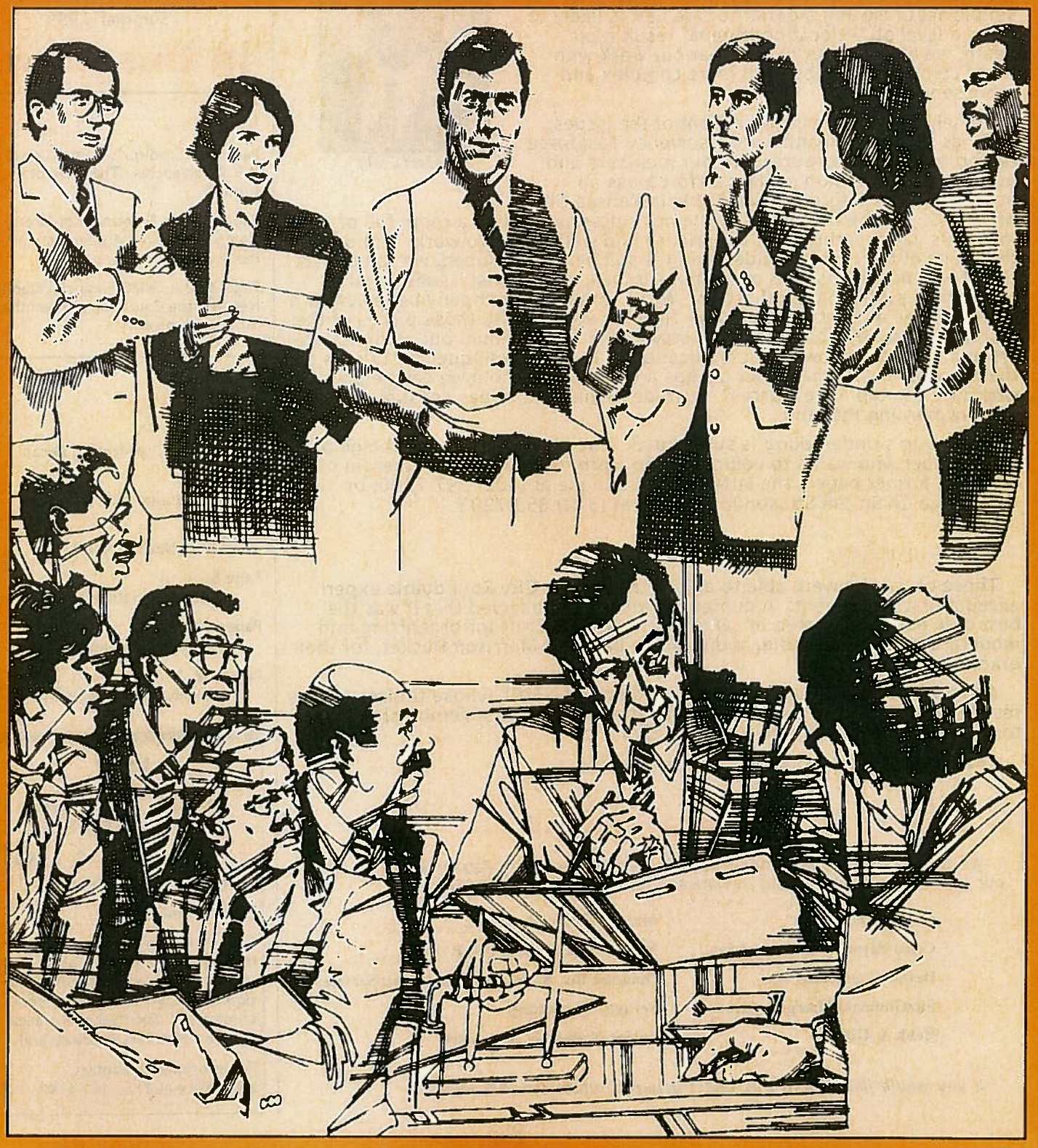
The INSURANCE RECEIVER

Promoting professionalism and ethics in the administration of insurance receiverships.

Volume 8, Number 2

Summer 1999



President's Message

By Robert Craig, Lamson, Dugan, & Murray

Health Care Insolvency!

Robert Craig

We've all read the recent articles on HMO's, PPO's and other alphabet entities failing. Health care insolvency is, by many accounts, the next wave in the insolvency cycle. And, when we realize that the simple act of closing a geriatric care unit is likely to bring a level of "relocation trauma" resulting in death, we also have to realize that our work with these companies will be both more complex and more sensitive.

To help our members get in front of the issues, IAIR has formed a Health Care Insolvency Taskforce tasked to develop resources for our members and our clients. Formation of the taskforce was announced at the Saturday Roundtable in Kansas City on June 5. At the first meeting the next morning we had a room full of IAIR members volunteering their experience and willingness to work. Although the scope of the group's undertaking is still being developed, we can expect that it will include insights on systems issues, operational issues, legal issues, and problem identification. When should the company be reviewed if there is to be a chance of survival? How do we deal with those pieces of the system that are eligible for bankruptcy relief? What should our commissioners and directors know about application of in-place delinquency statutes to these companies? What other groups are out there whom we can help and whom we can tap as resources? Just identifying the issues consumed the Sunday morning meeting .

The group's undertaking is substantial. The taskforce can use the help of any member who wants to volunteer. To learn more or to volunteer (in my book the former begets the latter) please call me at (402) 397-7300, or the Task Force Chair, Jim Stinson in Chicago at (312) 853-7203.

A Note of Thanks.

Those of us who were able to attend the Kansas City Roundtable experienced a first class event. A number of members observed that it was the best they had participated in. Our thanks to Jack Craft for organizing and moderating the Roundtable, and to Bruce Baty and Morrison Hecker, for their gracious hospitality.

And a final note of thanks to Bill Sneed and Bob Hall, whose tireless efforts resulted in the Reinsurance Arbitrator listing in the 1999 Membership Directory. We think you will find it very usefull.

And to everyone else, please, get involved!

A SPECIAL THANK YOU

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

Baker & Daniels	**Mealey Publications, Inc.**
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If you would like to join this select group, contact the IAIR Office.

The INSURANCE RECEIVER
Volume 8, Number 2
Summer 1999

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Features

Departments

IAIR
Staff Training Session
September 9-10, 1999
In St. Louis, Missouri

Who Should Attend:

Staff members of receiverships, insurance departments and vendors involved in the rehabilitation and liquidation of insurance companies. The flyer was mailed with the Membership Directory!

For information, contact:
IAIR Office at 312 / 961-4199.

Kansas City Meeting Recap

By Mary Cannon Veed

The Summer National Meeting of the National Association of Insurance Commissioners in Kansas City was, curiously, dominated by thoughts of the federal government. Again. Except this time the thinking was more constructive than defensive.

Exhibit A: the long-negotiated agreement between OCC and the states concerning consumer complaint investigation was formally signed. Swell photo opportunity, which they inflicted on several hundred of us who came to what was supposed to be a meeting about HR 10. But it seemed like progress, all the same.

Exhibit B-1: HR 10 itself. Apparently somebody broke a logjam in the Commerce Committee, and we now have anti-preemption language in the law which supposedly will prevent the development of a preemption no-mans' land between banks and insurance. Hope they're right.

Exhibit B-2: Giddy with success, the NAIC leadership apparently decided to employ their improved channels of Congressional communication to persuade lawmakers to add on a few "extra's" to HR 10. The result was what I think inside the Beltway they call a Christmas Tree bill — or it would have been if they had been able to produce legislative text as fast as they produced press releases. There were a number of "nice-to-have's" hung on that tree (Fabe cure wasn't one of them), but the gaudiest ornament was one creating federal oversight of agent licensing — suspended as long as the states themselves adopted uniform state licensing procedures during the next three years. Since the NAIC is only just getting around to drafting those uniform procedures, and support isn't exactly overwhelming yet, the broad-based reaction was akin to that of a householder who discovers a live reindeer grazing under the Christmas tree: Really interesting animal, but how did he get in the house?

Exhibit C: a whole laundry list of HMO bills followed by the NAIC's Washington counsel. They've been following these things around for quite a while now, and there are more where these came from. The news is that the lobbyists seem to have found some terminology and standard language to use when the drafters of the bill mean not to be preemptive, or conversely, when they do. That doesn't solve the basic problem of whether they should, but it at least avoids the headache that results when supporters of the same bill have conflicting expectations about how it would work — and insurance consumers get caught in the middle.

Exhibit D: HR833 and S625. These are the new commercial bankruptcy amendments, which have been under construction for some time. We've written about them before, because they tinker with §304 and because one version appeared to assert bankruptcy jurisdiction over health insurers. The good news is that the references to HMO's and health insurers have come out. The overbroad material in the §304 proposal has, too. On the other hand, it has gained a section creating ancillary proceedings relating to foreign receiverships that qualify for relief under Section 304. The ancillary proceedings could affect, among other things, US assets of foreign insurers. This builds on good ideas already developed under §304 jurisprudence, but the devil, as usual, is in the details. This change was drafted rather late in the game, and has not been widely circulated among practicioners. There are some implications for insurance receiverships which definitely need thinking about. Think fast, because at last word both the House and Senate versions had come out of committee.

Exhibit E: the Ad Hoc HMO Insolvency Committee, charged to:

"Evaluate the adequacy of current solvency protection measures and insolvency protection measures for consumers with regard to managed care organizations and entities that assume health risk other than traditional insurers. Make recommendations as appropriate, including the development of a new model act or the amendment of existing model acts."

In case that doesn't sound federal, suppose you occupied an office at the HCFA and were pondering the possibility that some of the entities which agreed to afford protection to Medicare recipients might fail. Is there any chance at all that the patients, understanding that their Medicare benefits have been privatized, will content themselves with filing claims in state insolvency proceedings? No, there is not. Will their respective Congresspeople, deluged with phone calls from constituents, resist the urge to call HCFA and ask what you are doing about it? No, they will not. Can HFCA have an additional budget appropriation to create a federal liquidation operation to operate in those cases where an HMO is determined not to be an insurance company, or where state regulators refuse to act effectively? Not unless you can start a rumor that state processes will fail to get the job done. Hmmmm.....Is there anything on earth that so galvanizes the NAIC as a whispered threat of a grab for jurisdiction by a federal agency? No there is not! The worry, however, is real. The gauntlet has been thrown down, and it is up to us to pick it up.

Exhibit F: IAIR's burgeoning interest and capability as a marketplace for health care entity liquidation intelligence, about which more *infra*.

The trouble with having themes for these articles is that, inevitably, something won't fit. In this case, it's the Roundtable, which was excellent, but had absolutely nothing to do with the federal government. It began with an excellent demonstration by Andrew Rapoport of EW Blanch of the amazing degree of volatility workers' compensation claims demonstrate, if you make tiny changes in such hard to predict items as the injured worker's life expectancy, the spread between medical cost inflation and investment interest rates, and other esoterica. Then it introduced Maxine Moody, of the IAIFA, and some insight into attribution of the insurer's sins to the liquidator, presented by Rusty Brace.

But the *piece de resistance* was the showdown between Missouri, in the persons of Jack Craft and Doug Hartz, and the reinsurers, gamely represented by Rob Graham of Gen

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IAIR Roundtable Schedule

NAIC Meeting - October 2 - 6, 1999
Atlanta, Georgia
IAIR Roundtable
October 2, 1:00 - 5:00 p.m.

NAIC Meeting - December 4 - 8, 1999
San Francisco, California
ABA/IAIR National Institute
December 3-4, 1999

NAIC Meeting - March 11-15, 2000
Chicago, Illinois
IAIR Roundtable
March 11, 1:00 - 5:00 p.m.

NAIC Meeting - June 10-14, 2000
Orlando, Florida
IAIR Roundtable
June 10, 1:00 - 5:00 p.m.

The *INSURANCE RECEIVER*

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.

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Kansas City Meeting Recap

(Continued from Page 3)

Re, with a cameo appearance by OSD's Lee Asbridge, playing the role of the preacher who walks between the gunmen and wonders why something can't be worked out — and retreats just in time to save his hat.

Just as they proved by the last scene of the movie, of course, the preacher is right. What used to be a huge area of disagreement is now settling down, mostly, to a residue of hard feelings and mutual distrust, probably deserved on both sides. As Lee aptly pointed out, honest-to-goodness IBNR is a relatively small component of the problem of long-tail claims. The real headache is IBNE and IBNSY — incurred but not settled yet — and the answer to that one is to settle claims on the same commercial basis that would have prevailed in the pre-liquidation insurer's claims department. Jack apparently assumed those claims were all taken care of already, which is generous. Rob was prepared to concede that there was nothing wrong with claims settlement in the abstract, although he wasn't issuing any blank checks.

The fight they were all spoiling for was over claims that might have been: the difference between a reasonable pre-liquidation reserve and the actual claimants that have the means and the optimism to liquidate their claims in time to meet the deadlines. The fact is that a significant number of claims "give up", "go away", and otherwise get lost, not because they are not valid claims, but because their owners don't want to or can't afford to prosecute them through the liquidation process. What may seem to the claimant like a simple decision not to spend more money collecting an uncollectible insurance claim ends up depriving the estate of an asset, and handing the reinsurers a windfall few will admit they want, but all will accept.

Jack seemed to be saying that a liquidator should prevent that windfall by establishing an estimation procedure which contemplated reinsurance collections for claims which he had no intention of actually allowing. Rob, on the other hand, seemed to object less to the violence done to his contract language by a reinsurance demand based on imaginary claims, than to the prospect that a liquidation court, called upon to make a "just estimate" of reinsurance recoverables, would put its thumb on the scales, ignoring the reasonable estimates (which he admitted could be and are being made) in favor of extortion in the name of the policyholder.

Doug staked out what, in that company, looked like middle ground, pointing out that IBNR claims were not imaginary, just hard to handle, and then quoting an eminent liquidation authority for the premise that liquidators owe a duty to their clients to seek out and evaluate all legitimate claims, easy and otherwise. He didn't quote the same "authority's" other conclusion: that the liquidators' long tail claims dilemma is largely self-inflicted, created out of a combination of rigid claim evaluation rules not called for by law, hostile treatment of reinsurers' interest in the claims process, and a tendency to ask for just a little more than we have coming. As both Lee and Philip Singer pointed out in the course of the ensuing lively discussion, it is possible to obtain good, albeit not perfect, results from reinsurers in liquidation. What is called for is some creative hard work on the claims side and a spirit of fairness in dealing with reinsurers. Neither can rescue a poisoned reinsurance relationship or resurrect lost actuarial data, but they can prevent the next insolvency from being quite as complicated as the last ones.

Now here's the *infra* part: absolutely the best event at the NAIC was a serendipitous one, and IAIR was responsible for it. It was announced at the Roundtable that a "task force" on health insolvency would meet at the end of the committee period on Sunday. It drew a crowd, perhaps under false pretenses, because the task at hand turned out to be setting up educational programming for the coming year, and not much headway was made on that one. But the crowd was worth watching for its own sake. They came mostly to point out their own interest and expertise on the subject, and to learn who else was who in the field. There ensued a really enlightening brainstorming session in which people who have had experience with different compo-

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Other News & Notes By Charles Richardson

Cataclysmic Forces: Tornadoes, Congress, and Executive Life

As this column was being written, three potentially cataclysmic forces were hitting the insurance marketplace all at once, producing headlines in the industry press and even in a popular rag or two. Within the span of three weeks:

> Tornadoes tore through Oklahoma and Kansas destroying thousands of homes and businesses and killing almost 50 people.
>
> The U.S. Senate passed its version of financial services modernization, making it more likely that some form of legislation will be passed by the Congress in 1999.
>
> California regulators had filed a fraud suit against the French investors which took over Executive Life Insurance Company in the early 1990s in the most expensive insolvency in U.S. history.

While unrelated, each event in its own way has the potential for fallout on the insolvency front, not to mention tremendous human implications.

Tornadoes

The first event is the most tragic. On May 3, a dozen tornadoes hit Oklahoma and Kansas, with winds higher than ever recorded in history. People lost their lives, and more than 2,000 homes were obliterated and 8,000 damaged. Initial estimates of homeowners, auto and business losses are in excess of a half billion dollars.

Oklahoma and Kansas lie in the nation's so-called Tornado Alley, ranking behind Texas as the top states for twisters each year. People there are usually prepared and have a solid insurance safety net in place. Nothing like the insurance company failures in the aftermath of Hurricane Andrew is expected. But tragedies like this should remind all of us how important rock-solid insurance companies are to the people who suffer though natural disasters and must rely on that stand-by insurance safety net. There is a human dimension to the protection that insurance provides in time of true need that the public — even those of us who toil in the insolvency vineyards and see first hand the dislocations caused when that net is torn by an insurance company insolvency — too often forget.

H.R.10 - S.900

The fences that have separated banks from brokerage firms and insurance companies may be falling. On May 7, in a 54-44 nearly party-line vote the U.S. Senate approved S.900, the financial modernization bill sponsored by Senator Phil Gramm of Texas that would give bankers, brokers and insurers new authority to enter each others' business. The Senate bill requires banks to enter brokerage and insurance ventures through subsidiaries of a holding company regulated by the Federal Reserve. Earlier in the year, the House Banking Committee approved the companion H.R.10, which now must be considered by the House Commerce Committee before it goes to the House floor for a vote. The House version would give banks a more direct approach to do their thing through operating subsidiaries — eliminating the need for holding companies. The Treasury Department and the Clinton Administration strongly support H.R.10's provisions rather than the Senate's bill.

The last issue of *The Insurance Receiver* contained an excellent article by Maine Superintendent of Insurance Alessandro Iuppa on the ins and outs of H.R.10. And several of you no doubt read the comments of Kentucky Insurance Commissioner George Nichols and Kansas Commissioner Kathleen Sebelius at a press briefing and in testimony before the House Commerce Committee warning that H.R.10 could seriously undermine the states' important consumer protection functions. Everyone on the insurance side of the debate — regulators, companies, agents, and others — are now focusing on the specifics. Why? Because bank reform may be a reality in a few months.

In short, the bank v. insurance company debate that quieted down late last year has come back to life in the 106th Congress over the shape of the insurance marketplace for the first decade of the next century and the role of state regulation in that marketplace. We on the insolvency side of the street cannot — and should not — ignore its implications. More on that in this column next issue.

Executive Life

Closer to our insolvency home, lawsuits have been filed against the owners of the insurance company that took over the business of Executive Life after it went down the tubes in 1991. The thrust is that a French-led investment consortium deceived California regulators over the role of a French government-owned bank in the deal, so that it could grab Executive Life's junk bond portfolio at bargain basement prices and make gigantic profits over time.

The financial and legal implications of the suits are large, given the sheer size of Executive Life and its role in shaping so much insolvency thinking in the early and mid 1990s. Is it possible that Executive Life will still be an issue in the next century as it was in the last decade of this one?

* * * *

The tornadoes in the Midwest will cause many insurance companies to shell out big bucks to consumers — hopefully, every single one of the companies has the money to do it. Financial services modernization means changes in the way insurance companies do business and the way state regulators will interact with those businesses. Executive Life may continue as a topic of debate in insurance insolvency circles as receivers digest lessons learned in the 1990s. All three of those events reflect the importance of insurance to the U.S. economy and the corollary role of the receivership/guaranty association system to be ready to respond when the insurance company safety net needs its own insolvency safety net.

Putting the "international" into International Association

In our recent survey of our membership a small but measurable number remarked that for an organization, which calls itself "International," we were producing a quarterly magazine that dealt mainly with U.S. domestic matters.

Bearing in mind that a significant majority of IAIR's members are to be found from the United States, this is perhaps not too surprising.

It is also the case that there are several articles each year from our international members dealing with non-US matters.

If you would like to see a magazine with more international content, part of the answer lies in your own hands and you are cordially invited and encouraged to provide contributions for inclusion. So don't be shy, find your muse and write!

Our editor Jim Stinson is looking forward to hearing from you.

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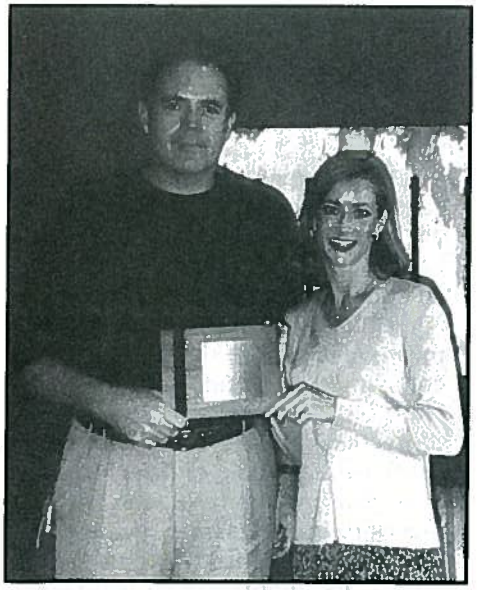


Certification Presented

Pictured above are Liz Lovette, 1st Vice President and Chair of the Accreditation & Ethics Committee presenting Robert Loiseau with his Certified Insurance Receiver- Property & Casualty plaque (CIR-P&C).

IAIR Now Has A Website

Effective July 1st IAIR now has a website at http:// www.IAIR.org. This Internet feature will allow us to promote the organization and will enhance the flow of information between members. The site is still under construction, but currently includes the following pages, with more to come:

Home Page - This page contains the name and address of IAIR as well as contact information.

History Page - This page includes a brief history of IAIR and explains our objectives.

Board of Directors & Committees - This page lists each director and includes their street address and a direct link to their e-mail address. The lower portion of this page lists the various committees, the chair, and each member of the committee.

Membership Directory - This page features the membership directory which can be searched by last name, state/country or in alphabetical order. Each entry includes the same information as provided in the written directory plus a direct link to the person's e-mail address.

Events & Schedule - This page lists all events in which IAIR is involved either jointly with another organization or as a stand-alone program. In addition to the event, location, and date, direct links are provided to the hotel, to a map of the city, a list of local restaurants, and a site detailing local happenings.

The Insurance Receiver - This page is under construction, but will eventually include issues of *The Insurance Receiver* henceforth with the exception of the most current which will only be accessible to members of IAIR.

Member Services - This page is also under construction and will be password protected. Each member will be given a password which will allow them to obtain information about their involvement with IAIR. A listing of programs attended, current billing status, and other features. The current newsletter will be available to members via this page.

Insurance Links - This page features direct links to other insurance related sites or sites of interest to IAIR members. If we are missing a site that is of interest to you, please contact us with your suggestions.

Additional ideas under development are an on-line membership application, an insurance glossary, a help board where you can request help on a topic or issue from other people in the industry, and a bulletin board with a different discussion topic each week.

If you do not want a direct link to your e-mail address or if for some reason, you do not want your address on a public domain, please contact IAIR. Also, if you do want this information available to others, please verify that the information is correct particularly your e-mail address.

Visit the IAIR website and give us your input. This site is your link to IAIR members and others interested in insurance insolvency. Please check it out!

IAIR Staff Training Session

IAIR is having its Staff Training Session on September 9th and 10th in St. Louis, Missouri. The topics will include but are not limited to "The Mechanics of Claims Estimation, An HMO Primer, and a UDS Information Workshop.

Brochures were mailed the middle of June to all members or you can contact Paula Keyes at email address epkeyes@aol.com or phone 312/ 961-4199 for more information.

Creditors' Committees in U.S. Insolvencies-The wave of the future?

(only if Creditor's demand it!)

By Thomas W. McCarthy *

Before I begin, I need to dispose of the mandatory disclaimers. While my law firm represents several insolvent estates, this article does not purport to represent the opinions of the liquidators of any of those estates, nor does it represent the opinions of my partners or my firm. It represents only the opinion of the author. Also, any references to departments of insurance do not mean any particular department or any particular regulator.[1]

There are many differences between the system used in the United Kingdom to wind up insolvent insurers and those used in the United States. One of the greatest differences, and the one dealt with herein, is the use of the creditors' committee. In the U.S. insolvent insurers have historically been administered and wound up by the same regulators who were charged with supervising their solvency, the state departments or divisions of insurance, supervised to a greater or lesser degree by the state courts. In the U.K., on the other hand, insolvent insurers are wound up by licensed professionals supervised, for the most part, by committees comprised of creditors of the insolvent company. There are substantive differences that result from these divergent approaches.

One of the most frequent complaints that is heard concerning insolvent estates in the U.S. is the failure to pay dividends quickly and regularly. In the U.K., dividend payments can be and usually are made early in the runoff. This is partially a function of the differences in the controlling statutes, but only partially.

The NAIC Model Act is a very flexible statute and in the hands of an innovative liquidator and an open-minded court could accommodate early distributions. Indeed, the statute specifically recognizes the needs of the state guaranty funds (hereinafter SGFs) to have access to early distributions, but there is no prohibition against others receiving early distributions, provided those distributions do not result in preferences to individual creditors. Innovations among U.S. liquidators in this area have been few. In the humble opinion of the author, a large part of the lack of innovation in the U.S. liquidations is due to a lack of incentive to innovate on the part of the liquidator. Under the current system, innovation brings few rewards if successful and potential criticism if unsuccessful. Creditors' committees could change all of that. Also, it is reasonable to expect that supervising courts would be heavily influenced by the desires of creditors since the assets in question do ultimately belong to them. As a result, those same courts might be more open to innovation.

Creditors' committees can be instrumental in designing the plan for winding-up, and in determining the investment policy of the estate during the period of runoff.

Under the current system in the U.S., creditors have nothing to say about the way in which a company is liquidated. Those decisions are made entirely by a combination of the regulator - a special deputy assigned to wind up the estate, or alternatively, the judge - who supervises the liquidation. In the U.K., the creditors' committee participates actively in the design and implementation of the winding-up strategy, as well as in any changes made along the way. In fact, the U.S. creditors frequently have trouble getting pertinent information concerning the plan or progress of the winding up of a U.S. estate in a timely manner, if at all. The information that is made available is only made available as determined by the regulator, the special deputy and/or the supervising court. It may or may not be the information that the creditors believe that they need. In some instances, the regulators, no doubt with the best of motives, release information that the creditors would probably choose to keep confidential. For example, some states make commutation results public while others release all details of employment contracts. The former approach makes maximizing commutation results problematic, while the latter can have an extremely detrimental effect on employee retention.

Just like in designing the plan for winding-up, creditors' committees can be instrumental in determining the investment policy of the estate during the period of runoff. Due to the nature of insurance insolvency, the winding- up process may take many years. Thus, the creditors' committee may choose to invest a portion of the portfolio of the estate in equities. In the U.S., the investment strategy is dictated by statute, by the court, by the regulator and/or by the special deputy or a combination of the foregoing, but not by the creditors, who ironically have the most at risk and stand to lose the most from that decision. As a result, most U.S. estates end up using a very conservative investment policy. This is largely attributable to the responsible persons viewing themselves as trustees, who are unwilling to take

** Thomas W. McCarthy is the senior partner in the law firm of McCarthy, Leonard, Kaemmerer, Owen, Lamkin and McGovern L.C. The firm serves as general counsel to the Transit Casualty receivership and as claims counsel to the Southern American liquidation, as well as having represented several foreign insolvencies and liquidators in various states. Mr. McCarthy serves as advisor or alternate for the creditors' committees of the KWELM estate in the United Kingdom and the Bermuda Fire & Marine Insurance Company estate in Bermuda.*

1 In particular, references to regulators ***are not*** references to regulators in either the Missouri or Utah Departments of Insurance.

(Continued Page 8)

Creditors' Committees in U.S. Insolvencies-The wave of the future? (Continued from Page 7)

any chances with the money entrusted to them. While it is very difficult to blame anyone who takes this view, it does not ensure that appropriate investment decisions are actually made when you consider that the opposite has also occurred in at least one estate where speculative investments cost the creditors millions of dollars. This begs the question: would this have occurred if the creditors had a voice in the decision making process?

The conventional wisdom among regulators in the U.S. responsible for runoffs is that the sooner the estate is wound up the better. This is, no doubt, based upon a desire to minimize administrative expenses and distribute money to the creditors as soon as possible. While these are laudable goals, the premise upon which it is based - insolvencies are all alike and should all be treated the same way - is obviously faulty. As such, just as each insolvency is unique, so is the composition of each creditor class.

For example, sometimes the maximization of reinsurance assets is dependent on the ability of the estate to wait out its debtors pending the maturation of long tail claims. This approach requires more administrative expense, but is a decision that should lay with the creditors, because they will either suffer the consequences or reap the benefits.

If the creditors were in a position to participate meaningfully in the determination and timing of dividend distributions, there would be no need for early winding-up in order to get money into their hands quickly. There would also be no need for spending millions of dollars on estimation plans against the bitter resistance of reinsurers. In the context of liquidation in the U.S. today, the current claims estimation litigation is based on the honest desire of the regulators administering runoffs to get money into the hands of creditors as soon as possible. But this approach, while innovative and well intended, is potentially very expensive and the outcome is far from certain. If creditors' committees were in wide use in the U.S., this might well be unnecessary.

Another sensitive area is the retention and motivation of employees involved in a winding up. The one thing which a U.S. style liquidation can be assured an abundance of is criticism. Regulators, special deputies and courts now charged with the responsibility for winding up estates in the U.S. typically trend towards conservative practices in order to avoid criticism. However, in situations where they do innovate, as in the case of estimation, they become criticized for spending too much money. If the insolvency is of sufficient size as to need its own staff, the problem of finding and keeping competent people for a sufficiently long period of time to accomplish the task is very difficult and expensive. If the estate is to be wound up by a state liquidation bureau, motivating the people involved in making the extra effort that is frequently needed to maximize assets presents a challenge. However, if a creditors committees were in charge, the use of estimation could hardly be criticized, because the money at risk is that of the creditors. Similarly, the same would be true of personnel retention policies, whatever they might be, or the choice to use a state liquidation bureau. If the option were left to the creditors, there should be no complaints as the consequences of the decision fall only on the decision-makers chosen by the creditors.

Where creditors' committees supervise the winding up, it is clearly a private affair.

Creditors' committees operating in the U.K. have an obligation to pass information along only to the creditors of the estate. Inquiring debtors, reporters or others can be dealt with on a one-off basis, because the runoff is clearly a private affair utilizing only private funds. While the use of only private funds is usually the case in the U.S., the involvement of state agencies in the winding-up tends to muddy the water as to what is public and what is private.

Since some states allow insurers contributing to the state guaranty fund a deduction or credit against premium taxes for that contribution, an argument is frequently made that taxpayer money is inevitably involved in the winding-up.

While this argument is surely specious, since it would also open up every company which took a job training credit or other similar credits to the dictates of the state and the inquiries of the press, it is also unnecessary. To give or withhold tax credits for contributions to a guaranty fund is a legislative decision that has nothing to do with winding-up an estate. In short, it doesn't matter to the creditors of the insolvent estate whether or not the deduction or credit is given or withheld. If state agencies were not involved, this question would not even occur. Where creditors' committees supervise the winding up, it is clearly a private affair. The control of information is clearly and correctly in the hands of those who would be affected by its release.

Due to the international nature of some of the larger insurance insolvencies in the U.S., the U.K. and Bermuda, many U.S. companies and law firms have been exposed to the use of creditors' committees and the effectiveness of those committees. As a result, U.S. creditors and their representatives are becoming more sophisticated in these matters. Anderson, Kill's Mark Keenan, Covington, Burling's Marialuisa Gallozzi and Dickstein, Shapiro's Scott Gilbert and Betty Orr are, to name a few, law firms and their respective attorneys who are actively involved in representing creditors' groups on committees. In the U.K., clear limits have been set on the liability of those serving on creditors committees. The NAIC Model Act can accommodate reasonable protection for creditors' committee members as the Missouri version of that law clearly demonstrates. Creditors' committee members can enjoy judicial immunity, as long as they serve as officers of the court under the direction of the supervising judge. This may not be a perfect solution, but it is workable. In fact, the Transit Casualty estate, which has had an ad hoc committee of the state guaranty funds since its inception, has recently adopted a broad and representative receiver on the winding-up. The decision to establish this committee was reached by the special deputy receiver and the supervising court

working together. With exception of the Mutual Fire estate in Pennsylvania, this is the only example of the use of creditors' committees in U.S. of which I am aware. The prospect of a creditor's committee has been warmly received by the Transit creditors.

The desirability of creditors' committees is manifest. After all, it is the creditors who paid good money for bad insurance. They are the only ones who are hurt by the insolvency. If a state wants to protect its taxpayers from the impact of tax credits for solvent insurers' contributions to state guaranty funds, then its legislature can repeal those credits. This is a collateral issue and should not detract from the clear view of the creditors (and through them the people which the insurance was procured to protect) as the only victims of an insurance company failure. The failed company should effectively become the property of the creditors for the purpose of winding up and maximizing assets. In an insolvency the regulators, the shareholders and the management of the failed insurer have all had their chance and despite their best efforts, the company has been unable to deliver on its promise to pay claims. In these circumstances, the decisions of the creditors should dictate how the resulting mess is best cleaned up.

In my numerous discussions with creditors' counsel and creditors, there has been expressed a clear desire to expand the use of creditors' committees in U.S. insolvencies and to cloak those committees with true supervising authority. While the use of a creditors' committees, such as the committee in the Transit estate, is currently possible under the NAIC Model Act, statutory changes will be needed to give those committees both the authority to supervise the winding up of an estate and a reasonable amount of protection from liability while doing so. The statutory changes needed are not complicated, but they are a sea change for U.S. liquidations. As a result, it is my strong belief that any move to the use of creditors committees in U.S. insolvencies must be championed by creditors' groups. They will have to make their case first to the NAIC and then to the legislature of the states.

A reasonable person, especially one who has been involved in U.S. insolvencies, might ask who would oppose a move to the use of creditors' committees in the U.S.

Initial opposition will come from some regulators. Indeed in the past I have heard a few regulators refer to the "greedy creditors" and to declaim that "you can't trust the creditors." This is a baffling mindset and is grounded, I believe in a view that the regulatory duty is to protect the public even from itself. It is also based on a misapprehension of the state's role in liquidations as mainly historic, as opposed to being grounded in any well thought out public policy considerations. Fortunately, there is no reason to believe that this view is widespread among regulators. There may also be concern among some regulators that the loss of control of liquidations to the creditors will adversely affect their regulatory performance.

Further opposition can be expected from some reinsurers who perceive that they have an easier time with state run insolvencies.

I recall a very frank discussion with the head of an insurance department (not a department for which my firm has ever worked). The regulator told me that he worried about pursuing reinsurance recoveries too aggressively for fear of bankrupting reinsurance companies which were also under his regulatory control. While as a representative of liquidators and, therefore creditors, I completely differ with this regulator's approach, I do understand it. In effect, our statutory scheme which requires regulators to also be responsible for liquidations causes the regulator to attempt to carry water on both shoulders.

Requiring a regulator to aggressively pursue to the collection of all reinsurance assets while preserving the insolvency of all reinsurers under the regulator's supervision is a built-in statutory conflict and should be resolved statutorily.

Finally, there will be the inevitable fear of job loss by some of those in regulatory liquidation departments. It is not much consolation to this group to say that times change, and that this is in the best interest of the creditors, so keep a stiff upper lip, etc.

But I believe that it is valid to point out that there will always be some companies that are too small or too broke to support a private runoff. In those cases the creditors should be allowed to choose to have the state run off the company. Also, there will always be room in the private sector for the many competent people who now toil for the various states in liquidating companies and the rewards in the private sector should be greater.

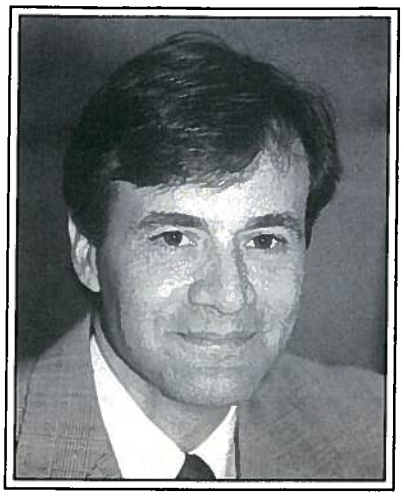
Further opposition can be expected from some reinsurers who perceive that they have an easier time with state run insolvencies. This perception is due either to the emphasis on early closure at all costs, thus rewarding stubborn refusal to pay; or the potential for regulatory conflict which could cause a liquidator to pull his or her punches. Not all reinsurers, however, will be opposed.

It has been suggested to me that state guaranty funds might be opposed to creditors' committees, but this flies in the face of my own experience. State guaranty fund representatives with which I have dealt have been very helpful and experienced. The formalization of the creditors' committee should include guaranty funds statutorily so long as they remain creditors. They are a real asset to a liquidator and I would expect them to be welcome on any creditors' committee.

Still none of this opposition can be overcome by anyone other than the creditors of these insolvencies insisting on their rights as creditors to make their own decisions and demanding the statutory tools with which to accomplish the task. Representatives of injured third parties should not be hesitant to speak up. After all, it is their clients for whose benefit the insurance was purchased and maximization of assets is in the interest of that same group.

This is, however, something very new for this country and, like any other new idea, will encounter resistance. If creditors of insolvent insurance companies want to take control of their own destiny in the U.S., they will have to say so, firmly and repeatedly.

Meet Your Colleagues



Gaetan J. Alfano

Gaetan J. Alfano is an officer and shareholder of Miller, Alfano & Raspanti, P.C. Born and raised in Philadelphia, Pennsylvania, Mr. Alfano attended Villanova University and graduated magna cum laude in 1977. He received his J.D. from Villanova University School of Law in 1980. Mr. Alfano then joined the Philadelphia District Attorney's Office where he acquired extensive trial experience.

From 1985 to 1989, Mr. Alfano was a senior litigation associate with the Philadelphia law firm, Hoyle, Morris & Kerr. Mr. Alfano formed Miller, Alfano & Raspanti, P.C. in 1989. He concentrates his practice in complex litigation. Mr. Alfano served as lead counsel for the Pennsylvania Insurance Commissioner as receiver for The Mutual Fire, Marine and Inland Insurance Company, Pennsylvania's largest property and casualty insurance insolvency.

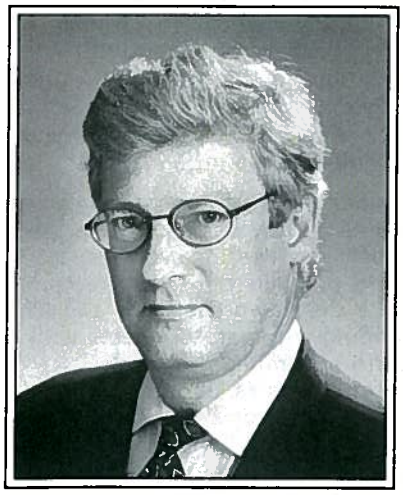
One of Mr. Alfano's more notable cases was a reinsurance collection action against GTE Reinsurance Company, Limited, the captive insurer of GTE corporation. The case involved the synthesis of over three thousand individual insurance agreements and testing on a 'sampling" basis, of tens of thousands of constituent insurance transactions.

After negotiating a "courthouse steps" recovery of $25.2 million, Mr. Alfano tried the quantification of GTE Re's reserve obligations based on a theory of anticipatory breach/acceleration of damages. After a seven day trial, Mr. Alfano negotiated an additional recovery of $19.7 million to resolve GTE Re's future obligations. This settlement of $44.9 million from GTE Re represents the largest litigated reinsurance recovery in Pennsylvania history.

Mr. Alfano currently represents the Delaware Insurance Commissioner as Receiver for National Heritage Life Insurance Company (In Liquidation) where he is responsible for prosecuting a variety of professional liability and asset recovery actions.

Mr. Alfano is a contributing member of the American Arbitration Association and a Member of the American Arbitration Association's Panel of Neutrals. He has extensive experience as an arbitrator.

He serves on the Board of Governors of the Justinian Society and also serves as Secretary/ Treasurer of the Justinian Foundation, a non-profit scholarship fund. Mr. Alfano resides in Wallingford, Pennsylvania with his wife and two daughters.



Robert M. Hall

Bob began his career as in-house counsel for various insurance companies including Reliance Insurance Company and later American Re-Insurance Company where he became general counsel and senior vice president.

During the course of his in-house career, Bob has worked in a wide variety of property and casualty fields including surplus lines, managing general agencies, brokers, intermediaries, premium financing, policy drafting, risk management, captives, commercial transactions, finite risk reinsurance, reinsurance contracts and insurance and reinsurance regulation.

In 1995 Bob left American Re to become a partner in Washington office of Rudinck & Wolfe where he practiced insurance and reinsurance law and represented receivers in a number of matters.

In 1998, Bob gave up his partnership at Rudnick & Wolfe (but retained "of counsel" status) to focus on a separate practice involving arbitrations, mediations and insurance consulting.

To date, Bob has engaged in approximately two dozen arbitrations including four in which he was either the party arbitrator or counsel for receivers. He is certified as an arbitrator by ARIAS-US and has formal training in mediation.

Bob has extensive NAIC experience. He has served on advisory committees dealing with guaranty funds, receiverships, electronic communication between receivers and guaranty funds, questionable transactions within holding company systems and credit for reinsurance. In addition, he has acted as an expert witness and is the author of numerous articles about reinsurance, arbitration, mediation and receivership issues.

Bob obtained his undergraduate degree at the University of Notre Dame and his law degree at the Villanova School of Law. He is admitted to practice in New York, Pennsylvania, Virginia and Washington D.C.

In his leisure time, Bob enjoys sailing and trying to keep up with his dynamic wife, Debra Hall.

James Gerber

Jim Gerber is the Director of Receiverships for the Michigan Insurance Bureau and is responsible for overall management and direction of seven open domestic receivership estates, several ancillary estates and other proceedings conducted under Michigan receivership laws.

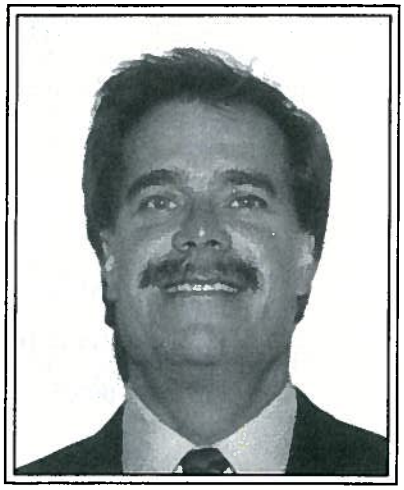
"Although new to the world of receiverships, I view my position as Director as an opportunity to apply over sixteen years of regulatory and business experience to new and challenging situations. I've enjoyed working with my staff in Michigan and meeting fellow receivers in other states. I really appreciate IAIR as a way for receivers to share experiences and exchange ideas."

Prior to his appointment as Director of Receiverships in 1996, he was a staff examiner for the Michigan Insurance Bureau for four years and an examiner-in-charge for twelve years. Jim was examiner-in-charge for such companies as Great West Life, Manulife, Canada Life, Jackson National, Sun Life of Canada and Blue Cross and Blue Shield of Michigan as well as several "special examinations" of troubled companies on behalf of various Michigan Commissioner. Jim is a Certified Financial Examiner and a member of the Society of Financial Examiners. He has been a member of the NAIC Examiner Team project as an instructor at the NAIC Regulating for Solvency seminar.

Prior to being employed by the Michigan Insurance Bureau in 1981, Associates Financial Corporation employed Jim in collecting loans in Associates Benton Harbor, Michigan branch office.

Jim has a BA in Business Administration from Eastern Michigan University.

In his "free" time, Jim enjoys his collection of over 1,200 records and CDs, rail photography and model railroading, playing sports, his 1960s San Francisco poster collection and reading the Wall Street Journal "just to relax". There isn't much "free time" since Jim is married to Lori, the world's most patient wife, and is father to four children: Angie, Dustin, Martha and Chris, who range in ages from 3 to 19. The Gerber household also includes a rampaging Beagle, a Siamese cat and assorted gerbils.



Joseph M. Hennelly, Jr.

Joe Hennelly is a sole practitioner and the principal of the law firm of Joseph M. Hennelly, Jr., P.C. Joe's practice is limited to insurance regulatory matters and includes representation of the Arizona Director of Insurance as the receiver of various insurers in receivership including Farm & Home Life Insurance Company, Diamond Benefits Life Insurance Company, AMS Life Insurance Company and American Bonding Company. Joe's practice also includes the representation of insurers and other entities on regulatory matters before the Arizona Department of Insurance and service as an expert witness on various aspects of insurance regulation.

Joe received his B.S. degree Phi Beta Kappa and summa cum laude in the Honors Program from Arizona State University in 1978, and received his J.D. cum laude from Arizona State University in 1981 where he was on the law review. Joe is admitted to practice in Arizona and Illinois.

Joe was the Deputy Director of the Arizona Department of Insurance from 1988 to 1993 where, as second in charge, he oversaw all of the divisions of the Department. During this time period, the position of Deputy Receiver, which position also reported to Joe, was created and the Department received its first accreditation by the NAIC. Thereafter, Joe continued his career in insurance regulation by joining the Phoenix, Arizona law firm of Guttilla & Murphy, P.C., where he was a partner.

In 1998 Joe formed his law firm and continues his insurance practice. Prior to embarking on what is now an eleven-year career in insurance regulation, Joe was an Assistant United States Attorney in the Phoenix Division of the United States Attorney's Office and prior thereto was an Arizona Assistant Attorney General, where his practice involved civil remedies for criminal conduct including civil racketeering prosecutions and civil and criminal forfeiture cases. As an AUSA, Joe spoke nationally to numerous law enforcement organizations about civil remedies and forfeiture.

Joe resides in Phoenix, Arizona with his wife, Sue. His hobbies include scuba diving (most recently in Belize), ocean kayaking, canoeing, hiking and camping.

Receivers' Achievement Report

Ellen Fickinger, Chair Reporters: Northeastern Zone -J. David Leslie (MA); William Taylor (PA); Midwestern Zone - Ellen Fickinger (IL), Brian Shuff (IN); Southeastern Zone - Belinda Miller (FL); Michael R. D. Adams (LA); Mid-Atlantic - Joe Holloway (NC); Western Zone - Mark Tharp (AZ); Amy Jeanne Welton (TX); Melissa Kooistra Eaves (CA); International - Phillip Singer (England); and John Milligan-Whyte (Bermuda)

Melissa Kooistra Eaves (CA) reports that in November of 1998, California Insurance Commissioner Chuck Quackenbush won a landmark decision in the California Court of Appeals, 2nd District, in the **Cal-American Insurance Company** insolvency. The appellate court rejected the arguments of Arthur Andersen that it could be sued only by its clients and a limited number of other parties who rely on its audits, but not by the Insurance Commissioner. In rejecting Arthur Andersen's contentions, the appellate court gave deference to the Commissioner's role as chief regulator over the solvency of insurance companies doing business in California, as well as the Commissioner's duty to protect the policy holders and consumers. Subsequent to this action, Arthur Andersen appealed to the California Supreme Court. In February, the NAIC filed an amicus letter with the Court on behalf of the Commissioner. On March 22, 1999, the California Supreme Court declined to hear the appeal.

Additional news from **California** includes the distribution of $2.3 million to claimants in the **George Washington Life of California** estate by the CLO in January. The CLO is also in the process of consolidating the operations of the **Mission Insurance Company** receivership in the CLO's offices in San Francisco. It is anticipated that all operations will be centered in the CLO's offices by the end of 1999.

Mike Rauwolf (IL) continues to report on the Illinois receiver's efforts to manage the reinsurance run-off for **American Mutual Reinsurance Company (AMRECO)**, in rehabilitation. Reinsurance payments to date total $123,986,410.00, Loss and LAE $30,449.00 and LOC Drawdown disbursements $9,613,386.00. Additionally, Illinois continues to manage the run-off of **Centaur Insurance Company**, in rehabilitation. Total claims paid inception to date are $50,791,292.00 for Loss and LAE, $4,945,493.00 in Reinsurance payments and $13,876,555.00 in LOC Drawdown disbursements. *(Continued on Page 13)*

Our IAIR achievement news received from reporters covering the fourth quarter of 1998 is as follows:

RECEIVERS' ACHIEVEMENTS BY STATE

California (Melissa Kooistra Eaves, State Contact Person)
Use and distributions made to policy/contract creditors and Early Access 4th quarter, 1998

Receivership	*Amount*
Miller's National Insurance Co.	$129,958.00

Illinois (Mike Rauwolf, State Contact Person)

ReceivershipEstatesClosed	Year Action Commenced	Licensed	Category	Dividend Percentage	
Reserve Insurance Co.	1979	Y	P&C	Class A: 100% -	$26,288,234
				Class D (GA's & Non GA's): 48.96% -	$41,088,281

Receivership	*Amount*
Amalgamated	$35,723.00
Amreco	$1,994,287.00
Centaur	$126,978.00
Coronet	$10,923.00
Equity General	$2,139,999.00
Inland	$181,051.00
InterContinental	$1,449,988.00
Kenilworth	$1,253,156.00
MedCare	$386,569.00
Merit	$488,823.00
Millers	$674,127.00
Pine Top	$66,573.00
Prestige	$38.00
Security Casualty	$23,395.00
State Security	$1,578.00
United Equitable	$1,799,999.00
United Fire	$1,799,999.00
Total	**$10,634,756.00**

Maryland (James A. Gordon, State Contact Person)

Receivership	*Amount*
Trans-Pacific Insurance C., et al	$194,858.44
Grangers Mutual Ins. Co.	$66,038.00 MD
	$38,614.60 DC
	$5,495.87 TN
Total	**$305,006.91**

New York (Frankie G. Bliss, State Contact Person)

Receivership	*Amount*
Consolidated	$71,837.00
Cosmopolitan	$551,604.55
Horizon	$17,805,360.07
Ideal Mutual	$1,576,445.03
Long Island	$7,089.00
Northumberland Reg. 41	$1,547,891.80
Whiting Nat'l.	$15,498.00
Total	**$21,575,725.45**

Pennsylvania (William Taylor, State Contact Person)

Receivership	*Amount*
Corporate Life Insurance Company	$20,000,000.00 GF
World Life and Health Ins. Co. of PA	$1,000,000.00 GF
Total	**$21,000,000.00**

James A. Gordon (MD) provided further information on civil litigation and criminal prosecutions. Collections during the fourth quarter of 1998 for **Trans-Pacific Insurance Company, et al.,** against former employees and rental income totaled $405.00. Liechtenstein returned funds that were found on Martin Bransom at the time of his arrest in the amount of $2,843,983.75. Additionally, collections during the fourth quarter of 1998 for **Grangers Mutual Insurance Company** totaled $36,448.87.

John Colpean (MI) reports that the U.S. estate of **Sovereign Life Insurance Company (Sovereign)** was closed by the order of the Ingham County Circuit Court for the State of Michigan on January 6, 1999. **Sovereign** was a Canadian domiciled company that used Michigan as its state of entry for purposes of conducting business the in the United States. **Sovereign** was originally found insolvent on January 25, 1993 by the Court of Queens Bench of Alberta, Judicial District of Calgary. On June 14, 1993, a liquidation order was entered by the Michigan court which ordered the immediate possession of all of **Sovereign's** assets located within the United States which totaled approximately $4.6 million. The Michigan Life & Health Insurance Guaranty Association was named the Special Deputy Receiver/ Liquidator of **Sovereign's** U.S. estate. The claims of U.S. policyholders were satisfied by transferring **Sovereign's** U.S. policies to the **Franklin Life Insurance Company** under an assumption reinsurance agreement. After payment of all of **Sovereign's** remaining claims, U.S. assets, in the amount of $1,552,753.50, were transferred to the Canadian Liquidator.

Pat McGuire and James Gerber (MI) report that American Commercial Liability Administrative and a 50% Interium Distribution on Paid Claims were distributed in 1999 to the following guaranty funds: Arizona, $186,405; Indiana, $741,394 and Michigan, $5,461,084 for a total of $6,388,883. Commercial Underwriters receivership estate was closed on January 30, 1998. The American Mutual Insurance Company of Boston and American Mutual Liability Insurance Company ancillary estates were closed on May 26, 1999 with over $8,000,000 returned to the domicilary receiver.

Bill Taylor (PA) continues to provide information on the ongoing rehabilitation of **Fidelity Mutual Life Insurance Company (FML)**, in rehabilitation. 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 12-31-98, **FML** showed a statutory surplus in excess of $106,000,000.

Further, the Commonwealth Court has begun appointing referees to hear the 51 disputed claims and 8 have already been settled or dismissed. The Rehabilitator is currently in the process of offering immediate payment to allowed creditors who are willing to waive

(Continued on Page 14)

Receivers' Achievement Report *(Continued from Page 13)*

any interest and penalty that might ultimately be provided in an approved rehabilitation plan. So far, the majority of the general creditors (excluding taxing authorities) have accepted the settlement for the principal amount of their claim. All but four of the state guaranty associations have returned the release necessary for payment of their outstanding assessments and they expect to hear from those four associations soon. **FML** will not be able to pay any expense claims of guaranty associations because none of the associations have been statutorily triggered. They are also in the process of working out settlements with the taxing authorities that will allow us 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.

Also, the Commonwealth Court recently issued an order setting a hearing for the Third Amended Rehabilitation Plan which was filed on June 30. The hearing will also include the Stock Allocation Report that details the allocation of stock to policyholders for their mutual member interests and the petition for approval of a new dividend scale, all of which 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 7% 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**.

The Court's scheduling order provides for the Rehabilitator and all objectors to file written testimony and objections to testimony prior to the actual hearing on July 7, 1999. The Bid Procedures submitted to the Court are not scheduled to be addressed in the hearing but must still be approved before the Rehabilitator can begin seeking an investor. Notice of the hearing date is going out to all **FML** policyholders.

We also received information from **Rheta Beach (UT)** on **Southern**

American Insurance Company, in liquidation. On July 1, 1998, a Service Agreement was entered into between **KWELM Management Service, Ltd. (KMS)** in London and the Liquidator of **Southern American** for **KMS** to handle the claims processing and reinsurance collections on the business written through the **HS Weavers (Underwriting) Agency** in which **Southern American** was a "stamp" participant for policies underwritten 1970-1975. **Southern American** is the only U.S. "stamp" company in liquidation proceedings. **HS Weavers (Underwriting) Agency** is also in liquidation. Notice of Issuance of Liquidation Order of **Southern American** was mailed in December, 1998 to all known potential claimants on the **Weavers** policies requesting that all claims be filed with **KMS** by June 15, 1999.

Judge Stephen Henriod of the Third Judicial District Court in and for Salt Lake County, State of Utah, signed an Order Authorizing Claim Estimation of Unliquidated Claims in the **Southern American** estate on November 16, 1998. Notice of the Application for Claim Estimation was mailed to approximately 2,100 potentially affected claimants, reinsurers, retrocessionaires and Guaranty Funds in July, 1998. No objections were filed with the Liquidation Court.

During 1998, a claims/reinsurance system was implemented at the **Southern American** office for handling of long-tail exposure claims and reinsurance notification and collection. The system was placed into production after nine months of systems research, modification, data gathering on policies, claims and reinsurance, data cleansing and testing.

Kansas City Meeting Recap

(Continued from Page 4)

nents of the problem compared notes and exchanged ideas and warnings. I think most of them went home impressed at how many different pieces this problem has, and how much we can do about it. I know I did. We do, in fact, have a tremendous reservoir of knowledge and experience applicable to health insolvencies. The trick will be deploying it to best advantage. IAIR is just the organization to showcase those talents and demand that they be applied. I hope that IAIR's officers can find several ways to channel all those would-be volunteers and their energy in ways that confirm its standing as a leader in developing the practice of insurance insolvency.

And one last word: part of the reason that task force drew so many participants was because its precise time and location was announced at the Roundtable. It would have drawn even more if Roundtable attendance hadn't been limited to those intrepid (and fortunately numerous) souls who found their way into Morrison and Hecker's lovely offices. Recently, IAIR committee meetings have been held on Sunday mornings, but the times have been announced only informally, via communication from the chairman. That allows some last-minute flexibility, but tends to limit participation to the usual suspects, and even they sometimes get lost. Committee chairs should be asked to set meeting times early enough to put them in the quarterly mailing. Failing that, pencil them in on the IAIR display. (Our new Executive Director should be asked to leave a spot on the display for each committee, naming its chair.) Last but not least, announce them at the Round Table. You want volunteers? Stop hiding the committee meetings!

INSOL International

One of the earliest things that IAIR did was to become a member of INSOL International, the International Federation of Insolvency Practitioners.

Initially IAIR's membership fees were calculated and paid to INSOL by reference to its Principal and Associate members but not its Sustaining members.

With the abolition of those classes of membership we reviewed with INSOL how IAIR's fees should be charged in the future. Unfortunately, it proved impossible to find a formula that would enable IAIR to remain a member of INSOL at a price that it could afford. As a consequence and with considerable regret it was decided that IAIR should cease to be specialist member of INSOL, paying full fees, but should explore the practicability of becoming a non-specialist member with its fees calculated by reference only to those members of IAIR who elected to become part of Special Interest Group within IAIR and who would pay additional fees to IAIR to cover the cost of INSOL membership.

We are aware that a significant number of IAIR's members are also members of other organizations, which are themselves members of INSOL and who therefore will not feel the need to join a Special Interest Group. Should they wish to do so, of course there is nothing to stop them. Most of those IAIR members who are themselves members of other organizations, which are members of INSOL, are to be found within our international membership.

A letter will shortly be circulated to members inviting them to elect whether or not to become part of the Special Interest Group. The final cost of membership of the Special Interest Group has not yet been fixed.

Current INSOL dues are $30 per head per annum but it will be necessary to charge an additional sum to cover the administrative costs incurred by IAIR in processing membership of the Special Interest Group.

At the time of going to press this has not been fixed but it will probably be in the region of $10 or $15 per annum.

TREATMENT OF INTER-COMPANY POOLING AGREEMENTS IN INSOLVENCY PROCEEDINGS *

by Harold S. Horwich and Patrick J. Trostle, Hebb & Gitlin, P.C., Hartford, Connecticut

Pooling arrangements have become common among affiliated insurance companies. In a typical arrangement, companies (the "Ceding Companies") cede all their premiums and losses to another company (the "Pool Company") and receive in return a share of the combined underwriting profits or losses. Pooling transactions provide access to unused capital and surplus as well as opportunities to diversify lines of business and geographic risk. Despite these laudable goals, pooling arrangements present unique insolvency problems, and in at least one instance (The Home State Insurance Group) such arrangements have resulted in the receiverships of otherwise healthy companies.

Pooling arrangements are typically considered to be long-term arrangements of indefinite duration. Agreements typically state that the arrangement may be terminated by any party on thirty days notice, a dangerous provision from the perspective of solvency regulation.

Even if a subsidiary member of a pool is sustaining losses over a long period as a result of other pool members' losses, it may not be able to extricate itself from the agreement if it has the same management as other group members. Management may not terminate the arrangement if termination would adversely affect other group members. A related problem occurs when a parent company continues to support unprofitable subsidiaries, an unjustifiable threat to the parent's solvency.

Those situations would not occur in a relationship with an external reinsurer, since external reinsurers are seldom willing to sustain losses year after year. Thus, market forces typically ensure that external reinsurance arrangements are fair on an ongoing basis, while no such forces protect pool members suffering group losses. As a result, once a company reaches insolvency, there may well be substantial inter-company claims.

This article evaluates the insolvency remedies available to a receiver when a pooling transaction has been unfair to an insolvent company. It concludes that these remedies do not provide sufficient or reliable relief.

I. POOLING OBLIGATIONS IN INSOLVENCY PROCEEDINGS

A. Basic rules.

An unterminated pooling agreement is an executory contract that the receiver may (if profitable) adopt for the benefit of the insolvency estate or (if not profitable) abandon.[1] When a group of companies becomes insolvent, at least one receiver is likely to abandon the pooling agreement, effectively discontinuing the agreement for all participants. Such abandonment constitutes a breach of the agreement and gives rise to claims against the abandoning company's estate. These breach-of-contract claims have the same status and priority as general claims, such as claims under abandoned reinsurance treaties.[2] Thus, the claims are junior to administrative expenses and to policyholders' claims. However, they may be subject to setoff rights under state law: a receiver with a claim against another pool member arising under another agreement may use that claim to offset the claim under the pooling agreement.

Where the pooling arrangement significantly contributed to a company's insolvency, abandonment of the agreement could give rise to substantial claims by other pool members. In such cases, the receiver looks for ways to avoid these claims and, more important, to recover losses paid before insolvency proceedings commenced. Several insolvency remedies may be available to the receiver, including preference, fraudulent transfer, breach of fiduciary duty, substantive consolidation, and equitable subordination. Each of these remedies involves proof that the pooling transaction was unfair to the insolvent company.

B. Fairness under the National Association of Insurance Commissioners' 1996 Model Insurance Holding Company System Regulatory Act.

Under the National Association of Insurance Commissioners' 1996 Model Insurance Holding Company System Regulatory Act (the "Holding Company Act"), a pooling transaction cannot be implemented without prior approval of the relevant insurance commissioners,[3] and it must be "fair and reasonable" to be approved.[4] Thus, in an insolvency situation, other pooling group members may argue that the insurance commissioner's prior determination under the Holding Company Act precludes a receiver from attacking the pooling transaction's fairness. That contention should fail.

For an issue to be precluded on the basis of a prior determination, the parties to the litigation must be the same.[5] However, the insurance commissioner acting as regulator is a different party from the insurance commissioner acting as receiver.[6] Moreover, for an issue to be precluded on the basis of a determination in prior proceedings, the issue decided in the prior proceedings must be the same as the issue to be precluded.[7] A determination of fairness at the inception of the pooling transaction may be based on facts and circumstances materially different from those existing when losses resulting from the pooling transaction occurred. For example, marketplace changes or developments in the law may have changed loss patterns, and the receiver's challenge may be based on such

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factors. Nevertheless, the insurance commissioner's prior fairness determination under the Holding Company Act is not entirely irrelevant. Accordingly, such a determination may be submitted as evidence of the transaction's fairness if circumstances have not changed materially.

II. INSOLVENCY REMEDIES AVAILABLE TO THE RECEIVER

A. Preference.

Preference law permits the receiver to recapture from creditors certain payments made by the insurer before the filing of a rehabilitation or liquidation petition. For example, a Ceding Company may have made payments under a pooling agreement to the Pool Company. If the Ceding Company becomes insolvent, its receiver may be entitled to recover certain payments as statutory preferences. In addition, if preferences are not repaid to the receivership estate, that fact constitutes a complete defense to any claims the Pool Company may have against the Ceding Company.

The elements of a preference are established by statute. For example, Section 32 of the 1995 National Association of Insurance Commissioners Insurers Rehabilitation and Liquidation Model Act (the "Model Liquidation Act") provides in relevant part as follows:

> A preference is a transfer of any property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation . . ., the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then the transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two (2) years before the filing of the successful petition for liquidation, whichever time is shorter.[8]

To be entitled to recover preferential transfers that satisfy the above-stated requirements, a receiver must prove certain additional statutory elements. For example, under Section 32 of the Model Liquidation Act, transfers are "avoidable" if the above requirements are met *and* the transfers were made within four months before the filing of the liquidation petition.[9] Moreover, if the receiver can prove that the Ceding Company was "insolvent" or that the Pool Company had reasonable cause to believe that the Ceding Company was "insolvent" or about to become "insolvent" at the time of the transfer(s), such transfers may be avoided subject only to proof of the other elements set forth above, even if the transfers were made outside the four-month period.[10]

Ordinarily, if a transferee has received a voidable preference from the insurer in receivership, the receiver may obtain and enforce a judgment against that transferee with respect to the preferential transfer. However, the transferee may be protected by an antilitigation injunction in insolvency proceedings. For example, the transferee may be the Pool Company, which itself may be in liquidation proceedings and protected by the antilitigation injunction. The Ceding Company's receiver is therefore limited to filing a claim for the preference in the Pool Company's proceedings. That claim will be junior to claims of the Pool Company's policyholders. Thus, *any* distribution on the claim is unlikely. However, if the receiver's preference claim against the Pool Company remains unpaid, the existence of such a claim (or any claim for avoidance under the insurance insolvency statutes) typically constitutes a complete defense by the Ceding Company's receiver to any claim by the Pool Company against the Ceding Company's receivership estate.[11]

B. Fraudulent Transfer.

Under fraudulent transfer laws, a receiver may recover certain assets conveyed away or payments made by the insolvent company and may also eliminate or subordinate certain claims against the estate. For simplicity of presentation, this discussion centers on the recovery of payments. A receiver typically has available two sets of fraudulent transfer laws: the receivership statutes[12] and the general creditors' rights laws of the state.[13] Fraudulent transfer laws typically permit avoidance of transfers made with actual fraudulent intent, although such a transfer would not likely occur within a pooling transaction. Fraudulent transfer laws also permit the avoidance of constructively fraudulent transfers. A transfer is constructively fraudulent if the transferor did not receive "reasonably equivalent value," "fair consideration," or the like in exchange for the payment made and either was insolvent at the time of the transfer or became insolvent as a result of it.[14] Consideration must be substantially unequal[15] at the time the relevant asset is transferred or the relevant debt is incurred to trigger the constructive fraud aspects of fraudulent transfer laws.[16]

Fraudulent transfer statutes define a period when transactions are subject to avoidance, typically from one to four or more years.[17] However, in ongoing transactions such as pooling agreements it may be difficult to determine when a transaction is deemed to have occurred. Some cases hold that each segment of the transaction is to be evaluated separately as it occurs.[18] Others hold that an ongoing transaction is to be measured at inception.[19] Thus, in these latter jurisdictions, transactions under a longstanding pooling agreement might not be attacked at all on fraudulent conveyance grounds.

Fraudulent transfer law has special rules for interaffiliate transfers. First, payments by a parent corporation for the benefit of its subsidiary generally are not deemed to be a fraudulent transfer if the subsidiary is solvent.[20] (If the subsidiary is insolvent, there is generally a contrary result.[21]) Second, many jurisdictions follow an "indirect benefit" rule,[22] recognizing that corporate affiliates frequently operate like a single enterprise. One affiliate may make a payment in exchange for consideration rendered to another yet receive no direct benefit. Courts recognize that in certain circumstances all affiliates benefit from the synergy of such groups;[23] thus, benefit directly received by one affiliate may indirectly benefit others. Arguably, a pooling arrangement benefits all group members by giving them access to the group's combined financial strength. That effect, if quantifiable, could support an "indirect benefit" defense. However, if the pool's performance is

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poor, that defense is correspondingly weak. Also, the "indirect benefit" defense may be unavailable if an insolvent insurer consistently suffered losses as a result of pool participation.

C. Breach of Fiduciary Duty.

Under the law of breach of fiduciary duty, the receiver may obtain affirmative recoveries and may also avoid claims. The receiver would allege that a member of a pooling group or interlocking management owed the insolvent company fiduciary duties with respect to the pooling arrangement — duties breached in causing the insolvent insurer to enter into or to remain subject to the pooling arrangement.

The duties of pooling companies to one another are not always clear. Generally, a parent corporation owes no fiduciary duty to wholly owned subsidiaries, and affiliates owe no fiduciary duties to one another.[24] However, when a subsidiary is insolvent or financially vulnerable, courts generally recognize the existence of a fiduciary duty running from the parent (or controlling affiliate) to the subsidiary and its creditors.[25] It may also be argued that members of a holding company group should be deemed fiduciaries for one another by virtue of the Holding Company Act, whereby all transactions within an insurance holding company system must be fair to the regulated company. Accordingly, it may be argued that the Holding Company Act imposes liability in the event of an unfair transaction. No reported decisions have tested this theory.

Once a fiduciary duty has been established, questions arise regarding applicable standards for breach of that duty. Ordinarily, directors of a corporation receive the benefit of the "business judgment rule," which protects them from liability for mere negligence. However, the benefit of that rule is lost if an individual has an interest in the transaction being challenged. Such a transaction is avoidable, and the individual is liable for its consequences unless the transaction was fair to the corporation.[26] Furthermore, the burden is on the defendant to prove the fairness of the transaction.[27]

A pooling transaction involving a parent and subsidiaries is self-interested for the parent but may not be for officers and directors.

To impose liability on interlocking officers and directors, it may be necessary to show not only concurrent presence on boards of directors of involved companies but also that directors benefited personally,[28] which may be difficult to demonstrate unless the director is a shareholder. Moreover, tracing a specific benefit to a director through stock ownership may not be feasible where shares of the pooled group are widely held. A better argument may be that officers and directors aided and abetted a breach of the controlling company's fiduciary duties to the insolvent company.[29]

D. Equitable Subordination.

Under the theory of equitable subordination, one creditor's claims are subordinated to other creditors' claims to the extent necessary to redress harm caused by the first creditor's inequitable conduct.[30] A related remedy, reclassifying debt owed to a shareholder as equity, is available if the shareholder inequitably substituted debt for equity.[31] Equitable subordination and reclassification address the priority of claims asserted against an insolvent company; they are not means of making affirmative recoveries.

The doctrine of equitable subordination has long existed as a matter of general equity under the federal bankruptcy laws[32] and should accordingly be available in insurance insolvency cases. The standards for obtaining equitable subordination depend on whether the claim holder is a fiduciary for the insolvent company. If so, the burden is on the [fiduciary]... "not only to prove the good faith of the transaction but also to show its inherent fairness from the viewpoint of the corporation and those interested therein.[33] If not, the plaintiff must prove" "egregious misconduct."[34] In the second situation, equitable subordination has been used as an alternative remedy for torts such as fraud.[35]

Equitable subordination may also be an alternative to the doctrines of fraudulent transfer and breach of fiduciary duty.[36] In fact, it may be the only remedy available when the target is another insolvent insurance company. Though subject to the anti-litigation injunction in the target's proceedings, equitable subordination, unlike other actions, should not be held to violate that injunction. If the target company files a claim in another insolvent insurance company's proceedings, equitable subordination submits the target company's receiver to the jurisdiction of the court and should be held to waive any stay of actions related to a determination of the priority of the filed claim.

It might be argued that Section 46 of the Model Liquidation Act precludes equitable subordination: "No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes [of Section 46] through the use of equitable remedies." But equitable subordination (as proposed to be used here) is a collective remedy for the insolvent insurer's receiver, not a remedy for a specific "shareholder, policyholder or other creditor" of such insurer. Moreover, Section 46 refers not to the insolvent insurer's receiver but to certain persons other than the receiver and accordingly should not be construed to prohibit the receiver from seeking subordination for the benefit of a class of creditors.

E. Substantive Consolidation.

Substantive consolidation may be used to consolidate one or more non-insurer affiliates of an insurer into the insurer's pending insolvency proceedings.[37] The doctrine may also be used to consolidate two or more insurers' pending proceedings. Substantive consolidation of pending cases is well established in bankruptcy practice[38] and accordingly ought to be applicable to insurance insolvency cases as well. Generally, when entities are substantively consolidated, their assets and liabilities are "pooled" and administered on a pooled basis. As a result, inter-entity obligations are eliminated.[39] A receiver may substantively consolidate parties to a pooling agreement as a means of administering their assets and liabilities on a pooled basis without a pooling agreement.

Generally, courts limit consolidation of companies in proceedings with companies not in proceedings to situations where the test for "piercing the corporate veil" is met.[40] A lesser showing is needed to substantively consolidate companies when all such companies are in proceedings.[41]

Courts generally agree that consolidation is appropriate if the entities' assets are so commingled that the costs of segregation threaten creditor recovery.[42] Outside those circum-

stances, courts differ regarding the appropriate standard for consolidation. Most courts look to certain characteristics of the entities,[43] generally requiring the proponent of consolidation to prove that the entities operated as a single enterprise and that consolidation is necessary to achieve some benefit or to avoid some harm. Other courts focus on creditor behavior, requiring the proponent of substantive consolidation to prove that creditors generally dealt with the entities as if they were one enterprise.[44]

Three limitations on the doctrine of substantive consolidation appear to apply to insurance insolvency proceedings. First, since the receivership court's jurisdiction is typically limited to insurers domiciled in its state, the court may lack jurisdiction to order substantive consolidation of an insurance company domiciled in another state with a domestic insurance company.[45] It might be argued that substantive consolidation overcomes the limits of jurisdiction because the effect of substantive consolidation is to disregard the separateness of legally separate entities when that would achieve an equitable result. But substantive consolidation merely disregards corporate separateness; it does not change a corporations' legal characteristics. Therefore, it seems unlikely that substantive consolidation alone could confer jurisdiction over a foreign insurance company.[46]

Second, a creditor that can prove that it relied on the separate credit of a single entity generally is entitled to a recovery based on that entity's assets and liabilities.[47] However, if the insurers have been rated on a pooled basis by rating agencies, creditors may not be able to satisfy that test.

Third, substantive consolidation cannot be used to achieve or preserve an inequity. For example, courts have denied a parent company's attempt to substantively consolidate a subsidiary into its own proceedings where the effect would have been to eliminate the subsidiary's claims against the parent for fraudulent transfer, breach of fiduciary duty, and the like.[48] An insurer with such claims against its affiliates is unlikely to be substantively consolidated into the cases of one or more of its affiliates over the objection of that insurer's receiver.

III. CONCLUSION

There are a number of remedies available to the receiver in an insurance insolvency where the insolvent company has been treated unfairly under a pooling agreement, but they are not always sufficient to correct the harm suffered by the insolvent company. Jurisdiction is a key concern: pooling agreements often involve companies incorporated in different states, and the receiver may have to contend with other insolvent pool members with cases pending in multiple jurisdictions. Even if jurisdiction is not an issue, the receiver's ability to obtain recoveries from pool members will be limited, since some of the remedies discussed herein are defensive and thus do not entitle the receiver to an affirmative recovery.

1. *See In re* C&S Grain Co., 47 F.3d 233 (7th Cir. 1995); Commercial Union Ins. Co. v. Texscan Corp. *(In re* Texscan Corp.*)*, 976 F.2d 1269 (9th Cir. 1992); *In re* NewComb, 744 F.2d 621 (8th Cir. 1984). For a discussion of executory contracts, *compare* Westbrook, 1989 and Countryman, 1973.

2. *See In re* Swiss Re Life Co. of America, 479 S.E.2d 857, 861 (Va. 1997) (claims under reciprocal treaties of reinsurance were mere general claims).

3. *See* Holding Company Act ' 5.A(2)(c) 1996. The Holding Company Act (or similar legislation) has been enacted in most jurisdictions.

4. *See* Holding Company Act '' 5.A(1), 5.A(4) (1996).

5. *See* Claim of Moriarity, 899 P.2d 879 (Wyo. 1995).

6. Id. (commissioner as liquidator acts in different capacity from commissioner as receiver).

7. 46 Am. Jur. 2d *Judgments* ' 541, 213-14. (1994).

8. Model Liquidation Act, ' 32.A(1), (1995). There may be certain statutory affirmative defenses to an action for recovery of a preference. For example, the Model Liquidation Act provides for an affirmative defense to the extent that, under certain conditions, the transferee gave the insurer further credit without security of any kind, for property which becomes part of the insurer's estate. Model Liquidation Act ' 32.D, (1995). For simplicity's sake, this article assumes that such affirmative defenses are not sustainable on the facts presented here.

9. Model Liquidation Act ' 32.A(2)(b) (1995).

10. *See* Model Liquidation Act ' 32.A(2), 1995. Insolvency typically includes the concept of balance sheet insolvency. For example, Section 3.M of the Model Liquidation Act defines insolvency as follows:
For any . . . insurer [other than an insurer issuing only assessable fire insurance policies], [insolvency means] that it is unable to pay its obligations when they are due , or when its admitted assets do not exceed its liabilities plus the greater of:
(a) Capital and surplus required by law for its organization and continued operation; or
(b) The total par or stated value of its authorized and issued capital stock.

11. *See* Model Liquidation Act ' 33.

12. *See* Model Liquidation Act ' 29.A ("Fraudulent Transfers Prior to Petition").

13. *See* Uniform Fraudulent Transfer Act, 1985, 639 *et seq.*; Uniform Fraudulent Conveyance Act, 1985, 427 *et seq.* The foregoing laws would be applicable in insolvency proceedings pursuant to insolvency law provisions that permit the receiver to assert the rights of the insolvent insurer's creditors (among others). *See, e.g.*, Model Liquidation Act ' 24.A(15) ("The liquidator shall have the power ... to prosecute any action which may exist on behalf of the creditors, policyholders or shareholders of the insurer against ... any ... person.").

14. *See* Uniform Fraudulent Transfer Act ' 5 ("reasonably equivalent value"); Uniform Fraudulent Conveyance Act ' 4 ("fair consideration"). *See also* Model Liquidation Act ' 29.A (avoidance of transactions made within one year before institution of receivership proceedings without regard to insolvency if made without "fair consideration").

15. *See* U.S. v. Orozco-Prada, 636 F.Supp. 1539 (S.D.N.Y. 1986), *aff'd*, 847 F.2d 836 (2d Cir. 1988) (to be "fair," consideration for transfer must have been "not disproportionately small").

16. *See* 4 J. Moore et al., *Collier on Bankruptcy* ¶ 67.33 at 510-11 (14th ed. 1978) ("The critical time is that of the transfer: neither subsequent depreciation nor appreciation in the value of the consideration given affects the question of the original fairness of the consideration.").

17. *See* Model Liquidation Act ' 29.A (one-year period); Uniform Fraudulent Transfer Act ' 9(b) (four-year period).

18. *See* Rubin v. Manufacturers Hanover Trust Co., 661 F.2d 979 (2d Cir. 1981) (date of each incurrence of debt under continuing guaranty was significant date for fraudulent conveyance purposes rather than date of execution and delivery of the guaranty agreement).

19. *See* Uniform Fraudulent Transfer Act ' 6(5) (for purposes of the Act, "an obligation is incurred: (i) if oral, when it becomes effective between the parties; or (ii) if evidenced by a writing, when the writing executed by the obligor is delivered to or for the benefit of the obligee.").

20. *See* Branch v. F.D.I.C., 825 F.Supp. 384 (D. Mass. 1993).

21. *See In re* Duque Rodriguez, 77 B.R. 937 (Bankr. S.D. Fla. 1987).

22. *See* Mann v. Hanil Bank, 920 F.Supp. 944 (E.D. Wis. 1996).

23. *See In re* Miami Gen. Hosp. Inc., 124 B.R. 383 (Bankr. S.D. Fla. 1991).

24. *See* Aadarko Petroleum Corp. v. Panhandle Eastern Corp., 545 A.2d 1171 (Del. 1988). It is reasonably well settled that a parent corporation does owe a fiduciary duty to a corporation when less than all of the subsidiary's stock is owned by the parent. *See* 18A Am. Jur. 2d *Corporations* ' 773 (1985).

25. *See* Pioneer Annuity Life Ins. Co. v. National Equity Life Ins. Co., 765 P.2d 550 (Az. App. 1988) (parent company owes a fiduciary duty of fairness to its subsidiary insurer and such subsidiary's cognizable communities of interest (including policyholders); duty may be asserted by insurer's receiver); *see also* FDIC v. Sea Pines Co., 692 F.2d 973 (4th Cir. 1982), *cert. denied*, 461 U.S. 928 (1983) (duty when company is in insolvent or failing condition). Moreover, in some states, when a subsidiary becomes insolvent its assets are deemed to be a trust fund for its creditors and its parent owes a fiduciary duty to the insolvent subsidiary's creditors. *See, e.g.*, Abraham v. Lake Forest, Inc., 377 So.2d 465 (La. Ct. App. 1979), *writ denied*, 380 So.2d 100, *writ denied*, 380 So.2d 99 (La. 1980) (indirect and direct parents' appropriation of insolvent subsidiary's assets held to be a breach of fiduciary duty to subsidiary's creditors).

26. *See generally* 33 A.L.R. 2d 1061 (1954).

27. *Id.*

28. 18B Am. Jur. 2d *Corporations* §§ 1733, 1734 (1985).

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HMO Financial Stability Heeding the Caution Lights on the Road to Insolvency

*By: James Outland, Momentum Health Services, Inc. **

HMO Operations Pitstops before Receivership

To a great extent, the concerns that one faces with an HMO insolvency are effectively the same as those faced with a property and casualty insolvency (i.e., lack of capital, adequacy of systems and controls, effectiveness of management, and lack of capital). The differences really exist in the timing and the genesis of these causative factors. Simply stated, your time frame for addressing an HMO insolvency once the company is placed in a formal receivership is short to nonexistent. Additionally, your claimant class will be comprised largely of well-educated, well-funded and extremely impatient individuals and businesses. Thus, the easiest way to handle an HMO insolvency is to simply not have one. We now move into the second article in our series on the unique issues confronted as an HMO starts to pull up lame. James Outland of Momentum Health Services has authored a piece that provides a survey analysis of the causative factors that can result in an HMO insolvency if unheeded, along with the options that can help an HMO to avoid a cessation of business operations.

1998 proved to be a difficult year for HMOs. Under continuing legislative pressure and media scrutiny, the majority of HMOs including large national insurers such as United Health Group, Humana and Oxford as well as smaller insurers, especially provider owned HMOs, throughout the country faced significant financial challenges. As an example of the financial hardships for HMOs around the country, HMOs in Texas lost $333 million in 1998, according to State of Texas figures. The majority of HMOs are incurring these financial difficulties because they are making decisions for managing their business based solely on competitive pressures in the marketplace instead of the internal cost of running their business. As such, regulating HMOs and their financial performance will continue to be necessary to protect consumers. In addition to understanding how and why HMOs can get in financial trouble, the state regulatory agencies responsible for overseeing the financial stability of HMOs need to understand how HMOs can get out of these financial troubles. Are there options available to the smaller independent HMOs to address their financial challenges before receivership becomes the only option? The answer is YES. Before we get to the options though, the question that must first be answered is how do the problems develop?

Why are HMOs losing money?

In a year when the largest players struggled financially, the independent HMOs and provider owned HMOs were hit just as hard and usually harder. The reasons are varied, but have application across the board:

1. Continued consolidation within the industry and the speculation of further consolidation resulted in many HMOs under-pricing their business to gain market share and/or maintain market share.
2. In an effort to continue to compete, many smaller HMOs were forced to offer less restrictive products and price those products relative to their competition in the market versus their cost infrastructure.
3. The race to capture Medicare Risk business led many HMOs to enter Medicare markets with extremely rich benefit plan designs including unlimited pharmacy benefits in counties where the reimbursement was too low to provide a Medicare Risk product.
4. The increasing regulatory focus and universal demand for quality measures and accountability has resulted in higher administrative costs and significant resource allocation toward information systems, quality

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assurance and legal and regulatory compliance.

All of these factors combined to create an environment of financial losses among the majority of the nation's HMOs.

Large versus Small HMOs

In addressing losses, the larger national insurers such as Aetna/U.S. Healthcare, Cigna, United Health Group and Humana can spread their administrative costs over a much larger membership base. Additionally, the larger membership base allows for the negotiation of favorable reimbursement contracts with health care providers. Alternatively, the larger national insurers can also offset operational losses with investment income from large cash reserves. Conversely, smaller HMOs with fewer options and flexibility may price their products well below their cost in order to increase market share to negotiate competitive prices with hospitals and doctors participating in their networks; thereby realizing economies of scale on administrative costs.

Many HMOs believe that capturing greater market share, even if at a loss in the short term, is necessary to survive in order to compete long term. Other HMOs assume they will be able to sell their HMOs at a significant profit before the real losses of the under-priced business hit their balance sheet. Yet, both strategies fail if the HMO lacks the necessary information systems or managed care sophistication to understand issues like claims data lag and its ultimate actuarial impact of their underwriting methodology. For example, the Incurred But Not Reported ("IBNR") claim lag is typically more than 90 days and can result in huge unforeseen claims liability for HMOs aggressively adding business. If an HMO lacks the deep pockets to continue to meet capital and surplus requirements by failing to appreciate the direct impact an IBNR reserve can have on a member population that can grow quickly, then an insolvent situation can be created literally overnight.

Most large national insurers are more concerned with their stock price relative to earnings estimates and drive their operations based on short term financial results. If their stock price drops, the large insurers will be limited in their ability to acquire competitors and may become a potential takeover candidate. As their stock prices rise, the large national insurers have greater buying power in the marketplace. Large insurers often are more concerned with keeping the stock price high for their shareholders than with delivering quality care to the consumers.

Private versus Provider-Owned HMOs

Privately owned HMOs (like many of the large publicly traded HMOs) are focused on the short-term performance of their company and may not focus on ensuring health plan stability and long-term profitability through responsible health plan management. These privately owned HMOs do not typically have the financial reserves to grow their membership through acquisition and are most often short-term candidates to be acquired. Conversely, provider-owned HMOs typically have well financed parent companies but are meeting resistance from their governing Boards who, when faced with dismal financial performance, question the strategic value of even being in the insurance business because it is a non-core competency of the provider organization and directly competes with the providers' other paying insurers. With continued capital demands to maintain the HMOs operational performance and statutory reserve requirements, provider-owned HMOs will continue to meet with resistance from their Boards of Directors hesitant to approve additional capital expenditures. In addition, provider-owned HMOs are incurring negative ratings from their bond underwriters concerned about the risk of financial exposure resulting from ownership of HMOs. However, providers that have divested themselves of their ownership interest can experience a rebound in their bond rating.

As the HMO industry continues to consolidate, large national health insurers will focus on improving profitability by trying to reduce their reimbursement rates to hospitals and doctors. As they capture additional market share through merger, acquisition and the defaulting of financially troubled HMOs, the large national insurers will try to use their additional market share strength to further reduce payments to hospitals and doctors. Unfortunately, as the health insurance industry scrambled for market share and created an artificial pricing environment from 1995 to 1998, health insurance premiums remained relatively flat and most insurers have already reduced the rates paid to hospitals and doctors to the lowest point in years. As such, the hospitals and doctors cannot solve the financial problems of the nation's HMOs by reducing their fees. In addition, much of the increase in health care costs these past few years has been related to the extremely high increases in the cost of providing pharmacy benefits.

What should HMOs be doing to ensure profitability and thereby avoid insolvency?

Solvent and strong competition among HMOs is necessary to ensure consumer choice and improved value. The tried and true definition of value remains applicable here as in other insurance scenarios: Value = **Quality + Cost + Patient Satisfaction** In order to protect consumer choice and foster greater value in the health care industry, the presence of multiple health insurers that are profitable and successful is necessary. Whether the survivors are publicly traded, privately owned or provider-owned is largely dependent upon the ability of the HMO to survive the obstacles listed above. Perhaps a hybrid of the organizations is the most likely to succeed. In the hybrid model, the provider owns or has ownership in the entity, yet the management of the HMO is handled by a professional managed care entity. In this hybrid structure, the HMO is well positioned to provide high quality and cost competitive health insurance products through its owner-providers, but gains the strength of a professional managed care company to handle the administrative functions which can foresee and more accurately predict the impact of rising membership with capital needs. Nonetheless, the key for all HMOs in maintaining financial stability is to clearly understand their costs, exercise discipline in their underwriting and pricing methodology and comprehend how the two interrelate.

Because employers and other purchasers of health care will always seek value for their company and employees in contracting with an insurer to provide health care coverage, the incentive for HMOs to continue to aggressively price their products remains. Under this

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HMO Financial Stability Heeding the Caution Lights on the Road to Insolvency *(Continued from Page 21)*

scenario, the HMO bets on its ability to reduce medical cost expense through contracting, using their volume for deeper discounts, and their ability to reduce their administrative expense by spreading the cost over a larger population of membership. However, HMOs must not blindly follow the pricing competition into bankruptcy and they must be willing to capitalize their administrative costs until they can capture enough membership to gain economies of scale on their administrative expense. The HMO must realize that there are many employers and their agents who do not want to work with health insurance companies that under price the business in an attempt to win the account and then deliver large rate increases the following year to compensate for their losses. These wild swings in premium rates create difficulties for employers to budget their internal costs. Thus, the HMOs that can deliver the best value in the marketplace will be the HMOs that appropriate price their products and deliver consistent value for consumers in quality, pricing and satisfaction.

HMO Cost of Services - Where do the premium dollars go?

HMOs have three components to their cost basis, which can be described through the following equation: Health Care Costs = Administrative Cost + (Medical Unit Price X Medical Utilization)

1. Administrative Costs - The SG&A, which encompasses all costs associated with sales & marketing, claims and customer service, medical management, information systems, accounting, legal and regulatory, etc.
2. Reimbursement Rate - These are the fees paid to hospitals and physicians, pharmacy services mental health/ substance abuse, lab and diagnostic services, etc.
3. Utilization - This is the least predictable component of the health care cost equation. It is the number of medical services used by the membership population of the health plan.

A portion of the administrative cost is allocated to reduce the medical utilization through medical management programs designed to improve health care outcomes and reduce health care costs. HMOs must typically make large investments in information systems and reporting capabilities to run the backroom operations of paying claims and handling customer service issues but, more importantly, to capture health care data and develop programs for improving the health of the membership population. Most HMOs have medical directors and nurses on staff to work with the network hospitals and doctors to improve utilization. Medical management programs designed to improve health care outcomes and reduce costs include disease state management for heart disease, diabetes and asthma. In addition, HMOs focus on keeping people healthy by providing affordable access to preventive care for routine check-ups, pediatric immunizations, mammographies and pap smears.

The national average administrative costs of the large publicly traded HMOs was approximately 15.7% of the collected premium revenue.[1] Health care costs should be targeted to run approximately 82% of the collected premium revenue which allows for a profit margin of just over 2% of the collected premium revenue. Unfortunately, there are only a handful of HMOs in each state that are currently running administrative costs of 15% and health care costs in the low to mid 80% range. The good news is the average premium rate increase for 1999 has been between 7% to 10% across the nation signaling an end to the artificial underpricing of health care coverage. These rate increases coupled with disciplined underwriting and competent management will result in drastically improved bottom line profitability for many of the nation's financially troubled HMOs.

What are the options?

There will remain a number of HMOs unable to turn around their health plan operations or lacking the necessary capital to invest in the infrastructure and thereby improve their financial results. For these HMOs, there are multiple opportunities to improve the operation and continue serving the consumer through one of the following options:

1. Sale of the HMO.
2. Partial sale of the HMO.
3. Sale of the HMOs assets including provider contracts and membership.
4. Re-capitalization of the HMO through equity partnership or venture capital funding.
5. Sub-contracting the management of the HMO.

What is important to remember in selecting an option is that flexibility is a necessary component to all five options. Regardless of your chosen path, each option has distinct advantages and disadvantages both for the current HMO shareholders and management team as well as the community and the consumers served by the HMO. There are many companies that will work with HMOs to develop the best strategy for either selling all or part of the company or pursuing other strategic alternatives to turnaround the HMO in any number of creative ways to improve the health plan's operations and profitability. These options include investing capital in exchange for equity, the replacement of existing management or the supplementation of current management with an experienced management team who utilize industry-leading information systems to profitably grow membership.

The first of option of selling the HMO is often the first consideration of troubled health plans. If the HMO has significant membership and is not losing tens of millions of dollars, the company may be successful in attracting qualified buyers for the HMO. Given the industry consolidation, there are fewer buyers for HMOs than there were a few years ago and the average price per member is much lower than it was just two years ago. A larger HMO (over 100,000 lives) which is losing only a few million dollars a year will have much more interest than a smaller HMO (less than 50,000 lives) regardless of the losses. If the HMO is in a strategic geographic location or has a unique provider network or product, then the interest among buyers would be elevated. Typical purchasers of HMOs will be the large national HMOs or strong regional and local HMOs. Another option is a managed care organization that is

interested in entering the market. Potential concerns with selling a financially troubled HMO to a strong competitive HMO in the marketplace are the reduction of consumer choice and the lack of payors for the hospitals and physicians.

The second option of a partial sale may be attractive for an HMO to sell a specific line of business or product. A partial sale makes sense in a market where an HMO may have relatively good management and a commitment to managed care, but has financial difficulty in a particular business line such as Medicare or small group commercial. In this instance, the HMO may sell that line of business to another health plan in the market that is either successfully managing that type of business currently or is planning to introduce that line of business. The buyer of this business would need to be a licensed entity in the state as the HMO license would not be transferred. In addition, the Health Care Financing Administration ("HCFA") would not allow the transfer of the Medicare business, unless the new buyer was already licensed for Medicare or was acquiring all of the material assets of the company.

This process can be a win-win for everyone involved but typically results in confusion among the members and the providers and often causes multiple administrative challenges.

The third option would be for the HMO to sell all or certain of the assets of the company and allow the new purchaser to manage those lines of business moving forward. For seriously troubled HMOs, this option allows the membership to be transferred to a new owner and management company without all or certain of the liabilities of the HMO. The HMO would be responsible for the majority of the liabilities including legal claims and employment issues and may or may not be responsible for the IBNR. Again, the potential acquirers of an asset purchase would be primarily existing HMOs already licensed in the state. There may even be a company that would activate a dormant license to consummate such an asset acquisition.

The fourth option of re-capitalizing the HMO would represent a material change in the ownership of the health plan by infusing new capital into the HMO from new equity shareholders. Sources of capital in an equity joint venture could come from companies that specialize in turnaround situations by bringing in an experienced management team and investing capital in exchange for ownership.

Other sources of capital could come from outside investors such as venture capital or angel investors that believe the company is well positioned to succeed. In a re-capitalization situation, it is important to understand from the company why additional capital will result in improved operations. How is the money going to be spent and what is the turnaround plan, particularly if the same management team will be running the company.

The fifth option is for the current shareholders to replace the management team in whole or sub-contract out parts of the management function without changing the ownership. Several companies specialize in working with HMOs to bring in new management to implement turnaround or divestiture strategies.

Few of these companies take risk for their efforts and the majority are compensated on a fee basis with certain bonuses for performance. There is also the ability to contract with companies that may only perform certain functions to improve the health plan's operations.

For example, an HMO could subcontract out claims payment to Txen and their information systems to Perot Systems. Both are excellent companies in providing systems and human resource talent to fill a void in struggling HMOs.

The difficulty with sub-contracting out the different functions of the operation is it can sometimes increase cost and reduces accountability.

In summary, the best managed HMOs will price their products in relation to their actual cost. For those HMOs that continue to underprice their business and continue to lose money or are unable or unwilling to commit the necessary capital to profitably grow their membership, there are options for them to minimize their losses and protect the consumers they serve.

TREATMENT OF INTER-COMPANY POOLING AGREEMENTS IN INSOLVENCY PROCEEDINGS

(Continued from Page 19)

29. *See* Banco de Desarrollo Agropecuario, S.A. v. Gibbs, 709 F.Supp. 1302 (S.D.N.Y. 1989).

30. *See generally* 4 L. King et al., *Collier on Bankruptcy* ¶ 510.05 (15 ed. 1997).

31. *See e.g., In re* Hyperion Enters., Inc., 158 B.R. 555 (D.R.I. 1993); *In re* Diasonics, Inc., 121 B.R. 626 (Bankr. N.D. Fla. 1990). *See also In re* Herby's Foods, Inc., 2 F.3d 128 (5th Cir. 1993) (equitable subordination on similar theory).

32. *See, e.g.*, Pepper v. Litton, 308 U.S. 295 (1939); Taylor v. Standard Gas & Elec. Co., 306 U.S. 307 (1939).

33. *In re* Mobile Steel Co., 563 F.2d 692, 701 (5th Cir. 1977).

34. *In re* Giorgio, 862 F.2d 933 (1st Cir. 1988).

35. *See In re* Osborne, 42 B.R. 988 (W.D. Wis. 1984) (remedy for misrepresentation).

36. *See In re* Crowthers McCall Patterns, Inc., 120 B.R. 279 (Bankr. S.D.N.Y. 1990).

37. *See generally* L.M. Weil and H.S. Horwich, *Substantive Consolidation in Insurance Company Insolvency Proceedings*, The Insurance Receiver, Vol. 5, No. 4 (1997).

38. *See* Chemical Bank New York Trust Co. v. Kheel, 369 F.2d 845 (2d Cir. 1970).

39. *See* Flora Mir Candy Corp. v. Dickson, 432 F.2d 1060 (2d Cir. 1970).

40. *See, e.g.*, Sampsell v. Imperial Paper & Color Corp., 313 U.S. 215 (1941); Soviero v. Franklin Nat'l Bank of Long Island, 328 F.2d 446 (2d Cir. 1964); Maule v. Gerstel, 232 F.2d 294 (5th Cir. 1956); Fish v. East, 114 F.2d 177 (10th Cir. 1940).

41. *See In re* Wm. Gluckin Co. Ltd., 457 F.Supp. 379 (S.D.N.Y. 1978); In re Alpha & Omega Realty, Inc., 36 B.R. 416 (Bankr. D. Idaho 1984).

42. *See In re* Gulfco Inv. Corp., 593 F.2d 921, 929-30 (10th Cir. 1979); Chemical Bank New York Trust Co. v. Kheel, 369 F.2d at 847.

43. *See* Eastgroup Properties v. Southern Motel Assoc. Ltd., 935 F.2d 245 (11th Cir. 1991); Drabkin v. Midland-Ross Corp. (*In re* Auto-Train Corp.), 810 F.2d 270, 276 (D.C. Cir. 1987).

44. *See In re* Augie/Restivo Baking Co., Ltd., 860 F.2d 515, 518 (2d Cir. 1988).

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