The INSURANCE RECEIVER

Promoting professionalism and ethics in the administration of insurance receiverships.

Volume 8, Number 3 **Fall 1999**

President's Message

By Robert Craig, Lamson, Dugan, & Murray

Mark your calendars to attend the Year 2000 IAIR/NAIC Insolvency Workshop scheduled for January 20th and 21st in Tucson, Arizona. This year's program, Managed Care: A Different Millennium Bug, will focus on health care insolvencies with a faculty made up of representative experts in the many facets of the health care system in addition to IAIR members and others who have already had to work in the area.

Robert Craig

Those who were able to attend the Atlanta Roundtable were treated to what has been called the best Roundtable ever. Something that's becoming a habit. The topic: health care insolvency. Our thanks to Hank Sivley of Atlanta, his staff and panel members for a job very well done. The panelists each developed a paper for this program, which Hank bound into booklets for those attending. Rumor has it he has extras if you would like one. You can write him at MC Consulting, 11260 Old Roswell Rd., Alpharetta, Ga. 30004 or e-mail him at sivley@mccon.com.

Because of the ABA insolvency program being held in conjunction with the NAIC's December meeting in San Francisco, there will be no IAIR Roundtable. Members are urged to attend the ABA program, *Insurer Insolvency Revisited: 1999*, on Friday and Saturday, December 3rd and 4th. Be sure to request the IAIR discount when you register.

Also, the IAIR annual meeting will be held in conjunction with the Insolvency Workshop in January. It will be immediately following the Thursday, January 20th afternoon session. The exact time and place will be advised.

Finally, not all IAIR members are aware of the commitment many of our members and their organizations have made to help IAIR prosper and grow, both in terms of time and resources. Although the number of such volunteers is too large to list, I am taking this opportunity to thank Dale Stephenson, Kevin Harris and the National Conference of Insurance Guaranty Funds for their "over the top" support. From serving on the board and IAIR committees to providing meeting space, co-sponsoring events and anything else IAIR has needed, Dale and Kevin and the NCIGF have been out in front and willing to help. My personal thanks and, I'm sure, that of our members, goes out to them.

Get involved.

A SPECIAL THANK YOU

We would like to thank those companies that served as Patron Sponsors of our quarterly reception held in Atlanta during the NAIC Meetings:

Baker & Daniels
Bingham Dana LLP
Cross River International Inc.
Devito Consulting, Inc.
FitzGibbons, Tharp & Assoc.
Mealey Publications, Inc.
Morrison & Hecker, L.L.P.
Ormond Ins. & Reinsurance Mgmt. Services
Peterson & Ross
Scruggs Consulting
Taylor-Walker & Associates

If you would like to join this select group, contact the IAIR Office.

The Insurance Receiver
Volume 8, Number 3
Fall 1999

In this Issue

Features

Page 7-9 and 12-13: Rehabilitation of Managed Care Organizations

Page 18 - 19: The Guaranty Association System: Ready For Y2K

Page 20 - 23: One Insolvency's Experience with Arbitration

Departments

Pages 3 - 4 & 17: Atlanta Meeting Recap

Page 4: IAIR Roundtable Schedule

Page 5 & 23: Other News & Notes

Page 6: IAIR Association Information

Pages 10 - 11: Meet Your Colleagues

Pages 14 - 16: Receivers' Achievement Report

ABA/IAIR

Insurer Insolvency Revisited: 1999

December 3 - 4, 1999
In San Francisco

A comprehensive survey and analysis of the law impacting insurer insolvency.

For information, contact:
Debra Dotson (312) 988-5708 or
debradotson@staff.abanet.org

Atlanta Meeting Recap

By Mary Cannon Veed

I'm not sure what it means, exactly, but I came home from Atlanta with more "stuff" in my briefcase than I can ever remember doing. I do not know if the NAIC is making progress toward its objectives, but it sure is eliminating trees at a breathtaking pace.

Some of them died honorably in support of Hank Sivley, who organized what was probably the single most interesting roundtable I have ever attended. Every speaker was new blood, and every one was provocative and expert. To top it off, we received nifty booklets full of written materials, much of which is distinctly usable.

The only thing that wasn't crystal clear, oddly enough, was what all of this has to do with insurance liquidation. Intuitively, it seems obvious that the insolvency of entities which, in exchange for a fixed sum of money, undertake either to pay for or directly provide whatever medical services prove to be necessary over a defined period of time to a defined population is acting like an insurer, whether we call it a provider organization, an MCO, an HMO, a health insurer, an ERISA Welfare Benefit Plan, or invent a whole new name. Many of our speakers, and the others who have recently joined us, have developed their expertise in forums quite different from the state court, insurance-commissioner-controlled liquidations we are used to. Yet several thoughts occurred to me:

1. The skill sets and decision matrices which they were demonstrating would be directly transferrable to the insolvency of a health insurer or insurance-regulated HMO;
2. Some of the entities which were being dealt with in non-insurance receivership proceedings could properly have been the subject of insurance liquidation — and might very well have been handled there more effectively; and
3. Some of the logistical and legal issues with which our speakers were currently struggling are already familiar ground to veterans of other types of liquidation. The precedents established in insurance liquidations, and the techniques employed, can often be transferred to other forums, if other forums are appropriate, without great loss of precedential or teaching value.

For instance, Bob Loiseau gave a very interesting talk about "insolvency issues facing ERISA benefit plans." Most of the examples he used were in the context of federal court receiverships, because that was where the Department of Labor brought them. The process is not without drawbacks, however. Welfare Benefit Plans under ERISA apparently can't go to bankruptcy court. DOL has established the precedent that it is entitled to seek receivership for such plans when its fiduciaries are misbehaving, and the impression persists that it would have similar authority over a plan which was just plain broke. The trouble is that federal receivership law is about as well defined as the state receivership law which is considered the backdrop to our usual work — i.e. not at all. There is no automatic stay; there is no preference period; there is no claims bar date, no standards for approval of a rehabilitation plan, no policyholder priority. DOL's authority is based on ERISA provisions entitling it to seek remedies for malfeasance by fiduciaries. The mere fact that a plan had more liabilities than assets does not necessarily mean that the fiduciaries have misbehaved. Even when they do, somebody has to make at least a *prima facie* case before a receiver can take over. In the meantime, perishable assets get away, and beneficiaries fret and fume.

I have the sense that most states have statutory authority to liquidate any entity which assumes health risk. Illinois, for instance, defines an HMO as "any organization formed...to provide or arrange for ...health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers," and subjects HMO's, as defined, to its liquidation code. That would appear to include most ERISA plans, unless something in ERISA preempts the field. Federal statute does not specifically address the insolvency of ERISA plans, but it does affirm the authority of state insurance regulations. It seems likely that state jurisdiction in this area is broader than we usually think, and should probably be used more often than it is. It shouldn't be necessary to claim fiduciary misconduct to wind up an insolvent welfare plan.

Whatever the answer to that question is, the roundtable demonstrated that anyone dealing with financially troubled health care entities will be working with a web of interconnected and interdependent concerns. In particular, as Dr. Mihale showed us in a terrifically entertaining presentation, the actual providers (what he called the "doc's") are a critical piece of the puzzle. Hal Horwich, Jean Johnson, Lew Hassett and Michael Warren each added worthwhile components to the mix. What a tremendous demonstration of the importance of IAIR!

Here's a spooky set of statistics that awaited me on my return: The collapse of just two provider organizations in California last year left over $100 million in outstanding unpaid bills to be absorbed by physicians and hospitals. Of 13 providers licensed by the State of California to assume full financial risk of health care contracts, one is considered fiscally sound, four are frankly insolvent, and one is on monthly watch. The rest are considered too new to have a track record. The press release from the California Medical Association (which had an obvious axe to grind) reported that a "major health plan representative," not further identified, stated that 80% of the provider groups they dealt with were in serious financial trouble. An even less well identified source said 90%. The CMA blames the problem on inadequate capitation rates (which is the aforementioned axe), but whatever the cause,

(Continued on page 4)

IAIR Roundtable Schedule

NAIC Meeting - March 11-15, 2000
Chicago, Illinois
IAIR Roundtable
March 11, 1:00 - 4:00 p.m.

NAIC Meeting - June 10-14, 2000
Orlando, Florida
IAIR Roundtable
June 10, 1:00 - 4:00 p.m.

NAIC Meeting - September 9-13, 2000
Dallas, Texas
IAIR Roundtable
September 9, 1:00 - 4:00 p.m.

The INSURANCE RECEIVER

is intended to provide readers with information on and provide a forum for opinion and discussion of insurance insolvency topics. The views expressed by the authors in *The Insurance Receiver* are their own and not necessarily those of the IAIR Board, Publications Committee or IAIR Executive Director. No article or other feature should be considered as legal advice.

The Insurance Receiver is published quarterly by the International Association of Insurance Receivers, 174 Grace Boulevard, Altamonte Springs, FL 32714, (312) 961-4199, Fax: (773) 395-8786, Email: IAIRHQ@aol.com.

Paula Keyes, CPCU, ARe, CPIW, Executive Director; Nina Mack, Office Manager; Gregg Burga, Administrative Coordinator.

Editorial Board: James Stinson, Publications Committee Chair; Ellen Fickinger,Tom Clark, Mary Cannon Veed, Michael Cass, Joseph DeVito, Charles Richardson, Trish Getty and Paula Young.

Officers: Robert Craig - President; Elizabeth Lovette - 1st Vice President; James Stinson - 2nd Vice President; Dale Stephenson, CPA - Treasurer; James Gordon,CIR - Secretary.

Directors: Richard Darling, CIR; Philip Singer, CIR; Lennard Stillman, CIR; Michael Surguine; Steve Durish; Charles Richardson; Ellen Robinson; Robert Greer, CIR; Michael Marchman, CIR & Paula Keyes,CPCU, ARe, CPIW.

Legal Counsel: William Latza and Martin Minkowitz of Stroock Stroock & Laven LLP.

Accountant: Stephen Phillips, CPA, FLMI, AIR of Cunningham, Porter & Phillips

Copyright © 1999 by the International Association of Insurance Receivers.

ATLANTA MEETING RECAP

(Continued from Page 3)

consider the consequences to a managed care organization which paid capitation, and set its own rates, based on the assumption that a provider organization could and would perform as agreed — and they just can't. Or consider what a bankruptcy stay for a provider in financial distress could do to a rehabilitation plan which contemplated reassignment of patients to new carriers (alienating a patient block which is arguably an asset of the provider bankruptcy), combined with enforcement of hold harmless clauses to prevent recovery of unpaid bills from enrollees. The moral: even if we could miraculously cure our jurisdictional headaches, resolution of the affairs of a managed care system in crisis will demand a multi-jurisdiction, multi-disciplinary approach more sophisticated than any we have yet applied.

The bulge in my briefcase actually came from the number of non-HMO items I brought home to think about at leisure. New ideas, and new takes on old ones, appear to have been widespread in Atlanta, not only among liquidators but in pockets all over the meeting. Here is a sampling of what looked interesting to me:

- The UDS group, usually prime nap territory (with apologies to Dick Darling) heard a proposal to promulgate uniform accounting and reporting standards for receiverships. This one is still producing sounds of snoring, as well as what looks suspiciously like passive resistance, and it's a shame. There are undoubtedly things wrong with what I tend to think of as "Doug Hartz's rules," but the concept is irresistible and would distinctly improve the public and industry opinion of our specialty. What's with the deafening silence here?
- GF Issues considered a topic that somewhat exceeds its jurisdiction: suppose one of those diversified financial entities contemplated by S. 900 fails, who liquidates it? Is policyholder priority in its assets (a/k/a priority for subrogation claims of GF's) preserved?
- The same group happily punted the question of HMO failure, and specifically whether they need GA's, to the new "Ad Hoc" umbrella group. That is a sensible attempt to take some sort of unified look at HMO performance, regulation, and solvency protection. There seems to be a developing consensus that HMO's do not have the financial depth or numbers to support a GA system. Is that the end of the question? It better not be. How did we get ourselves in a spot where a whole line of business is so grossly undercapitalized that, when one of its number fails, the only option is to transfer its business to another, equally flimsy, and leave hundreds of millions of dollars of unpaid bills laying around? Granted the victims of the default are usually the "docs", not the patients, it's still an unacceptable solution. The docs are not only unwilling to be risk-bearers, (never mind what they signed) they are unregulated when they do so, and (which is the point of the California report) financially unable to hold up their end of the bargain. Tolerating inadequate capitalization of risk-bearers not only exposes us to insolvency of the insufficiently capitalized; it also drives down prices of health protection to a level below its cost, and threatens the stability of both providers and garden variety health insurers who compete in the same market.
- The Uniform Receivership Law Working Group met. That's about all I can say about it. I attended the whole meeting, but failed to discern where it is going or why. In default of any more active direction, discussion was dominated by assertions that the URL was an assault on insurance department prerogatives and flexibility, which bordered on fatuous. Apparently the idea is that, by clearly setting out the rights of interested parties to a degree of participation in the insolvency process, the URL deprives liquidators of the right to behave as though those people had no standing. The last liquidator I know of who attempted to defend that idea ended up convincing his court, contrary-wise, that policyholders were entitled to bankruptcy-court-style participation which permitted

(Continued on page 17)

Other News & Notes

By Charles Richardson

The Power of Three is At It Again

Last issue, I mentioned three potentially cataclysmic forces that were then hitting the insurance marketplace all at once — the tornadoes that tore through Oklahoma and Kansas on May 3, the U.S. Senate's passage of financial modernization legislation, and the suit filed by California regulators against the French investors which took over Executive Life in the early 1990s.

Well, the power of three is at it again. As I sit at my computer writing this column, three more issues rise to the top of my brain as being particularly significant for the insurance industry, generally, and the insurance insolvency field, specifically.

- The capture on September 4 by federal law enforcement of fugitive money manager Martin Frankel after a 4-month pursuit
- Renewed Y2K worries and a flurry of Y2K exterminator activity
- The vote by the American Bar Association at its Annual Meeting in Atlanta to tube for the time being any movement toward multi-disciplinary practice rules

Frankel Frenzy

Few events have so dominated the financial and popular press as the disappearance in early May of 44-year old insurance financier Martin Frankel, leaving behind eight victimized life insurance companies. While receivers in Arkansas, Mississippi, Missouri, Oklahoma, Tennessee, and Virginia, along with NOLHGA and its guaranty association members around the country, were busy cleaning up the mess, the federal government was in hot pursuit of Frankel in Europe for four months as the U.S. press monitored every report of Frankel sightings. The chase ended on September 4 with Frankel's capture at the plush Hotel Prem in Hamburg, Germany. To the end, Frankel appears to have indulged his expensive tastes.

Thus begins the process of getting Frankel back to the United States to face what are sure to be massive criminal and civil charges. The collective chant by receivers, guaranty associations and the press when Frankel reaches our shores will be: Show Me The Money!

"Y2K Exterminators To The Rescue"

That's the headline in the September issue of the ABA Journal. The article begins by ticking off the pagan hordes of lawyers poised to exploit the worst kept secret predictable tragedy in history — (1) "law firm Y2K teams, ready to race in with expertise in contracts, warranties, insurance and all manner of commercial law," (2) "plaintiffs lawyers, ready to bring class actions, they've even tried out a few before the plane crash," and (3) lawyers "offering alternative dispute resolution is handing out parachutes to as many passengers on as many planes as possible."

Those are the groups waiting to rescue us from what they believe are going to be near certain Y2K failures of massive proportions. But are they right? How likely is it that there will be failures on any kind of grand scale? And how successfully have U.S. and foreign businesses, governments, utilities, educational and charitable organizations, and John Q. Public — not to mention insurance insolvency receivers and guaranty associations — inoculated themselves from the Y2K bug? That is a subject about which I wrote a year ago as several state legislatures and Congress were considering legislation to protect governments and businesses from various layers of Y2K liability. Much of the legislation passed, including a compromise piece of federal legislation that limits punitive damages, gives federal courts jurisdiction over major class action lawsuits, and allows businesses a 90-day fix period.

But when it gets down to it, businesses — including insurance companies — continue to say they may not yet be Y2K compliant and refuse to minimize the potential size of their Y2K problem, even as we turn the fourth quarter corner and head toward New Year's Day 2000. To some extent, that means that we have collectively failed, for there were many computer authorities and business/government leaders that had hoped we could breathe a sigh of relief by no later than September 9, 1999, the first anticipated failure date. Not so. Moreover, the status of Y2K remediation abroad remains a big issue. The State Department released Y2K assessments in mid-September on 200 countries around the world, some not in very good shape. Obviously that was done to warn U.S. travelers of the risks they face as January 1 approaches.

In short, you receivers, guaranty associations and others in the insolvency system need to have my summer 1998 article on the bedside table as you retire on New Year's Eve. When you wake up, you may well find yourself responsible for companies with locked-up computers, policyholders unable to receive their benefits, and a financial situation that is neither black nor white, but a fine shade of paralyzed gray.

Attorney-Accountant Mating Dance

Earlier this year, a special commission of the American Bar Association recommended a broad multi-disciplinary policy permitting law and accounting practices to join together under legal ethical guidelines, including keeping clients' secrets and avoiding conflicts of interest. It was the first major push toward an accommodation with an accounting profession eager to pitch its entrepreneurial tent in the middle of the practice of law.

(Continued on page 23)

Thinking about applying for the CIR designation? Now is the time!

By Liz Lovette

At the request of the Accreditation and Ethics Committee (A&E), the IAIR Board of Directors recently approved sweeping revisions to the CIR designation standards. While the revisions expand the population of persons able to qualify for the designation, the "overall goal of these standards [is] that the designation only be awarded to those candidates that currently possess the entire spectrum of skills required to manage an entire receivership operation." While the following summation highlights the major changes to the CIR standards, please be aware that the newly revised CIR standards as well as the Application for Certified Insurance Receiver and accompanying Statement of Qualifications can be viewed in their entirety on IAIR's website at www.IAIR.org.

The CIR standards no longer require that an applicant have "overall control and management responsibility on a day to day basis of all facets and parts. . . ." of a receivership. Instead, the revised standards allow senior level personnel or others that have gained the requisite experience to qualify for CIR. Applicants are required to submit evidence of experience in the areas of management, reinsurance, claims, guaranty funds, legal, accounting/financial reporting, and asset management.

The standards now provide that relevant experience may, but does not have to be, obtained from working on receiverships. For example, experience gained in the insurance industry may be appropriately transferable in satisfying the experience requirements.

Size requirements of a receivership have been omitted. The standards no longer require that an applicant have managed a receivership estate with $25 Million in assets and 5,000 policyholder, policy claimant, or creditor claims. Similarly, reinsurance no longer is required to be a material determinant of net assets of the receivership.

The standards no longer require that an applicant have been involved with a receivership in the twelve months immediately prior to the date of application. The revised application expressly provides, however, that timeliness of experience will be a consideration in reviewing an application.

The CIR applicant now must satisfactorily complete a personal interview with representatives of the Accreditation and Ethics Committee. Such interview will assist in determining whether the applicant meets the various experience requirements as set forth in the standards.

A listing of approved Continuing Education courses are now attached to the application form to assist the applicant in determining if the CE requirements are satisfied.

On a final note, only minor revisions have been made to the AIR standards mainly to make such standards consistent, where appropriate, with the CIR standards. The A&E Committee intends to focus on a comprehensive review of the AIR standards with recommendations to the IAIR Board. Should you have questions or desire additional information, please do not hesitate to contact a member of the A&E Committee (Bob Craig; George Gutfreund; Kevin Harris; Bob Loiseau; Liz Lovette; Linda Spann; Len Stillman; Tom Wrigley).

IAIR's 2000 Educational Events

IAIR/NAIC
Insolvency Workshop
Managed Care:
A Different Millennium Bug
January 20-21, 2000
Tucson, Arizona
For a brochure, fax a request to NAIC at 816-889-6840.

IAIR/NCIGF/NOLHGA
Joint Meeting
November 16-17, 2000
La Maisonette
San Antonio, Texas

For more information about IAIR's educational programs, visit our website at www.iair.org

Certification Presented

Pictured above are Bob Craig, President, presenting a designation plaque to Christopher M. Maisel, CIR - P&C.

Certifications Presented

Pictured above are Liz Lovette, 1st Vice President and Chair of the Accreditation & Ethics Committee, presenting designation plaques to Richard L. White,CIR-P&C and Jack M. Webb, CIR-P&C.

Congratulations to the new CIRs

Jack M. Webb, CIR - P&C
Michael J. FitzGibbons, CIR - ML
Houghton Furr, Jr., CIR - P&C
Christopher M. Maisel, CIR - L&H
Philip J. Singer, CIR - ML
Richard L. White, CIR - P&C

The patient's monitor erratically chirps as the crash carts arrive at the doorway.
Code Blue.

No, it's not another cardiac patient requiring the healing hands of Drs. Benton or Green, instead it's the figurative demise of a managed care entity. With the third installment in our series of the unique issues confronting a managed care organization insolvency, Patrick Cantilo - our own Mark Green, provides us with a veritable checklist to handle as the patient succumbs to regulatory oversight.

REHABILITATION OF MANAGED CARE ORGANIZATIONS: *A THUMBNAIL SKETCH OF CERTAIN KEY CONSIDERATIONS*

By Patrick H. Cantilo

Introduction

This brief article seeks to provide an overview of four critical aspects of the rehabilitation of an insolvent or impaired managed care organization (a "MCO"). It will first address the problems a rehabilitator is likely to face immediately upon seizure of the organization. Attention will then turn in the second section to issues in the preservation of the health care provider network. The third section addresses the back office. The fourth and final section will address preservation of the customer base. The brevity of this article precludes detailed consideration of any of these topics and an assumption is made that the reader is familiar with the fundamentals of rehabilitation and liquidation of insurers. While the aim of the following paragraph is to provide useful and practical suggestions for the actual management of a managed care rehabilitation, it is not intended to constitute a comprehensive checklist of the items to which the rehabilitator should address himself. There exists a growing body of literature that can serve as useful references for the fundamentals of rehabilitations and liquidations, a key component of which is the NAIC *Receivers Handbook for Insurance Company Insolvencies.*[1] The reader may also benefit from reference to the NAIC's *Health Maintenance Organization Model Act* (the "Model Act") and the corresponding statute in the state in which the reader is interested.

I. IMMEDIATE PRIORITIES

Though certainly not exhaustive, the list of problems on which the rehabilitator must focus his attention immediately after seizure includes control of the organization, addressing patient care needs, and the dissemination of information.

A. CONTROL OF THE ORGANIZATION

The seizure of control of a MCO is a matter that is not dissimilar from the issues that arise in any insurer or similar insolvency. Suffice it for our purposes to note that it is essential to obtain unrestricted control of the assets of the organization, including its cash, lines of credit, reinsurance recoveries and other sources of funding. Equally important is effective control of the physical plant, including all offices, data processing and management information systems, equipment, and books and records.

A principal respect in which these issues may present themselves differently in the context of the MCO than in the context of an insurer insolvency arises from the possibility that bankruptcy proceedings may also be instituted for the organization by management or a frustrated creditor. In that event, a jurisdictional contest may ensue the resolution of which will be of critical importance to the rehabilitator. While a detailed discussion of these issues is beyond the scope of this paper, it may be helpful to note that the current state of American law with respect to the availability of bankruptcy jurisdiction for insolvent health maintenance organizations ("HMO's") generally tends to favor state insurance proceedings such as to require that bankruptcy proceedings be abated or dismissed.[2] However, the facts of each case are of critical importance and the U.S. Supreme Court has not addressed this subject. But it is important to note that a bankruptcy proceeding is likely to divest the insurance commissioner or other state regulator of jurisdiction or, at a minimum, to substantially impede his or her ability to discharge rehabilitation responsibilities and perform associated functions.

B. PATIENT CARE

Having achieved control of the organization, an equally important priority is that surrounding the delivery of health care to the MCO's subscribers or members. In at least four circumstances, patient care needs may present urgent problems. The first arises in the context of medical emergencies. Remembering that MCO's (unlike insurers) play a substantial and very active role in the actual delivery of health care (as distinguished from simply financing it), provision must be made immediately by the rehabilitator to assure that members will receive emergency medical care when necessary. To achieve this goal the rehabilitator must assure that hospitals, physicians, ambulance services and other health care providers to whose services the members are contractually entitled will

(Continued on page 8)

1 The NAIC *Receivers Handbook for Insurance Company Insolvencies* provides the most current, complete information available on insurance company insolvencies. This publications can be obtained by accessing the NAIC's website at www.naic.org.

2 For a discussion of the bankruptcy jurisdiction issue, for example, see Patrick H. Cantilo, *Health, HMO and Related Entity Insolvencies,* in, LAW AND PRACTICE OF INSURANCE REGULATION OF HEALTH CARE ARRANGEMENTS 13-1, 13-25, 13-42 (Dennis G. LaGory, Ed., A.B.A. 1996).

REHABILITATION OF MANAGED CARE ORGANIZATIONS

(Continued from page 7)

continue to provide such services despite the financial difficulties faced by the MCO. Assuring the availability of such services in the event of emergencies may require nothing more than contacting the relevant providers to remind them of what are likely to be their contractual or statutory obligations to continue providing care and to assure that they will abide by such obligations. There may, of course, be other ethical and legal requirements imposing a similar duty on the health care providers and it may be helpful to remind them of those as well. The issue of how to deal with recalcitrant providers will be addressed in more detail below.

Equally important will be the need to assure that subscribers or members confined in health care facilities (hospitals, hospices, nursing homes and the like) on the date of seizure will continue to receive uninterrupted health care. Specifically, steps must be taken to assure that confined individuals are not discharged prematurely or do not face reductions in health care services as the result of the MCO's misfortunes. Again, this point can be addressed by immediate contact with the relevant health care facilities. It may be necessary to make special arrangement for the facilities to assure that payment will be made for prospective care, even if payment due in arrears cannot yet be made due to applicable priority schemes or other constraints. In most instances, an assurance that prospective payment will be made (typically defensible as a cost of administering the estate) suffices to continue treatment that has commenced prior to the seizure. More importantly, however, such facilities may be obligated to continue providing such care without prospective payment guaranties under terms of contracts in force or applicable statutes. The rehabilitator should review these sources before contacting the providers. If possible, such review should take place even before the seizure.

A comparable concern may arise with respect to pregnant subscribers. Given the importance of adequate prenatal care (for the health of both the mother and the child), it is incumbent on the rehabilitator to assure that such care will not be interrupted because of the MCO's seizure. Lamentably, there exists a sordid history of difficulty on the part of pregnant subscribers of troubled MCO's in obtaining appointments for prenatal checkups or other prenatal care, including scheduling of confinement for delivery. Notwithstanding contractual or other obligations to provide care even in the case of insolvency, there have certainly been episodes in which obstetricians have frustratingly been unable to find on their calendars slots for prenatal office visits of such individuals. Such providers should again be reminded of their obligations. When that does not suffice, the rehabilitator may be compelled to make alternate arrangements by enlisting the assistance of non-participating obstetricians upon promises of guaranteed prospective payment. In smaller communities, however, that may be difficult. For example, the author wrestled with one such situation in which all of the obstetricians in the MCO's community were contracting providers who in a cartel-like fashion refused entirely to provide obstetric services to the HMO. In that instance, therefore, it became necessary to make arrangements with obstetricians from a neighboring community to provide such care. Such arrangements are expensive, burdensome, and awkward, and the need for them should be avoided if at all possible. In addition, the rehabilitator should take the necessary steps to assure that the hospitals in which participating obstetricians have privileges will facilitate the confinement of the subscriber at the required time. Again, contractual and statutory obligations may be dispositive but candid discussions with the institutions may nonetheless be necessary.

Finally, in the category of urgent patient care, attention should be devoted to the needs of chronically ill patients who find themselves in a continuous course of treatment, frequently from specialists, not simply primary care providers. Again, the contractual arrangement in effect with such specialists should be reviewed to ascertain what obligations they have to continue providing such care if the MCO becomes insolvent. If a satisfactory answer cannot be found in relevant statutes or contracts, it may be necessary to make an ad hoc arrangement with each such provider to guarantee partial or complete prospective payments so that care is delivered without interruption. Similar arrangements may be necessary with therapeutic and diagnostic facilities that play a role in the necessary course of medical treatment.

C. PUBLIC INFORMATION

Another area of immediate concern to which the rehabilitator should devote his or her efforts involves the dissemination of information. Unfortunately, the insolvency or near-insolvency of a MCO frequently receives adverse publicity without the control of the rehabilitator or state regulators. In such instances, mitigation of the adverse results is both possible and necessary. Most effective in many such cases is the dissemination of balancing information. Thus, where the printed or electronic media announces the demise of the MCO in terms which dramatize the adverse impact on the delivery of health care and the continuation of coverage, the panic or severe concern which is likely to ensue must be prevented or at least minimized by more factual and positive information disseminated by the rehabilitator. The very same print and electronic media can typically be persuaded to run balancing stories, indeed may be very interested in doing so. To achieve the best result, the rehabilitator should first compile and organize through careful thought the information he or she intends to disseminate. Such information typically must include appropriate assurances about the continued availability of health care for those in need of such services, information about the continuation of coverage, information about the availability of "safety nets" such as guaranty fund coverage and the like where available, and (if possible) quotes from key health care providers incorporating helpful assurances.

Beyond such public information,

equally important is the dissemination of more specific information to affected constituencies, such as health care providers, employers or enrolled groups, reinsurers and lenders. Typically such constituencies become most alarmed when they learn from third parties of the MCO's insolvency and, in the absence of favorable information, will tend to jump to the most adverse conclusions. The conduct that will follow such conclusions, not surprisingly, is likely to be disadvantageous to the rehabilitator. To prevent this, therefore, it is useful for the rehabilitator to contact such constituencies early in the process explaining to the maximum degree possible the circumstances in which the MCO finds itself (so as to prevent even more dire assumptions) and providing a preview of the measures that the rehabilitator will implement for the protection of such constituencies. Thus, by way of illustration, health care providers can be told that arrangements will be made for prospective payments in short order even if payment of amounts due for care delivered prior to the seizure may have to be postponed to a less definite date.

II. PRESERVATION OF THE PROVIDER BASE

What MCO's do for a living is to arrange for the delivery of health care services to enrolled populations on a prepaid basis. They do so by entering into contractual arrangements (the nature of which may vary along a broad spectrum of structures that are the fruit of imaginative lawyers and managers) with the entire array of health care providers. With few exceptions, primary care physicians (general practitioners, family physicians and, in at least some cases, obstetricians and internists) become principally responsible for designing and implementing a program of health care for each enrolled subscriber. In many MCO's these primary care physicians serve the role of gatekeepers and must approve access by the patients to specialists or other health care facilities. It is not atypical in such cases that the primary care physician shares with the MCO benefits of successful utilization control and the adverse results of over utilization. In many cases such primary care physicians are compensated on a "capitated" basis pursuant to which each such physician is paid a flat monthly fee for each member assigned to him or her regardless of the number of times the physician sees the member during the month. By contrast, specialists and other facilities most commonly enter into contractual arrangement with the MCO under which they are paid on a fee for service basis although, hopefully, the fees are discounted or are otherwise made more advantageous than those which would be paid by other patients. In any event, the mature MCO has direct or indirect contractual relationships with the entire spectrum of health care providers whose services are necessary to fulfill the MCO's contractual obligations to the subscribers. Under the Model Act and in most states, governing statutes require that such providers agree in their contracts to continue providing care for some period of time following the cessation of business of a MCO even if compensation is not forthcoming. The period of time during which that obligation persists, however, is generally limited to three to six months. Rehabilitation of the organization requires a longer commitment from the providers, and fundamentally, the confidence of the enrolled population that derives from knowledge that the providers will be around during a prolonged period. Thus, an early responsibility and burden for the rehabilitator is to assure that a sufficient provider network will exist to satisfy contractual obligations already in place or to be undertaken by the rehabilitator as part of a turnaround plan.

Health care providers should be assumed to be economically rational. That is to say, assumptions should not be made that health care can be obtained without compensation. No more do doctors and hospitals believe that there is a free lunch than do reinsurers or other creditors. Therefore, the rehabilitator should assume that realization by the medical community that the MCO is in financial straits will lead contracting providers to seek a termination of their obligation as early as possible in order to avoid the need to provide uncompensated care. Such terminations, however, will all but doom any rehabilitation effort since the MCO will be nothing without an adequate provider network.

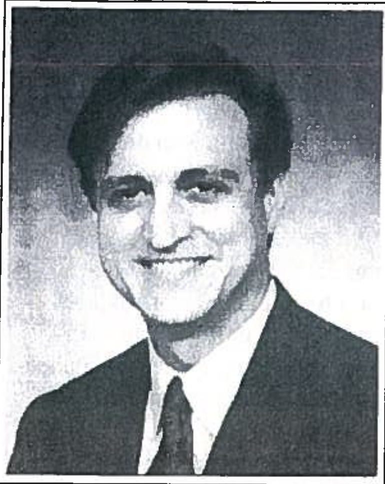
There is no secret formula for preserving a provider network, but there are a number of techniques which, singularly or in combination, may be very useful. First and foremost is establishing a line of communication with the affected providers the foundation of which is candor and reliability. In short, a rehabilitator should make available to each such provider as early as possible sufficient information to dispel the worst doubts and begin instilling the requisite confidence. Such information should include a candid explanation of the implications of the receivership, a practical description of the prospects for the MCO, preliminary indications of efforts contemplated by the rehabilitator to turn the MCO around, and a brief explanation of the likely effects of the MCO's problems on the affected providers. Initial information should be updated as material changes occur, with due regard for any applicable confidentiality and other constraints. In all such communications, the rehabilitator should bear in mind that the principal concerns of the provider will be when and how much he, she or it will be paid and what impact developments will have on his, her or its practice. Thus, hospitals will want to know how many beds they must continue to commit to MCO subscribers, physicians will want to know how many office visits they should anticipate, and so on.

While contractual arrangements may deprive the providers of the right to immediate payment, a rehabilitator that can make such payments is likely to be in a much better position to establish a good working relationship with such providers. To the extent, therefore, that the applicable priority scheme permits it, at least some partial payment for prospective care should be delivered to providers along with some estimation of when and how much will be paid for amounts due for pre-takeover care.

Frequently, the rehabilitator will benefit substantially from assistance provided by the plan's medical director or other health care professionals in communicating with network providers. Physicians and health care providers have a

(Continued on Page 12)

Meet Your Colleagues



Tom Clark

Tom Clark is a native of Louisiana, residing in Baton Rouge. He is a partner with the law firm of Crawford & Lewis, with which he has worked since 1992.

Upon joining Crawford & Lewis, Tom began working on savings and loan insolvencies - defending former directors and officers from the efforts of the FDIC, FSLIC, and the RTC. With this experience, he crossed over to begin representing the Louisiana Commissioner of Insurance. While working in the financial industries insolvencies of the early nineties would seem like adequate preparation for insurance insolvency, in hindsight it is difficult to conceive of sufficient training for the creatively Byzantine structures of insuring entities found in the realm of insurance insolvency.

In the relatively short span of seven years of insolvency practice, Tom has represented various insurance commissioners and/or superintendents in placing various companies into conservation, rehabilitation and liquidation, as well as handling a variety of disputes arising within and outside of the receivership proceedings. During this time, Tom was involved with the attempted rehabilitation and subsequent liquidation of a single business enterprise comprised of twelve separate entities, including an unauthorized insurer, a domestic Lloyd's partnership, a risk pool, an offshore reinsurer and a variety of affiliated entities.

Most recently, Tom has focused on insolvency issues confronting managed care, representing shareholder and other creditors' interest. Over the past two years, he has been actively involved in the private wind down and successful transfer of lives of Advantage Health Plan, one of the largest HMO's in Louisiana.

Tom has been a member of IAIR since 1995 and currently serves as one of the feature articles' editors for *The Insurance Receiver.*

He received both his bachelor's and juris doctorate degrees from Louisiana State University and continues to suffer, albeit not-so-silently, through the misadventures of Tiger Athletics. Tom and his wife, Karen, have two children, Michael, 5, and Sarah, 1 1/2.

Diane J. Bartels

Diane Bartels has been an attorney since 1983, after having obtained her law degree from the Dickinson School of Law in Carlisle, Pennsylvania. She is a member of the Delaware and Pennsylvania bars, and is admitted to practice before the United States District Courts in Delaware and the Middle District of Pennsylvania. Her office is located in a historic stone building in the Brandywine Village section of Wilmington, Delaware.

Diane served for four years as Assistant Counsel for the Pennsylvania Department of Public Welfare, litigating hospital and nursing home Medicaid rate and reimbursement matters, as well as personnel issues. She subsequently served as a Deputy Attorney General for the State of Delaware, representing various state agencies. Unable to handle the excitement of such projects as drafting boiler safety regulations, Diane left government service for private practice in 1990.

Diane has been involved in insurance litigation since March 1990. Her office currently represents the Delaware Insurance Commissioner in the liquidations of two property and casualty insurers and two life and health insurers, as well as other matters for the Department. She has also represented insurers in insurance coverage litigation, as the defense coordinator for a major product liability coverage action in Delaware, bankruptcy matters and litigation.

Diane regularly attends the NAIC meetings, has contributed to the Receiver's Handbook, and has recently hosted an IAIR roundtable.

When not engulfed in the responsibilities of running her own office, Diane's hobbies include reading, gardening, and raising her two spoiled English Pointers.

C. Phillip Curley

Almost twenty years ago, on the first day on the job at a new law firm (which, by the way, was a Saturday), Phil Curley was asked to prepare a lawsuit on behalf of the Liquidator of Reserve Indemnity Company against, among others, former company officers and directors, three national auditing firms and one of the world's largest reinsurers. The case resulted in the landmark *Schact v. Brown* decision which upheld the use of the civil provisions of the new federal RICO statute in a commercial setting. Thus began his career in the law of insurance insolvency.

In the intervening years, Phil along with friend and partner, Ellen Robinson, formed Robinson, Curley & Clayton, a practice predominantly grounded in the representation of liquidators of failed insurance companies. Their assignments have included asset recovery work, insolvency investigation, director and officer and professional liability litigation, and reinsurance collection. Phil and his firm have represented liquidators in many states, including most recently Illinois, West Virginia, Rhode Island, Texas and Louisiana and have recovered over $100 million on behalf of their clients. Phil has spoken at many seminars and workshops on issues of concern to insurance regulators and liquidators.

Along with his wife, Judy, and their children, Samantha and Spencer, Phil lives in Naperville, Illinois. He played competitive soccer until earlier this year when a torn Achilles tendon and three broken ribs convinced him that not only was he getting slower, but the opponents were getting bigger and faster. He still enjoys the game through his daughter who plays on a state championship team and his son whose team Phil coaches. He enjoys playing golf and tries to organize outings whenever the NAIC or IAIR meet in warm weather locales. Phil is also a Civil War buff, in particular, and an avid reader of history, in general.

Paula M. Young

Paula is a partner in the law firm of McCarthy, Leonard, Kaemmerer, Owen, Lamkin & McGovern located in St. Louis, Missouri. This firm serves as General Counsel to the Special Deputy Receiver of Transit Casualty Company. She has assisted the SDR and his staff in collecting approximately $1 billion in assets for distribution to Transit's 220,000 claimants.

Paula received her undergraduate and law degrees from Washington University located in St. Louis. She is licensed to practice law in Missouri, Illinois and the District of Columbia. She is on the mediator list for the local state and federal court. She is a member of the Better Business Bureau's National Panel of Consumer Arbitrators, the Association of Attorney-Mediators, Inc., and the ADR committees of national, state and local bar associations. She is currently setting up a *pro bono* mediation program for the small claims docket of the local court.

Paula serves on the editorial board of *The Insurance Receiver.* Her hobbies include gardening and strength training. She is a member of the National Association of Women Business Owners' Public Policy Interest Group and the Sue Shear Institute for Women in Public Life. She is a volunteer in the American Cancer Society's Colorectal Cancer Education Program and a *pro bono* mediator for the St. Louis Volunteer Lawyers and Accountants for the Arts. She was recently appointed to the city's Beautification Board. In that role she will participate in landscape design for a new recreational center and in the selection of public art for the city.

REHABILITATION OF MANAGED CARE ORGANIZATIONS

(Continued from page 9)

tendency to be naturally distrustful of lawyers and state officials. What would otherwise be a very effective message may lose some of its persuasive power if delivered just by the rehabilitator. Conversely, it may become far more persuasive if delivered (at least jointly) by other physicians, preferably those not closely associated with the plan. The rehabilitator, therefore, may wish to enlist the local hospital or medical association in communicating these messages. However accomplished, the point is that health care providers should be persuaded not only to avoid interruptions in the delivery of care to subscribers immediately following the takeover, but also to commit to the provision of health care services for a longer period of time so as to enable the development and implementation of a rehabilitation plan.

III. THE BACK OFFICE

While any analysis of the many financial and administrative issues that are likely to be presented by the financial demise of a MCO are well beyond the scope of this article, a few general observations are likely to be useful. Experience teaches us that failed MCO's tend to share certain common traits that contribute to their demise. Key among these are the failure to properly monitor and manage utilization of health care services, poor cash flow management, and an inadequate reinsurance or stop loss program. Recognizing the foregoing, it behooves the savvy rehabilitator to devote some of his energies in the initial stages of the process to determining the condition and the needs of the plan's back office.

Early attention should be devoted to understanding the capabilities and limitations of the MCO's management information and computer systems. For example, does the management information system ("MIS") track adequately the plan's enrollment? Many large and small MCO's have suffered tremendously because their systems did not track adequately additions to, and deletions from, the enrolled population. As a result, there have been some notable instances of organizations failing to bill for premium due to them (the passage of time making such billing all but a waste of time) and, conversely, billing individuals and groups which were no longer their customers (thereby creating a substantial public relations problem). Little explanation is required to prompt an understanding of the potential pitfalls of such weaknesses.

Similarly, effective management of health care utilization lies at the core of a successful MCO. Effective utilization review management, in turn, depends on prompt availability of accurate utilization data that in turn depends on effective management information and data processing systems.

Many MCO's also enter into risk-sharing arrangements with their health care providers. While a detailed explanation of the terms of such arrangements cannot be undertaken in this article, it is important to note that performance and reporting under those arrangements is critical both to the financial viability of the plan and to the preservation of an effective relationship with the providers. To this function as well, the integrity of the plan's MIS is critical.

In addition (and certainly not surprising) it is very important that the plan's accounting systems be accurate, reliable and sufficiently quick. Both in terms of cash flow management and in terms of prompt and accurate financial reporting, the functions of the accounting staff are indispensable and shortcomings in this area can, by themselves, doom to failure an otherwise well developed rehabilitation plan. Where there is insufficient confidence in the plan's own staff, thought should be given to retention of consultants and experts at an early stage.

Equally important for many plans is the development and preservation of an effective reinsurance and stop loss program. Many small and medium sized MCO's simply lack the financial resources to shoulder in its entirety the risk transferred to them by their enrolled population. Provision, therefore, must be made for some of the risk (both as to frequency and severity) of health care claims to be assumed by a stop loss reinsurer. Although there is certainly no free lunch (and a reinsurer will presumably charge an adequate premium over a period of years which, in the aggregate, will exceed the total of claims paid by the reinsurer to the MCO by a sufficient amount to provide for a reasonable profit), the predictability afforded by an effective stop loss reinsurance program in itself constitutes a substantial value without which an effective rehabilitation plan is far less likely. Attention should therefore be given to verification that the reinsurance program has been properly constructed and is sufficiently well managed. The requisite reports must be provided to the reinsurer to avoid a fatal breach and, on the other hand, confirmation should be obtained that collection has been made of the amounts to which the plan is entitled.

It is worth observing that HMOs and other MCO's typically monitor revenues and expenses on a per-member-per-month ("PMPM") basis. Thus, every item of expense is calculated for individual enrollees for each covered month and, the same is true for revenue items. Stop loss reinsurance and other risk shifting devices are also frequently priced and modeled on that basis. The rehabilitator should analyze and develop corrective action plans, which not only take into account financial impacts on a PMPM basis, but also in the aggregate. Blind concentration on measures which have the effect of lowering PMPM costs or increasing revenues on that basis without recognizing aggregate impact may overlook an insurmountable cash or capital deficit, daunting aggregate debt or deficiencies in the MCO's portfolio management program.

IV. PRESERVATION OF THE CUSTOMER BASE

Even if all other ingredients exist, no rehabilitation plan can be successful if the MCO has lost all of its customers. Among the constituencies that first become nervous about a MCO's financial dilemma is likely to be its enrolled population, which is so dependent upon the viability of the MCO for its indispensable medical

large employer groups are likely to scatter in search of alternatives. The rehabilitator, therefore, should implement immediately an effective program of communications and assurances that will keep these enrolled groups around for the duration of the rehabilitation plan. Among other measures, important in this regard will be instilling in the customer base the confidence that the health care provider network will not only be around but will be delivering care without new burdens or conditions.

The rehabilitator should also be well informed as to when each group comes up for renewal. Even if an enrolled group is willing to stay with a MCO during the remainder of its group contract term, it is far less likely that it will renew when the contract expires (typically in the last quarter of each year). The loss of a substantial number of groups at renewal time is likely to doom any rehabilitation plan. Therefore, the rehabilitator should determine what inducements would be necessary to provide the requisite number of renewals. In doing so, however, the rehabilitator may also wish to become familiar with the utilization history of each group, because there may be groups whose nonrenewal may actually be a blessing for the plan.

CONCLUSION

This article has sought in relatively little space to provide an overview of a number of important aspects of the rehabilitation of a managed care organization. Notwithstanding its brevity, it should serve to identify many of the pitfalls that lurk in the bushes as well as the resources that will be indispensable in attempting to restore a MCO to financial viability. Many industry observers have expressed a view that the coming months and years are likely to witness an increasing number of MCO failures. If these unfortunate predictions are borne out by experience, there will be a need for well-trained and well-informed rehabilitators and liquidators to assist in the state regulatory response. It is hoped that the thoughts provided in these few paragraphs can make a contribution to that response.

* * * * *

Patrick H. Cantilo is a founding partner of the Cantilo & Bennett, L.L.P. law firm. His practice is concentrated in the areas of insurance transactions, regulation, reorganization, and insolvency. He has been engaged in the reorganization, rehabilitation or liquidation of dozens of insurers and related entities, having first become involved in that area two decades ago as a staff lawyer for the Texas State Board of Insurance's Liquidation Division.

P|A|R|A|G|O|N

Reinsurance Risk Management Services, Inc.

- Preliminary Assessment of Reinsurance Structure and Recoverables
- Loss Reserve and Unearned Premium Portfolio Transfers
- Ceded / Assumed Software Solutions: Mainframe, Mid-Range and PC
- Identification, Billing and Collection of Reinsurance Recoverables
- Commutation and Run-off Administration
- Actuarial Services
- Ceded & Assumed Reinsurance Management

For Additional Information Contact:

David D. Grady, CPCU
Senior Vice President
Minneapolis, Minnesota
(800) 854-8523

Trish Getty
Vice President
Atlanta, Georgia
(800) 766-5620

Mike Stinziano, Ph.D.
Vice President
Chicago, Illinois
(800) 621-7295

A Subsidiary of E. W. Blanch Holdings, Inc.

Receivers' Achievement Report

Ellen Fickinger, Chair

Mark Tharp (AZ) submitted information on several **Arizona** estates. In the matter of Cohen v **The Hartford Fire Insurance Company**, a four day trial occurred in November 1998 relative to the Receiver's attempts to recover on a $1 million fidelity bond issued to **AMS** by the **Hartford**. The Court entered judgment in favor of the Receiver on January 4, 1999. Further, effective October 1, 1998, the Receiver and **Chesapeake Life Insurance Company (CLIC)** entered into an Agreement of Reinsurance and Assumption whereby **CLIC** assumed **Diamond Benefits Life Insurance Company (DBLIC)** blood plan and hospital indemnity business. The Court heard and approved Petition 375, Petition for Approval of Sale of Blood Plan Business of DBLIC on February 26, 1999.

Litigation settlements of claims against former officers and directors for **Farm and Home Life Insurance Company** resulted in an additional cash payment to the Receiver of $7,022,313 during the first quarter of 1999. These litigation recoveries were, in turn, distributed to the **Arizona** Life and Disability Insurance Guaranty Fund in the form of early access payments. Additionally, on October 15, 1998, Petition 49, Receiver's Report of Claims and Recommendations Thereon for **North American Physicians Insurance Risk Retention Group, Inc.**, was filed with the Court. A hearing on the Receiver's recommendations was held on January 29, 1999 resulting in the Court's entry of an order setting policyholder claim liability at $5,857,034 with liability for all classes of creditors set at $6,932,496. And, in closing, on November 4, 1998, the Court entered an Order for Liquidation for **USA Property & Casualty Insurance Company**. The Company was placed in receivership on May 7, 1997.

Mike Rauwolf (IL) continues to provide updates on Companies under **OSD** supervision. The company is managing the reinsurance run-off of the **American Mutual Reinsurance Company (AMRECO)**. Total claims paid inception date; Loss and Loss Adjustment Expense $30,449, Reinsurance payments $125,343,303 and LOC Drawdown disbursements $9,613,386. Another Company under **OSD** supervision, **Centaur Insurance Company**, also continues to manage the run-off of their business. Total claims paid inception to date; Loss and Loss Adjustment Expense $50,816,836, Reinsurance payments $4,945,493 and LOC Drawdown disbursements $13,876,555.

James A. Gordon (MD) reports that collections during the first quarter of 1999 against former employees and rental income of **Trans-Pacific Insurance Company, et al.** totaled $355.00. Liechtenstein returned additional funds that were found on Martin Bramson at the time of his arrest in the amount of $416,145.07. Collections during the first quarter of 1999 totaled $127,817.51 for **Grangers Mutual Insurance Company.**

Bill Taylor (PA) continues to apprise us on the continued rehabilitation of **Fidelity Mutual Life Insurance Company (FML)**. Policyholder death benefits and annuity payments continue to be paid at 100%. Crediting rates are at or above policy guarantees. The Court recently approved a fourth moratorium relaxation which allows policyholders to access up to 30% (or 50% for those over age 65) of their cash value through applicable policy provisions. As of 6-30-99, **FML** showed a statutory surplus in excess of $121,000,000.

The Commonwealth Court authorized payment of all approved creditor claims if the creditors are willing to waive any interest or penalties that may be applicable. Most approved creditors have accepted that settlement and have been paid. This includes all of the guaranty associations who are accepting immediate payment of assessments owed to them in exchange for waiving any possible interest or penalty. A handful of other creditors have chosen to wait and see what interest rate will be approved in the rehabilitation plan for payment at Closing. All disputed claims have now been assigned to referees and almost half of those have already been settled, withdrawn or determined to be abandoned. They are also in the process of working out settlements with the taxing authorities that will allow them to retroactively credit the paid guaranty association assessments against any premium tax owed. This involves preparing and filing amended returns from 1993 forward for each state with an offset provision.

On August 5, the Rehabilitator filed a petition to establish Claims Bar Date to effectively determine the date as of which any new or contingent claims would prejudice the orderly administration of the estate. The Court has not yet approved the proposed notice of the petition.

Hearings on the Third Amended Rehabilitation Plan and the accompanying Stock Allocation Report began on July 16. The testimony continued on July 19, August 8 and August 9. One additional day of testimony is expected in late September. At the conclusion of the hearing on the rehabilitation plan, the Court will also hear oral arguments on the Rehabilitator's petition for approval of a new dividend scale. Direct testimony was filed in writing by both the Rehabilitator and the 3 objectors prior to the hearing. Cross-examination of the witnesses is taking place during the hearing.

All of these documents have been negotiated over the last two years with the court appointed Policyholders Committee. The plan proposes that **Fidelity Life Insurance Company (FLIC)**, a stock life insurance company, will assume and reinsure **FML's** obligations under all of its life insurance policies and other insurance contracts. No reduction will occur in cash value, death benefits, dividend accumulation or policy loan accounts. Substantially all of **FML's** assets will be transferred to **FLIC** to support these obligations. The plan proposes that creditors with approved claims will receive payment in full, in cash, with simple interest at 6% per year. Policyholders will receive both common and convertible preferred stock in the holding company for **FLIC**, **Fidelity Insurance Group (Group)**. An outside investor will be selected through approved Bid Procedures to contribute additional capital to **FLIC** through the purchase of **Group** stock. The investor will purchase a slight majority of the

common stock and appoint the majority of the board of directors. The petition for approval of a new dividend scale would distribute, through a one-time dividend and increased crediting rates, approximately $90 million to policyholders over a 12 month period while maintaining minimum capital and surplus levels and meeting risk-based capital requirements for **FML**.

In **South Carolina, Thomas Baldwin** reports that there continues to be ongoing supervision by the Receiver that will lead to the eventual sale of **Select Health, Inc.**, an HMO.

It has been an eventful few months as reported by **Philip Singer (UK)**. There have been increases in the dividends paid to creditors by the five **KWELM** companies. The dividend for **Kingscroft** has been increased from 20 to 24 percent, the dividend for **Walbrook** has been increased from 13 to 16 percent, the dividend for **El Paso** has been increased from 20 to 26 percent, the dividend for **Lime Street** has been increased from 21 to 26 percent and the dividend for **Mutual Re** has been increased from 13 to 16 percent.

Further, a first dividend of 25 percent has been declared in the case of **Fremont Reinsurance Company (UK) Limited**. A fifth and final dividend has been declared in the case of **Monument Marine & General** bringing the total dividends to 36.9 percent. The dividend for **Trinity Insurance Company** has been increased from 40 to 47.5 percent. The dividend for **Bryanston Insurance Company** has been increased from 22.5 to 25 percent and the dividend for **OIC Run-Off** (formerly **Orion Insurance Company Limited)** has been increased from 20 to 25 percent. A fifth and final dividend of 2.83 percent has been declared in the case of **St. Helen's Insurance Company** bringing total dividends to 47.83 percent. The assets of the estate having now been distributed to creditors, the liquidation was closed on September 10, 1999.

In other news in the **UK**, there will be a meeting of creditors for **Charter Reinsurance Company Limited** on September 22, 1999 to consider and, if thought fit, approve a scheme of arrangement for the company as an alternative to liquidation. If approved, the scheme should become effective mid October 1999. Finally, the solvent scheme of arrangement for **Mutual of Omaha (UK) Limited** became effective February 2, 1999. Under the provisions of the scheme all creditors' claims have been paid in full and the scheme terminated on July 30, 1999.

Our achievement news received from reporters covering the first quarter of 1999 is as follows:

RECEIVERS' ACHIEVEMENTS BY STATE

Arizona (Mark Tharp, State Contact Person)
Use and distributions made to policy/contract creditors and Early Access.

Receivership	*State/GA*	*Amount*
Azstar Casualty Co.	Arizona GA	$3,684,465.00
	Florida GA	2,086,839.00
	Maryland GA	319,248.00
	Nevada GA	2,488,632.00
	Pennsylvania GA	420,816.00
		$ 9,000,000.00

Receivership Estates Closed	**Year Action Commenced**	**Licensed**	**Category**	**Dividend Percentage**	
Americas Life Insurance Co.	1990	N/A	L&H	Arizona Life & Disability Ins. G.F. -	$2,923,311.00
				Total 60% -	$4,432,357.00
Southwest Fire & Casualty Ins. Co.	1993	N/A	P&C	Arizona P & C Ins. G.F. 30% -	$402,861.00

Illinois (Mike Rauwolf, State Contact Person)
Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*
Amreco	$1,356,893.00
Centaur	25,544.00
Coronet	205,691.00
Inland	1,335.00
Intercontinental	49.00
Millers	1,812.00
Pine Top	23,880.00
Prestige	444,507.00
Total	**$2,059,711.00**

RECEIVERS' ACHIEVEMENT REPORT *(Continued)*

California (Melissa Kooistra Eaves, State Contact Person) Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*
Integrity Insurance Co.	$1,363,336.00
George Washington Life Insurance Co.	2,281,633.00
Total	**$3,644,969.00**

Georgia (Harry Sivley, State Contact Person) Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*
Stone Mountain Insurance Co.	$3,025,613.00 (GF)
Victoria Insurance Co.	8,100.00 (GF)
Total	**$3,033,713.00**

Receivership Estates Closed	Yr Action Commenced	Licensed	Category	Dividend %	Amount
Stone Mountain Insurance Co.	1988	Y	P&C	Class I : 100% -	$ 622,337.00
				Class II : 47.5% -	$4,735,607.00
Victoria Insurance Co.	1988	Y	L&C	Class I: 100% -	$ 10,919.00
			P&C	Class II: 18.9% -	$ 215,529.00

Louisiana (Michael R.D. Adams, State Contact Person) Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*	
Dixie Lloyds	$ 330,000.00	(LIGA)
Total	**$ 330,000.00**	

Receivership Estates Closed	Yr Action Commenced	Licensed	Category	Payout	
Old Hickory Casualty	1991	Y	P&C	$ 285,331.61	(LIGA)
Sovereign Fire & Casualty	1991	Y	P&C	$ 45,630.31	(LIGA)
Anglo-American	1989	Y	P&C	$2,898,735.09	(LIGA)
				$1,068,486.02	(GA Pool)
First Republic Life	1977	Y	LIFE	—	

Maryland (James A. Gordon, State Contact Person) Use and distributions made to policy/contract creditors & Early Access

Receivership	*Amount*
Trans-Pacific Ins. Co. et al	$240,053.00
Grangers Mutual Ins. Co.	169,365.42 (MD)
	20,317.99 (DC)
	5,062.55 (GA)
	26,775.75 (NC)
	2,244.74 (TN)
Total	**$463,819.45**

Pennsylvania (William S. Taylor, State Contact Person) Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*
EBL Life Ins. Co.	$ 9,500,000.00
PIC Ins. Group Inc.	1,053,920.00
Summit National Life Ins. Co.	35,995,900.00
Total	**$46,549,820.00**

Receivership Estates Closed	Year Action Commenced	Licensed	Category	Dividend Percentage
Highland Mutual Ins. Co.	1994	Y	P&C	100%

South Carolina (Thomas M. Baldwin, State Contact Person) Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*	
Western Pacific Life	$ 125,000.00	(Dom. Liq.)
Kentucky Central Life	2,050,000.00	(Dom. Liq.)
Integrity	91,357.00	(Pol/Con Cred.)
Total	**$2,266,357.00**	

Receivership Estate Closed	Year Action Commenced	Licensed	Category	Dividend Percentage
Western Pacific Life	1992	Revoked	Life	100%
Kentucky Central Life	1997	Revoked	Life	100%
Integrity	1987	Revoked	P&C	75%

ATLANTA MEETING RECAP *(Continued from page 4)*

them to Monday-morning quarterback every step of the procedure. The same argument was made about the URL's idea that a liquidator must present a liquidation plan within a specified period of time. In this day of sunshine laws and the death of *parens patriae*, is it really tenable to assert that state agents should take control of hundreds of millions of dollars of other people's money without explaining what they are going to do with it or accounting for their stewardship? The days when a court, presented with a demand for a plan in the absence of a statutory framework, will exercise its authority to wrap the liquidator in a judicially sanctioned cocoon are long gone. The short answer to the "commissioner's rights" argument is that the rights to which the proponents aspire are illusory, and they don't really want them anyway. Yes, there is a place for a liquidator's discretion, but if we try to overreach it, we will end up losing the whole thing.

The reason for the sullen looks on this working group is that, back at home, every one of those people had legislators, governors, and even commissioners who are a whole lot more interested in the URL than they are, precisely because it is transparent and customer-focused. What does that tell you about the long-term defensibility of those imaginary commissioner's prerogatives?

There were several interesting non-insolvency developments, too; space doesn't permit them to get the coverage they deserve. One of them had the inauspicious title of "regulatory confidentiality." This is a "big picture" effort to put some consistency into the way we handle private information and the public interest. Remember a few sessions back, when the "access to information" working group asserted that companies should not be entitled to shroud their market conduct self-evaluations in privilege wrappers, and the industry responded by claiming that, if information were made available to examiners, sooner or later it would also be accessible to nasty class-action lawyers, who would turn the company's good-faith efforts to monitor and regulate itself into admissions against interest? Fairly shrill statements about regulatory access being the price of a license, never mind the inconvenient consequences, didn't appreciably reduce the conflict. Going at the problem from the constructive end, however, several groups are now attempting to amend each of the model laws which raises the issue so they have consistent, crystal clear language exempting examination information from FOIA coverage. That should put debate on a more sensible footing.

Another fascinating exchange came up in a committee named the "automatic export of deregulated commercial lines working group." It might have been more aptly called the "I've located the halter, but the horse seems to have left the barn" group. Their charge was to consider whether the Non-Admitted Model Act should be changed to permit "automatic export (export without the diligent search requirement) for coverages that qualify for deregulated treatment under commercial lines deregulation laws and regulations." As background, in the course of the summer, and almost entirely without NAIC participation, the number of states that statutorily authorize non-admitted insurance for "industrial insureds" or ECP's (large commercial policyholders) crossed the 50% threshold and began what looks like an accelerating downhill run. Clearly, the members of the working group believed that nobody should be entitled to buy non-admitted insurance unless he first offered the admitted market an opportunity to bid. It appeared that the group's intention was to require that, even when a state had already adopted an ECP rule, the surplus lines producer must still perform, and document, an admitted market search before he would be permitted to place non-admitted coverage. The rationale, for what could only be interpreted as a backdoor assault on ECP as well as the Re-Engineering White Paper, was frankly protectionist: protectionist not of the policyholders, but of a state's licensees. To drop diligent search requirements for ECP's would "devalue the worth of a license," putting the licensed market, because of its greater "regulatory costs and restraints", at a competitive disadvantage vis-a-vis non-admitteds. The current proposal attempts to restore balance without actually repealing ECP by compelling diligent search but permitting the commercial policyholder to purchase non-admitted coverage even if the search turned up an admitted quote. I'm a little mystified how offering the admitted market an opportunity to quote against a competitor with a better cost structure (i.e. either to sell below cost or ignore the opportunity) redresses the competitive disadvantage they supposedly suffer from. Or to say it the other way, if the costs of regulation so far exceed its benefits that sophisticated policyholders rationally seek to escape it, why regulate? For good or ill, legislators seem to have gotten 'way out ahead of regulators on this one. Unless the regulators can come up with a better rationale than protectionism for retaining the dilligent search rigarmarole, they're going to stay there, too.

Looking forward to the next few months, several interesting events loom. There won't be a Roundtable or Annual Meeting in San Francisco, because IAIR is co-sponsoring the ABA-TIPS National Institute on Insurer Insolvency. The IAIR annual meeting will be held January 20th at the Insolvency Workshop. By that time, NAMCR will have held its *reprise* Solvency Seminar (Charleston, Nov. 3-4). January 20-21 is the NAIC/IAIR shindig in Tucson called "Managed Care: A Different Millennium Bug", which appropriately widens the horizons beyond HMO's. See you there!

FREMONT INSURANCE COMPANY (UK) LIMITED

(SCHEME OF ARRANGEMENT)

Notice of Declaration of First Interim Dividend

NOTICE IS HEREBY GIVEN that a first interim dividend of 25% of Scheme Creditor's Ascertained Scheme Claims has been declared in the above matter.

Dividend cheques in respect to those claims that have been agreed will be despatched to Scheme Creditors shortly.

PHILIP J SINGER & CHRISTOPHER JOHN HUGHES
Joint Scheme Administrators

Fremont Insurance Company (UK) Limited
Plumtree Court, London EC4A 4HT United Kingdom
Dated this 26th day of August 1999

THE GUARANTY ASSOCIATION SYSTEM: READY FOR Y2K

By John J. Falkenbach and Peter J. Marigliano

We have all seen the predictions. The Year 2000 computer bug may cause planes to fall out of the sky, the electrical grid to shut down and banking systems to fail. While these predictions may seem overblown, the Y2K bug may cause problems for those persons caught unprepared. With its reliance on computers and date sensitive data, the insurance industry could be considered a prime candidate for Y2K-related problems.

Over 1,600 life and health insurers are licensed in the United States. Even if one percent of those companies were severely affected by Y2K problems, the resources of the guaranty association system could be tested. In the fall of 1998, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) appointed the Year 2000 Insolvency Contingency Plan Committee (Committee). Its members include guaranty association administrators, insurance company representatives, consultants and NOLHGA staff. NOLHGA asked the Committee to consider Y2K issues and the level of response that the guaranty association system could and should make when the Y2K bug caused insurance insolvencies or made them more difficult to manage.

The Committee developed a plan with several components. First, NOLHGA and each guaranty association had to be certain that its own computer systems were ready for the Year 2000. To this end, the Committee has provided a broad array of information to assist guaranty association administrators as they worked to bring their systems into Y2K compliance.

Y2K Readiness Disclosures

Many organizations have either requested or received confirmation notices from their suppliers, vendors and business partners acknowledging their systems' Y2K compliance. The Committee has provided each guaranty association with a sample Year 2000 Readiness Disclosure Statement as well as a document listing frequently asked questions. The Committee intended that these materials could guide the guaranty associations when they responded to various inquiries they received from vendors, policyholders and others.

Communication With The Regulatory Community Is Essential

The real work of the committee focused on developing a relationship with the regulatory community so that insurance departments (1) would understand how Y2K related problems could affect the guaranty associations and (2) would know what the guaranty association system is doing to be prepared to respond to insurer insolvencies either caused by or made more complicated by Y2K problems. The speed with which a guaranty association can meet it obligations is largely dependent on how quickly a receiver notifies the guaranty association that a problem exists and then invites it to participate in the process of resolving an insolvency. In an insolvency with Y2K complications, early guaranty association involvement is even more critical.

The Committee believes that by explaining to the regulatory community what steps guaranty associations have taken to prepare for insolvencies affected by Y2K problems and by highlighting the critical data that the guaranty associations need in order to meet their obligations to policyholders, regulators will be more likely to alert the guaranty associations and/or NOLHGA earlier about any problem companies. The Committee has also prepared a list of the essential records that guaranty associations need in order to process claims and to determine company policy types and individual policy values. By sharing this information with insurance departments, guaranty associations hope that the regulators will consider including these data elements in any back-up requirements that the departments may impose on their domestic insurers.

The Committee has had an active dialogue with insurance regulators, both on an individual basis and through the National Association of Insurance Commissioners. On an individual state level, many guaranty association administrators have met regularly with the insurance commissioner or with the staff members responsible for Y2K issues in each state. These meetings provide a two-way exchange of information with regulators. By and large, the regulators are confident that the vast majority of their domestic insurers will be prepared for Y2K. Those companies that seem lagging behind are often targeted for enhanced monitoring by the insurance department. This advance monitoring provides states with an early indication of those insurers that will most likely be affected by the Y2K bug. The Committee expects that this greater scrutiny will provide timely notice of any potential insolvencies and will lead to their more efficient resolution.

NOLHGA is currently surveying its member guaranty associations regarding their capability of lending temporary assistance to receivers and insurance departments, as well as other guaranty associations that may experience Y2K problems.

The Committee is optimistic that the relationships developed in these meetings will serve policyholders well in the event insurance company insolvencies are complicated by the Y2K bug.

Static Back-Up Data Files Needed

Regulators are being encouraged to recognize the need for insurers to have static back-up data files in advance of January 1, 2000. If a company with Y2K problems becomes insolvent, it is likely to

have outdated and/or poor computer systems. Lack of back-up data files could affect the quality of data available to both receivers and guaranty associations as they address their respective obligations. Additionally, if bad data is carried through from one quarter to the next, it will be necessary to reconstruct records from the point when the Y2K bug first came into play. This reconstruction process can be an extremely costly and time-consuming process. Therefore, accurate and usable back-up records maintained prior to January 1, 2000 will be critical to receivers and guaranty associations as they sort out policies, payments and a host of other data issues.

In June 1999, several members of the Committee took this same issue into the development of a national contingency plan sponsored by the NAIC that state insurance departments could use in the event their operations are adversely affected by Y2K problems. Planning participants reviewed six areas: consumer complaints, market conduct examinations, financial surveillance, rehabilitation and liquidation, agent licensing, and rates and forms filing. While the plan addresses primarily the responsibilities of insurance departments and receivers, participants recognized that guaranty associations may play a critical role in assisting regulators and receivers in dealing with any Y2K issues affecting financially impaired companies. A major item within the plan, as drafted, calls for regulators to direct each domestic insurer to confirm that it is maintaining static data archives on a monthly basis. If a Y2K problem does arise, historical information will be invaluable in the event records need to be restored by regulators, receivers and guaranty associations.

Preparing for Potential Y2K Insolvencies

While preparing both internal guaranty association systems for Y2K and communicating with insurance departments regarding Y2K are critically important, having the available resources to respond to a potential Y2K-affected insolvency is equally important.

The Committee has developed an "early response team" concept as one avenue for addressing Y2K-related insolvencies. It has identified a list of the skills that would be needed to address Y2K issues in an insolvency. It has also identified consultants, primarily computer experts, third party administrators, and others that could quickly analyze the insolvent company for Y2K problems. By identifying any Y2K problems rapidly, prompt action can be taken to protect company records and policy data from further deterioration. NOLHGA is also preparing a list of providers of commonly used industry software who can address any software difficulties experienced by a company.

Although the work of the Committee is not yet completed, it has shared information with current NOLHGA insolvency task forces in order to increase the awareness of Y2K-related issues as these other task forces address the problems associated with their particular cases. The Committee will provide support to each task force to assist it in ensuring that an insolvent company's systems are Y2K compliant or that the necessary steps to address Y2K problems can be taken.

Most people associated with the insurance industry, from regulators to company executives to guaranty association administrators, are confident that the industry is prepared for January 1, 2000. While it is impossible to predict what challenges the millennium bug may bring, the guaranty association system is ready to address them.

* * * * *

John J. "Jack" Falkenbach is the Executive Director of the Delaware Life and Health Insurance Guaranty Association and chairs NOLHGA's Year 2000 Insolvency Contingency Plan Committee.

Peter J. Marigliano is the manager of communications at NOLHGA.

IN THE HIGH COURT OF JUSTICE
CHANCERY DIVISION
COMPANIES COURT

No 4655 of 1999

IN THE MATTER OF THE CHARTER REINSURANCE COMPANY LIMITED
and
IN THE MATTER OF THE COMPANIES ACT 1985

Following approval by the requisite majority of creditors of the Scheme of Arrangement ("the Scheme") between The Charter Reinsurance Company Limited and its Scheme Creditors (as defined in the Scheme) on 22 September 1999 and sanction of the Scheme by the High Court on 11 October 1999, a copy of the order sanctioning the Scheme was delivered to the Registrar of Companies on 12 October 1999.

The Effective Date of the Scheme is therefore 12 October 1999.

The Joint Scheme Administrators are Philip John Singer and Christopher John Hughes of PricewaterhouseCoopers.

The deadline for the return of amended Provision of Information Forms and Broker Statements is 11 January 2000. Unless amended forms are received by that date at the address set out below, the Scheme Creditor concerned will be bound by information contained in that form.

Amended forms must be returned to the following address:
The Charter Reinsurance Company Limited
c/o PricewaterhouseCoopers
3 St Philips Central
Bristol BS2 0XJ
United Kingdom

ONE INSOLVENCY'S EXPERIENCE WITH ARBITRATION

By Paula M. Young

The role of arbitration in insurance insolvency continues to be a controversial issue. Courts precluding arbitration in insolvency have taken four approaches. First, the court may find, as a Missouri Court of Appeals found, that the contract language itself precludes arbitration of the particular dispute. Second, courts may determine that the comprehensive insurance insolvency code vests the receivership court with exclusive jurisdiction over the claims in question. These courts, especially the New York courts, express concerns about turning over to private arbitrators the power to decide issues relating to the principle source of the assets of an insolvent insurer. Arbitrators, they note, need not consider and are not bound by existing precedent, the insolvency code or the impact the individual decision may have on the orderly administration of the estate. Third, courts may find that a specific state statute precludes arbitration of insurance contracts or the commencement of arbitration proceedings against an insolvent insurer's liquidator. These courts also find that the state law is saved from pre-emption by the Arbitration Act, 9 U.S.C. §§ 1 to 14, under the three-part test of the McCarran-Ferguson Act, 15 U.S.C. § 1012.[1]

Convention not Sacrosanct Source of Arbitration Rights

In the case of alien reinsurers, courts have precluded arbitration by applying certain preconditions and exceptions to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards, June 10, 1958, 21 UST 2517, TIAS No. 6997 (Convention).[2] Art. II(1) of the Convention applies to an agreement "concerning a subject matter capable of settlement by arbitration." Liquidators have argued that claims against a reinsurer are not capable of settlement by arbitration simply by virtue of the fact that the cedent is now in statutory liquidation. The RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES § 488, Rptr's note 1 (1987) states that: "[T]he law of most states regards certain kinds of issues as not subject to arbitration ... [including] public law issues such as... matters as to which particular legislation has been enacted for the protection of certain parties." Art. II(1) may take "proper account of laws in force in many countries which prohibit the submission of certain questions to arbitration." S. Exec Doc. E, 90th Cong., 2d Sess. 19 (1968). The same executive document noted that the non-arbitrability provision of Art. V(2)(a) and the public policy exemption of Art. V(2)(b), discussed below, "would give the courts to which application is made considerable latitude in refusing enforcement." *Id.* at 21. When the United States has particular legislation — the McCarran Ferguson Act — which cedes to the states the regulation of the business of insurance, including the liquidation of insurance companies, and when a state, in turn, has passed specific legislation to regulate the liquidation of insurers, a court may find that the public policy set forth in the insurance insolvency code precludes application of the Convention to the dispute.

Convention Art. II(3) also provides that the court will refer the matter to arbitration "unless...said agreement is null and void, inoperative or incapable of being performed." When state law precludes arbitration, a court may find that the statutes make the arbitration provisions of the parties' agreements inoperative. The court may allow the state law to operate even if it contravenes the Convention. The Convention specifically contemplates that result.

Art. I(3) and Art. XIV of the Convention requires reciprocity. Article XIV of the Convention provides: "A Contracting State shall not be entitled to avail itself of the present Convention against other Contracting States except to the extent that it is itself bound to apply the Convention." When that reciprocity is lacking, the Convention is not enforceable.

Several exceptions to enforcement of an arbitral award also appear in the Convention. Convention Art. V(1)(a) provides that recognition and enforcement of arbitral awards "may be refused...if the said [arbitration] agreement is not valid under the law to which the parties have subjected it or...under the law of the country where the award was made." When the reinsurance agreement subjects the dispute to the laws of a state that vests exclusive jurisdiction in the receivership court or includes an anti-arbitration statute, a court may find that the arbitration "agreement is not valid under the law to which the parties have subjected it."

Convention Art. V(1)(c) further provides that recognition and enforcement of an arbitral award may be refused if the award deals with a difference not contemplated by or not falling within the terms of the submission to arbitration.

[1] *See* J. Moody III and S. Pickels, "Compelling a Receiver to Arbitrate Under the Federal Arbitration Act," MEALEY'S LITIGATION REPORT; INSURANCE INSOLVENCY, vol. 10, no. 23 (May 5, 1999); J. Veach, "Courts, Legislatures and Reinsurers Struggle with Receiver's Refusal to Arbitrate," MEALEY'S LITIGATION REPORT; INSURANCE INSOLVENCY, vol. 9, no. 20 (March 18, 1999).

[2] *See* L. Quigley, "Accession by the United States to the United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards," 70 YALE L.J. 1049, 1079-1080 (1961); K. Carr, "The Conflict Between the Arbitration Convention and the McCarran-Ferguson Act," 18 TUL.MAR.L.J. 71, 82-83 (1993).

Thus, if the liquidator successfully argues that the parties did not agree to submit to arbitration the reinsurer's failure to pay claims, this provision could preclude the application of the Convention to the dispute.

Convention Art. V(2) provides that recognition and enforcement of an award may also be refused if "competent authority in the country where recognition...is sought finds that: (a) the subject matter of the difference is not capable of settlement by arbitration under the law of that country; or (b)the recognition or enforcement of the award would be contrary to the public policy of that country." When the parties have agreed that the particular dispute is not subject to arbitration or when the state law precludes arbitration, then a court may find that the exception found at Art. V(2)(a) applies. The court may also apply the Convention exception found at Art. V(2)(b). The McCarran-Ferguson Act expresses a strong public policy that "the continued regulation...by the several States of the business of insurance is in the public interest...." 15 U.S.C. § 1011. In passing the McCarran-Ferguson Act, Congress ceded primary regulation of the insurance industry to the states and provided an exemption under certain circumstances from the application of federal laws. The public policy expressed in the McCarran-Ferguson Act is at least equal to, if not stronger than, the policy of encouraging arbitration. That policy has remained unchanged for over fifty years since 1945. While the Convention's public policy exception is to be applied in good faith and narrowly, a New York court found that "McCarran-Ferguson states a clear congressional mandate that regulation of the insurance industry be left to the individual states."

A. Transit Casualty Company v. Certain Underwriters at Lloyd's (Transit I).

Transit Casualty Company in Receivership (Transit) has litigated with four reinsurers over whether the liquidator may be compelled to arbitrate disputes involving amounts due the estate. In *Transit Casualty Company in Receivership v. Certain Underwriters at Lloyd's London*, 963 S.W.2d 392 (Mo. App. 1998)(*Transit I*), the appellate court affirmed the denial of a motion to compel arbitration. It based its decision on an interpretation of the service-of-suit and arbitration clauses found in the reinsurance agreements. The court ruled that the specific contract language did not require arbitration of the dispute between Transit and a Lloyd's syndicate.

The court found that the service-of-suit clause was unambiguous. It pertained to a very specific situation. It permitted Transit to litigate a failure to pay any amount "claimed" to be due under the agreement in any court of competent jurisdiction. It provided that Lloyd's would comply with all requirements of "such court" that all matters will be determined by "such court," and that Lloyd's would abide by the final decision of "such court." It also provided for review on appeal. *Transit I*, 963 S.W.2d at 397.

The court next held that the arbitration clause was also unambiguous. It was, however, broad and general and referred to all disputes or differences arising out of the entire contract. It precluded any review by appeal. *Transit I*, 963 S.W.2d at 398. Nonetheless, Lloyd's had to prove that Transit agreed to arbitrate the particular dispute between the parties. That factual or contractual evidence simply did not exist.

The court next applied a rule of contract interpretation requiring that when one contract clause is general and inclusive and another is more limited and specific, the more specific clause acts to modify and "pro tanto" nullify the more general clause. *Transit I*, 963 S.W.2d at 398. According to this rule, the disputes relating to Lloyd's failure to pay reinsurance claims should be governed by the more specific service-of-suit clause. The arbitration clause simply did not apply to this particular dispute. Under this interpretation, the clauses acted in harmony. The service-of-suit clause permitted Transit to bypass arbitration by bringing Lloyd's to court in the event Lloyd's failed to pay a claim submitted to it. The arbitration clause still provided the exclusive forum for disputes not involving a failure to pay claims.

The court also ruled that the service-of-suit clause did not pertain solely to the enforcement of an arbitration award. *Transit I*, 963 S.W.2d at 387-98. The plain language did not mention the word arbitration or refer to Article XXII of the agreements governing arbitration. Id. Moreover, Lloyd's interpretation would render the words "amounts claimed to be due" found in the service-of-suit clause meaningless; it would change the contract to read "amounts awarded by an arbitration panel." Id. Finally, the court noted that the syndicate or Lloyd's of London had developed the language at issue: "[A] body of case law [exists] construing Lloyd's service of suit clauses in a related context which is consistent with our interpretation." 963 S.W.2d at 399.

Prior to this decision, a federal district court in Missouri and the Eighth Circuit Court of Appeals had also considered the issues raised by Lloyd's motion to compel arbitration under the Convention. The district court determined that the McCarran-Ferguson Act protected from preemption the Missouri anti-arbitration statutes and that the Lloyd's syndicates had waived the right to arbitrate disputes involving Transit under the Convention. *Transit Casualty Co. v. Certain Underwriters at Lloyd's of London*, 1996 WL 938126 (W.D.Mo. 1996); *Transit Casualty Co. v. Certain Underwriters at Lloyd's of London*, 1997 WL 854496 (W.D.Mo. 1997). In both cases, the district court remanded the action to the state receivership court. (Id.) On appeal in both cases, the Eighth

(Continued on page 22)

[3] The Eighth Circuit also dismissed on the same basis two appeals involving court orders denying motions to arbitrate filed by two other London Market reinsurers in *Transit Casualty Co. v. Winterthur Swiss Ins. Co.*, No. 97-4220-CV-C-2, slip op. (W.D. Mo. Oct. 8, 1997), *appeal dismissed*, No. 97-4191WM, slip op. (8th Cir. April 7, 1998); *Transit Casualty Co. v. Compagnie Europeene D'Assurances Industrielles S.A.*, No. 97-4194-CV-C-2, slip op. (W.D. Mo. Oct. 8, 1997), *appeal dismissed*, No. 97-4190WM, slip op. (8th Cir. April 7, 1998).

ONE INSOLVENCY'S EXPERIENCE WITH ARBITRATION

(Continued from page 21)

Circuit let the remand order stand. *Transit Casualty Co. v. Certain Underwriters at Lloyd's of London*, 119 F.3d 619 (8th Cir. 1997), *cert. denied*, 66 U.S.L.W. 3298, 118 S.Ct. 852, 139 L.Ed.2d 753 (1998); *Transit Casualty Co. v. Certain Underwriters at Lloyd's of London*, Nos. 97-3879 et al., slip op. (8th Cir. 1998). In all these cases, the courts have refused to compel Transit to arbitrate its collection actions against reinsurers.[3]

B. Transit Casualty Company v. Certain Underwriters at Lloyd's (Transit II).

In April 1998, a second set of Lloyd's syndicates appealed a decision of a special master denying Lloyd's motion to compel arbitration. *Transit Casualty Company v. Certain Underwriters at Lloyd's*, No. WD 55735 (W.D. Mo.). Transit filed a motion to dismiss the appeal as premature since the special master's order from which Lloyd's took the appeal was not a final appealable order. The order had to be confirmed, modified or reversed by the circuit court first. Lloyd's argued that the court had jurisdiction to hear the appeal because the special master's order was an interlocutory order appealable under the state's version of the Uniform Arbitration Act. The appellate court did not grant the motion to dismiss at that time and instead it instructed the parties to brief and argue the case.

At the oral argument, Transit withdrew its motion to dismiss the appeal. It advised the court that at least one more reinsurer intended to appeal a similar order entered by a trial court in the Transit insolvency proceedings. Thus, out of an interest for judicial economy, Transit asked the court to rule on the statutory and Convention issues raised by the reinsurers' motion to compel arbitration. On June 30, 1999, the court considered its jurisdiction on its own motion. It issued an opinion finding that there was no valid appealable order.

C. Transit Casualty Company v. CEAI.

As Transit predicted, a third reinsurer appealed the arbitration issue to the Missouri Court of Appeals in February 1999. *Transit Casualty Company v. Compagnie Europeene D'Assurances Industrielle, S.A.*, No. WD56891 (Mo. App. W.D.). Transit again asked the appellate court to resolve the statutory and Convention issues raised by CEAI's motion to compel arbitration. Specifically, Transit asked the court to resolve the case in its favor by applying the pre-conditions and exceptions found in the Convention and by applying Mo. Rev. Stat. §§ 375.1154, 375.1155.1, 375.1176 and 375.1188. The first statute provides that all actions taken under the insolvency code "shall be brought in the circuit court of Cole County...." The second statute permits the supervising court to issue orders or injunctions he deems necessary and proper to prevent a waste of the insurer's assets, the institution or further prosecution of any actions or proceedings and any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders or the administration of any proceeding under the insolvency code. Section 375.1176 provides that the liquidator manages the assets of the estate "subject to the supervision of the court until the liquidator is discharged...." Section 375.1188 provides that "no action at law or equity or in arbitration shall be brought against the insurer or liquidator...." Based on these statutes, Transit asserts that the receivership court has control over the assets of the estate and the reinsurer cannot compel Transit to arbitrate any of its claims for breach of contract, pre-answer security, vexatious delay penalties or commutation of the agreement.

Transit also argued that the McCarran-Ferguson Act, 15 U.S.C. § 1012, protects the state statutes from preemption by the Convention. In support of both arguments, Transit cited several cases: *Davister Corp. v. United Republic Life Ins. Co.*, 152 F.3d 1277 (10th Cir. 1998)(statutory stay makes clear the policy of the state to consolidate in one forum all matters involving liquidation of insurer; McCarran-Ferguson Act precludes arbitration under 9 U.S.C. §§ 1-14); *Munich American Reinsurance Co. v. Crawford*, 141 F.3d 585 (5th Cir. 1998)(arbitration of reinsurer's action would interfere with insurer delinquency proceedings); *Stephens v. American Int'l Ins. Co.*, 66 F.3d 41 (2nd Cir. 1995)(same); *Ideal Mut. Ins. Co. v. Phoenix Greek Gen. Ins. Co.*, 1987 WL 28636 at * 1 (S.D.N.Y. 1987)(Art. V of Convention denies recognition to arbitral awards if "contrary to the public policy" of the United States; the McCarran-Ferguson Act clearly mandates that the insurance business be regulated by the states; thus, where state insolvency code offers the exclusive remedies, arbitration may be denied); *Washburn v. Corcoran*, 643 F. Supp. 554 (S.D.N.Y. 1986)(finding that McCarran-Ferguson Act saves the state insolvency statute from preemption by 9 U.S.C. §§ 1-14 and precludes arbitration). *See also United States Financial Corp. v. Warfield*, 839 F. Supp. 684, 689 (D. Ariz. 1993)(decision in *U. S. Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993) controlled finding that state statute vesting exclusive jurisdiction in the liquidation court was not preempted); *Albany Ins. Co. v. Wright*, Cause No. 85-CI-0591, slip op. (Franklin County Cir. Ct., Kent. Feb. 4, 1994)(Kentucky Liquidation Act is not superseded by the Convention; liquidator cannot be compelled to arbitrate); *Corcoran v. Ardra Insurance Co., Ltd.*, 77 N.Y.2d 225, 567 N.E.2d 969, 566 N.Y.S.2d 575 (Ct. App. 1990), *cert. denied*, 500 U.S. 953 (1991) (applying exceptions to Convention to preclude arbitration); *Corcoran v. AIG Multi-Line Syndicate, Inc.*, 167 A.D.2d 332, 562 N.Y.S.2d 933 (N.Y. 1990), *reversing*, 143 Misc. 2d 62, 64, 539 N.Y.S. 2d 630, 632 (Sup. Ct. 1989) (Convention Art. V(2) exception precludes arbitration against a liquidator); *Union Indemnity Ins. Co. v. American Centennial Ins. Co.*, 137 Misc.2d 575, 521 N.Y.S.2d 617 (Sup. Ct. 1987)(exclusive jurisdiction is vested in the receivership court, therefore, arbitration was "inappro-

priate and would only lead to piecemeal determination of the relevant issues and possible duplication of efforts and inconsistent results...."); *Mich. Nat'l Bank v. Am. Centennial Ins. Co.*, 137 Misc. 2d 575, 521 N.Y.S.2d 617, 620 (Sup. Ct. N.Y. Co. 1987)("Arbitration is...inappropriate and will only lead to piecemeal determination of the relevant issues...."); and *Knickerbocker Agency, Inc. v. Holz*, 4 A.D.2d 71, 162 N.Y.S.2d 822, (N.Y.A.D. 1957), *aff'd*, 4 N.Y.2d 245, 149 N.E. 2d 885, 889, 173 N.Y.S.2d 602 (1958)(legislature vested exclusive jurisdiction over all claims against an insolvent insurer in the supervisory court; that exclusivity of jurisdiction prevails over contractual right to arbitrate).

The reinsurer argued that cases from New York and Kentucky are not persuasive since the states have not adopted the Model Act prepared by the National Association of Insurance Commissioners. The reinsurer also argued that the courts in *Davister* and *Munich America* did not rule that the state statutes precluded arbitration. They found instead that the federal court was not the proper forum to compel arbitration. Similarly, the reinsurer argued that the decision of the United States District Court for the Western District of Missouri in the four Transit-related cases dealt only with removal jurisdiction, not arbitration, even though the reinsures removed the cases under a special section of the legislation implementing the Convention.

The reinsurer has relied on eight cases: *Quackenbush v. Allstate Ins. Co.*, 121 F. 3d 1372 (9th Cir. 1997); *Bennett v. Liberty National Fire Ins. Co.*, 968 F. 2d 969 (9th Cir. 1992); *Selke v. New England Ins. Co.*, 995 F. 2d 688 (7th Cir. 1993); *Phillips v. Lincoln Nat'l Health & Casualty Ins. Co.* 774 F. Supp. 1297 (D. Colo. 1991); *Ainsworth v. Allstate Insurance Company*, 634 F. Supp. 52 (W.D. Mo. 1985); *Fabe v. Columbus Ins. Co.*, 587 N.E.2d 966 (Ohio Ct. App. 1990); and *Foster v. Philadelphia Manufacturers Ins. Co.*, 592 A.2d 131 (Pa. Cmmw. 1991).

Transit argued that none of these cases involve arbitration under the Convention. None involve two forum selection clauses. None involve a statute expressly precluding arbitration in insolvency. Moreover, at least three of the cases do not involve a statutory scheme held to be comprehensive and exclusive which set outs the only procedures permitted in liquidation. All but one of these cases were decided before the United States Supreme Court's clarification in *U.S. Dept. of Treasury v. Fabe*, 508 U.S. 491 (1993) of the three-part test governing reverse pre-emption under the McCarran-Ferguson Act. Finally, none of the cases involved estates as complex as the Transit estate. Transit originally had contracts with over 900 reinsurers. Arbitration with Transit's reinsurers would result in the unnecessary dissipation of assets expended to re-educate each new arbitration panel. Different arbitration panels could issue inconsistent rulings that could ignore, with impunity, the insolvency code and prior decisions interpreting it. Thus, requiring the liquidator to arbitrate its disputes with reinsurers would interfere with the orderly administration of the liquidation in violation of the Missouri statutes.

In the past few weeks the parties settled the underlying action and the court dismissed the appeal on September 15, 1999.[4] Transit will have to wait to another day to get the ruling it seeks on the statutory and Convention issues raised by a reinsurer's motion to compel arbitration.

D. Conclusion.

Even though federal policy favors arbitration in most commercial settings, insurance insolvency still operates largely outside that policy. Liquidation of an insolvent insurer under state laws that the legislature has carefully crafted for that purpose offers a compelling countervailing policy that often trumps a reinsurer's right to compel arbitration of disputes arising under its contracts. State legislatures are free to amend those statutes to permit arbitration in insolvency, but few have taken that opportunity. Legislators apparently intend that courts, not private arbitrators, should resolve disputes that can have a significant impact on the recovery of assets for policyholders and other creditors of an insolvent insurer.

* * * * *

Paula M. Young is a partner in the law firm of McCarthy, Leonard, Kaemmerer, Owen Lamkin & McGovern, L.L.C. located in St. Louis, Missouri. Her practice is concentrated in the areas of insurance insolvency, reinsurance, insurance coverage issues and mediation of commercial disputes. Her firm serves as General Counsel to the Special Deputy Receivers of Transit Casualty Company. We are introducing her to IAIR members in this month's "Meet Your Colleagues" section.

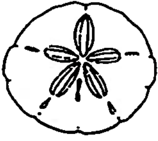
[4] The appeal involving the fourth reinsurer also settled before the appellate court could rule on the statutory and Convention issues raised by the motion to compel arbitration. *Transit Casualty Co. v. Winterthur Swiss Ins. Co.*, No. CV597-2CC , *In Camera* Order Approving Agreement to Commute Reinsurance Obligations (Cole County Cir. Ct. Mo March 19,1999).

OTHER NEWS & NOTES

(Continued from page 5)

As the Big Five accounting firms were moving into the legal profession abroad, particularly in Europe and Canada, the commission's report sent a strong signal to the legal profession that a marriage between law and accounting in the United States was not far off.

Well, the marriage will not be consummated any time soon. On my birthday, August 10, the ABA House of Delegates at their Annual Meeting in Atlanta voted overwhelmingly (304-98) against the commission's initiatives. It likely will be at least a year before another proposal will be considered. In the meantime, the commission will go back to the drawing board and likely hold more hearings on the whole question of multi-disciplinary practices and whether that is in the best interest of the consumer and of the law profession.



ORMOND INSURANCE AND REINSURANCE MANAGEMENT SERVICES, INC.

SERVICES OFFERED

- **Administration of MGA, Primary or Reinsurance Books of Business**
  data processing, accounting, underwriting claims, regulatory filing, rehabilitation strategies. . .
- **Arbitration and Litigation Support**
  expert testimony, discovery work, case management, depositions, litigation assistance, reconstruction of records, arbitration panel member. . .
- **Audits and Inspection of Records**
  pre-quotation, contract compliance, aggregate exhaustion, reserve adequacy. . .
- **Commutation Negotiations**
  reserve determination, present value calculation. . .
- **Contract Analysis**
  analysis of reinsurance contracts, analysis of primary or excess coverage, contract drafting. . .
- **Reinsurance Recoverable Administration**
  reporting, collections, letter of credit control, security review. . .
- **Special Projects for Rehabilitators, Liquidators, and Insurance Company Management**
  reconstruction of premium and loss history, loss development analysis, reserve determination. . .
- **Statutory Accounting**
  annual and quarterly statement preparation, diskette filing, premium tax returns. . .
- **Client Representative**
  settlement conferences, attend informational meetings, monitor activities of defense counsel. . .
- **Reinsurance Data Systems**
  main frame and PC systems in place for processing of underwriting, claims and accounting for assumed, ceded or retrocessional business

ORMOND INSURANCE AND
REINSURANCE MANAGEMENT SERVICES INC.

140 South Atlantic Avenue, Suite 400
Ormond Beach, Florida 32176

Telephone: (904) 677-4453
Telefax: (904) 673-1630

John B. "Jay" Deiner
Executive Vice President
Secretary & General Counsel

A.L. "Tony" DiPardo
Senior Vice President

William T. "Bill" Long
Senior Vice President