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LETTER FROM WASHINGTON

CONGRESS WILL CHANGE INSURANCE REGULATION: PROGRESS AND PITFALLS

By Robert H. Myers, Jr.

The meltdown of the financial markets has created a new environment for federal reform of insurance regulation. Ever since the passage of the McCarran-Ferguson Act of 1945, Congress has toyed with reforming the regulation of insurance. However, there is now an alignment of interests favorable to changing the way financial services (including insurance) are regulated. The collapse of the credit markets and the devastation of the values of publicly traded companies likely will result in the reorganization of the financial services business, and insurance regulation will be drawn into this process.

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HASSETT'S OBJECTIONS

TITLE INSURERS HAVE RIGHTS, TOO

By Lewis E. Hassett

The United States Court of Appeals for the First Circuit has upheld a court's decision protecting a title insurer from what appeared to be a conscious effort to withhold relevant information. See *Commonwealth Land Title Insurance Company v. IDC Properties, Inc.*, Case No. 08-1130 (1st Cir., November 5, 2008). The facts of the case are complicated. Essentially, a developer owned 23 acres of land on Goat Island in Newport, Rhode Island, which it intended to develop into a condominium. The property was divided into six parcels, including three existing residential complexes and three undeveloped parcels. Each parcel had its own association.

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PLAYER'S POINT

INSURANCE HOLDING COMPANY ACT OUT OF DATE

By Thomas A. Player

Prior to AIG's deal with Treasury, it was shopping private sources for a needed cash infusion. The question became very real as to how quickly private sources could invest in AIG. Any investment of that magnitude would include a substantial equity interest in AIG and would automatically trigger the change of control approvals required under insurance holding company acts. We were asked this question: assuming a highly coordinated and cooperative response by state insurance regulators, how long would it take to gain the necessary regulatory approvals to invest in AIG?

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Inside this issue

Announcements

The firm is pleased to announce that **Brian Levy** has joined the Insurance Group as a litigator. Brian holds a B.A. degree from the University of Virginia and a J.D. from William & Mary Law School. After law school, he served as a staff attorney with the United States Court of Appeals for the Eleventh Circuit.

Georgia Trend magazine has included Morris, Manning & Martin, LLP on its 2008 Honor Roll of the Best Places to Work in Georgia. The magazine's editorial staff selected the winners from more than 400 nominations submitted by employees from businesses, government offices, educational institutions and nonprofits. The firm is one of only two law firms on the list of 15 Honor Roll companies, which are featured in the magazine's November 2008 issue, and available online at www.georgiatrend.com.

Jim Maxson spoke and moderated a panel on litigation-related issues impacting the life settlement industry at the Life Insurance Settlement Association's 14th Annual Fall Conference on November 6-7 in Washington, D.C. **Lew Hassett** and **Tony Roehl** also attended the conference.

Skip Myers will speak on February 26, 2009 at the Regulatory Compliance in the Insurance Industry conference in New York City sponsored by the American Conference Institute.

Joe Holahan spoke on the topic of "Legal Considerations for Designing an Employee Wellness Program" at the National Business Coalition on Health 13th Annual Conference held November 9 – 11 in Washington, DC.

Skip Myers spoke at the Annual Meeting of the Captive Insurance Council of DC on November 14 on regulatory compliance with corporate governance standards.

Joe Holahan and **Ward Bondurant** attended the 5th Annual Life Settlement Conference sponsored by Fasano Associates in Washington, DC on November 4th.

Jim Maxson will serve as moderator for a panel of experts on the regulation of life settlements at the Life Settlement 2008 conference sponsored by the Institute for International Research in Asterdam, the Netherlands December 15-17, 2008.

REGULATORS TAKE ON CREDIT DEFAULT SWAPS

By Ward S. Bondurant and Joseph T. Holahan

The role that credit default swaps (CDS) have played in the recent turmoil in financial markets, including the downfall of AIG, has focused the attention of state, federal and international regulators and legislators on these financial instruments. Until now, CDS have been largely unregulated. That is about to change.

The last several months have seen a number of actions aimed at regulating the CDS market. On September 22, the New York Department of Insurance announced that it will regulate covered CDS agreements as insurance contracts. In addition, the New York Attorney General's office has launched an investigation to determine whether short sellers may have manipulated CDS transactions to push down the price of stocks. Other states also are considering regulating CDS as insurance, and the National Association of Insurance Commissioners (NAIC) has formed a working group to examine coordinated state regulation in this area. The NAIC also recently released proposed changes to statutory accounting standards that will require insurers to provide greater disclosure regarding their holdings of credit derivatives and credit-based guarantees.

Regulatory attention on the CDS market is not limited to the states. In September, Securities and Exchange Commission (SEC) Chairman Christopher Cox requested that Congress grant the SEC jurisdiction to regulate the CDS market. The Federal Reserve and the Commodity Futures Trading Commission (CFTC) also are looking at ways to regulate CDS transactions. On November 14, the SEC, CFTC and Federal Reserve released a memorandum of understanding pledging cooperation in overseeing clearing platforms being developed in the private sector for CDS and other derivatives. Some of these clearing platforms may become operational even before this article goes to press.

An Overview of CDS

A CDS is a swap contract in which the buyer of the CDS makes a series of payments to the seller and, in exchange, receives a payoff if a credit instrument (typically a bond or loan) goes into default or some other specified credit event occurs (such as bankruptcy or a restructuring). It is not necessary for the buyer of a CDS to own the underlying credit instrument.

As an example, imagine that an investor buys a CDS from Bank, where the reference credit is a debt obligation of B.I.G.

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Corporation. The investor will make regular payments to Bank under the CDS, and if the reference debt of B.I.G. goes into default (or B.I.G. suffers some other, specified credit event), the investor will receive a lump sum payment from Bank and the CDS contract will terminate. If the investor actually owns the referenced B.I.G. debt, the CDS is referred to as a "covered" swap and can be thought of as hedging. Investors, however, also can buy CDS contracts referencing B.I.G. debt, without actually owning any B.I.G. debt. This is referred to as a "naked" swap and may be done for speculative purposes, betting against the solvency of B.I.G. in a gamble to make money if the company fails, or to offset other risk that may or may not be directly related to B.I.G.'s prospects.

Credit default swaps are entered into using "over-the-counter" or "OTC" trades, meaning that the terms of each swap are privately negotiated between the parties to the swap. The swaps are usually documented on the standard forms of the International Swaps and Derivatives Association (ISDA), but each swap may have its own specific, negotiated terms.

Credit default swaps originated in 1997 and their regulatory status at the federal level was established by the Commodity Futures Modernization Act of 2000 (CFMA). Under the CFMA, CDS were defined as "swap agreements" rather than "securities," placing them outside the reach of most SEC regulations. They were also generally excluded from being treated as "futures" under the Commodity Exchange Act. While a CDS functions like insurance for the buyer if the buyer suffers an actual loss as a result of the default on the underlying referenced credit, pursuant to the prior position of the New York Insurance Department, CDS were not classified as insurance, in part because no insurable interest (or actual loss or indemnity) was required, and in part because the department relied on such trades being documented on standard forms developed by ISDA and negotiated by the parties as standard swaps.

The growth of the CDS market since 2003 has been remarkable, with the market reaching an estimated currently outstanding notional amount in excess of $60 trillion, more than the gross domestic product of all the nations on earth, combined.

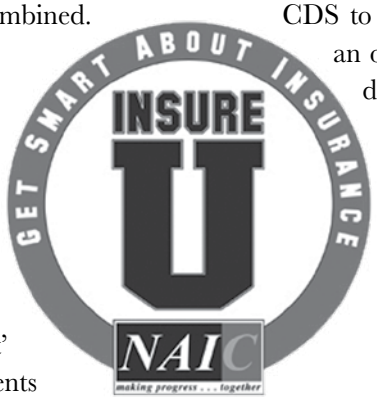
New York's Decision to Regulate CDS

Recently, in a reversal of its previous view, the New York Department of Insurance (the Department) announced that it would regulate CDS agreements as "insurance contracts" in any instance in which the buyer "at the time the agreement is entered into, holds, or reasonably expects to hold, a 'material interest' in the referenced obligation." CDS agreements that fall within this description and have a sufficient nexus with New York will be required to be written by an insurer licensed as a financial guaranty insurance company under New York law. In addition, such agreements will be subject to certain "Best Practices" guidelines issued by the Department for financial guaranty insurers.

The Department's revised view that certain CDS agreements constitute insurance comes in the form of a Circular Letter—Circular Letter 19—and an accompanying press release from the Governor's office, both of which were released on September 22, 2008. Circular Letter 19 is effective January 1, 2009.

Circular Letter 19 leaves open the issue of what constitutes a "material interest" in the referenced obligation under a CDS agreement sufficient to cause the agreement to be deemed an insurance contract. It is clear that the Department does not intend to regulate naked CDS. It is equally clear that the Department will regulate CDS as insurance where the buyer owns legal title to the referenced obligation. It remains to be seen, however, where the Department will draw the line between these two extremes. The Department states in Circular Letter 19 that it intends to issue additional guidance clarifying its position on this issue.

CDS agreements guaranteed by insurers subject to the Department's jurisdiction will be subject to the Best Practices guidelines set forth in Circular Letter 19. Among other things, the guidelines provide that an insurer guaranteeing CDS will be permitted to offer protection against a pool of asset-backed securities that is comprised of, or includes portions of, other asset-backed securities only if (i) the insurer holds an unsubordinated, senior position with an investment rating of single-A or above, (ii) the pool consists solely of asset-backed securities that are issued or guaranteed by a government-sponsored enterprise or certain similar entities, or (iii) certain other conditions limiting risk are present. In addition, in an attempt to limit the exposure of insurers to accelerated liability, the guidelines restrict the guarantee an insurer may offer on CDS to circumstances where there is a failure to pay an obligation when due and payable as a result of default or insolvency. The guidelines also prohibit insurers from offering guarantees of CDS that require the insurer to post collateral. The Department states in Circular 19 that it will be issuing regulations defining permissible credit and termination events that may trigger payment under CDS backed by an insurer.



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Other States Are Considering Whether to Regulate

A number of other states are considering whether to regulate CDS as insurance. The National Association of Insurance Commissioners (NAIC) has organized a Working Group to examine the issues arising from the proliferation of the CDS markets and to consider various approaches to the regulation of CDS under the insurance laws. Additionally, revised statutory accounting rules recently released for comment by the NAIC modify the financial disclosure obligations of insurance companies relative to their CDS holdings and exposure. The proposed amendments would require any insurers which are sellers of credit derivatives to disclose additional information regarding their holdings of credit derivatives and credit-based guarantees to help others evaluate the impact of these products on the company's financial position, financial performance and cash flow. The comment period for the proposed amendments ended November 10th, public hearings are proposed for the December meeting of the NAIC and the revised rules are proposed to apply to annual statements filed after December 31, 2008. In its recommendation of the changes, the NAIC staff noted that the significant growth of credit default swap products and their potentially adverse effect on the financial condition of insurers required that "thorough credit derivative and guarantee disclosures are necessary to provide state regulators the ability to fully understand the solvency condition of insurers that guarantee, or otherwise provide the credit protection, for credit derivatives and credit-related guarantees." The statutory accounting sections to be amended by the proposal are *SSAP No. 86 – Accounting for Derivative Instruments and Hedging Activities*, paragraph 53 and *SSAP No. 5 – Liabilities, Contingencies and Impairment of Assets*, paragraph 16.

With respect to efforts to regulate CDS as insurance, insurance regulators have focused on covered swaps because of their similarities to financial guaranty insurance. Though covered swaps only comprise approximately 10% of the CDS market, according to the NAIC, most state regulators believe that existing law already provides them the right to regulate these swaps as insurance contracts. A number of insurance regulators have questioned whether naked CDS should be allowed at all. While the NAIC has suggested that the CDS market will not lend itself to an easy separation into products that are insurance contracts and those that are not, they would support a comprehensive solution that provides transparency and includes capital or margin requirements and security funds or other mechanisms to control counterparty risk. According to the NAIC, "In the absence of congressional action to legislate an effective comprehensive approach of regulating this market, insurance regulators intend to do what is necessary, within their authority as financial guaranty insurance regulators, to provide this protection is a manner consistent with solvency regulation of other insurance products."

Developments in the Federal Regulation of CDS

In an October *New York Times* Op-Ed piece, Christopher Cox, the Chairman of the SEC, identified the primary objectives that he believed were critical to begin the reform of the CDS market. These are: enhanced transparency in CDS trading, more reliable systems for valuation of CDS, reliable methods for CDS participants to assess counterparty risk, and regulatory authority to identify and address fraudulent or manipulative trading practices in the CDS market. To promote transparency, Cox advocates public reporting of trades and trade values by dealers. This, he suggests, will not only give market participants a clearer picture of the activity in the market, but will also allow participants to assess the value of positions in the market. Reporting would also create consistent transaction records that would permit regulators to more easily identify fraudulent or manipulative trading activity. Next, Cox believes that the SEC should be given clear authority to regulate fraudulent, deceptive or manipulative acts and practices relating to the CDS markets. Finally, he supports current efforts to develop central counterparties and exchange-like trading platforms for the market in order to promote transparency and provide to the investors additional methods for assessing the risks associated with the CDS market.

"The regulatory black hole for credit default swaps is one of the most significant issues we are confronting in the current credit crisis, and it requires immediate legislative action," Cox said. "Manipulation in this completely unregulated and hidden space can drive prices in the regulated market for securities. That is why I believe it is important for Congress to act now to provide for regulatory oversight of the credit default swaps market."

Echoing these comments have been calls for increased federal regulation of the CDS market from U.S. legislators, such as Senator Tom Harkins (D-Iowa), the Chairman of the Senate Committee on Agriculture, Nutrition and Forestry (the Senate Committee that oversees the commodities futures markets). Among his comments, Harkins characterized the market as part of "casino capitalism" operating outside any meaningful federal regulation. Harkin has introduced legislation that would ban naked swaps.

On November 14th, the President's Working Group on Financial Markets (PWG) which consists of Chairman Cox, Walter Lukken (the Acting Chairman of the Commodity Futures Trading Commission), Ben Bernanke (the Chairman of the Board of Governors of the Federal Reserve System), and Henry Paulson (the Secretary of the Department of the Treasury), released their

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"Policy Objectives for the OTC Derivative Market." These objectives are: (1) improve market transparency and integrity for CDS, (2) enhance risk management of OTC derivatives, (3) strengthen OTC derivatives market infrastructure, and (4) continue cooperation among regulatory authorities. In the release, the PWG confirmed that their highest near-term objective is the establishment of central counterparty services for CDS, an objective that they believe will reduce systemic risk in the CDS market and provide greater market transparency. They also confirmed that "several potential counterparty providers" are actively developing such services and that regulators are currently evaluating the developing options, with the objective of accelerating the regulatory approval so that one or more CDS central counterparties can be operational before the end of 2008. At the same time, the PWG released the Memorandum of Understanding among Cox, Lukken and Bernanke by which these three major federal regulators confirmed their agreement to cooperate, coordinate and share information in relation to the establishment of the new central counterparties for CDS.

The development of a comprehensive regulatory framework for the CDS market, even with the full cooperation and coordination of the primary U.S. federal regulators, may still be a very difficult task due to the global nature of the market. Since CDS are frequently bought and sold between parties located in major financial centers throughout the world, it seems that any effort to regulate CDS in a meaningful way will require the coordination of regulators from each of those countries, otherwise the CDS market may just migrate to the jurisdiction having the least regulation.

Conclusion

The recent flurry of regulatory action surrounding CDS poses interesting questions, the answers to which have yet to be resolved. Greater regulation of CDS is a certainty, but what form will it take? In broad terms, it seems clear that any new regulation will mandate greater transparency for CDS transactions coupled with solvency and risk mitigation standards for the sellers of credit protection. Beyond that, the details have yet to emerge. It also seems clear that close cooperation will be required among state, federal and international regulators. State regulators have begun to craft regulatory controls for covered swaps, but such transactions represent only a small portion of the CDS market. Moreover, state regulators face the obvious problem that CDS transactions can be structured to place them outside the jurisdiction of a particular state. Given the growing federal commitment to the solvency of protection sellers, it may be that federal regulation of CDS will supersede state action in this area. In addition, federal regulators face a problem similar to that confronted by state authorities in that the CDS market is global. Only internationally coordinated regulation of CDS is likely to be effective. ❑

Note: On November 20, just prior to publication of this article, New York Insurance Superintendent Eric Dinallo announced that New York will delay indefinitely its plans to regulate covered CDS in recognition that federal authorities are working to develop a comprehensive solution for regulating the CDS market, including both covered and naked swaps. "We understand that the market for credit default swaps is large and complex and it will take time to complete a holistic solution. But while we support these beginning [federal] efforts, we also recognize that they do not yet constitute a completely transparent and fully regulated market. We urge the industry, federal agencies and Congress to continue working until that essential goal is reached. At that point, we will be prepared to consider any necessary changes in state law to prevent problems that might arise from the fact that some swaps are insurance," Dinallo said.

Ward S. Bondurant is a Partner in the firm's Insurance and Corporate Practice. Mr. Bondurant has counseled businesses in general corporate and corporate finance matters for over 20 years, with his primary focus on representing clients in the insurance industry. Mr. Bondurant received his bachelor's degree from University of North Carolina and his law degree from University of Georgia.

Joseph T. Holahan is Of Counsel in the firm's Insurance Practice. He also is a member of the firm's Privacy Practice. Mr. Holahan advises insurers and reinsurers on a variety of legal matters, including all aspects of regulatory compliance. His experience includes assisting insurers with company formation and licensing, including the formation of alternative risk transfer vehicles; mergers and acquisitions; corporate restructuring; assumption reinsurance; portfolio transfers and other transactions. He also advises clients on the negotiation of reinsurance agreements and development of policy forms. In addition, Mr. Holahan has substantial expertise in the law of information privacy and security. He regularly advises clients engaged in insurance and other financial services on compliance with state and federal requirements in this area.

OHIO SUPREME COURT HOLDS THAT INSURER'S ALLEGED BAD FAITH INSUFFICIENT TO PIERCE CORPORATE VEIL TO HOLDING COMPANY

By Jason Cummings

The Ohio Supreme Court recently held that an insurer's alleged bad faith is not enough to pierce the corporate veil and hold liable the insurance holding company. *Dombroski v. Wellpoint, Inc.*, Case No. 2007-2162 (Ohio Sept. 30, 2008). Specifically, the Court held that "insurer bad faith is a straightforward tort, a basic example of unjust conduct; it does not represent the type of *exceptional wrong* that piercing is designed to remedy." (Emphasis added).

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In so holding, the Court modified the second prong of the three-prong test for piercing the corporate veil that was outlined in *Belvedere Condominium Unit Owners' Assn. v. R.E. Roark Cos., Inc.*, 617 N.E.2d 1075 (Ohio 1993). Under that second prong, a corporate veil may be pierced when control of the corporation "was exercised in such a manner as to commit fraud or an illegal act against the person seeking to disregard the corporate entity." *Id.* at 1086. The Court's modified version of the second prong of the *Belvedere* test states that to pierce a corporate veil, the "plaintiff must demonstrate that the defendant shareholder exercised control over the corporation in such a manner as to commit fraud, an illegal act, or a *similarly unlawful act*." *Dombroski*, Case No. 2007-2162, at *17 (emphasis added). The other two prongs of the *Belvedere* test, which address shareholder control and injury to the plaintiff, were not the focus of the Court's analysis.

The case involved the denial of coverage to an insured whose physician prescribed cochlear implants. The insured had a health insurance policy from Community Insurance Company ("Community"). Anthem UM Services, Inc. ("Anthem") and Anthem Insurance Companies, Inc. ("Anthem Insurance") participated in the administration of the policy. The defendant Wellpoint, Inc. ("Wellpoint"), a publicly traded company, controlled 100 percent of the stock of all three companies. Community denied coverage on the grounds that the use of such implants to improve hearing was investigational.

The insured filed an action against Community, Anthem, Anthem Insurance and Wellpoint claiming breach of contract, promissory estoppel and insurer bad faith. Specifically, the insured alleged that the defendants acted in bad faith in processing and denying the insured's request for the implant and that such acts caused the insured emotional distress and physical and pecuniary losses. Additionally, in a bid to enhance her leverage, the insured alleged that the corporate veils should be pierced to render Wellpoint liable for her claims.

Both Wellpoint and Anthem Insurance moved to dismiss, alleging a lack of privity of contract and an insufficient basis to pierce the corporate veil. The trial court dismissed the insured's claims against WellPoint and Anthem Insurance, because the insured did not allege sufficient facts showing privity of contract or to pierce the corporate veil. Specifically, the trial court stated the insured did not demonstrate "the type of illegal or unjust result intended by *Belvedere*." *Id.* at *7. The Seventh District Court of Appeals reversed the trial court's decision, holding that the insured had pleaded sufficient facts to advance its veil-piercing claim. In so holding, the Court of Appeals interpreted the second prong of the *Belvedere* test broadly so as to permit piercing the corporate veil for not only fraud or illegal acts, but also for unjust and inequitable acts. However, the Court of Appeals determined that its decision conflicted with the Sixth District Court of Appeals and certified the case as a conflict to the Ohio Supreme Court.

The Ohio Supreme Court noted that, on the one hand, some courts have broadly construed the second prong of the *Belvedere* test so as to permit piercing for unjust or inequitable conduct. See *Wiencek v. Atcole Co.*, 109 Ohio App. 3d 240 (Ohio Ct. App. 1996); *Taylor Steel, Inc. v. Keeton*, 417 F.3d 598 (6th Cir. 2005). On the other hand, the Sixth District Court of Appeals had limited the second prong of the *Belvedere* test where the defendant uses its control of the corporate form to commit fraud or an illegal act. See *Collum v. Perlman*, Case No. L-98-1291 (Ohio Ct. App. Apr. 30, 1999). Thus, the Court stated that expanding the second prong of the *Belvedere* test to include liability for unjust and inequitable conduct would permit a court to pierce the veil of virtually every close corporation. However, the Court also rejected a literal interpretation of the *Belvedere* test because such an interpretation would allow a shareholder to seriously abuse the corporate form and evade person liability.

Consequentially, the Court modified the *Belvedere* test so as to require a plaintiff to "demonstrate that the defendant shareholder exercised control over the corporation in such a manner as to commit fraud, an illegal act, or a *similarly unlawful act*." *Dombroski*, Case No. 2007-2162, at *17 (emphasis added). The Court held that even under its new modified version of the *Belvedere* test, the insured's claims failed because "insurer bad faith is a straightforward tort, a basic example of unjust conduct; it does not represent the type of *exceptional wrong* that piercing is designed to remedy." *Id.* at *18 (emphasis added).

The dissent disagreed, stating that insurer bad faith is an exceptional wrong and that insurer bad faith breaches a legal duty. The dissent stated such a breach "constitutes an illegal or similarly unlawful act." *Id.* at *24 (Pfeifer, J., dissenting). The dissent also stated that there was no notable distinction between the broadly interpreted version of *Belvedere* and the new modified version.

Therefore, under this modified version of the piercing the corporate veil test, an Ohio court likely will hold that an insurer's bad faith in denying a policyholder's claim is insufficient to pierce the corporate veil and hold the shareholders liable. ❑

Jason Cummings is an Associate in the Insurance and Reinsurance Practice. He received a B.A. in Political Science from Wake Forest University, and a J.D., cum laude, from Mercer University School of Law. While at Mercer University Law School, Mr. Cummings was awarded a faculty merit scholarship for academic achievement.

AIG BAILOUT - HAS THE FEDERAL GOVERNMENT ALREADY PREEMPTED STATE INSURANCE REGULATION?

By Tony Roehl

While the financial crisis has postponed attention from the debate over an optional federal charter for insurers, we may have already witnessed the states ceding regulatory grounds to the federal government. I am speaking, of course, of the unprecedented federal bailout of AIG.

In addition to the initial $85 billion loan by the Federal Reserve Bank of New York to AIG at confiscatory rates, collateralized, in part, by the stock of substantially all of AIG's insurance subsidiaries, the Treasury, through a trust, also acquired a new series of non-redeemable, convertible participating serial preferred stock (the "Preferred Stock") for $500,000. The Preferred Stock is entitled to participate in any dividends paid on AIG common stock and is convertible into a number of shares of common stock equal to 79.9% of the outstanding common stock when converted. In addition to being convertible into a supermajority of the outstanding common stock of AIG, the Preferred Stock has the right to vote with the common stock on all matters submitted to AIG shareholders and is entitled to an aggregate number of votes equal to its equity share as converted (79.9%). AIG renegotiated the terms in early November but the government's total equity stake remained largely unchanged. Thus, the federal government currently enjoys complete control of AIG.

Interestingly, from an insurance regulatory perspective, to our knowledge, the federal takeover of AIG and subsequent investments were accomplished without any requests for approval with the twenty-state Departments of Insurance that have jurisdiction over an AIG domestic insurer. Control is presumed to exist when any person holds with the power to vote 10.0% or more of the voting securities of an insurer's ultimate controlling person. While the presumption of control can be rebutted, a finding that a 79.9% shareholder doesn't have control would be unprecedented. No hearings were held despite the fact that the federal government now has 79.9% voting control in the AIG domestic insurers' ultimate controlling person. Nor did the federal government seek approval for AIG's $37.8 billion "loan" of securities from its insurance company subsidiaries to the Federal Reserve Bank of New York.[1]

1 One notable exception from the requirements for prior approval would be New York, which exempts the federal government from its holding company law.

In fact, under existing state law any transaction between the federal government and an AIG regulated entity should be subject to Department of Insurance approval as a transaction between affiliated parties. Moreover, there should be no deference for the federal government acquiring AIG. The lack of state approval contradicts the McCarran-Ferguson Act, which states in relevant part "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance…unless such Act *specifically relates to the business of insurance*." 15 U.S.C. § 1012(b) (emphasis added).

State laws dealing with the business of insurance, therefore, apply over generally applicable federal laws - which is the case with the federal takeover of AIG. This requirement for federal laws to specifically state that they apply to the business of insurance is called "express preemption."

The government proceeded under Section 13(3) of the Federal Reserve Act, which states that:

> In unusual and exigent circumstances, the Board of Governors of the Federal Reserve System, by the affirmative vote of not less than five members, may authorize any Federal Reserve bank, during such periods as the said Board may determine…to discount for any individual, partnership or corporation notes, drafts and bills of exchange when such notes, drafts and bills of exchange are indorsed or otherwise secured to the satisfaction of the Federal Reserve Bank.
>
> 12 U.S.C. § 343.

Section 13(3) of the Federal Reserve Act (and the Federal Reserve Act itself generally) clearly does not specifically relate to the business of insurance and therefore would not be the express preemption required for federal law to supersede a state law under McCarran-Ferguson. Because the Treasury now has super majority control of AIG, and through AIG effective control of its insurance subsidiaries, it would appear that there should have been state Departments of Insurance change of control hearings to approve the government's actions.

States will, presumably, require change of control hearings to review and approve any transaction whereby AIG sells an insurance subsidiary to another entity. However, the case for state oversight and regulation of that subsequent transaction is weakened by states' inaction on the previous change of control. ❑

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.

THE LONG ROAD TO ARBITRATION

By Cindy Chang

Reinsurance contracts, particularly contracts for treaty reinsurance, often mandate arbitration. See *Employer Reins. Corp. v. Laurier Indem. Co.*, No. 8:03CV1650, 2007 U.S. Dist. LEXIS 45670 at *7 (M.D. Fla., June 25, 2007) (noting dearth of case law "because most . . . reinsurance cases end in arbitration"). Arbitration is perceived to be both time- and cost-efficient in comparison to adjudication through the court system, and these efficiencies are among the paramount reasons clients often elect to include arbitration clauses in their agreements.

However, imprecise or ambiguous drafting of the arbitration clause itself may lead disputing parties down a road much longer than they anticipated. In fact, once a party elects to dispute a motion to compel arbitration on the basis of arbitrability, this preliminary dispute on the validity of the agreement to arbitrate may lead to series of hurdles that may stretch longer than the underlying dispute itself.

Although the Federal Arbitration Act, 9 U.S.C. § 1. *et seq.* (the "FAA"), creates a strong presumption favoring arbitration, the Supreme Court has repeatedly held that "[a]rbitration under the [FAA] is a matter of consent, not coercion." *Volt Info. Sciences, Inc. v. Bd. of Trs. of Leland Stanford Junior Univ.*, 489 U.S. 468, 479 (1989); see also *AT&T Techs., Inc. v. Commc'ns Workers of Am.,* 475 U.S. 643, 648 (1986). Accordingly, the presumption favoring arbitration does not apply to the determination of whether there is a valid agreement to arbitrate between the parties. *Fleetwood Enters. Inc. v. Gaskamp*, 280 F.3d 1069, 1073 (5th Cir. 2002). Instead, ordinary state contract principles determine the validity of the agreement. *First Options v. Kaplan*, 514 U.S 938, 943-44 (1995).

And who is responsible for applying these contract principles? A court (unless, of course, the arbitration agreement provides otherwise). *Howsam v. Dean Witter Reynolds*, 537 U.S. 79, 84 (2002) ("[A] gateway dispute about whether the parties are bound by a given arbitration clause raises a 'question of arbitrability' for a court to decide."); *First Options*, 514 U.S at 947 (holding when parties do not clearly agree to submit the question of arbitrability to arbitration, the arbitrability of a dispute is subject to independent review by the courts).

Although this rule prevents forcing parties to arbitrate a matter that they may not have agreed to arbitrate, it also precipitates the possibility of a "trial" on the issue of arbitrability. The FAA mandates that "[i]f the making of the arbitration agreement or the failure, neglect, or refusal to perform the same be in issue, the court shall proceed summarily to the trial thereof." 9 U.S.C. §4. In other words, if the court finds that there is a material issue of fact as to the arbitrability of the agreement, it will order a trial on the issue. See *Bensadoun v. Jobe-Riat*, 316 F.316 171, 175 (2d. Cir. 2003) ("If there is an issue of fact as to the making of the agreement for arbitration, then a trial is necessary."); *Institut Pasteur v. Chiron Corp.*, 314 F. Supp. 2d 33, 40 (D.D.C. 2004).

With trial come discovery, depositions, additional motions, and a litany of other time-consuming and costly endeavors that accompany any trial. More importantly, regardless of the outcome of arbitrability, the underlying dispute must then still either undergo arbitration proceedings or submit to a trial in court.

Consequently, if parties want to ensure that they bypass any trial, their arbitration agreements should unambiguously reflect their intention. Otherwise, the parties may find themselves in a trial to avoid a trial. ❑

Cindy Chang is an Associate in the firm's Washington, D.C. office and is a member of the Insurance and Reinsurance and Litigation Practices. Prior to joining the firm, Ms. Chang completed a clerkship with the Honorable Kathianne Knaup Crane of the Missouri Court of Appeals.

IS A VUL POLICY ALWAYS A SECURITY IN A LIFE SETTLEMENT TRANSACTION? MAYBE NOT.

By James W. Maxson

A variable universal life insurance policy ("VUL") is a policy in which the cash value of the policy is segregated into one or more separate accounts, rather than in the carrier's general account. Typically, policy owners have the choice to select from a wide range of separate account investment options (fixed-income investments, stocks, mutual funds, bonds, money market funds, etc.), and earnings from, and changes in value of, those investments adjust the policy's cash value.

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It has become accepted wisdom in the life settlement industry that a VUL must be treated as a security when purchased and sold in the secondary market for life insurance. Indeed, in its Notice to Members 06-38, the Financial Industry Regulatory Authority, Inc. ("FINRA") stated, "A variable life insurance policy is a security, and the sale of such product in the secondary market is a securities transaction subject to [FINRA] rules."

On its face, this position appears unassailable. To sell VULs, an agent must have a life insurance license and an appropriate securities license, and the product must be sold through a broker-dealer and delivered with a prospectus. How, then, can an argument be made that a VUL is not a security in the context of a life settlement transaction?

The answer lies in the nature of the product itself. A VUL is a life insurance policy with an investment account "bolted" onto it. Under the terms of Section 3(a)(8) and Rule 151 of the Securities Act of 1933 (the "Act"), insurance policies issued by a state-regulated insurance company are exempt from regulation under the Act, assuming certain conditions are met. Even when funds are allocated to the separate account, the reason a VUL is considered a security is not the underlying insurance policy, but the policy's link to accounts that clearly are securities under the Act. The question, then, is whether a VUL is still a security for purposes of the Act if all cash value is moved from the separate account to the carrier's general account.

As a general matter, when one security is exchanged for another security, the Securities and Exchange Commission ("SEC") views this as the redemption of one security and the purchase of another security; and, unless an exemption is available, the SEC requires that the security to be acquired must be registered under the Act and a prospectus delivered, because the purchaser is making a decision to invest in a new security. When a VUL owner redeems funds from the separate account and moves those funds to the carrier's general account, is an investment decision being made? The answer likely is no.

Nothing under federal securities laws, or current court or SEC interpretations of the Act, suggest that a VUL must be treated as a security after all of the funds have been redeemed from the separate account and transferred to the carrier's general account. A policy owner is not making a decision to purchase a "security" when the redemption and transfer occurs and, therefore, is not entitled to the protections afforded by the Act.

Nor does anything under federal securities law, or current court or SEC interpretations of the Act, suggest that once funds have been transferred to the carrier's general account, the VUL must still be considered a "security" simply because the policy owner has the right to transfer funds back to the separate account at some future date. This option is distinct from a typical option, which is a security, because the underlying instrument, a life insurance policy, is not itself a security.

Does this mean that the participants in a life settlement transaction can simply ignore securities laws by moving funds from the separate to the general account? The answer is no. Each case must be looked at individually, and each player in the transaction must assess their role and the potential risks associated with their decisions. Brokers that solicit VULs for sale, unless the funds have already been moved to the general account, are clearly soliciting the sale of a security. And, even if the broker facilitates the movement of any cash value from the carrier's separate account to its general account, the transaction could be re-cast as an attempt to do in two steps what cannot be done in one.

Providers and financing entities interested in purchasing a case should also look at each policy carefully, but if the funds are moved to the general account prior to the purchase of the policy a strong argument arises that no investment decision is being made (vis-à-vis the separate account). And, assuming funds are not thereafter moved to the separate account, it can be argued that securities law, and hence FINRA rules and other securities regulations, would not be applicable to any subsequent re-sales of a VUL in the tertiary market.

The most conservative (and hence safest) course is to treat VULs as securities, whether or not any cash value resides in the separate account, and to make payments to broker-dealers pursuant to FINRA regulations. However, under the circumstances noted above, it may be that VULs are not securities for purposes of the Act and, therefore, it is not necessary to comply with FINRA rules or securities regulations when purchasing and selling these policies. ❑

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NEW YORK APPEALS COURT DEFINES "CLAIM" WITHIN A CLAIMS-MADE INSURANCE POLICY

By J. Ben Vitale

In *In re Ancillary Receivership of Reliance Insurance Company*, 2008 NY Slip Op. 06690 (1st Dep't., September 2, 2008), the New York Supreme Court, Appellate Division, addressed the meaning of the word "claim" when that term is undefined in a claims-made policy. The Court held that a letter, "which neither makes any demand for payment nor advises that legal action will be forthcoming, is insufficient to state a claim." *Id.* at *2.

Plaintiff, Yale Club of New York, was the insured under two "claims-made" insurance policies issued by Lloyds, London and Reliance Insurance Company ("Reliance"). *Id.* While the plaintiff was insured under the Lloyds policy, it received a letter from an attorney representing certain waiters and other employees, who alleged that they had been deprived of tips and bonuses. *Id.* At the time the letter was sent, the Yale Club was involved in an ongoing dispute with the local waiters' union concerning these issues, and the letter concerned those waiters who had declined union representation regarding their individual claims. The first sentence of the letter stated, "Please be advised that our office represents the above named employees of the Yale Club with respect to wage claims . . ." *Id.* at *8 (Catterson, J. dissenting). The second paragraph of the letter began, "They claim, among other things, that they have been deprived of tips and bonuses which amounted to hundreds of thousands, and probably, millions, of dollars." *Id.* at *10 (in dissent). Finally, the letter requested information and documents to enable compliance with the court rules requiring "a reasonable inquiry into the facts before filing a pleading with the courts." *Id.* at *2.

The Yale Club did not notify Lloyds of the letter and, after coverage under the Reliance policy had commenced, the waiters filed suit. *Id.* Reliance disclaimed coverage on the grounds that the letter constituted notice of a claim. *Id.*

A Referee, to whom the issue was submitted, found that "the letter was merely a request for information; the claim was properly filed after the Reliance coverage began." *Id.* Reliance argued, before the Referee and on appeal, that because the Yale Club was already involved in a dispute with the employees' union regarding the same accusations that were raised in the letter, the letter "could not have been viewed in any other light than as a claim." *Id.* at *3.

Because the lack of a definition for the word "claim" created an ambiguity in the policy's language and New York law

ascribes no generally accepted meaning to the term in the context of a claims-made policy, the Court was required to resolve the ambiguity against the insurer. *Id.*

The operative question before this Court is the meaning to be ascribed to the word "claim," a term that defendant concedes is undefined in the Reliance policy. While the disputed letter certainly conveys the suggestion that a lawsuit was being contemplated, it also states unequivocally that counsel was seeking information in connection with his obligation to determine whether legal action was warranted. Moreover, the letter does not even state that the purpose of any such action would be the recovery of civil damages, merely alleging that the Yale Club's actions variously "constitute criminal violations, as well as civil violations of RICO and the New York State Labor Law, and fraud and conversion." *Id.* at *3.

The Court held that the "letter to plaintiff falls far short of a demand for money or services or even the expression of a present intent to initiate legal proceedings" because any action was "implicitly conditioned upon the outcome of counsel's investigation of its merits." *Id.* at *4 (internal citations omitted). As a result, "the letter received by plaintiff is not 'an assertion of a legally cognizable damage, . . . a type of demand that can be defended, settled and paid by the insurer.'" *Id.* (citations omitted).

Addressing the defendant's argument that, given the circumstances, the letter must be considered a claim, the Court stated:

> It is uncontested that the workers on whose behalf the letter sought information were represented by a union, and it is apparent that the union was engaged in efforts to resolve the dispute on their behalf and on behalf of the rest of its members employed at the Yale Club. Plaintiff's mere awareness that an action was being contemplated by the attorney for the 13 Yale Club employees was hardly tantamount to notice that an action would be brought, since his investigation could have revealed that suit was unwarranted or subsequent events could have rendered

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an action unnecessary. The mere awareness of alleged wrongdoing is not a "claim" within the meaning of the typical claims-made policy. *Id.* at *5. As a result, the Court held that the defendant's argument that the letter must be recognized as containing a claim relies on hindsight and must be rejected as speculative. *Id.*

The Court held that "[u]nder these circumstances, the subject letter requesting documents and information in support of counsel's 'inquiry into the facts' does not suffice to state a demand for payment so as to warrant the conclusion that a claim arose at such time." *Id.* at *6.

Two judges dissented, writing that "claim" should be "given its ordinary understanding of a demand by a third party against the insured for money damages or other relief owed." The dissent concluded a "claim" does not require something akin to an express demand for payment combined with an express threat that legal action will be forthcoming. ❑

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NEW FEDERAL RULE OF EVIDENCE 502 ADDRESSES WAIVER OF PRIVILEGES

By Brian J. Levy

Modern litigation has become increasingly document-intensive. Production of millions of pages during discovery is not uncommon, and the electronic age has complicated the discovery process with emails, drafts, and hidden data.

Given the discovery burden, parties incur high costs in identifying and removing documents protected as privileged or as work product. Notwithstanding such efforts, inadvertent disclosures of privileged material have become more common. The consequences of an inadvertent production are exacerbated by the possibility that the production of a privileged document waives the privilege, not only for that document, but also for all documents and communications addressing the same subject matter. See *Gray v. Bicknell*, 86 F.3d 1472, 1482-84 (8th Cir. 1996) (discussing the varying approaches courts employ to determine whether an inadvertent disclosure waived the attorney-client privilege before upholding district court's order that the privilege had been waived only as to the inadvertently produced documents); *Texaco Puerto Rico, Inc. v. Dep't of Consumer Affairs*, 60 F.3d 867, 883-84 (1st Cir. 1995) (affirming district court ruling that litigant's inadvertent disclosure of 4 protected documents waived the attorney-client privilege as to 14 other documents concerning the same subject matter).

Recognizing these problems and the inordinate cost generated by current practice, Congress has enacted new Federal Rule of Evidence 502 to provide heightened protection against inadvertent waiver of the attorney-client privilege and work-product protection during discovery. Rule 502 applies to all proceedings that commence after September 19, 2008, and to any actions pending on that date "insofar as is just and practicable." Fed.R.Evid. 502.

The Rule has four primary functions. First, it eliminates the possibility of an inadvertent "subject-matter" waiver in state or federal court caused by disclosure of a protected document in a federal proceeding. Under Rule 502(a), the attorney-client privilege or work-product protection is preserved for undisclosed communications or information related to the material inadvertently disclosed in a federal proceeding or before a federal agency. In the situation where a litigant discloses protected material, undisclosed communications or information that concern the same subject matter as the disclosed material lose their privileged status only where waiver of the disclosed material was intentional and fairness requires the undisclosed material to be considered with the disclosed material. Fed.R.Evid. 502(a). Protected material remains protected where the disclosure was inadvertent, it does not concern the same subject matter, or fairness does not require that it be considered with the disclosed material. Thus, an inadvertent disclosure cannot waive the attorney-client privilege or work-product protection as to an entire subject matter. Whether the inadvertent disclosure waives the protected status of the revealed document depends on the second feature of Rule 502.

That second feature reduces the likelihood that that inadvertent disclosure of a protected document would result in a waiver

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of the attorney-client privilege or work-product protection. A disclosure made in a federal proceeding does not operate as a waiver in a federal or state proceeding if the disclosure was inadvertent, the holder of the privilege or protection took reasonable steps to prevent disclosure, and the holder promptly took reasonable steps to rectify the error. Fed.R.Evid. 502(b). Reasonable steps to rectify the error include asserting that the material is privileged or protected and notifying the party in receipt of the material, pursuant to Federal Rule of Civil Procedure 26(b)(5)(B). *Id*.

Third, the rule clarifies whether a disclosure in a state court proceeding operates as a privilege waiver in a federal proceeding where state law conflicts with federal law. As long as the disclosure made in a state court proceeding is not the subject of a state-court order concerning waiver, the material disclosed in a state proceeding remains privileged or protected in a federal proceeding if the disclosure either (1) would not have been a waiver had it been made in a federal proceeding or (2) would not have been a waiver under applicable state law. Fed.R.Evid. 502(c). The law that prevails in such conflicts is whichever provides greater protection for the privileged or protected materials.

Finally, if a federal court rules that the privilege or protection is not waived with regard to a disclosure inadvertently made in a federal proceeding or before a federal office or agency, that ruling is controlling in any other federal or state proceedings. Fed.R.Evid. 502(d). Rule 502 allows parties to reach a binding agreement as to the effect of a disclosure in a federal proceeding, although any such agreement is binding on only the parties to the agreement. Fed.R.Evid. 502(e). If either party wishes to preserve the privileged or protected status of disclosed material vis-à-vis a third party it should move to have the agreement incorporated into a court order. *Id.*

Other than the four features discussed above, the law of evidentiary privilege remains unchanged by Rule 502. Whether a document is protected by the attorney-client privilege or work-product protection remains governed by the otherwise applicable privilege law. Fed.R.Evid. 502(g). Furthermore, the rule has no application where a disclosure of privileged or protected material is made in a state proceeding and offered in a subsequent state proceeding on the ground that the privilege or protection was waived by the disclosure. Whether the privilege or protection was waived in that circumstance will be determined by a state court based on state law. ❑

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HASSETT'S OBJECTIONS

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The problem was that, although the condominium declaration allowed it to be amended with the approval of 67 percent of the voting interests, the Rhode Island Condominium Act requires unanimous consent to amendments that "create or increase special declarant rights, increase the number the units, change the boundary of any units, the allocated interest of any unit, or the uses to which any unit is restricted." R.I. Gen. Laws, Section 34-36.1-2.17(d). The inconsistency between Rhode Island statute and the condominium declaration with respect to the consent needed to amend the declaration came to a head in 1994. At that time, the developer was facing a deadline for its right to develop a parcel known as the "Reserve Area." The developer then promulgated amendments that granted it an additional sixteen years to develop those parcels. Although the amendments were approved by more than 67 percent of the voting interests, they were not approved by all the individual unit owners. The developer recognized the risk that the amendments could be declared invalid, but noted that the unanimous consent of all unit owners was "impossible to obtain." *Id.* at 2. Therefore, the developer decided to assume an "aggressive posture." *Id.*

On October 21, 1994, the developer obtained a $10 million dollar owner's title insurance policy from Chicago Title. However, the policy did not cover the Reserve Area. "Both Chicago Title and [the developer's counsel] recognized that the …purported extension of [the developer's] time to exercise its development rights might be invalid because it was not approved by all individual unit owners." *Id.*

Thereafter, the condominium associations of the three developed parcels and several individual unit owners challenged the developer's right to develop the Reserve Areas, claiming that the time to exercise the development rights had expired and that the purported extensions of time were invalid. The developer's counsel expressed to the developer his concerns that the extension of time was invalid.

Meanwhile, the developer was attempting to persuade Chicago Title or Commonwealth Title to issue a policy

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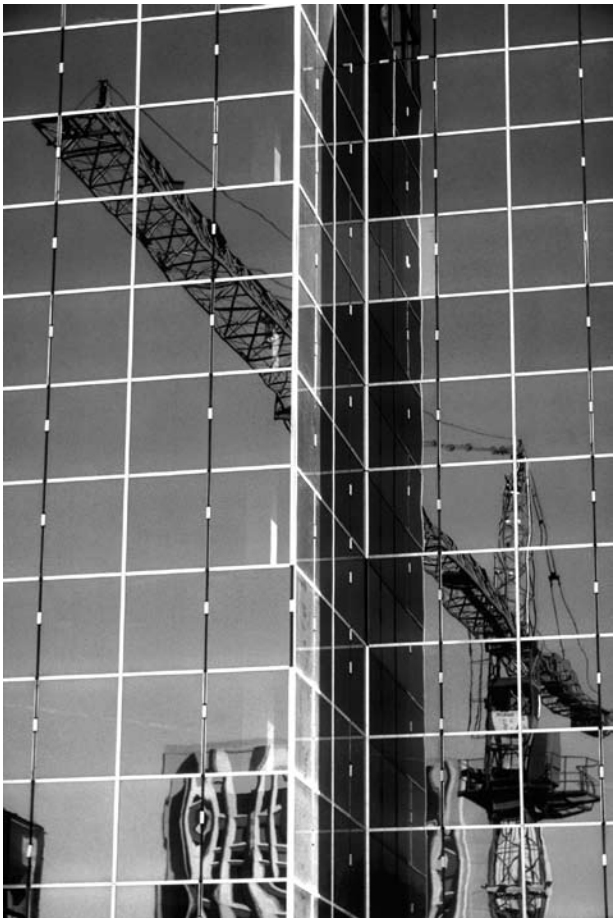
covering the Reserve Area. To encourage Commonwealth to issue a policy, the developer sent Commonwealth copies of the declaration, the amendments, the earlier Chicago Title Policy and a memorandum dated November 17, 1997, stating two theories upon which the developer's rights in the Reserve Area were based. One of the theories was that, even if unanimous consent had been required, any claim was barred by a one year period of limitations. The November 17 memorandum failed to mention that one of the executive board members of the America Condominium objected to amending the declaration and had abstained from voting on what he considered an illegal proceeding. Similarly, the memorandum did not refer to the threat of litigation from the condominium associations or the individual unit owners. Moreover, the developer had negotiated a tolling agreement with the prospective plaintiffs to delay the litigation. "At no time did [the developer] disclose to Commonwealth that individual condominium owners [had] threatened a suit challenging [the developer's] development rights or that there was a tolling agreement extending the time for bringing such a suit." *Id.* at 3.

Shortly thereafter, Chicago Title declined to issue the requested title insurance policy. In a rejection memorandum, Chicago Title stated that it was aware of threatened litigation and discerned a substantial risk of litigation. The developer did not provide Commonwealth with a copy of Chicago Title's memorandum or disclose Chicago Title's stated reasons for declining to issue a policy. On January 13, 1998, Commonwealth issued a $7 million dollar title insurance policy, which was increased to $12 million dollars approximately one month later.



The associations sued the developer on May 29, 1999. The court found against the developer, which was affirmed on appeal. Meanwhile, Commonwealth sought a declaratory judgment that coverage was barred by the developer's failure to disclose material facts. The District Court ruled in favor of Commonwealth, finding that the developer "knowingly failed to disclose" that litigation has been threatened, that the developer had entered into a tolling agreement and that the threat of litigation was cited by Chicago Title as a reason for declining coverage.

On appeal, the developer argued that, because the District Court did not find fraud, the developer had no obligation to disclose information to a prospective insurer unless specially asked questions on point. The Court of Appeals held that it need not decide whether the developer had an affirmative duty to disclose the information at issue, because a half-truth or failure to speak when necessary to qualify misleading prior statements amounts to a misrepresentation. *Id.* at 6. The Court of Appeals concluded that by articulating its theories about the basis for development rights, while excluding information about threats of litigation and the tolling agreement, the developer had made a misrepresentation. The Court also cited the developer's decision to send Commonwealth the earlier Chicago Title Policy without disclosing that Chicago Title had declined to issue the subsequent policy. "A prospective insured cannot select and present only favorable information on a subject and delete less favorable information on the same point, even if no follow-up questions are asked."

The Court of Appeals is correct. A title insurer should not be required to ask questions about material submitted by the insured. If the insured elects to submit materials, it should be required to disclose both favorable and unfavorable information. ❑

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Best Case

We first determined that a change of control of all insurers in the AIG group would involve approvals from 20 states. We then examined each of these states to determine the timeline of non-waivable statutory notice periods. For example, if a state mandated a hearing and that hearing mandated 14 days' notice, we were of the opinion that a state could not waive such notice, especially when the notice benefits the public. There were other timelines which are less clear. For example, the pre-notification periods. Some states require acquirers to provide at least 30 days' prior notice before closing an acquisition. A few states require 60 days' notice. There is no statutory authority for waiving such notice periods. As a matter of practice, however, states with pre-notification could take the position that the pre-notification is for the benefit of the state itself and, thus, is waivable. Even when taking the most aggressive view by: (i) using a common Form A; (ii) assuming the form will be agreed upon by all states as being in final form, (iii) filing simultaneously in all states, and (iv) all states holding a single common hearing as soon as possible and issuing an approval order immediately thereafter, it is our opinion that the earliest approval to disburse funds to rescue AIG would be twenty (20) days. Clearly, too long in this economic environment for a private rescue of a failing insurer.

Most Reasonable Case

Twenty days is the most aggressive timetable. If all of the statutory notice periods were satisfied, even with highly cooperative regulators rendering orders of approval promptly after a single mandatory hearing presided over by multiple commissioners, a rescue of a multi-state insurer such as AIG could not be done in less than 61 days. Clearly, this is unacceptable.

The Problem

These economic times may well highlight the best and the worst in state insurance regulation. It can be characterized as the "best" because state regulators are usually close to the financial condition and management of insurers domiciled in their state. Long before public disclosure of weakness, regulators generally have examiners on site reviewing the financial condition of troubled insurers. Certainly, Superintendent Dinallo gets high marks for his leadership with the NAIC AIG Task Force for an effective, concerted state regulatory response. Such concerted action has historically been limited and reserved only for the very high profile problems.

It can be considered the "worst" because even a concerted, well directed regulatory task force would be hamstrung in the face of statutory time periods which are not waivable. Currently, there seems to be no way around the problem. We know of no federal pre-emption which could be invoked, even though Treasury seems to have taken the risk in funding AIG with control even though not state approved. The fact remains, there is no federal insurance nor bankruptcy law which appears helpful.

Two Answers

There may be two ways in which to address this dilemma. The first would be a targeted federal law which would set aside McCarran-Ferguson for the limited purpose of approval of a rescue of an insurer or insurance holding company where failure to do so would be substantially harmful to policyholders or the public. The legions of proponents of McCarran-Ferguson and state regulation of insurance would be opposed to this exception as constituting a first step toward the federal regulation of insurance.

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The other solution is to amend the Model Holding Company Act and seek to get changes in all state laws. A suggested form of a change to the NAIC Model Insurance Holding Company Act would be along these lines:

"Emergency Capital Infusion. If, in the opinion of the Commissioner and the [Governor or Attorney General] there exists an Emergency Condition of a domestic insurer or domestic insurance holding company, the Commissioner shall have the authority to expedite a change of control, as defined in [insert statute], including waiving any requirements for a public hearing, waiving statutory notice periods and pre-notification periods. An Emergency Condition is one in which the Commissioner is satisfied that an insurer or insurance holding company requires an immediate substantial capital infusion that results in a change of control if the insurer, failing which the policyholders would be irreparably harmed."

Conclusion

As we work through the application of the federal Troubled Assets Relief Program ("TARP") to insurers, it could be expected that a federal "cut through" will be devised wherein McCarran-Ferguson will be set aside for both federal and emergency private relief to be provided to troubled insurers without the application of state holding company laws. ❑

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LETTER FROM WASHINGTON

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The 110th Congress is scheduled to have a "lame duck" session. It is extremely unlikely that any insurance reform legislation will be addressed at that time. This Congress has acted on a variety of insurance regulatory reform proposals, e.g. surplus lines and reinsurance reform (H.R. 1065); national optional federal chartering (S. 40); national registration of insurance agents (H.R. 5611); establishing an office in the Treasury to oversee and gather information about insurance regulation (H.R. 5480); and expansion of the Liability Risk Retention Act (H.R. 5792). Several of these proposals made progress, but none passed.

The 111th Congress will take office in January. It will likely consider those issues referenced above but in the context of overall financial services reform. In other words, Congress will consider much broader and more inclusive issues.

It is charitable to say that the legislative process is imperfect. Because Congress has relatively little experience with the insurance industry, the opportunities for missteps and outright bad legislation is increased. The "law of unintended consequences" should be foremost in every legislator's mind.

A good example of this is what happened to the legislation to facilitate the multi-state licensing of insurance agents known as "NARAB II" (H.R. 5611). This legislation would have created a non-profit organization that would have been granted limited authority regarding agent licensing. In the 110th Congress, the bill was moving with great speed and momentum. It had been reported out of the relevant House committee and had been sent to the floor of the House to be passed on the "consent calendar." H.R. 5611 was supported by a coalition of insurance trade associations as well as the NAIC (which had obtained favorable amendments of the original proposal).

During the legislative process, only one group noted that H.R. 5611 had a significant problem; more specifically, it was unconstitutional. The National Association of Professional Insurance Agents ("PIA")[1] pointed out that the draft legislation would implement an unlawful delegation of authority to the members of the board of NARAB because they would be "politically unaccountable." This would violate the "Appointments Clause" of the United States Constitution. H.R. 5611 also had problems related to the "Separation of Powers Doctrine," i.e., Congressional involvement in executive branch functions.

Because the political compromise had been struck, this point of view was particularly unpopular and universally ignored until the Department of Justice (Office of Legislative Affairs) issued an opinion in the form of a letter dated October 1, 2008, articulating why the legislation was unconstitutional. The result, of course, is that H.R. 5611 has been sent back to the shop to be rebuilt so that it can pass constitutional scrutiny.

This is an example of just one of the many pitfalls that must be avoided in any legislative effort to implement insurance regulatory reform. The road to reform will be a bumpy one. Nonetheless, a larger federal role in the regulation of insurance will be high on the agenda of the 111th Congress. Congress generally needs either a consensus or a crisis to act. The 111th Congress may have both. ❑

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1 Full disclosure: Morris Manning & Martin advises PIA on selective issues and worked with PIA on H.R. 5611.

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