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LETTER FROM WASHINGTON

CONGRESS MAY GIVE LITTLE TIME TO INSURANCE REFORM

By Robert H. Myers, Jr.

Now that the "stimulus" package has been enacted into law, Congress will turn its attention to a variety of issues. Among the foremost will be an investigation into the financial services industry's regulatory scheme. Under ordinary circumstances, Congress would investigate and hold hearings on this massive issue at a snail's pace. After all, it took almost 50 years for the Gramm-Leach-Bliley Act to amend the Glass-Steagall Act, which separated banking from commerce. Continued on page 10

HASSETT'S OBJECTIONS

DEFENDING ON THE MERITS BEFORE ADJUDICATING CLASS CERTIFICATION

By Lewis E. Hassett

The prevailing wisdom among class action defense attorneys is to focus on defeating class certification, rather than on a claim's legal merits. This attitude is supported by various court rules and decisions that require a prompt adjudication of class certification. See Fed. R. Civ. P. 23(c)(1)(A); Florida R. Civ. P. 1.220; Ala. Code 1975 § 6-5-641; Ga. Code Ann. § 9-11-23(f)(2); *Eisen v. Carlisle and Jacquelin*, 417 U.S. 156, 177-178 (1974) ("In determining the propriety of a class action, the question is not whether the plaintiff . . . has stated a cause of action or will prevail on the merits. . . ."). In fact, class defendants typically have been at the forefront of seeking a stay of merits discovery, apparently content to rely on the prospects of defeating certification. Continued on page 11

PLAYER'S POINT

ARE CREDIT DEFAULT SWAPS INSURANCE? [1]

By Thomas A. Player

The short answer to the question is, "it depends." The result of the analysis may also have an impact on who regulates. Central to this debate is whether a Credit Default Swap (CDS) contract is itself insurance and, therefore, should be regulated by the states, or whether a CDS contract is more accurately defined as a security and is not insurance, in which case it should be regulated (if at all) by the federal government. Continued on page 12

1 My appreciation to Tony Roehl of our Atlanta office for his invaluable assistance in the preparation of this article.

Inside this issue

Announcements

Morris, Manning & Martin, LLP is pleased to announce a webinar presented by **Chris Petersen** and **Joe Holahan** focused on the American Recovery and Reinvestment Act of 2009 and its impact on health plans, agents, brokers, TPAs and other business associates of health plans. The webinar will examine changes to the HIPAA privacy and security regulations and new requirements regarding security breach procedures. The webinar will be held April 1, 2009 at 3:00 p.m. EST. To register for the webinar please contact Carly Hartwick at chartwick@mmmlaw.com.

Jim Maxson spoke on how the new phenomenon of life insurance policy loans are impacting the life settlement industry at the Financial Research Associates Fifth Investors Summit on the Secondary Life Marketing, held in New York on January 26-27, 2009.

Lew Hassett and **Tom Player** have been recognized as 2009 Georgia Super Lawyers. Georgia Super Lawyers are chosen based on *Law & Politics'* and *Super Lawyers*' magazines statewide nomination process, review of individual resumes and the evaluation of peers. Only five percent of the attorneys in Georgia are chosen each year.

Jim Maxson was a featured panelist on the International Society of Life Settlement Professionals' first teleconference focusing on the impact of mark-to-market principles on the life settlement industry, held February 5, 2009.

Chris Petersen spoke at the Delta Dental Plans Association Legal Conference on February 26, 2009. Mr. Petersen spoke on extraterritorial issues and how it impacts the historical regulation of insurers and group products through the "issued and delivered" standard. Mr. Petersen also discussed the NAIC's draft white paper on jurisdictional and extraterritorial issues.

Lew Hassett and **Ben Vitale** have submitted an *amicus curaie* brief to the United States Court of Appeals of the Eleventh Circuit on behalf of Georgia Land Title Association in the case of *Terrace Mortgage Corporation v. Gordon*, Case No. 08-16105-DD. The case involves whether a defectively attested mortgage which is actually recorded and properly indexed provides constructive notice sufficient to trump a bankruptcy trustee's strong-arm powers. The issue is of great importance to the title insurance industry.

Skip Myers spoke on Congressional action on insurance reform at the American Conference Institute on February 26, 2009, in New York City.

STATUTORY ACCOUNTING STANDARDS SOME INSURERS ARE RECEIVING PERMITTED ACCOUNTING PRACTICES REJECTED BY THE NAIC

By Tony Roehl

Recently proposed changes to relax solvency and reserving requirements for life insurance companies which were roundly rejected by the Executive Committee of the NAIC are quickly finding a more receptive audience among individual state Commissioners of Insurance. As you may recall, in December 2008 the ACLI proposed nine changes to statutory accounting standards. The ACLI proposals were designed to help insurers cope with the current volatility in the financial markets.

Various NAIC working groups narrowed the original nine requested changes down to six and held a public hearing on January 27 chaired by the NAIC Capital & Surplus Relief Working Group. Following the public hearing, the working group quickly gave its approval of the six proposed changes. The six proposals would have amended mortality tables for certain products, provided additional regulator discretion for allowing collateral for reinsurance, revised the standalone asset adequacy for variable annuities and followed generally accepted accounting protocols for deferred tax assets, among other changes. However, on January 29, the NAIC Executive Committee overwhelmingly rejected the proposed changes which had been approved by the Capital & Surplus Relief Working Group only two days earlier.

The NAIC Executive Committee's swift action in voting down the ACLI proposals has not put an end to this issue. Responding to domiciled insurers, a number of states have now begun to grant permitted accounting practices along the lines of the ACLI proposal. This has the practical effect of giving insurers some of the relief sought by the ACLI proposal, but in an *ad hoc* and non-unified fashion.

Under the NAIC Accounting Practices & Procedures Manual, states have always had the ability to grant permitted accounting practices that allow insurers to vary their accounting from what is prescribed by the statutory accounting principles. Prior to granting a permitted accounting practice, a domiciliary state is required to provide 30 days' advance notice to all other states where an insurer is licensed. States can provide a shorter notice period with an explanation for the shorter notice, but never less than five days. However, if states fail to provide this notice, the permitted accounting practice is still valid. The notice is made through a regulator only database within the NAIC Exam Tracking System. The notice must

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disclose: (1) the nature and a clear description of the permitted accounting practice request; (2) the quantitative effect of the permitted accounting practice with all other previously approved permitted accounting practices then in effect for the insurer; (3) the effect of the requested permitted accounting practice on a legal entity basis and on all parent and affiliated insurance companies; and (4) identify the potential effects on, and quantify the potential impact to, each financial statement line item affected by the request.

So far, regulators in at least four states, Illinois, Iowa, Kansas and Ohio, have recently granted permitted accounting practices. As expected, the permitted accounting practices can have a substantial effect on the balance sheet of an insurer. For example, the Illinois Department of Insurance approved accounting changes that had a positive impact in excess of $700 million for its domestic property and casualty writer Allstate Insurance Company.

Because the permitted accounting practices are generally not disclosed to the public until insurers make a disclosure in the notes to their annual financial statement, it is difficult to immediately compare the quality of insurance company balance sheets from state to state. In addition, some states, most notably New York, have announced that they are not willing to consider permitted accounting practices along the lines of the ACLI proposals. New York has gone so far as to issue a Circular Letter requiring insurers receiving permitted accounting practices to back out the effect of the permitted practice when filing financial statements with New York. Rating agencies are taking notice of these additional assets on insurance company balance sheets and are evaluating how to handle the different qualities of capital present on insurance companies' balance sheets. Meanwhile, the uneven application of accounting practices is adding more fuel to the fire for advocates of a federal charter on the grounds that a federal charter would create regulatory consistency and common capital requirements for all insurers.

Currently, there is no prohibition on the use of permitted accounting practices in the NAIC state accreditation procedure, so it would appear that currently the NAIC has little ability to enforce uniformity. Consumer groups continue to insist that in a weak economy, the public needs strong financial standards to limit the effect of any insolvencies or rehabilitations. The tension from this issue is far from being resolved, and we expect to see more states granting permitted accounting practices in the near future to ensure that their domestic insurers are not at a competitive disadvantage, *vis-à-vis* their competitors. ❑

Anthony C. Roehl is an Associate in the firm's Insurance and Reinsurance and Corporate Practices. Mr. Roehl's principle areas of concentration are insurance regulation and corporate matters involving entities within the insurance industry. Mr. Roehl received his bachelor's degree from the University of Florida and his law degree from the University of Michigan.

Announcements

Jim Maxson's article "Regulation in the Life Settlement Industry: Has the Pendulum Swung Too Far?" will be published in the March 2009 issue of *Life Settlement Review.*

Skip Myers will be speaking on three panels on captive insurance and risk retention group issues at the Captive Insurance Companies Association (CICA) annual meeting in Indian Wells, CA on March 8 - 10.

On March 4, 2009, Morris, Manning & Martin hosted an interactive webinar designed to educate sophisticated investors about life settlements. Of counsel **Jim Maxson**, along with Partners **Ward Bondurant** and **Bill Winter**, in association with Proverian Capital, LLC, hosted *Life Settlements: What Investors Should Know* for an audience of approximately 150 participants.

Jim Maxson and **Ward Bondurant** will speak at the Morris, Manning & Martin, LLP sponsored First Annual Life Settlement Investment Summit in New York on March 25 - 26, 2009. For information, please contact www.iqpc.com/us/lifesettlement, or Marie-Louise Adlercreutz at 212-885-2687.

Skip Myers will be an instructor at the NAIC program for regulators on risk retention groups and their regulation on April 21, 2009 in Kansas City.

Jim Maxson will be a speaker at the Life Insurance Settlement Association (LISA) conference to be held May 6-8, 2009, in New York.

Jim Maxson will speak at The International Life Settlements Conference 2009 in London, May 20 -21, 2009.

Bob Gutkin recently joined the firm in January 2009. Mr. Gutkin has an extensive litigation background in intellectual property matters and insurance matters. Mr. Gutkin has been a faculty participant with the National Institute of Trial Advocacy (NITA) and currently serves as a committee member in the Intellectual Property Owners Association (IPO).

Jim Maxson and **Donna Fuller** participated in the Life and Health Compliance Association (LHCA) meeting January 21-23, 2009, held in Atlanta.

Joe Holahan's article, "A Primer for Risk Retention Groups on the Terrorism Risk Insurance Act (TRIA)," appeared in the February 2009 issue of the *Risk Retention Reporter.*

Skip Myers spoke on captive insurance issues at the Vermont Captive Insurance Association "road show" in Atlanta on February 17, 2009.

ILLINOIS SUPREME COURT HOLDS MULTIPLE INJURIES CAUSED BY CONTINUOUS NEGLIGENCE CONSTITUTE SEPARATE "OCCURRENCES" UNDER LIABILITY POLICY

By Cindy Chang

The Supreme Court of Illinois recently held that the deaths of two boys caused by a property owner's single but continuous negligent act constituted multiple "occurrences" under the owner's liability policy. *Addison Ins. Co. v. Fay*, No. 105752 (Ill. Jan. 23, 2009). Although the court expressed agreement with the majority view, which focuses on the cause of the damage or injury rather than the effect of the negligence when determining the number of occurrences, its holding in this case appears to conflict with that principle.

In *Addison*, the insurer filed a declaratory action against the estates of two teenage boys who died after becoming trapped in an excavation pit partially filled with water on the insured's property. The insurer did not dispute its liability but asked the court to determine whether the injuries to the boys constituted a single occurrence or multiple occurrences under the terms of the insured's liability policy.

The boys' bodies were discovered in the pit three days after last seen leaving for a fishing trip together. Investigators concluded that when the boys reached the pit and water, one boy attempted to jump across the water but became trapped in the pit's sand and clay. The other boy attempted to help his friend but became trapped himself. When their bodies were discovered, the boys were facing different directions but physically touching. However, investigators could not ascertain how much time had elapsed between the boys' entrapments.

Medical doctors for both parties concurred that the immediate cause of death for one boy was hypothermia and the immediate cause of death for his friend was drowning secondary to hypothermia. Neither medical doctor could conclude the time of death of either boy nor how closely in time they died.

The property owner's liability policy provided a "general aggregate limit" of $2 million and an "occurrence" limit of $1 million. The policy defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."

To determine the number of occurrences under an insurance policy, Illinois courts have adopted the majority view's "cause theory," which examines the cause or causes of the damage or injury rather than the number of individual claims or injuries resulting from the negligence. *Addison*, Slip Op. at 5 (citing *Nicor, Inc. v. Assoc. Elec. & Gas Ins. Servs.*, 860 N.E.2d 280 (Ill. 2006)); *see also Heggem v. Capitol Indem. Corp.*, 154 P.3d 1189, 1194 (Mont. 2007).

The trial court found that the boys' deaths were the result of two occurrences because the causes of death were different and the circumstances immediately prior to their deaths were different. *Addison*, Slip Op. at 2. The Illinois Court of Appeals reversed the trial court's decision by holding that the boys' deaths were "so closely linked in time and space as to be considered by a reasonable person as one occurrence." *Id.* (Citation omitted.)

The Supreme Court held that, the property owner's liability arose from his negligent failure to properly secure and control his property. Slip Op. at 6. Although the court held that he did not commit any intervening acts between the injuries of each boy, calculating "occurrence" according to the number of negligent acts by the insured alone would result in an unreasonable interpretation of the insurance policy. *Id.* at 7. Under such an interpretation, the insured would be exposed to a significantly greater liability by allowing multiple injuries sustained over an indefinite period of time to be subject to a single per-occurrence limit. *Id.* To limit the insured's liability, the court applied a "time and space" test that deems multiple injuries to be the result of one occurrence "if cause and result are simultaneous or so closely linked in time and space as to be considered by the average person as one event." *Id.* at 8.

Under the time and space test, the court concluded that the boys' deaths were two occurrences because the evidence demonstrated that the boys did not become trapped simultaneously and that one boy became trapped in an attempt to free his friend. *Id.* at 9. However, the court's rationale indicates that the uncertainty surrounding the exact amount of time that elapsed between each boy's entrapment and death prevented the insurer, who bore the burden to demonstrate an exclusion or limitation

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to the coverage, from showing that the boys' deaths were so closely linked in space and time as to be considered one event. *Id.* This holding suggests that if the insurer had evidence that the entrapments and deaths occurred only seconds or minutes apart, the court's ruling may have been different.

The "time and space" test and holding in *Addison* appears to be inconsistent to the "cause theory" by focusing on the effects of the insured's negligence. In fact, *Addison* conflicts with some holdings in other jurisdictions under similar circumstances where the insured is accused of some inaction or inadequate action. *See, e.g., Donegal Mut. Ins. Co. v. Baumhammers*, 938 A.2d 286, 294-96 (Pa. 2007) (holding homeowners' negligence in securing firearms used by son to kill six individuals was one occurrence because the insurer's obligation is to the insured and the occurrence should be an event over which insured had some control); *Washoe Co. v. Transcont'l Ins. Co.*, 878 P.2d 306, 308 (Nev. 1994) (holding where separate instances of molestation arose from the same negligent licensing of a daycare center, insurer only liable for single occurrence of negligent licensing). ❑

Cindy Chang is an Associate in the firm's Insurance and Reinsurance Practice. Her practice includes an array of insurance and reinsurance dispute, regulatory, and corporate matters. Ms. Chang received her bachelor's degree from Washington University and her law degree from Washington University School of Law.

TRANSAMERICA LIFE FOUND TO INFRINGE "BUSINESS METHOD" PATENT ON VARIABLE ANNUITIES

By Robert A. Gutkin

On February 13, 2009, in *Transamerica Life Insurance Co. et. al. v. Lincoln National Life Insurance Co.*, (USDC, ND Iowa, Case No. 06-cv-00110-MWB), a jury found that certain Transamerica Life Insurance Company benefit riders infringed a Lincoln National Life Insurance Company patent. The Lincoln National patent, U.S. Patent Number 7,089,201 was issued in 2006 and is entitled "Method and Apparatus for Providing Retirement Income Benefits." The patent describes a computerized method for administering variable annuity plans, including provisions for guarantees related to retirement income and death benefits in both the accumulation and distribution phases (also known as "Guaranteed Minimum Withdrawal Benefits" or "GMWBs"). The jury found the patent valid and ordered Transamerica to pay Lincoln National $13.1 million for the sale of the infringing variable annuity products. The jury award was based upon a .11 percent royalty on the $11.9 billion in assets derived from the company's variable annuity products during the infringement period.

A separate patent litigation is pending in Massachusetts involving Sun Life, the '201 patent, as well as other Lincoln National patents concerning GMWBs.

Lincoln National's '201 patent is known as a "business method" patent, and is classified by the USPTO under "apparatus and corresponding methods for performing data processing operations, in which there is a significant change in the data or for performing calculation operations wherein the apparatus or method is uniquely designed for or utilized in the practice, administration, or management of an enterprise, or in the processing of financial data." Although patents on processes involving business methods had previously been issued, for many years the USPTO held that methods of doing business were not patentable. The USPTO changed their position in the 1980's and 1990's with the emergence of patent applications on internet or computer enabled methods of doing business. In the 1998 decision of *State Street Bank v. Signature Financial Group*, 149 F.3d 1368 (Fed. Cir. 1998), the Federal Circuit held that the USPTO was correct in finding that a computerized accounting system for managing a mutual fund investment structure was patentable matter.

There was substantial concern by intellectual property practitioners that the *State Street* decision would open the floodgates for patenting common business methods, and thereby stifle business, rather than reward innovation. This argument, while not new in the intellectual property community, generated a mountain of commentary and controversy regarding business method patents. In fact, the filings of applications for business method patents have exponentially increased since *State Street*. The issue recently came to the forefront again in the Federal Circuit's 2008 decision in *In re Bilski,* 545 F.3d 943 (Fed. Cir. 2008), in which the Federal Circuit upheld a ruling by the USPTO denying a patent for methods of hedging in commodities trading. The *Bilski* decision reflects a growing tendency among courts to subject patents to increased scrutiny, and suggests a return to the pre-*State Street* views on business method patents. In January 2009, Bilski petitioned the U.S. Supreme Court for a writ of *certiorari* seeking to overturn the Federal Circuit decision. Should the U.S. Supreme Court decide to grant *cert.*, its decision will have a multi-billion dollar impact on both the viability of business method patents for future inventions, and the enforceability of business method patents that have already issued. ❑

Robert A. Gutkin is Of Counsel in the firm's Intellectual Property Litigation and Insurance and Reinsurance practices. Mr. Gutkin has tried cases in state and federal courts before judges and juries, and participated in all aspects of alternative dispute resolution, including arbitrations and mediations. Mr. Gutkin has also been successful in developing innovative approaches and strategy to resolve significant disputes and avoid litigation. Mr. Gutkin recieved his bachelor's degree from Brandeis University, his master's degree from the University of Chicago and his law degree from the University of California.

DUE DILIGENCE: THE KEY TO AN INVESTMENT GRADE LIFE SETTLEMENT ASSET

By James W. Maxson

There has been much discussion in recent months over the revisions to mortality tables by several of the major life expectancy providers. While this should be a matter of concern to anyone interested in life settlements as an asset, another matter of equal or greater concern is just starting to get the attention of investors: the proper due diligence necessary to ensure that investors are purchasing an investment grade asset with clear and unencumbered title.

Life settlements have characteristics that make certification of title more difficult than typical investments. The life insurance policy may have been owned by an individual or entity, usually for a period of several years, prior to being sold as a life settlement. As a result, it may be subject to liens, loans, divorce decrees, judgments and other encumbrances. If these encumbrances are not discovered prior to an investor's purchase of a life settlement, significant impairment to the value of the asset can result.

"Trust, but verify"

A policy can be owned by an individual, a corporate entity or by a trust, often an irrevocable life insurance trust, also known as an ILIT. ILIT's can be complex, and are usually structured by trusts and estates experts. Whenever the purchase of a policy owned by a trust is contemplated, the trust agreement must be reviewed carefully for two particular issues: the state of the trust's situs or location and whether the current trustee(s) of the trust are properly authorized to act on behalf of the trust.

Life and/or viatical settlement transactions currently are regulated in 41 states, and the state of residence of the policy owner determines which state's settlement laws will govern the transaction. Trusts, like people, have a "residence," also known as the trust's situs. Determining the situs of a trust can be surprisingly difficult. If a trust agreement does not contain a situs provision, then several factors must be reviewed to determine the state of the trust's residence, including, but not limited to: 1) any choice of law clause in the trust agreement; 2) the state of residence of the trustee; 3) the location of the bank account used to pay premium on the policy; 4) the location of the trust's tax situs; 5) the state in which the physical policy is located; and 6) where the grantors lived at the time the trust was created. If an investor assumes that a trust's situs is New York simply because the trust contains a provision stating that New York law governs the trust agreement's interpretation, she might be in for an unpleasant surprise if it later turns out that the trustee lived in, and administered the policy from, the State of Florida, making the sale of the policy by the trust subject to Florida's life settlement laws. Any life settlement that was originated illegally in an unregulated transaction from a regulated state will lose significant value if an attempt to re-sell the policy is made at a later date.

It is also necessary to confirm that the trustee of the trust is properly appointed and has the specific authority to sell the policy. Some trusts contain complex succession provisions, and if they are not followed the purported trustee will not posses the authority to act on behalf of the trust. Other trusts specifically prohibit the sale of a life insurance policy to anyone not having an insurable interest in the insured. Both of these issues can impair the value of a life settlement in a subsequent re-sale transaction because they call into question whether the policy was properly sold by the trust, thus creating tail risk of a challenge to the validity of the policy's sale.

Background Checks

Because a life insurance policy can only be obtained by individuals making representations about their health and financial status, running a basic background check on the policy owner is a simple step that can help ensure the quality of life settlement assets. For instance, a background check can reveal whether a policy owner has a judgment or liens levied against him that cloud title to the policy to be sold. If the seller does not affirmatively disclose this fact, it could remain undiscovered until some later date, causing serious issues for the then-owner of the policy.

A background check can also show if the policy owner has filed for bankruptcy. And, notwithstanding a specific exemption for life insurance policies in the bankruptcy code, if the owner is currently in bankruptcy an order from the court approving the sale should be obtained to confirm that the bankruptcy trustee approves of the transaction and will not later try to unwind it.

Divorce Decrees

It is not unusual for one party to a divorce decree to have an obligation to keep a life insurance policy in force, with the other spouse as the beneficiary. Case law holds that the beneficiary spouse has an equitable interest in any life insurance policy subject to such an obligation, and it is probable that the insurance policy sale transaction could be unwound by the beneficiary spouse if it is undertaken without his or her consent.

Similarly, in states that have martial property laws, if the existence of the policy was not disclosed to the court and addressed in the property settlement agreement, the former spouse will retain an interest in it. If that former spouse learns of the sale of the policy, he or she might have a cause of action to challenge the sale of the policy to an investor.

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Premium-Financed Policies

A profusion of premium-financed policies have flooded the secondary market in the last few years. Originally, sellers of these policies tended to disclose that the policies were originated through a premium finance program, but as the market for premium financed policies has bottomed out, promoters of these programs have been less forthcoming about the origin of the policies they are attempting to sell. This presents a particularly significant issue for investors in life settlements. If a policy was originated from an improperly structured premium finance program, the owner may not have had an appropriate insurable interest at the time it was issued, thereby potentially rendering it null and void. This is of particular concern given the recent aggressive steps some life carriers have been taking to challenge and rescind policies they allege were originated for the benefit of strangers without an insurable interest in the insured.

Conclusion

Thorough due diligence is a basic tenant of virtually every corporate transaction. Because of the relatively informal origin of the secondary market for life insurance, and its comparative nascency, however, the life settlement industry is only beginning to embrace a comprehensive due diligence regimen designed to ensure that the life settlement assets purchased by investors are of the highest quality possible. Any investor considering deploying capital into life settlement assets is well advised to make certain that any participants in the life settlement industry with whom they work has implemented a robust diligence program. ❑

James W. Maxson is Of Counsel in the firm's Insurance and Reinsurance Practice and co-chair's the firm's Life Settlement Practice. Mr. Maxson concentrates his practice in corporate and regulatory matters for the life settlement industry, as well as focusing on mergers and acquisitions and securities transactions. Jim received his bachelor's degree from Denison University and law degree from the Ohio State University School of Law.

REINSURANCE MODERNIZATION – IN A TIME OF BACK TO BASICS, TWO WORDS THAT STILL NEED TO BE HEARD TOGETHER

By Stacey D. Kalberman

The New York Department of Insurance recently concluded its public comment period on the proposed amendments to Regulation 20, Credit for Unauthorized Insurers (Proposed Tenth Amendment to Regulation No. 20 (11 NYCRR 125.); the "Amendment"). The Amendment relaxes the collateral requirement for unauthorized insurers conducting business in New York where the reinsurer meets certain financial criteria. The Amendment is not unlike the Reinsurance Regulation Modernization Model Act proposed by the NAIC in that collateral requirements are based on financial strength and not the licensing or the domicile of the reinsurer.

Under the current regulation, unless a ceding company conducts business with an authorized New York reinsurer, a cedent may only take credit for reinsurance where the reinsurer posts collateral equal to 100 percent of the transferred policyholder claims. Requiring 100 percent collaterization of claims has resulted in alien reinsurers posting approximately to $120 billion in collateral in the U.S. with $500 million per year in related transaction costs.[1] The high cost of reinsuring U.S. risks as an alien insurer has resulted in decreased reinsurance capacity for the U.S. market.

The Amendment not only places obligations on the reinsurer it also requires the authorized ceding insurer to account for the financial health of its own reinsurance arrangements. The cedent is required to assess the credit risk and regulatory compliance of each reinsurer in its program through a series of specific criteria outlined in the Amendment (referred to under the Amendment as "Credit Risk Management", Section 125.1). The Credit Risk Management provisions require the cedent to account for diversification in its program through two separate reporting requirements. The authorized ceding company must report to the Superintendant the following occurrences within thirty days after: 1) reinsurance recoverables from any one reinsurer exceed 50% of its surplus; or 2) the ceding of risk to any single reinsurer which exceeds more than 20% of gross written premium in any calendar year.

The real meat of the Amendment is set forth in the section on alternative credit for cessions to unauthorized reinsurers (Section 125.2(h)). The Amendment permits unauthorized reinsurers in New York to post a sliding scale of collateral based on its credit rating while still permitting the cedent to maintain full reinsurance credit. An unauthorized reinsurer with a triple A rating from two of the specified rating agencies[2] (on a stand alone basis separate from its parent or any affiliated entities) is not required to post any collateral. Reinsurers with a double A rating are required to post collateral of 10% of the reinsured liabilities; reinsurers with a single A rating must post 20%; and those with a triple B must post 75% of reinsured liabilities. A reinsurer with less than a triple B rating must still post 100% of the reinsured liabilities as collateral.

Despite the above requirements, nothing in the Amendment prevents the authorized ceding insurer from negotiating stricter collateral requirements with reinsurers. Additionally, if

1 Regulatory Impact Statement for the Tenth Amendment to 11 NYCRR 125 (Regulation 20).

2 The rating agencies specified in the Amendment are S&P, Moody's, Fitch, Best and any other rating agency recognized by the SVO.

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the ceding insurer becomes subject to an order of receivership or liquidation, the unauthorized reinsurer is required to post collateral equal to 100% of the reinsured liabilities within 30 days of the order. Failure by the reinsurer to post the collateral will result in all members of the reinsurer's holding company system failing to meet the standards necessary to permit ceding insurers to qualify for reinsurance credit (unless the Superintendent deems it to be in the public interest to allow the credit in whole or in part).

In addition to the financial rating requirements, unauthorized reinsurers, whether U.S. based or foreign, must meet certain regulatory obligations. First, the cedent must verify that the reinsurer 1) meets the standards of solvency and capital adequacy established by its domiciliary regulator, 2) is authorized by its domicile to assume the types of reinsurance ceded, and 3) maintains surplus in excess of $250,000,000.

Additional regulatory requirements are imposed on alien or non-U.S. reinsurers: 1) The New York Department and the domestic regulator must have signed a memorandum of understanding addressing issues deemed relevant by the Superintendant and 2) the reinsurer's domestic regulator must provide reciprocal access to U.S. reinsurers.

The Amendment specifies certain contractual obligations as well. The reinsurance agreement must require that the unauthorized reinsurer notify the cedent within 30 days of any changes to its domicile or its rating status. The reinsurance agreement must also include an insolvency provision in compliance with New York insurance law, a provision designating an agent for service of process in New York and a provision designating choice of law as New York.

The Amendment also mandates that reinsurance contracts require all disputes to be subject to U.S. jurisdiction. The language was written, however, to state that all disputes would be subject to the jurisdiction of the U.S. Courts which, would eliminate the parties' ability to resolve disputes through arbitration. As those in the reinsurance arena are well aware, the great majority of reinsurance contacts require that disputes be settled through binding arbitration. The New York Department has informally stated that the language will be amended to include the ability to arbitrate disputes.

The New York Department is still considering comments received on the proposed Amendment. The original effective date for the Amendment was planned as July 1, 2009, however the Department may delay the effective date in order to synchronize the timing of the Amendment with the NAIC's Reinsurance Modernization Model Act. ❑

Stacey D. Kalberman is Of Counsel in the firm's Insurance and Reinsurance Practice. Stacey concentrates her practice in regulatory matters for alternative risk programs, including insurance captives, risk retention and purchasing groups. Stacey received her bachelor's degree from George Washington University and her law degree from Emory University School of Law.

THE ATTORNEY-CLIENT PRIVILEGE IN LITIGATION BETWEEN AN INSURER AND ITS INSURED

By Brian J. Levy

When an insurer and its insured become adversarial litigants in a coverage dispute the question that often arises is whether and to what extent each party's communications with counsel during the resolution of the underlying claim are protected from disclosure in the subsequent litigation by the attorney-client privilege. The most probative evidence an insured could offer against the insurer in an action for breach of contract or bad-faith would be the insurer's communications with its counsel assessing whether coverage is due for the underlying claim. Conversely, the insurer's ideal exculpatory evidence would consist of communications between the insured and its counsel revealing that during the underlying claim the insured provided inadequate notice of the claim, failed to cooperate with the insurer, or agreed to an unreasonable settlement. This evidence is equally important where the insurer is the plaintiff seeking a declaratory judgment regarding its obligation to provide coverage for the underlying claim.

When the insurer undertakes defense of the insured against a third-party claim, communications by either party regarding the claim are not privileged as to the other because the parties' interests are aligned. *See Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co.*, 654 F.Supp. 1334, 1365 (D.D.C. 1986) ("IPC") (ordering insured to produce its communications with its attorneys regarding the underlying claim to insurer where insurer has a duty to defend insured). This result is based on the "common interest" doctrine, which states that while two parties share a "common interest" statements each party makes to its attorney are privileged *vis-à-vis* third-parties, but not protected from disclosure in a subsequent suit between the formerly jointly represented parties. *Eureka Inv. Corp. v. Chicago Title Ins. Co.*, 743 F.2d 932, 936-37 (D.C. Cir. 1984). For a party to successfully assert the "common interest" doctrine to compel document production in subsequent adversarial litigation, it must demonstrate that both it and the communicant had an identical legal interest, not merely an identical pecuniary interest. *Fed. Deposit Ins. Corp. v. Ogden Corp.*, 202 F.3d 454, 461 (1st Cir. 2000) (affirming order in action between former partners compelling production of communications with attorney jointly representing partners against efficacy insurer).

Communications made after the joint representation has terminated, or under circumstances where the communicant otherwise has a reasonable expectation of confidentiality are privileged. *Id.*; *Eureka*, 743 F.2d at 937-38. The joint attorney-

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client relationship remains intact until expressly terminated, or until circumstances arise by which it becomes clear to all the joint clients that the relationship is over. *Ogden*, 202 F.3d at 463. It is clear that joint representation ceases if either the insured or insurer retains separate counsel for advice in a burgeoning coverage dispute. *See Int'l Ins. Co. v. Peabody Int'l Corp.*, 1988 WL 58611, at *3 (N.D. Ill. June 1, 1988); *Nat'l Union Fire Ins. Co. v. Cont'l Ill. Group*, 1987 WL 4806, at *4-5 (N.D. Ill. May 1, 1987). In such circumstances, communications with joint counsel regarding defense of the underlying claim must be produced in subsequent adversarial litigation, but communications to independent counsel regarding the scope of coverage are protected by the attorney-client privilege. *Id.*

In some circumstances the privilege applies although it is not outwardly apparent to all parties the joint representation has ceased. *Eureka* presents the interesting, and likely unethical scenario where counsel jointly representing the insurer and insured against a third-party claim provided advice to the insured regarding a potential adversarial suit against the insurer without the insurer's knowledge. *Eureka*, 743 F.2d at 936. In the eventual adversarial suit, the insurer argued it was not obligated to indemnify the insured because the insured breached its duty of cooperation in defending the underlying claim. *Id.* To support its defense, the insurer sought all communications between the insured and joint counsel. *Id.* The district court ordered the insured to disclose such documents that related to the underlying claim, but allowed it to withhold communications with counsel regarding its claim against the insurer. *Id.* The U.S. Court of Appeals for the District of Columbia affirmed, holding that notwithstanding joint counsel's ethically questionable behavior, the attorney-client privilege belonged to the insured, and the insured reasonably expected that its communications with counsel regarding a future suit against the insurer were confidential. *Id.* at 937-38.

Where the insurer refuses to provide any defense to the insured in the underlying claim, or has not made a coverage determination, the insured may assert the attorney-client privilege to withhold communications from the insurer in the subsequent suit. This view was recently confirmed by a court in the Southern District of Texas in *Fugro-McClelland Marine Geosciences, Inc. v. Steadfast Ins. Co.*, 2008 WL 5273304 (S.D. Tex. Dec. 19, 2008) ("FMMG"). In *FMGG*, the insured settled the underlying claim after its insurers denied coverage. *Id.* at *1. One of the insurers moved to compel the insured to produce, *inter alia*, communications between the insured and its defense counsel and communications amongst representatives of the insured regarding the underlying claim on the ground that the insurer and insured had a common interest in minimizing exposure in the underlying claim. *Id.* at *1-2. The court upheld the insured's assertion of the attorney-client privilege, ruling that throughout the defense of the underlying claim the insured was represented by separate counsel and had a reasonable expectation that its communications with counsel would remain confidential. *Id.* at *3.

The ruling by the Southern District of Texas is sound. An insured and its insurer do not share a "common interest" when the insurer has been provided an opportunity and has not assumed the insured's defense against a third-party claim because "the existence of a 'common interest' is itself at issue." *Pittston Co. v. Allianz Ins. Co.*, 143 F.R.D. 66, 69 (D.N.J. 1992). Although the insured and insurer share a common pecuniary interest in limiting the damage, until and unless the insurer undertakes the insured's defense, the insured acts alone in the underlying litigation. *Id.* at 70-71. While acting alone, the insured has a reasonable expectation of confidentiality in its communications with counsel regarding settlement or a potential indemnity action against the insurer. *Id. See also Carey-Canada, Inc. v. Aetna Cas. and Sur. Co.*, 118 F.R.D. 250, 251-52 (D.D.C. 1987). Thus, it would pervert the "common interest" doctrine to allow an insurer access to its insured's communications with counsel in defending the underlying claim for which the insurer refused coverage. *Northwood Nursing & Convalescent Home, Inc. v. Cont'l Ins. Co.*, 161 F.R.D. 293, 297 (E.D. Pa. 1995). ❑

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2009 PROPOSED LEGISLATION TO HAVE A SIGNIFICANT IMPACT ON THE LIFE SETTLEMENT INDUSTRY

By Jason Cummings

A life settlement is a financial transaction in which the owner of a life insurance policy enters into a contract to sell an unneeded or unwanted policy to a purchaser for more than the policy's cash surrender value but less than the death benefit. Viatical settlements (in which the policy owner is terminally ill) and life settlements (in which the policy owner is not terminally ill) have been regulated in many states since the early 1990s. As we have come into the new millennium, however, the pace of states adopting regulation has increased dramatically, with forty-one states now regulating viatical and/or life settlement transactions.

In 2008, which was an active year for life settlement legislation, twelve states saw the passage of new settlement legislation. This year, however, promises to be even more active, with

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legislation already proposed in sixteen states in just the first six weeks of the 2009 legislative session. In addition to the number of states proposing legislation, what makes the 2009 legislative activity significant is the fact that five unregulated jurisdictions, including Alabama, New Hampshire, Rhode Island, Wyoming, and the District of Columbia, currently have proposed settlement legislation pending. Additionally, several states that regulate only viatical settlements have proposed full regulation, including Massachusetts, New York and Washington, and it is anticipated that the State of California will also enact full settlement legislation in 2009.

There are currently two competing model acts under consideration by the states: (1) the National Association of Insurance Commissioners' Viatical Settlement Model Act (the "NAIC Act"), as amended in 2007, and (2) the 2007 version of the National Conference of Insurance Legislators Life Insurance Model Act (the "NCOIL Act"). However, if history is any guide, most states will adopt a hodgepodge, grab-bag of provisions from both model acts, as well as adding their own unique provisions.

The passage of so much new settlement legislation will have a significant impact on the industry as many life settlement brokers and providers continue to rely on the existence of unregulated states in order to avoid the time and expense of obtaining licenses. As of January 1, 2009, there were still thirty-two jurisdictions in which unlicensed entities could engage in life settlement transactions (a combination of unregulated. viatical-only and the existence of loopholes in certain states' settlement acts). However, with legislation proposed in many unregulated or viatical-only regulated states, brokers and provides transacting business may become subject to full licensure, and all of the requirements concomitant thereto, in order to engage in life settlement transactions. While the requirements that brokers and providers must satisfy will not be uniform from state-to-state, some typical requirements are: (1) fingerprinting and background checks; (2) mandatory department of insurance contract approval; (3) annual reporting; (4) restrictions on disclosing financial or medical information; (5) payment through escrow accounts; (6) mandatory rescission periods; (7) extensive disclosures to the policy owner and insured; (8) minimum payment requirements for terminally ill individuals; (9) restrictions on advertising; and (10) civil and criminal penalties for violations of the law.

Another issue getting top billing in the 2009 legislative session is so-called stranger-originated life insurance transactions or STOLI. STOLI transactions typically involve a promoter who identifies a high net worth elderly person and lends them the funds to pay premiums on a large face policy for two years. At the end of the two years, the policy owner can either pay off the loan (which is often unfeasible due to high origination and interest fees) or "surrender" the policy to the lender in full satisfaction of the loan. There is concern, both among the life insurance and life settlement industries, that these schemes violate the requirement that insurable interest must exist at the time a life insurance policy is issued because the policy was initiated at the behest of and for the benefit of an investor with no insurable interest in the insured life.

The NAIC Act and the NCOIL Act take differing approaches to the issue of STOLI. The NCOIL Act provides a definition of STOLI and prohibits engaging in schemes to originate STOLI policies. It also provides for civil and potential criminal consequences for violations. The NAIC Act, however, does not specifically define STOLI. Instead, it prohibits all settlements for five years (the so-called "five-year-ban") from a policy's issuance, unless certain defined circumstances are satisfied. Criticism of the NAIC Model Act has emerged because the five-year-ban effectively extends the two-year contestability period, potentially curtailing a consumer's right to sell a valuable asset.

Brokers and providers must take note of the fact that many unregulated or viatical-only regulated states likely will adopt new legislation this year, and they should be prepared to obtain the necessary licenses to continue their business. Most states enacting new legislation include a "grandfather" clause permitting companies engaged in settlement transactions to continue their business, pending approval or disapproval of a license application, so long as such application is submitted within two to three months of the effective date of the legislation. Thus, industry participants doing business in currently unregulated states need to carefully monitor the status of new legislation and be prepared to file license applications as necessary. ❑

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LETTER FROM WASHINGTON

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From the perspective of insurance regulatory and corporate practioners, the prospects for reform are daunting. We always have examined the strengths and weaknesses of state insurance regulation in the context of the possibility of a federal alternative. However, recent events have demonstrated that this perspective is unrealistically narrow.

The problems in the United States financial system unrelated to insurance are so extensive that the regulation of the business of insurance will take a back seat in the 111th Congress. It is clear that the financial regulatory system of the United States has been overwhelmed by unanticipated forces and problems. The system of regulating banks, securities, and insurance through

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a variety of federal and state authorities has been the result of governmental responses to financial crises dating all the way back to the Civil War. As a result, we now have a regulatory system that is inadequate, overlapping and understaffed. The array of federal and state agencies and self regulatory organizations is vast and confusing. Here are just a few of the agencies represented by their acronyms: OCC, FRS, CFTC, SEC, FHFA, OTS, NCUA, FDIC, FINRA etc.

A good way to understand the current financial meltdown is to review the recent publication by the Government Accountability Office ("GAO") entitled *Financial Regulation: A Framework for Crafting and Assessing Proposals to Modernize the Outdated U.S. Regulatory System* (GAO-09-216; January 2009). This study analyzes the multitude of important issues and developments that have contributed to the current state of affairs.

The foremost of these is issues the aggregation of financial market risks under what is designated as "systemic" risk. In addition to the fact that financial services – banking, securities, and insurance – are regulated separately and generally without regulatory reference to each other, i.e., in "silos," many of the risks that have brought down the current system are not regulated at all. For example, hedge funds are largely unregulated because they are structured to qualify for exemptions from securities laws and regulations. Similarly, special purpose vehicles ("SPVs") are designed to be "off balance sheet" entities. There are numerous other financial products and services, such as collateralized default obligations, credit default swaps, and derivative contracts, traded outside of regulatory frameworks.

Add to this mix the fact that the credit rating agencies have done a miserable job in anticipating the new forces in the financial marketplace and have contributed to the crash of the financial services business by shockingly optimistic credit ratings for entities whose financial strength has been demonstrably hazardous. Even though Congress was sufficiently alarmed in 2006 to pass the Credit Rating Agency Reform Act to provide the SEC with limited oversight, credit rating agencies instilled false confidence into the marketplace as late as the end of 2008.

The GAO report succinctly lays out the wide variety of issues that will need to be considered in any attempt to address the "systemic risk" that exists in the U.S. financial system. There are unregulated products and entities, forces favoring regulatory global harmonization, inadequate regulatory oversight, misleading financial analysts and rating organizations, overly trusting consumers, inappropriate accounting rules and practices, and an inflexible and, in some cases, antiquated regulatory system.

While Congress is attempting to sort this all out, insurance regulatory reform is likely to be kicked to the back of the line. Unless asset values continue to decline, thereby causing a major solvency crisis for insurers, Congress is likely to keep insurance reform as a relatively low priority.

Nonetheless, Congress is cognizant of the fact that the federal government does not regulate insurance, and, therefore, does not understand it. As a result, either by legislation or by administrative action by the Secretary, an Office of Insurance Information is likely to be established in the Treasury. ❑

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HASSETT'S OBJECTIONS

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The strategic problem with staying merits discovery pending the outcome of class certification is that few class defendants have the stomach to fight the merits following certification. The stakes are perceived as too great to await the outcome of merits discovery, so class defendants elect to pay substantial sums to settle class actions before the merits are decided.

This strategy bears reevaluation. Where a defendant has a viable defense on the merits, it should consider pursuing those defenses either before or with certification. *See Project Release v. Prevost*, 722 F.2d 960, 963 (2d Cir. 1983)(summary judgment granted on individual claims before adjudication of class certification); *Acker v. Provident Nat'l Bank,* 512 F.2d 729, 732 (3d Cir. 1975)(same); *Life Ins. Co. of Ga. v. Meeks*, 617 S.E.2d 179, 185 (Ga. App. 2005)(same). Judges themselves have noted that, notwithstanding an affirmance of class certification, the action may not be viable on the merits. *See Ameriquest Mortgage Co. v. Sheb*, 995 So.2d 573 (Fla. App. October 15, 2008); *Marx v. Centran Corp*., 747 F.2d 1536, 152 (6th Cir. 1984). In the *Ameriquest* decision, the concurring opinion noted that the defendant had "raised colorable arguments as to whether [the] complaint effectively states a cause of action. [While these arguments are not properly considered in the context of class certification . . . , it] seems highly inefficient to proceed with the rather expensive and involved steps of certification of the class in this case when it is uncertain whether the complaint alleges a cognizable claim." *Id*.

We see the same issues arise in our class action cases, particularly those involving financial services. If an adjudication of the merits depends upon the resolution of disputed facts, then adjudication on the merits prior to class certification would be difficult. Instead, the particular facts applicable to a plaintiff could render that plaintiff inappropriate to serve as a class representative. Conversely, when the merits ride upon a

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question of law, it makes sense to focus on the merits of the claim prior to class certification. While, in theory, it sounds great to win on the merits following class certification, class defendants understandably shy from that risk.

Courts also have recognized the difficulty in distinguishing between class certification discovery, on the one hand, and merits discovery, on the other. *See Cooper & Lybrand*, 437 U.S. 463, 469, n.12 (1978) ("the class determination generally involves considerations that are 'enmeshed in the factual and legal issues comprising the plaintiff's cause of action'" and "'[e]valuation of many of the questions entering into determination of class action questions is intimately involved with the merits of the claims.'"); *In re Plastics Additives Antitrust Litigation,* 2004 WL 2743591, *4 (E.D.Pa.) ("class certification discovery in this litigation is not 'easily' differentiated from 'merits' discovery"); *Commonwealth v. Higgins*, 975 So.2d 1169, 1175 (Fla. DCA1 2008)(recognizing "that there is not always a bright line between issues relating to class certification and issues relating to the merits of a claim or defense"); Manual for Complex Litigation, Fourth, § 21.14 (same). Flaws in the factual merits of a class plaintiff's claims go to the heart of whether he or she is an appropriate class representative. Similarly, the more the operative facts vary among putative class members, the less likely the requisite commonality will be shown. However, a legal flaw in the plaintiff's cause of action does not fit so neatly into class discovery. While some courts have encouraged motions to dismiss on the merits before class certification, that is difficult where the class plaintiff submits merely a cursory notice pleading. *See Ameriquest,* 995 So.2d at 573.

Looking ahead, as the class action industry continues to expand into legally meritless claims obfuscated by the inherent vagueness of notice pleading, we expect class defendants to focus earlier on defeating the merits. ❑

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PLAYER'S POINT

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There are two basic types of CDS contracts. The first is what is called a "covered" contract. At its most basic level, the buyer of the protection owns the bond to be protected and will have a loss in an insolvency event. Certainly, the buyer has an insurable interest which is being protected.

The other type of CDS, and by far the most common, is a "naked" contract. In this type contract the buyer does not own the underlying bond. This contract becomes a vehicle for speculating on a bond issuer's credit. The buyer of the protection is essentially short on the credit, while the seller is long. Some have called these type contracts a wager and suggested they be outlawed.

In the early stages of the CDS market, the covered swaps were used to transfer and reduce risk of the owner of a bond (the risk that the bond issuer will default.) Covered CDS contracts are a method of protecting an investment. These types of recovery swaps are still in use, although it is estimated that they represent a small minority of the overall CDS market.

Eventually, Wall Street bankers became involved and created markets where the institutional buyers and sellers of swaps did not own the underlying obligation and bought and sold the swaps to place a directional bet on a company's creditworthiness. These naked default swaps became more valuable as a company became less credit worthy. Instead of hedging risks, these transactions created risk, which some believe are at the core of the current financial crisis.

New York Superintendent Eric Dinallo provides a detailed history of the regulation of credit swaps in his testimony to the House Committee on Agriculture[2]. Since being authorized as a financial instrument in the year 2000 by amendment of federal law, the credit default market has been entirely unregulated.

No one seriously debates the conclusion that credit swaps should be regulated. But how and by whom?

A ruling in 2000 by the New York Department of Insurance that swaps were not insurance was based upon a factual request describing a "naked" contract, not a "covered" contract. The market ran with the ruling as if it pertained to both.

In late 2008, the New York Department issued a notice that it intended to regulate "covered" contracts, but not "naked" contracts. More recently, Superintendent Dinallo has said he would hold off regulating "covered" contracts as insurance until Congress provided guidance, but that he favored regulating all credit default swaps "holistically", meaning that a single regulator should regulate the entire CDS market.

There seems little doubt that under New York law a "covered" swap is insurance. However, there are differences of

2 The House Committee on Agriculture has primary jurisdiction over futures markets and has proposed legislation to begin the process to regulate the OTC derivatives market. See H.R. 997, The Derivatives Markets Transparency & Accountability Act of 2009.

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opinion regarding whether a naked default swap constitutes insurance. Proponents of an unregulated approach to naked credit default swaps point to an argument that insurance requires an insurable interest and a pooling of risks. A buyer of a CDS has an insurable interest when it can expect to suffer a loss if the underlying company defaults on its obligations. Pooling is also present where a seller of a swap engages in multiple transactions. While this argument has a basis in the general understanding and definition of insurance, it ignores the fact that there are more ways to suffer loss when a company defaults on its bonds than solely by owning the bonds. For example, credit default swaps are useful to hedge a number of different risks, such as the risk that a key supplier would go bankrupt and would not be able to perform on its contract or by a bank wishing to hedge its risk in granting a line of credit. These uses of a CDS could easily give rise to an insurable interest. These examples broaden the definition of what is a covered swap, and hence, insurance.

Of course, a core principle of insurance is indemnification and the principle that an insured cannot profit from the loss. Since losses for an insured party not owning an underlying bond would be difficult to quantify, the bright line between "covered" swaps, which are treated as insurance, and "naked" swaps, which may be treated as securities, is blurred.

Further, the states have adopted expansive definitions of what constitutes insurance. For example, in New York an insurance contract means "any agreement or other transaction whereby one party, the insurer, is obligated to confer benefit of pecuniary value upon another party, the 'insured' or 'beneficiary', dependent upon the happening of a fortuitous event in which the 'insured' or 'beneficiary' has, or is expected to have at the time of such happening, a material interest which will be adversely affected by the happening of such event." NY Ins. Law § 1101(a)(1). New York Law further defines a "fortuitous event" as "any occurrence or failure to occur, which is, or is assumed by the parties to be, to a substantial extent beyond the control of either party." NY Ins. Law § 1101(a)(2). This statutory definition is broad enough to encompass traditional covered swaps where the buyer owns the underlying bond as well as more attenuated covered swaps mentioned above.

We agree with Superintendent Dinallo that a single Federal regulator of the credit default swap market makes sense. Even though a persuasive argument can be made that "covered" swaps are insurance, we believe the bifurcated oversight of the swap market, with some regulated by the states as insurance, and some regulated at the federal level as securities, would be chaotic and unmanageable. ❑

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BACK TO BASICS – ANNUAL CORPORATE MAINTENANCE

By Brooks W. Binder

In these turbulent economic times, there is a lot of talk about "getting back to basics." One major insurer has even made this theme the focus of a national marketing pitch, implying that there is no better way for consumers to get back to their basic needs than to buy insurance from this company rather than its competitors. But what does it mean to get back to basics? Obviously, the basics are contextual and to a great extent, subjective.

In the corporate realm, however, there is perhaps nothing more basic than the need to observe certain corporate formalities. Like death and taxes, corporate formalities are an unavoidable fact of every company's governance process. As we all know, failure to observe certain corporate formalities can result in some unwelcome problems such as disregard of the corporate veil and shareholder liability for corporate obligations. Beyond the obvious corporate formalities, such as holding board meetings and properly executing contracts in the name of the company, taking care of some basic corporate and legal housekeeping is a great way to build a foundation toward "getting back to basics" and ensuring that your company is observing the essential corporate formalities.

Here, then, as a reminder of the basics that every company should be thinking about, is a general checklist for annual corporate maintenance. Please note that this checklist has been generalized to cover corporations, limited liability companies and other types of entities, and should generally apply whether your company is an insurer, a broker, an agency or other intermediary in the insurance industry. This list is not intended to be exhaustive but instead should be used as a catalyst for thought and discussion of the corporate maintenance requirements of your company:

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Category	Action Item
Officers and Directors	• Is the list of your directors and officers up to date and are there proper Board consents or minutes reflecting the actions electing them? • Do your corporate records reflect approval of salaries, benefits and other economic terms applicable to your officers, directors and other employees? • Have any officers or directors resigned in the past year and are these departures reflected in the official corporate records? • Have you scheduled regular Board of Director meetings to be held throughout the coming year? • Has your company adopted a Conflicts of Interest policy and if so, have all potential conflicts of interest of officers and directors been properly disclosed in compliance with that policy? • Is your D&O insurance policy up to date and adequate to cover any potential liability, when viewed in the context of your company's current situation?
Employees	• Are all of your contractors and employees properly classified as either W-2 employees or independent contractors? • Are all of your restrictive covenant agreements and non-compete agreements in place and customized for the employee's specific circumstances (such as scope of responsibility and geographic location)? • Is your company's employee handbook up to date and do your practices comply with the requirements set forth in the handbook?
Shareholders	• Do your company bylaws or other organizational documents require an annual shareholder meeting, and if so, must it occur on or before a particular date? • What sort of notices and other proxy-like materials need to be prepared and how much time does your company need to prepare? • Is your company a party to a shareholders agreement and if so, is your company in compliance with its terms? • Do you have a program in place to ensure good investor relations, including appropriate communication of the company's performance?
Annual Reports and Franchise Taxes	• Has your company filed its annual report and paid the applicable franchise tax to the Secretary of State of your state of organization? • Has your company filed and paid fees with the states in which your company is authorized to do business?
Minute Book Maintenance	• Is your company's minute book up to date, including final resolutions, signed consents and properly approved minutes of the Board and shareholder meetings? • Has your Board approved all material corporate actions taken in the previous year, including significant purchases of equipment, stock issuances, redemptions and major contracts that the Company has entered into? • Is your capitalization table up to date?

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Material Contracts	• Does your company maintain copies of all of its fully executed contracts and is there a central compliance program in place to ensure the integrity of the company's contracts? • Have your company's relationships with customers and vendors changed in the past year and if so, have written amendments been executed, if required?
Business and professional license review	• Are all necessary business licenses in place and currently valid? • Do your employees have business or other licenses that are critical to your company's operations and are these employees in good standing under these licenses? • Many agencies put themselves at risk of regulatory violations by not verifying employee licenses or leaving license renewals up to their agents. Consider if you want to bring this compliance function in house.
Intellectual Property protection	• Does your company have an intellectual property protection program? • Are there renewals and other filings that need to be made? • Did your company create or acquire any intellectual property in the past year that should be reviewed to determine whether intellectual property protection is desirable? • Are all of your company's employees subject to confidentiality and inventions/work for hire agreements?
Certificate of Incorporation and Bylaws	• Have you reviewed your company's organizational documents recently to ensure that the company is operating in compliance with the expectations of its investors? • Do your organizational documents include requirements that you notify investors of material events and if so, is your company in compliance with these requirements?
Regulatory Compliance	• Does your company have an appointed regulatory compliance officer? • What filings and other submissions to regulatory agencies need to be made and what is the timing of these filings? • Are your employee handbooks and procedures up to date with any recent changes in the law? • Have you recently undergone a compliance audit or mock market conduct examination to proactively identify any area of regulatory compliance weakness? If not, consider the benefits of identifying weaknesses before they come to the attention of a regulator. Using outside counsel can help ensure that the audit is privileged. • Does your company maintain a website and if so, has it been reviewed to determine legal compliance with laws regarding internet communications, restrictions on advertising and applicable industry regulations?

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