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LETTER FROM WASHINGTON

D.C.'S NEW FLEXIBLE CAPTIVE LAW

By Robert H. Myers Jr.

When the District of Columbia Council passed the initial captive law in 2000, it made a significant commitment to the alternative risk transfer industry. During the past four years, the captive industry has continued to grow, and the D.C. Department of Insurance, Securities and Banking ("DISB") has benefited from the experience of other captive domiciles.

There are twenty-two states, in addition to the District of Columbia, that have a captive program of one sort or another. The laws of the states are different, although there are common aspects to all of them.

On the basis of these four years of experience, DISB recommended to the Council a new captive law, which was passed on November 30, 2004. The Captive Insurance Company Emergency Act of 2004 ("2004 Act") constitutes a serious rewriting of the original Act based on several basic principles: (1)

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HASSETT'S OBJECTIONS

I HAVE TO ADMIT, IT'S GETTING BETTER

By Lewis E. Hassett

In 2002 and 2003, the American Tort Reform Association ("ATRA") dubbed portions of Mississippi a "judicial hellhole." What a difference a year makes. For 2004, the ATRA removed Mississippi from that dubious list and actually praised it. The praise primarily flowed from legislative tort reform passed during 2004. ATRA also praised the Mississippi Supreme Court's decision in *Janssen Pharmaceutica, Inc. v. Armond*, 866 So. 2d 1092 (Feb. 19, 2004), and subsequent cases applying that opinion. Prior to that decision, Mississippi's liberal joinder rules allowed seemingly distinct claims to be joined in a single action, thereby creating the *sine qua non* of the mass tort bar – economies of scale. Under *Janssen*, joinder no longer is so easy. As a result, the plaintiffs' bar loses economies of scale, as well as desired venues.

During this same time frame, Mississippi's Supreme Court also has issued some important opinions in the financial services area dealing with a consumer's

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PLAYER'S POINT

MODEL LAW, MODEL REGULATION OR MODEL AFFIDAVIT

By Thomas A. Player

The original concept of the National Association of Insurance Commissioners ("NAIC") was an association of regulators exchanging ideas for the purpose of coordinating consistent and workable state insurance laws and regulations. Circumstances and pressures have forced the NAIC to become more timely and uniform in its response. The purpose of this article is to urge caution in this approach to national regulation.

Model Laws and Regulations

Through the years, a number of model laws and model regulations have been created by the NAIC,

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Announcements

For the second consecutive year, **Lew Hassett** has been named a Georgia "Super Lawyer" in business litigation by ***Atlanta Magazine***. **Tom Player** was named a Georgia "Super Lawyer" in general business, also for the second consecutive year.

Tom Player and **Jim Grover**, VP and Associate General Counsel of Transamerica Reinsurance, gave a joint presentation to the Mealey's Reinsurance 101 Conference: Litigation & Arbitration held in Washington, D.C. in mid-February. Mr. Grover spoke on life reinsurance and Mr. Player spoke on property/casualty reinsurance.

Lew Hassett and **Bob Alpert** have been tapped to defend a trade association in a putative class action alleging insurance fraud, which was recently fined in a notorious venue in extreme south Texas.

Tom Player and **Lew Hassett** will serve as Session Leaders at the ARIAS 2005 Spring Conference in Las Vegas, Nevada, in May.

Skip Myers spoke to the Captive Insurance Companies Association meeting in Carlsbad, CA on March 7, 2005 on regulatory issues affecting risk retention groups.

Lew Hassett and **James Kitces** have been tapped to defend an MGA in an arbitration brought by the receiver for Reliance Insurance Company. They already are representing another MGA in claims brought by the receiver.

Bill Winter and **Tom Player** are attorneys for ERM Institute International, a non-profit worldwide actuarial society focused on enterprise risk management. A primary sponsor of the Institute is the Department of Risk Management and Insurance of Georgia State University.

On February 4, **Joe Holahan** spoke before the 2005 Oklahoma City Sales Congress on the subject of "HIPAA Privacy for Agents and Brokers." The Sales Congress was jointly sponsored by the Oklahoma City and Oklahoma State Associations of Insurance and Financial Advisors. If you would like a copy of Mr. Holahan's presentation, please contact him at 202-408-0705 or jholahan@mmmlaw.com.

Lew Hassett and **James Kitces** have been tapped to represent a national lender in a RICO action arising from a secured lending transaction.

On April 13, **Joe Holahan** will be a panelist for the annual Reinsurance Symposium sponsored by the CPCU Society in Phoenix, Arizona. Mr. Holahan has been invited to speak on the topic of terrorism risk insurance. Mr. Holahan is director of Morris, Manning & Martin's Terrorism Insurance Practice Group.

SWEEPING TORT REFORM BILL IS ENACTED IN GEORGIA

By Joseph L. Cregan

On Monday, February 14, 2005, the Republican dominated Georgia Senate sent a valentine to everyone who had spent the last few years working for meaningful tort reform: passage of Senate Bill 3, by a vote of 38-15. The comprehensive civil justice reform bill, a priority for the new Republican majority in the House and Senate, is the first major bill of the session signed into law by Governor Sonny Perdue on February 16, 2005.

The version of the bill signed by Governor Perdue differs quite a bit from the version originally pre-filed by Senator Preston Smith (R-Rome) and other members of the Senate Republican Caucus late in 2004. Perhaps the most significant difference is an increase in the cap imposed on non-economic medical malpractice jury awards from $250,000 or up to $750,000 in multiple defendant cases, to $350,000, or up to $1.05 million in multiple defendant cases. This increase in the non-economic cap originated in the Georgia House, which was searching for compromise between members that supported a $250,000 cap and those who wanted a higher $750,000 cap. That key House vote took place on February 10, 2005.

Another key provision of the new law is the heightened standard of proof in medical malpractice cases involving emergency care providers. Under the new legislation, no emergency care provider can be held liable in a claim arising from emergency medical care in a hospital emergency department, or treatment in an obstetrical unit or a surgical suite immediately following an emergency, without proof of gross negligence by clear and convincing evidence. Additionally, in these cases, juries will be instructed to consider the key circumstances and context of the provision of emergency care, including whether the patient's medical history was available to the treating physician and the circumstances constituting the emergency.

SB 3 repeals joint and several liability in tort actions and replaces it with an apportionment of fault standard. Current Georgia Code Section 51-12-3 is revised to provide that damages for an injury may be recovered "against only the defendant or defendants liable for the injury. In its verdict, the jury may specify the particular damages to be recovered of each defendant." The bill also contains venue reforms that allow a nonresident defendant the right to request that the case be transferred to his home county when all defendants residing in the original venue are discharged from liability. This is intended to address the practice of adding one or more "nominal" defendants to a case in order to go to trial in a county viewed as more favorable to the plaintiff.

The new law also includes an offer of settlement provision meant to encourage early settlements of tort claims. While unclear, the new section appears to require one party to the litigation to pay the costs and attorney fees of the other party if either party rejects a pretrial settlement offer that is at least 25 percent more favorable than the ultimate judgment in the case. It also addresses the public's growing concern over frivolous lawsuits by imposing an additional process whereby the prevailing party can request

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NAIC ADOPTS COMPENSATION DISCLOSURE AMENDMENT TO THE PRODUCER LICENSING MODEL ACT

By Anthony C. Roehl

On December 29, 2004, the NAIC Joint Executive Plenary Committee adopted the Compensation Disclosure Amendment to the Producer Licensing Model Act (the "Amendment"). The NAIC drafted and adopted the Amendment in response to allegations of improper market conduct by large insurers and brokers. The Amendment has two different disclosure requirements – brokers that receive a fee and commission on the same transaction are required to disclose the amount of compensation they will receive and producers that do not receive any compensation from the policyholder for the placement of insurance are required to disclose the fact that they represent the insurer.

The Amendment requires all brokers receiving compensation from the policyholder and from the insurer (1) to obtain the policyholder's documented acknowledgment that such compensation will be received by the producer or its affiliate and (2) to disclose the amount of compensation from the insurer or other third party for placing the insurance. The Amendment requires disclosure even if the amount of compensation is not known at the time of placing the business. Where the exact amount of compensation is not known, the producer must disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount of expected compensation.

Insurance producers that do not receive compensation from the policyholder and represent an insurer with respect to a transaction are still required to provide a notice to the policyholder. The producer notice must disclose to the policyholder (1) that the producer will receive compensation from the insurer in connection with the insurance transaction or (2) that in connection with the placement of insurance, the insurance producer represents the insurer and that the producer may provide services to the policyholder for the insurer. Thus, a producer will be required to make a disclosure no matter whether acting as a broker or acting strictly as a producer appointed by an insurer.

The Amendment and its disclosure requirements are not applicable to participants or beneficiaries under an employee benefit plan or those persons covered by a group insurance policy. Additionally, managing general agents and producers who only act as an intermediary between the insurer and the policyholder's producer are exempt, as are reinsurance intermediaries.

At press time no state has adopted the Amendment, and states still appear to be working on their own independent responses to the broker compensation scandal. However, it appears that soon mandatory disclosures will be part of the regulatory and business environment for insurance producers as they work to comply with the emerging legal framework.❑

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

Announcements

Ward S. Bondurant and **Leigh Els Wilde** recently represented Global Preferred Holdings, Inc. in its successful negotiation of a definitive purchase agreement with Aegon N.V. Subject to approval by the Global Preferred stockholders and other customary closing conditions, Global Preferred will receive approximately $57.0 million in the transaction in exchange for its interest in Global Preferred Re Limited, its Bermuda-based life reinsurance subsidiary.

Chris Petersen will be speaking at the Delta Dental Plans Association's Public Policy Conference in Washington, DC April 10-12, 2005. Mr. Petersen will be discussing recent developments at the NAIC including Sarbanes-Oxley implementation, broker disclosures requirements resulting from the Spitzer investigations and changes to the NAIC model regarding coordination of benefits.

Bill Megna was co-lead counsel for the successful application of a New York domestic insurer to change its charter from health to property and casualty authority, which was the first such conversion in New York State. The application also involved a restructuring of the insurer's holding company. **Bill Winter** assisted with the tax issues for the transaction.

Skip Myers will be speaking on April 27, 2005 on the formation of captives and related regulatory issues at a conference in Durham, NC sponsored by the Captive Insurance Council of the District of Columbia.

Chris Petersen has been invited to speak at the International Health Economics Conference in Riyahd, Kingdom of Saudi Arabia. The conference will examine differing approaches to financing and delivering health care. Mr. Petersen will speak on the cost implications of various forms of health insurance regulation.

In June, **Tom Player** will speak on broker activities at the American Institute of Certified Public Accounts (AICPA) held in Anaheim, California.

Lew Hassett and **Jessica Pardi** are representing an MGA in California litigation regarding the collection of broker fees.

Jeff Schulte has been recognized among the nation's top IPO counsel. According to ***IPO Lawyer Yearbook,*** he was ranked 19th in the US among issuers' and underwriters' counsel taken together, and measured by aggregate proceeds, over the most recent five year period. ***IPO Lawyer Yearbook*** is published by IPO Vital Signs and is a self-described advanced IPO research analysis tool.

RECENT IRS RULINGS ON LIFE INSURANCE QUALIFIED ADDITIONAL BENEFIT CALCULATIONS & APPLICATION OF THE LOOK-THROUGH RULES OF CODE §817(H) TO MULTIPLE INVESTMENT COMPANIES

By Bruce H. Wynn

The IRS has recently issued two rulings in the insurance area. The first, Revenue Ruling 2005-06, deals with how charges for life insurance qualified additional benefits ("QABs") should be taken into account in determining whether the contract providing such insurance qualifies as a life insurance contract or as a modified endowment contract. Effective as of February 7, 2005, this ruling may cause some life insurance contracts to fail to qualify as such and/or to become modified endowment contracts. If the ruling causes any issued life insurance contracts to fail to meet the definition of life insurance in Code §7702(a), the IRS offers a closing agreement alternative whereby such existing contracts will not be challenged by the IRS if the issuer will pay certain pre-set "penalty" fees.

Under Code §7702(a), for a contract to qualify as a life insurance contract for federal income tax purposes, the contract must be a life insurance contract under applicable law and also must either satisfy a cash value accumulation test of Code §7702(b), or must meet the guideline premium requirements of Code §7702(c) and fall within the cash value corridor of Code §7702(d). To meet the guideline premium requirements of Code §7702(c), the sum of the premiums paid under a contract must not at any time exceed the guideline premium limitation as of that time. To meet the cash value accumulation test of Code §7702(b), the cash surrender value of the contract must not exceed the net single premium that would have to be paid at that time to fund future benefits under the contract. In making these determinations, there are certain mortality charge rules (Code §7702(c)(3)(B)(i)) and expense charge rules (Code §7702(c)(3)(B)(ii)) which must be applied.

With respect to expense charges, Code §7702(f)(5)(B) provides that QABs are not treated as future benefits under a contract, but the charges for such benefits are treated as future benefits. With respect to mortality charges, under Code §7702(c)(3)(B)(i), reasonable mortality charges are taken into account under certain conditions. As a result, accounting for charges for life insurance qualified additional benefits under the mortality charge rule, rather than the expense charge rule, would, in some cases, produce a higher net single premium and higher guideline level premium for purposes of testing a contract's compliance with Code §7702. Accordingly, to resolve this ambiguity, in the ruling, the IRS takes the position that charges taken into account with respect to QABs are subject to the expense charge rule of Code §7702(c)(3)(B)(ii) for purposes of the Code §7702 guideline premium requirements.

Code §7702A sets forth the rules by which to determine whether a contract is a modified endowment contract ("MEC"). Under this provision, a contract which meets the requirements of Code §7702, but which fails to meet the "7-pay test" set forth in Code §7702A(b) (the accumulated amount paid under the contract at any time during the first seven contract years cannot exceed the sum of the net level premiums that would have been paid on or before that time if the contract provided for paid-up future benefits after the payment of seven level annual premiums) will generally be a MEC. Generally, provisions in Code §7702 will apply in determining charges for QABs in applying the MEC "7-pay test," and, again, the ambiguity discussed above applies. Accordingly, the IRS applies the same position discussed above with respect to QABs – that they are subject to the expense charge rule of Code §7702(c)(3)(B)(ii) for purposes of MEC determinations.

The second ruling, Revenue Ruling 2005-07, concerns the "look-through" rule of Code §817(h)(4).

For a life insurance contract or an annuity contract to be a variable contract, it must provide for the allocation of all or a part of the amounts received under the contract to an account that is segregated from the general asset accounts of the issuing insurance company. Code §817(h) provides generally that a variable contract based on a segregated account shall not be treated as an annuity, endowment or life insurance contract for any period for which the investment made by such account are not adequately diversified.

The "look-through" rule of Code §817(h)(4) generally provides that a beneficial interest in an investment company shall not be treated as a single investment of a segregated asset account, and, instead, a pro rata portion of each asset of the investment company shall be treated as an asset of the segregated asset account. The rule generally applies to an investment company if all the beneficial interests in the investment company are held by one or more segregated asset accounts of one or more insurance companies, and public access to such investment company is available exclusively through the purchase of a variable contract.

The IRS, in the ruling, provides an example of how the "look-through" rule applies to an investment in a regulated investment company (the "first fund") that, in turn, owns an interest in another regulated investment company (the "second fund"). Under the ruling, the IRS applies the "look-through" rule independently to each investment company separately, and, if they both independently meet the requirements, then a segregated account owning an interest in the first fund can be treated as owning a pro rata portion of each asset of the first fund, including a pro rata portion of each asset of the second fund.❑

Bruce Wynn is a senior partner in the benefits and compensation group. He has extensive experience dealing with tax-qualified retirement plans, employee welfare benefit plans, nonqualified deferred compensation arrangements, stock option plans, and restricted stock arrangements. He has also represented and advised clients in numerous administrative matters and in many tax and ERISA litigation matters. Bruce received his bachelor's, master's, and law degrees from Duke University.

OWNERS OF OFFSHORE CAPTIVES: NOW IS THE TIME TO TAKE YOUR MONEY AND RUN

By William M. Winter

For the owners of offshore captive insurance companies, the American Jobs Creation Act of 2004 (the "AJCA") offers a not-to-be missed tax incentive.

Beginning October 22, 2004, corporate-owned offshore captive insurance companies may repatriate their earnings to the U.S. at an unbelievable federal tax cost of only 5.25 percent -- an enormous tax savings over the traditional 35 percent tax rate. As a result, U.S. owned offshore captives should consider repatriating every available dollar to the U.S. to the extent financially feasible (and to the extent allowed by the local insurance regulators). The potential savings are incredible: Under the old tax rules, repatriating $500,000 in surplus profit to a captive's U.S. corporate shareholder would trigger a U.S. income tax of approximately $175,000. Under the AJCA, distributing the same funds during the next year will trigger a federal income tax cost of approximately $26,250 – giving the U.S. shareholders $148,750 of additional cash.

As you might expect, the tax incentive is not without a few quid pro quos, provisos and conditions. First, the tax incentive is available only if U.S. shareholders own, in the aggregate, greater than 50 percent of the offshore captive's outstanding capital stock (*i.e.*, the offshore captive is U.S. owned and controlled). Second, the tax incentive is available only to those U.S. corporations holding at least 10 percent of the captive's capital stock. Finally (and this is the big one), in keeping with the "jobs creation" theme of the AJCA, the tax incentive is available only if the U.S. corporate shareholder of the captive implements a "domestic reinvestment plan" – whereby the cash received from the offshore captive is used "as a source for the funding of worker hiring and training, infrastructure, research and development, capital investments, or the financial stabilization of the corporation for the purposes of job retention or creation."[1]

The IRS recently outlined its requirements for domestic reinvestment plans in Notice 2005-10. In general, the domestic reinvestment plan must be a written plan that describes with specific detail how the cash will be invested in the U.S., the time period over which the investment will be made, and whether factors beyond the taxpayer's control may affect the ability to make the contemplated U.S. investment. For purposes of the reinvestment plan, the term "invested" does not mean squirreled away in stocks and bonds. Rather, the investment must be used to create or preserve jobs. Permitted investments include (but are not limited to):

- spending on research and development activities;
- spending on infrastructure for manufacturing plants or corporate offices (including the purchase of new or upgraded computer hardware and software, or the expansion of distribution systems);
- training existing or newly-hired employees;
- repayment of debt to increase financial stability; and
- funding of qualified employee benefit plans (such as a 401(k) plan).

Note that monies used in a domestic reinvestment plan may not be used for paying additional compensation to executive officers. Note too that monies used in the domestic reinvestment plan may be used for any business owned or operated by the corporate shareholder of the captive. Thus, a plan to train new and existing employees does not mean that the corporation must train new underwriters or sales agents for the captive. Rather, the corporation may train any employee in any facet of the corporation's business.

Finally, the domestic reinvestment plan must contain enough detail for both the taxpayer and the IRS to determine with certainty that the investments have been achieved, and the senior executive officer and the Board of Directors of the corporation must expressly approve the plan. Without these criteria, the IRS is free to deny eligibility for the tax incentive.

For U.S. corporations that own an offshore captive as well as other U.S. businesses, the tax incentive offered under the AJCA provides a great opportunity. By reducing the tax cost of repatriating an offshore captive's excess surplus to the U.S., U.S. corporate shareholders may quickly free-up funds to help improve and expand their other U.S. businesses. And at an overall income tax savings of 85 percent, owners of offshore captives would be remiss in not taking advantage of this opportunity.

As a parting note on the tax incentive, please keep in mind that the tax incentive is available for only one of two tax years: (1) the last taxable year of the corporate shareholder that begins on or before October 22, 2004, or (2) the first taxable year of the corporate shareholder that begins after October 22, 2004. In addition, corporate shareholders of offshore captives must affirmatively elect the tax incentive under section 965 of the Internal Revenue Code, and must otherwise comply with its provisions. So before sending those offshore dollars back to the U.S., please be certain to consult your tax advisor – after all, what Congress gives the IRS undoubtedly will be looking to take away.❑

Bill Winter is a senior associate in the firm's international and tax groups. His international practice focuses on helping clients succeed in growing their businesses overseas. He regularly assists clients in establishing joint ventures, selling or acquiring non-U.S. subsidiaries, establishing cross-border operations, and developing effective organizational structures. He concentrates his tax practice on U.S. federal tax issues for U.S. corporations, partnerships and individuals, and issues relating to the formation, operation, acquisition and sale of multinational and foreign national businesses. Bill received his bachelor's degree from the University of Illinois and his law degree from Emory University.

Endnotes

[1] Section 965(b)(4) of the Internal Revenue Code of 1986, as amended.

LAWYERS IN A MIIX

By William F. Megna

Attorneys representing plaintiffs with claims against insureds of MIIX Insurance Company ("MIIX") may have a Hobson's Choice: to settle or not to settle. MIIX, at one time New Jersey's biggest medical malpractice insurer and one of the largest nationally, was placed into rehabilitation by the New Jersey Department of Banking and Insurance ("DOBI") in September 2004. The company had stopped writing new policies in May 2002 and had been in a voluntary run-off ever since. The rehabilitation was always intended by DOBI to be a first step to restore MIIX to a "solvent run-off condition," instead of an immediate liquidation. Neither MIIX nor the Medical Society of New Jersey opposed the rehabilitation. The order of rehabilitation did not stay payment of claims or any litigation that was then pending against MIIX or its insureds and did not bar claimants from filing new actions against MIIX insureds. As of October 31, 2004, MIIX was determined by the Rehabilitator to have assets of approximately $542,565,000, and liabilities of approximately $848,000,000.

In January 2005, the Commissioner of DOBI sought a seven month stay of any trials against insureds of MIIX and the scheduling of settlement conferences and arbitrations. The Commissioner was not, however, seeking to stay discovery in on-going matters or the filing of new claims against insureds of MIIX. During this period, the Commissioner will evaluate whether DOBI could provide a solvent run-off of future and existing claims without going into liquidation.

The Commissioner's proposed plan further provides for the immediate settlement and payment of approximately 700 to 900 likely meritorious claims, with a maximum payment of $1,000,000 per claim. MIIX currently has approximately 2600 open claims of which 50 percent are in New Jersey. The proposal to offer settlements will be made only to about one-third of MIIX existing claimants. The maximum offer would apply to the most severe and crippling injuries, with settlement amounts based on a sliding scale of nine categories of decreasing severity.

If a significant number (not specified in the proposed plan) of these offers are not accepted, the plan will not work and will be withdrawn, with all claims then going to the New Jersey Property-Liability Insurance Guaranty Association (New Jersey Guaranty Fund) and other state Guaranty Funds, with the attendant limits on recovery (a maximum of $300,000 in New Jersey). Rather than pay claims until there are no claimants left subject to the $300,000 maximum limit of the New Jersey Guaranty Fund (or the limit of other state Guaranty Fund), the Commissioner is trying to make an equitable apportionment of the Company's remaining assets for all claimants. Otherwise, those claimants ready to go to trial in the next few months will be fully compensated, and all other claimants will be subject to the limits of the Guaranty Funds. As a result, many attorneys who receive offers under this proposed plan will have to advise their clients whether to take the offer in support of the plan or reject the offer in hopes of a bigger pay out at trial but also risking that a client's claim will be paid through a Guaranty Fund instead.

By not including the state Guaranty Funds as parties in the proposed run-off, the Commissioner also hopes to avoid the significant expense to the public of involving those Funds. An expense that ultimately is passed to the public in the form of insurance premium surcharges.

On February 18, 2005, Judge Shuster of the Chancery Division of the Superior Court of New Jersey agreed with DOBI to enter the requested order of stay. At the time this article went to print, the order was not available for publication. ❑

Bill Megna is Of Counsel in the firm's insurance and reinsurance 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. He received his bachelor's degree from Fordham University and his law degree from Seton Hall Law School. For updates on new developments regarding New Jersey's lobbying requirements please forward your contact information to Bill for future client alerts,

ACCESS CLAUSE DOES NOT TRUMP ATTORNEY-CLIENT PRIVILEGE

By Jessica F. Pardi

Most, if not all, reinsurance agreements contain what is commonly referred to as an "access clause," wherein reinsurers are granted the right to inspect an insurer's records. On December 28, 2004, the Supreme Court of New York County, an appellate court, held that access clauses, "no matter how broadly phrased, are not intended to act as a per se waiver of the attorney-client or attorney work product privileges." *Gulf Ins. Co. v. TransAmerica Reins. Co.*, 2004 N.Y. Slip Op. 09683 (December 28, 2004). The Court explicitly stated that any other holding "would render these privileges meaningless." *Id*.

The agreement at issue in *Gulf* was a quota share reinsurance agreement covering a vehicle residual value protection policy. The agreement contained a boilerplate access clause which provided in part: "The Reinsurers … will have the right to inspect … all records of the Company [i.e., plaintiff] that pertain in any way to this agreement." TransAmerica sought to rescind the reinsurance agreement and, as part of the rescission litigation, requested documents that were clearly privileged, including opinions of counsel and communications between Gulf and its counsel. The underlying court granted TransAmerica's motion to compel such discovery, holding that the access clause was "an extremely expansive clause without any limitation."

While protecting privileged materials as a class, the appellate court did state that TransAmerica is not precluded from challenging the assertion of privilege with respect to any particular document requested and that the underlying court was not bound by Gulf's characterization of any particular document as being privileged. Thus, the Court protected necessary privileges but prevented parties in this case or in future disputes from asserting blanket objections and privileges not subject to challenge.❑

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.

NASD MOVES TO REASONED ARBITRATION AWARDS

By Ross A. Albert

On January 27, 2005, the National Association of Securities Dealers (the "NASD") announced that its Board of Governors had approved an amendment to the NASD's Code of Arbitration Procedure that would allow customers arbitrating disputes with their brokers or brokerage firms to demand that the arbitration panel provide a written explanation of the panel's decision. Brokers arbitrating disputes with their employers or other industry participants would also have the right to demand a written explanation. The NASD has been working on this proposal for more than a year, and it is a marked change from current NASD procedures, under which the arbitration panel has the sole discretion to determine whether to issue a written explanation.

The NASD's proposed amendment is subject to approval by the SEC. While some large brokerage firms may oppose the proposal, the SEC's approval seems likely, given the current atmosphere of heightened regulatory scrutiny. The NASD's proposal has particular significance because the NASD's arbitration forum handles the vast majority – about 90 percent – of all securities arbitrations filed in the United States.

In announcing the proposed amendment, the NASD explained that, in its experience, investors wanted to know more information about how the panel had reached its decision. The NASD also expressed the view that the proposal would increase investor confidence in the fairness of the NASD arbitration process. In the past, many investor advocates, particularly lawyers who represent customers in NASD arbitrations, had argued that NASD arbitration favored industry interests, in large part because arbitration panels are required to include industry representatives. Some felt that these industry participants dominated arbitration proceedings to the detriment of customers. In more recent years, however, most knowledgeable observers would agree the NASD's reputation has improved in regard to giving investors a fair or at least a fairer shot.

Under the NASD's proposed rule, customers would have to request a written explanation before the arbitration panel held its first hearing. If the customer exercised this right, then the panel would have to provide a written award describing why each claim was granted or denied. The panel's written explanation would not have to cite legal authority or precedent, such as case or statutes. Arbitrators would each receive an additional $200 stipend for matters in which they provided a written explanation.

Many investor advocates have hailed the NASD's proposed rule as a boon to customers, even those who might otherwise have been disappointed with a loss in arbitration. Others have expressed concern that the new rule might transform NASD arbitrations into more lawsuit-like proceedings, contrary to the original intent that arbitration be a quick and efficient alternative to the traditional judicial system.❑

Ross Albert is Of Counsel in the firm's litigation group. He represents parties involved in securities litigation, class actions and other complex cases before state and federal courts, administrative agencies and arbitration panels. He also represents individuals and entities involved in investigative and regulatory inquiries conducted by the U.S. Securities and Exchange Commission, the Georgia Securities Commissioner, other federal and state law enforcement authorities, and self-regulatory organizations. He conducts internal investigations of alleged corporate misconduct. Ross received his bachelor's degree, cum laude, from Harvard University and his law degree from Boalt Hall School of Law, University of California, Berkeley.

THE IMPACT OF THE OBESITY EPIDEMIC ON INSURERS

By Kristin B. Zimmerman

As everyone has heard time and time again, obesity is a major health problem facing the United States right now. In fact, according to the Centers for Disease Control and Prevention ("CDC"), obesity has risen at an epidemic rate during the past 20 years. In addition to the significant health consequences, the spiraling rate of obesity has, and will continue to have, significant economic consequences. In the year 1998 alone approximately $78.5 billion went to treat health problems of overweight or obese people.[1] The impact of these escalating costs is being felt by all segments of society, including the insurance industry. Because weight and obesity has attained such a high profile in recent years, a number of states, as well as the federal government, have considered and/or enacted legislation that would significantly impact the insurance industry's liability and responsibility with regard to the issue of obesity.

The liability and excess casualty insurance sector is particularly affected by the issue of obesity. Although there is certainly enough blame to go around, much of the blame for Americans' ever expanding waistlines is being laid at the feet of the food industry. In recent years, a number of lawsuits have been brought against various fast food companies and snack food manufacturers, testing the theory that those who sell fattening, unhealthy food should be held legally liable for making people who consume these products fat.

These cases have raised substantial concern that lawsuits brought against the food industry could leave insurers exposed to potential claims under general liability and product liability coverages. In an effort to reign in such lawsuits, at least fourteen states have passed laws banning consumers from filing suits that blame restaurants and other food sellers for their obesity. In addition, another nineteen or so states have obesity-lawsuit bills pending. Many of these states have modeled their legislation on the federal Personal Responsibility in Food Consumption Act, which would prevent individuals from suing restaurants and other food-sellers, marketers, distributors, advertisers, and trade associations for obesity-related reasons.[2] The same bill passed the House of Representatives in 2004, but was not taken up by the U.S. Senate.

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resulting in widely adopted, generally consistent state laws. Some say the process was too slow and too industry driven. There is some truth to that criticism. However, the process also was thoughtful, had input from all sides, and had the appearance of due process. Model laws and regulations were hard fought at the NAIC level and again at the state level when tailored for use on a state-by-state basis.

NAIC and Sarbanes-Oxley

Now, many critical changes are created in the rooms on Thursday at the NAIC when the accountants and actuaries decide, "what's best." No more striking example of this exists than the current NAIC discussions of Sarbanes-Oxley. As most of us know, Sarbanes-Oxley is a federal law applying primarily to public companies and, like most federal laws, is a reaction to bad circumstances. Notably, the corporate misdeeds of Enron and WorldCom, among others.

Almost everyone agrees that the most expensive provision of Sarbanes-Oxley to implement is Section 404, which requires that management make an assessment and report on the adequacy of the internal accounting controls and that the company's independent auditor attest to the adequacy of management's statements on the internal controls. The NAIC "Title IV Subgroup" is now proposing that Section 404 of Sarbanes-Oxley be mandated through the audit rules for all private insurers, including mutual insurance companies.

While some private companies follow key elements of Sarbanes-Oxley as "best practices," we know of no other industry requiring the implementation of Section 404 of Sarbanes-Oxley to private companies. If adopted by this subgroup of the NAIC/AICPA Working Group, the change will apply to the NAIC's model audit regulation.

This NAIC activity is squarely in the midst of an evaluation of the workings of Section 404 by the Securities and Exchange Commission. On Feb. 7, 2005, the Commission announced that it would host a roundtable discussion and would solicit written feedback regarding the experiences of registrants, accounting firms and others in implementing the new internal control requirements under Section 404 of the Sarbanes-Oxley Act. The Commission announced that the roundtable will be held on Wednesday, April 13, 2005.

NAIC and Broker Activities

In response to broker investigations by Eliot Spitzer, Congress, and state Attorneys General, the NAIC developed what it called a "Model Questionnaire." Accompanying the model questionnaire was a form of sworn statement or affidavit to be sought from industry executives and brokers. Failure to answer, or giving a false answer to the statement or affidavit, may result in a misdemeanor or a felony, depending upon the state of origin.

The model questionnaire and statement or affidavit as developed by the NAIC Task Force on Broker Activities seems to establish new standards. One such standard is called "Inappropriate Solicitation Activities." Where did this concept of "Inappropriate Solicitation Activities" originate? The answer is in the New York Attorney General Eliot Spitzer's complaint against Marsh. Should the NAIC, through its questionnaire and affidavit, overlay the standard of "Inappropriate Solicitation Activities" on the laws of each state? Irrespective of the variance of each state's laws, its executives are required by the questionnaire and the affidavit to respond to what amounts to be a national definition of wrongdoing.

I am not faulting the NAIC for reacting, nor am I faulting the NAIC for encouraging states to examine insurers or brokers based upon violations of state law. What I am objecting to is an overlay of standards which are founded in a lawsuit brought by the New York Attorney General, which standards are then handed off to state regulators as being "Inappropriate Solicitation Activities." What is the authority for this practice?

North Carolina and Broker Activities

Another illustration of a reaction to Spitzer's examination is the requirement of the North Carolina Department of Insurance requiring Presidents or Chief Executive Officers of insurers and brokers to identify in detail any information as to "Bid Rigging of which you are aware by any person, insurer or insurance producer regarding any North Carolina insured or any North Carolina business." Search as I might, I could not find any North Carolina insurance law concerning Bid Rigging. For example, the definition in the questionnaire tells me that I am to report any bid, price quote, or other information regarding terms of insurance that was intentionally uncompetitive with other bids, quotes or other information. How am I to know a competitor's intent? Is it now a violation of North Carolina law to give an uncompetitive bid?

Moreover, the statement or affidavit extends to not only reporting on activities within the executive's organization, but also any North Carolina Business. There also seems to be a continuing life of the statement or affidavit. Questions and answers accompanying the statement or affidavit explain that if you, as the signer of the statement or affidavit, come into information which might change your statement or affidavit (such as you know of no person engaged in bid rigging), you must report the same to the Department. This might result in making the executive a continuous whistle-blower as to all North Carolina businesses with which he comes into contact. Even Sarbanes-Oxley does not require this.

This sort of blanket statement or affidavit raises other difficult legal issues. For example, what about the implications of slander and libel? When is a respondent's answer protected from libel or slander? Is there protection for an action for tortious interference as to third party contracts? Is there a waiver of attorney-client privilege when the information provided is the subject of attorney work product? Is that information now discoverable by third parties?

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Conclusion

I understand and am sympathetic as to the reaction of the NAIC to the Spitzer investigation and illegal bid rigging by some significant industry participants. I certainly believe the North Carolina Department is trying to do the right thing. However, the unintended consequences of regulation by statement or affidavit should be taken seriously and thoughtfully by state regulators and legislators.❑

UPDATE ON BROKER ACTIVITIES

In the Winter 2004 edition of this newsletter, I wrote an article entitled "Brokergate: The Fallout" discussing the legal and definitional problems associated with the activities of a broker and an agent. It seems that others see the same problem. Conning Research & Consulting recently released a report highlighting that regulators and legislators are struggling to get a distinction between the terms "agent" and "broker." While I thought at the time that regulators may treat brokers and agents the same under the umbrella definition as a "producer," it is still too early to tell what actions states will take. However, as noted in the Conning report, the lack of a regulatory distinction between agents and brokers is problematic, and we may see regulators moving to create a definition distinguishing between the two, similar to the regulatory regime before the adoption of the Producer Licensing Model Act.

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Federal implementation of the Medicare Part D prescription drug benefit continues apace. Insurers that wish to sponsor a stand-alone Medicare prescription drug plan as well as entities that intend to modify a Medicare Advantage contract or Cost Plan to include the Part D drug benefit must submit a Part D application to CMS by March 23, 2005. For more information, please contact Joe Holahan at 202-408-0705 or jholahan@mmmlaw.com.

ELEVENTH CIRCUIT ADDRESSES COVERAGE FOR ADVERTISING INJURY

By Marshall Seese Jr.

The Eleventh Circuit is the latest court to address the applicability of a CGL policy's coverage for an advertising injury to a claim for misappropriation of trade secrets. *See State Farm Fire and Cas. Co. v. Steinberg*, Case No. 03-12565 (11th Cir., Dec 17, 2004). Holding that allegations of misappropriation of a customer list and of using confidential information to pirate customers did not constitute an "advertising injury," the court stated that the alleged wrongdoer's insurer had no duty to defend the underlying action.

The court cited its earlier decisions in *Hyman v. Nationwide Mutual Fire Ins. Co.*, 304 F.3d 1179 (11th Cir. 2002), and *Elan Pharm. Research Corp. v. Employers Ins.*, 144 F.3d 1372 (11th Cir. 1998), in devising the following three-part test. To trigger coverage for an "advertising injury" (1) the suit must allege a cognizable advertising injury; (2) the infringing party must have engaged in advertising activity; and (3) there must have been a causal connection between the injury and the activity. The court's analysis focused on the first prong, holding that misappropriation of a customer list constitutes neither "infringement of copyright, title or slogan" nor "misappropriation of advertising ideas or style of doing business." As to the first point, the court cited *Zurich Ins. Co. v Amcor Sunclipse*, 241 F.3d 605 (7th Cir. 2001), noting that acceptance of the insured's position would give "infringement" and "title" unusual meanings. In rejecting the second point, the court relied upon the comments in *Sentex Systems, Inc. v. Hartford Accident & Indemnity Co.*, 93 F.3d 578 (9th Cir. 1996), that misappropriation of a customer list can only constitute an advertising injury when coupled with other injuries such as misappropriation of marketing techniques and other confidential information. Several federal circuits have aligned with this view including the Third, Seventh, and the Ninth Circuits. *See Frog, Switch & Mfg. Co., Inc. v. Travelers Ins. Co.*, 193 F.3d 742 (3rd Cir. 1999); *Western States Ins. Co. v. Wisconsin Wholesale Tire, Inc.*, 184 F.3d 699 (7th Cir. 1999); *Sentex Systems, Inc. v. Hartford Accident & Indemnity Co.*, 93 F.3d 578 (9th Cir. 1996). However, courts have differed on how they reach the conclusion. Some courts have let misappropriation of customer lists pass the first prong of the three-part test, but fail the third. *See Pierce Companies, Inc. v. Wausau Underwriters Ins. Co.*, 201 F.3d 444 (9th Cir. 1999). Regardless of how courts are interpreting the connection between an advertising injury and misappropriation of customer lists, the trend is to deny coverage.❑

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HASSETT'S OBJECTIONS

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obligation to read his or her contract. A series of Mississippi cases well-illustrated by *Myers v. Guardian Life Ins. Co.*, 5 F.Supp. 2d 423 (N.D. Miss. 1998), had held that, although claims in contract were barred by inconsistent contractual language, claims in tort were not so barred. The upshot was that plaintiffs could bring claims in financial cases that were inconsistent with the very terms of the agreements they had signed.

Allowing such fraud claims to proceed eviscerated the parol evidence rule, which bars evidence of oral representations inconsistent with the written agreement, and made it difficult, if not impossible, for a financial services company to draft language that would preclude allegations that an agent or employee made inducements or promises not reflected in the written agreement. Opponents of application of the parol evidence rule lament that excluding evidence of misrepresentations contrary to written language gives fraudsters freer reign.

They have a point. The application of the parol evidence rule to bar inconsistent fraud claims probably does protect some perpetrators of fraud at the expense of trusting consumers. Perhaps that is what regulatory agencies are for.

However, one thing worse than a clear rule that excludes morally defensible claims is no rule at all. Allowing parol evidence to support a fraud claim inconsistent with written contractual language is the equivalent of no rule. The plaintiff has a great incentive to lie, and the retail employee generally is no match, and may not even remember, the particular transaction.

Fortunately, Mississippi seems to be changing on this point, as well. For example, in *Stephens v. Equitable Life Assur. Society of US*, 850 So. 2d 78 (Miss. 2003), the court rejected a claim based upon oral representations inconsistent with written policy language. Federal courts applying Mississippi law have followed the Mississippi Supreme Court's cue. *See Ross v. CitiFinancial, Inc.*, 344 F.3d 458, 464-465 (5th Cir. 2003) (misrepresentation claim cannot be predicated upon alleged misrepresentations inconsistent with the contract); *Smith v. Union National Life Ins. Co.*, 286 F.Supp. 2d 782, 788-789 (S.D. Miss. 2003) (same).

These decisions are important and crucial to the financial services industries. Hopefully, they will continue, but the real test will be how these principles are applied by Mississippi's trial courts and how diligent Mississippi's appellate courts are in ensuring fairness.❑

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SWEEPING TORT REFORM BILL IS ENACTED

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that the jury be permitted to determine if a party raised a frivolous claim or defense. This jury review of the losing party's claims or defenses supplements current Georgia Code Section 9-15-14, which allows the judge to rule on whether a party's claim or defense was frivolous at the conclusion of the case. The new law allows the prevailing party to have the issue of frivolous litigation put before either the judge or the jury, but not both.

Selection and use of expert witnesses in medical malpractice cases will also be significantly impacted by SB3. Among other things, experts will be required to have practiced or taught for at least three of the five years immediately preceding the action in the same specialty or field of practice at issue in the malpractice claim. These qualification requirements will be applicable to both trial witnesses and in pre-trial affidavits. Also, SB3 allows the defendant until the end of discovery to challenge the expert's affidavit, where previously such challenge needed to be made in the first responsive pleading.

Another highly touted provision of SB3 permits healthcare providers to express regret or otherwise apologize to a plaintiff or to his/her family for unsatisfactory medical results without such an apology or statement being considered admissible as evidence. The new legislation also empowers the Composite State Board of Medical Examiners to investigate the fitness of any health care provider who has been the subject of three or more disciplinary actions over a ten-year period.

SB3 may not be the last word in litigation reform during this current Georgia legislative session. Several other bills are pending in the House and Senate and one or more of these bills could be considered as a means to further revise the state's civil justice system or a means to modify the provisions of SB3. For example, Senate Bill 19 would make it more difficult for class action lawsuits to be filed and impose additional requirements to determine if a qualified class exists prior to trial. Another bill, House Bill 416, tightens the standards applicable to asbestos related tort claims

A court challenge to SB3, particularly the non-economic damage cap and emergency room protections, is a near certainty. Consequently, it may be two to three years before Georgians may truly understand the impact of this key legislative enactment. One thing is for certain: SB3 moved through the Georgia General Assembly more quickly than anyone predicted, and has given the new majority a key win only halfway through their first legislative session.❑

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LETTER FROM WASHINGTON

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captives are different from traditional insurers and need a different regulatory environment; (2) regulatory flexibility is required to efficiently and effectively regulate captives; and (3) certain problems that had arisen in the District, as well as in other states, needed to be addressed.

The new D.C. law, as a result, is the most flexible and the most directly responsive to current alternative risk market demands, while at the same time maintaining appropriate regulatory authority. Highlights of the law are:

Cells. The movement towards segregated cells started offshore about 20 years ago with the first "rent-a-captive", which provided the benefits of a captive for smaller risks (e.g., sharing the existing capital of the rent-a-captive and its management and infrastructure). "Protective cell captives" were an elaboration upon this theme. Several states, including D.C., have or had protected cell capability.

D.C.'s new 2004 Act takes this one step further by permitting any kind of captive to have a cell or cells. Significantly, this includes any D.C. chartered risk retention group. Moreover, the 2004 Act not only permits a cell to be a separate accounting entity, it also permits the cell to be a separate legal entity. This enhances the protection of one cell from the liabilities of another cell, which, although clear in the law, has never been tested by a court.

Best Practices. The 2004 Act permits the Commissioner to authorize a captive insurer chartered in the District to engage in any activity permitted to a captive insurer in any other "jurisdiction." This provision authorizes the Commissioner to permit any activity permitted by the laws of another captive domicile (U.S. or foreign) so long as the activity would not be harmful to the captive or its policyholders. This provides enormous flexibility to District of Columbia domiciled captives so long as the business practice for which an approval is requested meets this test. This change is responsive to the growth and adaptation occurring in the alternative risk transfer market today.

Investment Flexibility. The 2004 Act changes the previous law which had only allowed certain captives to deviate from the D.C. investment law (comparable to the NAIC Model law). The 2004 Act now permits all captives to seek approval of an investment policy that may deviate from the NAIC Model. It will be up to the Commissioner to approve any such proposed investment plan.

Credit for Reinsurance. Under the old law, captives were restricted to taking credit for reinsurance only as permitted by the D.C. Credit for Reinsurance Act, which is based upon the NAIC Model. The 2004 Act will permit a captive to apply for credit for reinsurance which may not qualify under that law. It will be up to the judgment of the Commissioner as to whether such credit should be granted. The Commissioner's authority is only limited by the need to determine that the solvency of the captive and policyholder rights will not be threatened.

Non-Profit Captives. Many captives are operated in a manner that does not generate a profit. Nonetheless, those captives had been required to be chartered as a for-profit insurer. The 2004 Act acknowledges this reality and permits a captive to charter on a non-profit basis. In some instances, particularly in qualifying for federal tax exemption, this change may be very beneficial.

Conclusion. D.C. now has the most flexible captive law in the nation. The success of the domicile in the future will depend upon the good judgment and effective oversight of its regulators and the diligence of its captive managers.❑

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THE IMPACT OF THE OBESITY EPIDEMIC

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In addition to liability insurers, the issue of obesity also significantly affects the health insurance sector as health insurers bear the direct cost of treating overweight and obese people. Currently, few private insurance plans or managed care organizations appear to cover the costs associated with the treatment of obesity. However, state legislators in a number of states have introduced legislation that would increase health insurers liability with regard to the treatment of obesity (as opposed to banning lawsuits, which would limit the impact of the obesity epidemic on insurers). For example, in Georgia a bill was introduced in the current session of the Georgia General Assembly that would require every health benefit policy issued in Georgia that provides major medical benefits to provide coverage for the treatment of morbid obesity.[3] A similar bill was introduced in the Ohio General Assembly last session. That bill would have required health insurers to offer coverage for the surgical treatment of morbid obesity on the same terms as for any other medically necessary surgical procedure.[4] The Ohio bill was not acted upon and many members of the Georgia General Assembly have already noted their opposition to enacting additional mandates for health insurers.

The potential impact of the obesity epidemic on the insurance industry is significant. Insurers of all types, including health insurers, life insurers, liability insurers, and disability insurers, among others, are at risk of being affected by this epidemic. Legislators, consumers, insurers, and other interested parties must develop a cohesive and effective strategy to address the issue of obesity, and determine who, if anyone, should be held liable for treating and paying for obesity related health occurrences.❑

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Endnotes

1 See CDC Web site, Overweight and Obesity: Economic Consequences http://www.cdc.gov/nccdphp/dnpa/obesity/econmic_consequences.htm

2 See H.R. 554

3 See Georgia General Assembly House Bill 43

4 See Ohio 125th General Assembly, Senate Bill 41

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