The Insurance Receiver

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Promoting Professionalism and Ethics in the Administration of Insurance Receiverships

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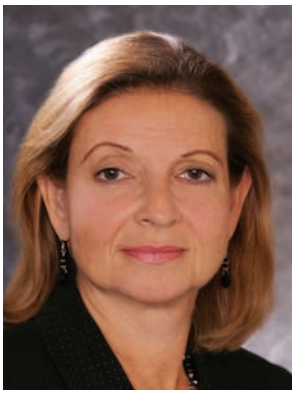
Dear IAIR Members and Colleagues:

As the "lazy, hazy, crazy days of summer" approach, the outlook for IAIR, its members and the insurance industry overall is anything but calm.



Francine L. Semaya, Esq.

I dream of those summer days when I would sit on the beach and the only care I had was what would happen in the next chapter of my book. Now I open up my emails and wonder what crises are looming ahead, for not only our industry, but for the economy overall.

There seems to be a slight improvement in the economy – enough to give optimists some hope – and although AIG and its troubles remain in the daily headlines – the insurance industry is relatively stable. Now that doesn't mean that receivership practitioners or the guaranty funds should pack up and go home – far from it – but a crisis of multiple failing insurers is not on the immediate horizon.

What does the current economic climate mean for IAIR and its members? As I attend IAIR meetings, other industry conferences and chat with fellow practitioners, there seems to be a common focus on our efforts to do more than just "survive." We must improve our productivity, give greater support to our members, and provide expanded and high quality educational programs. Our members, our clients, senior management, regulators and others are not only looking for more enhanced services but for the most knowledgeable service provider.

On that particular note, IAIR continues to strive to be the best educational forum for the insurance receivership community and beyond. Our exceptional Issues Forums attract the attention of our members, regulators and non-members alike. We now have highly qualified speakers seeking

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... provide guidance and assurance in troubled times. For three decades, our lawyers have represented public officials in insurance insolvency and other matters.

IAIR's President's Message (Continued)

time on our programs. My favorite forum is our Think Tanks – not only are they intellectually challenging, but it allows me to walk off about 5 pounds during each session.

But with every organization, the strength and success is its members, and we must continue to grow and expand our membership. Change is good – and new members, along with our "established" members, bring new ideas and life to IAIR.

As I round the corner into the second half of 2009 and the final six months of my two year term as IAIR President, I pledge to continue to help IAIR grow to meet the needs of our members and the receivership community; to become a more active member in INSOL; to educate regulators on the value IAIR and its members have to the larger regulatory community, and to be the premier educational facility in insurance receivership. But I need your help – no WOMAN stands alone on these endeavors and I need each and every one of you beside me as we move forward. I need your ideas, your articles for our newsletter, your attendance and participation in the Think Tanks, Issues Forums and Committees and the upcoming Insolvency Workshop 2010. Please entrust me to continue IAIR's mission with your help.

Have a wonderful safe summer. School may be out but IAIR is working for you.

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IAIR Welcomes New Members

The following members were approved at the Spring 2009 IAIR Board of Directors Meeting:

Dennis W. Cahill is the Chief Operating Officer of Arrowpoint Capital Corp., located in Charlotte, North Carolina. Mr. Cahill has responsibility for Legal & Regulatory and Information Systems, as well as all U.S. commercial and personal insurance operations.

James F. Meehan is General Counsel for Arrowpoint Capital Corp., located in Charlotte, North Carolina. Mr. Meehan leads the Legal & Regulatory Division, bringing more than 26 years of experience in practicing law, with focus and expertise in the insurance industry.

Jeanette M. Smith is Of Counsel for Kutak Rock LLP located in Omaha, Nebraska. She primarily focuses on insurance regulatory matters and general corporate representation.

John Tighe is President and CEO of Arrowpoint Capital Corp., located in Charlotte, North Carolina. Mr. Tighe is an insurance executive with over 25 years of experience in the property and casualty insurance field. Prior to his position as President and CEO of Arrowpoint Capital, Mr. Tighe held various leadership positions with Royal & Sun Alliance, including President and CEO of Custom Risk Division.

Board Talk – James Kennedy

By Michelle Avery & Jamie Saylor

"And I think that…you probably spend more time in planning and training and designing for things to go wrong, and how you cope with them, than you do for things to go right."

James Kennedy

While not a quote from a colleague dealing with receivership issues, this quote attributable to NASA astronaut Alan Shepard in reference to space exploration seems an appropriate way to launch our article on IAIR Board member James Kennedy not only because of its clear application to the receivership world but because of who the quote comes from (more on that later in the piece).

James Kennedy has been a member of IAIR since 2001 and is due to complete his first term on the IAIR Board at the end of this year. As a lawyer with over 20 years of receivership experience, James has spent the last dozen years working for the Texas Department of Insurance ("TDI") in the legal and regulatory affairs division. This is his second assignment with the Department, having previously worked in the liquidation division from 1989-1993. Between his time with the TDI, James represented special deputy receivers with Jo Ann Howard & Associates. James worked for the TDI at a seminal point in its evolution. In the early 1990s within the liquidation division, through a change in the statutes, the TDI separated the receivership function from the guaranty fund function. At the same time, the Department began outsourcing receivership work to special deputy receivers. During a challenging period in which over 100 receiverships were transitioned to outside contractors, James left the TDI to work for Jo Ann Howard & Associates, filling the demand for outside special deputy receivers that was created by the changes within the Department. James spent four years at Jo Ann Howard & Associates providing legal counsel to special deputy receivers. After rejoining the TDI and with a long-term perspective, James is happy to declare the TDI's transformation a successful one both for the Department and for the estates in Texas.

James cites his work on passing Texas' Insurer Receivership Act in 2005 as one of the most meaningful accomplishments of his career. Modeled after the NAIC's Insurance Receiver Model Act ("IRMA"), Texas succeeded in passing its Insurer Receivership Act prior to the NAIC's adoption of IRMA. Also while at the TDI, James played an integral role in placing

(continued on page 6)

Board Talk (Continued)

Highlands Insurance Company into receivership, to the greater benefit of the policyholders, and keeping it from liquidation.

As public scrutiny and federal oversight continue to be at the forefront of the discussion regarding the insurance industry, James believes that one of IAIR's biggest challenges will be its ability to adapt and be responsive to a rapidly changing environment.

On the personal side of things, James was born in New Orleans and spent part of his youth in New York before moving to Texas in junior high school. James settled in Texas and never looked back. He went on to the University of Texas for both his undergraduate and law degrees and currently makes his home in Austin.

We also asked James some of our typical hard-hitting, probative questions.

Q. What is your favorite sports team?

A. While not a huge professional sports fan, James is a big supporter of the University of Texas Longhorns which also happens to be the only game in the town in Austin of any consequence.

Q. What is the last fiction book you read?

A. Similar to several of our other recent board member interviewees James is a non-fiction reader. James includes himself among those whose interests lie primarily in historical non-fiction. He just finished a book that documents the history of the various state capitals of Texas. For all of you geographically challenged, the current state capital of Texas is Austin.

Q. What is the last place you vacationed?

A. New York City and the borough of Long Island. James enjoys the nostalgic trips back home and looks forward to the unrivaled views from the Rainbow Room at the top of Rockefeller Center looking out at the Empire State Building.

Q. What is your favorite leisure activity?

A. James is an aviation buff and attends air shows and aviation museums alike.

Q. What is your favorite NAIC/IAIR conference location?

A. Having spent part of his childhood in New York, James' favorite spot for NAIC locations is New York City. James also gives a nod to San Francisco as another favorite conference location.

Q. If you could have dinner with any three people in the world, dead or alive, fictional or non-fictional, who would they be and why?

A. James is a huge fan of the NASA space program and has always taken a particular interest in space exploration. As such, his first dinner guest would naturally be Alan Shepard who commanded Apollo 14 and was the first American in space. James has also always had an interest in architecture and even dabbled in pursuing some college courses for a brief moment. James interest in architecture draws him to include as his second guest, Frank Lloyd Wright who was recognized as the greatest American architect of all time by the American Institute of Architects ("AIA"). James' has not yet visited Frank Lloyd Wright's Falling Water, which was voted "best all-time work of American architecture" by the AIA but James' intends to make the trip to Pennsylvania for a visit soon. Finally, highlighting both his political and historical interests, James would invite Theodore Roosevelt for his political courage and his unlikely ascension to the presidency as his third dinner guest. Quite a group.

Q. Give us one piece of personal information that your business acquaintances might not know about you?

A. James tests his comedic skills in Austin every year with the Austin Bar Association's annual Capitol Steps style show that pokes fun at his colleagues and comrades. James helps to write and even takes part in some of the skits.

Thanks to James for his time and cooperation on this article.

Michelle Avery, CPA is an Executive Vice President and Managing Director at Veris Consulting, LLC within the firms forensic accounting practice. Michelle has extensive experience assisting counsel in causation and damage assessments related to failed property/casualty and life and health insurance companies. Michelle is a member of the NAIC/AICPA Working Group Task Force.

Jamie Saylor, CPA is an Executive Vice President and Managing Director at Veris Consulting, LLC. Jamie directs the outsourced accounting practice at Veris from its Reston, VA office.

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Argentine Insurance Insolvency

By Ricardo Cantilo

Insolvency systems differ from country to country. The current status of the worldwide insurance market demands that global companies be aware of the main cornerstones in respect of

insolvency since it may be part of an exit strategy, something that some global players may be examining nowadays. The Argentine legal framework on insurance insolvency is one of the oldest in Latin America, dating from 1973, when Law 20.091 was passed by a military government and was later confirmed by Congress during the then established democratic government. Before that law, insurance contracts were regulated by the Commercial Code, and insurance insolvency was ruled by Bankruptcy Law, which was not sufficient to fill in gaps due to the specific nature of insurance which requires regulation that addresses the uniqueness of the business.

Lawmakers focused on the creation of the Superintendency of Insurance, a governmental entity with enough powers to supervise insurers and reinsurers with special emphasis on policyholder protection. Importantly, the Superintendency was created as a centralized entity which supervises insurers and reinsurers established in all the Argentine territory.

In general terms, Law 20.091 establishes how the Superintendency has to be organized, what are the authorization conditions, main rules to administer Insurance and/or Reinsurance Companies, a sanctionatory procedure in case of breach of regulation, and how to deal with authorization withdrawal, liquidation and/or insolvency. In the specific area of liquidation, the Law distinguishes between voluntary and mandatory liquidation, both of which are explained as follows.

Voluntary liquidation

This system is analogous to what in the U.S. is often called "solvent run-off." It takes place when the decision to liquidate the company is made by the company itself. The Board of Directors must decide to liquidate the company and prepare an action plan based on financial statements. The Company is expected to show its ability to meet all liabilities in time with the existing assets. The Superintendency will monitor frequently the evolution of this action plan and in case of breach, or if policyholder protection so requires, the Superintendency will be appointed as liquidator.

In practice, voluntary liquidation cases end up almost always in mandatory liquidation because of the inability of companies to cope with pressure by the Superintendency. Only a few cases which were initiated as voluntary liquidations ended up as such.

Mandatory liquidation

This type of liquidation is more common in Argentina than the previous one and it is triggered by a Resolution of the Superintendency deciding to withdraw authorization to operate as an insurer or reinsurer. Such decision may be based on a variety of reasons, key among them, not commencing operations within six months of being authorized, failure to comply with a regularization plan due to minimum capital shortfall; non compliance with its articles of association and/or authorization conditions; insolvency of its home office; and liquidation as an administrative sanction due to repeated non compliance with the law and/or regulations.

Effects of liquidation

Both in voluntary and mandatory liquidation, once the process starts, it is the end of the insurer as such. Regardless of whether all obligations to policyholders were honored or not, the company will no longer be able to operate as an insurer again.

Argentine Insurance Insolvency (Continued)

This is one of the most negative aspects of Argentine regulation since it does not contemplate rehabilitation as a viable option. The only alternative to rehabilitate an insurer would consist of discontinuing all underwriting activity and to run off liabilities until the company is completely clean. In such case, there is of course the possibility of resuming operation since the authorization was never lost. However, there is a big gap in Argentine regulation in this sense because companies in run off status are required to comply with the same minimum capital requirements as those of an active company, which normally is a heavy burden.

A specific effect of mandatory liquidation is that the Superintendency will be in charge of liquidating the company, acting as a kind of receiver, and this process will be subject to control and approval of a Commercial Court. Therefore, the Superintendency will specifically be in charge of selling all existing assets, collecting all credits and making those funds available to those creditors who appear before the Commercial Court to lodge their claims.

Difference between insurance liquidation and bankruptcy in general

Law 20.091 establishes that insurers are not permit-ted to file for bankruptcy. If no liquidation process is in place and an insurance company is technically in a position to be declared bankrupt, the competent Court must dissolve the company and appoint the Superintendency in order to liquidate it.

This issue was tested in Argentine Courts in the year 2000 in re "I.A.B." where a company, after deciding to enter into voluntary liquidation, filed for bankruptcy, which was accepted by a District Court. This decision was appealed by the Superintendency. The main argument advanced by I.A.B. was that upon entering into voluntary liquidation, the company changed status and was no longer an insurer but a company dealing with running off assets and liabilities. The Court of Appeal reversed the First Instance decision establishing that companies in liquidation still have to comply with law 20.091 and, therefore, have to be liquidated in accordance with said law.

The attempt by I.A.B aimed mainly at stopping interest accrual from the date of declaration of bankruptcy - which is possible under bankruptcy law but not under the liquidation process set out in law 20.091 - and to potentially solve the situation in a more convenient fashion than what the specific insurance insolvency regulation would permit.

The role of reinsurance recoverables under mandatory liquidation

This is an important aspect since normally insolvent insurers have insufficient tangible and / or fixed assets in order to satisfy all of their policyholders' claims. However, most of them have reinsured their risks and have a potential source of income by means of collecting reinsurance credits or commuting open claims and IBNR reserves.

Illogical as it seems, reinsurance recoverables historically have been neglected in the liquidation process for a variety of reasons, ranging from lack of supporting documentation, which was lost as a consequence of the deterioration of the insurers' records, to the absence of capabilities and resources to face those tasks. In the last few years, the Superintendency appointed external consultants to support them in dealing with the specific issue of reinsurance commutation and a few deals were successfully agreed. However, this is another weak point of insolvency regulation in Argentina, which was mainly left up to individual initiatives rather than being a matter of regulation.

Conclusions

According to information published by the Superintendency, there are 179 companies in liquidation, of which 30 are voluntary and 149 are mandatory. Among the latter, 31 started between 1979 and 1989; 86 between 1990 and 1999 and 32 between 2000 and the present. Furthermore, only 23 of the 149 have been closed and 126 remain opened.

These figures show that the Argentine insolvency system is not as efficient as it was thought to be. As explained above, lawmakers emphasized the policyholder protection aspects of Law 20.091, which, in the specific issue of insolvency, should have meant to ensure quick asset realization upon a company becoming insolvent in order to apply those funds to satisfy policyholders' claims.

Argentine Insurance Insolvency (Continued)

Bureaucracy, a slow judicial system and deterioration of the insolvent companies' records rank among the most common reasons why the The ideal situation would be to have similar tools as those available in the United Kingdom, where the Scheme of Arrangement was developed successfully in order to enable a company to agree with its creditors on a mutually acceptable method of valuing the company's liabilities at a prescribed date and paying them in full.

This solution is not available in Argentina nor is it in United States, though in the latter there are more developed solutions than there are in Argentina. However, companies interested in honoring all their obligations can adopt exit strategies like solvent run off, using specialized technical advice especially focused on pro-active management of liabilities and regulatory issues. Pro-active handling of a book of business will help reduce liabilities and perhaps save a company from having to go into involuntary liquidation.

Ricardo Cantilo

Ricardo Cantilo, is a lawyer specialized in Insurance and Reinsurance, Master in Insurance in Risk Management and Professor of Insurance Law at the Buenos Aires University. Ricardo is General Manager of Chiltington Internacional S.A., Buenos Aires Office of the Chiltington International consulting group.

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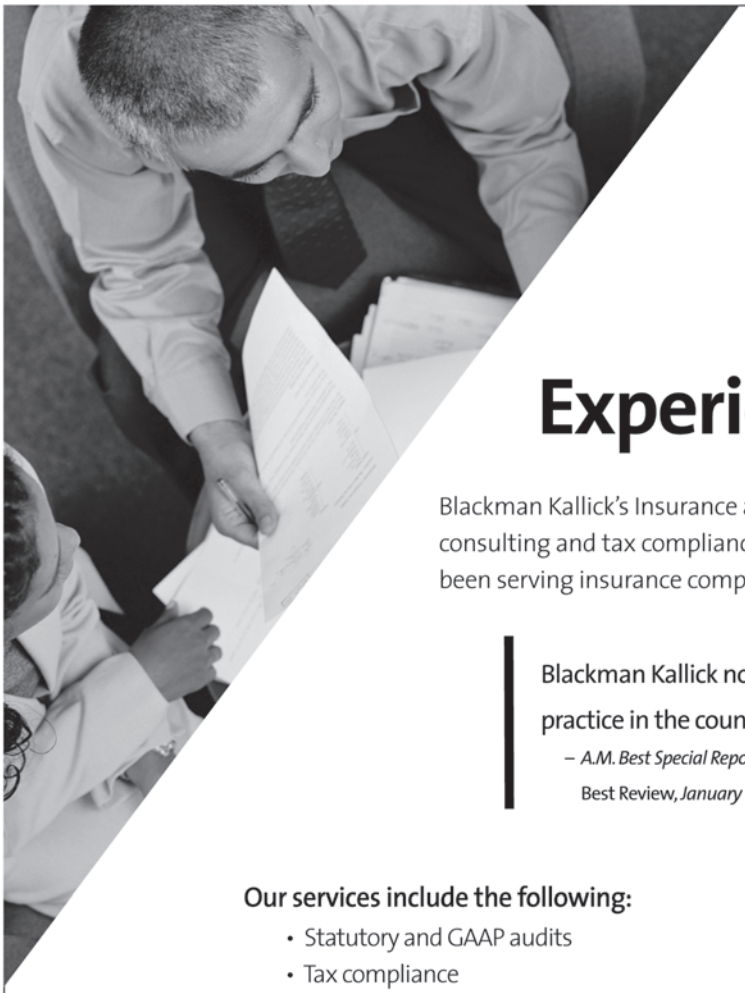

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Data Data Everywhere and So Hard to Collect!

By Jenny L. Jeffers, CISA, AES

This is the second in a series of articles regarding the importance and criticality of Information Systems processing during the liquidation of an insurance company the "Company")

This article will discuss the gathering of data in preparation for delivery to the appropriate entities. The existing IT staff can contribute greatly to the Receiver staff's understanding of the systems and the availability of possible data sources. They can also be helpful in determining the scope of each data request.

This sounds like a pretty easy job – just export the data from the Company system–yeah–right!

In general, the first request made by the Receiver to the IT Department is to produce a list of all policyholders with policies currently in force. All policy holders must be informed of the date their policies will cancel. This too sounds like a very simple request and sometimes it is.

There are some companies that have a single system for the administration of policies for all lines of business and they do not utilize MGAs (Managing General Agents) and/or TPAs (Third Party Administrators) for any processing. However, this is usually not the case, Some of the complicating scenarios are:

Multiple Systems Exist Due to Acquisitions

A typical way for an insurance company to expand is through acquisition of other existing companies, who have computer systems of their own. Ideally, the acquiring company would convert the information from the acquired company's systems into their systems – OR – the decision would be made that the acquired company's systems are better and the conversion would be done in the other direction. In either case, the data would all end up in a single system. Often, the conversion from one system to another is not easily done and therefore the conversion does not happen. Some reasons for this are:

- Systems are not on the same or compatible platforms – Mainframe, Server based, UNIX, etc.;
- Data that is critical in one system is not available from the second system;
- The acquired company has a different or additional line of business that the current system does not handle – such as a Workers Compensation system not being set up to process auto claims;
- The IT Department cannot fit the conversion into a crowded schedule of priority items (the acquired system is working – so conversion is not considered to be an immediate need);
- The acquiring company's IT Department does not have the expertise to perform the conversion; or
- After the acquisition, each company in a group is allowed to continue to run their company as they always had, i.e., no central systems are enforced.

Any of these scenarios can result in the company that is being put into liquidation having multiple systems – meaning multiple sources of policy holders that must be included in the list.

Companies in a Group Function Independently

Some company groups allow each entity to function independently. This means that each individual company has its own computer system. If the group is going into receivership, data must be acquired from each member entity – all of which may utilize differing platforms and formats.

Companies in a Group Share the Same System–Only One Company is Going Down

This scenario presents a problem in that the Receiver may have difficulty separating the liquidated company 's data from that of the surviving companies.

Data Data Everywhere and So Hard to Collect! (Continued)

Policies are managed by an MGA

Many companies are now utilizing "programs" to branch out into additional lines of business or niche markets. This sometimes occurs when an MGA comes to the company and says:

"We can sell thousands of policies to widget users to insure their widgets against getting old. Our group will sell the policies, do all the billing and processing of premium as well as processing claims. We will then pay you 15% of the premium just for using your paper. We will report the total premium collected and claims paid monthly and send you a check for your share of the premium."

The significant phrase here is - using your paper – therefore the policies are part of the liquidation and the responsibility of the Receiver.

This seems like a great deal – no work and making money – the company may agree to more and more "programs". This scenario creates what could be considered a data nightmare. The data for the policies administered by the MGAs is not on the company's system but is on the system of the MGA(s). The detail at a policy level is not immediately available, but must be acquired from the MGA. The data is only as good as the MGA system requires.

All of these scenarios may mean that a simple request for a list of in force policy holders can develop into a gigantic undertaking. It is the responsibility of the IT Specialist working with the Receiver to gather all information from every source:

- All in house systems – making sure to include only data for the correct company
- All external systems - including MGAs, TPAs and independent companies in the group

The second request will probably be to create a loss run for the Company to allow the Receiver to determine the outstanding reserves. The complications with regard to this request include all of the above plus one additional:

The Company and/or the MGA utilizes TPAs to Process Claims

In this scenario, even though the policies are being administered by the Company or the MGA, the most current and possibly only claims information is on the system at the TPA – or perhaps 200 different TPAs! This data must be acquired from the TPA(s). When a company goes into liquidation, the TPAs lose business. There are some instances where the TPA may be forced out of business due to the loss of business from the Company. TPAs in this situation are not interested in performing services for the Receiver – it costs them money to pack up claim files and provide data transmissions. Some TPAs utilized purchased systems and do not have the ability to perform exports of data. This further complicates getting data from these entities. If the TPA can provide the needed data in an electronic report file, there are data mining programs that will allow the extraction of data from reports. The acquisition of data and physical files from TPAs can be a very arduous task, but needs to be done quickly.

The IT Specialist can greatly benefit in these endeavors if the company's IT personnel are able to assist. Their knowledge of the monthly reporting by MGAs and TPAs can contribute to the list of data sources that must be pooled in order to provide complete data to the Receiver for distribution.

The collection of data from all sources can be much quicker if the state insurance department notifies the Receiver of the impending liquidation as much in advance as possible.

To submit an article, please contact Maria Sclafani at mcs@iair.org. Deadlines for 2009 submissions are August 1 & October 31.

Data Data Everywhere and So Hard to Collect! (Continued)

The involvement of an IT Specialist as early as possible contributes to the success of the acquisition and distribution of data to the appropriate entities. All data should be collected from external sources – including historical data for policies and claims. Although current data is more relevant, historical data is a must. In addition to claims data, the TPA should provide payment data (including recoveries and refunds that have been received by the TPA). If claims notes have been kept on the TPA system, they too should be made available to the Receiver. Sometimes, claims notes are not able to be exported. If that is the case, they should be printed and put into the physical claim folders.

When providing instructions to the TPAs regarding provision of data and physical claim files, the more specific the Receiver can be, the more likely the process will be done correctly. For example, the TPA should not be expected to make decisions while packing claim boxes. If possible, a list of claims should be sent by the Receiver indicating which claim numbers should be sent to which state. If the data to create this list is not on the Company system, the TPA will have to make the determination.

More and more companies (including TPAs) have a paperless environment. This means that all documents have been imaged and are stored only in the imaging system. It is not unusual for a company to destroy original documents after three weeks following the imaging process. In this case, there will not be any physical files and the IT Specialist will need to assist the Receiver to assure that the images are provided in a form that can be utilized both by the Receiver and the Guaranty Funds. The complete discussion of handling imaged records will be addressed in the next article.

The claims and policy data are a good start. Once the data has all been collected, the creation of UDS transmissions can also be done in cooperation with the company IT personnel. This process will be discussed further in a subsequent article.

We are dependent on data – for live companies and liquidated companies. Data can be easy or difficult to collect. The pleasure is in the success of doing a great job of collecting all of the data needed to be able to protect the policy holders from further harm.

Jenny L. Jeffers, CISA, AES

Jenny Jeffers, CISA, AES is Managing Member of Jennan Enterprises, LLC in Tallahassee Florida providing IT Services including regulatory IS examinations for states and contracting firms around the country as well as IS services for liquidators and guaranty associations. She is currently serving on the Website Committee of SOFE and is the chair of the AES (Automated Exam Specialist) Committee for SOFE. Jenny is a past Education Committee Chairman for IAIR and is a current member of the Education and Website Committees for IAIR and the ASWG (Audit Software Working Group) for NAIC.

The Insurance Receiver is intended to provide readers with information on and provide a forum for opinions and discussions 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 advise.

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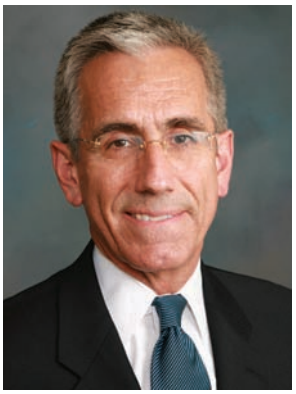
View from Washington

By Charlie Richardson

Code Red: End of Summer Timeframe for Health Care Reform Legislation

With President Obama and his Office of Health Reform offering support from the bully pulpit, House and Senate lawmakers have promised to pass healthcare reform legislation by the August Congressional recess.



Charlie Richardson

Many doubt that Congress will be able to meet this timeframe, as bills are not expected to be introduced until after Memorial Day. The leading Congressional lawmakers crafting healthcare reform legislation, Chairman Baucus (D-MT) of the Finance Committee and Kennedy (D-MA) of the Health Committee, established a joint process that they hope will bring complementary legislation to the floor by early summer. Baucus's bill is expected to be modeled after his health care reform white paper released in November 2008, which called for mandated individual health insurance coverage, creation of a national clearinghouse for individuals to find coverage, improving health care quality, requiring employers to provide coverage to workers or pay into a fund and reforming Medicare. Kennedy and House lawmakers have yet to reveal the framework for their approaches. The big issue in health reform is really between proponents of a government sponsored insurance plan and private insurers who want to avoid a government plan. With such strong Democratic Congressional majorities, the public plan option has gained some greater political credibility. Even if a public plan option does not pass the Congress, this new political credibility may force insurers into accepting a more regulated approach than they would have otherwise.

Card Legislation Moving to the Front of the Deck

On April 30th, the House of Representatives passed the Credit Cardholders' Bill of Rights by a vote of 357-70. While passage was expected, the wide voter margin and strong support from the Administration increases the likelihood that some legislation on credit cards will become law. The bill mirrors many of the new Federal Reserve rules; however, it includes several provisions that further strengthen consumer protection. The Senate Banking Committee reported similar legislation by a very narrow margin. That bill – sponsored by Banking Chairman Chris Dodd (D-CT) – had no Republican support, but Senator Reid (D-NV) plans to bring it up for a Senate floor vote before Memorial Day.

TARP Coverage - Will Insurers Warm to It?

After weeks of internal debate, the Treasury Department has allowed insurers who purchased banks to participate in the Capital Purchase Program (CPP). Under the CPP, Treasury purchases non-voting preferred stock in a bank and receives a dividend of 5 percent rising to 9 percent. Some large insurers immediately announced they did not need assistance. Some other interested insurers had not completed their bank purchase and, under Treasury's view, would not be eligible. Insurers who have not bought a bank cannot stop at the CPP window. The CPP is one of several parts of the Troubled Asset Relief Program (TARP) which has invested $ 600 billion in financial institutions since October 2008.

Chatter about an Optional Federal Charter

Representatives Melissa Bean (D-IL) and Ed Royce (R-CA) introduced their 121-page National Insurance Consumer Protection Act, H.R. 1880 on April 2. To review the text of the proposal go to http://www.house.gov/apps/list/press/il08_bean/h_r_1880.pdf. The Act would establish a federal insurance

View from Washington (Continued)

regulator, permit interested insurers, agencies and producers to seek a national charter, and provide for "systemic risk" regulation. Since its introduction, there have been several critics of the bill, but it has not received as much attention as similar legislation introduced by the authors in prior Congresses. The conversations surrounding this bill, however, are competing with the debates surrounding systemic risk regulation currently at issue in the Administration and the Congress.

Surplus Lines Insurance Legislation Not Surplus to Some

Among the many issues facing the Senate Banking and House Financial Services Committees, Senator Evan Bayh (D-IN) announced his intention to introduce the Nonadmitted and Reinsurance Reform Act (NRRA) in the Senate this year, along with the bill's longtime leader, Senator Mel Martinez (R-FL). In the House, Representative Dennis Moore (D-KS) will again sponsor the legislation, and Ranking Member Scott Garrett (R-NJ) has agreed to be the Republican lead. This Act would streamline the regulation of nonadmitted insurance and reinsurance. In the 109th and 110th Congresses, the House passed the bill without a single vote against it; the same result is expected again this year. A number of Senate leaders have expressed strong support for the NRRA.

Rockefeller is Watching

Senate Commerce Committee Chair Jay Rockefeller (D-WV) has introduced a bill to regulate various health insurer underwriting practices. Rockefeller recently stated his belief that insurers find ways to "exploit loopholes" in laws, and has promised ongoing oversight by the Commerce Committee of insurance industry practices. Rockefeller is also interested in expanding Medicaid and promoting electronic health record utilization. Rockefeller clearly has a powerful position, but with such statements he is also putting down his marker that Senators Baucus and Kennedy will have to pay attention to his views as they structure health care reform.

Don't be an Ostrich – Why Insurers Should Pay Attention to New CMS Reporting Requirements

Between May 1 and September 30, insurers subject to the Medicare Secondary Payer (MSP) mandatory reporting provisions included in the Medicare, Medicaid and SCHIP Extension Act of 2007 must register electronically with the U.S. Centers for Medicare and Medicaid Services (CMS). These reporting requirements, imposed by CMS, are an effort to better enforce existing MSP laws and are triggered where Medicare is the secondary payer to some other primary liability insurer for an injury or illness. Why should affected insurers care? In a word: penalties insurers subject to these requirements must submit claims data in accordance with the time frames established by Medicare or risk civil monetary penalties of $1,000 a day for each individual for whom they should have submitted claims information. For further information, see the MSP Mandatory Reporting User Manual available at http://www.cms.hhs.gov. or go to http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedImplementationTimeline050909.pdf.

The Insurance Industry and Post-Kyoto Climate Risks

The global climate change framework to be drafted this December in Copenhagen could give insurance a formal role in international efforts to confront increasing threats related to drought, flooding and growing storms. The creation of a global insurance pool to protect billions of people from these natural and man-made disasters has been proposed by a coalition of researchers, insurers and scientists founded by Munich Re. The first tier of the two-tiered insurance program proposed by the Munich Climate Insurance Initiative would indemnify developing country property and infrastructure against low-frequency, high consequence climate related events; the second tier of the program would not provide direct insurance to farmers, households or governments, but would offer support to growing disaster insurance systems in developing nations.

Issues Forum Recap

Once again, IAIR put together a great program at the Spring Issues Forum in San Diego, California held on March 14, 2009.

The program, led by Mike Cass, was well attended and included content that was both relevant and informative. In case you missed it, below is a summary of the topics and issues presented.

California Update: Discussion on Current California Issues

John Horner, Reinsurance Officer at the California Conservation & Liquidation Office reviewed the CLO's efforts directed at optimizing the collection of reinsurance. The CLO uses a Reinsurance Plan each year that is monitored monthly and tied to the overall CLO Plan.

The CLO Reinsurance Department has fourteen staff members. The Los Angeles operation will be consolidated to San Francisco this year. The key benchmarks for reinsurance are billings, collections and commutations. Commutations are only used when the data is determined to be statistically reliable, actuarial support has been employed and the commutation results in a sound business decision. As expected, the cumulative reinsurance assets of the CLO have declined as the estates have matured.

The most significant challenges to the reinsurance department are the availability of records and data as well as maintaining relationships with the reinsurance community. The CLO rarely subcontracts the reinsurance collection function and, if undertaken, would normally involve placements outside the United States.

In connection with dispute resolution, the CLO first evaluates the merits of the reinsurer's claims and will generally attempt to resolve the dispute through negotiation. If a negotiated settlement cannot be attained then other more formal remedies will be pursued. These consist of arbitration, mediation, and, in rare cases, litigation. Notwithstanding the shortcomings of the arbitration process, the CLO is an advocate of arbitration over litigation principally because of the industry expertise that the arbitrators bring to the process. As in all matters, the CLO is sensitive to the costs inherent in all forms of reinsurance dispute resolution.

David Wilson is CEO & Special Deputy Insurance Commissioner responsible for the California Conservation & Liquidation Office. David explained that the CLO represents the California Insurance Commissioner in administering failed California domiciled insurance companies. The CLO's 2008 goals included the distribution of approximately $164 million to claimants and the closing of 3 estates. The CLO actually distributed $380 million in 2008. The CLO continually reviews its business objectives to ensure that the organization is right sized relative to the number and complexity of the estates under its administration.

The 2009 estate goals are to continue the distribution of assets to claimants and close 5 estates. Legal and administrative expenses as a per cent of overall assets managed are budgeted to increase as assets decrease. Of the 26 Estates presently under the direction of the CLO, the majority are either workers compensation or property and casualty companies. The number of employees at the CLO has decreased from 103 in 2004 to a projected number of 58 at the end of 2009.

Bermuda's Insurers Meeting Global Challenges

Bradley Kading, President and Executive Director of the Association of Bermuda Insurers and Reinsurers (ABIR) discussed Bermuda's Role in the Global Insurance Market.. The members of the ABIR are the twenty three Class 4 companies domiciled in Bermuda. The Class 4 companies are subject to distinct regulation and are highly capitalized with $73 billion in surplus at year

end 2007. All twenty three Class 4 companies in Bermuda have been rated by A.M. Best.

Based on 2007 data, A.M. Best has sixteen Bermuda Class 4 companies in its list of top thirty five reinsurers. Most of the business assumed by the Bermuda companies relates to high severity, low frequency exposures including property catastrophe and excess casualty. More specifically, the Bermuda Class 4 companies are the largest property catastrophe market with an approximately 40% share of the US and EU market.

The Bermuda Class 4 companies are niche writers of specialty business. Their objectives are not market share or sheer growth. There is only one Bermuda domiciled company in the A.M. Best list of thirty five largest US property and casualty groups of companies. One view of Bermuda carrier growth is that it provides greater market choice and less concentration.

Bermuda Class 4 companies are subject to significant and evolving solvency regulation. Current regulations meet IAIS international regulatory standards and the International Monetary Fund (IMF) has certified Bermuda's compliance with current international standards. Further, the Bermuda Monetary Authority (BMA) has committed to a robust evolution of Bermuda's regulatory scheme to be line with both Solvency II and the developing regulation in the United States. Included in the BMA's efforts are stress and scenario testing, public financial statements and risk based financial examinations.

Overview of the Bermuda Solvency Regime and New Initiatives

Christina Nguyen is Assistant Director (Analytics) for the Bermuda Monetary Authority in Hamilton. Her primary responsibilities relate to policy, research and risk assessment.

Bermuda's risk-based regulatory framework has received a favorable assessment from the International Monetary Fund, however the Authority continues to enhance its insurance regulation. Its goal is to keep pace with international regulatory standards including IAIS and Solvency II. Equivalence tests are on the horizon. This will initially relate to Solvency II and will most likely be followed by the United States.

The Authority's primary objective is to aggressively build on its insurance regulation over the next two to five years. Further to this, it is developing and updating its policies in the following areas over the next two years: Group Supervision, Code of Conduct, Internal Models, Own Risk and Solvency Assessment (ORSA), Eligible Capital, Statutory Accounting & Economic Balance Sheet, Long Term Business (Life) and Transparency.

What's the Difference Between an FDIC Receiver and God?

This issue was presented by William D. Latza, Esq., Stroock & Stroock & Lavan LLP.

Beginning in 2008, a number of insurance groups acquired small banks or thrifts to satisfy a condition precedent to receipt of TARP funds. Since 1994, several bank-insurance affiliations have occurred. Passed in 1999, the Gramm-Leach-Bliley Act removed most prohibitions on such affiliations and embodies the principle of functional regulation of the banking, securities and insurance components of financial supermarkets. Regulatory silos result in receivership silos: FDIC receivership affects only the insured depository institution (each such institution, the "bank") and its subsidiaries. Insurance receivers may have to co-exist with the FDIC as receiver where the holding company system in question includes both insurers and a bank. As conservator, the FDIC may take such action as may be necessary to put the bank in a sound and solvent condition and appropriate to carry on the business of the bank and preserve and conserve its assets and property. Additionally, as receiver, FDIC may place the bank in liquidation and proceed to realize upon the assets of the bank, having due regard to the conditions of credit in the locality. The FDIC must be conservator or receiver (each a "receiver") of Federal banks and may be receiver of State banks. The FDIC may in certain circumstances appoint itself as sole

Issues Forum Recap (Continued)

receiver of any State bank that is closed or is in State receivership. There are thirteen grounds for appointment of the FDIC as receiver. Among these are that the bank (i) has incurred or is likely to incur losses that will deplete all its capital and has no reasonable prospect to become adequately capitalized without Federal assistance, or (ii) exhibits any unsafe or unsound practice or condition likely to cause insolvency or dissipation of assets or earnings, weaken the bank's condition or otherwise seriously prejudice the interests of the bank's depositors or the Federal Deposit Insurance Fund. Bank receivership proceedings exhibit many attributes similar to insurance receiverships. Among these is a priority of distribution, with depositors having priority over general unsecured creditors and over equity owners. There is no automatic stay, but if the FDIC requests a stay, the court shall grant it. A fraudulent transfer is one made within the preceding five years with the intent to hinder, delay, or defraud the bank, the FDIC or the pertinent Federal banking agency. The FDIC, as receiver, may disaffirm or repudiate any contract in which the FDIC, in its discretion, determines performance to be burdensome or when disaffirmation of repudiation will promote the orderly administration of the bank's affairs. Moreover, the FDIC as receiver can avoid certain contracts. The D'Oench Doctrine, as codified, provides that no agreement tending to diminish or defeat the interest of the FDIC in any asset acquired by it either as security for a loan or by purchase or as receiver of any bank, shall be valid against the FDIC unless such agreement: (i) is in writing; (ii) was executed contemporaneously with the acquisition of the asset by the bank; (iii) was approved by the board of directors of the bank or its loan committee, which approval shall be reflected in the minutes of said board or committee, and (iv) has been, continuously, from the time of its execution, an official record of the bank.

Be sure to mark your calendar for Saturday, June 13th for IAIR's next Issues Forum at the summer NAIC meeting in Minneapolis, Minnesota.

Bob Fernandez receives his IAIR designation at the IAIR March Issues Forum in San Diego from Joe DeVito, Chair of the A&E Committee

Medicare Secondary Payer Reporting – What Insolvency Professionals Should Know

By Mark D. Steckbeck, J.D., CPCU

There is nothing better than a good old fashioned fine to get one's attention. This is especially true where the fine is up to one thousand dollars per day per violation.

In this case, the fines would be levied by the Centers for Medicare and Medicaid Service (CMS) for failure to report required data under their secondary payer program.[1] The persons subject to these fines include non–group health arrangements which include issuers of liability insurance, self insurance, no-fault insurance, and workers' compensation insurance. By extension, this includes insurance receivers and liquidators whose insolvent insurers issued these lines of business, and the state guaranty associations, who may have statutory obligations to pay "covered claims" under these lines of business.

The concept of making Medicare secondary to other available insurance is not new and has been in force for years with respect to group health plans. What is new is the vigorous enforcement of the Medicare secondary payer rules with respect to non-group plans including the types of plans noted above.

The Medicare Secondary Payer rules provide that when the injured party is a Medicare beneficiary, and the date of incident is on or after December 5, 1980, Medicare is secondary to other primary plans, including liability insurance, self insurance, no-fault insurance, and workers' compensation insurance. If a Medicare beneficiary has no-fault coverage, providers, physicians and suppliers must bill the no-fault insurer first. If a Medicare beneficiary has made a claim against liability insurance (including self insurance) or under a workers' compensation plan, the provider, physician or other supplier must generally bill the insurer first before seeking payment from Medicare. To enable it to enforce Medicare's status as secondary payer, Congress created an affirmative duty to report certain information to CMS, and assigned this responsibility to the Responsible Reporting Entity (RRE).[2]

The RRE is required to report to CMS, on a quarterly basis, specified data on all claimants who are eligible for Medicare. As of the present time, there are over one hundred data fields in the required reporting format, some that are mandatory while others are conditional. A number of these data elements are not captured in the NAIC's UDS A record. This means that RREs will need to modify their data systems and begin capturing this data and reporting it electronically on a quarterly basis. They will need to implement procedures in their claims resolution process to determine whether an injured party is eligible for Medicare.[3] In its reports to CMS, RREs must submit either the claimant's Social Security Number or Medicare Health Insurance Claim Number (HICN). CMS will permit RREs to query, once per month, a limited data base through which it can verify the claimant's status as a Medicare beneficiary.

The definition of RRE is very broad and covers a multitude of parties, some of whom may be surprised to learn they have reporting responsibilities under the mandatory reporting rules. While the statute does not attempt to define the RRE in each and every circumstance, the CMS User Guide provides numerous examples of which entity is the RRE in various common arrangements. For example, an employer that self insures up to a certain amount and utilizes a TPA to administer its claims is an RRE. Although the employer may contract with the TPA to do its CMS reporting for it, the employer remains the RRE and is ultimately responsible for compliance with the reporting rules. The key factor in determining who the RRE is appears to be which entity has the contractual or statutory obligation to make the payment to the claimant. The entity that has the obligation to make the payment, even if it utilizes an intermediary, is the RRE.

Medicare Secondary Payer Reporting... (Continued)

In the context of state insurance guaranty funds and insurance liquidators, it would appear that the RRE is the guaranty association to the extent of its payment to the claimant. If the guaranty association makes a payment to the claimant that is within the insured's deductible, the guaranty association would be the RRE with respect to that payment. On the other hand, if the insured makes the payment to the claimant within the insured's deductible, then the insured would be the RRE with regard to that portion of the claim. If the guaranty association pays out its statutory maximum and the claim file is returned to the liquidator who then makes payments above the guaranty fund cap, the guaranty association would be the RRE for the payments it made, and the liquidator would be the RRE with respect to any additional payments made by the estate on the claim. Clearly, there can be more than one RRE on a single claim, depending on who paid what. This suggests that there is a need for general understanding and sharing of information among insureds (with regard to deductibles and self insured retentions), insurance liquidators, and state guaranty associations.

With few exceptions, RREs are required to register with CMS between May 1, 2009 and September 30, 2009. RREs who do not initially register are still required to register in time to allow for a full quarter of testing once there is a reasonable expectation of having to begin reporting. Once registered, RREs must submit test files. The testing period for claim input files begins on January 1, 2010 through March 31, 2010. The initial production claim input file submissions are due between April 1, 2010 and June 30, 2010.

All data must be reported electronically using the required reporting format. Reports provided in any other format will not be accepted and will be deemed to not meet the RRE's reporting obligations. Reporting for contested claims resulting in a single settlement, judgment, award or other payment in which there is no continuing obligation to pay need only be done once. Claims involving on-going medical treatments will require on-going reporting, as will be discussed further below.

The RRE's initial file submissions must report on all claims where the injured party is or was eligible for Medicare benefits on a claim resolved by settlement, judgment, award or other payment on or after January 1, 2010. Once the claim file is closed and the RRE has no further potential responsibility for payments on the claim, it may report the file as "closed" and stop reporting on that claim. This may be seen in cases where a guaranty association has paid its statutory cap, or where the policy limits have been paid.

RREs need to be aware that CMS's concept of what constitutes a "closed file" differs in an important way from how that concept is commonly used in the insurance industry. Most insurers will consider a file "closed" when it becomes reasonably certain that the file requires no further investigation or payment, even though there may be at least a possibility of the file being later re-opened. CMS considers a file to be "open" so long as there remains any possibility of future medical payments, no matter how remote they may be. CMS has coined a term for this concept: ongoing responsibility for medicals (ORM). So long as the RRE has ORM, as may be the case with some workers' compensation laws that provide for lifetime medical benefits, the general rule is that the RRE may not file a report terminating its ORM for the claimant. In such cases, the quarterly reports could conceivably continue until the claimant dies. CMS does provide for one exception, apparently to avoid the absurdity of requiring life long information reporting on a minor injury. The RRE may submit a termination date for its ORM if it obtains a signed statement from the injured claimant's physician that the claimant will require no further medical services associated with the injuries.[4] However, the RRE is still required to resume reporting on such individual in the event further medical treatments become necessary.

Where ongoing responsibility for medicals was assumed prior to July 1, 2009 and continues after that date, the RRE must report on such individuals, even though they may have previously closed the file. In order to obtain the required data for its quarterly reports, RREs may have to go back and re-open these previously closed files. The potential cost of reopening countless claim files with ORM could be staggering. Confronted by enormous costs and the questionable benefit of this exercise, CMS

Medicare Secondary Payer Reporting... (Continued)

created a "qualified exception" that will require RREs to report only on cases in which they had ORM and the file was closed after December 31, 2008. In other words, if a file on which the RRE had ORM closed prior to January 1, 2009, the RRE need not report on that claim unless and until there is new claim activity on the file.

The mandatory reporting rules apply only to the payment of medical and health care benefits. RREs are not to report payments they make for non-medical or non-health related claims, which may include such things as payments for property damage, pain and suffering, medical evaluation costs for defense purposes, or workers' compensation indemnity benefits. However, where a settlement, judgment or award is made or entered into by the parties, and medicals were an element of the claim, the RRE must report the entire amount, regardless of the damage allocation that may have been assigned by the parties or the court. CMS is not bound by such allocations and can challenge them should it decide to do so.[5]

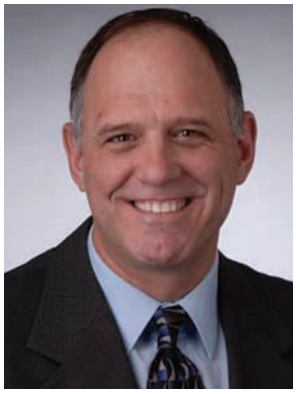
By this time, RREs should be well under way in their preparations to become compliant with the mandatory secondary payer requirements. They will need to modify and update their information reporting systems to enable them to submit the required reporting format. They will need to adopt internal procedures and assign responsibilities for capturing and reporting information that they may not currently capture. They will need to register with CMS no later than September 30, 2009 and test their system, and begin reporting on a quarterly basis no later than July 1, 2010.

Although not insurmountable, implementation of these changes will require a significant investment of time and resources on behalf of all RREs. Any RRE who has not begun preparations by now would be wise to take immediate steps to do so before these deadlines pass. CMS has stated in its public conference calls that it does not intend to extend its compliance deadlines. Although CMS has stated publicly that is more interested in securing compliance with the mandatory reporting rules than in than in assessing penalties for non-compliance, it is unlikely they will be tolerant of an RRE that neglects its reporting responsibilities. Such entities could find themselves on the receiving end of crippling fines, a result that would be unfortunate and avoidable.

Any RRE that has not yet begun its preparations should visit the CMS website at http://www.cms.hhs.gov/MandatoryInsRep/

The National Conference of Insurance Guaranty Funds created a working group to evaluate the required data fields and, ultimately, to develop a new UDS record to comply with the CMS requirements. The anticipated "M record" will form part of the mechanism through which the guaranty associations and liquidators share information and coordinate their compliance efforts in their respective roles as RREs under the Medicare Secondary Payer Reporting rules. The working group is composed of representatives from the property and casualty insurance guaranty associations, insurance receivers, and members of the NAIC UDS Technical Support Group. Although work is underway now, it is not expected this will be completed before RREs must begin to file their initial reports with CMS. Liquidators or other interested parties who wish to contact this working group are invited to contact John Arment at jarment@mpcga.org.

1 See Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (See 42 U.S.C. 1395y(b); C.F. R. Part 411)
2 The responsible reporting entity is the "applicable plan," which is defined as the following law, plan, or arrangement, including the fiduciary or administrator for such law, plan , or arrangement: (i) Liability insurance (including self insurance); (ii) No fault insurance; and (iii) Workers' compensation laws or plan. 42 U.S.C. 1395y(b)(8); http://www.cms.hhs.gov/MandatoryInsRep/
3 Medicare eligible individuals include: (i) Persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement benefits; (ii) Persons of any age who have received Social Security, widow or Railroad Retirement benefits for 25 months; (iii) Persons with end-stage renal disease who require dialysis treatment or a kidney transplant; and (iv) "Working aged" persons over age 65 who are not eligible for either Social Security or Railroad Retirement Benefits who purchase Medicare coverage by monthly payment as an employee of an employer with 20 or more employees. See: 42 U.S.C. Sec. 1395c; 42 C.F.R. Sec. 405.340-341; http://www.medicare.gov/MedicareEligibility/Home.asp
4 MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting User Guide, Version 1.0, March 16, 2009, p. 51
5 Id. at p. 57



Mark Steckbeck

Mark is the Assistant Vice President, Legal Affairs, with the National Conference of Insurance Guaranty Funds in Indianapolis, Indiana where he has been since 2003. From 1989 to 2003, Mark was the Assistant General Counsel at Indianapolis Life Insurance Company, where he worked on product development, compliance, litigation oversight, and other corporate matters. Mark was with the Indiana Department of Insurance from 1987 to 1989 where he handled agent licensing and discipline, bail bonds, and negotiating medical malpractice settlements on behalf of the Indiana Patient's Compensation Fund. Before that, Mark was in private practice with Steckbeck and Moore where he focused on insurance defense litigation, including personal injury and workers' compensation.

Rethinking Priority in a Post Credit Crisis World

By Hal Horwich & Bill Goddard

In United States insurance receiverships, it is axiomatic that claims by policyholders are given priority over general creditors.

See Cal. Ins. Code § 1033. When funds are insufficient to pay all creditors in full, an insurance company traditionally enters liquidation or proposes a rehabilitation plan based upon a statutory system of priorities.[1] See e.g. Mich. Comp. Laws § 500.8142. Generally, administrative expenses of the receivership come first, policyholders come next, the federal government and employees come next and then come general creditors. See e.g. N.Y. Ins. Law § 7434(a)(1).[2] While there are variations among the states, the basic result is likely to be the same: policyholders should fare better than general creditors if assets are insufficient to pay everyone.[3]

The Insurer Receivership Model Act ("IRMA"), promulgated by the National Association of Insurance Commissioners, refines the types of contracts that give rise to policyholder priority claims. IRMA § 801; see also Tex. Ins. Code § 443.301. However, in a specific situation, the distinction between a "policyholder" and a "general creditor" claim is not always clear.

There is a split of authority on whether surety bond beneficiaries are entitled to policyholder priority.

Priority Benchmarks

It is now universally recognized that reinsurance claims are not entitled to policyholder priority, and yet, many priority statutes do not specifically refer to reinsurance claimants. See *Covington v. Ohio General Ins Co, 99* Ohio St.3d 117, 789 N.E.2d 213 (Ohio 2003); *In re Liquidations of Reserve Ins. Co.*, 122 Ill.2d 555, 120 Ill.Dec. 508, 524 N.E.2d 538 (Ill. 1988); *Neff v. Cherokee Ins. Co.*, 704 S.W.2d 1 (Tenn. 1986); *Foremost Life Ins. Co. v. Indiana Dep't. of Ins.*, 274 Ind. 181, 409 N.E.2d 1092 (Ind. 1980); *In the Matter of the Liquidation of Sussex Mutual Ins. Co.*, 301 N.J. Super. 595, 694 A.2d 312 (N.J. App. 1997); *Northwestern National Ins. Co. v. Kezer,* 812 P.2d 688 (Colo. App. 1991).[4] *See also State ex rel Long v. Beacon Ins. Co.*, 87 N.C.App. 72, 359 S.E.2d 508 (N.C. App. 1987); *Van Schaick v. General Indemnity Corp. of America*, 274 N.Y. 510, 10 N.E.2d 523 (N.Y. 1937); *Cunningham v. Republic Ins. Co.*, 127 Tex. 499, 94 S.W.2d 140 (Tex App. 1936).

If a state priority statute does not specifically dictate the priority of reinsurance creditors, courts have determined their priority by examining which classes of creditors the priority statue is designed to protect. The "purpose of the priority for Class 2 claims is to protect consumers who have purchased direct insurance and those in related situations, rather than to protect reinsured insurance companies" *Covington v. Ohio General Ins Co,* 99 Ohio St.3d at 120, 789 N.E.2d at 216; *Neff,* 704 S.W.2d at 3 ("'[t]he emphasis [of insurance regulation] has been placed simply upon *protecting the little policy-holder*'" (quoting Richards, *Insurance* § 39)). Courts also look to the claim's relationship with the underlying loss. Reinsurance is a contract of indemnity providing contractual reimbursement, not risk of loss. *Liquidations of Res. Ins. Co.*, 122 Ill.2d at 562, 120 Ill.Dec. at 511, 524 N.E.2d at 541; see also Neff, 704 S.W.2d at 3 ("reinsurance is more in the nature of a contractual device or business practice employed among insurance companies to spread their risks, than it is a policy of insurance for which a person or business bargains to obtain specific protection from a given risk.").

Rethinking Priority in a Post Credit Crisis World (Continued)

There is a split of authority on whether surety bond beneficiaries are entitled to policyholder priority. The Pennsylvania Supreme Court determined that surety bond claims should not be accorded policyholder priority. *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086 (Pa. 1992). The decision was based upon two overarching principles: first, that surety is not insurance and second, that the tri-partite nature of surety allows both beneficiaries and sureties to look to the bond principal for payment. *Foster,* 531 Pa. at 623, 614 A.2d at 1099. The Pennsylvania Supreme Court, as did the receivership court, relied upon *Pearlman v. Reliance Insurance Co.*, 371 U.S. 132, 140 n. 19 (1962) ("Among the problems which would be raised by a contrary result would be the unsettling of the usual view, grounded in commercial practice, that suretyship is not insurance."). The Chancery Division of the New Jersey Superior Court took the opposite position based upon interpretation of the specific language of the New Jersey statute. "The Pennsylvania statute uses very different language to govern liquidation priorities from the applicable New Jersey insurer liquidation statute." *In the matter of the Liquidation of Integrity Ins. Co.*, 251 N.J. Super. 501, 504, 598 A.2d 940, 942 (N.J. Super. 1991).

New products have arrived on the insurance scene that have blurred the lines between policyholders, investors, reinsurers and sureties. Although reinsurance and surety bonds have been with us for many years, new products such as financial guarantees, credit insurance, auto warranty coverage and other new forms of financial insurance are constantly developing. Guaranteed investment contracts have been around for a long time, but recently life insurance companies have been using them to back debt issues, funding the insurance company's obligations as a bank would use deposits to fund its loan portfolio. Guaranty associations have excluded many of these products from coverage, but priority statutes generally fail to deal with specific products.[5]

Markets have moved much more quickly than state insolvency statutes have evolved. As the pace of financial innovation quickens, courts will need principles that breathe content into the words of the statute if they are to distinguish the priority of claimants under newly developed products.

A Principled Approach to Construction

State priority statutes use generic terms such as "policies," "losses" and "general creditors," that are either not defined in state priority statutes or the definitions are so wide reaching as to be of little assistance in determining the priority of claims under particular products. *See e.g.* Fla. Stat. § 631.271; 40 Pa. Stat. Ann. § 221.44. To make matters worse, these terms are in general use and have many different definitions in different contexts. Use of the term "policy" in a contract cannot be determinative of priority. *See e.g. Covington,* 99 Ohio St.3d at 120, 789 N.E.2d at 216. If it were, then every agreement with an insurance company would be drafted as a "policy" even if it were clear that the agreement (such a reinsurance agreement) would not give rise to a policyholder priority claim. Further, the fact that a product is regulated by a state insurance department does not necessarily mean that its beneficiary is entitled to policyholder priority. *Foster,* 531 Pa. at 623, 614 A.2d at 1099. Instead of using problematic labels, it makes more sense to look at the underlying public policy of insurance insolvency statutes and to derive principles which enable the determination of priority.

The case law suggests three tests that should be used to separate those claims meriting "policyholder priority" from those made by true "general creditors" of an insolvent company.

1) Is the activity part of the "business of insurance"?
2) Is the policyholder someone transferring risks incidental to life or business, or someone in the business of assuming risk?

3) Is the risk giving rise to the loss a fortuitous risk?

1) The Business of Insurance.

In order to receive policyholder priority, a claim must arise from the "business of insurance." This requirement arises out of the Supreme Court's decision in *United States Dep't. of the Treasury v. Fabe* 508 U.S. 491 (1993).[6] This decision dealt with the conflict between an insurance insolvency priority system and the Federal Priority Statute, 31 U.S.C. § 3713(a), which requires that any claim against an insolvent entity (other than in a bankruptcy proceeding) must be subordinated to the claims of the federal government. Even though federal statutes generally preempt conflicting state statutes, the United States Supreme Court determined that McCarran-Ferguson Act, 15 U.S.C. § 1012, allows state priority statutes to reverse-preempt the Federal Priority statute, but only to the extent that the state statute fits within the parameters set by McCarran-Ferguson.

Higher priority "claims compensate individuals for losses that stem from the chance occurrences of life and do not compensate businesses for the calculated commercial

"No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance" 15 U.S.C. § 1012(b). The Federal Priority Statute does not specifically relate to the business of insurance and would impair state statutes that put policyholders ahead of the federal government. *Fabe* therefore holds that a state statute can reverse pre-empt the Federal Priority Statute only if it is found to regulate "the business of insurance." A practice is part of the "business of insurance" if it meets a three part test: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Fabe*, 508 U.S. at 497-98 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982)).

The Fabe majority parsed the Ohio priority statute and upheld those subsections found to have "the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance." Fabe, 508 U.S. at 505. However, if a clause of the priority statute "is designed to further the interests of other creditors, . . . it is not a law enacted for the purpose of regulating the business of insurance." Fabe, 508 U.S. at 508. Therefore if an insurance product does not withstand the three part test listed above, the federal government should rank ahead of the claims of beneficiaries under such a product. Since Fabe allows state priority statutes to rank policyholders ahead of the federal government, it follows that claims under products outside of the business of insurance must come after policyholders.

2) Policyholder Priority and the Business of Assuming Risk.

The reinsurance cases indicate that policyholder priority is not appropriate for certain claims asserted by those who are primarily in the business of assuming risk. Insurance statutes must "protect the insuring public" in part because the "consumer is not possessed of equal bargaining power, knowledge, or resources as that of the reinsurance entities and financial institutions." *Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 132 Pa.Cmwlth. 196, 215, 572 A.2d 798, 807 (Pa. Commw. Ct. 1990) *aff'd sub nom. Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086 (Pa. 1992). Higher priority "claims compensate individuals for losses that stem from the chance occurrences of life and do not compensate businesses for the calculated

commercial risks covered by reinsurance agreements." *Covington,* 99 Ohio St.3d at 120, 789 N.E.2d at 216. The purpose of priority statutes is "to provide preferred protection to individual policyholders and claimants who, unlike a reinsured company, had little means of analyzing the risks involved in dealing with the now insolvent concern." *Northwestern Nat'l. Ins. Co.,* 812 P.2d at 692.

Companies in the business of assuming risk that are transferring a portion of that risk to an insurer are in a better position to assess the capabilities and financial strength of insurers than consumer policyholders. Consumers insure risks incidental to their lives or businesses. A factory owner insures against fire, but his business is making goods. To be sure, major manufacturers have sophisticated insurance purchasing capabilities. However, unlike those in the business of assuming risk (such as insurers or warranty issuers), sophisticated manufacturers are transferring risk that is incidental to their business rather than risk that is fundamental to their business.

3) Policyholder Priority and Fortuitous Risk.

Case law involving reinsurance priority carefully distinguishes the nature of the risk of the direct policyholder from the risk of the insurer. The former is fortuitous risk incidental to pursuing business or other activities. The latter is a voluntarily assumed risk that is the inherent business of the insurer. The "purpose of reinsurance agreements is to protect an insurer from a business risk, not from a loss occasioned by the destruction of property." *Covington,* 9 Ohio St.3d at 119, 789 N.E.2d at 216. The purpose of policyholder priority is to protect consumers from risks such as destruction of property, personal injury, and "losses that stem from the chance occurrences of life" not to "compensate businesses for the calculated commercial risks covered by reinsurance agreements." *Id.* at 120, 789 N.E.2d at 216. "Reinsurance contracts are not policies of insurance. Neither are they 'contracts of insurance,' as that term is generally understood. . . . By such a contract, one insurance company does not insure the property of another insurance company, but only engages to indemnify it against liability upon its policies or contracts issued to owners of property." *Cunningham,* 94 S.W.2d at 142. A "reinsurance contract is primarily one of indemnity to the reinsured only, not against loss by hazard specified in the original policy but against loss or liability by virtue of original contracts of insurance." *Foremost Life Ins. Co.,* 274 Ind. at 187, 409 N.E.2d at 1096.[7]

Policyholder priority is not appropriate for claims that arise from contractually assumed risk. For example, the Pennsylvania statute states as one of its purposes, "the equitable apportionment of any unavoidable loss." 40 Pa. Stat. Ann. § 221.1(c)(iv); *see also* Tex. Ins. Code § 443.001(e)(4). Loss assumed under an agreement is inherently avoidable since an agreement is a voluntary act. Losses from fortuitous events are not avoidable. As a matter of public policy, where resources are scarce, state insolvency statutes allocate resources to the losses which are fortuitous and therefore unavoidable. Contractually assumed loss for certain types of entities are less favored in the priority scheme.

Application of these Principles

The goal of the analysis above is to move the debate away from dueling dictionaries and endless semantic battles over the meanings of "policy" or "loss," and towards a principled basis of decision rooted in the public policy behind insurance insolvency statutes. Courts can ask three basic questions. Is this product part of the business of insurance? Is the claimant a consumer of insurance that state insolvency statutes were designed to protect or a professional risk bearer? Does this claim arise from the type of fortuitous loss that state legislatures intended to prefer? These questions are designed to highlight the features of an insurance transaction that should matter for priority purposes.[8] By examining these features, courts will

reach decisions that are more in tune with the fundamental policies of the insurance insolvency statutes.

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1 Priorities in a rehabilitation plan must reflect those used in liquidations because "[u]nder Neblett, [Neblett v. Carpenter, 305 U.S. 297 (1938)] creditors must fare at least as well under a rehabilitation plan as they would under a liquidation . . ." Foster v. Mutual Fire, Marine and Inland Ins. Co., 531 Pa. 598, 613, 614 A.2d 1086, 1093-94 (Pa. 1992).

2 There are variations on the theme. In some states, administrative expenses of the state guaranty associations come before policyholders, see e.g. Conn Gen. Stat. § 38a-944 (a)(2). In Arizona all guaranty association claims come before policyholders. Ariz. Rev. Stat. § 20-629(A)(2). In some states, claims of state and local governments come before general creditors, see e.g. Ga. Code Ann. § 33-37-41; N.C. Gen. Stat. § 58-30-220(3), in some states they come after general creditors, see e.g. Oh. Rev. Code Ann. § 3903.42(F).

3`Some state priority statutes include: Cal Ins. Code § 1033; Tex. Ins. Code 443.301; N.Y. Ins. Law 7434; Fla. Stat. § 631.271; 215 Ill. Comp. Stat. § 5/205; 40 Pa. Stat Ann. § 221.44; Oh. Rev. Code Ann. § 3903.42; Mi. Comp. Laws § 500.8142; Ga. Code Ann. § 33-37-41; NC. Gen. Stat. § 58-30-220; NJ. Stat. Ann. § 17:30C-26; Va. Code §§ 38.2-1509, 38.2-1603, 38.2-1701.

4 The Ohio priority statute does not mention reinsurance, Ohio Stat. § 3093.42, neither does Illinois, 215 ILCS § 5/205, Indiana, Ind. Code § 27-9-3-40, New Jersey, NJ. Stat. Ann. § 17:30C-26 or Colorado, Co. Rev. Stat. § 10-3-541. Today, Tennessee's priority statute, Tenn. Code Ann. § 56-9-330 includes the "claims of ceding and assuming companies in their capacity as such" in the same priority class as general creditors, but it did not do so at the time Neff was decided. See 1991 Tennessee Laws Public ch. 142 (H.B. 689) § 40 (codified as Tenn. Code Ann. § 56-9-330). When statutes are silent, courts must rely on basic principles to reach the conclusion that reinsurance creditors are to be accorded general creditor priority.

5 State statutes may specifically save guaranteed investment contracts or funding agreements from general creditor priority. See e.g. Va. Code § 38.2-3100.2(G)("the holder of the funding agreement shall be entitled to the same priority of distribution as other policyholders").

6 It has often been speculated that, since four of the five justices in the majority for Fabe have left the Court and all four dissenters remain, Fabe is vulnerable. See Boozell v. United States, 979 F. Supp. 670, 679 (N.D. Ill. 1997). Justice Breyer, who was not on the Court when Fabe was decided, has well known views on the limited reach of Fabe. See Garcia v. Island Program Designer, Inc., 4 F.3d 57 (1st Cir. 1993). Yet stare decisis, the lack of meaningful circuit splits on the interpretation of Fabe, and the Court's general aversion to insurance insolvency questions would seem to make an overruling unlikely. In addition, one of the dissenters, Justice Souter, will be retiring during 2009.

7 The distinction between the risk contractually assumed by reinsurance and the underlying fortuitous risk is very old. "Its contention is that the loss it insured against was a loss by fire. This is a mistake. It indemnified, to a limited extent, against the liability which the first insurer assumed by his contract . . ." Royal Ins. Co. v. Vanderbilt Ins. Co., 102 Tenn. 264, 52 S.W. 168, 170 (Tenn. 1899).

8 In some cases, a negative answer to a question will not be dispositive. For example, an insurance company that buys life insurance on its executives is in the risk assumption business but would still be a policyholder if the life insurer failed.

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