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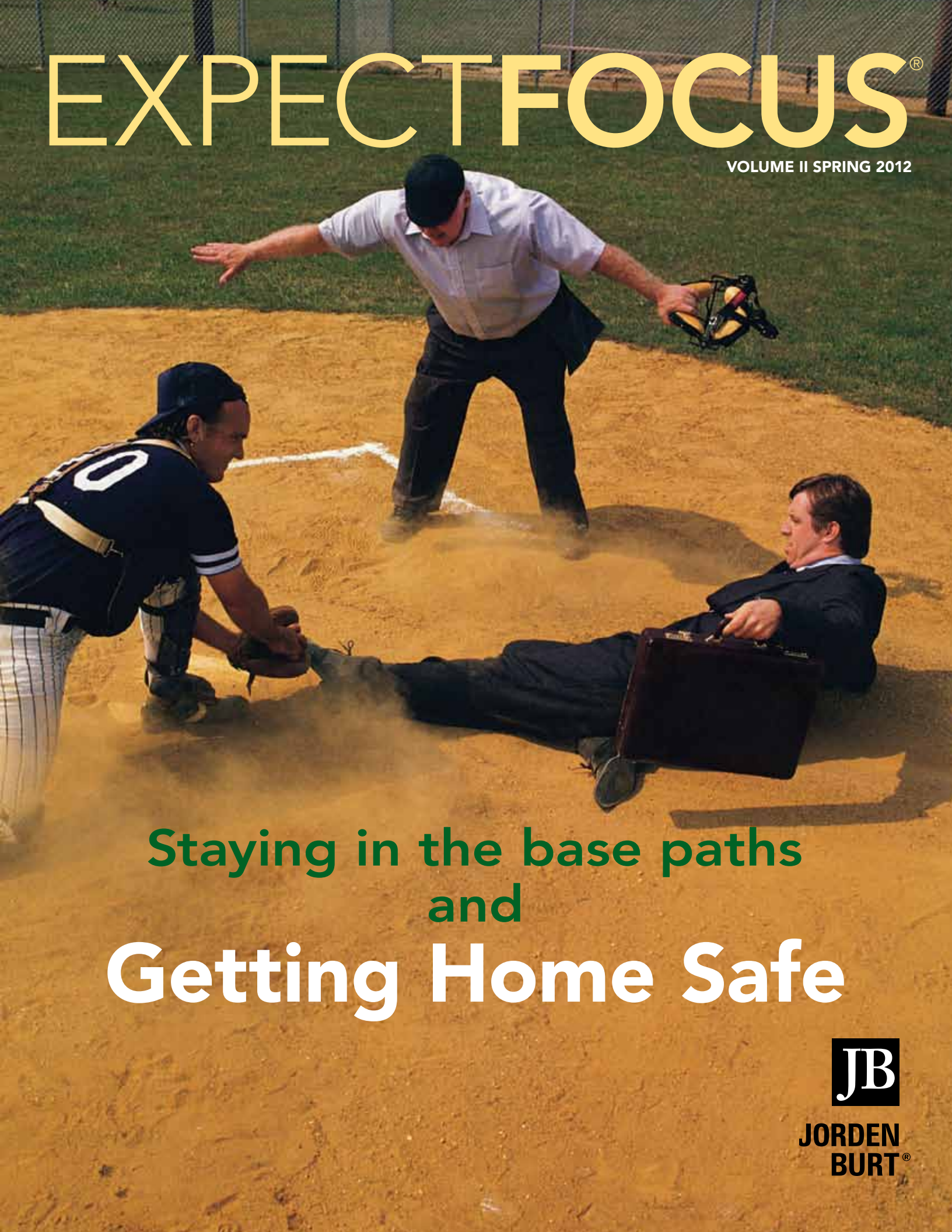
VOLUME II SPRING 2012



Staying in the base paths and Getting Home Safe

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EXPECT**FOCUS**® VOL. II SPRING 2012

EXPECT**FOCUS**® is a quarterly review of developments in the insurance and financial services industry, provided on a complimentary basis to clients and friends of Jorden Burt LLP.

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DOL Seeks Clarity and Accountability From Retirement Plan Service Providers

BY MICHAEL KENTOFF

Striving for more transparency in the retirement plan market

On the heels of introducing its final 401(k) fee disclosure requirements for plan service providers earlier this year, the Department of Labor has intensified its examinations of third-party providers, targeting provider compensation and potential areas of conflict of interest. Industry analysts believe that the increased regulatory attention might portend a tougher enforcement climate once the new fee disclosure rules become effective on July 1, 2012.

As detailed in Jorden Burt's February 3, 2012 Client Alert, the DOL's fee disclosure rules, now a condition of the "service provider" statutory exemption from ERISA's prohibited transaction provisions under ERISA Section 408(b)(2), require plan service providers to furnish plan sponsors with, among other things, information about service provider direct or indirect compensation as well as administrative and individual plan expenses. According to the DOL, the new disclosure rules, which apply to all ERISA-covered plans, including ERISA-covered 403(b) arrangements (but not IRAs), are designed to enhance transparency in the retirement plan market and allow employers to more easily "shop around" for retirement services. Where plan assets are held in an insurance company's separate accounts, the insurer would be a fiduciary and, therefore, a service provider subject to the new rules.

Both the new disclosure rules and the increased regulatory scrutiny of service providers address concerns, expressed by the DOL for several years, that third-party service providers received compensation undisclosed to plan sponsors and that some providers might receive increased compensation for recommending certain investments. **The shift in investigatory focus from plan sponsors to third-party providers also parallels the recent sharp increase in 401(k) fee class action lawsuits**, including the March 31, 2012 federal district court bench decision in *Tussey v. ABB, Inc.* wherein the Court held the employer, individual members of the plan committee, and service provider Fidelity Investments liable for approximately $37 million in damages for violating ERISA's fiduciary standards of conduct.

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Courts in Insurance Disputes Address Absent Class Member Contacts

BY DAWN WILLIAMS

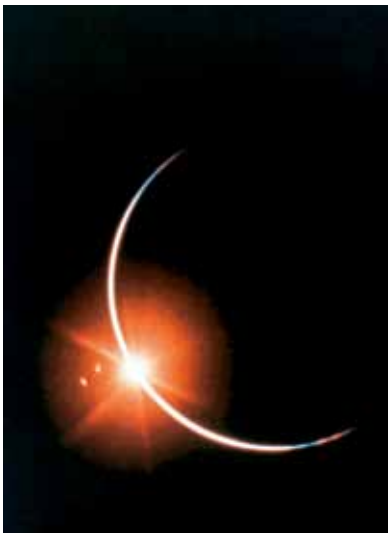
Two insurers have recently been embroiled in disputes about contact with and discovery from absent class members. In a case involving equity indexed universal life policies, the Life Insurance Company of the Southwest sought, and obtained, an order from the Central District of California proscribing the parties' contact with absent class members due to allegedly improper contact by plaintiffs with the putative class. **The court ruled that (1) parties must first recite scripted language before communicating with potential class members; (2) contact with minors or individuals who were reasonably certain not to be in the class was prohibited; (3) counsel could not solicit parties to the litigation; and (4) individuals who had been contacted by plaintiffs in the past must be sent an explanatory letter.** The court emphasized that its ruling should not be interpreted as interfering with LSW's interaction with its customers in the ordinary course of business.

Murr v. Midland Nat'l Life Ins. Co. is a putative deferred annuity class action pending in the Southern District of Iowa in which the plaintiffs claim the insurer breached its contracts by incorrectly calculating the interest adjustment upon surrender. The insurer served a subpoena on an absent class member who was also the wife of the named plaintiff, requiring her to produce documents and to testify at a deposition. She moved to quash the subpoena issued to her in Arizona federal court, asserting that Midland neither met its high burden of proof that the discovery from absent class members is necessary nor shown how her testimony or understanding is relevant to a case primarily asserting breach of contract. Midland filed its opposition under seal, and briefing has been completed.

Recent STOLI Decisions

BY DAWN WILLIAMS

Federal courts in New York, California and Florida have all recently issued opinions in litigation concerning stranger-originated life insurance (STOLI). First, a positive result: the Eastern District of New York, adopting a magistrate's recommendation, **denied the defendant trust's motion for summary judgment because the insurer's complaint had been filed within the policy's contestability period.** The court declined to adopt *dicta* in the magistrate's opinion concluding that challenges to a policy based on a lack of insurable interest could not be made outside the contestability period, as it was not necessary to the opinion rendered.



Taken together recent STOLI decisions may shed little light

On the other hand, in California (*see* Expect Focus Vol. I, Winter 2012), the Central District recently granted a defendant trust's motion for summary judgment against the insurer, who sought a declaratory judgment that the policy was void. Even though the court found that the insured intended to sell the life insurance policy prior to its purchase, established a trust to facilitate the sale, and lied about her net worth and intent to transfer the policy on the application, the court decided that, when the policy was issued, the trust had an insurable interest and afterwards the policy could be freely transferred.

Additionally, a jury in the Southern District of Florida found in favor of an alleged STOLI scheme participant who sued to recover benefits under the policy. The jury concluded that, while the trust knowingly committed fraud and civil conspiracy with the intent that the insurer rely on its fraudulent statements, the insurer did not rely on the misrepresentation and was not harmed by acts done in furtherance of the conspiracy. The court entered final judgment for the trust and awarded it the $5 million death benefit.

Federal Insurance Office Update

BY ROLLIE GOSS

There has been some visible progress in the development of the FIO over the past several months. The Department of Treasury formed a committee, the Federal Advisory Committee on Insurance (FACI), to provide advice and recommendations to the FIO. The FACI, composed of members from the insurance industry, academia, consumer advocates and state insurance regulators, recently held its first meeting, which was largely organizational in nature. FIO Director McRaith chaired the meeting, and announced the appointment of the CEO of Marsh & McLennan Companies as the chair of the committee. Director McRaith focused his comments on guiding the committee to the consideration of broad international and demographic issues such as the so-called "silver tsunami" or wave of persons at or near retirement in the US as a potential systemic insurance issue.

Following this guidance, the FACI formed two subcommittees, which will address international competition between insurance companies and issues relating to the aging US population and the potential impact of changing demographics on the international insurance market. **This focus reflects one of the FIO's stated purposes – to play a leading role in being the voice of the US in international insurance markets and international insurance regulation efforts.** Furthering that international focus, the FIO is now a member of the Executive Committee of the International Association of Insurance Supervisors.

Another focus of the FIO stems from the Dodd-Frank Act's requirement that the FIO provide Congress a report on how to improve and modernize insurance regulation. That report is now over three months overdue, and is widely anticipated. It is not known what role, if any, the FACI is playing in the preparation of that report, or when the report may be made public.

Annuity Class Action Update

BY JOHN BLACK

The vigorous annuity class action arena recently spawned two federal court decisions favorable to defendant insurers. While the details of the two cases are very different, each provides a useful guide to future litigants.

In *Rowe v. Bankers Life and Casualty Co.*, the Northern District of Illinois denied class certification as to a putative class of elderly consumers who purchased indexed annuities. The putative class alleged that Bankers had conspired with its independent sales agents to induce elderly consumers to buy indexed annuities that were unsuitable to those over age sixty-five. The complaint alleged federal RICO violations along with violations of California consumer protection statutes. The court denied plaintiffs' motion for class certification, finding that common issues did not predominate because there was insufficient evidence showing that putative class members saw the allegedly "uniform" disclosure documents and sales presentations. The court also found class-wide causation lacking, and refused to infer reliance.

In *Vaccarino v. Midland Nat'l Life Ins. Co.*, the Central District of California granted in part Midland's motion to dismiss the claims of a putative class of deferred annuity purchasers alleging bonus and commission recoupment. Plaintiffs alleged common law claims along with violations of California's Unfair Competition Law. The district court dismissed the majority of plaintiffs' claims on multiple grounds. **Most notably, the court concluded that claims related to annuity surrender charges and interest adjustments should be dismissed because plaintiff had failed to allege an actionable injury.** The court also expressed confusion as to what sales materials and representations constituted the "contract" for purposes of plaintiffs' breach of contract claim. Finally, the court dismissed the "unlawful" prong of plaintiffs' UCL claim, and additional claims on the basis that they were time-barred.

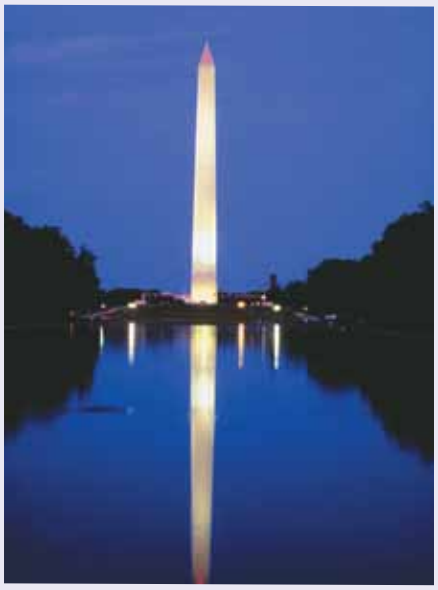
MARKYOURCALENDAR

IRI Litigation Summit in the Nation's Capital – June 25th, 2012

Jorden Burt LLP will co-lead the Litigation Summit featured at the Insured Retirement Institute's Government, Legal & Regulatory Conference being held in Washington, D.C on June 24-26th, 2012. The Litigation Summit will take place on Monday, June 25th and feature sessions covering development, trends, regulatory actions and legislation regarding annuity-focused topics:

- Annuity and Life Insurance Litigation
- Class Certification Law and Procedures Since *Wal-Mart v. Dukes*
- Unclaimed Property
- Retirement Plan Litigation Including 401(k), 403(b), and 457 Plans

The member rate to attend the Litigation Summit is $495 (non-member $695). For registration information and pricing for full conference attendance, please visit *www.iriconferences.org* or contact Nicole Nicols at IRI (202-469-3015 or nnicols@irionline.org).



JOBS Act Lifts PPVIP Limits

BY ED ZAHAREWICZ

The Jumpstart Our Business Startups Act was signed into law on April 5, 2012, for the purpose of facilitating American job creation and economic growth. While it makes a variety of changes in the ways small and medium-sized businesses may gain access to capital, the JOBS Act also comes with a few notable regulatory changes for private placement variable insurance products (PPVIP). These products are typically offered only to accredited investors in reliance on Rule 506 of Regulation D and Section 3(c)(1) or 3(c)(7) of the Investment Company Act.

Presently, PPVIP carriers must ensure that their products are not offered or sold through any manner of "general solicitation or general advertising." They should also limit the number of contract owners that a particular separate account may have to 499 to avoid becoming subject to public company reporting requirements under the Exchange Act. The JOBS Act will eliminate the prohibition on the use of general solicitation and raises the threshold for registration under the Exchange Act.

Among other things, the JOBS Act mandates that the SEC revise its rules, within 90 days, to provide that the prohibition will not apply to offers and sales made pursuant to Rule 506, provided that all purchasers are accredited investors. The revised rules must also require the issuer "to take reasonable steps to verify that purchasers of the securities are accredited investors, using such methods as determined by the [SEC]." Currently under Regulation D, an accredited investor includes any person who the issuer "reasonably believes" is an accredited investor. Carriers have traditionally relied on purchaser questionnaires to establish the purchasers' accredited investor status. It is unclear at this time whether the rulemaking will require any changes to how carriers go about "verifying" a person's status as an accredited investor.

Offers and sales of securities that satisfy the conditions of the Rule 506 are deemed to be transactions "not involving any public offering" within the meaning of Section 4(2) of the Securities Act. But reliance on Section 3(c)(1) or 3(c)(7) of the Investment Company Act is also dependent upon the offering not being a "public offering." **To ensure that the use of general solicitation in a Rule 506 offering does not result in any public offering, the JOBS Act amends Section 4 of the Securities Act to clarify that such offerings will "not be deemed public offerings under the Federal securities laws as a result of general advertising or general solicitation."**

The JOBS Act also amends the threshold for registration of securities under Section 12(g) of the Exchange Act. Prior to the amendment, Section 12(g) required an issuer with total assets exceeding $10 million and a class of equity security held of record by 500 or more persons to register that class of security absent an available exemption. The amendment changes the number of holders of record required to trigger registration from "500 or more" to "either (i) 2000 persons, or (ii) 500 persons who are not accredited investors." This effectively raises from 499 to 1999 the number of contract owners that a PPIV separate account may have without becoming potentially subject to public company reporting requirements.

NAIC Takes Next Steps in Collateral Reduction Initiative

BY ANTHONY CICCHETTI

With the adoption in November 2011 of the revised Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786), **the NAIC's Reinsurance (E) Task Force is now tackling the following charges in 2012**:

NAIC Task Force seeks to provide guidance

- Provide guidance to the Financial Regulation Standards and Accreditation (F) Committee with respect to key elements of the revised Models to be considered for the purposes of the NAIC's Financial Regulation Standards and Accreditation Program.
- Develop a process to evaluate the reinsurance supervisory systems of non-U.S. jurisdictions to identify jurisdictions recommended by the NAIC for recognition by the states as qualified jurisdictions for the purposes of the revised Models.
- Form a new group to provide advisory support and assistance to the states in the review of collateral reduction applications.
- Develop reporting instructions for forms CR-F and CR-S applicable to certified reinsurers under the revised Models.
- Consider any other issues related to the revised Models.
- Addressing the first charge, the Task Force in March exposed for comment (with a comment deadline of April 6) proposed revisions to the standards for Reinsurance Ceded found in Part A (Laws and Regulations) of the Financial Regulation Standards and Accreditation Program. A detailed discussion of the revised Models is available in a Special Focus feature on Jorden Burt's reinsurance and arbitration blog, *reinsurancefocus.com*.

Mark Your Calendar

Ann Furman and **Richard Choi**, partners in the DC office will be moderating panels at the Insured Retirement Institute's Government, Legal & Regulatory Conference. Ms. Furman will present on Effective Social Media and Advertising Strategies and Mr. Choi will present on SEC Disclosure Initiatives. The conference will take place June 24-26, 2012 at the Omni Shoreham Hotel in Washington, DC.

The ACLI Compliance and Legal Sections Annual Meeting will be held July 16-18 in Las Vegas, NV. Jorden Burt is a President's Level sponsor and **Ann Furman** will present on the topic "General Counsels With Broker-Dealer Affilliations: Are You the Gatekeeper/Supervisor for Securities Salespersons Activities?" For more information please visit *www.acli.com*.

Brian Perryman will be presenting on "Class Actions: Disclosure of Interest Rates, Fees, and the Liabilities Related to the Maintenance of Life and Annuities Products" at the American Conference Institute's Litigating Life Insurance and Annuity Claims Conference, July 30-31, 2012 in New York, NY. For additional information, please visit *www.americanconference.com*.

Scribner, Hall & Thompson, LLP

IRS Third-Party Summonses – Negotiated Cooperation Usually Is the Best Approach

BY SAMUEL MITCHELL

Over the last several years many life insurance companies have received third-party administrative summonses from IRS agents seeking documents and information concerning life insurance policies sold to trusts and individual taxpayers. Most of these summonses arise in the context of trust arrangements the IRS considers abusive. The summonses typically arise in two types of IRS examinations – (1) income tax examinations of the individual taxpayers who participated in the arrangements and (2) promoter penalty examinations of the agents or brokers.

An IRS third-party summons, and particularly one issued in promoter examinations, can be very costly and burdensome. For example, the summons may request detailed information over a period of many years regarding everything from actuarial and reinsurance documents and information to all types of communications with the promoter. An IRS summons is not self-enforcing. If the company refuses to comply, however, the IRS can go to Federal District Court to seek enforcement. There are legal remedies available to a third-party summons recipient in Federal District Courts; however, the IRS has specific statutory authority under I.R.C. § 7602 to issue such a summons and the courts generally have not been kind to recipients who resist. These summons enforcement actions in court can be time-consuming and costly. Therefore, satisfaction of the IRS's request for information outside of court in the most cost-effective manner is usually the best course.

There are a number of things to think about when a company receives a third-party summons, such as privileged and proprietary information, ongoing lawsuits filed by policyholders, and the effect of document production on the company's relationships with agents, brokers and policyholders. Although the deck is stacked in favor of the IRS in obtaining all non-privileged information demanded in the summons, most IRS agents will be cooperative if the situation is handled properly. The IRS agents do not want to be overwhelmed with paper and, perhaps more importantly, operate under timing and budgetary restrictions that incentivize them to be reasonable. The best approach for the company in terms of managing both its costs and external risks is to cooperate with the IRS agents within the scope of their limitations and attempt to negotiate a process that will result in a more limited compliance burden.

States Seeking to Adopt New Unclaimed Property Requirements

BY STEPHANIE FICHERA

Insurers' unclaimed benefits practices continue to occupy state regulators, many of whom are introducing and adopting initiatives addressing their concerns. Their initiatives include:

- Amendments to NCOIL's Model Unclaimed Life Insurance Benefits Act (the Model Act), which will be discussed during its Summer Meeting.
- In February and April 2012, respectively, Alabama introduced and Kentucky adopted Model Act-based legislation.
- In April 2012, New York introduced legislation that requires insurers to undertake a Death Master File match semi-annually, rather than quarterly as under the current Model Act. Also different from the Model Act, it specifically permits insurers to require "satisfactory proof of loss, such as a death certificate, as a condition for conclusively determining the death of the policyholder or account holder."

Carefully Constructed Settlement Shields Funds From ERISA Equitable Lien

BY W. GLENN MERTEN

Larry Griffin received nearly $300,000 in settlement from the party responsible for an automobile accident in which he was seriously injured. Pursuant to the settlement, Mr. Griffin's ex-wife, Judith, received $40,000 pursuant to their divorce settlement, and the remainder of the settlement was paid directly to Hartford CEBSCO, which was required to purchase an annuity from the Hartford Life Insurance Company to make monthly payments into a Trust for Mr. Griffin's benefit. Mr. Griffin's employer and the benefits manager of the Group Medical Plan sought an equitable lien against Mr. Griffin, the Trustee, the Trust, and Judith Griffin to recover more than $50,000 Mr. Griffin received in medical benefits, although the Griffins' attorney constructed the settlement purposefully to avoid such a lien. The district judge, in *ACS Recovery Services, Inc. v. Griffin*, held that the relief requested was not equitable and therefore unavailable under ERISA § 502(a)(3), and dismissed the claims.

Ship in a bottle – lawyer-style

On appeal, the Fifth Circuit Court of Appeals affirmed. Citing *Knudson* and *Sereboff*, the court applied the test previously established in *Bombardier Aerospace Emp. Welfare Benefit Plan v. Ferrer, Poirot & Wansbrough*, which asks whether the plan "seeks to recover funds (1) that are specifically identifiable, (2) that belong in good conscience to the Plan, and (3) that are within the possession and control of the defendant beneficiary[.]" **The court held that since the funds were not in the possession of Mr. Griffin, plaintiffs sought to impose personal liability upon Mr. Griffin, which was not equitable relief within the meaning of ERISA.** The court further held that Hartford CEBSCO, not the Trust or the Trustee, actually possessed the annuity, and even if Mr. Griffin previously had "fleeting possession" of the funds, the *Bombardier* test requires current possession or control. This holding underscores the need for plans and insurers to carefully monitor cases where an equitable lien might be appropriate, and act quickly, and preemptively, to protect their interests.

Mark Your Calendar Again

Shaunda Patterson-Strachan spoke during a securities session at the Association of Life Insurance Counsel's Annual Meeting May 19-22, 2012 in Ponte Vedra, Florida. The Session was titled, "Update on Contingent Annuities in Variable Products; and (2) Developments on the Impact of Litigation on Disclosure Priorities for Variable and Index Products."

Elizabeth Bohn is presenting a teleconference for the National Business Institute on Bankruptcy Exemptions, Discharge and Objections in Dischargeability. The Teleconference is scheduled for June 4, 2012. For more information, visit *www.nbi-sems.com*.

James Sconzo, **Michael Petrie**, and **Jonathan Sterling** will lead the 2012 FMLA Master Class for Connecticut Employers: Overcoming Compliance and Employee Leave Challenges. The program will be held on June 20, 2012 in Hartford, Connecticut.

Seventh Circuit Holds Dependent SSDI Benefits Can be Offset

BY W. GLENN MERTEN

Plan language allowed Social Security benefits to offset those from the plan

The Seventh Circuit Court of Appeals recently considered whether a disability plan insurer could offset Social Security disability benefits received by a dependant child based on a parent's disability from amounts paid to the parent pursuant to a long-term disability plan. In *Schultz v. Aviall, Incorporated Long Term Disability Plan*, two long-term disability plans insured by Prudential each contained similar language providing that benefits would be offset by amounts "you, your spouse and children receive or are entitled to receive as loss of time disability benefits because of your disability under . . . the United States Social Security Act." In dismissing plaintiffs' claims, the district court held that based on the relevant plan language, children's Social Security benefits could be offset.

The Seventh Circuit affirmed, holding that "the only reasonable interpretation of the applicable language is that when a disabled employee's dependent children receive Social Security payments by reason of the parent-employee's disability, those benefits are disability benefits based on the employee's 'loss of time.'" In so holding, **the court rejected plaintiff's argument that dependant benefits are not meant to replace household income, but to provide "additional support" for the child**. The court also noted that "virtually all courts considering" similar language have held that dependent children's Social Security disability benefits could be offset.

Long-Term Care Insurance: Litigation Updates

BY JASON KAIRALLA & CLIFTON GRUHN

Older long-term care insurance policy forms are coming under increasing attack by plaintiffs seeking to bootstrap statutory and regulatory requirements enacted after the policies were originally issued. **In recent cases, plaintiffs have argued that unambiguously-defined policy terms should be deemed amended by statutes or regulations defining the terms more broadly or differently than the policy.** For example, plaintiffs claimed, in recent putative class actions, that subsequently-enacted law indicating that a home or residence is anywhere an individual resides prevented the **policy definition of "home"** from excluding assisted living facilities. In other cases, plaintiffs have asserted that additional coverage under the policy is mandated, or exclusions rendered invalid, based on insurance laws enacted long after the policy's effective date. Plaintiffs have also argued that **ambiguities have been created by policy amendments** or endorsements, added at the behest of regulators, that purportedly conflict with existing policy terms or definitions.

Straining to see ambiguity?

Additionally, Plaintiffs have argued that policy terms have become ambiguous or unlawful based upon changes in the commonly-accepted definitions of words contained in the policies. In one recent case, **a Montana jury returned a verdict of over $34 million** (including $32 million in punitive damages) to a plaintiff suing for coverage under a long-term care policy. One of the central issues was the meaning of **"continual supervision"** in a policy. The insurer argued that "continual" means round-the-clock, while the plaintiff argued, and the court ultimately found, that the term means "repeated often; continuous."

Update of NAIC Separate Account Initiatives

BY ANN BLACK AND JO CICCHETTI

Concerned about the use of **separate accounts to fund products with general account guarantees**, the NAIC continues to examine these products and to consider how these products and the underlying assets should be regulated and treated for insolvency purposes.

As background, the NAIC's examination stemmed from a referral request in June 2009, of the Separate Accounts (E) Subgroup of the Statutory Accounting Principles (E) Working Group (the "Separate Accounts Subgroup"). The Separate Accounts Subgroup had been reviewing AICPA SOP 03-01 – *Accounting & Reporting by Insurance Enterprises of Nontraditional Long-Duration Contracts and Separate Accounts* (which has subsequently been incorporated into Accounting Standards Codification 944-80) to determine if the pronouncement should be adopted for statutory accounting principles. As part of its discussion of the appropriate statutory accounting for separate account contracts, **the subgroup became concerned** that for separate account products, including variable annuities with living benefits, **the general account was not being compensated for the risk associated with the guarantees** contained in these products.

This initial referral request led the Financial Condition (E) Committee to form, in the fall of 2009, the Separate Account Risk Charge (E) Working Group, which is now known as the Separate Account Risk (E) Working Group ("Separate Account Risk WG"). **The Separate Account Risk WG initially focused on the need to develop "new regulatory guidance requiring the establishment of risk charges for the risk assumed by the general account** in support of individual separate account products guaranteed by the general account." As it began to address this issue, the Separate Account Risk WG determined that a broader focus was necessary and decided that it should consider all products funded by a separate account that included general account guarantees.

Beginning in 2010, several other NAIC groups began to study or address other aspects of separate account funded products with general account guarantees, including:

- the Receivership Separate Accounts (E) Working Group (the "Receivership Separate Accounts WG"), which began **studying receivership issues related to separate accounts**, including guaranty fund issues, and it continues to address these issues.
- the Financial Analysis (E) Working Group, which as part of its monitoring efforts, obtained information from state insurance departments concerning non-unit linked products. It conducted a **survey on the non-unit linked products funded by separate accounts**, the insulation of those separate accounts, and the investment restrictions imposed on those separate account assets. The results of that survey were submitted to the Financial Condition (E) Committee on February 9, 2011.
- the Financial Analysis Handbook (E) Working Group was asked to consider whether additional procedures are needed to the Life/A&H Financial Analysis Handbook to address these products and to consider whether to make recommendations to the Blanks Working Group for additional changes to the annual statement blank or instructions. This Working Group adopted enhancements to the Financial Analysis Handbook to address analysis of the information obtained as a result of the new reporting requirements in the separate account general interrogatories and included additional guidance and procedures for separate accounts by expanding the discussion on non-variable products, guarantees, insulated, and non-insulated products.
- the Capital Adequacy (E) Task Force, which was asked to **assess whether any changes were needed to the life risk based capital formula** for these products. At this point, this referral has been added as an agenda item to be addressed by this Task Force in 2012 or later.
- the Life Actuarial (A) Task Force, which was asked to provide guidance with respect to product expertise and to consider nonforfeiture issues related to these products.

This Task Force submitted an initial response memorandum in September 2011 to the Financial Condition (E) Committee.

Currently, two NAIC working groups have actively been considering the issues related to separate account funded products with general account guarantees:

- the Receivership Separate Accounts WG, which is assessing **how these products would be treated in an insolvency**; and
- the Separate Account Risk WG, which was charged to compare U.S. generally accepted accounting principles (GAAP) with statutory accounting requirements for separate accounts to help **discuss what should be allowed as insulated products**.

At the NAIC Spring Meeting on March 3, 2012, the Receivership Separate Account WG recognized that there was a l**ack of uniformity in the states** as to the distribution of separate account assets and **the definition of "insulated."** In addition, the Receivership Separate Account WG discussed the uncertainty of the roles of the states and the U.S. Securities and Exchange Commission (SEC) when an insolvency involves variable products that are registered with the SEC. The National Organization of Life and Health Insurance Guaranty Associations (NOLGHA) stated that it is examining the possibility that separate account assets would not be sufficient to satisfy product guarantees and, if so, whether NOLGHA would continue coverage in those instances. The Receivership Separate Account WG appointed a subgroup to discuss issues related to SEC-registered variable products and acknowledged the need for further discussions on the definition of "insulated" and "non-insulated." No other public meetings have yet been scheduled.

For its part, the Separate Account Risk WG has been holding meetings to discuss its proposals for product characteristics to determine whether insulation should be permitted for separate account funded insurance products with general account guarantees. During its April 30th meeting, the working group learned more about GAAP accounting for separate account arrangements.

The representatives from the AICPA NAIC task force explained that for "separate account arrangements" GAAP requires, in general, a separate presentation of accounting information of those assets for which contract holders have assumed investment risk. They also noted that because the insulation status of a separate account is a legal determination, the accountants do not make any determination as to whether the separate account assets are legally insulated. Instead, accountants look to insulation language in the applicable contracts.

NAIC actively considering the issues related to separate account funded products with general account guarantees.

At the April 30th meeting, **industry reiterated its comments to the Separate Account Risk WG that insulation should not be based upon whether the investment experience was passed through to the contract holder**. Industry also expressed its willingness to further explore limiting insulation to assets contributed by policy or contract holders. At that meeting industry also urged regulators to:

- consider that under the proposed product characteristics numerous beneficial products would no longer be insulated, such as group pension products and individual market value adjusted or modified guaranteed annuities.
- specifically identify the regulatory concerns related to insulation for guaranteed products.

The **Separate Account Risk WG** determined that it **will** hold a regulator-only meeting to **review annual statements and products within separate accounts and to discuss specific regulatory concerns related to insulation for guaranteed products**. It is anticipated that a revised schedule for public calls will be forthcoming. The Working Group noted that interested parties can continue to provide comments to it.

In Colossus Cases, Insurers Bestride Narrow Constructions

BY BERT HELFAND

Computer Sciences Corporation (CSC) licenses a tool called "Colossus" that helps insurers evaluate bodily injury claims. In 2005, over 500 Colossus users were sued, with CSC, in a class action in Arkansas state court, entitled *Hensley v. CSC*. The case ended after the insurers agreed to pay hundreds of millions of dollars to members of the Arkansas and Oklahoma Bars.

In February 2012, exactly none of those insurers was disappointed to learn that CSC had failed to obtain coverage for *Hensley* under its CGL policy, which covered amounts CSC had to pay "for … bodily injury … that … is caused by an event," such as an "accident." The *Hensley* plaintiffs were all injured in accidents; they alleged that CSC and the insurers had conspired to underpay their claims for uninsured/underinsured motorist coverage. CSC argued that the claim sought "damages for … bodily injury."

In *Travelers v. CSC*, a California court rejected that argument and affirmed summary judgment for Travelers. The court cited a California Supreme Court decision holding that **"the word 'accident' in … a liability policy refers to the conduct of the insured for which liability is sought to be imposed …."** Because CSC's conduct had not caused the bodily injuries of the Hensley plaintiffs, the conditions for coverage were not met.

The court observed that CSC confused CGL coverage with errors and omissions coverage. In fact, one of the insurer defendants in *Hensley* obtained coverage under an Insurance Company Professional Liability Policy. In *Chubb v. Grange Mutual Casualty*, the issuer of the policy argued (among other things) that Grange, its insured, had incurred liability by licensing the Colossus product, rather than "while performing Insurance Services." The federal court in Ohio found, however, that the gravamen of *Hensley* was that Grange had improperly used Colossus to underpay claims while discharging its duty as an insurer.

Florida Appeals Court Finds Mediation Statute Does Not Preclude Appraisal Under Property Policy

BY JOHN PITBLADO

Interpreting section 627.7015 of the Florida Statutes, which requires that disputes about first party property insurance claims be subjected to mediation before any other dispute procedure, the Florida Appellate Court reversed a lower court decision that denied State Farm's motion to compel appraisal under a property insurance policy.

In *State Farm Florida Ins. Co. v. Unlimited Restoration*, State Farm's insured suffered water damages to his home, and he contracted with Unlimited Restoration Specialists for repairs. Under the repair contract, the insured assigned the benefits of his State Farm property policy to Unlimited, which estimated repair costs greater than those estimated by State Farm. When State Farm issued a check based on its own estimate, Unlimited refused to cash it.

State Farm notified the insured and Unlimited of the right to statutory mediation, specifically indicating it was not seeking mediation itself. Unlimited invoked statutory mediation, but the parties failed to come to an agreement. State Farm thereafter demanded appraisal per the policy. Unlimited refused and filed suit. State Farm moved to compel appraisal, but the Florida Circuit Court denied the motion, reading the statute as precluding appraisal after an unsuccessful mediation. The decision was affirmed by the Circuit Court's Appellate Division.

On review, the Court of Appeal reversed, finding that the mediation statute did not preclude appraisal. The statute provides that the insurer can waive its right to appraisal after mediation in two circumstances: where it fails to notify the insured of the statutory right to mediation, or where the parties fail to agree after a mediation that the insurer has requested. **Neither circumstance was present** in this case.

Florida Appellate Court Rules Extrinsic Evidence Appropriate to Construe Ambiguous Reinsurance Provision

BY JOHN BLACK

In February 2012, in a dispute under a personal accident reinsurance policy, a Florida Court of Appeals reversed an award of summary judgment, on the ground that the trial court should have considered extrinsic evidence relevant to the construction of the policy.

Court ruling allows submission of additional evidence

Kiln PLC v. Advantage Gen. Ins. Co., LTD, arose out of a reinsurance policy relating to risks under a personal accident policy that Advantage had issued to an airline. After a crash in which two passengers were killed, Advantage paid $600,000 to the passengers' families on behalf of the airline, and it sought reimbursement under its reinsurance policy with Kiln. The reinsurance policy provided coverage of "US$300,000 any one person as original not exceeding 10x annual salary." Kiln contended that this language excluded coverage for unemployed passengers, and it denied coverage.

The trial court found the language ambiguous and construed it against the reinsurer, Kiln. The parties disagreed, however, about which side had drafted the language in the first place. On appeal, the appellate court agreed that the policy was ambiguous, and that "[a]mbiguous policies are often simply construed against the insurer, as the drafter." But it held that **consideration of extrinsic evidence "may be" appropriate to construe an insurance contract, and that such evidence was appropriate here, in light of the unique and highly specialized nature of the insurance at issue**, as well as the existence of a factual dispute about which side chose the language to be construed. The court of appeals remanded the case to allow the parties to submit extrinsic evidence on what, if any, coverage is provided to unemployed passengers.

Minnesota Court (Slightly) Shifts Burden of Proof for Auto Glass Claims

BY JOHN PITBLADO

Where an insurer must pay the "reasonable" cost of a repair or service, providers often argue that the billed amount is presumptively reasonable. Such presumptions can make the difference in whether a claim for underpayment can be maintained as a class action. A recent Minnesota case shows presumptions can arise unexpectedly.

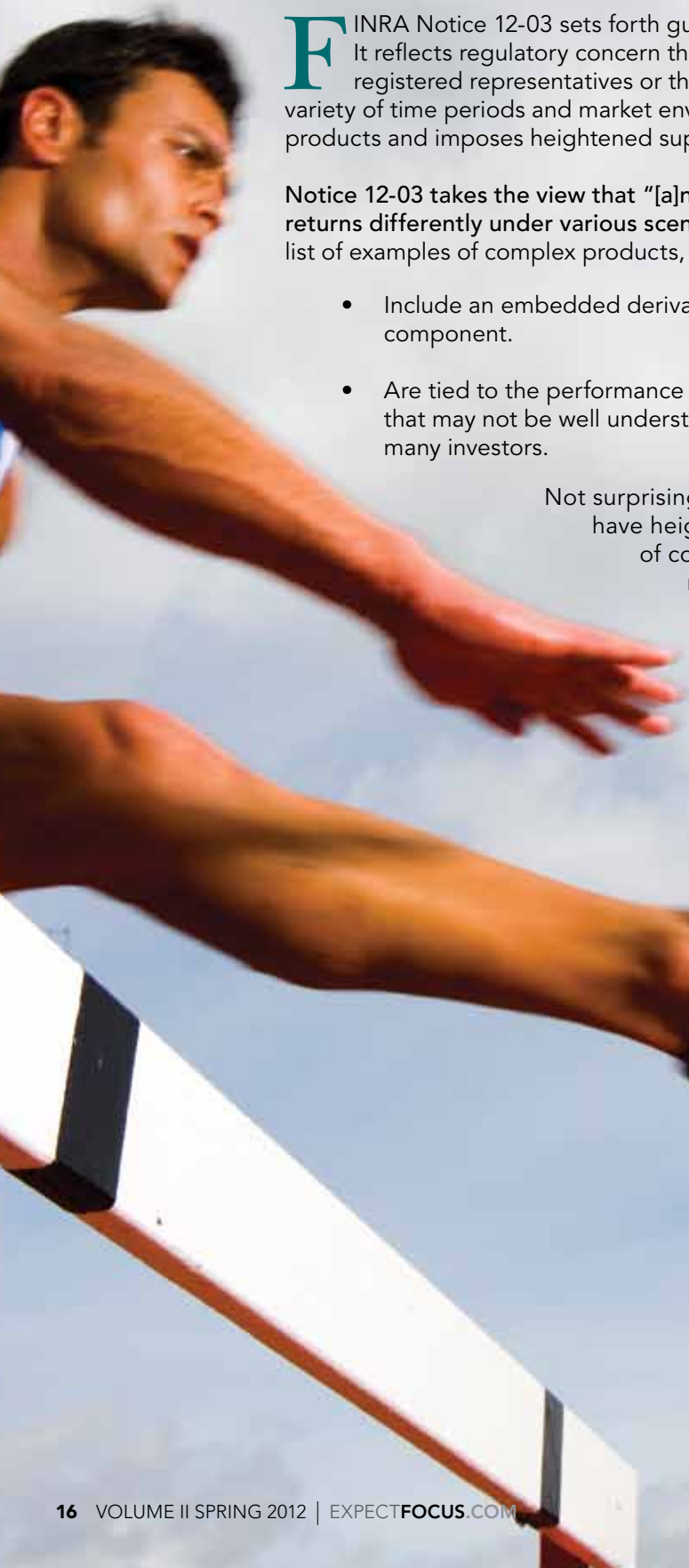
Garlyn, Inc. v. Auto-Owners Ins. was an appeal from consolidated arbitrations of multiple auto glass claims. The policies required Auto-Owners to pay "no more than … the necessary cost, at local prices, to repair or replace … with material of similar kind or quality." The court held this required payment of "a price that is reasonable in the marketplace," and it upheld an award against the insurer.

The record supported this outcome, because the arbitrator had found both that Garlyn had charged a reasonable price, and that Auto-Owners had failed to show it had paid amounts sufficient to obtain "similar kind or quality." But the court also rejected the insurer's argument that paying a "reasonable" amount means paying "any amount in the range of reasonableness[,] even if a higher amount billed is also" in that range.

This ruling suggests an invoiced price could be "reasonable," even if it is more than is "necessary" to obtain "similar kind or quality." Thus, if the plaintiff submits evidence that the billed amount is reasonable, the insurer must do more than show the reasonableness of its own payment; it must also prove the billed amount is unreasonable. Given the language of the policy, this additional burden on the insurer is unwarranted.

BDs Must Jump Higher Hurdles for Complex Products

BY TOM LAUERMAN



FINRA Notice 12-03 sets forth guidance to member firms about products viewed as "complex." It reflects regulatory concern that the intricacy of complex products can "impair the ability of registered representatives or their customers to understand how the product will perform in a variety of time periods and market environments." Notice 12-03 identifies characteristics of complex products and imposes heightened supervision requirements for complex products.

Notice 12-03 takes the view that "[a]ny product with multiple features that affect its investment returns differently under various scenarios is potentially complex." It then includes a non-exhaustive list of examples of complex products, such as products that:

- Include an embedded derivative component.
- Are tied to the performance of markets that may not be well understood by many investors.
- Have principal protection that is conditional or partial.
- Have complicated limits or formulas for the calculation of investors gains.

Not surprisingly, Notice 12-03 expands upon past advice that firms have heightened supervision, including a system for pre-approval of complex products to be available for recommendation by registered representatives. Firms also should consider "procedures to monitor how the products performed after the firm approved them."

Notice 12-03 also includes suggestions for firms' procedures for their registered representatives' recommendations of complex products. FINRA states that registered representatives "should consider whether less complex products could achieve the same objectives for their customers." Firms are also "encouraged" to require that salespersons recommending a complex product have a reasonable basis for believing that the customer has such knowledge and experience in financial matters as to be capable of evaluating the risks. FINRA also notes that "some firms make approval of complex products contingent upon specific limitations or conditions, such as investment concentration limitations or limitations on the type of investors to whom the product may be sold."

The Potential of Rising Standards for Insurance Product Sales Materials

BY TOM LAUERMAN

Litigation always has the *potential* to influence issuers' business considerations, including those relevant to the materials used in connection with sales of their products. A recent ruling in a still-pending case, *Walker v. Life Insurance Company of the Southwest*, raises some flags in this regard.

Looking for too much from illustrations?

In *Walker*, the plaintiffs **alleged that illustrations used in connection with the sale of certain indexed universal life policies contained material misrepresentations and omissions**. In particular, the plaintiffs pointed to alleged failings with respect to the illustrations' depiction of **policy costs, guaranteed rates, and tax consequences** associated with owning the policies. After first allowing the plaintiffs to amend their complaint in an effort to address certain previously identified pleading deficiencies, the U.S. District Court for the Central District of California recently issued an opinion denying the defendant's second effort to dismiss the complaint, finding that the plaintiffs had sufficiently alleged an injury arising out of each of the illustrations' alleged flaws sufficient to support their fraudulent inducement claims.

Importantly, no ultimate merits determination has been made in *Walker* – rather, the district court merely found that the plaintiffs' allegations are now sufficient to withstand a motion seeking early dismissal of the suit. Nevertheless, **the action is worth watching because the plaintiffs' theory of liability seems to conceive of the illustrations as having a disclosure function beyond what regulations currently require**. If plaintiffs were to ultimately prevail, on its face, the case might call for illustrations that are (a) more comprehensive and (b) include more explanatory and cautionary disclosure.

Shareholders Say Misuse of DMF Caused MetLife "Stock Drop"

BY BEN SEESSEL

MetLife and certain of its officers and directors have been sued three times by shareholders regarding the company's alleged failure to use the Social Security Administration's Death Master File to identify deceased policyholders in order to make payments to beneficiaries or to the state under applicable escheatment laws.

All three lawsuits claim that MetLife's disclosure of expanded state regulatory investigations of its alleged failure to use the DMF for this purpose caused the company's stock price to sharply decline. One of these cases, filed in the Southern District of New York, alleges that MetLife violated SEC Rule 10b-5 by issuing statements about the company's financial condition that did not account for "millions of dollars in benefits" that purportedly "should have been paid out to policyholders or escheated to the states." This lawsuit also alleges "control-person" liability against the officer and director defendants.

The second case, filed in New York state court, alleges common law claims of breach of fiduciary duty, gross mismanagement, contribution and indemnification, abuse of control, and corporate waste against certain MetLife directors and officers. This action also contains allegations regarding MetLife's alleged misuse of retained asset accounts. The third case alleges common law breach of fiduciary duty and unjust enrichment claims against MetLife directors and officers. MetLife is only named as a nominal defendant in these state court cases. All three cases are in their infancy and it remains to be seen whether the courts will give any credence to plaintiffs' theory.

Key Investor Protection Position Takes Back Seat at SEC

BY SCOTT SHINE

The Chairman of the SEC has not yet complied with an important Dodd-Frank Act mandate to appoint an "investor advocate." Nor has the SEC set up the related Office of the Investor Advocate (OIA) contemplated by the Act.

The investor advocate will have considerable independence and power to promote investors' interests by proposing legal or regulatory changes and making periodic reports directly to Congress each year concerning such matters as what investor protection problems exist and how quickly the SEC is addressing those problems. Among other things, **the investor advocate will be authorized to employ independent counsel and research staff for the OIA and will have access to all documents of the SEC and FINRA**. Furthermore, the SEC will be required to formally respond within three months to any recommendations (including for changes in SEC rules and orders) that it receives from the investor advocate.

Despite the significance of the investor advocate's functions, the SEC's published timetable for complying with Dodd-Frank does not yet give a target date for setting up the OIA. Reportedly, the delay is largely attributable to lack of adequate funding, which the SEC is seeking to remedy as part of a proposed 18.5% increase in its 2013 budget request. In the meantime, many functions of the OIA are being performed by existing SEC offices.

Tick-Tock! What's taking the SEC so long?

SEC Disclosure Report May Advance VA Summary Prospectus

BY GARY COHEN

The SEC has a July 21 deadline to submit to Congress a report of its study of financial literacy and disclosure improvement mandated by the Dodd-Frank Act. There is speculation that the SEC might use the report to address the VA (variable annuity) summary prospectus as a disclosure improvement. When the author addressed this possibility at last November's ALI-ABA Conference on Life Insurance Company Products, SEC staff neither confirmed nor denied it. The SEC staff did agree that the Dodd-Frank Act language was broad enough to comprehend VA disclosure issues.

While industry groups have lobbied for a VA summary prospectus for years, and the SEC staff has continually responded that the Commission considers it an important priority, the SEC has not announced any timetable. This is, perhaps due in part to knotty issues regarding the processes for updating VA prospectuses and amending VA registration statements to change or add riders.

The SEC recently invited public comment on what it might address in its report. The Committee of Annuity Insurers and The American Council of Life Insurers urged more consise and simplified VA disclosure. Another commenter said that "[i]t should be a high priority of the SEC to require summary prospectuses" for VAs.

Others were not so constructive. Regarding mutual fund prospectuses, a commenter complained that investors "do not have the time or inclination to wade through the legalese and drivel of a [fund] prospectus." Regarding marketing, one wrote that "pornography may actually be easier to recognize than the suitability of a securities transaction." Still another showed little confidence in the SEC Report, asserting that "the SEC and FINRA have demonstrated their own brand of financial illiteracy."

Unauthorized Transactions in Customer Accounts:
Many Faces of Fraud

BY MARILYN SPONZO

Citing examples that range from technologically sophisticated to lowbrow theft, regulators are warning financial firms and investors about prevention and detection of unauthorized transactions in customer accounts.

Fraud can be highly sophisticated and … not so much

FINRA, in Regulatory Notice 12-05 and a related Investor Alert, described email hackers who, after gaining access to an individual's email account, email the individual's brokerage firm instructions to transfer funds from the account to a third party. FINRA reminded brokerage firms of their responsibility to establish supervisory controls addressing transmittals of funds and securities, and recommended that firms reassess their policies and procedures for accepting electronic instructions to move funds. FINRA suggested that such policies and procedures: (1) identify a process for verifying that the email instructions were sent by the customer; (2) identify and require responses to red flags, such as transfer requests that are unusual or designate an unfamiliar third party account as the recipient; and (3) include testing and employee training.

The SEC Office of Compliance Inspections and Examinations (OCIR) recently published a risk alert on preventing and detecting unauthorized trading by broker-dealer and investment advisory personnel. OCIE recommended: (1) independent and mutually reinforcing control functions, such as audit, legal, compliance and risk management; (2) effective business line supervision; (3) exercising caution in offering trading positions to personnel with awareness of idiosyncratic procedural weaknesses that could hide unauthorized activity; (4) mandatory vacations without remote access to trading accounts for traders and related personnel; and (5) consolidating automated processing and recordkeeping systems.

Additionally, t**he SEC and CFTC have jointly proposed rules (as mandated by Dodd-Frank) requiring their regulated entities to adopt "red flag" programs to combat identity theft** with respect to certain kinds of customer accounts. The comment period for this proposal closed May 7.

Court Rebuffs Schwab's Challenge to FINRA on Class Arbitration Ban

BY SHEILA CARPENTER

FINRA brought a disciplinary proceeding against Charles Schwab in February 2012, alleging that Schwab violated FINRA rules by amending its standard customer agreement to (a) prevent customers from bringing claims against Schwab on a class or representative basis and (b) prohibit arbitrators from consolidating similar cases. Schwab struck back in federal court in San Francisco, seeking an injunction against the FINRA proceeding and a declaration that FINRA's legal position conflicted with recent Supreme Court decisions interpreting the Federal Arbitration Act. **As in past years, the Supreme Court this term has stressed the primacy of the FAA, absent clear Congressional indications that the FAA is to yield to other authority.**

The Supreme Court has consistently stressed the primacy of the FAA.

FINRA moved to dismiss Schwab's lawsuit, arguing that Schwab failed to exhaust its administrative remedies: i.e., FINRA's five-step administrative process that culminates in the right to appeal to a federal court of appeals. In a May 11, 2012 opinion, Magistrate Judge Elizabeth Laporte agreed with FINRA and dismissed Schwab's Complaint without leave to appeal. Judge Laporte found that the opportunity for circuit court review protects Schwab's rights.

Third Circuit Sinks (b)(2) Class for Lack of Standing

BY MICHAEL WOLGIN

The Third Circuit Court of Appeals affirmed the denial of certification of a Rule 23(b)(2) injunctive relief class for the named plaintiffs' lack of Article III standing. In *McNair v. Synapse Group Inc.*, former magazine subscribers alleged that the marketing company through which they initially subscribed, fraudulently induced them to renew their subscriptions through misleading mailings that masked automatic renewals. After failing to certify classes under Rules 23(b)(2) and (b)(3), the plaintiffs attempted to certify only a (b)(2) injunctive relief class of individuals who received allegedly misleading mailings. The district court denied certification because it found the class lacked the cohesion required under 23(b)(2).

No standing where threat of harm is "pure speculation"

The Third Circuit affirmed, not for lack of cohesion, but for **lack of Article III standing, explaining that plaintiffs were no longer customers of the marketing company, and thus were "not currently subject to [the company's] allegedly deceptive techniques for obtaining subscription renewals."** The court rejected as "pure speculation" and "wholly conjectural" plaintiffs' argument that they were "subject to a sufficiently real and immediate threat of future harm" because the company "is the leading marketer of magazine subscriptions and bombards the public with its offers; because it offers compelling deals in which it does not clearly identify itself; and because it sends customers advance notifications that are, by design, meant to fool consumers into discarding the notification received." The court also found that the alleged harm was not "capable of repetition yet evading review" because: first, plaintiffs could not sufficiently demonstrate that they would suffer the same harm again, and second, that a prospective class representative would satisfy Article III standing simply by maintaining the subscription until the class certification motion was filed.

Fifth Circuit Applies *Dukes* "Commonality" and "Cohesiveness" Rulings

BY JASON KAIRALLA

In a post-*Wal-Mart v. Dukes* development, the Fifth Circuit Court of Appeals recently weighed in on how lower courts should apply the Supreme Court's clarified standard in *Dukes* for commonality under Rule 23(a)(2) and for injunctive relief under Rule 23(b)(2). In *M.D. v. Perry*, plaintiffs challenged the Texas long-term foster care program in a class action, alleging that the state's mismanagement of the program caused an assortment of problems for thousands of children under its care. The trial court acknowledged that different children are necessarily treated differently by the system, but certified the class anyway, accepting that commonality was satisfied if the plaintiffs' proffered common questions (relating to the legality of the foster-care regime as a whole) could be applied to all class members, even though the questions yielded different answers depending on the members' circumstances.

The Fifth Circuit did not agree. Applying the reasoning in *Dukes*, it found that **the commonality prerequisite could not be satisfied where the alleged "common issues" were too general to result in common answers that would serve to advance the litigation**. Also applying *Dukes*, the appellate court found that, because the injunctive relief sought was to be "individualized" depending on the circumstances of each class member, the proposed class lacked the "cohesiveness to proceed as a 23(b)(2) [injunctive-relief] class." The court vacated the certification and remanded the case for further proceedings.

11th Circuit Rules Bank Customers Must Arbitrate Class Action Overdraft Claims

BY ELIZABETH BOHN

The 11th Circuit Court recently ruled in *Buffington v. SunTrust Banks* (*In Re Checking Account Overdraft MDL*) that SunTrust Bank account holders must arbitrate claims against it for excessive overdraft fees. Reversing the district court's order denying the bank's motion to compel arbitration, the 11th Circuit found that a clause in the depositor agreements requiring arbitration of all claims relating to the accounts was neither procedurally nor substantively unconscionable.

Nationwide class claims of consumers against numerous banks alleging improper overdraft fee practices are part of the multidistrict Checking Account Overdraft Litigation proceeding in the Southern District of Florida. The Plaintiff's class action complaint in *Buffington* was typical of such claims, and alleged that SunTrust breached its contract, converted funds, acted unconscionably, and was unjustly enriched by assessing overdraft fees improperly on their accounts by processing the transactions deceptively to maximize overdraft fees and assessing overdraft fees when accounts contained sufficient funds to pay charges.

SunTrust sought arbitration under a clause in its depositor agreement requiring arbitration of all disputes relating to the account. The district court initially denied SunTrust's motion, finding the arbitration clause was substantively unconscionable under Georgia state law because it contained a class action waiver. **The 11th Circuit remanded SunTrust's appeal to the district court in light of the Supreme Court's decision in *AT&T Mobility LLC v. Concepcion*, which held that the Federal Arbitration Act (FAA) preempted a California state rule relating to the unconscionability of class arbitration waivers in the contracts.**

The district court then denied SunTrust's renewed motion to compel arbitration, finding this time that the arbitration clause was substantively unconscionable because its provisions granting SunTrust the right to recover its arbitration expenses disproportionately allocated the risks of loss in the dispute to the Plaintiffs. In its reversal of that decision, the 11th Circuit held that the arbitration clause was neither procedurally nor substantively unconscionable, and that the bank was entitled to arbitration "in the manner provided for in [its deposit] agreement," under the FAA.

Seventh Circuit Affirms "Clear Trend" Against RESPA Section 8 Class Actions

LARA O'DONNELL GRILLO

Perhaps signaling an increased unwillingness of courts to certify putative class actions premised on alleged violations of Section 8 of the Real Estate Settlement Procedures Act (RESPA), the Seventh Circuit Court of Appeals affirmed the district court's denial of class certification where plaintiffs alleged a title insurer made illegal kickbacks to real estate attorney title agents in violation of both RESPA (12 U.S.C. § 2607) and the Illinois Consumer Fraud Act. In *Howland v. First American Title Insurance Company*, the court found that class actions pursuant to Section 8, premised on unreasonably high compensation for services actually performed, are rare and inherently unsuitable for class action treatment, explaining that the claim in such cases is that the amount paid exceeds the value of the services performed or the goods provided, such that the additional amount is intended to compensate for the referral itself. **The existence or the amount of the kickback, therefore, generally requires an individual analysis of each alleged kickback to compare the services performed with the payment made.** The court further found that the plaintiffs could not establish the sole recognized exception to the unsuitability of RESPA Section 8 claims for class treatment, namely, that the insurance company split fees with attorney agents who performed no services on a class-wide basis.

Is the wind blowing against RESPA classes?

ARBITRATION ROUNDUP

BY LANDON CLAYMAN

Since the Supreme Court's 2010 Stolt-Nielsen decision, some have argued that unless the words "class arbitration" are written into the arbitration agreement, the agreement is "silent" on that question and class arbitration is unauthorized. The Third Circuit Court of Appeals rejected such a reading of *Stolt-Nielsen* in *Sutter v. Oxford Health Plans LLC*, upholding an arbitrator's decision that a broadly worded arbitration agreement authorized class arbitration although the agreement did not expressly address the issue. In Sutter, the arbitration agreement provided that "No civil action concerning any dispute" arising under the parties' contract would "be instituted before any court," and that "all such disputes shall be submitted to final and binding arbitration." The arbitrator concluded that the first phrase embraced all conceivable civil actions, including class actions. Because the second phrase required "all such disputes" to be arbitrated, the arbitrator concluded that the arbitration agreement authorized class arbitrations.

In rejecting the proposition that *Stolt-Nielsen* established a "bright line rule" that class arbitrations are unauthorized unless the arbitration agreement "incants" the term "class arbitration" or "expressly provides" for aggregate procedures, the Third Circuit interpreted *Stolt-Nielsen* to mean that under the FAA a party may not be compelled to arbitrate classwide unless there is a "contractual basis" for concluding that is what the party agreed to do. Thus, even after *Stolt-Nielsen*, contractual "silence" may not prevent a finding that the parties agreed to class arbitration. Parties should ensure that their intent concerning class arbitration is accurately expressed in their arbitration agreements.

FTC Sets Forth Consumer Privacy Best Practices in Final Report

BY MICHAEL KENTOFF

FTC seeks to protect private consumer data

Placing its focus squarely on companies engaged in online commercial marketing and sales, the FTC issued its final report on March 26, 2012 concerning best practices for businesses that collect and use consumer data. The report, "Protecting Consumer Privacy in an Era of Rapid Change: Recommendations For Businesses and Policymakers," also recommends that Congress consider enacting legislation addressing general privacy, data security, data brokerage, and breach notification issues.

The Commission's final report represents a significant revision to a preliminary staff report issued in December 2010. Most of the revisions are derived from the over 450 comments received in response to the preliminary report as well as the many technological and industry developments that took place over that period. In the final report, the FTC urges companies to implement a consumer data privacy protection strategy embracing three primary concepts:

- **Privacy by Design**: "build[ing] in consumers' privacy protections" at each stage of product development;
- **Simplified Choice for Businesses and Consumers**: providing consumers the capacity to make decisions about if, how, and with whom their data is shared; and
- **Greater Transparency**: calling upon companies to disclose data collection and use information to consumers.

With the final report's roll-out, FTC Chairman Jon Liebowitz noted that many companies have already started incorporating the report's core concepts and that, while the Commission believes legislation is crucial, further self-regulatory measures should continue to move forward. The FTC also indicated that, over the course of 2012, it will emphasize to businesses five primary areas of action: (1) developing and implementing an "easy-to-use, persistent, and effective" Do-Not-Track mechanism, (2) improving privacy protections and disclosures on mobile devices, (3) enhancing transparency and disclosure of data broker operations, (4) addressing heightened concerns associated with large platform providers, such as internet service providers, and (5) advancing industry-specific codes of conduct.

Employers Feel Backlash For Facebook Snooping

BY MICHAEL PETRIE

Social media websites, especially Facebook.com, are growing in popularity as a source of information for employers trying to learn about potential new hires. Generally, it is acceptable for an employer to view information on Facebook that a user makes available to the public but other more covert or aggressive tactics have attracted attention. For instance, sending an applicant a "friend" invite under false pretenses when the real objective is to investigate that person has been criticized as an invasion of privacy. More recently, there have been reports that some employers have simply demanded that applicants provide their Facebook user name and password as a condition of being considered for employment. Now: the backlash.

Private information must stay private

In March, Facebook publicly denounced that practice, stating that it violated Facebook's terms of service and the privacy rights of its account holders. Facebook even threatened legal action against employers over these practices. In addition, on April 27, 2012, House Democrats introduced the Social Networking Online Protection Act, which would ban employers from demanding a username or password to a social networking account. The proposed law includes a $10,000 civil penalty for violations. As of early May, a similar Senate bill was still being drafted.

Setting aside the bluster of Facebook and Congress, the bigger concern for employers is (or should be) potential exposure to discrimination claims brought by rejected applicants. **By examining private Facebook information, hiring managers may unwittingly learn about a candidate's disability, age, or other protected-class status.** It is unlawful to make such inquiries during the application process. Looking at such information opens the door for applicants to claim that their protected-class status was a motivating factor for an adverse employment decision. Since the law in this area is rapidly evolving, consider consulting with legal counsel before instituting a policy that uses social media to learn about applicants.

Financial Institutions and the White House Consumer Privacy Bill of Rights

BY DIANE DUHAIME & JASON MORRIS

On February 23, 2012, the White House released a 62-page comprehensive report titled "Consumer Data Privacy In a Networked World: A Framework For Protecting Privacy and Promoting Innovation In The Global Digital Economy." Appendix A to the report contains "The Consumer Privacy Bill of Rights."

The Consumer Privacy Bill of Rights sets forth seven elements: Individual Control, Transparency, Respect for Context, Security, Access and Accuracy, Focused Collection, and Accountability. In his cover letter to the report, President Obama calls on "companies to begin immediately working with privacy advocates, consumer protection enforcement agencies, and others to implement these principles in enforceable codes of conduct" and notes that his "Administration will work to advance these principles and work with Congress to put them into law." Until such time as the Consumer Privacy Bill of Rights is enacted into law, no company is legally obligated to comply with them. However, **the Administration intends that "even without legislation," it will work to ensure that the Consumer Privacy Bill of Rights will be used as a template for codes of conduct that are enforceable by the Federal Trade Commission**.

In the past several years, a good deal of consumer privacy and data security legislation has been introduced in Congress. While Congress has struggled to sustain solid support for any of the proposed legislation to date, many financial services companies look forward to the passage of federal law that would be practically compatible with the data privacy laws of many foreign countries and eliminate the discrepancies among the consumer privacy and data security laws of the individual states.

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