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LETTER FROM WASHINGTON

WHY MOVE ONSHORE?

By Robert H. Myers Jr.

The creation of captive insurance companies started offshore almost 40 years ago in exotic locations such as Bermuda, Guernsey, and Gibraltar. In part, the establishment of these alternative risk transfer mechanisms in these offshore domiciles can be attributed to the ease with which they could be created and the relatively liberal way in which they were regulated. Their establishment reflected a desire to escape the inflexible strictures of the U.S. state-based regulatory system.

The use of captives has burgeoned over the past 30 years. Bermuda is now a *bona fide* world financial center, and the Cayman Islands has

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HASSETT'S OBJECTIONS

IT'S ABOUT TIME

By Lewis E. Hassett

I just received my American Express statement, which reflected a credit of 41cents for a class action settlement. Imagine my relief that the class action bar made so valuable a contribution to my economic well-being. I was not even aware of the settlement. Like many of you, over the past ten years, I have received numerous class action notices, informing me of the settlement of some alleged wrongdoing for which I might be a member of the plaintiff class. The gist of these notices is that, if I spend three hours of my time going through my records to show that I am a member of the class, I might collect benefits of dubious value. I would be entitled to benefits worth 41 cents. Moreover, typically, these benefits are in the form of unwanted coupons or vouchers.

Juxtaposed against the pittance of value to class members are hefty attorneys' fees to the lawyers for the plaintiff class. My first reaction

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PLAYER'S POINT

INDUSTRY IN TURMOIL: THE FINITE REINSURANCE MESS[1]

By Thomas A. Player

In a recent speech, Eliot Spitzer is reported to have said, "We need fundamental rewriting of the insurance law. The insurance industry deserves real scrutiny."[2]

We have brought it on ourselves.

High Profile Misdeeds

I have given some thought as to how we got to where we are and what it will mean in the future. The insurance industry arrived at this point because of a limited number of high-profile misdeeds. Specifically, bid-rigging between Marsh and AIG. That has led Mr.

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Inside this issue

Announcements

Joe Holahan and **Tom Player** contributed an article for the May 2005 issue of ***Business to Business*** titled "Terrorism Insurance: A Changing Prospect." If you would like a copy of this complete article, please e-mail Joe Holahan at jth@mmmlaw.com.

Lew Hassett's article in the Winter 2004 MMM Review is quoted in an article in the March edition of ***Mealey's Reinsurance Reports*** (15 Mealey's Litig. Rep. Reinsurance 10 (March 17, 2005)) titled "Me Judice," written under the pseudonym Pollux.

Tom Player and **Tony Roehl** contributed an article for the June 2005 issue of ***INTERSEC: The Journal of International Security*** regarding the substantial limitation of liability benefits to manufacturers of antiterrorism technologies available under the SAFETY Act. If you would like a copy of this complete article, please e-mail Tony Roehl at acr@mmmlaw.com.

Tom Player chaired a panel discussion on broker activities at the Insurance Accounting & Systems Association (IASA) Annual Conference in Anaheim in June. The topic was "The Regulation of Broker Activities: A Sea Change in the Insurance Industry?" Other panel members were **Ernst Csiszar**, President & CEO of Property Casualty Insurers Association of America (PCI) and **Gary Cohen**, General Counsel at the California Department of Insurance.

The Georgia Department of Insurance Commissioner John Oxendine recently initiated an investigation into finite risk transactions. The investigation so far includes: (1) orders to preserve documents (sent to all Georgia domestic companies and large reinsurers doing business or licensed in Georgia); and (2) subpoenas for information related to finite transactions (sent to holding company groups of major reinsurers.) **Dick Dorsey**, **Tom Player** and **Tony Roehl** are assisting respondents in this process.

The non-profit enterprise risk management organization, the ERM Institute International, Ltd. (ERMII), is up and running. Among its initial members are the Casualty Actuarial Society as well as a number of international universities, including Georgia State University. The purpose of ERMII is to focus on education, research and training in enterprise risk management. Our firm is proud to be legal counsel for ERMII. Assisting in the creation and organization of the Institute were **Bill Winter** and **Tom Player**.

GEORGIA ENACTS LIFE SETTLEMENT STATUTE

By Anthony C. Roehl

Georgia Governor Sonny Perdue recently signed into law the Georgia Life Settlement Act (formerly Senate Bill 217). The Governor signed the legislation into law on May 9, 2005, and the Act is fully effective 180 days later on November 5, 2005. The life settlement industry was not previously regulated in Georgia.

The Act creates a new license category for a life settlement provider. The statutory definition of a life settlement provider is a person, other than a seller, who enters into or effectuates a life settlement contract.[1] Along with the requirement for a license to effectuate a life settlement contract, the Act also imposes form restrictions on life settlement contracts. Under the new law, life settlement providers may only use pre-approved life settlement contracts and disclosure statements filed and approved by the Georgia Commissioner of Insurance. The Commissioner has the authority to disapprove a life settlement contract form or disclosure statement if, in the Commissioner's opinion, the contract or provisions are unreasonable, contrary to the public interest or otherwise misleading or unfair to the seller.

Also, the Act mandates specific disclosure requirements to be met in conjunction with any sale or purchase of a policy. The disclosures must be in a separate writing signed by the seller and the life settlement provider and, among other things, must provide the following: that there exists possible alternatives to the life settlement contract; that some or all of the proceeds of the life settlement contract may be taxable; and that the seller has the right to rescind a life settlement contract before the earlier of 30 days after the day upon which the life settlement contract is executed by other parties or for 15 days after the receipt of the proceeds from the transaction. Additionally, and potentially more significant than the other changes, the Act also restricts parties from entering into life settlement contracts within the two-year contestability period of a policy. This provision may pose a problem to life settlement companies operating in Georgia because the definition of life settlement contract, as noted above, includes financing transactions at inception, thus making illegal the premium financing of life insurance policies.

In short, the Georgia Life Settlement Act presents a complex new regulatory scheme for life settlement transactions in Georgia and includes a myriad of restrictions and requirements that life settlement providers are required to comply with in order to avoid substantial penalties for

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GEORGIA'S 2005 DOI HOUSEKEEPING LEGISLATION IMPACTS AGENTS, THIRD-PARTY ADMINISTRATORS AND P&C INSOLVENCY POOL

By Joseph L. Cregan

In the most recently concluded session of the Georgia General Assembly, the Georgia Department of Insurance successfully lobbied for and obtained the passage of H.B. 407 which makes a number of significant changes affecting Georgia's insurance regulatory structure. The Bill clarifies Georgia's law with respect to the simultaneous acceptance of fee and commission by insurance producers, tightens up the regulation of third-party administrators (TPAs), enhances the Commissioner's power to regulate persons involved in the sale of insurance to military personnel on bases in Georgia, and makes a number of enhancements to Georgia's property and casualty guaranty association law. The changes in this Bill affect a broad spectrum of persons and entities in the insurance industry and are worth a more detailed look.

Third-Party Administrators

Sections 1, and 7-10 of the Bill reflect the Commissioner's to standardize the regulation of TPAs to follow the same guidelines and format as applies to the regulation of agents, brokers, counselors and other entities (other than insurance companies) regulated by the Georgia DOI. For example, the bill clarifies that a violation of the law by a TPA could subject the TPA to the same penalties (*i.e.*, $1,000 for every proven violation of the Insurance Code or $5,000 if willful) as now pertains to an agent or broker. The definition of administrator is broadened to include premium collection and claims settlement work done on behalf of nearly every type of insurer; whereas the prior law only required licensure for handling such activities for life, accident and sickness insurance or certain types of self-insured workers' compensation business. It limits the exemption that an insurance company (or its affiliate) enjoys from the requirement to be licensed separately as a TPA so that TPA activities done for an insurer that is unlicensed in Georgia do not quality for the exemption. It tightens the requirements for general renewal of the administrator's license, allows for the issuance of probationary TPA licenses in certain circumstances and increases from 2 to 5 years the "cooling off" period that a revoked TPA licensee must wait before reapplying for another TPA license. The Bill also codifies a $100,000 minimum amount of errors and omissions insurance (this was formerly required by regulation, the new bill makes this a statutory requirement and requires use of an admitted carrier for such coverage). The Bill also requires the TPA's E&O coverage and fidelity bond to remain in place for at least one year after the TPA surrenders or otherwise terminates its license. The Bill provides that TPAs are subject to market conduct and financial examinations and are responsible for the cost of such examinations. Representatives from the Commissioner's office indicate that the tighter regulation of TPAs is necessary to "standardize" regulation of this industry group and to address certain problems identified with both TPA applicants and TPA licensees in the past few years.

Military Sales

Sections 4 and 5 of the Bill are responsive to Commissioner Oxendine's recent inquiries into certain sales activities on or near United States military installations in Georgia. The Bill expands an existing law that allows for special registration of non-resident agents to sell policies to military personnel on bases outside the United States, provided that the applicant has not been previously sanctioned by any United States military installation in any manner. Another section amends certain of the grounds for refusal, suspension or revocation of an agent's license to clarify that transgressions involving a sanction imposed by another governmental authority -- including the United States military or a particular military installation -- are added to the reasons the DOI can rely on to sanction an agent.

Agent Entertainment Issues

Sections 2 and 3 of the Bill create new laws modifying Georgia's unlawful inducement statute (§ 33-9-36); providing that an agent, broker or insurance company employee can pay for food or beverages consumed by current or prospective clients at a seminar or sales presentation, provided that no insurance or annuity contracts are offered or accepted at such events. It adds similar language to the unfair trade practices chapter (O.C.G.A. § 33-6-4) so that providing food or refreshments is also not considered a potential Unfair Trade Practices Act violation.

Agent Commission and Fee Regulation

HB 407 enacts a new Code section that deals with the highly controversial issue of compensation to producers and to counselors. "Counselors" is a Georgia insurance license category for persons who are deemed to have special expertise in the insurance field and who typically draw their compensation from fees paid by the insured party, rather than commissions paid by the insurance carrier. The new statute indicates that a counselor cannot simultaneously accept a fee from the customer and a commission from the insurer unless the counselor has obtained the customer's written acknowledgement that such compensation will be received and adequately discloses the amount of such compensation from all sources. The same section also requires that an insurance producer not

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CALIFORNIA COURT CURTAILS FISHING EXPEDITION FOR REINSURANCE INFORMATION

by James A. Kitces

A California appellate court recently ruled that plaintiffs in a sexual abuse case could not obtain documents concerning a non-party insurer's financial condition, including its reserves and any reinsurance agreements. *Catholic Mutual Relief Society v. Superior Court of the County of Los Angeles, et al.,* No. B178101, Calif. App., 2nd Dist., Div. 8 (Apr. 25, 2005). This litigation stemmed from a suit involving approximately 150 plaintiffs who sued the Roman Catholic Archdiocese of San Diego alleging that they were sexually abused during their childhood by various church priests.

After a stipulated order regarding settlement and mediation proceedings, the trial court directed the church to produce copies of all relevant insurance policies issued by Catholic Relief Insurance Company of America. *Id*. at *2. Over objection by the church, the trial court then allowed the plaintiffs' deposition subpoenas seeking information as to whether the church was financially sound enough to cover their policy obligations. *Id.* at *3.

The appellate court disagreed with the trial court, ordering the subpoenas to be quashed because the information sought was not discoverable. While the court acknowledged that the existence and contents of an insurance policy are discoverable under California law, nothing in California jurisprudence "even remotely suggests that [the scope of discovery] was intended to authorize discovery by an injured plaintiff into the financial health of the defendant's insurer." *Id*. at *13.

The plaintiffs argued that the scope of discovery encompasses discovery of reinsurance agreements because discovery of "any agreement under which any insurance carrier may be liable to satisfy or reimburse a judgment" is allowed. *Id*. at *16. The court rejected this argument, relying on the notion that reinsurance is a contract of indemnity between an insurer and its reinsurer and the original insured has no rights to that reinsurance. *Id*. at *18. The court distinguished this situation from the situation where the injured plaintiff becomes a third-party beneficiary of the insured plaintiff's liability policy. *Id*. Under

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WORLDCOM SETTLEMENT HIGHLIGHTS D & O COVERAGE

By Kristin B. Zimmerman

Earlier this spring headlines once gain turned to the WorldCom, Inc. ("WorldCom") securities class action when it was reported that eleven of the company's onetime directors announced that they had agreed to pay in excess of $20 million out of their own pockets to settle the suit. At the time the settlement was announced, Bert C. Roberts, WorldCom's former chairman, had not agreed to the settlement, leaving him the only remaining ex-director involved in the litigation. News of Mr. Roberts' reluctance to participate in the settlement followed on the heels of *In re WorldCom, Inc. Sec. Litig*., 354 F.Supp.2d 455 (S.D.N.Y. 2005), in which Mr. Roberts brought suit against WorldCom's excess D & O insurer, Continental Casualty Company ("Continental"), to compel Continental to honor an excess D & O liability policy that it issued to WorldCom and to immediately advance the costs of defending Mr. Roberts against the federal securities law claims.

WorldCom and its officers and directors were insured under a D & O liability policy issued by National Union Fire Insurance Company ("National Union"). The National Union policy provided primary coverage and required that the insurer advance defense costs prior to the final disposition of a claim. In December 2001, Continental sold an excess D & O liability policy to WorldCom. The excess policy followed the form, including the terms, conditions, and exclusions, of the underlying National Union D & O policy.

Continental was notified of the first WorldCom lawsuit in the spring of 2002 and informed WorldCom in September 2002 that it had unilaterally rescinded WorldCom's D & O policy due to submission of allegedly false financial statements with WorldCom's application for insurance. Roberts contended that under the terms of the National Union and Continental policies and under New York law, he was entitled to defense costs prior to the adjudication of whether Continental had effectively

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licensed as a counselor (*i.e.*, a "standard" agent) may not lawfully receive a fee from the customer for placement of insurance and therefore cannot ever receive a simultaneous fee and commission on the same transaction. These sections codify what the DOI already believed was current law (*see*, O.C.G.A. § 33-23-1.1 which was explicit as to the counselor's disclosure requirements, but silent on the issue of whether a "standard" agent could receive fee and commission if disclosure were provided).

Insolvency Pool Changes

Georgia's "safety net" protection for policyholders against the failure of a licensed property and casualty insurance company is known as the Georgia Insurers Insolvency Pool or "GIIP." Sections 11-23 of House the Bill make a number of important changes to the Georgia Insurance Code chapter that deals with GIIP's operations and authority. These changes were strongly supported by the GIIP Board, the insurance industry and the insurance trade groups. The amendments to the GIIP law are intended to align Georgia's law more closely with the NCIGF Model Act and the NAIC's Property and Liability Insurance Guaranty Association Model Act. There are numerous changes, the most significant of which are highlighted below:

- It raises the *de minimis* covered claim threshold amount from $25 to $50.
- It raises the maximum first-party covered claim from $100,000 to $300,000.
- It raises the maximum third-party covered claim from $100,000 to $300,000 (except for workers' compensation claims, who continue to receive statutory benefits).
- It clarifies that covered claims do not include repayments from the insolvent insurer to reinsurers or other insurers, HMOs or health plans.
- It adds a provision that a first-party covered claim cannot be paid to an insured whose net worth exceeds $10 million or a third-party covered claim on behalf of an insured whose net worth exceeds $25 million, and permits the GIIP to require financial statements from persons that may trigger those net worth thresholds.
- It clarifies that a covered claim does not include refunds for unearned premiums in excess of $20,000 or for unearned premiums from a policy that was not in force at the date the liquidation was ordered.
- It expands on the existing exemption of credit insurance products to state that certain coverages akin to credit insurance, such as vendor's single interest or other types of creditor protection insurance, are not covered by the GIIP.
- It greatly simplifies the process for the Commissioner to make appointments to the GIIP Board.
- It also outlines what is required for the Board's plan of operations and provides specifics as to what must be included in such plan.
- It creates exclusive venue for all actions taken by or against the GIIP in the Superior Court of DeKalb County, Georgia.
- It deletes a provision in the current law that assessments to solvent insurer members of the GIIP may be used by such insurers as a factor in their rate making.
- It establishes a mechanism by which solvent member insurers recoup their GIIP assessments via policyholder surcharges.
- It provides that the GIIP may borrow monies (with the Commissioner's approval) to carry out its obligations.
- It clarifies and makes optional the role for the GIIP to make reports on, and recommendations to, the Commissioner regarding insurer solvency regulation in order to help prevent future insolvencies.
- It provides immunity from any tort liability against the GIIP, its employees and agents, any of the GIIP member insurers, or the insurer executives who sit on the GIIP Board of Trustees.

H.B. 407 moved through the General Assembly with relative speed and was sponsored by one of the Governor's floor leaders in the House. It met with little resistance or controversy from either the House Insurance Committee or on the House Floor. There were a few minor amendments that were made when the Bill was sent to the Senate, but in the end the Bill did not draw any significant opposition from any company or industry trade group.

This Bill and several others passed this year (most notably H.B. 291) show the Department's increasing ability to pass significant legislation through the Georgia General Assembly. This increased legislative influence is attributable, at least in some part, to Commissioner Oxendine's longevity in office, as well as the recent shift of both chambers of the General Assembly from Democratic to Republican control. H.B. 407 was signed by Governor Sonny Perdue on May 2, 2005 and its provisions will become law on July 1, 2005.❑

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NEW JERSEY'S ANTISUBROGATION STATUTE PREEMPTED BY ERISA

By William F. Megna

In *Levine v. United Healthcare Corp.,* the Third Circuit ruled that New Jersey's antisubrogation statute is preempted by the Employee Retirement Income Security Act of 1974, as amended (ERISA). 402 F.3d 156 (3rd Cir.2005).

The New Jersey Supreme Court previously ruled that subrogation and reimbursement provisions in health insurance policies were invalid, because they conflicted with N.J.S.A. 2A:15-97, the state's antisubrogation statute. *Perreira v. Rediger*, 169 N.J. 399 (N.J. 2001). This law, essentially reverses the common law collateral source doctrine by requiring a plaintiff who receives benefits from any source other than a joint tortfeasor to deduct that amount from his or her recovery in any civil action. Thus, payments made by health insurers are deducted from a plaintiff's tort recovery under New Jersey law. In enacting the antisubrogation statute, the *Perriera* Court noted that the New Jersey Legislature had two choices: to benefit health insurers by allowing repayment of costs expended on a tort plaintiff, or to benefit liability carriers by reducing the tort judgment by the amount of health care benefits received. The liability carriers won.

After the *Perriera* case was decided, three insureds who had made reimbursement payments to their carriers sought recovery on the basis that the health insurers had been unjustly enriched. The health insurers moved the case to federal court and argued that the antisubrogation statute was preempted by ERISA. The U.S. District Court for the District of New Jersey ruled that the antisubrogation statute regulated insurance and was not preempted by ERISA. *Levine v. United Healthcare Corp.,* 285 F. Supp. 2d 552 (D.N.J., 2003) The District Court certified the case for Third Circuit review.

If the Third Circuit were to uphold the antisubrogation statute, the Court reasoned that it would have to determine that the statute regulated insurance since it related to ERISA plans. In *Kentucky Association of Health Plans Inc. v. Miller*, 538 U.S. 329 (2003) the United States Supreme Court held that a state law of insurance regulation is one that (1) is specifically directed toward entities engaged in insurance and (2) substantially effects the risk pooling arrangement between the insurer and the insured. The Third Circuit found that the anti-subrogation statue failed to meet this test and viewed the law broadly as one of civil procedure that went beyond the specific regulation of insurance. It's worth noting that the District Court used three McCarran – Ferguson factors relied earlier by the United States Supreme Court to determine if a state statute regulated insurance for ERISA purposes. See *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 366 (2002). The Third Circuit's opinion uses the two prong test explained in the United States Supreme Court's later decision in *Miller*.

After the *Perriera* decision by the New Jersey Supreme Court, the New Jersey Department of Banking and Insurance (DOBI) effective August 5, 2002 repealed its regulation that allowed subrogation for health carriers and replaced it with a regulation that conversely prohibited subrogation provisions in group health policies. N.J.A.C. 11:4-42.10. The claims of the individuals in *Levine* predated the *Perreira* decision and subsequent change in regulation. After 4 years of conflicting decisions and rulings, it remains unclear as to whether DOBI again will allow group health carriers the right to subrogate. Self insured health plans, however, continue to have the right to subrogate.❑

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

GEORGIA ENACTS LIFE SETTLEMENT STATUTE

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violating the Act, including imprisonment, fines and revocation and suspension of licenses. Also, a violation of the Life Settlement Act is considered an unfair trade practice under Chapter 6 of the Georgia Insurance Code carrying with it separate penalties and administrative remedies.

(Footnotes)

[1] Life Settlement Contract means a written agreement establishing the terms under which compensation or anything of value is paid, which compensation for value is less than the expected death benefit of the policy, in return for the seller's assignment, transfer, sale, devise or bequest of the death benefit or ownership of any portion of the policy. The definition of a life settlement contract also includes a contract for a loan or other financing transaction where the loan is secured primarily by the life insurance policy.❑

Tony Roehl is an associate in the firm's insurance and corporate groups. His principle areas of concentration are insurance regulation and insurance company financial matters. Tony received his bachelor's degree from the University of Florida and his law degree from the University of Michigan.

TAKING THE "PROMPT" OUT OF "PROMPT NOTICE"

By Jessica F. Pardi

Employers Reinsurance Corporation ("Employers Re") reinsured Allstate Insurance Company's ("Allstate") automobile insurance line for 44 years from 1934 until 1978 pursuant to several different reinsurance treaties. As part of these treaties, Employers Re reinsured Allstate's personal injury protection ("PIP") coverage which encompassed *unlimited*, lifetime medical payments to persons injured in automobile accidents. Thus, Employers Re's obligations endured long past the close of the treaties in 1978.

In 1999, Allstate reported to Employers Re eighty-eight (88) claims reinsured under a treaty in effect from 1972 to 1978 (the "Treaty"). Employers Re denied all 88 claims, and Allstate filed a lawsuit in the United States District Court for the Northern District of Illinois. *Allstate Ins. Co. v. Employers Reins. Corp.*, Case No. 01 C 1093, U.S.D.C. N.D. Ill., March 18, 2005.

Under the Treaty, Allstate initially had a $250,000 retention per claim. This was increased in 1976 to $350,000 per claim. Above such retention, Employers Re was obligated to indemnify Allstate for 100% of its claim payments. In 1999, as part of a PIP claims review, Allstate discovered 88 open claims that were covered under the Treaty but had not yet been submitted to Employers Re. Of the 88 claims, seven (7) had exceeded Allstate's retention, twenty-two (22) had reserves greater than 50% of Allstate's retention, and the remaining fifty-nine (59) had reserves of less than 50% of Allstate's retention.

Allstate's notification obligations under the Treaty were to "give prompt notice to [Employers Re] of any event or development which, in the judgment of [Allstate], might result in a claim upon [Employers Re] hereunder, and will forward promptly to [Employers Re] copies of such pleadings and reports of investigation as may be requested by [Employers Re]." Notwithstanding that there was no express provision requiring such action, Employers Re contended that Allstate had an obligation to notify Employers Re of claims that reached 50% of Allstate's retention. Employers Re claimed it used the 50% mark to illustrate that Allstate's claims reporting was "particularly dilatory." Additionally, Employers Re argued that Allstate's "bulk reporting" of the 88 claims, more than 20 years after the accidents occurred, violated the prompt notice language of the Treaty. Conversely, Allstate argued that the 88 claims were submitted timely, that Employers Re was not prejudiced by such submissions and that Employers Re should be estopped from denying claims because it previously had accepted similarly submitted claims.

The task for the Court was to determine whether Allstate acted reasonably under the circumstances in determining when to report claims to Employers Re. The Court noted cases such as *Atlanta Int'l Ins. Co. v. Checker Taxi Co.*, 214 Ill. App. 3d 440, 574 N.E.2d 22 (1991), in which it was held that if an excess insurer desired immediate and/or automatic notice of all accidents, it could have inserted language to that effect in the Treaty. Because the Treaty gave Allstate discretion to determine when a claim upon Employers Re might result, there was no requirement for immediate notice. Additionally, the Treaty makes no mention of the manner in which Allstate must provide notice, so Employers Re's claims of sloppiness and bulk reporting were disregarded by the Court. Further, the Court found that the Treaty imposed upon Employers Re the obligation to seek additional information if it believed the information provided by Allstate was insufficient.

The Court held that Employers Re's defenses with respect to the 59 claims that had not yet reached 50% of the retention were wholly without merit and Employers Re must pay those claims. With respect to twenty-one (21) of the 22 claims where Allstate's reserves exceeded 50% of the Treaty retention at the time Allstate gave notice of claims to Employers Re, the Court found that Allstate's exercise of its discretion to report such claims in 1999 was reasonable because "there has yet to be an event or occurrence which Allstate, in a reasonable exercise of judgment, believe[d] that a claim under the Treaty might arise."

There was, however, one claim within the 22 wherein a dramatic increase in payment on the claim began in 1995 and continued for a period of three years. The Court felt that it was unreasonable for Allstate to delay reporting the claim to Employers Re for four years until 1999 when the claim had nearly reached the retention. Employers Re was not obligated to pay that particular claim but was ordered to pay the other 21 of the claims.

The only category of claims which Employers Re did not have to pay was those claims first reported *after* they had surpassed Allstate's retention. With respect to these claims, the Court found that Allstate did not comply with the notice requirements. Additionally, the Court held that a notice requirement, such as the one contained in the Treaty, is a condition precedent to coverage, and Employers Re need not prove prejudice when such notice requirement was breached.❑

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

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Spitzer on a productive hunt for wrong-doing which, so far, has deposed two out of three Greenbergs and painted an entire distribution system utilizing performance incentives as illegal. Of course, I am referring to contingent commissions.

Contingent Commissions

Much comment has been made that contingent commissions are not necessarily illegal or unethical. Nonetheless, Joe Pulmeri, Chairman of Willis, in his keynote address at the Philadelphia RIMS Annual Conference, called for elimination of all contingent commissions. Easy for him to say, some remarked, having just settled with Mr. Spitzer for a $50 million set-aside for clients and a voluntary agreement to eliminate contingent commissions. Predictably, there was backlash.

But honestly, the public is not listening to us in the industry debate the issue. They have made up their collective minds. In their opinion, Spitzer is right. The industry is cutting corners at their expense.

Finite Reinsurance

Enter finite reinsurance. Finite reinsurance is that blurred financial transaction where the bright line is a 10% chance of a 10% loss. (The so-called 10/10 rule.) If you've got that probability, it's reinsurance. If you don't, it's simply a loan. Again, Spitzer has uncovered several transactions which seem to be poster children for abuse. For example, "reinsuring" losses which have already occurred: AIG and Brightpoint. Reinsuring to affiliates and claiming risk transfer: Union Excess, Richmond Insurance Company and Capco. These findings have energized the SEC to initiate its own investigation, the NAIC to examine changes in the 10/10 rule, and regulators everywhere, including Georgia, to set loose a cascade of subpoenas, some of which are warranted.

What may not be warranted is the Spitzer notion that we need fundamental rewriting of the insurance law. This is not the tax code. That is, insurance laws are not generally driven for social change nor amended to advantage one group over another. Ninety-nine percent of the insurance laws are fundamentally sound laws, which regulate financial products that are incredibly complicated. As reported earlier, some of the problems of the right and wrong of contingent commissions arise because of a muddling of the laws reflecting the responsibilities of an agent (who owes a duty to the insurer issuing the policy), and the broker (who owes a duty to the buyer).

Proposed Solutions

If you are not yet convinced that it's a complex business, take a look at the proposed solutions to the finite reinsurance dilemma. As I'm writing this Player's Point in mid May, the NAIC has focused on two potential changes to address the emerging finite reinsurance dilemma. The first change, proposed by the New York Department of Insurance, is to bifurcate the accounting treatment of a reinsurance treaty into its risk bearing and non-risk bearing elements. This change would require a revision to Statement of Statutory Accounting Principles 62 ("SSAP 62"). Under the proposed amendment to SSAP 62, the reporting insurer is required to estimate that layer of coverage within a reinsurance treaty where there is greater than a 90% probability that the ceding insurer will be reimbursed for its losses by the reinsurer. As proposed, such a layer of coverage would be reported as deposit accounting pursuant to guidance found in SSAP 75. The remainder of the coverage would be reported as reinsurance pursuant to guidance found in SSAP 62. Commissions and expenses would be prorated according to the percentage of premium allocated to reinsurance accounting and deposit accounting, respectively. Losses incurred and accompanying accounting entries would first be reported as deposit accounting until the coverage is exhausted, and thereafter, reported as reinsurance accounting.

The New York Department has also proposed changes to the Property & Casualty Annual Statement Blank interrogatories. The revised interrogatories would require companies to report contracts that contain one or more of the following features:

- A term longer than two years when the contract is non-cancelable by the reporting entity during the term;
- A provision that upon a cancellation, the reporting entity is required to enter into a new reinsurance contract with the reinsurer;
- Retroactive reinsurance coverage;
- Aggregate stop loss contract coverage;
- An unconditional or unilateral right by either party to commute the reinsurance contract disclosure if the management of the reporting entity believes that there is a greater than 50% chance that the reporting entity will commute the treaty;
- A provision permitting reporting of losses or payment of losses less frequently than on a quarterly basis; and
- Any payment schedule or accumulating retentions for multiple years or any features inherently designed to delay the timing of the reimbursement to the ceding entity.

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In addition, if the reporting entity answered "yes" to any of the above questions, it is required to complete a supplemental filing providing a summary of the reinsurance contract terms, a brief description of management's principal objectives in entering into the reinsurance contract, including the economic purpose to be achieved, and the financial statement impact of all such reinsurance contracts.

Moreover, the New York interrogatory proposal would also add an attestation by the chief executive officer and chief financial officer regarding reinsurance agreements. The officers would be required to attest under penalty of perjury that:

- The accounting treatment for all reinsurance contracts are consistent with SSAP 62;
- There are no separate written or oral agreements between the parties that would reduce, limit, mitigate or otherwise affect any actual or potential loss to the parties under the reinsurance contract;
- For each reinsurance contract the reporting entity has an underwriting file documenting the economic intent of the transaction and the risk transfer analysis evidencing the proper accounting treatment; and
- The entity has appropriate controls in place to monitor the use of reinsurance and adherence to the provisions of SSAP 62.

Conclusion

Having said all of this, the horse is out of the barn as far as the public is concerned. I am not sure we will long have the option of fixing the problems at the NAIC level. When Mr. Spitzer says "We need fundamental rewriting of the insurance law", you can bet that is code for Federal Legislation.❑

(Footnotes)

[1] *My sincere appreciation to Tony Roehl of our Atlanta office for his invaluable assistance in preparing this column.*

[2] *Speech to the Society of American Business Editors and Writers, May 2, 2005.*

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WORLDCOM SETTLEMENT
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rescinded the policy. Continental argued that, under New York law, Mr. Roberts was required to show that he could defeat Continental's rescission defense before Continental could be required to provide Mr. Roberts' with defense costs.

In holding that Continental's effort to avoid payment of defense costs before the legality of the rescission had been litigated failed, the court noted that a contract of insurance includes the duty to defend or to pay for the defense of its insured, that duty is a "heavy" one, and any doubts about coverage are resolved in the insured's favor. Further, the court stated that under a D & O policy with a duty to pay defense costs provision, the insurer's obligation to reimburse the directors attaches as soon as the attorneys' fees are incurred.

According to the court, Mr. Roberts was not required to show that he would succeed in defeating Continental's rescission argument. Mr. Roberts was only required to show that under the terms of the policies, he was entitled to payment of defense costs as they were incurred, and that as a matter of law, that obligation existed until the rescission issues have been litigated and resolved.

The court also discussed a public policy underpinning of its holding, stating that "[u]nless directors can rely on the protections given by D & O policies, good and competent men and women will be reluctant to serve on corporate boards." Ultimately, Mr. Roberts joined the other ex-directors and agreed to settle the class action over the bonds and securities issued by WorldCom. Mr. Roberts reportedly agreed to pay $4.5 million of his own money and WorldCom's D & O insurers are reported to have agreed to contribute an additional $1 million to settle the claims against Mr. Roberts.❑

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HASSETT'S OBJECTIONS

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was that I need to stop representing insurers and start representing plaintiffs. However, my jealousy eventually turned to disappointment at a system that essentially forces businesses to buy peace through the payment of attorneys' fees. These settlements make great sense for businesses. Even though the claim may be marginal on the merits, they can settle with the entire class for a finite (as a reinsurance lawyer, can I still use this word?) amount. Rarely do the opt outs present a significant problem.

[Full Disclosure: Our firm represents businesses in class actions and frequently arranges settlements. The views expressed herein do not necessarily represent the views of this firm or its clients.]

It seems that the Florida Court of Appeals has had enough. In *Fung v. Florida Auto. Joint Underwriter's Assn.*, Case No. 3D03-3050 (Fla. Dist. Ct. App. April 6, 2005), the Florida Court of Appeals rejected a class settlement that would pay class members benefits totaling $10,000 with attorneys' fees of $200,000. That is the good news. The bad news is that the trial court still approved a fee of $135,000. That still is too much in comparison to the benefit conferred. Where the fee award is thirteen times the aggregate class recovery, something is wrong. Such a ratio reflects a wasteful use of societal resources. The purpose of class actions is to allow a large group to benefit from a single lawsuit where the damages to any one defendant would not justify the cost of litigation. Class actions should not be used to bring cases where the ***aggregate*** of all class damages is less than the expenses incurred in obtaining the award. Societal resources should not be so readily squandered.

The *Fund* court is not the first to inject sanity into the class settlement process. In *Garabedian v. Los Angeles Cellular Tel. Co.*, 12 Cal. Rptr. 3d 737 (App. 2004), the court held (a) that a court must review the reasonableness of attorneys' fees no matter the language of the settlement and (b) that a class settlement may not be conditioned upon a particular award of attorneys' fees. In *Garabedian*, the court rejected a fee request of $14.125 million, allowing instead $8 million.

Federal courts also are participating in the trend. In *Staton v. Boeing Co.*, 327 F.3d 938 (9th Cir. 2003), the court reviewed a class settlement of $7.3 million to the class and $4.05 million in attorneys' fees. Expressing concern about possible collusion between class counsel and the defendant, the court disapproved the settlement and skewered the amount of requested attorneys' fees. The court focused on the value to the class of purported injunctive relief, holding that "[p]recisely because the value of injunctive relief is difficult to quantify, its value is also easily manipulable by overreaching lawyers . . ." *Id*. at 974.

We also have seen legislative action to control class actions. Similarly, jurisdictions, such as Texas, with business-friendly supreme court justices, are tightening class certification rules. Hopefully, the Florida court's decision will be part of a trend to balance fee awards to the class benefit conferred.❑

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CALIFORNIA COURT

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reinsurance, an injured plaintiff cannot be a third-party beneficiary to the reinsurance contract of the plaintiff's liability insurer.

The court rejected the plaintiffs' contention that the insurer's financial condition was relevant and discoverable for settlement purposes. *Id*. at *23. The plaintiffs argued that the information was discoverable because it would permit the plaintiffs to determine if the insurer could meet its coverage obligations. *Id*. at *25. That information, according to the plaintiffs, might facilitate settlement between the parties. *Id*. The court rejected this argument categorically. *Id*.

The court seemed to issue a warning to future plaintiffs attempting to seek this type of information: "If plaintiffs obtain the reinsurance information, do they next intend to subpoena documents from the reinsurers concerning their own financial condition?" *Id*. at *30-*31. Both plaintiffs and defendants alike should take heed that "although 'fishing expeditions' are sometimes allowed by the discovery rules, there are limits on the catch. In short, while a rod and reel may be permitted, gill nets are not." *Id*. at *31.❑

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established expertise in health industry captives. Other offshore domiciles have found their respective niches.

However, in some circles, serious thought is being given to abandoning the creation of new captives offshore in favor of establishing them in the United States. This is the result of the growth of the domestic U.S. captive business lead by the State of Vermont during the late 80s and 90s, followed by numerous other states including Hawaii, South Carolina, and the District of Columbia. These domiciles provide a viable alternative to the domiciles of the Caribbean and elsewhere.

As a result, there is also an increasing interest now in redomesticating some captives from their existing offshore domiciles to U.S. domiciles. Why bother? Redomesticating an insurance company (even a small insurance company) takes a fair amount of work, even though some states, such as the District of Columbia, have enacted laws facilitating captive redomestication.

There are a number of answers. Probably the foremost reason is that captives can now do onshore almost everything they previously could only do offshore. It was true previously that a captive could be established more easily and more rapidly offshore. That is no longer the case. A captive with a well-organized business plan can get licensed in 30 days in several of the U.S. domiciles.

In addition, it used to be that regulatory requirements offshore were more industry friendly than onshore. Now, the increasing sophistication of captive regulation in the United States has meant that captive states have modernized their regulatory requirements and made them more "user friendly". No doubt, the number of sophisticated and experienced captive managers in the more popular captive states have made this possible.

Another reason to charter a captive offshore was taxation, or more precisely, the lack of taxation. Most offshore captive domiciles levy neither income taxes nor premium taxes. While almost all U.S. domiciles have some form of captive premium taxation (except Arizona), the level of premium taxation is miniscule compared to taxation of conventional insurance companies. Nonetheless, offshore insurance companies can avoid the taxation on investment income until that income is remitted to an owner in a domicile with an income tax, e.g., the United States or the U.K.

However, the tax laws of the United States make difficult the accumulation of assets offshore not subject to U.S. income tax. As a result, most offshore captives make an election known as a "953(d)" election to be taxed as a U.S. corporation, anyway. The result is that very few captives owned by U.S. taxpayers find any benefit to being located offshore.

A further disincentive to creating offshore reinsurance captives is the federal excise tax of 1% on such reinsurance. This can become substantial, which may result in increased collateral requirements.

Another issue is credit for reinsurance. Reinsurance provided by an offshore captive to a U.S. insurer may not result in credit for reinsurance without a "funds held" arrangement or a fully collateralized trust or a letter of credit. The extra cost and inconvenience of this collateralization can be avoided by chartering the captive reinsurer in the domicile of the U.S. insurance company.

The current regulatory environment is a disincentive to chartering offshore, as well. The investigations of Attorney General Elliot Spitzer of New York have highlighted that some U.S. insurers have entered into reinsurance arrangements with offshore companies that may not pass muster under U.S. regulatory requirements. Few corporations, and in particular few non-profit entities, would want to have their insurance programs subjected to additional scrutiny, or the skepticism of its constituents, as a result of chartering a captive insurer offshore.

Finally, travel requirements to Caribbean locations are a problem. Most offshore and onshore domiciles require at least one meeting per year in the domicile. While an annual trip to a sunny island may sound like fun, the time, expense and inconvenience is a significant concern.

In sum, in some cases, there are good reasons to continue to do business offshore. However, in many cases, it makes good sense to consider a move back to the USA.❑

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