundup**, an annual affair sponsored by Billy Hill and Great American Senior Benefits Group which raises funds for the March of Dimes.

Joe Cregan recently participated in the Annual State Issues Conference for America's Health Insurance Plans ("AHIP") in Phoenix Arizona. This is an annual gathering of the AHIP staff and local counsel from around the country.

Chris Petersen was a roundtable presenter at the Professional Insurance Marketing Association's annual meeting. Mr. Petersen discussed recent regulatory, legislative and litigation activities impacting association business. Mr. Petersen also discussed the proposed changes to the National Association of Insurance Commissioner's group model act and strategies for insurers and associations to comply with the proposed changes.

Jessica Pardi has recently been accepted for membership in GlobalEXECWomen, a leadership forum for female executives.

Lew Hassett, **Bob Alpert** and **Jeff Douglass** served as co-counsel for a developer in a Katrina related suit. The court recently granted the developer's motion for partial summary judgment. *DEL Property Management, Inc. et al. v. Underwriter's at Lloyd's, London*, Civil Action No. 1:06CV186 (S.D. Miss. 2006).

Skip Myers will be speaking at the Arizona Captive Insurance Association Annual Conference on May 16 in Phoenix on "Little Known Ways to Use Captives."

Lew Hassett, **Natalie Suhl** and **Orlando Ojeda** obtained a favorable settlement in a confidential arbitration involving personal accident business. They represented the ceding company, a national health insurer.

Joe Cregan, **Dick Dorsey** and **Kristin Zimmerman** are again this year handling a number of legislative matters for MMM clients with business at the Georgia General Assembly. At press time, the Georgia Legislature was just half way past its allotted 40 day session, and our lobbying trio reports that there are still a number of insurance-related and judiciary reforms that have yet to pass either Chamber, so it appears that these efforts will "go down to the wire" in terms of passage or failure.

OUT-OF-STATE REINSURER REQUIRED TO POST COLLATERAL BEFORE LITIGATING IN CONNECTICUT

By John D. Hadden

A federal district court in Connecticut recently ruled that a reinsurer without authority to engage in business in the state must post collateral with the court prior to defending a lawsuit. Otherwise, its pleadings may be stricken. The court also denied the reinsurer's motion to dismiss the case for lack of federal subject-matter jurisdiction and for lack of standing on the part of the plaintiff. *Security Insurance Company of Hartford v. Universal Reinsurance Company Ltd.*, 3:06cv158 (D. Conn., January 26, 2007).

Security Insurance Company's predecessor, The Fire and Casualty Insurance Company of Connecticut ("Fire & Casualty"), entered into a "Quota Share Treaty Reinsurance Agreement" with Universal Reinsurance Company Ltd ("Universal"). Under the terms of the agreement, Fire & Casualty ceded to Universal 100 percent of the first $100,000 of its net liability up to the greater of $1,000,000 or 80.4 percent of its gross written premium. The contract also required Universal to post collateral in the amount of the difference between a "loss fund" and the greater of $1,000,000 or 80.4 percent of the gross written premium. Security Insurance Company filed suit alleging that the collateral owed by Universal was deficient by $111,186. Universal answered and moved to dismiss and for summary judgment, alleging that Security Insurance Company had failed to prove that the amount in controversy was sufficient under the federal diversity statute and that Security Insurance Company lacked standing to file the action. Security Insurance Company responded by moving to strike Universal's answer and motions, because Universal had failed to comply with Connecticut law requiring insurers not authorized to conduct business in the state to post collateral before participating in litigation.

In its decision, the court first considered the motion to strike Universal's pleadings. Under Connecticut General Statute § 38a-27, "unauthorized insurers" are required to post collateral before filing any pleadings. An unauthorized insurer is defined by Connecticut General Statute § 38a-1 as an insurer that has not been granted a certificate of authority by the insurance commissioner to transact the business of insurance in Connecticut, and Universal did not contest its status as such. Instead, it argued that it was statutorily exempt from the requirement, claiming that it was not acting as a reinsurer for Fire & Casualty but was rather acting only as a "rent-a-captive" company without accepting any liability or risk under the contract. In rejecting this argument, the court recited the relevant statute defining insurers, Connecticut General Statute § 38a-271, and concluded that Universal met that definition, because its contract with Fire & Casualty was one of reinsurance and Universal received a fee pursuant to that contract. The court further rejected Universal's argument that the requirement to post collateral did not apply to insurers providing only out-of-state coverage, holding that the reinsurance agreement did in fact provide coverage in Connecticut. Finally, the court rejected Universal's contention that the statute did not apply to reinsurers, noting that such an exception appears nowhere in Connecticut's insurance statutes. The court thus required Universal to post collateral in the amount of $111,186 and stated that if it failed to do so, its pleadings would be stricken.

Having declined to strike Universal's pleadings, the court then considered Universal's motion to dismiss for lack of federal subject-matter jurisdiction, based on the contention that Security Insurance Company had not demonstrated that the amount in controversy exceeded $75,000. Two factors are relevant. First, courts apply the "legal certainty" test, which provides that where it appears to a legal certainty that the amount at issue is less than the jurisdictional minimum, the case should be dismissed. *See Hough v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 757 F. Supp 283 (S.D.N.Y. 1991). Second, where the legal certainty test does not require dismissal, a party attempting to invoke such jurisdiction must prove to a reasonable probability that the amount in controversy requirement will be met. *See Chase Manhattan Bank, N.A. v. Am. Nat'l Bank and Trust Co. of Chicago*, 93 F.3d 1064 (2d Cir. 1996). In reviewing the propriety of diversity jurisdiction, federal courts look to the substance of the plaintiff's allegations, rather than the merits of the case; defensive pleadings are not considered. *See Zacharia v. Harbor Island Spa, Inc.*, 684 F.2d 199 (2d Cir. 1982).

Looking to the face of the complaint, the court concluded that Security Insurance Company's allegations appeared to a reasonable probability to satisfy the jurisdictional minimum for the amount in controversy, and denied defendant's motion to dismiss. Universal also moved to dismiss the complaint based on the argument that Fire & Casualty, and not Security Insurance Company, had entered into the contract so that the plaintiff lacked standing to file suit. Denying the motion on this alternative basis, the court found that the Security Insurance Company had standing as a successor in interest to Fire & Casualty. ❑

John D. Hadden is an associate in the firm's corporate and commercial litigation group where he focuses his practice on insurance and reinsurance dispute resolution. He received his bachelor's degree from Emory University and his law degree, cum laude, from the University of Georgia.

MMM Announces New Exempt Organizations Practice Group

The new Exempt Organizations or "EXOG" Group focuses on the unique legal needs of nonprofit and charitable organizations. The members of the new EXOG Group are drawn from all major areas of the Firm's practice: Tax, General Corporate, Real Estate, Litigation, and Healthcare, and Technology. With an interdisciplinary approach, the attorney's in the Firm's EXOG Group are well-equipped to handle the diverse legal needs of all types of nonprofit and charitable organizations.

For more information, please contact Cassady V. Brewer at 404.504.7627

PRESERVING CONFIDENTIALITY WHEN COMMUNICATING WITH AGENTS AND BROKERS

By John Williamson

Insurers regularly communicate with independent agents and brokers about litigation brought by the insured. Are those communications confidential? The answer, as is often the case, depends on the facts.

As an initial matter, communications between the insurer and its agents and brokers may be protected from discovery in litigation by either the attorney-client privilege or the work product doctrine (and these protections may overlap). While even courts sometimes confuse these two protections, they are different in purpose, scope, and application, so it is important to understand the differences.

The Attorney-Client Privilege

In general, the attorney-client privilege attaches to communications between a client and an attorney made for the purpose of obtaining or giving legal advice. There are two key points here. First (and the focus of this note), for purposes of determining whether the privilege applies, the client and the attorney can each communicate through third parties without waiving the privilege – provided those third parties are reasonably necessary to facilitate the obtaining or giving of legal advice. *See generally* Edna S. Epstein, The Attorney-client Privilege And The Work-product Doctrine, P. 134-150 (American Bar Association 4th ed. 2001& Supp.). Second, the privilege will not apply in the first instance to routine business communications not involving legal advice. Thus, for example, where an attorney functions as a claim adjuster, the privilege does not apply. *See, e.g., First Aviation Servs., Inc. v. Gulf Ins. Co.*, 205 F.R.D. 65 (D. Conn. 2001); *Amerisure Ins. Co. v. Laserage Tech. Corp.*, 1998 WL 310750, *1, 11 (W.D.N.Y. Feb. 12, 1998).

The Work Product Doctrine

The work product doctrine protects from disclosure documents and other tangible things prepared in anticipation of litigation by or for a party, or that party's representative. *See* Fed. R. Civ. P. 26(b)(3). There are several important points here. First, for the doctrine to apply, the document or thing must have been prepared in anticipation of litigation. Thus, for example, documents prepared in the routine course of business will not qualify as work product. Second, while the doctrine is often called the "*attorney* work product doctrine," that label is something of a misnomer because the doctrine also applies to materials prepared "by or for" a party, or the party's representative. Third, unlike communications protected by the attorney-client privilege, which are generally immune from discovery, a court may compel the production of work product materials upon a showing a special need. *Id.* Fourth, work product protection is less easily waived than the attorney-client privilege. While disclosure of attorney-client communications to third parties generally waives the privilege, most courts hold that disclosure of work product materials to third parties does not necessarily waive the protection unless the disclosure is to an adversary. *See, e.g., McKesson HBOC v. Adler*, 254 Ga. App. 419 (2002); *McKesson Corp. v. Green*, 279 Ga. 95 (2005).

Agents, Brokers, and other Third-Parties

The general rule is that attorney-client privileged information may be communicated to (or by) employees or agents (in the generic sense) without waiver of the privilege, provided there is a need to share the privileged information with them. *See, e.g., In re: Copper Market Antitrust Litig.*, 200 F.R.D. 213 (S.D.N.Y. 2001); *Bank Brussels Lambert v. Credit Lyonnais (Suisse), S.A.*, 160 F.R.D. 437 (S.D.N.Y. 1995). This general rule also applies to independent third-parties, but courts will closely scrutinize such disclosures and the proponent of the privilege should expect to have to justify the need for the disclosure. *See, e.g., Energy Capital Corp. v. United States*, 45 Fed. Cl. 481 (Fed. Cl. Ct. 2000).

Safeguard Lighting Systems, Inc. v. North American Specialty Ins., 2004 WL 3037974, at *1-2 (E.D. Pa. Dec. 30, 2004), is a good illustration of the application of the privilege in an insurer-insured dispute. In that case, the insured, Safeguard, sought to compel the production of reports prepared by an outside claims adjuster for the insurer, NAS. The court noted that NAS had previously produced the portions of the reports that reflected the "ordinary course of business in the evaluation, analysis and adjustment of the claim." The court denied Safeguard's motion to compel the remaining portions of the report, which reflected the adjuster's communications with NSA's outside counsel. The court ruled that NSA had hired the adjuster to take over the complex adjustment of the loss and made the adjuster its agent authorized to act on its behalf with respect to the adjustment. Thus, the adjuster's communications with counsel were protected from disclosure. *Id.*

Sauce for the goose is sauce for the gander, and the same rule also applies to the insured's agents. For example, in *Allianz Underwriters, Inc. v. Rusty Jones, Inc.*, 1986 WL 6950 (N.D. Ill. June 12, 1986), Allianz moved to compel the production of two documents that reflected attorney-client communications between RJI and its outside counsel. One document was a letter from an RJI executive to outside counsel that RJI also sent to the broker, and the other was notes of a conference call among RBI, outside counsel, and the broker. The court denied the motion to compel, ruling that because the broker had been substantially involved in negotiating and administering the policies at issue, and because RBI relied on the broker for insurance expertise, the broker acted as RBI's agent in obtaining and receiving legal advice about the policies. *Id.* Similarly, in *Amtel Corp. v. St. Paul Fire & Marine Ins. Co.*, 409 F. Supp. 2d 1180 (N.D. Cal. 2005). St. Paul moved to compel the production of attorney-client privileged materials that its insured, Amtel, had given to its broker, arguing that insurance brokers are independent contractors and do not act as agents for either the insurer or insured. The court quickly rejected that argument, noting that Amtel's broker and negotiated the polices at issue, and thereafter served as a "necessary advisor" to Amtel on coverage and claim

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insurers have stood firm, asking federal courts in Mississippi to enforce policy language as written and have had some success. The leading federal judge in these cases is L.T. Senter, Jr. of the Southern District of Mississippi. Judge Senter has now become something of a protagonist himself. Let us first review some of Judge Senter's recent decisions.

In *Leonard v. Nationwide Mutual Ins. Co.*, 438 F. Supp. 2d 684 (S.D. Miss. August 15, 2006), Judge Senter held that a storm surge is a specie of "flood" and, therefore, is excluded from coverage under a typical homeowner's policy. Judge Senter also held that, anti-concurrent loss clause notwithstanding, actual losses from wind must be covered even if the property also sustained flood damage. The finder of fact would identify and value losses caused by wind versus flood. This decision was consistent with Mississippi law and kept a broadly worded concurrent cause clause from eviscerating coverage in the policy.

The practical result is that a jury (judge in a bench trial) must allocate wind loss and flood loss. Given the wide range of expert opinions available on the subject, insurers took limited comfort from his decision. However, Judge Senter acted as the trier of fact in the *Leonard* case and found that only slightly over $1,000 in damage was caused by wind.

In *Sima/Signature Lake, L.P. v. Certain Underwriters at Lloyd's London*, Case No. 1:06CV186 (S.D. Miss. December 6, 2006), a commercial real estate developer had separate wind and flood policies. After the developer recovered the limits under the flood policies, it demanded payment under the wind policies. The insurer argued that, under the wind policies' proration clause, the developer's losses must be prorated based on the limits of the respective policies. In granting the developer's motions for partial summary judgment, Judge Senter rejected the insurer's proration argument, holding that the jury was free to determine the value of the losses caused by wind, except (a) that the developer could not obtain a duplicative recovery and (b) that the property values on the developer's insurance applications would be admissible, but not dispositive, evidence of the total value of loss. [FULL DISCLOSURE: THIS LAW FIRM REPRESENTED THE DEVELOPER IN THAT CASE].

This part of Judge Senter's legal approach makes sense. He has upheld the flood exclusion and rejected fictitious distinctions between "flood," on the one hand, and "storm surge," on the other. Conversely, he has refused to allow an insurer to seize upon a smidget of flood damage to avoid any liability for wind damage. The danger in Judge Senter's approach is that, given the vagaries of expert witness testimony, a jury may be swayed by sympathy rather than focus on the causation inquiry. Strict control by the trial judge is necessary to avoid this problem.

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On the other hand, Judge Senter recently upheld a jury's punitive award against State Farm, albeit reducing it to $1 million, finding that State Farm had acted in a grossly negligent way in adjusting a homeowner's claim. *Broussard v. State Farm Fire and Casualty Co.*, Case No. 1:06cv6 (S.D.Miss., January 31, 2007). According to Judge Senter, State Farm impermissibly placed the burden on the policyholder to prove the amount of damage properly apportioned to wind. The decision is troubling, since the anti-concurrent clause issue has not yet been decided by an appellate court. (That issue is now before the Fifth Circuit). In any event, regardless of the merits of Judge Senter's decision, it is unlikely to comfort insurers ensnared in federal court in Mississippi.

While enjoying limited success in the courts, Mr. Hood and policyholder counsel have used the media in an attempt to embarrass and shame insurers into covering flood damage. Thus far, insurers have resisted these efforts. As stated by Robert P. Hartwig of the Information Institute, "Fundamentally, what is happening is that insurers are being forced to pay hundreds of millions, if not ultimately billions, in excluded flood losses – a type of loss for which insurers have never collected a penny in premiums."

In an effort to resolve these issues, State Farm and attorney Richard Scruggs (on behalf of his clients) submitted to Judge Senter a request for class certification and a proposed class settlement. The proposed settlement included the following:

1. A minimal $50 million settlement fund;
2. A minimum payment to those policyholders with only a slab remaining of their improvements, but no minimum payment to those with lesser damage;
3. Binding arbitration of disputed claims before arbitrators paid by State Farm, with the length of the hearing not to exceed two hours and with no right of appeal;
4. A cap equal to the difference between the policy limit under the wind policy and amounts collected under a flood policy;
5. Release of State Farm and all its agents and representatives; and
6. A payment of $10 million or $20 million to the class attorneys.

Judge Senter denied the request to approve the settlement, holding that he did not see the settlement as beneficial to policyholders. He specifically cited the following:

1. The court could not determine the fairness of the $50 million fund, because the parties did not show the total number of class claims or how thinly the fund would be spread among class members;

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2. The court was not comfortable that class counsel had earned the minimum $10 million fee;
3. Limiting State Farm's liability to the difference between the policy's limits and any flood recovery abrogated the policyholder's legal rights without any compensation. *See Sima/Signature Lake, supra;*
5. The arbitration process did not appear fair or to require compliance with past court decisions. "I will certainly never approve of any procedure that does not honor the decisions of both state and federal courts on relevant points of law;" and
6. The opt-out process was so convoluted as to stifle opt-outs.

In a letter to counsel in all Katrina cases, dated February 2, 2007, he explained his rejection and requested ideas. He noted that 150 cases were set for trial in 2007 and that other judges could assist in trying the cases.

Mr. Hood, who previously lauded the proposed settlement, then distanced himself: "Our office did not negotiate the terms of the proposed federal court class action. In fact, our office had reservations about some of the terms of the class agreed to by plaintiffs and State Farm."

On February 14, 2007, State Farm announced that it would not write new policies in Mississippi, citing the uncertainty engendered by massive litigation. State Farm stated that Mississippi's "current legal and political environment is simply untenable. We're just not in a position to accept any additional risk in this homeowners' market."

In a remarkable litigation tactic, plaintiffs' counsel also criticized Judge Senter, expressing regret that State Farm would not write new policies for homeowners, adding that "the [t]he balanced settlement we presented to Judge Senter could have prevented this and started sizable checks flowing to thousands of Mississippi Gulf Coast families by summer. At this point in time, the Judge chose to block the agreement." Mr. Scruggs also attacked State Farm: "State Farm's extreme reaction could surely hinder the Coasts' recovery and jeopardize new home mortgages throughout Mississippi . . . Our legal team will continue to pursue this balanced resolution to head off an all-out economic war for out state. It's time for everyone to take a deep breath and think through the consequences of their actions." His sensible sentiments apply at least as forcefully to him and the homeowners' assault team as to State Farm.

In a subsequent statement on February 16, 2007, Mr. Hood decried State Farm's alleged "bullying tactics" and proposed legislation to force State Farm to write new homeowner's policies. He characterized his proposal as looking the "robber barons in the face."

In a response, State Farm cited Mr. Hood's statement and proposal as illustrating "the legal and political challenge we face in Mississippi." Governor Haley Barbour declined Mr. Hood's suggestion that Mr. Hood's proposal be enacted by executive order pending legislative action. "I have no authority to force a private company to sell its products in the state of Mississippi," said Mr. Barbour. Governor Barbour previously has criticized Mr. Hood's lawsuits against insurers.

In a welcome display of deliberation, Mississippi's Insurance Department reacted cautiously to Mr. Hood's proposal, noting that Florida had passed similar legislation and that "we're seeing [insurance] companies leave Florida daily." "We must proceed cautiously and not jeopardize an already fragile insurance market."

State Farm also has attacked the judicial system more directly by filing a separate suit seeking to disqualify a law clerk for Judge Senter from hearing any more Katrina damage suits against State Farm. State Farm alleges that, because the clerk had brought a Katrina-related lawsuit against Allstate (later settled), he appeared to have a bias against insurers generally in Katrina cases. According to State Farm, the clerk unduly influenced Judge Senter in his rulings in the *Broussard* case.

The efficacy of State Farm's strategy is debatable. Even if State Farm's attack on the law clerk is successful, Judge Senter himself would not necessarily be disqualified from hearing State Farm cases. At press time, State Farm's seperate motion to disqualify Judge Senter had been denied.

My column previously has railed against class action settlements that benefit primarily the lawyers and has lauded judges that block such settlements. Judge Senter is determined that a settlement benefit more than the attorneys. On the other hand, State Farm is understandably skeptical as to whether it will receive impartial trials in coastal Mississippi. The *Broussard* decision seems to have opened the punitive floodgates.

Much remains uncertain. It is unclear whether the settlement can be structured in a way to satisfy Mr. Scruggs, State Farm and Judge Senter. ❑

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.

PLAYER'S POINT
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In order to understand the remainder of this article, you will need a Glossary of Terms.

Glossary of Terms

- McCarran-Ferguson Act. One of the few times Congress has chosen not to expand federal power, ceding to the states the authority to regulate the business of insurance.
- NAIC. A group of state insurance regulators that assist the states in knowing what laws to pass in this complex world of insurance.
- Model Act. The way in which the NAIC signals to the state legislators that this is our reasoned consensus on the best solution to a legislative problem.
- NCOIL. Those legislators who lead the states in insurance legislation.

With this background, it is difficult to understand how the Viatical Settlements Model fits in. A fundamental property right is being abridged basically at the urging of a single regulator: Jim Poolman of North Dakota. Mr. Poolman suggested the five-year limitation. Mr. Poolman drafted the initial amendment, and he sorted through comments to the A Committee and came up with the final language. Where is the reasoned debate? Where is the consensus? During the course of consideration by the Committee, there was no mention by Committee members, at least publicly, of any of the following points:

- That the five-year ban may cause a hardship on national and state banks in that it erodes the value of collateral.
- Many insurance companies don't believe the value of their bread and butter product should be summarily reduced.
- Almost all current policyholders will cry foul about the loss of value and flexibility as to the product they bought.
- Future policyholders will be seriously penalized when circumstances change (like Congress changing the Death Tax).
- The problem can be addressed by limiting non-recourse financing within constraints of the Federal banking laws, while not limiting the transferability of a fundamental property right.
- The problem is being currently solved in the market place by lawsuits seeking to rescind policies abusing insurable interest laws, and by insurer inquiries which limit the issuance of policies and winnow out opportunistic agents. These activities have chilled investor interest in financed policies.

The A Committee leadership has been restructured, replacing Commissioner Poolman with Julie McPeak of Kentucky as Chairman and Tim Wagner of Nebraska as Vice Chairman. However, the A Committee might not review the Viatical Settlements Model Act because it has been passed on to the Executive Committee of the NAIC for approval. We urge the Executive Committee to see the need for more deliberation and understand the gravity of the five-year ban on a fundamental property right. In the alternative, we would urge NCOIL to carefully examine the NAIC Viatical Settlements Model Act as it emerges from the NAIC to determine if NCOIL might wish to create its own model. ❑

Endnotes
[1]See MMM Client Advisory, NAIC Life Insurance and Annuities (A) Committee Adopts Changes to Viatical Settlements Model Act (December 2006), available on the MMM website at www.mmmlaw.com.

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MMM Announces New Green Industries Practice Group

The Firm has formed a new legal group that will focus on serving businesses in "green industries" including renewable energy, clean technology and green building and development , focusing in particular on serving green businesses in the areas of capital formation, tax structuring, financing, patent and trademark, technology licensing and distribution, government contracting and sustainable development.

"We have been representing an increasing number of green businesses across a number of existing groups within the firm, due to the explosive growth of these businesses and their varied legal needs," said Bruce Wobeck, the Chair of the new group. "Our Green Business Group can better serve these clients by focusing our efforts and expertise in a coordinated and cohesive manner on relevant legal issues," he added. "The combination of global warming, pollution, depletion of traditional energy resources, and threats to the security of these energy resources present great challenges for our country and the world. We are facilitating the efforts of those companies and individuals who are developing and implementing solutions for these challenges by delivering the legal expertise they need to succeed in those efforts."

"Responsible businesses are developing new products and technologies to help preserve the environment," said John Yates, Chair of the firm's Technology Group. "We believe it's important to serve the growth of these businesses and the new venture funds and private equity investors that are financing green initiatives."

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TENTH CIRCUIT EXAMINES THE RELATIONSHIP

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Plan's fiduciary, which left issues regarding the extent of Devine's fiduciary duty and whether he breached those duties. On October 31, 2005, after a bench trial, the district court concluded that Devine did not breach his fiduciary duties and granted judgment in favor of Devine, which Plaintiff appealed.

The Tenth Circuit began its analysis by reviewing the facts and holding in *Luna*. In *Luna*, the court examined the decisions made by the two shareholders and managers of the company to use the limited funds available to pay other business expenses rather than make contributions to the employee benefit plans. *Luna* recognized that the shareholders attempted to keep the business afloat and, although the decisions to pay operation expenses instead of contributing to the plans had a detrimental impact on the funds, the court failed to impute fiduciary status and liability to the shareholders. *Holdeman* held that the district court properly applied *Luna* and *Pegram* when it concluded that Devine was acting as CEO when he made all the allocation-of-funding decisions, including the distributions to State Line's owners, and, therefore, Devine did not breach any fiduciary duties to the Plan through those disbursements and other payments.

Though the Tenth Circuit recognized that Devine had no funding allocation authority in his role as the Plan fiduciary, but rather only possessed such authority as State Line's CEO, the court found that there remained additional allegations relating to Devine's breach of his fiduciary duties, which remained undecided. *Holdeman* found that the district court failed to examine and rule on four allegations raised by Plaintiff relating to actions Devine failed to take as fiduciary of the Plan. Specifically, Plaintiff claimed Devine should have resigned as Plan fiduciary, informed the Plan's beneficiaries of the status and uncertainty of the Plan, retained outside counsel for the Plan, and should have threatened or sued on behalf of the Plan to collect unpaid contributions. The Tenth Circuit recognized these claims and remanded the remaining allegations to the district court for further proceedings.

Under *Holdeman*, *Luna* and *Pegram* remain the litmus test for adjudging an employer's operational actions and decisions as compared to the employer's duties as an employment benefit plan fiduciary, but a court must also fully examine other claims alleging an employer's failure to act as a plan's fiduciary. *Holdeman* explains that a fiduciary of a benefit plan who is serving the Company in two roles must act in only one role at a time, and though actions taken while in a non-fiduciary role will not subject an employer to liability for breach of the employer's fiduciary duties, an employer's inaction as the plan's fiduciary could result in a breach of the fiduciary duties owed a benefit plan under ERISA. ❑

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PRESERVING CONFIDENTIALITY

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issues. Accordingly, the court ruled that "[g]iven the relationship between [the broker] and Amtel, the attorney-client privilege was not waived because [the broker] was present to further Amtel's interests and disclosure to [the broker] was reasonably necessary to provide information to the insurers." *Id.* While *Allianz* and *Amtel* involve disclosures of privileged information to third parties related to insureds, the rational of those cases is equally applicable to insurers.

As noted above, because work product protection in less easily waived than the attorney-client privilege, courts generally deny motions to compel the production of work product that an insurer or insured discloses to a third party – but courts will carefully examine whether the materials constitute work product in the first instance. For example, in *Spirco Environmental, Inc. v. American Int'l Specialty Lines Ins. Co.*, *Id.*, Spirco moved to compel the production of its insurer's reserve estimates. While setting reserves may in many instances be a routine business activity, the court noted that because the reserve reflected the opinion of the insurer's agent regarding the insurer's liability in potential litigation and, moreover, went to the issue of coverage, the reserve information constituted work product. Accordingly, the court denied Spirco's motion to compel absent a showing of substantial need. *Id.*

A last word of caution

Whether the attorney-client privilege or the work product doctrine apply, and whether their protections are waived by the involvement of third parties, is highly fact specific and will turn on the circumstances of the particular case. Additionally, privilege issues are particularly fluid and the rules vary from jurisdiction to jurisdiction. Lastly, because of the confusion even among lawyers and judges about the differences between the attorney-client privilege and the work product doctrine, case law is often muddled, inconsistent, or apparently wrong. *See, e.g., Cigna Ins. Co. v. Cooper Tires and Rubber, Inc.*, 2001 U.S.Dist LEXIS 7546 (N.D. Ohio May 24, 2001) (while recognizing that an investigative report prepared for the insurer constituted work product, the court found the protect waived when the insurer gave the report to its broker because, the court ruled, "the 'common interest' extension of the attorney client privilege should not be applied in this case to this report"). For these reasons, insurers and their counsel need to take particular care when involving third parties in confidential matters, and be particularly thorough when briefing responses to motions to compel, taking care to explain sometimes fine distinctions to the court. ❑

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nuance that is generally the product of the legislative process. The result can be that innocent parties are injured in the rush to punish the guilty. Moreover, the balance of power between the legislative, executive and judicial branches of the state governments can become unhinged.

The insurance brokerage antitrust litigation in the U.S. District Court in New Jersey (CA No. 04-5184) (FSH) is a good example. [Full disclosure: MMM represented the National Association of Professional Insurance Agents as *amicus curiae* in this litigation.] The litigation has resulted in several settlement arrangements by defendant Zurich Insurance Company ("Zurich") and its affiliates.

On March 20, 2006, the Zurich insurers entered into an agreement with several states ("Multistate Agreement"). This Agreement required the Zurich insurers to agree to the entry of an Order and Stipulated Injunction in the state courts in each of the signatory states . This Order requires that the agents for Zurich to provide a stipulated mandatory disclosure statement to their policyholder customers.

On March 24, 2006, the Zurich insurers entered into an agreement with the states of New York, Connecticut and Illinois ("3-State Agreement"). Unlike the Multistate Agreement, the 3-State Agreement contains a direct attack on the payment of contingent commissions. This Agreement prohibits the payment of contingent commissions relating to the placement of any excess casualty insurance policy from 2006 to 2008. In addition, it requires that the Zurich insurers cease paying contingent commissions on additional insurance lines when and if other carriers enter into similar agreements such that those carriers, combined with the Zurich insurers, represent more than 65% of the national gross written premium in the given insurance line in any calendar year. Finally, the 3-State Agreement also has a provision requiring the Zurich insurers to "support legislation and regulations . . . to abolish contingent compensation for insurance products or lines."

Mandatory Inaccurate Disclosure

The zealous investigation and prosecution of "bid rigging" and "steering" by some of the largest brokerages has resulted in proposed settlements which will do more than simply compensate policyholders who have been forced, as a result of these actions, to pay excessive premiums. The Mandatory Disclosure Statement ("MDS") shows how this process has run amok. The language of the MDS, which was developed by the AGs is, in many cases, misleading, inaccurate and occasionally just plain wrong. This shows what can happen when the checks and balances provided by a state's mandated administrative procedures are ignored.

The MDS has several critical flaws: First, it creates the inaccurate impression that the role of an independent agent is identical to that of a broker. Second, it misleads insureds regarding the nature of compensation received by independent agents. Third, it creates the incorrect impression that independent agents have the sort of market power vis a vis insurers that is wielded by large brokers, who not only have the ability to negotiate the compensation they receive, but also can negotiate the level and price of coverage on behalf of the insured. These inaccuracies in the MDS place independent agents in direct legal jeopardy on a number of fronts.

The MDS includes the following disclosure: "Your agent or broker is an independent businessperson or team of people not employed by Zurich or any other insurance company." This statement looks innocuous on its face, but is dangerously misleading. The statement is correct, of course, in its representation that the independent agent is not employed by the insurer. Nowhere, however, does the MDS mention that the agent is appointed by the insurer, acts under contract with the insurer and directly represents the insurer. Instead, the MDS one-sidedly characterizes the independent agent as "your agent."

The law draws an important distinction between an independent agent, who primarily represents the *insurer*, and a broker, who primarily represents the *insured*. This distinction is critical to determining the legal duties owed by the insurance producer to the insured. By creating the impression that an independent agent acts in the same capacity as a broker, the MDS upends the fundamental legal relationship of the independent agent to the insured, placing inappropriate legal risk on independent agents.

Because brokers primarily represent the insured, they are charged with certain heightened legal duties to the insured. Yet the MDS blurs the distinction between independent agent and broker, leaving insureds with the impression that the independent agent—"your agent"—acts in the same capacity as a broker. This is a dangerous development for independent agents, as it places them at risk of liability for having misrepresented the nature of their relationship with the insured. In addition, it places independent agents at risk of being deemed to have assumed the expanded duties of a broker towards the insured.

The situation is reminiscent of the time in the not-too-distant past when insurers sought to limit their liability for the actions of their independent agents by placing language in their policies asserting that the agent acted solely on behalf of the insured. Policy wording of this sort eventually was rendered invalid by state lawmakers, who enacted statutes voiding such provisions as against public policy and not representative of the actual role of the independent agent. Now, however, the actions of state AGs mandating the MDS seem to be cutting the opposite way.

The Damage to Independent Agents

The MDS further places independent agents in legal jeopardy by forcing them to present insureds with statements that mischaracterize the nature of the compensation received by independent agents and the bargaining power of independent agents with respect to insurers. For example, the MDS suggests that independent agents may receive contingent commissions under circumstances that have virtually no application to most "Main Street" independent agents. The MDS also suggests that an insured may choose to compensate an independent agent directly, rather than through the agent's commission from the insurer. In fact, direct payment by an insured to an independent agent is prohibited by law in several states. The MDS further suggests that independent agents "choose" how they will be compensated by insurers, creating the impression that independent agents have the ability to negotiate their compensation and other aspects of their dealings with insurers in the same way as large brokers.

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By being forced to present inaccurate and misleading statements to insureds regarding the nature of their representation, compensation and bargaining power, independent agents run the risk of being found liable under state unfair trade practices laws and common law. It makes little difference that independent agents do not intend to mislead insureds by presenting the MDS. State unfair trade practices laws prohibiting misleading statements generally do not require any specific intent to deceive in order for an agent to be found liable.

Nor does it necessarily matter that independent agents are required to provide the MDS to insureds under the terms of a settlement agreement reached by state authorities. A fairly recent case in New Mexico is instructive on this point. The case, *Palmer v. St. Joseph Healthcare P.S.O., Inc.*, 77 P.3d 560 (N.M. Ct. App. 2003), *cert. dismissed* 101 P.3d 808 (N.M. 2004), involved a Medicare+Choice provider service organization ("PSO") that was required by federal regulators to send a misleading notice to subscribers as a condition of continuing to participate in the Medicare+Choice program. The court held that the PSO could be found liable to its subscribers for circulating the misleading notice under the New Mexico unfair trade practices statute and state common law principles, notwithstanding the fact that federal regulators had generated the misleading notice and had refused to allow the PSO to change the notice to correct its inaccuracy.

In reaching this decision, the court acknowledged that the PSO had found itself "between the proverbial 'rock and a hard spot.'" Moreover, the court expressed discomfort with the possibility that the PSO might be found liable for the misleading notice when a federal regulator ultimately was to blame. Nevertheless, the court found itself compelled to permit the subscribers' lawsuit to proceed. The decision in *St. Joseph Healthcare* is a cautionary tale for those who would subscribe uncritically to the settlement agreement encompassing the MDS, and it serves to highlight the legal jeopardy in which independent agents now find themselves.

Punishing Many for the Sins of the Few

The multi-state settlements work harm to the state insurance regulatory system in another way: The prohibition on the payment of contingent commissions is an ill-considered "remedy" which does not fit the underlying wrongdoing. Certainly, prohibiting the payment of contingent compensation to agents or brokers that engaged in "bid rigging" and "steering" is appropriate. However, requiring the entire industry to adhere to such a prohibition is excessive and even irrational. Compensation based upon efficiency and production is utilized in almost every industry – and certainly, in the financial services industry, *e.g.*, banking and securities. In fact, economic experts recognize that contingent commissions can "help keep property-casualty and other markets efficient." J. David Cummins & Neil Doherty, *The Economics of Insurance Intermediaries*, May 20, 2005.

Finally, probably the most obvious example of overreaching by the AGs is the mandatory injunction requiring the Zurich insurers to "support legislation and regulations in the United States to abolish contingent compensation for insurance products or lines." Can a settlement require that a defendant in a lawsuit waive its First Amendment rights regarding legislation and, in addition, to support a position mandated by a state attorney general? It could be argued that, as part of its punishment, Zurich could be required not to oppose any regulatory or legislative effort that was consistent with the terms of the settlement, *i.e.*, no contingent commissions by Zurich. However, that hardly supports the conclusion that it should have to allocate its corporate energy and funds to support legislation affecting and entire industry. Moreover, if denial of the ability to provide contingent compensation is a reaction to Zurich's improper behavior, why should Zurich be required to lobby for a similar punishment for those who have not engaged in such improper conduct?

Conclusion

The serious shortcomings of the multi-state settlements could have been avoided, and could still be mitigated, through the proper operation of two aspects of the state insurance regulatory system--regulatory rulemaking and, if necessary, the legislative process. The state regulatory rulemaking process embraces the important procedural safeguards of notice, public comment and reasoned deliberation of public authorities in light of the interests of all stakeholders. These safeguards are required for a rulemaking because it is recognized that a rulemaking is a quasi-legislative function with broad effect on the regulated community. Similarly, the state legislative process naturally engenders open public debate and consideration of the interests of all major stakeholders before new law is made.

The multi-state settlements illustrate only too well what happens when state AGs attempt to legislate through litigation. The settlements have a broad impact on a variety of stakeholders beyond the immediate parties to the lawsuits brought by the AGs. The AGs clearly recognized this fact when they turned to a task force of the NAIC for advice in formulating the settlements. Yet major stakeholders who are directly affected by the settlements were locked out of the process leading up to their implementation.

The result is a new, ill-crafted regulatory regime that unfairly penalizes those who are guilty of no wrongdoing and reformulates the relationship between insured and agent in ways that could put independent agents in legal jeopardy. State insurance regulators should take control of this situation now by working with the affected parties to develop reasonable standards. State insurance regulation will not survive if it allows itself to be overwhelmed by ambitious attorneys general. A challenge in state court may be necessary to turn the tide. ❑

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