Morris, Manning & Martin, LLP

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HASSETT'S OBJECTIONS

DELAY THAT CONFESSION: THE COMMENCEMENT OF THE COMMON INTEREST

By Lewis E. Hassett

Loose lips sink ships. They also can sink the protections of the attorney-client privilege. A case in point is a recent decision from the Southern District of Florida. *Guarantee Insurance Co. v. Heffernan Insurance Brokers, Inc.,* Case No. 13-23881-CIV (S.D. Fla. June 13, 2014). In that case, Guarantee Insurance had been sued for the alleged bad faith handling of a worker's compensation insurance claim. The worker's compensation insurer had its own errors and omissions coverage in two layers. The underlying layer was provided by XL, and the excess layer was provided by Catlin. The underlying insurer was promptly notified and participated in the settlement. The current lawsuit arose from the errors and omissions broker's alleged failure to report the underlying bad faith claim to Catlin.

During the underlying tort litigation, Guarantee Insurance's counsel wrote a detailed analysis of its exposure and alternatives. Its notification to XL of the claim included the counsel's analysis letter. Since the attorney's analysis letter had been provided to XL through the broker that allegedly failed to notify Catlin, it was undisputed that the letter could be used in the litigation. However, the broker argued that, by providing the letter to XL before XL had accepted coverage,

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LETTER FROM WASHINGTON

A MEASURED APPROACH TOWARD CAPTIVES IS NEEDED

"SENTENCE FIRST, VERDICT AFTERWARDS" - THE QUEEN OF HEARTS

By Robert H. Myers

As noted in numerous recent publications, captives have been receiving an increased amount of regulatory attention, not just from the domicile states which regulate them, but, more significantly, from national or international bodies. The NAIC Captives and Special Purpose Vehicles Working Group completed its examination of captives and now two captive related proposals are being considered at the NAIC. First, the Financial Condition (E) Committee has been asked to determine whether a captive manager should be considered to exercise "control" over a risk retention group ("RRG") under the Holding Company Systems Act. Second, the Financial Regulation Standards and Accreditation (F) Committee is considering a proposal to include captives in the definition of "multistate reinsurer" in the preambles to Parts A and B of the NAIC Accreditation Standards.

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Inside this Issue

HHS REGULATES, AND CONFUSES, FIXED INDEMNITY MARKET

By L. Chris Petersen

The Department of Health and Human Services ("HHS") recently released regulations and guidance on the treatment of fixed indemnity products. HHS action is important since it provides a road map as to how HHS believes these products should be regulated under the Patient Protection and Affordable Care Act ("ACA").

HHS bifurcated the regulation of "individual" and "group" fixed indemnity products. Group fixed indemnity products, defined as products offered as part of an employee welfare benefit plan, are defined under a FAQ that HHS released on January 9, 2014. (FAQ 18) Individual products, i.e., all products that are not part of an employee welfare benefit plan, are regulated under regulations that HHS published in the Federal Register, May 27, 2014.

Individual Products. The new individual regulations establish four standards that must be met in order for a

Announcements

Skip Myers appeared on World Risk and Insurance News TV (WRIN.tv) to discuss the Risk Retention Modernization Act. Skip is General Counsel of the National Risk Retention Association (NRRA).

Tony Roehl attended the 2014 Institute for Healthcare Consumerism Forum & Expo, where he moderated several panels on the future of health insurance and the rise of healthcare consumerism.

Skip Myers taught a three-segment course on risk retention groups for the international center for captive insurance education, a non-profit based in Burlington, Vermont.

Lew Hassett and **Larry Kunin** presented a webinar entitled "Attorney-Client Privilege and Similar Protections in Insurance and Reinsurance."

Skip Myers spoke on a webinar entitled "The Perfect Storm: NAIC v. Captives," hosted by Morris, Manning & Martin with Saslow, Lufkin & Buggy and Government Entities Mutual, Inc. (GEM). A replay of the webinar, as well as the slides, are available on the firm's website (www.mmmlaw.com).

Jessica Pardi spoke on Cyber Insurance Coverage and Declaratory Judgment Actions during a webinar entitled "Obtaining Cyber Insurance & Adopting a Security Incident Response Plan."

Jessica Pardi's article entitled "Application of the Abuse Exclusion" was featured in *Texas Lawyer*.

Chris Petersen spoke at the Association of Insurance Compliance Professional's Mid-Atlantic Chapter E-day in Atlantic City, New Jersey.

Tony Roehl spoke at the Association of Insurance Compliance Professional's Regional Conference where he discussed the technical evolution of automobiles and what innovation means for the future of automobile insurance. MMM was a Silver Sponsor of the event.

Lew Hassett and **Patrick Lowther** recently obtained the dismissal of contract and unjust enrichment claims attacking limited medical insurance in a putative class action brought in Alabama federal court.

Representing a title insurer in a coverage case involving an unsatisfied mortgage, **Lew Hassett** and **Shannon McNulty** obtained a partial summary judgment that the title agency must indemnify the insurer for all amounts awarded to the mortgagee.

Joe Holahan spoke at the Association of Insurance Compliance Professionals Mid-Atlantic Chapter Education Day on the topic of Recent Developments in Data Security Regulation.

Skip Myers will be speaking at the Vermont Captive Insurance Association annual conference on August 14 in Burlington, VT on "Hot Topics in Captive Regulation."

John MacNaughton will participate on a panel of class action and multidistrict litigation (MDL) practitioners and federal judges on September 11 and 12 in connection with the Duke Law Center's MDL Conference in Washington, D.C.

hospital or other fixed indemnity product to qualify as an excepted benefit (i.e., a benefit not subject to ACA reforms). The first standard provides that the benefits are provided only to individuals who have other health coverage that qualifies as "minimum essential coverage". Insurers are required to obtain an attestation from the proposed insured that the individual has coverage for minimum essential coverage. For new business issued after January 1, 2015, this attestation must be obtained at application. For existing business, the new regulation states that an attestation must be obtained at renewal.

The regulation also implies that coverage must be cancelled if an insurer is unable to obtain this attestation at renewal. Unfortunately, this standard does not seem to take into consideration either the fact that fixed indemnity products are guaranteed renewable under state law or the inherent unfairness of cancelling an individual's coverage simply because the individual purchased the product under existing state insurance department interpretations of what qualified as a fixed indemnity product. State regulators, working through the NAIC and with HHS, will need to resolve this issue to ensure that consumers are protected.

The second standard provides that there is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage. This is consistent with existing state regulation.

Third, the HHS regulations provide that the benefits must be paid in a fixed dollar per day and/or illness or per service, regardless of the amount of expenses incurred and regard to the amount of benefits provided with respect to the event or service under any other health coverage.

Finally, the regulation provides that the following notice must be provided: "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES." For new business, beginning January 1, 2015, this notice must be included in the application. For in-force business, the notice must be delivered shortly before the first renewal although insurers are only required to provide the notice once.

Group Products. HHS' rules for group fixed indemnity products also include a four-part test; however, the group standards vary significantly from the individual rules. For example, the group rules do not include an attestation or the notice requirement. In addition, per service benefits are not permitted in the group market. In order to qualify as an excepted benefit, a group fixed indemnity product must meet the following requirements: 1) it must be a separate policy, certificate, or contract of insurance; 2) there may not be any coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; 3) the benefits must be paid with respect to an event without regard to whether benefits are provided, with respect to the event under any group health plan maintained by the same plan sponsor; and 4) the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

Left unanswered is how recent state regulations and insurance department guidance on fixed indemnity insurance interact with the new HHS rules. Hopefully this is another issue that the state regulators and the NAIC will be able to clarify. ❑

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ELEVENTH CIRCUIT EXCEPTION TO THE "EIGHT CORNERS RULE"

By Jessica F. Pardi

On March 20, 2014, the Eleventh Circuit ruled in favor of The Continental Insurance Company ("Continental") in an appeal from the United States District Court for the Middle of Florida brought by Composite Structures Inc. d/b/a Marlow Marine Sales ("Marlow"). Like the lower court, the Eleventh Circuit ruled there was no obligation for Continental to defend or indemnify Marlow because of a pollution exclusion (the "Pollution Exclusion") contained in the Continental policy issued to Marlow (the "Policy"). The Pollution Exclusion was considered in conjunction with *extrinsic evidence* as to Marlow's awareness of the claim and notice to Continental. Accordingly, the Eleventh Circuit looked beyond the eight corners of the underlying complaint and the Policy (known as the "Eight Corners Rule") and considered facts not

contained in either document.

In the underlying tort action, two employees aboard a ship built by Marlow allege that during the time they worked aboard the ship they were injured through excessive exposure to carbon monoxide. They allege negligence and strict product liability claims against Marlow. The Policy contains a Pollution Exclusion as well as a "pollution buy back" endorsement wherein, if five specific conditions are met, coverage will be afforded for a pollution claim despite the presence of the Pollution Exclusion. The criteria at issue were the following: 1) that the occurrence be known to Marlow within 72 hours after its commencement; and 2) that the occurrence then be reported in writing to Continental within 30 days after Marlow has knowledge of the occurrence.

Marlow conceded its notice to Continental of the occurrence was not timely. Nonetheless, Marlow argued that the Court should not consider extrinsic evidence when determining Continental's duty to defend, and the complaint in the underlying lawsuit was silent on the notice issue. The parties argued as to whether Florida law permitted exceptions to the Eight Corners Rule to determine whether an insurer is obligated to defend its policyholder. Marlow unsuccessfully argued against the creation of an exception to the Eight Corners' Rule for "undisputed facts," claiming if such an exception exists, it would imperil the duty to defend in many cases.

Initial concerns regarding policyholder vulnerability to immediate coverage denials and earlier litigation over payment of defense expenses were assuaged by the fact that the Eleventh Circuit opinion (the "Opinion") was not published, but Continental, wanting to use the Opinion as precedent in other matters, filed a motion to have the Opinion published.

Continental argued the Opinion should be published because application of the extrinsic evidence exception to the duty to defend was one of first impression in Florida and is a recurring issue. In its response, Marlow argued the extrinsic evidence exception contained in the Opinion is based upon well-established Florida case law and that the specialized nature of the insurance policy at issue and the unique facts involved do not warrant publication. In reply, Continental argued that if the case law were "well established," then Marlow's filing of the declaratory action at the outset and its subsequent appeal to the Eleventh Circuit should be deemed frivolous. Moreover, the central issue in the case was not the interpretation of the Policy provisions because both parties conceded the Policy provisions were unambiguous. Rather, the issue was whether Continental could look to undisputed extrinsic facts (*i.e.,* the date of notice by Marlow) to determine its duty to defend obligation when the undisputed facts would not normally be alleged in the complaint.

On June 5, 2014, the Eleventh Circuit denied Continental's Motion for Publication. The Court did not provide an explanation for the denial, leaving the parties to speculate as to the rationale and the possible persuasive impact of the unpublished Opinion. To date, it has not been cited by any other litigants calling into question whether the issue is truly a common one. ❑

Jessica F. Pardi is a partner in Morris, Manning & Martin, LLP's Insurance and Reinsurance Practice. Ms. Pardi's practice includes reinsurance arbitrations, complex coverage disputes, bad faith matters, managing general agency disputes and life settlement controversies. Ms. Pardi received her undergraduate degree from Boston University and her law degree from the University of Virginia.

THE LIFE SETTLEMENT OPTION: A DUTY TO INFORM?

By James W. Maxson

For the past two-and-a-half decades owners of life insurance policies who decide they no longer want or need those policies have had an alternative to surrendering those policies back to the issuing carrier - access to an organized and vibrant secondary market for life insurance, giving policy owners liquidity in a previously illiquid asset. Surprisingly, unlike most originators of an asset for which there is a secondary market, life insurers have been slow to embrace this pro-consumer option. In fact, the American Council of Life Insurers has actively opposed legislation creating an obligation for life insurance carriers to inform policy owners who have decided to lapse or surrender their policies that a life settlement might be an option.

The inevitable consequence of the ACLI's and life insurance carriers' position on voluntary disclosure is playing out in the recent lawsuit *Larry Grill, et al. v. Lincoln National Life Insurance Co.,* filed in federal district court in California. In this case, the owners of a life insurance policy brought suit alleging claims for fraudulent concealment, financial abuse

of an elder and violation of California's Unfair Competition Law, all stemming from the carrier's failure to inform them of the existence and possibility of selling their policy into the secondary market for life insurance.

The plaintiffs purchased a policy from the defendant in 2004 with a face value of over $7,000,000; and, notwithstanding having paid hundreds of thousands of dollars in premiums, the investment returns on the policy became insufficient to cover the on-going cost of insurance charges. The plaintiffs approached the defendant's agent and were told their only options were to pay more premiums into the policy or undertake a partial surrender to decrease the cost of insurance. The plaintiffs chose to surrender over $5,000,000 of the original face value of the policy. When the plaintiffs learned that they might have been able to sell that $5,000,000 in coverage into the secondary market for life insurance, they filed suit. The carrier filed a motion to dismiss for failure to state a claim upon which relief can be granted; that is, the carrier argued even if the plaintiffs' claims were accepted as true, they were still entitled no relief.

On the basis of a technical analysis focused on the sufficiency of the claims pleaded by the plaintiffs, the court ultimately dismissed all of those claims; however, it did so with leave to amend to cure the deficiencies in the pleadings, and with a clear indication that the court believes that the plaintiffs' claims are viable and can proceed once they were correctly presented. For instance, the court stated that "the Court agrees that Plaintiffs have sufficiently alleged a duty to disclose based on partial representations by alleging that Defendant's agent represented that they had two options and concealed the life settlement option". Further, the court concluded that the plaintiffs had sufficiently alleged a claim under California's Unfair Competition Law on the basis of their claims that 1) elder citizens are unaware of the option of a life settlement; 2) that the defendant has a practice or policy of concealing the option from such citizens; and 3) that there is no utility or countervailing benefit to the defendant's conduct. Faced with these facts, the court concluded "[t]he Court agrees that there does not appear to be any utility to this alleged practice [failing to disclose the life settlement option], but the possible monetary harm to the insured and policy beneficiaries is clear."

In sum, while this is one of the first lawsuits alleging that life insurers have an affirmative obligation to disclose the existence of the life settlements option, even in the absence of a legislative obligation to do so, it is unlikely to be the last. For nearly 30 years the secondary market has offered consumers an option to realize additional value from their life insurance policies, it is time for life insurers to voluntarily embrace the secondary market before they are ordered to do so. ❑

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Guarantee Insurance had waived the privilege as to all communications on that subject matter.

Guarantee Insurance argued that it had a common interest with XL, because both would want to defeat the underlying tort claim. That position has legal support. Guarantee Insurance was the "insured" in this context, and courts routinely recognize a common interest between an insured and its liability insurer sufficient to avoid the waiver of a privilege via disclosures between them or their counsel. *See Nationwide Mut. Ins. Co. v. Bourlon,* 617 S.E.2d 40 (N.C. App. 2005); *Woodruff v. Am. Fam. Mut. Ins. Co.,* 291 F.R.D. 239 (S.D. Ind. 2013); *State, ex rel., U.S. Fidel. And Guaranty Co. v. Montana Second Jud. Dist.,* 783 P.2d 911 (Mont. 1989). Conversely, courts typically reject common interest protections where the liability insurer has denied coverage. *See Metropolitan Life Ins. Co. v. Aetna Cas. and Sur. Co.,* 730 A.2d 51 (Conn. 1999); *Northwood Nursing & Convalescent Home, Inc. v. Continental Ins. Co.,* 161 F.R.D. 293 (E.D.Pa. 1995); *Milinazzo v. State Farm Ins. Co.,* 247 F.R.D. 691 (S.D.Fla. 2007). Courts are split on whether common interest protections attach after an insurer agrees to defend under a reservation of rights. *Compare Vicor Corp. v. Vigilant Ins. Co.,* 674 F.3d 1, 19-20, (1st Cir. 2012) (common interest applicable even where insurer has reserved rights), *with Rockwell Int'l Corp. v. Superior Court,* 32 Cal. Rptr. 2d 153 (Cal. App. 1994) (no common interest where insurer defends under reservation of rights).

In *Guarantee Insurance*, the question was whether the common interest protections applied where, at the time of the disclosure the insurer had neither accepted nor rejected

coverage. The court found that a "common interest" had not yet arisen, even though the insurer later accepted coverage, and found that the privilege had been waived.

At least one case supports the Court's decision where the insurer ultimately rejects coverage. *See Northwood Nursing*, 161 F.R.D. at 297 (no common interest protection before adjudication of coverage). Conversely, other courts have protected communications to an insurer as privileged even where coverage was contested or later denied. *Taylor v. Temple & Cutler*, 192 F.R.D. 552 (E.D. Mich. 1999) (insured's communications to insurer protected, even if insurer contests coverage for some period); *State, ex rel., L.Y. v. Davis*, 723 S.W.2d 74 (Mo. App. 1986) (pre-denial communications to insurer protected, notwithstanding subsequent denial of coverage).

The *Guarantee Insurance* court took a unique step in finding a waiver of the privilege, notwithstanding the insurer's acknowledgement of coverage, just because the communication preceded the insurer's coverage determination. As explained in *Davis*, 723 S.W.2d at 74-75:

> If communications between insured and insurer are to be privileged only if the insurer ultimately admits coverage, there is no incentive for the insured to make full disclosure to his insurer. In fact, it may be impossible and, at best, difficult for the insurer to determine whether coverage exists without the insured making a full explanation of the circumstances surrounding the claim.

The *Davis* court had it right, and the *Guarantee Insurance* court has it wrong. Policyholders expect their insurer to be on their side, until informed otherwise, and both insureds and insurers benefit from candid communications until coverage is denied. ❑

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LETTER FROM WASHINGTON

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Both of the above proposals would impose substantially greater regulatory compliance responsibilities and costs on captives. In fact, the proposal to consider captives to be multistate reinsurers would effectively impose traditional regulatory licensing and reporting requirements on reinsurance captives.

Captives have recently drawn the attention of international bodies, as well. The Organization for Economic Co-operation and Development ("OECD") included captives in its examination of methods by which "multinational entities" reduce income taxation ("base erosion") in its recent study "Addressing Base Erosion and Profit Shifting". The Federal Insurance Office ("FIO") referenced life and annuity reinsurance captives (but not captive insurance in general) as a potential danger to the financial solvency of that segment of the insurance business. That position was further supported by a recent report of the Financial Stability Oversight Council, which asserted that, while state regulators must approve reinsurance cessions from insurers to captive reinsurers, inconsistent state regulatory practices, capital requirements and accounting issues might undermine regulatory oversight.

The use of captives has been an important component of business and non-profit entity risk management for decades. Captives were created offshore initially in the 1970s as a result of the failure of the commercial insurance industry to provide coverage at affordable prices to certain niche markets. As the use of captives grew in the 80s and a few states adopted captive laws, the types of coverages available through captives expanded. In today's market, captives provide competition in the market because coverage that may not be available or affordable can be assumed, either in whole or in part, by the insured's captive. As a result, capacity in the insurance market, particularly in niche markets, expands.

What is driving this increased attention to captives? Even though captives have continued to grow in number over the past few years, there have been no major insolvencies of captives or in the traditional insurance industry. By contrast, bank failures precipitated the Great Recession and the increase in bank regulation in the form of the Dodd-Frank Wall Street Reform and Consumer Protection Act, which

resulted.

Three causes seem to be foremost in increasing the attention on captives. First, there is more competition among insurance regulators and the appetite for regulation has been enhanced due to the perceived failure of financial regulation, which contributed to the Great Recession. The exclusive dominion of the states over insurance regulation is long gone. Now the states have to deal with the specter of the FIO, which has the authority and capability to examine the insurance industry and its regulation and to issue substantive reports, which will influence both state and federal regulators and legislators (particularly Congress). In addition, the states have to consider the positions of international groups, such as the International Association of Insurance Supervisors ("IAIS") and the OECD.

Second, there has been the proliferation of captive domiciles. There are now 38 states with some form of captive law. Fifteen years ago there was just a handful. Several states which have previously exhibited an aversion to captives have adopted favorable laws in an effort to provide a home to the captives to be formed by their domestic companies.

Third, there has been substantial growth in "micro captives", also sometimes called "831(b)" captives. These are small captives with limited capitalization which are frequently operated in a bundled fashion by a single operating entity. In some cases, concerns have been expressed by regulators or other critics that these entities are undercapitalized or do not actually transfer risk. Micro captives are frequently promoted by financial advisors who emphasize their potential tax effects, rather than simply the insurance benefit. This issue has come to the attention of the IRS, which has announced that it is investigating the use of micro captives. Moreover, there are several cases in the IRS pipeline challenging captives of this sort and at least one recent case *(Salty Brine 1, LTD, et al. v. United States of America*, 5:10CV00108 (TX U.S. Dist. Ct., North) (2013), which has disallowed the tax benefits of "insurance company" status.

Proposals to give non-domiciliary states broad regulatory authority over captives are misplaced. The abuses of micro captives are being attacked by the IRS, which is in the best position to deal with the problem since the problem is driven by the tax benefits of micro captives, not their regulation by states. Once it is clear that tax advantages cannot be obtained if the micro captive is not properly structured demand will evaporate.

Captives are an integral part of the commercial risk management system. State regulators should examine significant issues, such as whether life and annuity reinsurance captives which assume risk from traditional reinsurers are properly structured and regulated. However, they should not expend their limited time and attention on the operation of the captive system as a whole, which operates well and provides a valuable service to commercial insureds. ❑

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