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REVIEW

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LETTER FROM WASHINGTON

RECENT CASES SUPPORT LEGALITY OF CONTINGENT COMMISSIONS

By Robert H. Myers, Jr. and Cindy Chang

After then-New York Attorney General Elliot Spitzer initiated industry-wide investigations into allegedly anti-competitive conduct in 2004, some regulators and industry commentators advocated the reform or abolition of the accepted practice of insurance producers receiving contingent commissions. New York's Insurance Department announced on November 2, 2007, that it is drafting a regulation that will require all retail brokers who deal directly with the public to disclose the value of all compensation agreements with insurers.

However, recently decided and filed cases support the legality of contingent commissions. Some cases even suggest that insurance producers do not have a fiduciary duty to disclose contingent commissions to their clients. These cases directly support the conclusion that, absent a horizontal conspiracy to restrain trade, contingent commission agreements are lawful and do not violate the antitrust laws.

Continued on page 11

HASSETT'S OBJECTIONS

THE INSURER'S DUTY TO LOSE

By Lewis E. Hassett

Cases uniformly hold that an insurer's duty to defend the insured under a liability or title insurance policy is separate and apart from its duty to indemnify for any loss. In the context of title insurance, the duty to defend generally involves litigation over the quality of the policyholder's title via actions to quiet title, for ejectment, or the like.

In such actions, the trial court's ultimate judgment may contain both favorable and unfavorable elements. For example, a trial court may uphold the policyholder's interest in a portion of the insured real estate, but not in another portion of it, or may recognize the policyholder's interest in the property but subordinate it to particular claims or interests.

Continued on page 9

PLAYER'S POINT

A DISCUSSION OF GOVERNMENT BACKSTOPS

By Thomas A. Player

In 1954, the Spanish government established Corsico de Compensación de Seguros in response to Basque terrorism. Since that time, most catastrophic risks have been added as covered risks in this national program which enjoys unlimited backing by the Spanish government. In 1994, the United Kingdom established Pool Re as a voluntary terrorism insurance program, backed by the British government. This was in response to the IRA bombings. In early 2002, our Terrorism Risk Insurance Act ("TRIA"), was put into place as a combination of private coverage with a government backstop. Similar state supported responses were established in France and Germany that same year. The implementation of each such program quieted jittery market conditions and provided stability.

Continued on page 10

Inside this issue

Announcements....2
Sales to Seniors Under Increased Scrutiny....2
English Court Limits Applicability of "Follow the Fortunes" Clause....4
California Court of Appeals Protects Communications Between Non-Attorney Agents of Corporate Client....5
Making Sense of the New Affiliate Marketing Rule....6
New Jersey Lame-Duck....7
Supreme Court of California Rules That Reinsurance Agreements Are Not Discoverable....8

Announcements

Ben Erwin has joined the Insurance/Reinsurance Dispute Resolution Group as an associate in Atlanta. Ben is a 2004 graduate of Duke University School of Law. Prior to joining Morris, Manning & Martin, he practiced with Powell Goldstein, LLP, focusing on complex civil litigation and health care matters.

Representing a liability insurer, **Lew Hassett** and **Ben Vitale** recently settled on favorable terms an action alleging a fraudulent concealment of insurance coverage.

Skip Myers will be speaking to the South Carolina Captive Insurance Association on December 7, 2007 on corporate governance for risk retention groups.

Lew Hassett and **Skip Myers** have been renamed to the *Guide to the World's Best Insurance and Reinsurance Lawyers*.

Jessica Pardi will be speaking on strategies and practice points for each of the phases of a reinsurance arbitration at Mealey's Fundamentals of Reinsurance and Arbitration Conference on February 11, 2008, at the Westin in Washington D.C.

Lew Hassett and **Jessica Pardi** are serving as lead counsel in litigation in federal court in California involving the allocation between an insurer and its managing general agency of the settlement of a bad faith claim.

Representing the cedant, **Lew Hassett** and **Ben Erwin** recently settled on favorable terms a dispute with a London-based reinsurer.

Bill Megna and **Donna Fuller** participated in the Life and Health Compliance Association (LHCA) meeting September 26-28, 2007, held in Greenville, South Carolina.

Joe Holahan and **Skip Myers** conducted a Webinar on Terrorism Risk Insurance with Brady Young of Strategic Risk Services on November 21, 2007.

Bill Megna was nominated as one of *America's Best Lawyers* for Government Relations in 2008.

SALES TO SENIORS UNDER INCREASED SCRUTINY

By Chris Petersen

Over the past few months, there has been increased scrutiny of insurance and financial products sold to senior citizens. This scrutiny has taken many forms and has appeared in many forums. Both national and local media have run stories on senior sales and products. A recent example is the *New York Times* article on the claims practices of long-term care insurers.

Legislators have also responded. Congress has held hearings on the suitability of products sold to senior citizens, the marketing of Medicare Advantage products, and on the qualifications and "designations" of financial advisors who market products and make recommendations to seniors.

Regulators at the state level have also entered the fray. State insurance departments and attorneys general are very active in this arena. For example, two months ago the New York State Insurance Department established the New York State Insurance Department Elder Protection Unit. In establishing the unit, the Department stated that the "suitability of products for seniors and the deceptive marketing practices of both life insurance and annuities are among the areas of prime concern to the Department." New York State is just one of many state insurance departments that have or will be taking action in this area.

State attorney generals are also aggressively pursuing what they perceive to be abusive sales and marketing practices in the senior market. In Minnesota, the attorney general is taking insurers to court for allegedly selling deferred annuities to senior citizens without determining whether the products were suitable for the seniors purchasing the products. The attorney general has already settled one of the suits. The settlement includes a significant fine, a restitution process and the imposition of a suitability process within the company subject to the suit. Minnesota is not alone, however; several other state attorney generals are also looking at sales to seniors.

Although there probably have been some questionable practices in this area, regulators and legislators must be careful not to overreact. First, policymakers should not lump all products sold to seniors under one umbrella. There are significant differences between complex financial products (both in cost and in structure) and some straightforward insurance products. In addition, for some products sold to seniors, the answer is not new laws, but rather the enforcement of existing statutes and regulations.

For example, states already extensively regulate the sale and design of both long-term care and Medicare supplemental insurance. The NAIC's Long-term Care Insurance Model Regulation includes standards for marketing and suitability. It also includes provisions relating to required disclosures provisions, required provisions for application forms, and a requirement to deliver a shopper's guide. In addition, the model regulation includes model regarding disclosures and personal worksheets, among others. The NAIC's Model Regulation to Implement the NAIC Medicare

Supplement Insurance Minimum Standards Model Act includes similar requirements and protections.

Regardless of whether policymakers heed the call to enforce rather than legislate, insurers must expect to see, and be prepared to respond to, increased regulatory scrutiny. Regulators will expect to find, and insurers should have, processes in place to monitor the marketing and selling of products to seniors. What should this process encompass?

Obviously, a first step is for insurers to identify the products that they market and sell to seniors. Insurers should also identify existing state statues regulating the marketing of products to seniors. State market conduct examiners will expect insurers to be able to identify these statutes and to show the steps that the insurers have initiated to implement a compliance program. For products like long-term care and Medicare supplement, the presence of a compliance program based on state law should be sufficient to show suitable sales.

However, for potentially more complex products, such as deferred annuities, regulators might expect or require processes that are more detailed. The Minnesota Attorney General's settlement discussed above provides some guidance as to the type of suitability requirements that regulators might demand when complex products are sold to seniors

That settlement provides that, as part of the application process, the insurer subject to the settlement "will request and obtain additional information from consumers that is necessary to determine whether a deferred annuity is suitable for the particular consumer. This additional information includes whether the consumer has sufficient liquid assets and disposable income to pay for ongoing living expenses and emergencies without having access to all of the money that would be paid into the long-term deferred annuity.

The settlement provides that the insurers must obtain the following information from seniors: "1) monthly income; 2) monthly living expenses; 3) monthly disposable income; 4) total liquid assets; 5) percentage of liquid assets placed into the annuity; and 6) anticipated significant changes in household monthly income, living expenses, or liquid assets, such as a reduction in income caused by retirement or pension changes or by an increase in expenses such as housing, medical, nursing home, or assisted living expenses."

In addition, under the settlement, the insurer's suitability process must also include a "manual 'elevated review' of annuity applications if a consumer is 65 years of age or older and:

1. the consumer has liquid assets, after purchase of the annuity, of less than or equal to $75,000; or
2. the consumer anticipates a significant increase in living expenses or a significant reduction in net income or liquid assets during the annuity's deferral or surrender charge period, whichever is longer; or
3. the premium the consumer paid for the annuity exceeds 25 percent of the consumer's net worth (excluding the consumer's home); or

Continued on page 4

Announcements

Lew Hassett and **Jessica Pardi** have been retained to represent a managing general agency in litigation brought in Chicago by a reinsurer alleging negligent underwriting and claims handling.

Lew Hassett and **Tom Player** attended the Winter meeting of ARIAS in New York and participated in various sessions on procedure and technology in arbitrations.

Bill Megna has been selected for inclusion in the 2008 edition of The Best Lawyers in America in the specialty of Government Relations Law.

Lew Hassett and **Ross Albert** are representing a claims administrator in a dispute with an insurer in Pennsylvania. Lew and Ross recently filed an action in federal court in Philadelphia challenging arbitrability.

Skip Myers addressed the National Conference of Insurance Legislators on the uses of interstate compacts for insurance regulation on November 17, 2007.

Lew Hassett and **Jessica Pardi** recently settled on favorable terms federal litigation in Georgia brought by an automobile insurer against a claims administrator.

On the first day of the new Session of the Supreme Court, **Tom Player** was sworn in by Chief Justice Roberts, along with other members of the Senior Attorneys in the South Carolina Bar. Player has been a member of the South Carolina Bar for over forty years.

(Note: In the picture below Player is third from the right - clean shaven for a change!)

4. the consumer's annual income is less than or equal to $20,000; or

5. the premium the consumer paid for the annuity is greater than four times the annual income of the consumer."

Although this is only one state's opinion as what is required when marketing complex products to seniors, it is a good example of how seriously states are taking this issue. Insurers that operate in the seniors' market must anticipate that their sales practices will be subjected to heightened scrutiny. ❑

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 in St. Louis, Mo., and his law degree from Georgetown University.

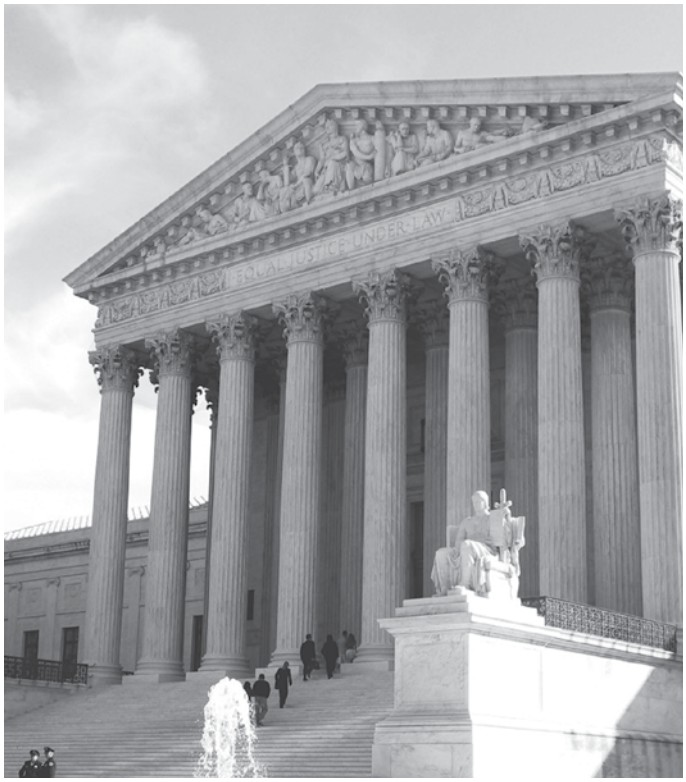
ENGLISH COURT LIMITS APPLICABILITY OF "FOLLOW THE FORTUNES" CLAUSE*

By Jessica F. Pardi

Insurers and their reinsurers are all too familiar with the competing tensions of a "follow the fortunes" clause wherein a reinsurer is prevented from challenging the claim settlement decisions of its cedant. First, there is the interest of the insurer in avoiding duplication of its claims investigation by a reinsurer whose knowledge of the underlying facts and general ability to adjust claims likely is inferior to that of the insurer. This interest often "butts heads" with the desire of the reinsurer to protect its interest in the event of questionable or erroneous settlement practices of the insurer. These opposing interests often evolve into a legal dispute wherein the obligations and standards of the "follow the fortunes" clause are hotly contested. Interestingly, most of the reported opinions on these disputes deal with treaties wherein the reinsurance coverage is "back to back" with the insurance coverage, *i.e.* they are equal in scope and terms.

The more interesting question arises, however, when the reinsurer agrees to reinsure only certain types of claims or occurrences covered by the insurer. Combine this disconnect with the addition of the phrase "as far as applicable" to the end of the "follow the fortunes" clause, and you have the much more complex issue recently decided by the Commercial Court of the Queen's Bench Division in London. *(See Aegis Elec. & Gas Int'l. Servs. Co. Ltd. v. Continental Cas. Co.,* 2007 EWHC 1762).

Essentially, new layers are added to the "follow the fortunes" analysis when the reinsurance cover differs from the underlying cover, and the following issues must be analyzed:



1. Is the claim within the coverage of the underlying policy;

2. Is the claim within the coverage of the reinsurance agreement; and, most importantly,

3. Does the reinsurer have to accept the insurer's assessment of the claim in determining whether it falls within the scope of the reinsurance?

Consider the example of an underlying policy covering losses of any kind at a power plant and a reinsurance treaty that excludes coverage for explosions. Is the reinsurer bound by the insurer's determination that a loss at the power plant was caused by an explosion as opposed to precedent, intervening or subsequent causes? Not according to the court in *Aegis Electric* which refused to apply the "follow the fortunes" clause if it meant that the reinsurer was forced to put itself unconditionally in the hands of the underlying insurer even where their interests were diametrically opposed. The court did not force the reinsurer to rely upon or "follow" the causal determination of the insurer. Instead, the reinsurer was allowed to deny coverage based upon its independent determination that the loss (which had been paid by the insurer) was due to a cause excluded under the terms of the reinsurance coverage (e.g. explosions).

Insurers and reinsurers should take note that the "follow the fortunes" clause is not applicable to claim determinations made by the underlying insurer if there is a relevant difference in scope between the underlying coverage and the reinsurance coverage. ❑

Jessica Pardi is a partner in 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.

** While the Court appears to interpret a "follow the settlements" clause, the analysis and holding are presented in terms of a "follow the fortunes" clause.*

CALIFORNIA COURT OF APPEALS PROTECTS COMMUNICATIONS BETWEEN NON-ATTORNEY AGENTS OF CORPORATE CLIENT

By John H. Williamson

In its recent decision in *Zurich Am. Ins. Co. v. Superior Court,* Case No. B194793 (decided October 11, 2007), the California Court of Appeals provides a lengthy and thoughtful analysis of the scope of the attorney-client privilege in the corporate context. The case involved a coverage dispute where the insured moved to compel the production of Zurich documents that reflected reserve and reinsurance information as well as "Zurich's evaluation of, or its litigation or settlement strategies concerning, the action . . . ." *Slip Op.* at 8. Zurich argued that the documents were protected from disclosure by both the attorney-client privilege and the work product doctrine. The trial court, however, rejected that position. First, the trial court held that "the attorney-client privilege is limited to communications by counsel to a client, and by a client to counsel." *Id.* at 6. Second, the trial court held that "[t]he fact that many of the disputed items contain discussions of legal matters, strategy, and status of the bad faith litigation cannot be used to cloak them with either the attorney-client privilege or the work product privilege for that reason alone." *Id.* The trial court ordered Zurich to produce any documents other than direct communications between Zurich and its lawyers, including internal communications summarizing or discussing the legal advice Zurich had received from its outside counsel. *Id.* at 8. Zurich appealed the order.

The California Court of Appeals framed the issue before it as follows: "Here, we are asked to decide whether the corporate attorney-client privilege extends to confidential communications between agents of the client regarding legal advice and strategy, in which the corporation's attorneys are not directly involved or which do not include excerpts of direct communications from the attorneys." *Id.* at 9. Drawing upon a large body of case law and other authorities, the appellate court concluded that the trial court's definition of the attorney-client privilege had been too narrow. Consistent with judicial and commentator consensus, the appellate court held that the attorney-client privilege applies, not only to communications directly between client and counsel, but to communications between "third persons to whom disclosure is reasonably necessary to further the purpose of the legal consultation . . . ." *Id.* at 11. Thus, while the trial court found that the internal communicationssummarizing or discussing legal advice were not privileged in the first instance, the appellate court recognized that those communications were at least presumptively privileged, and the issue to be decided was whether Zurich had waived the privilege by disclosing the legal advice to persons not reasonably necessary to furthering the purposes of that advice. *Id.* at 18. The appellate court remanded the issue for further consideration by the trial court.

While the appellate court may have reached the correct practical result, it took the long way to do it. The court did not focus sufficiently on distinctions between the attorney-client privilege and the work product doctrine. These two protections often overlap in litigation, but they are different and must be analyzed separately. While the scope of the work-product doctrine is more narrow than the attorney-client privilege, work product protection is not waived as readily. Because the appellate court did not separately analyze the work product issue, it apparently overlooked a more direct basis for its decision.

The court may have assumed, as courts sometimes do, that waiver of the attorney-client privilege necessarily waives work product protection as well, but that is incorrect. See generally EDNA S. EPSTEIN, THE ATTORNEY-CLIENT PRIVILEGE AND THE WORK-PRODUCT DOCTRINE 607-10 (ABA Litigation Section 4th ed.). "While the attorney-client privilege is often treated as waived by any voluntary disclosure, only disclosures that are 'inconsistent with the adversary system' are deemed to waive work product protection." *Id.* at 610 (collecting cases). Thus, waiver of work product protection only occurs if the disclosure "is inconsistent with the maintenance of secrecy from the disclosing party's adversary." *See United States v. American Tel. & Tel. Co.,* 642 F.2d 1285, 1299 (D.C. Cir. 1980). Two other points about work product bear emphasis, because they are often misunderstood. While often referred to as "attorney work product," work product materials do not necessarily have to be prepared by an attorney; work product may be prepared by a party or a representative of the party. *See* Fed.R.Civ.P. 26(b)(3). The term "attorney work product" is misleading in another significant respect. "Work product" does not encompass all materials prepared by an attorney, but only those materials prepared in anticipation of litigation. *Id.*

Applying these principles to the documents at issue in *Zurich*, while the appellate court correctly observed that communications "reflecting a discussion of litigation strategy . . . would come within the privilege[,]" the court should have added that those communications also constitute work product. Because those communications were only disclosed to Zurich employees and agents (who presumably could be trusted not to disclose them to Zurich's litigation adversary), there was no waiver of work product protection. ❑

John Williamson is a partner in the firm's commercial litigation group. He focuses his practice on the litigation and resolution of complex commercial disputes, and has experience in a wide range of matters, including E&O and D&O insurance coverage, technology, shareholder and partnership disputes, business torts, breach of contract and healthcare. He primarily represents public and private companies, and corporate officers and directors. John received his bachelor's degree from Princeton University and his law degree from the University of Virginia. John can be reached at 404.495.3618 or jwilliamson@mmmlaw.com.

MAKING SENSE OF THE NEW AFFILIATE MARKETING RULE

By Joseph T. Holahan

In October, the Federal Trade Commission ("FTC") issued its long-awaited Affiliate Marketing Rule implementing amendments made to the Fair Credit Reporting Act ("FCRA") by the Fair and Accurate Credit Transactions Act of 2003 (the "FACT Act"). The new rule, which has been a very long time in coming, has important consequences for the handling of consumer information by insurers and other providers of financial services.

The Affiliate Marketing Rule implements provisions of the FACT Act governing the use of certain consumer information shared among affiliated companies for the purpose of making marketing solicitations. The compliance date for the Affiliate Marketing Rule is October 1, 2008. Covered information shared among affiliates before that date may be used to make marketing solicitations without having to comply with the new rule.

The FTC refers to information covered by the Affiliate Marketing Rule as "Eligibility Information." Generally speaking, the most important categories of Eligibility Information for insurers are (1) information about an individual collected on an application for personal insurance that is used to determine eligibility for coverage or rate risk and (2) information as to transactions and experiences between the insurer and the consumer, other than medical information. An example of information in Category 1 would be the marital status reported by an insured where this information is used to set rates for private passenger auto insurance. An example of information in Category 2 would be the claims history for a homeowner's insurance policy.

A third category of information—consumer report information received from a third party—also is governed by the Affiliate Marketing Rule. Such information generally cannot be used to make marketing solicitations unless the consumer gives express consent before the consumer report is obtained.

The Affiliate Marketing Rule and related provisions of the FCRA are, to put it mildly, less than straightforward in their operation. Nevertheless, a few important points can be extracted from what is otherwise a pretty tangled regulatory thicket.

First, under the FTC's interpretation of the FCRA, information that falls into Category 1 above may not be shared among affiliates for any purpose unless the consumer is given a reasonable opportunity to opt out of the sharing before it occurs. This is a longstanding interpretation of the FCRA by the FTC and is in effect now, even before the Affiliate Marketing Rule compliance date of October 1, 2008. In addition, if an affiliate wishes to use information in Category 1 that it receives from another affiliate to make a marketing solicitation, the consumer must either be given a reasonable opportunity to opt out of the marketing use by the affiliate or the affiliate using the information must have a "pre-existing business relationship" with the consumer. This limitation will become effective for information shared among affiliates on or after October 1, 2008.

Second, affiliates may freely share Category 2 information ("transaction and experience" data other than medical information) without offering an opt out. As a general rule, however, before an affiliate receiving such information may use it to make a marketing solicitation, it must either give the consumer a reasonable opportunity to opt out of the marketing use or have a "pre-existing business relationship" with the consumer. This limitation also will become effective for information shared among affiliates on or after October 1, 2008.

These are the general rules, but they ultimately may have little relevance to affiliate marketing programs because of a broad exception under what is known as "constructive sharing." The following example illustrates how constructive sharing works: Life Affiliate establishes a set of criteria for consumers to whom it wishes to market life insurance. The criteria might include, for example, individuals who have a better-than-average claims history for auto insurance. Life Affiliate shares the criteria with Auto Affiliate. Auto Affiliate matches its insureds against the criteria and sends those who meet the criteria a solicitation inviting them to contact Life Affiliate if they are interested in purchasing life insurance. The practice described in this example is permitted under the Affiliate Marketing Rule for information in Category 2. It also may be permitted for information in Category 1 under certain circumstances.

In addition, as a general matter, constructive sharing is permitted where, using the example above, a service provider to Auto Affiliate matches the criteria provided by Life Affiliate with Auto Affiliate's claims data and sends out marketing solicitations for life insurance. In this case, Auto Affiliate must have a contract with the service provider controlling the terms of access to information and requiring the service provider to establish reasonable policies and procedures concerning the terms of access. Note that the service provider may be an affiliate within the affiliated group of companies that includes Auto Affiliate and Life Affiliate.

The constructive sharing exception gives insurers and other companies considerable flexibility in the use of affiliate data for marketing purposes. Indeed, given the breadth of the exception, many companies may decide that there is no reason to provide an FCRA opt out concerning the use of shared data for marketing purposes. Insurers and other companies should keep in mind, however, that additional restrictions on the sharing and use of medical and other health-related information established by the FCRA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and state laws also need to be considered when fashioning an affiliate marketing program.❑

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 experience 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.

NEW JERSEY LAME-DUCK

William F. Megna

LEGISLATIVE ACTIVITY

A lame-duck legislative session in New Jersey started after the November 6 elections, and will last until the new Legislature is installed in January. Even though all 120 legislative seats were in play, there was very little change in party control. The Democrats continue to have a sizable majority in the Assembly and Senate.

This lame-duck session will have to deal with controversial issues such as paid family leave, school funding formulas, possible sale of toll roads and other asset monetization plans, repeal of the death penalty, eminent domain and affordable housing initiatives. Only two general voting sessions have been scheduled by the Assembly and Senate during this period.

Senator Vitale recently was reported in the press to say that he will not introduce his health reform plans until next year. If the Administration introduces any of its own health reform plans during lame-duck, I suspect the proposals would be heard in committee only as a trial balloon for the next year.

On October 26, the Governor signed A.439, a bill requiring health insurers to honor an assignment of benefits for ambulance service payments. The bill was amended during the legislative process to:

- Narrow the scope to include only emergency ambulance services;
- Lower the interest rate for overdue payments from 20% to 12%; and
- Exclude application to Medicaid coverage.

A.3790 was passed by the Assembly on June 21st and was referred to the Senate Health Committee. There is a possibility that the bill could be heard by this committee during lame-duck. The bill, as amended by the Assembly, reforms the review, processing and payment of certain health and other (e.g., workers' compensation, accident, auto) insurance claims relating to the provision of physical therapy services by physical therapists. Among other things, the bill:

- Bans the use of prior authorization for physical therapy services;
- Bans the use of a referral for physical therapy services;
- Requires the use of the PIP fee schedule for payment of certain physical therapy benefits;
- Requires a carrier to accept an assignment of benefits;
- Appears to empower only providers to make determinations of medical necessity;
- Defines a "covered physical therapy benefit" to be any service provided by a physical therapist to a covered person, irrespective of any coverage limit in the contract, and thus appears to create an unlimited benefit; and
- Requires carriers to respond to request for prior authorization within three days.

A.4430 was introduced in the Assembly on November 8th. This is an radical piece of legislation, which would replace any form of managed care with mandatory hospital and medical fee schedules. This is a bill to watch in the next session as health care issues will begin to take center stage with the Administration. The State's projected $3 Billion budget deficit, however, must be resolved by July 1st of next year before any real debate on health reform can take place.

REGULATORY ACTIVITY

The Department of Banking and Insurance (DOBI) has proposed amendments to its rules relating to general contract provisions for group life, group health and blanket insurance. The new rules provide the following changes of interest. require that an insurer shall not limit or exclude benefits for losses caused by third parties; prohibit carriers from limiting or excluding health benefits for losses resulting from complications from elective medical procedures, including surgeries (this may require changes to the standard SEH plans which currently exclude complications from cosmetic surgery); prohibit a carrier from reserving to itself the sole discretion to interpret the terms of the policy; require civil union partners to have the same benefits and protections afforded to spouses; and clarify what type of benefits are subject to rules governing preauthorization. Many of the changes simply put into regulation existing DOBI positions.

DOBI amended its HCAPPA Q & A on its website to provide guidance that offsets for alleged overpayments of HCAPPA-subject claims should only be made against future HCAPPA-subject claims involving the same health care provider and the same carrier. In effect, this would create a need to segregate the accounting of provider payables.

On October 17th, DOBI issued its eleventh-annual HMO report card. Generally, the findings were that health plans were consistent in most performance categories while customer satisfaction measures deteriorated somewhat. However, DOBI noted in its press release that some of the more significant changes in customer satisfaction could be a result of changes in the format of the customer satisfaction questionnaire.

OTHER DEVELOPMENTS

The Attorney General/Board of Medical Examiners Advisory Committee on Physician Compensation is seeking public comment concerning all forms of direct and indirect compensation to physicians from the pharmaceutical and medical device industries that may cause, or be perceived to cause, conflicts of interest or undue influence in medical practice. An informal committee hearing will take place on November 16, 2007. ❑

Bill Megna is Of Counsel in the firm's insurance and riensurance group. His practice spans the entire spectrum of insurance products and services including property and casualty, life and health, reinsurance, surplus lines, and captives. Bill is managing attorney of the firm's New Jersey office and also practices out of the D.C. office.

SUPREME COURT OF CALIFORNIA RULES THAT REINSURANCE AGREEMENTS ARE NOT DISCOVERABLE

By J. Ben Vitale

In *Catholic Mutual Relief Society et al. v. Superior Court of Los Angeles County,* Case No. S134545 (August 27, 2007), the Supreme Court of California held that the Code of Civil Procedure § 2017.210 does not require a nonparty liability insurer to furnish discovery of all reinsurance agreements entered into with nonparty reinsurers. In so holding, the Court affirmed a prior decision of the Court of Appeal.

The case involved a suit brought by approximately 140 persons against the Roman Catholic Archdiocese of San Diego ("Church") and the San Bernardino Archdiocese. *Id.* Petitioner Catholic Mutual Relief Society is a nonprofit corporation that administers a self-insurance fund for more than three hundred archdioceses in the United States and Canada through its wholly owned subsidiary, petitioner Catholic Relief Insurance Company of America. *Id.* Pursuant to a stipulated order regarding settlement and mediation proceedings, the trial court issued an initial case management order, directing the Church to turn over copies of all insurance policies that might provide coverage for the claims. *Slip Op.* at 2. After the Church produced copies of its liability insurance policies issued by petitioners, plaintiffs complained that this information was insufficient. *Id.* Plaintiffs contended that they also needed to know whether petitioners were financially sound enough to cover the policy obligations. *Id.* at 3. The settlement judge then issued an order permitting the plaintiffs to serve deposition subpoenas on the petitioners seeking broad categories of financial documents, including all writings reflecting the total amount of funds available from reinsurance to satisfy any defense expenses or indemnify losses in association with the claims. *Id.* at 3-4. "The information was sought for the exclusive purpose of informing and facilitating pretrial settlement" of the claims against the Church. *Id.* at 6.

Petitioners moved to quash the subpoenas on the basis that they were not reasonably calculated to lead to the discovery of admissible evidence and therefore were beyond the permissible scope of discovery. *Catholic Mutual Relief Society, Slip Op.* at 4. The settlement judge denied the motions, finding that the subpoena requests were "'clearly relevant and discoverable' to inform and facilitate settlement." *Id.* at 5.

Petitioners sought a writ of mandate from the Court of Appeal to vacate the settlement judge's order. *Id.* The Court of Appeal granted relief, concluding the information sought was not discoverable under either the general statutory discovery provision or the specific provision authorizing limited discovery of insurance information as a matter of right. *Id.* The Court of Appeal vacated the settlement judge's order, finding that (1) none of the broad financial information sought from the petitioners was relevant or discoverable on a showing of good cause and (2) "section [2017.210] was intended to reach only a defendant's [direct] insurer, not that insurer's reinsurance agreements." *Id.* at 5-6. The Supreme Court of California granted review on the limited issue of whether section 2017.210, which authorizes limited discovery of liability insurance coverage as a matter of right, likewise authorizes discovery of the nonparty liability insurer's reinsurance agreements for purposes of facilitating pretrial settlement. *Id.* at 6.

Although insurance information is inadmissible to prove negligence or other wrongdoing, Code of Civil Procedure § 2017.210 creates a statutory exception that provides, in pertinent part,

> [a] party may obtain discovery of the existence and contents of any agreement under which any insurance carrier may be liable to satisfy in whole or in part a judgment that may be entered in the action or to indemnify or reimburse for payments made to satisfy the judgment. This discovery may include the identity of the carrier and the nature and limits of the coverage. A party may also obtain discovery as to whether that insurance carrier is disputing the agreement's coverage of the claim involved in the action, but not as to the nature and substance of that dispute….

The Supreme Court acknowledged that reinsurance arguably falls within the language of the statute "because it is an agreement whereby the reinsurer agrees 'to indemnify or reimburse for payments made to satisfy the judgment.'" *Catholic Mutual Relief Society, Slip Op.* at 12. Nonetheless, considering the language of the statute as a whole, the Court found the statute ambiguous on the point. *Id.* Contributing to this ambiguity, the term "any insurance carrier" is qualified by the circumstance that the carrier "may be liable to satisfy in whole or in part a judgment that may be entered in the action." *Id.* The Court noted that "the liability insurer is directly liable to satisfy the judgment in the underlying action with respect to the parties, whereas a reinsurer is only derivatively liable to 'indemnify or reimburse' the liability insurer for payments made in satisfaction of the underlying judgment." *Id.* at 13. As a result, the Court further found the use of the term "satisfy the judgment" ambiguous in this regard. *Id.*

Due to the numerous ambiguities in the statute, the Court turned to the principles of statutory interpretation to determine the intent of the statute with regard to reinsurance. The Court found that "[n]othing in the language or legislative history of former section 2017(b) (now § 2017.210) discloses an intention to extend the scope of the limited discovery right beyond primary liability insurance policies to reinsurance agreements." *Id.* at 16.

> The availability and extent of a defendant's liability insurance coverage is important information that plaintiffs are clearly entitled to discover under section 2017.210. 'The presence or absence of liability insurance is frequently the controlling factor in determining the manner in which a case is prepared for trial.' A nonparty insurer's reinsurance information, in contrast, would not be of any relevance to plaintiffs in the vast majority of cases.

Id. (internal citations omitted). "The amounts of liability insurance policy limits directly available to respond to the underlying judgment are not increased by the existence of a liability insurer's reinsurance agreements." *Id.*

Continued on page 9

Ultimately, the Court held that:

> [t]he language of section 2017.210 allows for discovery of the "existence and contents" of liability insurance policies that may be available to satisfy a judgment, not the assets of the insurance companies providing the insurance. Reinsurance is an asset of a liability insurer, just as capital reserves are, and nothing in prior case law, legislative history, or the statutory language suggests that either the common law right to discover insurance information or section 2017.210 authorize broad discovery of the financial health of the liability insurer or its ability to meet its contractual obligations under its policies.

Id. at 17. As a result, the petitioners were not required to furnish plaintiffs with all reinsurance agreements entered into with nonparty reinsurers. ❑

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HASSETT'S OBJECTIONS

Continued from page 1

In those situations, a determination must be made of whether to appeal the trial court's ruling. An appeal may be self-defeating where the appellate court is at least as likely to reverse the portions of the ruling favorable to the policyholder as to reverse the portions of the ruling unfavorable to the policyholder. In those situations, it seems to make sense to allow the title insurer to decline to appeal and to indemnify the policyholder for the loss arising from the trial court's ruling.

A New York court appears to disagree with me. In *Schneider v. Commonwealth Land Title Ins. Co.,* Supreme Court, Kings County, Case No. 41320/2004 (decided September 11, 2007), the court held that the title insurer was obligated to appeal a trial court's ruling that included both favorable and unfavorable elements, notwithstanding the title insurer's conclusion that the risks of reversal of favorable aspects of the trial court's ruling outweighed the likelihood of an appellate reversal of the remainder of the decision.

Commonwealth had issued an owner's policy covering certain premises. The insured's neighbors subsequently commenced an action, claiming that they owned the insured property by adverse possession. The trial court entered a mixed decision; the adverse possessors were awarded the front portion of the land, but the insured was awarded the rear portion. Commonwealth declined to appeal but offered to pay the difference in value between the entire premises versus the value of the entire insured premises less the front parcel. Commonwealth was concerned that the appellate court was more likely to award the adverse possessors the entire parcel than to award the policyholder the entire premises. After weighing the risks and rewards, Commonwealth decided not to appeal but immediately to cover the policyholder's insured loss.

After Commonwealth declined to authorize an appeal, the insured retained its own counsel and prosecuted the appeal. As Commonwealth feared, the appellate court found in favor of the adverse possessors on all issues and awarded them the entire property.

The policyholder then brought an action against Commonwealth seeking reimbursement for its loss of the entire property, as well as costs and expenses associated with the appeal of the underlying case. Upon various cross motions, the *Schneider* court held that the Schneiders' decision to appeal was "reasonable," which imposed a duty upon Commonwealth to prosecute the appeal. Because Commonwealth did not do so, it was liable for the loss of the entire parcel, as well as costs and expenses from the appeal.

In my view, the court is wrong. It is not at all unusual for an insurer or counsel to be faced with a choice between two or more "reasonable" alternatives. Indeed, that is the essence of practicing law and handling claims. Not all "reasonable" alternatives are equally wise. In *Schneider*, New York law was uncertain as to whether a claim of adverse possession had to be made "under a claim of right" or whether open and hostile possession was sufficient. If a claim of right was required, then the Schneiders may well have won their appeal, given evidence that the neighbors had been well-aware of the insured's title. Conversely, if a claim of right was not required, the Schneiders likely would lose their appeal.

The insurer should have the authority to determine whether to cut its losses, rather than to gamble on appeal. The essence of title insurance is indemnification for the loss; the right and duty to defend is to ensure that the title insurance company can weigh the merits of the claim and the risks and rewards of further litigation. If the title insurer elects to pay the loss, it should be able to do so without risking a total loss and bearing the costs of an unwise appeal.

Granted, title insurance differs from liability insurance in the sense that the amount of the loss itself may be disputed. That is, under a commercial general liability policy, the loss usually will be the amount of an adverse judgment less any deductible. In the case of title insurance, the value of a loss of a portion of a parcel may be disputed, particularly where the loss does not proportionately affect road frontage, topography or other factors. However, whatever difficulties may apply to the evaluation of a partial loss of title does not justify a rule requiring the insurer to prosecute an appeal that it deems unwise. Indeed, the net effect of the court's ruling is to accord property owners additional settlement leverage with the title insurer to overpay a loss to avoid expenses on appeal. The more efficient rule would be to allow the title insurer to decide whether to appeal based upon its evaluation of the merits. ❑

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Continued from page 1

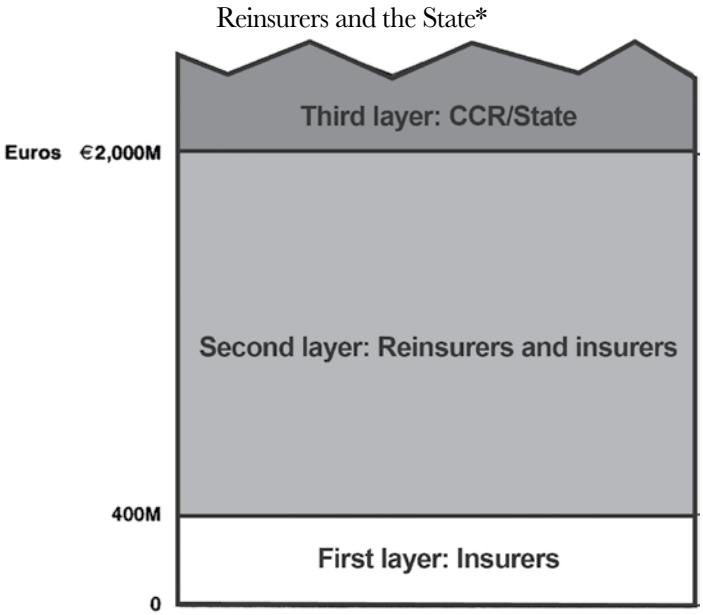
Just recently, Senators Hillary Clinton and Bill Nelson introduced The Homeowners Defense Act of 2007. A companion bill has passed the House. The legislation provides for a voluntary state catastrophe pool for federal catastrophe reinsurance and for low interest loans. In addition, much discussion has occurred concerning an expansion of the Federal Flood Program. Limited support has been garnered for sub-prime mortgage-holder relief, as well as a wildfire pool.

Such political talk and action only underscore the deep-seeded notion that a federal bailout is viewed in many cases as the answer to a large unreimbursed loss. Most experts believe in a market-driven economy, private insurance should always be primary, with a federal bailout only becoming necessary if the private sector is unable to handle the risk or social issues drive us as a society to conclude that a federal bailout is required. In September, 2006, a Government Accounting Office ("GAO") report on terrorism to the Chairman on Financial Services of the House of Representatives cited four criteria indicating private coverage should be preferred. The risk profile is:

1) Past occurrences sufficient in number and homogeneity;
2) Definite and measurable in dollar value;
3) Occur by chance (exception: terrorism); and
4) Will not result in an enterprise-ending loss for an insurer.

In my view, a leading criteria has been omitted: political pressure or support.

GAREAT 2004 Financing Structure Involves Insurers,



Source: GAO analysis of information from GAREAT.
* GAO-05-199 Catastrophe Risk

Government involvement in satisfying economic or financial losses is deep-seeded in our nation's history. President Franklin Roosevelt created the Works Progress Administration ("WPA") in 1935 in response to the Great Depression. Farm support, subsidies and price controls were born in the 1930's driven by the drought conditions in the Midwest. More modern bailouts were evidenced by government support during the Savings and Loan crisis and during the impending failure of Chrysler Corporation. After 9/11, the airlines sought a federal bailout but were unsuccessful. However, no federal backstop program has approached the $100 billion Terrorism Risk Insurance Act of 2002.

In other countries, programs were instigated for different reasons. Since inception, the Spanish program has built a substantial surplus and now covers most natural catastrophes as well as terrorism. Since its inception, Pool Re has also grown substantial surplus as the IRA bombings have subsided.

These facilities, together with our TRIA, provide confidence for the financial markets. Since 9/11, there have been several noteworthy terrorist attacks: the 2004 Madrid commuter train bombing, the 2005 London subway bombing, and the 2006 Madrid airport garage bombing. Interestingly, my information is that none of these losses triggered a state response. In essence, all these high profile, but manageable losses, were handled within the capacity of the terrorism programs without accessing state funds.

We are now in a deep debate about the extension of TRIA. Most think it will happen. The most problematic area of coverage which is being debated is whether our terrorism coverage should include coverage for so-called NBCR (nuclear, biological, chemical and radiological) losses. The latter may need some explanation. A radiological loss does not involve a nuclear bomb. It involves destruction by a conventional bomb spreading radiological debris. The House Bill requires that carriers "make available" limited NBCR coverage. The Senate Bill does not.

It seems the issue, even with limited NBCR coverage, is whether or not carriers can find reinsurance in order to cover their deductible and co-pay responsibilities. I am under the impression that whereas there is limited chemical and biological reinsurance, and perhaps a very limited amount of radiological reinsurance, there is almost no nuclear reinsurance. Perhaps in recognition of this, the House Bill requires the Secretary of the Treasury to establish a "terrorism buy-down fund" through which insurers may purchase coverage and pool risks for terrorism losses.

Many other state terrorism funds include reinsurers as part of the private sector solution. For example, the following schematic of the French system provided by the GAO report on catastrophe risk prominently relies upon reinsurance. Is it fanciful to believe that Congress might establish a blue ribbon study group, much like the 9/11 commission, to analyze the most efficient and fair method in which to cover societal risks? Whether such risks are terrorism, hurricane, flood or earthquake, a comprehensive plan might establish parameters for the private sector and set an attachment point or level at which we, as a people, believe society should respond to a natural disaster or act of terrorism. Wouldn't it be better to have federal backstop programs in place for market stability, even if not called upon? As an illustration, would we respond with federal assistance in the event of a reoccurrence of the 1906 San Francisco earthquake? Certainly. So why not engage in a thoughtful debate and enactment of corridors for private coverage and attachment points for federal backstops before a calamity occurs?

Continued on page 11

Otherwise, we are doomed to address politically motivated government support by passing the hat in Congress for large sums of money following a major loss. On a more realistic scale, we can only hope that Congress seriously addresses the need for a degree of NBCR coverage in the extended Terrorism Risk Insurance Act. ❑

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LETTER FROM WASHINGTON

Continued from page 1

A. Background and Spitzer Era Cases

Traditionally, insurance producers received contingent commissions from insurers on the back end based on profitability or volume of business. However, the Spitzer investigations indicated that some "mega-brokers" and insurers used contingent commissions and "placement service agreements" (which require insurers to pay upfront) to engage in business-steering, bid rigging, and other anti-competitive conduct.

On the heels of these investigations, then-Attorney General Spitzer and several other state attorneys general filed suit against brokers and insurers alleging antitrust, RICO, and other state business fraud claims. At least three cases in New York and Florida remain pending, and these cases reflect the erroneous assumption that undisclosed contingent commissions are per se illegal. The pending cases also conflate "contingent commission agreements," which are traditionally calculated after expiration of the policy term, with "placement service agreements," "market service agreements," and other agreements that are calculated upon the initial sale.

Nonetheless, in one of the pending cases, *People of the State of N.Y. v. Liberty Mutual Insurance,* No. 401726/2006 (N.Y. Sup. Ct. filed July 31, 2006), the defendants argued to the trial court both that contingent commissions were legal and that a fiduciary relationship does not arise between an insurance producer and the insured. When denying Liberty Mutual's motion to dismiss, the court found that even if the defendants' arguments regarding contingent commissions were true, they do not refute the allegations of bid rigging. The court maintained that "bid rigging schemes" are not "contractual agreements" and may violate duties owed to the insured. Thus, though somewhat circuitously, this ruling distinguishes legal contingent commissions from illegal bid rigging and manipulations of the market.

The final disposition of Liberty Mutual and other pending cases will provide additional guidance on New York's interpretation of "contingent commissions." Nevertheless, this preliminary ruling in Liberty Mutual is consistent with recent cases, discussed below, that recognize the distinction between standard contingent commissions and illegal schemes to manipulate the market.

B. Recent Cases

Most recently decided and filed cases depart from prior cases that conflated "contingent commissions" with overarching schemes to control the marketplace. These recent cases collectively support the argument that contingent commission agreements, in the absence of a horizontal conspiracy to restrain competition, are legal and do not violate antitrust laws.

In *Hersch v. DeWitt Stern Group, Inc.,* 841 N.Y.S.2d 516 (N.Y. App. Div. Sept. 7, 2007), the Appellate Division of the Supreme Court of New York ruled favorably for an insurance brokerage firm by dismissing a plaintiff insured's claims against a the brokerage firm for failing to disclose its contingent commission agreement with the insurer who issued insured's policy. The court held, "Contingent commission agreements between brokers and insurers are not illegal, and, in the absence of a special relationship between the parties, defendant had no duty to disclose the existence of the contingent commission agreement." *Id.* at 517-18 (citations omitted). Moreover, Hersch further supported the proposition that undisclosed contingent commissions are legal by holding that the broker did not have any fiduciary duties to the insured even though the parties' relationship extended over a considerable amount of time and the broker assured the insured that his insurance needs were being met.

In *In re Insurance Brokerage Antitrust Litigation,* Civ. Nos. 04-5184, 05-1079 (D. N.J., Aug. 31, 2007), a federal court dismissed class action antitrust claims against defendant insurers and brokers. The court made findings that demonstrate that undisclosed broker and insurer contingent commission agreements are legal as long as the brokers and/or insurers do not conspire with each other to use contingent commissions, or any other business transaction, in a manner, such as bid rigging, to restrict competition.

The federal court's findings are consistent with the allegations in a pending civil law suit the Ohio Attorney General filed against Marsh and an array of insurers on August 24, 2007. The petition focuses on schemes to allocate business using false bids and horizontal agreements between insurers through Marsh to orchestrate the division of industry business and restrain competition. Most notably, none of the allegations involve the use of standard contingent commissions, and, in fact, an alleged admission of an insurer in the complaint claims Marsh characterized the agreements as "beyond a contingent commission agreement."

In conclusion, recent cases support the legality of contingent commissions per se while rebuking bid rigging and other concerted anticompetitive conduct. Although some of the largest brokerage firms have pledged to cease use of contingent commissions, these holdings support insurance producers who continue to use contingent commissions legally without restricting competition.❑

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