MORRIS, MANNING & MARTIN, LLP
ATTORNEYS AT LAW

# REVIEW

Insurance • Reinsurance • Managed Healthcare

A Publication of Morris, Manning & Martin, LLP — Winter 2006

## LETTER FROM WASHINGTON

### FEDERAL REGULATION FALLOUT

**By Robert H. Myers Jr.**

There is no question that some form of federal regulation is creeping up on the insurance industry. The federal chartering legislation sponsored in the Senate by Senators John Sununu and Tim Johnson (S. 2509) and in the House by Representative Ed Royce (H.R. 6225) is gathering support. In addition, the federal surplus lines and reinsurance legislation which passed the House (H.R. 5637) promises to promote a form of federally mandated state regulation, as well. While the insurance industry used to be united in opposing federal regulation, recent years have seen a schism in the industry. This schism is reminiscent of the old mutual versus stocks split that occupied the tax writing Committees of Congress for so long.

Continued on page 11

## HASSETT'S OBJECTIONS

### CAREFUL WITH THOSE E-MAILS, REINSURER

**By Lewis E. Hassett**

The case books are scattered with decisions involving a direct policyholder's efforts to obtain communications between a direct insurer and its reinsurer. *See Rhone-Poulenc Rorer, Inc. v. Home Indemnity Co.*, 139 F.R.D. 609, 611 (E.D. Pa. 1991); *Potomac Electric Power Co. v. California Union Ins. Co.*, 136 F.R.D. 1 (D.D.C. 1990). A federal court in California recently addressed this question in the context of a policyholder's claim for an alleged bad faith denial of coverage. *Sotelo v. Old Republic Life Insurance Co.*, Case No. C-05-02238-RS (N.D. Cal., September 13, 2006). The court held that in such a case communications between the direct insurer and the reinsurer are discoverable.

In *Sotelo*, the plaintiff and her husband applied for life insurance in May of 2003. After undergoing medical examinations, both were issued policies

Continued on page 8

## PLAYER'S POINT

### LIMITATIONS ON POLICYHOLDER RIGHTS[1]

**By Thomas A. Player**

In a previous Player's Point (Summer 2006), I spoke about the emotional conflict between the life insurance industry and the life settlement industry, centering on investor-initiated life insurance (IILI). Just before the NAIC Life "A" Committee meeting in New York in May, Chairman Jim Poolman, Insurance Commissioner of North Dakota, developed a proposed amendment to the Viatical Settlements Model Act having a novel provision prohibiting a policyholder from selling a policy within the first five (5) years of ownership, except in certain circumstances such as terminal illness of the insured.

Continued on page 10

## Inside this issue

# Announcements

**Skip Myers** spoke to the Nevada Captive Insurance Association on September 29 in Las Vegas. His topic was the changing regulatory environment for captives and risk retention groups.

**Becky Patrick's** article on the lessons learned in the aftermath of the Hewlett-Packard debacle is featured in the October 2006 issue of *The Privacy & Data Protection Legal Reporter*.

**Skip Myers**, **Lew Hassett** , **Ross Albert** and **Natalie Suhl** submitted an amicus curiae brief on behalf of the National Association of Professional Insurance Agents with regard to the proposed Zurich class settlement of the federal multi-district broker antitrust litigation.

**Lew Hassett** will co-chair Mealey's "Fundamentals of Reinsurance Conference" in New Orleans on March 15 and 16, 2007. **Jessica Pardi** will be speaking on the arbitration process. For more information, visit www.mealeys.com.

**Lew Hassett** and **Larry Kunin** obtained a favorable settlement for a claims administrator of its claim for coverage under an errors and omissions policy. The insurer had relied on the prior knowledge exclusion.

An article by **Joe Holahan** appeared in the October 9, 2006 issue of *National Underwriter - Property & Casualty*. The article, "Keeping Secure Information Safe," examined the legal and practical considerations surrounding preparing for and responding to an information security breach.

During the ARIAS Winter meeting in New York, **Tom Player** participated in a panel discussion entitled "The Process of Selecting Arbitrators and Umpires" with Paul Aiudi of St. Paul Travelers Companies, Inc., and Eric Kobrick of American International Group, Inc.

Representing a reinsurance holding company, **Lew Hassett**, **Ward Bondurant** and **Orlando Ojeda** prevailed in a motion to compel contribution brought by a former agent of the direct insurer.

## UPDATE FROM THE LIFE INSURANCE NON-RECOURSE PREMIUM FINANCING BATTLEFRONT

**By Anthony C. Roehl**

In the Morris, Manning & Martin Fall 2005 Newsletter, I wrote an article concluding that insurers may be violating unfair trade practice laws by discriminating against applicants that used non-recourse premium financing to pay their life insurance premiums. ("Are Life Insurers Unlawfully Discriminating Against Potential Insureds that Finance Policies?") Since that article was published, a substantial number of large life insurers have begun using screening questionnaires to determine the source of premiums on new policies for older applicants. Insurers are also continually revising their questionnaires to include more detailed and invasive questions. For example, a major life insurer released a new questionnaire that, in addition to determining if the premiums will be financed, seeks disclosure of the loan terms including the interest rate, fees and whether a third party has evaluated the applicant's life expectancy. The widespread use of the questionnaires has prompted the NAIC and state departments of insurance to also get involved in the debate.

On September 5, 2006, the Louisiana Department of Insurance issued Bulletin No. 06-05 prohibiting insurers from asking certain questions regarding the source of financing for Louisiana life insurance policies. The Louisiana bulletin prohibits life insurers from discriminating "against applicants for life insurance based solely on the intention of the insured to subsequently sell the life insurance policy to a life settlement company or on the method of payment utilized by the insured to pay the premium." The Louisiana bulletin goes on to list specific questions that insurers may not ask, including inquiring about the intention of the applicant to use premium financing, the intention of the applicant to use the policy as collateral for a loan, questions regarding whether the applicant has previously settled a life insurance policy or questions that inquire about whether the applicant is aware that he has a vested property right to sell his life insurance policy in the future.

The bulletin is not all good news, however, for proponents of premium financing. The Louisiana Department has decided to permit certain questions that it regards as addressing abuses in the use of premium financing. For example, insurers may inquire whether the applicant has received a cash advance or other consideration as an inducement to purchase life insurance, inquire whether the applicant has been offered "free insurance," ask questions designed to determine if the applicant has entered into a financing arrangement that requires a life settlement with a particular investor or that entitles a lender to a portion of the death benefit above and beyond the repayment of principal and interest on the underlying loan. As of the beginning of November, no other state department of insurance has issued a similar bulletin addressing the topic of premium financing and life insurance questionnaires.

The battle regarding financing life insurance premiums is also raging at the NAIC. The NAIC Life Insurance and Annuities (A)

Continued on page 8

## SECOND CIRCUIT LIMITS DISTRICT COURT'S PERSONAL JURISDICTION TO ENFORCE ARBITRATION SUBPOENA

By Natalie C. Suhl

The Second Circuit recently held that Section 7 of the Federal Arbitration Act ("FAA Section 7") does not authorize nationwide service of process thereby precluding the court's exercise of personal jurisdiction over a motion to compel a non-party to comply with the arbitrators' subpoena. *Dynergy Midstream Services, LP v. Trammochem, et al*. 05cv3544 (2d Cir. June 13, 2006). Only the district where the subpoena is served, unless the subpoena is served within 100 miles of the location of the hearing or deposition, has the requisite jurisdiction.

**BACKGROUND**

The case involved somewhat complicated facts. Respondent/ Appellee Trammochem chartered a vessel from respondents/ appellees A.P. Moller and Igloo Shipping (the "Vessel Owners"). The charter agreement contained an arbitration clause, requiring any arbitration to be held in New York. The Vessel Owners hired Inert Gas Systems, Inc. to perform services on the vessel in Houston in preparation for use by Trammochem. Innert Gas Systems, Inc. engaged appellant-petitioner Dynergy Midstream Services ("DMS") to provide certain facilities and supplies. When the cargo arrived at its destination, Belgium, it became clear that the cargo was contaminated. A dispute arose between Trammochem and the Vessel Owners because the cargo had possibly become contaminated in Houston. Pursuant to the charter agreement the dispute was submitted to arbitration.

A report prepared by a member of the Nautical Commission to the Commercial Court of Antwerp concluded that the most likely cause of the contamination was DMS's shore-flare system. As a result of this report, A.P. Moller attempted to vouch[1] DMS into the arbitration and force DMS to indemnify and defend it. DMS refused to participate in the arbitration, arguing it had had inadequate time to prepare for the arbitration.

The arbitrators issued a subpoena to DMS on February 9, 2005, serving it on DMS's registered agent in Houston on February 16, 2005. DMS refused to comply because of its concerns about any participation in the arbitration. In response, the parties to the arbitration filed a motion to compel in the Southern District of New York ("SDNY"). DMS argued that the SDNY did not have personal jurisdiction over it because it has no contacts with New York. The district court disagreed, held that it had jurisdiction and ordered DMS to comply with the subpoena. DMS appealed to the United States Court of Appeals for the Second Circuit.

**ANALYSIS**

The Second Circuit found that it had jurisdiction to hear the appeal, but that the District Court had lacked personal jurisdiction. The Second Circuit determined that an arbitration subpoena pursuant to FAA Section 7 is akin to an administrative subpoena and that the litigation to enforce such a subpoena is an entirely self contained and independent court proceeding. The district court's order clearly ended the litigation on the merits and only left the enforcement of the order for the court. Therefore, the Second Circuit viewed this as a final order, allowing it to have appellate jurisdiction to review the order.

Appellees argued that FAA Section 7 authorizes nationwide service of process, thereby bestowing personal jurisdiction over DMS by SDNY. The Second Circuit disagreed. In its analysis, the Court pointed out that FAA Section 7 demands service in the same manner as subpoenas to appear and testify before the court, which are governed by Federal Rule of Civil Procedure 45 ("Rule 45"). Rule 45 limits service of process to 100 miles and equally limits enforcement proceedings. Similarly, Rule 37(a)(1) provides that "an application for an order [to compel discovery] to a person who is not a party shall be made to the court in the district where discovery is being, or is to be, taken."

The subpoenas in this case were served on DMS in Houston and required DMS to produce documents in Houston. Normally,

Continued on page 8

# Announcements

Morris, Manning & Martin co-sponsored a symposium on Terrorism Risk Insurance in Washington, D.C. on October 3, 2006. **Joe Holahan** spoke at the symposium on the subject of the Terrorism Risk Insurance Act.

**Tony Roehl** will be teaching insurance law during the spring semester of 2007 at Georgia State University School of Law.

**Lew Hassett** and **Jessica Pardi** obtained a favorable settlement for a managing general agency in a premium dispute with the liquidator of an insurer.

**Tom Player** hosted a reception during the fall meeting of the National Association of Life Companies.

**Tom Player** participated in the Vermont Captive Insurance Association Conference held in Atlanta during November 2006.

**Jessica Pardi** hosted the October meeting of the Georgia Chapter of the Association of Corporate Counsel and moderated a panel discussion to assist corporate counsel with the decision of whether to litigate of arbitrate.

## BROAD ARBITRATION CLAUSE ENCOMPASSES STATUTE OF LIMITATIONS DEFENSE

**By Jessica Pardi**

The Florida Supreme Court resolved a conflict between the Florida's Fourth and Fifth District Courts of Appeal regarding whether a statute of limitations defense (an "SOL Defense") is subject to arbitration. *O'Keefe Architects, Inc. v. CED Constr. Partners, Ltd.*, Fla. S.Ct. Case No. SC05-1417 (decided October 19, 2006). The arbitration clause at issue included broad language that all claims, disputes or other matters arising out of or relating to the contract were to be decided by arbitration. The dispute arose because the clause also provided that a demand for arbitration is prohibited if institution of legal or equitable proceedings would be barred by the applicable statute of limitations.

The Florida Arbitration Code (the "FAC") allows parties to agree to arbitrate any controversy.[1] Given the broad scope of the FAC, the Florida Supreme Court considered the arbitrability of the SOL Defense an issue of contract interpretation. The two contracts at issue were between O'Keefe Architects, Inc. ("O'Keefe") and its two clients, Vero Club Partners, Ltd. ("Vero") and Clearwater Phase I Partners Ltd. ("Clearwater"). O'Keefe contracted with both clients to design housing projects, and CED Construction Partners Ltd. ("CED") was the general contractor on both projects. After discovering defects in both projects, Vero and Clearwater demanded CED correct the errors, and in turn, they assigned to CED their claims against O'Keefe.

When CED demanded arbitration against O'Keefe, O'Keefe argued that the SOL Defense prevented CED from making such demand. After receiving several adverse rulings from the arbitrators, including one denying the SOL Defense, O'Keefe filed a complaint for a declaratory judgment. Among other things, O'Keefe sought a court ruling that the SOL Defense was not arbitrable.

The trial court held that the SOL Defense was arbitrable, and O'Keefe appealed such ruling to Florida's Fifth District Court of Appeals which affirmed on the grounds that the timeliness of a demand for arbitration is a question of fact to be decided by the arbitrators. Aware of a conflict with a diametrically opposed Fourth District Court of Appeals opinion, the Fifth District certified the question of arbitrability of the SOL Defense to the Florida Supreme Court. Because the parties agreed that a valid arbitration agreement existed, that the underlying claims were subject to arbitration, and that neither party had waived its right to arbitration, the sole question before the Florida Supreme Court was the arbitrability of the SOL Defense.

In its analysis, the Court first noted other Florida cases wherein issues of timeliness of an arbitration were held to be arbitrable. *See e.g., Stinton-Head, Inc. v. City of Sanibel*, 661 2d 119 (Fla. 2d DCA 1995). It then compared these decisions to those of other states, such as New York, wherein the state arbitration code mandates that an SOL Defense must be made "on an application to the Court." N.Y. C.P.L.R. 7502(b) (McKinney Supp. 2006).

Continued on page 9

## SIXTH CIRCUIT REQUIRES FULL DISCLOSURE OF ALL INFORMATION PROVIDED TO TESTIFYING EXPERTS

**By Orlando P. Ojeda, Jr.**

In *Regional Airport Authority of Louisville and Jefferson County v. LFG, LLC*, No. 05-5754 (6th Cir., August 17, 2006), the Sixth Circuit Court of Appeals held that Federal Rule of Civil Procedure 26(a)(2) requires the disclosure of all information provided to testifying experts. While analyzed as a matter of first impression for the Sixth Circuit, the court recognized that full disclosure and a "bright-line approach is the majority rule." *Id*. The court reviewed the history and amendments to Rule 26, the Advisory Committee Notes to the Federal Rules, and the two lines of cases regarding protections of work product associated with testifying experts.

*Regional* involved a dispute over liability under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980. The Regional Airport Authority of Louisville (the "Authority"), as part of an airport expansion program, condemned property belonging to LFG. The Authority knew the property was contaminated at the time of condemnation and, because federal funds were used in the airport expansion, completed an environmental impact statement. The discovery dispute involved thousands of documents between the Authority's attorneys and employees of outside companies and consultants involved in the airport expansion and related environmental impact study. The Authority objected to the production of documents, claiming that the documents were privileged. The magistrate judge and the district court found that the documents "were not made to provide legal advice to the client," and the Sixth Circuit affirmed. *Id*.

The Authority further objected to specific disclosures relating to certain documents the Authority gave to its testifying experts, claiming attorney work product protection. Regarding this issue, the Sixth Circuit examined the district court's conclusion that the Federal Rules require that all documents given to a testifying experts be disclosed to the opposing party upon request.

In deciding *Regional*, the court began its analysis with the 1993 amendments to Rule 26, which imposed new duties to disclose on parties. Rule 26(a)(2) concerns disclosure of expert testimony, and subsection (B) states "this disclosure shall, with respect to a witness who is retained or specifically employed to provide expert testimony in the case . . . be accompanied by a written report prepared and signed by the witness." This section also outlines specific information required in an expert report, which includes "the data or other information considered by the witness in forming the opinions." Fed.R.Civ.P. 26(a)(2)(B) (emphasis added). The 1993 Advisory Committee Notes to Rule 26 clearly address this issue and explain that "[g]iven this obligation of disclosure, litigants should no longer be able to argue that materials furnished their experts to be used in forming their opinions - whether or not ultimately relied upon by the expert - are privileged or otherwise protected from disclosure."

The amendments to Rule 26 and the related advisory notes led to two distinct lines of cases regarding work product protection and testifying experts. The first line held that work product is

Continued on page 9

## QUALIFIED INDEPENDENT DIRECTORS – NOW IS THE TIME TO RECRUIT

**By Brooks W. Binder**

By now, nearly everyone reading this article should be aware that having well qualified and effective independent directors on your Board is a good idea. Sarbanes-Oxley has been in place since 2002 and the reforms it brought to the public markets have been filtering ever since into areas such as the insurance industry and even non-profit organizations. The pursuit last year of Hank Greenberg by New York Governor-elect Spitzer focused intently on an apparent lack of effective independence at board and committee levels. This past June, the NAIC's Financial Condition (E) Committee adopted its final revisions to the NAIC's Model Audit Rule which includes far reaching independence requirements.

Among other significant changes to long term audit practices, beginning in 2010 the Model Audit Rule requires insurers with written and assumed prior calendar year premiums in excess of $300 million to have an audit committee and at least 50 percent of the members must be independent. The Model Audit Rule "encourages" all insurers below the $500 million premium level to have a supermajority of independent members on their audit committee, and for insurers at the $500 million plus level, a 75 percent supermajority is required.

Even if your organization falls below the $300 million threshold, you will be affected by the Model Audit Rule as it is expected to establish "best practice" standards that the entire industry will be expected to follow. Furthermore, to the extent that a smaller insurer is in a RBC action level event, the Model Audit Rule recognizes that regulators may have authority under state law to require it to "improve" the independence of its audit committee.

Under the Model Audit Rule, an independent member of the Audit Committee must be either a member of the Board of Directors of the insurer or a member of the Board of Directors of an entity which controls the insurer. Employees and officers of the insurer are disqualified from being considered independent for purposes of the Model Audit Rule. Moreover, your independent members cannot be affiliates and the only compensation that they may receive is compensation received for their role as a member of the Board of Directors, the Audit Committee or another Board committee.

While the audit committee independence rules will not come into effect until 2010, now is the time to prepare your organization for this changing environment. The experience of non-insurance organizations who have been living with mandated director independence since even before Sarbanes-Oxley tells us that installing and maintaining a group of qualified independent directors is a long term process which requires a permanent institutional focus. Among the reasons to start the process now are:

- Typically, qualified candidates are not easy to find and demand for their services will surely rise in the next few years as the industry prepares for the Model Audit Rule. Note that while the Model Audit Rule does not require audit committee members to be "financial experts," best practices may recommend such expertise.
- Candidates want to know that the organization they are joining is a forward-thinking organization with a serious commitment to the role of its audit committee.
- Even before the Model Audit Rule becomes a requirement of the regulatory framework, business partners with interests in the financial stability of your organization, such as policyholders, shareholders, rating agencies, banks, major customers, reinsurers, d&o carriers, distribution networks, potential acquirers or acquisition targets, will be asking you and your competitors about best corporate practices.
- Your organization's system of communicating and working with independent directors will need to run smoothly when compliance becomes a requirement and you will likely need time to work out some kinks in your system as it evolves. From an operational standpoint, your audit committee will be involved in approval of all audit and material non-audit services, as well as approval of Management's Report of Control over Financial Reporting required by Section 16 of the Model Audit Rule.
- To the extent that your independent directors will bring significant change to outdated and long standing processes, your organization will need time to adapt. You must allow for lead time to adopt an appropriate charter for your audit committee as well as develop a compensation program for the members and update your d&o coverage.
- Even if your organization currently meets the Model Audit Rule standards, you can expect that your independent directors will be recruited by other insurers and you might find compliance more difficult to maintain as the compliance deadlines approach.

Here is another thing to think about when it comes to your organization's need for independent directors: <u>when you need them most, it might be too late</u>. For example, suppose that you receive an unexpected and unsolicited bid to buy your company. Your board is currently composed of several major shareholders and the CEO, all of whom would receive significant financial benefit from the transaction and may be deemed "affiliates" of the company. Under state corporate laws, your board might not be considered independent and the board's decisions about the sale could be subjected to a high fiduciary standard (e.g., an "entire fairness" standard) rather than the more lenient business judgment rule that would likely apply if a committee of independent directors negotiated the transaction. Given the need to act quickly on the proposed transaction as well as most candidates' reluctance to step into such a volatile situation, it will likely be too late to recruit independent directors, leaving your board members exposed to the possibility of significant personal liability.

Ultimately, the pressure to develop independence at the board level will result in more effective corporate governance within our industry. Requiring that the independent members of the audit committee also be members of the board of directors means that their thought processes, perspective and stewardship will affect not just the audit process, but the organization as a whole.

Continued on page 9

## DESIGNING A COMPLIANT WELLNESS PROGRAM

**By Joseph T. Holahan**

Wellness programs have become increasingly popular among large and even medium-sized employers as a way to reduce the cost of employee health benefits, boost employee satisfaction and raise productivity. Now, as the benefits of wellness programs have become more widely recognized, interest has grown in programs that provide financial incentives, such as reduced contributions or reduced cost-sharing, for employees who participate in the program. Such programs generally are permitted under applicable law, but employers and insurers offering wellness programs must be careful to comply with a host of requirements under federal and, where applicable, state law.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), employer group health plans, and insurers offering coverage in connection with a group plan, are prohibited from discriminating against individual participants based on any "health status related factor." Group health plans, however, may offer premium or contribution discounts or lower co-payments or deductibles in return for a participant's adherence to a program of "health promotion and disease prevention." The Department of Labor and the Department of Health and Human Services have jointly issued proposed regulations establishing standards for what constitutes a lawful "program of health promotion and disease prevention." The regulations characterize an acceptable program as a "bona fide wellness program." Although the agencies have yet to issue final regulations, they have stated that they will consider any health plan that complies with the proposed regulations to be in good faith compliance with HIPAA and will not take enforcement action against such a plan.

The regulations distinguish between two general categories of wellness programs. In the first category are programs that offer a reward regardless of the individual's ability to meet a health-related goal. For example, a program that reimburses employees for the cost of health club membership would fall within the first category. A program that provides for voluntary testing for chronic health conditions, such as high cholesterol, and offers recommendations for addressing any identified condition also would fall within the first category. Wellness programs in the first category are considered "bona fide" without having to meet any regulatory standards.

In the second category are programs that offer a reward based on an individual's ability to meet a standard that is related to health. For example, a program that offers a premium discount to employees who maintain a certain body mass index (a ratio of height to weight) or who maintain a certain cholesterol level would fall within the second category. A program that rewards employees for not smoking also would fall within the second category.

Wellness programs in the second category must satisfy several conditions to be considered "bona fide." First, the reward for achieving the health-related goal generally must not exceed 10-20 percent of the cost of employee-only coverage under the

Continued on page 10

## REASONABLE MORTALITY CHARGE SAFE HARBORS ESTABLISHED

**By Sean Reynolds**

On October 12, 2006, the Internal Revenue Service, through its issuance of Notice 2006-95, established safe harbors for "reasonable mortality charges." Such safe harbors for "reasonable mortality charges" are important because mortality charges charged by an insurer in connection with a life insurance contract must be "reasonable mortality charges" in order for a life insurance contract to satisfy certain tests and qualify as a "life insurance contract" under the Internal Revenue Code (the "Code").

To qualify as a "life insurance contract" under the Code, it is necessary for a contract to satisfy certain tests set forth in Section 7702 of the Code. Specifically, to qualify as a "life insurance contract" under Section 7702 of the Code, it is necessary for a contract to be a life insurance contract under applicable law and to either meet (i) the cash value accumulation test of Section 7702(b) of the Code or (ii) both the guideline premium requirement of Section 7702(c) of the Code and the cash value corridor requirement of Section 7702(d) of the Code.

In order for a life insurance contract to meet the guideline premium requirement of Section 7702(c) of the Code, it is necessary for the "guideline single premium" (which is the premium that would be payable if only one premium were payable upon the issuance of a contract in order to fund all future benefits payable under the contract) to be determined on the basis of "reasonable mortality charges."

In each of 1980 and 2001, the Internal Revenue Service published mortality tables ("CSO tables") to be used in determining whether mortality charges are reasonable. In 2004, the 2001 CSO tables became the operative tables due to the adoption of such tables by 26 states. The 2001 CSO tables have now been adopted by all 50 states. Under the Code, there is a three year transition period during which an insurer may use either the prevailing operative CSO tables (i.e., the 2001 CSO tables) or the previously prevailing operative tables (i.e., the 1980 CSO tables). In 2004, when the 2001 CSO tables became the operative tables, the Internal Revenue Service requested comments for additional guidance on the adoption of the 2001 CSO tables. Notice 2006-95 was issued by the Internal Revenue Service to respond to the comments it received in connection with the 2001 CSO tables and proposed safe harbors for "reasonable mortality charges."

Under Notice 2006-95, the Internal Revenue Service will permit the use of the 1980 CSO tables for contracts issued in all calendar years through 2008. Additionally, the Internal Revenue Service has established the following safe harbors:

> A mortality charge will satisfy Section 7702 of the Code (and be deemed to be reasonable) so long as (i) the mortality charge does not exceed 100% of the applicable mortality charge set forth in the 1980 CSO tables, (ii) the contract is issued in a state that permits or requires the use of the 1980 CSO tables, and (iii) the contract is issued before January 1, 2009.

Continued on page 9

## MASSACHUSETTS HEALTH INSURANCE INITIATIVE DRAWING NATIONAL ATTENTION

**L. Chris Petersen**

As the number of people without health insurance continues to rise, the search for the "magic bullet" intensifies. Legislators, regulators, employers and insurers are all seeking ways to provide affordable health insurance coverage to as many people as possible. Recent initiatives have ranged from universal health care proposals based on the Canadian model to consumer-driven health care and mini-med insurance policies.

However, the "policy proposal du jour" is the recent initiative adopted in the state of Massachusetts. The National Association of Insurance Commissioners, national trade associations and individual state legislatures and governors are all reviewing the Massachusetts proposal to determine whether it would work as a national model.

The key element of the Massachusetts proposal (Chapter 58 of the Acts of 2006) is a play or pay scheme that applies to both individuals and employers. In short, if individuals do not purchase, or if employers do not provide, health insurance, the individuals and employers are required to pay into special government funds created by the law.

Under the individual mandate, every person over the age of 18 who files a tax return as a resident of Massachusetts must indicate on the return whether the individual has "creditable coverage." Essentially, creditable coverage is major medical coverage. Coverages such a vision, dental and supplemental insurance are excluded from the definition of creditable coverage. In the first year, if the individual indicates that he has creditable coverage, or if he fails to indicate whether he has coverage, then that individual's tax will be computed on the return without the benefit of the standard personal exemption. The state may also make its own determination, after investigation, that an individual does not have creditable coverage and can on its own initiative revoke the personal tax exemption. After the first year of operation, the penalty imposed on individuals for failing to have creditable coverage increases to 50% of the minimum insurance premium for which the individual would have qualified for coverage.

The Massachusetts statute also imposes an employer "play or pay" mandate on all employers with at least 11 employees. The Massachusetts law has a three-prong approach towards addressing employer coverage. First, the law provides that if an employer provides creditable coverage (major medical coverage) to its employees, the employer must contribute a "fair and reasonable" amount towards the insurance premium. By regulation, the state has determined that an employer's contribution will be deemed to be fair and reasonable if either (1) the employer is making a contribution and 25% of the employer's full-time employees have enrolled in the program or (2) the employer's contribution represents 33% of an individual's insurance premium. To help in enforce this provision of the law, it is anticipated that employers will be required to submit health insurance responsibility forms setting forth whether they have offered to provide or arrange for health insurance coverage.

Under the second prong, if it is determined that any employer of at least 11 employees has not contributed a fair and reasonable amount towards its employee's health insurance premium, then the state will assess a fair share contribution (presently $295.00 per employee) against the "non-providing" employer. In addition, Massachusetts may also assess employers with a "free rider" charge. The free rider charge will be assessed if the state determines that an employer's employees receive uncompensated care totaling in excess of $50,000.00 or after a certain number of visits for uncompensated care.

Finally, the third prong of the proposal requires an employer of at least 11 employees to establish Section 125 cafeteria plans. It is anticipated that the cafeteria plans will help employees in purchasing, and maintaining, health insurance coverage.

The Massachusetts law also addresses several other insurance issues which will have a significant impact on the market. Massachusetts intends to merge the individual and small group health insurance market (HIPAA's "excepted benefits" such as dental, vision and supplemental coverages are exempted from the Massachusetts law). The measure also includes modified community rating requirements and an "insurance connector" to assist individuals and employers in purchasing health insurance.

Although ambitious in scope, several issues will need to be resolved before it can be determined whether the Massachusetts law can deliver on its promise. First, can the law survive the inevitable ERISA challenges? Second, will insurers make a long-term commitment to a merging marketplace? Third, are the penalties imposed sufficient enough to force individuals and employers to purchase to insurance coverage? Finally, what will be the economic impact of the law?

Massachusetts will need to rethink its approach if the effect of the statute is employers leaving the state or of individuals moving into the state to receive coverage. On the other hand, if the economic impact is minimal then several other states will be giving this approach serious consideration. ❑

*Chris Petersen is a partner in the firm's insurance group. He concentrates in legal and compliance services relating to the Health Insurance Portability and Accountability Act (HIPAA), privacy, state small-group and individual insurance reform regulation and the interaction between state and federal law. Chris received his bachelor's degree from Washington University (St. Louis, Mo.) and his law degree from Georgetown University.*

## HASSETT'S OBJECTIONS

Continued from page 1

on June 24, 2003. The insurer reinsured the risk, although the opinion does not specify whether the reinsurance was pursuant to a treaty or a facultative placement. Apparently, the insurer "reissued" the policy on July 18, 2003, to correct an error in the calculation of premium. Two days after the initial issuance of the policy, the husband sought medical treatment for gastrointestinal symptoms, which eventually were diagnosed as Crohn's disease. He died while hospitalized for treatment.

Although the direct insurer initially concluded that the insured had not concealed or materially misrepresented his condition, it subsequently denied the claim. The wife then brought an action against the direct insurer, alleging a bad faith denial of coverage. She later served a subpoena upon the reinsurer, seeking communications between the insurer and the reinsurer. A court refused to quash the subpoena, holding that the cedant's and reinsurer's motives for rescinding the policy were directly relevant to the case and that coverage communications between the insurer and the reinsurer were not protected by any privilege.

The court relied upon an earlier decision by a federal court in Illinois, allowing discovery in similar circumstances. *See National Union Fire Insurance Company v. Continental Illinois Corp.*, 116 F.R.D. 78 (N.D. Ill. 1987). *National Union* involved a direct insurer's attempt to avoid liability under director's and officer's liability policies. The policyholder sought pre-issuance and post-issuance communications between the direct insurer and its reinsurer, arguing that those communications were relevant as to validity of the insurer's current bases for avoiding liability. The court agreed, holding that such communications, as well as the reinsurance agreements themselves, were relevant and discoverable.

The gist of these decisions is that communications between an insurer and a reinsurer regarding the grounds for coverage or rescission were relevant and discoverable, unless the coverage question may be answered fully by the language of the policy. Cedants and reinsurers beware; the most innocuous e-mails may appear suspicious in a subsequent bad faith case. Any hint of a motivation outside the narrow legal merits of the matter, or even the consideration of factors, could be devastating to the coverage defense. In this age of electronic communications and reinsurer involvement in the adjudication of direct claims, the discovery of cedant/reinsurer communications may affect profoundly the outcome of the case. ❑

*Lewis Hassett is a partner in the firm's litigation group and chairs the firm's insurance and reinsurance dispute resolution group. His practice concentrates in the areas of complex civil litigation, including insurance and reinsurance matters, business torts and insurer insolvencies. Lew received his bachelor's degree from the University of Miami and his law degree from the University of Virginia.*

## UPDATE FROM THE LIFE INSURANCE BATTLEFRONT

Continued from page 2

Committee is in the process of revising the Viatical Settlement Model Act, and various proposals seek to curtail or substantially restrict the non-recourse premium financing and life settlement markets. There are financing industry proposals that add clarifying language stating that insurers do not have the right to discriminate against applicants based on the method or source of financing. The revisions to the Viatical Settlement Model Act are still very fluid, and it is likely that a final version of the model will not be ready until after the Winter 2006 NAIC meeting.

While it is unclear which side will ultimately prevail, it is evident that battle lines have been drawn and both sides are fully engaged in the fight. It is clear that life insurers view non-recourse premium financing of life settlements as a threat to their way of doing business and are determined to eradicate the industry. ❑

*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.*

## SECOND CIRCUIT LIMITS DISTRICT COURT

Continued from page 3

such a subpoena would be issued by the District Court for the Southern District of Texas. In contrast, FAA Section 7 provides that subpoenas issued under that section may be enforced by the District Court for the District in which such arbitrators, or a majority of them, are sitting. Based on this analysis, the District Court determined that it had jurisdiction over DMS to enforce the subpoena. The Second Circuit, however, disagreed, holding that FAA Section 7's language does not suggest that Congress intended to authorize nationwide service of process. Furthermore, language in FAA Section 7 provides that subpoenas "shall be served in the *same manner* as subpoenas to appear and testify before the court…." (Emphasis added). Additionally, the Second Circuit noted that when Congress intends to permit nationwide personal jurisdiction, it uses affirmative language permitting service. Based on this analysis the Second Circuit held that personal jurisdiction to enforce arbitrators' subpoenas lies not where the arbitration hearing will be held, but relates to where the subpoena was served. ❑

Endnotes

[1] "Vouching" is a common law procedure, with some similarities to impleader, providing an opportunity for a defendant to bind an indemnitor to the outcome of litigation.

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

## BROAD ARBITRATION CLAUSE

Continued from page 4

Florida has no such express prohibition against arbitrating an SOL Defense.

Next, the Court examined *Reuter Recycling of Florida, Inc. v. City of Dania Beach*, 859 So.2d 1271 (Fla. 4th DCA 2003), wherein the Fourth District held that a court should rule on an SOL Defense because it presented an "issue or arbitrability;" *i.e.* even if the arbitration agreement was ambiguous, the parties "have not clearly and unmistakably manifested an intent to have arbitrators decide the issue as to what specific claims they have agreed to arbitrate." *Reuter*, 869 So. 2d at 1273.

The Florida Supreme Court noted that the Fourth District's characterization of this matter as an issue of arbitrability could be construed as an assumption that the claims were indeed time-barred and, therefore, contractually exempt from arbitration. It then held that the Fourth District ruling in *Reuters* failed to consider the United States Supreme Court ruling in *Howsam v. Dean Witter Reynolds, Inc.*, 537 U.S. 79 (2002), that "questions of arbitrability do not include allegations of waiver or delay and expressly held that whether a claim is timely is to be decided by arbitrators."

Based at least in part upon the holdings in *Howsam*, the Florida Supreme Court overruled *Reuters* and affirmed *O'Keefe* to establish that, in Florida, an SOL Defense is arbitrable. ❑

Endnotes

[1] Both parties agreed that the FAC, as opposed to the Federal Arbitration Act ("FAA"), applied to their dispute because the interstate commerce necessary for FAA application was not involved.

*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.*

## REASONABLE MORTALITY CHARGE SAFE HARBORS

Continued from page 6

> A mortality charge will satisfy Section 7702 (and be deemed to be reasonable) so long as (i) the mortality charge does not exceed 100% of the applicable mortality charge set forth in the 2001 CSO tables, (ii) the mortality charge does not exceed the mortality charge specified in the contract at issuance, and (iii) the contract is issued after December 31, 2008 or before January 1, 2009 in a state that permits or requires the use of the 2001 CSO tables.

Accordingly, any insurer that complies with either of the safe harbors above will be deemed to charge "reasonable mortality charges" and will, so long as it complies with all of the other requirements of Section 7702 of the Code, issue contracts that qualify as "life insurance contracts" under the Code. ❑

*Sean Reynolds is an associate in the firm's tax and capital markets groups. His practice focuses on tax matters related to insurance and real estate offerings, including listed and non-listed REITs and private real estate funds. Sean received his bachelor's degree and his law degree from the University of Georgia.*

## SIXTH CIRCUIT REQUIRES FULL DISCLOSURE

Continued from page 4

not discoverable merely because it was shared with a testifying expert. The court noted that this was the minority view as represented by *Haworth, Inc. v. Herman Miller, Inc.*, 162 F.R.D. 289 (W.D.Mich.1995). The Sixth Circuit, however, found the second line of cases, which adopted a "bright-line rule requiring disclosure of all information provided a testifying expert, including attorney opinion work product," more persuasive. *Regional*, No. 05-5754 (6th Cir., August 17, 2006). In addition, The court recognized that the only other appellate level decision concerning this issue, *In re Pioneer Hi-Bred Int'l, Inc.*, 238 F.3d 1370 (Fed. Cir. 2001), fell within this second line of cases.

Finally, The court denied the Authority's argument that other general provisions of Rule 26 should limit the requirements of Rule 26(a)(2). In particular, the court found that the requirement of "exceptional circumstances" for disclosures within Rule 26(b)(3) and (4) were in no way controlling on the provisions of (a)(2). The Sixth Circuit found further support in the language of the Rule 26(a)(2) that requires disclosure of "data or other information" within the expert report. The court explained that had the drafters merely intended the data of the expert to be disclosed, then terms "or other information" would be superfluous. The court held that this bright-line approach "represents the most natural reading of Rule 26." *Id*. With the adoption of this bright-line test by the Sixth Circuit, counsel may find themselves being forced to weigh work product protection of documents with complete disclosure to their testifying experts. ❑

*Orlando Ojeda is an associate in the firm's litigation group and focuses his practice on insurance and commercial matters. He received his bachelor's degree from George Washington University and his law degree, magna cum laude, from the University of Florida.*

## QUALIFIED INDEPENDENT DIRECTORS

Continued from page 5

The compliance date might appear to be a long way off, but every affected organization should be acting on its compliance plans now, not later.

If you have any questions about corporate governance or how the Model Audit Rule might affect your organization, please call Ward Bondurant (404-504-7606), Brooks W. Binder (404-504-7626), Tony Roehl (404-495-8477) or Chris Petersen (202-408-5147). Morris, Manning & Martin, LLP, also offers a Model Audit Rule Resource Center at www.mmmlaw.com/naic/default.asp, which includes a copy of the Model Audit Rule, the Model Audit Rule Implementation Guide, a Model Audit Rule FAQ, as well as helpful analyses of various issues raised by the Model Audit Rule. ❑

*Brooks Binder is a partner in the firm's corporate and securities practice groups. His practice concentrates in the areas of mergers and acquisitions, strategic investments, recapitalizations, venture capital financings, leveraged buyouts, debt offerings including mezzanine loans, equipment leasing and other commercial lending transactions. Brooks received his bachelor's degree from the University of North Carolina at Chapel Hill and his law degree from Emory University.*

## PLAYER'S POINT

Continued from page 1

Many commentators, including some members of the "A" Committee with whom I have spoken, feel the Poolman position is arbitrary and may have initially been added to the mix for discussion purposes only. However, as this article goes to print, the five-year prohibition remains a part of the Model Act as proposed by Mr. Poolman. Admittedly, this is the Chairman's proposal, and there has been little or no debate on the proposal by the "A" Committee, let alone a vote on this proposal.

Mr. Poolman substitutes his five-year ban in lieu of a two-year time limit which is currently in the Model. The two-year prohibition on sales of life insurance policies is not totally arbitrary. It is based on the two-year incontestable period which is mandated by most state laws.

Most buyers of life insurance policies decline to purchase a policy during the first two years because during that period the policy may be rescinded by the carrier for material misrepresentation or fraud on the part of the applicant. Incontestability clauses have been used in the insurance industry for more than one hundred years. The clauses were originally introduced in the middle nineteenth century in life insurance policies in England to assuage concerns by the public that insurers were unjustly avoiding payment on claims.[2] In 1864, the Manhattan Life Insurance Company was the first American company to offer a policy including an incontestability clause. In 1884, Prudential adopted a two-year incontestable clause in an attempt to remain competitive in the market and to build good will. Northwestern Mutual followed and adopted an incontestability clause in response to public demand and market pressures felt by its agents. New York Life adopted a two-year clause in 1889, and Mutual of New York followed in 1890, as did Metropolitan in 1895.[3] Incontestability clauses were included in policies as a way to boost sales and combat the skepticism of many Americans about the insurance industry. By the turn of the century the use of the clause was a common provision in life insurance policies.

Although common, the voluntary introduction of incontestability clauses in policies did not end concerns regarding insurance company practices.[4] Growing concerns by state legislators lead to reform commissions and hearings in a number of states, the most notable of which were the Armstrong Commission in New York in 1905 and the Committee of Fifteen in Chicago in 1906. Both groups developed model insurance policies and incontestability clauses. By 1907, twenty-seven states had enacted legislation mandating incontestability clauses in an attempt to protect the average insured from the power disparity that existed between the large insurers and the individual consumers.[5] In general, the laws of most states now require that life insurance contracts contain a two-year incontestable clause.[6]

One could say that a two-year prohibition on life insurance sales as proposed by the Model Act, being consistent with the incontestable periods, is no big deal. What is a big deal is extending that period arbitrarily by three years. Imagine, if you will, a large rancher in Commissioner Poolman's home state of North Dakota buying a substantial policy to provide estate planning liquidity in this time of uncertainty about the Federal Estate Tax. Suppose within the next, say, three years, Congress puts an end to that uncertainty and makes obsolete the need for such a policy. If Commissioner Poolman's version of the Model Act were enacted into law in North Dakota, that policyholder would be prohibited from selling what is excess coverage. It seems cavalier to propose model legislation which would limit policyholder flexibility, but especially harmful during a political period when there are legitimate pressures to materially modify or repeal the Federal Estate Tax.

Interestingly enough, the use of the contestable period by carriers seems to be an emerging tool in combating IILI. Some carriers have made it plain that they will take action to rescind policies where application questions concerning the intended use of the policies or the intended method of financing the policies are not answered truthfully. Whether carriers will use the contestable language to allege material misrepresentation and rescind on that basis, or whether the carriers will allege a lack of insurable interest as evidenced by such misrepresentation is unclear.

However, what is intrinsic in the life insurance business is consistency and reliability. Talk of limiting assignability during the first five years of ownership, or limiting assignability altogether, will certainly put a chill on the value of the life insurance asset. Likewise, widespread talk of rescissions by carriers and resulting reversal of commission payments to agents and brokers, will make a jittery marketplace even more so. ❑

Endnotes

[1] My appreciation to Kristin Zimmerman of our Atlanta office for her invaluable assistance in the preparation of this article.

[2] *New England Mutual Life Ins. Co. v. Doe*, 93 NY2d 122, 127 (1999).

[3] LUIS M. VILLARONGA, THE INCONTESTABLE CLAUSE: AN HISTORICAL ANALYSIS, J. David Cummins ed., S.S. Huebner Foundation for Insurance Education 1976, p.16.

[4] David G. Newkirk, *An Economic Analysis of the First Manifest Doctrine: Paul Revere Life Ins. Co. v. Haas*, 76 NEB. L. REV. 819, 826 (1997).

[5] Katherine Cooper, *Liar's Poker: the Effect of Incontestability Clauses After Paul Revere Life Ins. Co. v. Haas*, 1 CONN. INS. L. J. 225, 228 (1995).

[6] VILLARONGA at 23.

*Thomas Player is a partner and chairman of the insurance and reinsurance group. His areas of expertise include insurance and reinsurance, mergers and acquisitions, complex regulatory issues and dispute resolution. Tom received his bachelor's degree from Furman University and his law degree from the University of Virginia.*

## DESIGNING A COMPLIANT WELLNESS PROGRAM

Continued from page 6

plan. The 10-20 percent figure is not a hard-and-fast number. The agencies acknowledge that "based on all the facts and circumstances, a plan's wellness program that provides a reward in excess of the specified range of percentages… may also be found to meet the good faith compliance standard." Thus, even if the reward offered for adhering to a wellness program were to exceed 10-20 percent, the plan could still qualify as a bona fide wellness program.

Continued on page 11

## LETTER FROM WASHINGTON

Continued from page 1

Although federal regulation appears to be ascendant, its potential risks bear scrutiny. Two recent events in Washington have demonstrated the potential for federal mischief. Both are related to the mess that was created by Hurricane Katrina.

First, the Mississippi delegation to Congress is angry at the insurance industry about its unwillingness to open its coffers to those damaged by the hurricane. Senator Trent Lott, normally a predictably conservative Senator, inserted in the appropriations legislation for the Department of Homeland Security ("DHS") an "earmark" which mandates that DHS spend not in excess of $100,000 to investigate the settlement of claims resulting from Hurricane Katrina to determine if damages were improperly attributed to flooding covered by the National Flood Insurance Program rather than wind storm damage covered by insurers or windstorm pools. Senator Lott is among a group of Mississippi residents who are represented by the Senator's brother-in-law, famous plaintiff's lawyer "Dickie" Scruggs.

Of perhaps more significance are the recommendations of the House Democratic Caucus Hurricane Katrina Task Force (the "Task Force"). The Task Force recommends the repeal of the McCarran-Ferguson exemption from the antitrust laws for insurers. It also suggests that an "all perils" insurance policy be made available pursuant to the National Flood Insurance Program, which would mean that it would be backed by the Federal Government. The spokesman for the Task Force is Representative Gene Taylor from Bay Saint Louis, Mississippi, who is also represented by tort kingpin "Dickie" Scruggs.

It is noteworthy that the prospective Chairs of the House Commerce, Judiciary, and Financial Services Committees are Representatives John Dingell, John Conyers, Jr. and Barney Frank, each of whom has a history of hammering the insurance industry. Representative Dingell, in particular, utilized the Investigations Subcommittee of the House Commerce Committee, which he chaired during the 80's and 90's, to probe and embarrass the insurance industry with the hearings which resulted in the two studies known as "Failed Promises" and "Wishful Thinking."

We are all familiar with the imperfections of state regulation; however, we may be soon introduced to new and ever more challenging federally generated problems. As the saying goes: "Be careful what you wish for because you may get it!" ❑

*Robert "Skip" Myers is a partner in the firm's insurance group and practices in the areas of insurance regulation, antitrust, and trade association law. Skip received his bachelor's degree from Princeton University and his law degree from the University of Virginia.*

## DESIGNING A COMPLIANT WELLNESS PROGRAM

Continued from page 10

Second, the program must be reasonably designed to promote good health or prevent disease. To satisfy this condition, a program must, among other things, give individuals the opportunity to qualify for the offered reward at least once per year. For example, a program in which employees are offered an opportunity to obtain a premium discount by not smoking would need to offer employees a chance to satisfy the goal at least once per year.

Third, the reward under the program must be made available to all "similarly situated individuals." What it means for individuals to be "similarly situated" is not well defined under federal law. In most contexts, similarly situated individuals are individuals who fall into a category of employment that is not related to health status—for example, full-time versus part-time employees. Thus, a wellness program offered to employees who work a certain number of hours per week would have to be offered to all such employees without regard to health status.

In addition, in the specific context of a wellness program, the regulations state that a reward is not considered to be available to all "similarly situated individuals" unless the program offers a reasonable alternative standard to obtain the reward to any individual (a) for whom it is unreasonably difficult due to a medical condition to attempt to meet the general standard for obtaining the reward or (b) for whom it is medically inadvisable to attempt to meet the general standard for obtaining the reward. Consider, for example, a wellness program that offers a premium discount to nonsmokers. If an individual is addicted to nicotine (which the regulations consider to be a medical condition), a reasonable alternative standard for the individual to obtain a premium discount might be participation in a smoking cessation program.

Finally, all plan materials describing the terms of the wellness program must disclose the availability of the alternative standard for compliance. Plan materials that merely mention that a program is available, without describing its terms, do not need to contain this disclosure. In addition, the specifics of the alternative standard do not need to be disclosed in the plan materials. It is enough that the materials to disclose the availability of the alternative standard and provide instructions on how to obtain more information.

The requirements discussed above originate in federal law. State requirements also may apply to a wellness program offered in connection with fully-insured benefits. Although an analysis of state requirements is beyond the scope of this article, it is important for insurers and third-party providers to consider such requirements as they design wellness programs for insured products. ❑

*Joe Holahan is Of Counsel in Morris, Manning & Martin's Washington, D.C. office and is Director of the firm's Terrorism Insurance Group. His areas of experience include privacy and data security, compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), state and federal insurance regulation, and managed care. He received his bachelor's degree from University of Virginia and his law degree from Catholic University of America, J.D., 1990.*

# MMM Insurance & Healthcare Attorneys


| | | |
|---|---|---|
| Paul H. Arne | 404.504.7784 | parne@mmmlaw.com |
| Brooks W. Binder | 404.504.7626 | bbinder@mmmlaw.com |
| Ward S. Bondurant | 404.504.7606 | wbondurant@mmmlaw.com |
| Joseph L. Cregan | 404.504.7782 | jcregan@mmmlaw.com |
| Dick Dorsey | 404.495.3660 | ddorsey@mmmlaw.com |
| Jason Eakes | 404.504.7603 | jeakes@mmmlaw.com |
| Amanda S. McHugh | 404.504.7629 | amchugh@mmmlaw.com |
| Lewis E. Hassett | 404.504.7762 | lhassett@mmmlaw.com |
| Richard L. Haury Jr. | 404.504.7713 | rhaury@mmmlaw.com |
| Joseph T. Holahan | 202.408.0705 | jholahan@mmmlaw.com |
| Simon R. Malko | 404.495.3646 | smalko@mmmlaw.com |
| William F. Megna | 609.430.1414 | wmegna@mmmlaw.com |
| Robert H. Myers Jr. | 202.898.0011 | rmyers@mmmlaw.com |
| Orlando P. Ojeda Jr. | 404.504.7609 | oojeda@mmmlaw.com |
| Jessica F. Pardi | 404.504.7662 | jpardi@mmmlaw.com |
| L. Chris Petersen | 202.408.5147 | cpetersen@mmmlaw.com |
| Thomas A. Player | 404.504.7623 | tplayer@mmmlaw.com |
| Anthony C. Roehl | 404.495.8477 | troehl@mmmlaw.com |
| Natalie C. Suhl | 404.504.7690 | nsuhl@mmmlaw.com |
| Kelly Whitehart | 404.504.7670 | kwhitehart@mmmlaw.com |
| John H. Williamson | 404.495.3618 | jwilliamson@mmmlaw.com |
| Bruce H. Wynn | 404.504.7694 | bwynn@mmmlaw.com |
| Kristin B. Zimmerman | 404.504.7611 | kzimmerman@mmmlaw.com |





MORRIS, MANNING & MARTIN, LLP
ATTORNEYS AT LAW

# REVIEW

Insurance • Reinsurance • Managed Healthcare

**Atlanta • Washington, D.C. • Charlotte • Raleigh-Durham • Princeton** **Winter 2006**

**www.mmmlaw.com**