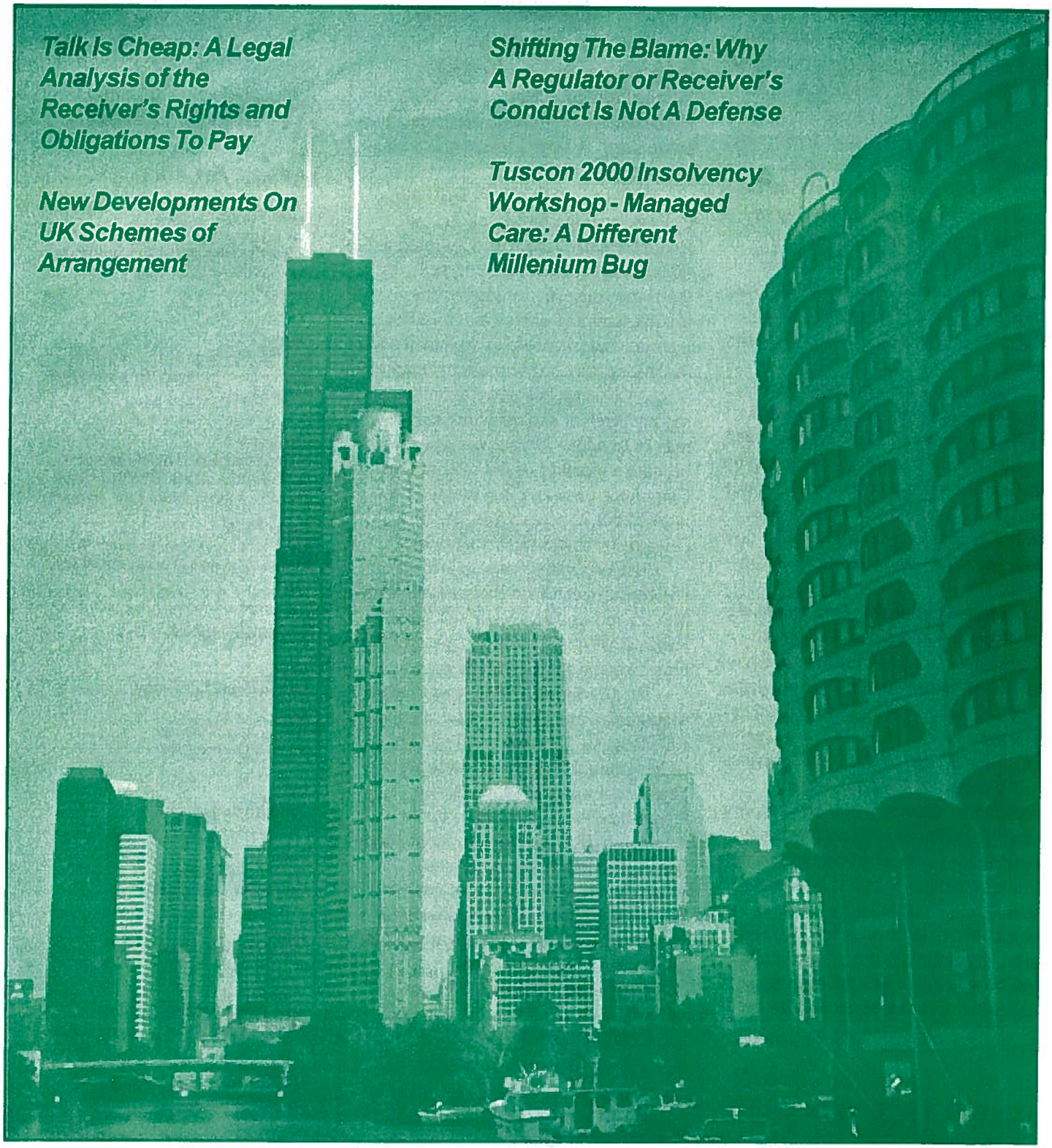
The INSURANCE RECEIVER

Promoting professionalism and ethics in the administration of insurance receiverships.

Volume 9, Number 1 **Spring 2000**



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President's Message

Robert Craig

By Robert Craig, Lamson, Dugan, & Murray

First, my thanks to our Board of Directors for their vote of confidence by returning me to IAIR's presidency for another term. I have once again been blessed with a blue ribbon Board and an outstanding Executive Director.

Also, welcome to our new board members, George Gutfreund, CIR - ML, CIP with KPMG, Inc. in Toronto, Mark Femal from the Wisconsin Insurance Security Fund, Kristine Bean who is with Navigant Consulting in Chicago and Vivien Tyrell of D. J. Freeman in London. And welcome back to my friend Dick Darling of the Illinois Office of the Special Deputy Receiver in Chicago who has been re-elected.

Our thanks to departing board members, Philip Singer, Len Stillman, Mike Surguine and Paula Keyes. Each has provided outstanding leadership on the board and its committees. Committee Chairs take notice: having retired from the board, each of them will now have more time for committee participation.

Those of you who have been able to attend the last several IAIR/NAIC meetings and the Insolvency Workshop in Tucson know that IAIR is moving forward on a number of fronts, some of which are discussed in more detail in this issue of The Insurance Receiver.

The Health Care Insolvency program in Tucson was a sell-out. Put together by Pat Cantilo of Cantilo & Bennett in Austin and Dan Orth of the Illinois Guaranty Fund, it was spectacular and considered by many as the best IAIR/NAIC insolvency seminar ever. Even though the program ran behind schedule from the beginning, due to the fact that some guy by the name of Craig insisted on making introductory comments, those in attendance were glued to their seats the entire time. All participants are to be commended.

Emphasizing the "I" in IAIR at its Chicago meeting on March 11, the Board formally established an International Committee whose charge is, as the name suggests, to address the involvement and objectives of IAIR's international members as well as IAIR's involvement in the international market place. Chairing this new committee is Vivien Tyrell, a partner with DJ Freeman in London. If you would like to become a member of the International Committee or would just like to know more about it, contact Ms. Tyrell. (Vivien_Tyrell@djfreeman.co.uk)

Also on the international front is IAIR's European meeting scheduled for May 25 in London. Contact Paula Keyes or Vivien Tyrell for the details. I hope to see many of you there.

The Marketing Committee. IAIR's Marketing Committee is now running at full strength. Chaired by Trish Getty of Paragon in Atlanta with able assistance from many volunteers, this Committee is focusing on ways to increase IAIR's presence in the market place. The initial objective is to incorporate the objectives of each of the standing committees to develop a cohesive product for our members and those with whom we work.

IAIR is on the move. Get involved.

The ***INSURANCE RECEIVER***
Volume 9, Number 1
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Chicago Meeting Recap

By Mary Cannon Veed

Just when you think you have this quarterly meeting thing all figured out, they throw you a curve. I'm not sure I recognized the NAIC this time.

Naïveté, perhaps, but I sort of thought "we won" the HR10/S900 debate. The conjunction of banks and insurance was an economic fait accompli, offering at least as many opportunities for insurance as threats. The objective was to get out of Washington with a system that left some unpre-empted scope for insurance regulation. And the results exceeded my expectations: not only did Congress not put the Federal Reserve in charge of Bankassurance, it actually confirmed state authority, cleaned up some of the pot-holes left by previous battles, and opened up a couple of new areas to state influence, notably in the areas of confidentiality and privacy. The federal insurance license went away for good; nobody even attempted an RTC-style approach to insolvency - state regulation came out of the process carrying vastly improved respect and dramatically better communication inside the Beltway. I firmly expected that, after patting themselves firmly on the back, the Commissioners would go back to business as usual rearranging the chairs on the deck of the Titanic, until the next iceberg was sighted.

The first clue was the "Changes to the Printed Program" sheet in my registration packet. "Speed to Market" Working Group. "Definition of Insurance" Working Group. "Treatment of National Companies" Working Group. **National What????** These folks seem to have brought back something contagious from that trip to Washington.

It got worse. 49 state signatures on a "Statement of Intent" on the "Future of Insurance Regulation". Just doing what is required to internalize Gramm-Leach-Bliley was going to be a big job. As a practical matter, present state rules often take a form-over-substance approach that is doomed to collision with GLB. NARAB, although more or less already written, still needs to be sold to the Legislatures. And some sort of modus operendi has to be worked out to keep bank and insurance examiners from stepping on each other's toes.

But they didn't stop there. They painted bulls-eyes on "anti-affiliation statutes, licensure laws, demutualization statutes" as well as sales and privacy regulations. As for producers, "while reciprocity is a short-term answer, uniformity is the efficient, long-term solution." How about "consolidated financial statements for the insurance operations of groups"? GLB gives the states the right to maintain state-to-state variations in privacy rules. The Statement of Intent proposes to make them uniform.

Having got up a pretty good head of steam by this time, they kept on rolling, proposing changes that would have been hooted out of the Commerce Committee if brought up there: How about "file once, use 50" rate and form filing? Putting ECP rules right in the middle of the Model Rate and Form law? Or even "a state-based system that could provide the same efficiencies as a federal charter for insurance companies"? Heady stuff! Now how much can they actually get done? Have the NAIC's young Turks spread their net too wide to catch anything at all, or have they laid out a strategy that might succeed precisely because it offers something for everybody, and plenty of work and fame for everyone?

The meetings themselves were anticlimactic. With a couple of exceptions I'll get to later, they consisted of solemn affirmations by the participants that they really did intend to start all those projects, an offer to get people to sign up on their advisory group lists, and a sort of promise to come up with something substantive by June. Take that as a litmus test: if anything shows up in June, there is a chance this initiative will work. If not, write it off as a pipe dream, and start worrying about NARAB and the examiners' toes. The risk of attempting to do more than GLB demands is that it will distract attention from the job of minimal compliance.

Notwithstanding all this excitement, the main events at any NAIC, if you're a receivership wonk, are the IAIR Roundtable and the EX5 working groups. While I can't say they were exactly exhilarating, they continue to produce solid information and useful progress. The Roundtable continues to grow less and less round, and more and more rectangular, because most of the time continues to be used for "set piece" presentations. As is becoming the norm, the set pieces were excellent, and such questions as were asked sort of lame. One does sort of wish it were the other way around.

I think my favorite presentations were Doug Hartz's post mortem on General American, Vivien Tyrell's on new legislation affecting insolvency practice in the UK, and Jack Blaine and Larry Harr on GLB. I can tell they were interesting, because I took lousy notes. Fortunately, they each had useful handouts, too.

Doug's review of General American contained a shock: There were thirty seven funding clients of that troubled company, and basically all thirty seven had demanded their money back by the time the rescue effort had gotten organized. Naturally, they put the company into supervision, and necessarily their activity was public. But they held off on formal proceedings. Instead they offered the account holders a 10% advance payment on account in exchange for thirty days of peace. Bear in mind that not only did General American have quite amazing volumes of nutty funding agreements, they also had, and had had for a much longer time, a whole lot of ordinary life and annuity contracts, with thousands and thousands of policyholders who were frantic, but nowhere near so likely to fight the Commissioner. That payment was proposed and made when all concerned knew there was a high likelihood that

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IAIR Roundtable Schedule

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

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

NAIC Meeting - December 2-6, 2000
Boston, Massachusetts
IAIR Roundtable
December 2, 1:00 - 4:00 p.m.

The INSURANCE RECEIVER

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

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

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

CHICAGO MEETING RECAP

(Continued from Page 3)

General American would be unable to pay its debts as they matured. In other words, it was a preference. Interesting question whether a preference made with the explicit approval of the administrative supervisor is still a preference.

Doug's answer, I know, is "So what? It worked." Not only did he buy himself what turned out to be sufficient time to elicit a purchase offer from Met Life, the account holders simmered down and became relatively calm about the rest of the process, even though, when the thirty days expired, they put the company into rehab and further forestalled payments. Without that olive branch, the mutual funds who held most of the funding agreements would have been virtually compelled to sell off their contracts to vultures of various kinds, causing catastrophic losses to some of them and loss of goodwill to Met, and turning up the litigation thermostat by 40 or 50 degrees. A failure to bail out General American would have been so ugly on so many fronts; one more preference battle would have been lost in the crush.

He's right this time, I think. But it would be interesting to hear some comment, and maybe war stories, about when it is appropriate to throw a preferential bone to big dogs yapping at the troubled company's gates, what the down sides might be if it doesn't work, and whether there is any way to mitigate them.

Another fascinating session was the Handbook. Roughly nine months ago, the committee decided the book needed a chapter on HMO insolvency. Since then a sizable and energetic group has been scribbling away, producing a complete-looking product I thought was pretty neat, especially given it set a land speed record for drafting by committee. That had something to do with Paige Waters doing all the work, but generally I was pretty impressed.

The sentiment was not exactly unanimous! We got the novel experience of hearing from trade organizations at a receiver's handbook meeting, which they usually assiduously avoid because insolvent members don't usually have legislative agendas. They convincingly demonstrated that the drafting group mostly knew more about insolvencies than HMO's (shocking nobody) and dangling the tantalizing prospect of filling that gap, and maybe even returning the favor by giving the trades an inside view of what receivership really is like. The net result should be interesting, but where does that leave Mike Surguine's publication schedule?

Another note of high drama was struck at the URL working group session. I frankly am unable to be objective on this one, but I think you could write a reasonably compelling novel about the personalities, objectives, and history that fed into the committee's announced hearing on the first four chapters of the URL. In spite of which, or maybe because of it, the idea seems to have taken on a momentum of its own. I felt that this session was the first time when the URL got discussed mostly by people who had actually studied it and were prepared to be fair. As a result, the issues that arose were primarily genuine ones, and there were some practical and constructive suggestions, too. Hopefully, the next session, on the rest of the law, will be equally intelligent. The first one reflected a great deal of hard work by dozens of individuals (sort of the usual thing where the URL has been concerned). If our collective stamina holds up for a couple more meetings, I am optimistic about the result.

I foresee one problem, mostly psychological. In narrowing down the debate to only legitimate issues, this process tends to gloss over the numerous positive things about the URL to which nobody has the nerve to raise an informed objection. In summing up a lengthy debate, as this one will inevitably be, it's all too easy to remember the trouble spot. To make sure the URL's advantages, if they are advantages, are present in people's minds as they begin to draw conclusions about the URL, I would hope

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Other News & Notes *By Charles Richardson*

The 2000 IAIR/NAIC Insolvency Workshop in January was a roaring success for a variety of reasons, including the timeliness of the topic (managed care), solid preparation by the planning committee (Patrick Cantilo, Dan Orth, Steve Durish, Jim Stinson and Mike Surguine), and a distinguished group of 22 speakers and panelists. The location (Tucson) didn't hurt either.

We have a report on the workshop elsewhere in this issue of the Insurance Receiver, so I won't cover the details; there was obviously plenty of grist for the discussion mill even after the workshop ended, given the predictions of significant HMO and other managed care failures to come. Instead, I want to use those predictions and a few of the other themes tossed around at the workshop as a springboard into some of the hot topics in the insurance world that have been slopping over into the popular press the past few weeks.

Harvard Pilgrim

Isn't it ironic that during the very week that IAIR was meeting in Tucson to talk about managed care insolvencies, the furor over the demise of the gigantic Harvard Pilgrim HMO in Massachusetts was starting to reach a feverish pitch? With a million members and thousands of providers, the financial, legal, and political problems created by Harvard Pilgrim's receivership will be staggering if the Massachusetts officials cannot put together a recapitalization/bail-out plan. At press time, the situation was stable as the receiver labored to do just that, yet trade associations were starting to file intervention petitions in the Massachusetts court, claiming some "special" interest in Harvard Pilgrim that should permit them to be somewhere in the receivership kitchen right along with the chief cook/receiver.

Because of its size, Harvard Pilgrim will be closely watched by receivers, regulators, providers and the managed care industry that is not in the best of financial health. Those of you who attended the Tucson Insolvency Workshop are well prepared to follow the action with an expert eye.

Gramm-Leach-Bliley

And speaking of watching a cauldron of complex legal and market forces, the NAIC's annual emerging issues symposium this year in Washington, D.C. on February 17-18 was a thoughtful, candid, at points scary snapshot of the insurance regulatory world post Gramm-Leach-Bliley. It examined what the future may hold for a state regulatory apparatus that has its hands full. The NAIC put together a star-studded group of experts on financial modernization, e-commerce, health issues, and international business. But the underlying theme was jarring in its simplicity: the state regulatory system must do things better, smarter and quicker if it hopes to retain most of its turf in the face of federal encroachment that may come from (1) the shattering of the walls of Glass-Steagall by Congress in passing S.900 last year, and (2) the resulting openness of major segments of the insurance industry to some kind of national or federal regulation. Indeed, on the very day the NAIC forum was held in Washington, the banking industry was making -- in a very public way -- a proposal to create a federal insurance regulator. State regulators are clearly up to that challenge, and the time to start beating the "better/smarter/quicker" drum at all levels of the state regulatory system is yesterday.

In doing that, state officials can point to the less than stellar record of federal regulators. On that score, note the announcement by the FDIC in February of the biggest losses from bank failures since the early 1990s. Regulators and lawmakers are concerned about the eight U.S. bank failures last year, which occurred within a booming economy. The eight collapses, and another one in July 1998, cost the FDIC about $1 billion last year, the most in a single year since the regional banking crises of the early 1990s. Compounding the worry, the FDIC is predicting that as many as 20 banks could go under this year. The message: the feds don't always do things perfectly, so don't automatically assume that a federal "solution" is any better than a state one.

Who Wants to Be a Millionaire?

And speaking of dumbing down, did you see the press reports of the spat between the producer of ABC's hit show "Who Wants to Be a Millionaire" and its London insurers? Seems that the British insurance syndicate that funds the big payoffs on "Millionaire" has filed suit claiming that the show has questions for the contestants so basic that the game is too easy to win. The insurers want to rescind their policy. ABC replied that "the integrity of 'Millionaire' is beyond reproach," and said the lawsuit is just a typical example of an insurance company "trying to deny coverage."

No matter what happens in court, though, the legal action has given the gleeful British media another excuse to haul out all their favorite stereotypes about stupid Americans. "You don't have to be a rocket scientist to become a millionaire -- you just have to be an American," noted the Guardian newspaper in London.

Elizabeth Lovette, CIR - 1st Vice President, obtains her CIR - ML designation.

IAIR's 2000 Educational Events

The American Bunkruptcy Institute
Pre-Seminar
Spring National Meeting
April 27, 2000
Washington, D.C.

In Association with IAIR

TRIAGE FOR MANAGED CARE
Law and Practice of Managed Care Organization Insolvency

Additional information on these seminar will be posted to IAIR's website as it becomes available.

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

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

The International Association of Insurance Receivers
Spring Event

London Market Run-Off

London, England
Thursday 2pm May 25, 2000
by Vivian Tyrell

The International Association of Insurance Receivers is holding a half day seminar in London on Thursday 25 May 2000 on London Market run-off. Key representatives of the insurance industry including Paul Taylor of the Financial Services Authority, Paul Jardine of Equitas Limited and Marie Louise Rossi of the International Underwriting Association will discuss the issues currently attracting attention in changing market conditions.

If you are involved in any aspect of run-off (solvent or insolvent) in the London Market you should consider attending. Senior personnel will be particularly interested in hearing and commenting on the current thinking of those driving the major changes in the industry today. You are also encouraged to bring along your colleagues. This event qualifies for up to 3.5 hours' structured Chartered Insurance Institute CPD where relevant to an individual's development needs.

The seminar will commence at 2pm promptly and will finish by 6pm when you will have the opportunity to relax over drinks with your fellow delegates.

There will be no charge for entry. Spaces will be limited and you are therefore encouraged to book your place as soon as possible.

Venue - 3 Noble Street London EC2V 7EE

To book, please send details of the name and organisation of each person wishing to attend by fax or by email to Tracy Connolly on #44 (2)07 796 6361 or tracy.connolly@dla-law.co.uk.

Congratulations

Congratulations to Elizabeth Lovette, 1st Vice President, on obtaining her CIR - ML designation.

Retiring directors, Lennard Stillman, CIR (above) and Philip J. Singer, CIR (below) were presented plaques thanking them for their time and effort. Michael Surguine was not available for a picture.

TALK IS CHEAP:

A LEGAL ANALYSIS OF THE RECEIVER'S RIGHTS AND OBLIGATIONS TO PAY

By Harold S. Horwich and Deborah M. Bibbins, Bingham Dana LLP

Wise consultants everywhere tell receivers to communicate promptly with all constituencies in newly filed MCO receiverships. Receivers should urge them to cooperate, be patient, invest in the future and hope for the best. This attitude of patience and cooperation, however, may be difficult to foster when the constituents are owed substantial amounts for pre-receivership obligations and have only uncertain prospects of payment in their future dealings with the MCO. This article examines the rights and obligations of a receiver in state receivership proceedings to pay (or not to pay) debts of the MCO and of the receivership estate.[1] It also offers the authors' observations about incentives that may foster patience and cooperation.

Because there are several different constituencies which are involved in MCO receivership proceedings, each with different and sometimes competing interests, the receiver cannot afford to lose the interest of any of them if the MCO is to achieve stability in the short term.

Providers: The doctors and hospitals, which have joined the MCO network, have, in a very real sense, furnished the capital on which the MCO operates. The receivership has placed that capital in jeopardy. The receiver must secure the providers' ongoing willingness to see patients and extend credit to the receivership estate. Without that willingness, there is no network for the enrollees to use and ultimately no MCO to rehabilitate.

In many cases, there will be obligations to providers, which are not part of the network. The ongoing participation of these providers may be less crucial to the MCO's future, but their patience may be very important in keeping subscribers enrolled. As discussed below, out-of-network providers may have the right to pursue patients for payments directly. This in turn may disenchant subscribers.

Subscribers and brokers: Maintaining the provider network is an important goal, but if subscribers are lost in the process, there will be no revenue from which to pay new claims. Thus, it is important to ensure that subscribers (or the enrolled employees of employers who are subscribers) do not suffer interruptions in service. It is also crucial to maintain the support of the brokerage community. In the end, brokers may influence the decisions of subscribers. Their decision may, in turn, be influenced by their long-term ability to get their commissions paid.

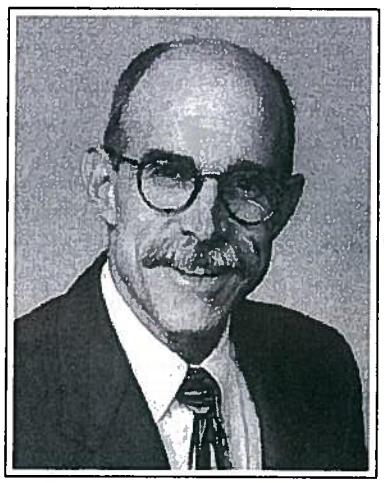
There is a two-part test for the allowance of administrative expense priority.

Employees: An MCO is a relatively simple business in that its three components are people, paper and money. Without the people, it is extremely difficult for a receiver to take control of an MCO and stabilize it. The people have more than just knowledge of the systems and products; they possess the institutional memory necessary to bring the business into the future. This institutional memory is particularly important in the area of claims processing.

Guaranty Associations: In a few states, there are guaranty associations, which cover MCO's. These may alleviate some of the pressure on the receiver, but in turn, they become major constituents in the case with their own goals and objectives.

What follows is an examination of the rules and tools available to the receiver for paying (or not paying) the constituents in the case. These are the tools the receiver can use to stabilize the MCO's operations, when mere talk is not enough.

THE GENERAL PAYMENT RULES OF RECEIVERSHIP



The receiver cannot pay pre-receivership claims.

Under generally accepted doctrines of receivership law, unsecured claims, which relate to the period before the receivership are not payable during the receivership.[2] This general rule is also applied in insurance rehabilitations.[3] Instead, payment of pre-receivership claims must await approval of a plan of rehabilitation, which generally provides for payment of claims according to a priority scheme.

The receiver must pay post-receivership expenses.

Claims, which are incurred after the receivership is initiated, must be paid in the ordinary course of the business (e.g., expenses of administering the receivership). The rationale for paying administrative expenses currently is that it encourages parties to continue to do business with the estate and to extend it credit during a time of need.[4] There is a two-part test for the allowance of administrative expense priority, which requires that the debt both arises from a transaction that occurs after the commencement of the case and be beneficial to the estate.[5]

A claim for an administrative expense may arise under a contract that was

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TALK IS CHEAP: A LEGAL ANALYSIS

(Continued from page 7)

executed before the insolvency proceeding if the non-debtor party provided services and benefits to the estate after the commencement of the case. Thus, in the case of In re Mutual Benefit Life Ins. Co., 1993 N.J. Super. LEXIS 940 (No. C-91-00109, Super. Ct., N.J., Aug. 12, 1991) Slip Op. at 109-115, the court held that a group of banks was entitled to administrative priority for a pre-petition swap agreement which the rehabilitator had kept in place post-petition in order to protect the value of the estate's bond portfolio. The court held that by keeping the swap agreement in place, the banks were providing new consideration to the estate in the form of continued risk with respect to the post-petition value of the bond portfolio.

In the case of a rehabilitating MCO, the receiver would therefore be required to make payment to providers for services rendered to enrollees after the commencement of the receivership. The receiver would also be required to pay ongoing trade vendors on a current basis.

The situation for brokers is less clear cut. Unquestionably, the estate would be required to pay commissions for business first placed subsequent to the receivership date. However, for business placed before the receivership, commissions may not be owed by the estate even though payments of that commission would ordinarily be made out of premiums received after the commencement of the receivership. The reason for this is that the commission arises as a result of a pre-receivership sale by the broker, and the obligation to pay the consideration to the broker is a pre-receivership obligation. Since the obligation is a pre-receivership obligation, it cannot be paid in the ordinary course.[6]

Brandenburg v. Coxe, 228 Pa. 212 (1910), although dated, illustrates the point in the context of a receivership. There, agents of a company that built automobile bodies claimed commission on bodies completed by the receiver under pre-petition orders placed by the agent. The court held that even though the receiver assumed the pending orders, he did nothing to assume the commission agreements. The court noted that if the receiver had accepted new orders and continued the business generally, the matter might stand on a different footing. Nevertheless, under the circumstances, the agents' contract could not be considered assumed; therefore, the indebtedness would not be treated as an expense of administration.

Although the foregoing cases do not deal with insurance brokerages and insurance contracts, the transactions at issue are closely analogous and the same rule should be applied. This conclusion is supported by numerous cases in other contexts, which hold that an insurance broker's commissions are earned when the policy is issued, not over the period when premiums are paid.[7] This may generate a serious incentive for brokers to move their business if they can.

The goal of a rehabilitation proceeding is to implement a business plan that corrects the operating deficiencies of the MCO

The situation as to brokers may be different if their contracts provide that they have a security interest or other property interest in premiums paid which secures their commission obligations. In that case, they would be entitled to payment as and when premiums are received. In order to establish a property interest in premiums, the brokerage agreement must provide for the segregation of commissions from premiums by the MCO or the holding of the premiums in trust by the MCO or the creation of a lien in favor of the broker against the MCO.[8]

One case, Cockrell v. Grimes, 740 P.2d 746 (Okla. Ct. App. 1987), has suggested that an agency agreement created a property interest in premiums with respect to commission based solely on a provision which entitled the agent to receive renewal premiums after termination of the contract. No provision creating an express trust or a security agreement was required by the court. However, that case dealt with an extreme set of circumstances, but one that the receiver should consider.

In Cockrell, a rehabilitator continued to collect premiums on policies written by the agent for over two years while determining whether to liquidate the company. At the time of the Oklahoma Appellate Court's decision, the rehabilitator had still not determined whether to liquidate or sell the company. The harshness in this situation is manifest. The rehabilitator had received the benefit of over two years of premiums without paying any commissions and without permitting the agent to earn commissions by placing the business with another insurance company. Thus, the agent was effectively blocked for two years from earning commissions on its book of business.[9] Absent a provision in the brokerage agreement authorizing the broker to hold premium received in its own name or providing the broker with a security interest in such premium, any premium in the broker's possession would be held in trust for the insurer.[10] Most cases, which have considered the issue, have determined that brokerage agreements do not create a property or security interest. If the possible loss of business due to broker defections is a serious problem, the solution may be to assume their contracts on a modified basis as discussed below.

Priority schemes and rehabilitation plans.

The goal of a rehabilitation proceeding is to implement a business plan that corrects the operating deficiencies of the MCO and recapitalizes it so that it will be financially stable in the future. In most states, a rehabilitation plan must be confirmed by a court.[11]

Each receivership statutory scheme assigns various priorities to receivership claims. A typical priority scheme would place expenses of administration first; enrollee, provider and guaranty association claims second; claims of the federal government third; claims of employees fourth; general creditor claims fifth; claims for state and municipal taxes sixth; and equity holders seventh. In a few states, provider and enrollee claims are segregated into two categories: claims for services from out-of-network providers and claims for services from in-network

providers. The enrollees and providers with out-of-network claims are given priority over providers and enrollees with in-network claims.[12] These priorities are a critical factor in developing and implementing rehabilitation plans.

A plan can only be confirmed if it is "fair and equitable." The doctrine of "fair and equitable" has been held to have several components. First, a plan is not fair and equitable unless creditors get at least as much as they would in a liquidation and the plan does not discriminate unfairly.[13] Second, a plan is not fair and equitable if creditors with lower priority claims are treated better than creditors with higher priority claims.[14]

The foregoing suggests that the receiver has little flexibility in dealing with the constituents whom he needs in order to have a successful rehabilitation. The foregoing rules appear to bar all payments to creditors (other than administrative creditors) until there is an approved rehabilitation plan. This may leave brokers and providers dissatisfied and uncooperative. However, receivers and their counsel who are prepared to think creatively may have the flexibility they need to keep the constituents in line. There are both positive and negative incentives that can be offered -- carrots and sticks.

CARROTS

The Doctrine of necessity and anticipation of priority claims.

The receiver may be able to use the doctrine of necessity to pay certain types of pre-receivership claims. The majority of federal bankruptcy courts allow the pre-plan payment of certain priority claims in receiverships based on the doctrine of necessity. The doctrine of necessity evolved from the necessity of payment rule, which originated in railroad reorganization cases.[16] The necessity of payment rule allows a reorganizing railroad to pay any unsecured pre-petition creditors that it determines it must pay in order to ensure its reorganization.[17]

In order to pay only certain pre-petition claims, a compelling business reason must exist, such as the preservation and protection of the debtor's business and ultimate rehabilitation.[18] This doctrine has only been applied to allow the payment of certain priority claims, but not the payment of general unsecured claims. The doctrine of necessity has not been recognized explicitly in insurance receivership cases. However, bankruptcy decisions are frequently applied to receivership proceedings where the underlying policy objectives are the same (see footnote 1). Here, they clearly would be. The doctrine of necessity may enable a receiver to pay the MCO's employees for pre-receivership wages and benefits. This may be extremely helpful in keeping the MCO's work force in place.

The doctrine of necessity may also enable a receiver to pay out-of-network claims before a rehabilitation plan in states where such claims have priority over in-network claims. This can be extremely important to the survival of the MCO. In many states, providers which are in the MCO's network do not have the right to collect their unpaid fees from their patients who were enrolled with the MCO.[19] However, many statutes permit out-of-network providers to pursue collection from patients. If out-of-network providers are pursuing enrollees for collection, this is likely to result in dissatisfaction by subscribers. This in turn is likely to result in defections and loss of premium critical to perpetuating the business. The doctrine of necessity may enable the receiver to pay out-of-network claims and thereby prevent erosion of the premium base.

The majority of federal bankruptcy courts allow the pre-plan payment of certain priority claims in receiverships based on the doctrine of necessity

Affirmance of executory contracts.

Among the powers given to receivers is the power to affirm or disavow contracts.[20] Most of the constituents who are key to the success of an MCO receivership have contracts with the MCO which could be affirmed or disavowed. If the receiver affirms a contract, he obligates the estate to pay all of the ongoing obligations under that contract on a current basis according to its terms. The receiver is also obligated to cure any existing defaults under such contracts.[21] The receiver may also disavow a contract which means that the receiver is excused from further performance of the contract and damages from the breach of the contract are relegated to the status of pre-receivership claims. The other party to the contract has little or no say as to whether the receiver will affirm or disavow a contract.[22]

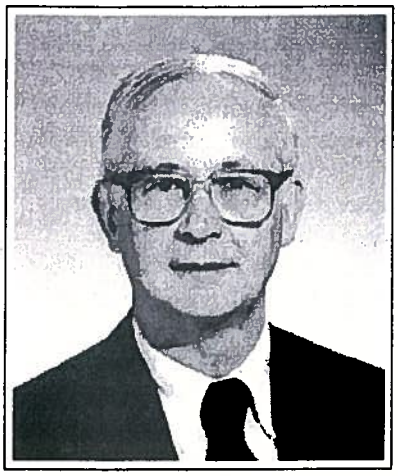
A receiver who affirms or disavows a contract against the will of the other party must affirm or adopt it in its entirety.[23] That is, the receiver cannot pick and choose among the provisions of the contract. He takes them all or rejects them all. However, some courts have held that contracts may be affirmed in a modified form if the receiver and the other party to the contract agree.[24] This may provide receivers an important tool to use in negotiations with constituents. For instance, the receiver could affirm a brokerage agreement under modified terms. The receiver would agree to pay the broker a certain percentage of pre-receivership obligations plus all post-receivership obligations in exchange for a continuing commitment by the broker to place business and retain business with the MCO. Modified affirmation might also be used with providers to pay them a portion of their pre-receivership fees in return for an ongoing commitment to the network.

However, affirmation of contracts must be used judiciously because it commits the estate to future liability. Early in a case, affirmation should only be used for individual contracts which are critical to the survival of the MCO. Broader decisions about affirmation can be made later in a case if the receiver develops a clear sense that the ongoing operations will support the future commitments which affirmation of contracts entails.

Classification in rehabilitation plans.

One of the key promises made by

(Continued on page 12)



BILLY L. AKIN

Billy L. Akin is President of Professional Consultants & Services, Inc., an insurance and reinsurance consulting firm of Hendersonville, Tennessee, a Nashville suburb. As a consultant for the last decade and a half, he has been extensively involved in a property and casualty insurance company receivership, in addition to serving as a litigation consultant and expert witness. Previously he had a career of thirty years in most every area of property insurance company operations, finally serving as Senior Vice President, Secretary and Member of the Board of Directors of a company. Billy has also had production and underwriting experience with an excess and surplus lines managing general agency.

Receivership experience consists of consulting with representatives of the Tennessee Department of Commerce and Insurance on several matters, most notably fourteen years of extensive involvement in the receivership of Cherokee Insurance Company. Working with the Rehabilitator and other attorneys involved in the Cherokee rehabilitation and ultimate liquidation, Billy, had far reaching hands-on experience in most every facet of the receivership. This activity included reinsurance and retrocession collections; gathering of other company assets, reinsurance treaty commutations; direct claim litigation assistance; preparation of forms and procedures for and confirmation of creditor claims; legal compliance; general administration; and preparation of a detailed chronology of the entire receivership process.

Born and reared in Nashville, Billy received a Bachelor of Science degree from David Lipscomb University and has taken courses at Vanderbilt University's Owen Graduate School of Management. He holds the designations of Chartered Property Casualty Underwriter (CPCU) and Associate in Risk Management (ARM).

Billy is Certified as a Mediator by the National Mediation Academy, Inc. and is a licensed insurance agent by the state of Tennessee. He has been involved in several arbitration and mediation settlements of direct insurance and reinsurance claims. Research capabilities and his broad insurance related background have been useful in legal expert witness work.

On a personal note, Billy enjoys work in various church related activities, hiking, travel, photography and spending time with his wife and their four grandchildren.

MICHAEL J. ANDERSON

Michael J. Anderson is Treasurer and Secretary of Vista Consulting Group, Inc. (Vista), an insurance consulting practice owned and operated by Betty Cordial. He is a certified public accountant currently licensed in the states of Wisconsin, West Virginia and Alabama. He holds a B.B.A. degree with majors in both accounting and finance from the University of Wisconsin. He has worked in both the insurance and reinsurance industries for over eighteen years.

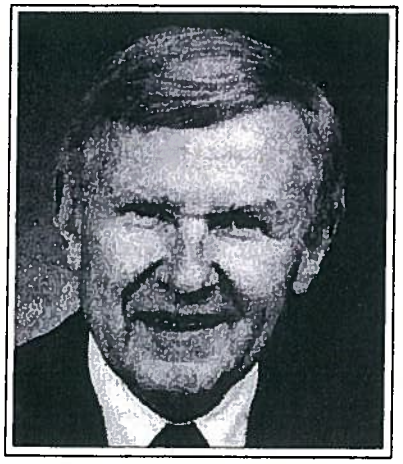
Vista manages the liquidation of all the insurance company liquidations in West Virginia and also is engaged by the Mississippi Insurance Department to manage the liquidation of three Mississippi domiciled companies which were part of the Thurnor Group of companies.

At Vista, he serves as the Assistant Deputy Receiver/Liquidator and Chief Financial Officer for all of the Vista client companies. He has provided expert testimony as an insurance accounting expert in civil litigation cases and was a speaker at the 1996 NAIC/IAIR Insolvency Workshop on various tax issues affecting life insurance companies.

Prior to joining Vista (and a predecessor company) in 1992, he was Vice President and Chief Financial Officer for a group of P & C insurance companies in Michigan. For four and an half years he was also a self-employed consultant for several solvent insurance companies which decided to run-off their insurance business. His clients included Imperial Casualty and Indemnity Company, in Omaha, Nebraska (owned by Amoco Oil) for which he managed their reinsurance commutation program and Northwestern National Insurance Company (NNIC) in Milwaukee, Wisconsin.

From 1981-1986, he worked as a staff accountant, senior accountant and accounting manager at both Armco Insurance Group, Inc. and NNIC.

Michael and his wife Monique reside in Birmingham, Alabama with their three teenage children. He is an avid tennis player and played on the varsity tennis team at Xavier University.



JACK H. BLAINE

Jack H. Blaine is of counsel to the Washington, D.C. office of Sutherland Asbill and Brennan LLP where his practice consists primarily of insurance regulatory issues for life insurance companies and other clients, including mergers and acquisitions, new product development, insurance insolvency and receivership law, reinsurance and guaranty associations.

Prior to joining Sutherland Asbill & Brennan Mr. Blaine was president of the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) from February 1992 until his retirement on December 31, 1997. NOLHGA is the national association of the 52 state, District of Columbia and Puerto Rico state insolvency guaranty associations for life and health insurance.

He was of counsel to the law firm of LeBouef, Lamb, Greene and MacRae, until he was named to head up NOLHGA. Before joining LeBouef, Lamb, Mr. Blaine was president and CEO of the Reinsurance Association of America, a trade association of property-casualty reinsurance companies.

From 1966 to 1989 Mr. Blaine represented the American Council of Life Insurance where he was Vice President, State Relations and General Counsel. His responsibilities for ACLI included management of state government relations activities in all states, corporate legal affairs, litigation and state insurance law compliance publications.

Mr. Blaine attended Bowling Green State University and received his undergraduate degree from the University of Dayton; he received his law degree from the University of Wisconsin Law School. He is admitted to practice law in the states of Wisconsin and Illinois, the District of Columbia and before the Supreme Court.

Mr. Blaine is Vice Chair of the Journal of Insurance Regulation, and a director of Guaranty Reassurance Corporation of America.

ANDREW MANEVAL

Andrew Maneval is President of Horizon Management Group, LLC, an insurance/reinsurance run-off management firm with offices in Boston, London, Hartford, and Bermuda. Over the past seven years, he has been responsible for running off the business of two large excess and surplus lines insurance companies, First State Insurance Company and New England Insurance Company, and a large treaty and facultative reinsurer, New England Reinsurance Corporation.

First State and New England Re are subsidiaries of The Hartford Financial Services Group; hence, Andrew has spent quite a bit of time recently in Connecticut's capital city. He is from New York City but currently lives with his wife and children in Newton, Massachusetts, a suburb of Boston.

Andrew's company, Horizon, now also manages the operations of a prominent London market company, The Excess Insurance Company, Ltd., out of offices located in London and a town on the south coast of England. Horizon performs a wide variety of services for other insurers, reinsurers, pools, and underwriting agencies in the U.S. and Europe.

For thirteen years, Andrew worked as an attorney in a law firm in New York, representing insurers and reinsurers. He is a graduate of Earlham College and Fordham Law School, and recently completed an AICPCU program at the Wharton School (Insurance Executive Development Program). In addition to providing run-off management services, Andrew serves as an arbitrator in insurance and reinsurance industry disputes.

When Andrew isn't working or traveling, he seems to spend most of his time taking his son to snow-boarding and skate-boarding sites, and his daughter to her ice-hockey games!

TALK IS CHEAP: A LEGAL ANALYSIS

(Continued from page 9)

receivers to constituents early in a case is that they will receive better treatment at the end of the case if they support the MCO during the case. It would be unfortunate if the receiver were required to treat the pre-receivership claims of constituents who supported the receiver the same as constituents who did not. The rigid classification of the liquidation priorities suggests that all pre-receivership claims of the same type must be placed in the same class and treated the same. Fortunately, in rehabilitation plans, there is more flexibility to deal with priority issues.

First, as discussed above, the receiver has the right to affirm contracts and cure pre-receivership defaults in doing so. If a contract has not been affirmed before the promulgation of a plan, the receiver can offer providers or brokers who supported the receivership a modified affirmation of their contracts. Such an affirmation would permit the receiver to differentiate treatment between the pre-receivership claims of those who supported the receivership and those who did not.

Second, there is a body of federal bankruptcy case law which permits a reorganization plan to treat pre-bankruptcy claims differently where certain of the claimants will provide ongoing services to the debtor.[25] Some courts have applied a "rational basis" test to determine whether separate classification is permissible. One of the essential factors is whether there is a "good business reason" for classifying separately.[26]

Many attempts to classify claims differently in bankruptcy plans have failed because the court found the differentiation to be an artificial device for the plan proponent to get votes needed for confirmation of the plan.[27] However, in insurance receiverships, plans are not the subject of voting and therefore, separate classification for those who supported the receivership and those who did not should be more readily acceptable.

STICKS

The automatic stay.

At the commencement of a receivership case, there is typically an automatic stay which prevents creditors and others from taking action against the assets of the receivership estate. The scope and effect of the stay varies widely from state to state. A broadly worded provision such as the following may be very helpful to a receiver:

"An application or petition [for rehabilitation, liquidation, etc.] shall operate as an automatic stay applicable to all persons, other than the receiver, which shall be permanent and survive the entry of an order of conservation, rehabilitation or liquidation, and which shall prohibit: (A) The transaction of further business; (B) the transfer of property; (C) interference with the receiver or with a proceeding under [the sections of the statute pertaining to rehabilitation, liquidation, etc.]; (D) waste of the insurer's assets; (E) dissipation and transfer of bank accounts; (F) the institution or further prosecution of any actions or proceedings in which the insurer is a party; (G) the obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders; (H) the levying of execution against the insurer, its assets, or its policyholders; (I) the making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer; (J) the withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or (K) any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholder, or the administration of any proceeding under [the sections of the statute pertaining to rehabilitation, liquidation, etc.]."[28]

Under this provision, it may be argued that parties to contracts with the insurer cannot terminate those contracts without first obtaining an order of the court lifting the stay. Such an interpretation would bar subscribers and providers from terminating their agreements. While there are no reported decisions construing the foregoing statute, there are federal bankruptcy cases which construe the automatic stay provision of the Bankruptcy Code as precluding contract termination. Such cases hold that a non-debtor party to a contract may not unilaterally terminate that contract without first seeking relief from the automatic stay. This is so because the rights of the non-debtor are subject to the debtor's rights to assume or reject that contract under section 365 of the Bankruptcy Code.[29]

Temporary injunctions.

Even when an action is not subject to the automatic stay, the court retains the power to enjoin acts that interfere with the rehabilitation efforts of the debtor.[30] Most courts use the traditional test for the issuance of an injunction, requiring a showing of (1) substantial likelihood of success on the merits; (2) that the moving party will suffer irreparable injury unless an injunction is issued; (3) that the threatened injury to the moving party outweighs the damage the injunction may cause the opposing party; and (4) that the injunction would not adversely affect the public interest.[31]

Under the statute quoted above, a court might well consider enjoining an out of network provider from attempting to collect from its patients. The case would be particularly strong if the receiver could demonstrate that such providers were highly likely to be paid under a plan or before a plan. The receiver would need to show that continued collection efforts would cause irreparable injury due to erosion of the subscriber base. This injury would be balanced against the relatively slight harm caused by a delay in payment to the providers. Nonetheless, it is highly unlikely that an injunction would actually compel physicians and brokers to continue to work for the MCO against their will due to the Constitution's prohibition of involuntary servitude. However, there are some cases which have come very close to this line. For instance, recently an Ohio court issued a temporary injunction against ValueRx Pharmacy Program Inc. in the liquidation of the DayMed Health Maintenance Plan Inc. in order to allow DayMed members to sign up with new HMO plans. The injunction prevented the provider from terminating its agreement with the HMO.[32]

The court may have the authority to prevent suppliers of products (rather than personal services) from refusing to do business with a rehabilitated MCO. In the case of In re Blackwelder Furniture Co., Inc., 7 B.R. 328 (Bankr. W.D.N.C. 1980), the court issued a preliminary injunction against the termination of contracts by various of its suppliers. The court first balanced the likelihood of irreparable harm to Blackwelder against the likelihood of harm to the furniture manufacturers' creditors, stating that, "[T]he cumulative harm that would result from the actions of the [suppliers], absent a preliminary injunction, would be incalculable and irreparable."[33] The court recognized that Blackwelder would lose customers without the ability to obtain furniture manufactured by the various suppliers, which would mean that Blackwelder's "reorganization plan would fail, that it would cease doing business, and that it would be liquidated - all to the detriment of Blackwelder, its customers, its employees and its suppliers." Id. The court next determined that the suppliers would not suffer any harm by being required to do business with Blackwelder on a cash basis. Having found that the balance was greatly in Blackwelder's favor, the court then determined that the suppliers' decisions to terminate their contracts raised serious questions, such as conspiracy, that were fair ground for litigation and deserved more investigation. Finally, related to the public interest portion of the test, the court determined that an injunction would protect Blackwelder's customers and other creditors, as well as entities that invest in rehabilitating debtors and entities that choose to take advantage of the bankruptcy laws.

Avoidance actions.

Some providers and brokers will not wish to continue providing services on credit to the MCO because they do not wish to take more credit risk. Curiously, this is often a position of providers and brokers which were paid in whole or in part before the commencement of the receivership proceedings. One of the receiver's tools for dealing with such providers is the preference statute. This statute allows the receiver to recover from creditor payments which they received within four months of the receivership and in some instances, up to a year prior to the receivership. Unlike federal bankruptcy law, there are very few defenses to preferences under receivership law. As part of the incentive package to be offered to providers and brokers, the receiver may wish to include a release of preference claims, as well as preferred payment status.

CONCLUSION

The receiver of an insolvent MCO faces a major challenge in keeping the enterprise together. Certainly, communication is an effective tool, but money often speaks louder. The basic rules of receivership law are designed to ensure that all creditors similarly situated are treated similarly. On the face of it, this would appear to preclude the receiver from offering better treatment to those who support the receivership. However, there are tools available to the receiver,[34] which permit the receiver to motivate providers, brokers and others to support the receiver in his ultimate goal - the stabilization and rehabilitation of the insolvent MCO.

Harold S. Horwich is a partner in the national law firm of Bingham Dana LLP (which merged with Mr. Horwich's former firm, Hebb & Gitlin). Mr. Horwich is a member of the firm's financial restructuring department and the head of the firm's insurance insolvency practice. That practice involves representation of receivers and creditors of insolvent insurance companies. It also involves representing insurance companies in other types of insolvency matters. Mr. Horwich is a graduate of Boston University Law School (1978) and Brown University (1975). He has written extensively on the subject of insurance company insolvency.

Deborah M. Bibbins is an associate in Bingham Dana LLP's financial restructuring department. Ms. Bibbins has over twelve years' experience working on various insurance, reinsurance, insolvency and regulatory matters. Ms. Bibbins is a graduate of the University of Connecticut School of Law (1998) and holds an M.B.A. degree from the University of Massachusetts (1993) and a B.S.B.A. (Finance) degree from the University of Connecticut (1987).

1 The authors acknowledge the number of disputes as to whether MCO insolvency proceedings should be the subject of state receiverships or federal bankruptcy proceedings, but note that the premise of this article is that MCO insolvency proceedings will be subject to state receivership laws in a state forum.

2 See American Bank and Trust Co. v. Feeney Tool Co., 106 Conn. 159, 165-66 (1927) (rights of creditors to take action against property of the debtor after a receiver is appointed are suspended); Lippitt v. The Thames Loan and Trust Co., 88 Conn. 185, 206 (1914) (interest on claims is not allowed after receiver's appointment date). See, also, 2 Ralph E. Clark, A Treatise on the Law and Practice of Receivers, § 403 at 691 (3d ed. 1959) ("If the property and funds are subject to the control of the court, it follows that the receiver should not pay out any funds except under orders of court. If he does he may hold himself personally liable for such improper payments."); 1 & 2 Henry G. Tardy, A Treatise on the Law and Procedure of Receivers (Second Edition of Smith on Receivers), § 34 at 142 (1920) ("The respective rights of the parties to the receivership litigation are preserved as they existed when the receiver was appointed but are ordinarily not determined until the final hearing on the matter.").

3 See In re Morgan, 277 N.Y. 203, 210-11, 14 N.E.2d 39, 42 (1938) (obligations of insurer held in abeyance during rehabilitation); Pink v. Title Guarantee & Trust Co., 274 N.Y. 167, 172, 8 N.E.2d 321, 323 (1937) (rehabilitation order stayed action against assets).

4 Courts around the country have turned to federal bankruptcy law for guidance in determining various legal issues affecting insurance company insolvency. Where published receivership decisions are not available, the authors have referred to bankruptcy precedents. See, e.g., Prudential Reinsurance Co. v. Garamendi, 14 Cal. Rptr. 2d 749, 756-57, 842 P.2d 48, 55-56 (1992) (setoff rights); In re Liquidation of Security Cas. Co., 127 Ill.2d 434, 451-55, 537 N.E.2d 775, 783-84 (1989) (treatment of shareholders' fraud claims); White v. Alaska *ex rel* Block, 597 P.2d 172, 174-75 (Alaska 1979) (priority of claims); People *ex rel* Bolton v. Progressive Gen. Ins. Co., 44 Ill.2d 392, 397, 256 N.E.2d 338, 341 (1969) (jurisdiction of liquidation court); People

(Continued on page 27)

Receivers' Achievement Report

by Ellen Fickinger

Reporters: Northeastern Zone - J. David Leslie (MA); W. Franklin Martin, Jr. (PA); Midwestern Zone - Ellen Fickinger (IL); Brian Shuff (IN); Southeastern Zone - Eric Marshall (FL); James Guillot (LA); Mid-Atlantic Zone - Joe Holloway (NC) Western Zone - Mark Tharp, CIR (AZ); Amy Jeanne Welton, AIR (TX); Melissa Eaves (CA); International - Philip Singer, CIR (England); John Milligan-Whyte (Bermuda)

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

Mark Tharp, CIR (AZ) reports that, in the matter of Cohen v. The Hartford Fire Insurance Company, a four day trial occurred in November 1998 relative to the Receiver's attempts to recover on a $1 million fidelity bond issued to **AMS** by the Hartford. On May 28, 1999, the Court entered judgment in favor of the Receiver and ordered that the Plaintiff (Receiver) is entitled to compensation under the fidelity bond in the total approximate amount of $1.2 million plus interest. While Hartford filed a Motion for New Trial, the Court denied such motion on October 1, 1999, thereby adopting the Receiver's position that the automatic termination of the bond upon the appointment of a Receiver is contrary to public policy and rejected Hartford's contention that the Receiver intentionally withheld notice of claim to Hartford pending Hartford's acceptance of renewal premium. Hartford has posted a $1.3 million supercedeas bond, pending its appeal.

Additionally, on April 2, 1999, the Receiver secured release of a $220,000 statutory deposit held by the State of Missouri for **Diamond Benefits Life Insurance Company**. The Multi-District litigation originally filed in 1989 in the United States District court was scheduled for trial in September 1999 but was postponed by the Court to an undisclosed 2000 date.

Finally, **Mark** reported that **Trenton National Insurance Company**, an Arizona domiciled property and casualty insurer, was placed into liquidation on April 25, 1988. This estate was closed effective September 29, 1999 pursuant to Order Re Petition 135. After the Receiver is paid in full all timely filed approved claims pursuant to Court Order Re Petition 115, the Receiver disbursed to the Arizona Property & Casualty Insurance Guaranty Fund (Fund), a liquidating dividend in the approximate amount of $228,000. The Fund had previously been paid $1.227 million, resulting in an excess of 100% distribution to the Fund.

Mike Rauwolf (IL) reports that, under OSD supervision, **American Mutual Reinsurance, In Rehabilitation (AMRECO)** continues to manage the reinsurance run-off of their business. Total claims paid inception to date; Loss and LAE $30,449, Reinsurance Payments $128,188,078, and LOC Drawdown disbursements $9,613,386. Another company under OSD supervision, **Centaur Insurance Company, In Rehabilitation** also continues the run-off of their business. Total claims paid inception to date; Loss and LAE $51,014,523, Reinsurance Payments $4,945,493 and LOC Drawdown disbursements $13,876,555.

James Gordon, CIR (MD) continues to provide collection information for **Trans-Pacific Insurance Company, et al.** Collections during the third quarter of 1999 for rental income totaled $127.50. For **Grangers Mutual Insurance Company**, total collections for the third quarter of 1999 were $285,649.71.

Frank Martin (PA) continues to report on the progress 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. As of September 30, 1999, **FML** showed a statutory surplus in excess of $126,000,000. The Commonwealth Court authorized payment of all approved creditor claims if the creditors are willing to waive any interest or penalties, which may be applicable. Most approved creditors have accepted that settlement and have been paid; however, a handful of the general creditors have chosen to wait and see what interest rate will be approved in the rehabilitation plan for payment at Closing. **Frank** states that they are also in the process of working out settlements with the taxing authorities that will allow them to retroactively credit the paid guaranty association assessments against any premium tax owed. This involves preparing and filing amended returns from 1993 forward for each state with an offset provision. So far there are only two states who allege that they are not allowed to waive interest and four states who cannot allow retroactive application of guaranty association credits.

On August 5, the Rehabilitator filed a petition to establish a Claims Bar Date to effectively determine the date as of which any new or contingent claims would prejudice the orderly administration of the estate. The Policyholder Committee filed various objections to the petition and extensive briefing just concluded on January 14, 2000. The primary objections of the Policyholder Committee relate to the barring of claims against any person or entity other than **FML**. The Bar Date Petition proposed barring claims that would affect the assets of **FML**, which would include claims against, related entities

and indemnified persons.

The Third Amended Rehabilitation Plan and all related documents have been negotiated over the last two years with the court appointed Policyholders Committee. The plan proposes the **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 contacts. No reduction will occur in cash value, death benefits, dividend accumulation or policy loan accounts. Substantially all of **FML's** assets will be transferred to **FLIC** to support these obligations. The plan proposes that creditors with approved claims will receive payment in full, in cash, with simple interest at 6% per year. Policyholders will receive both common and convertible preferred stock in the holding company for **FLIC, Fidelity Insurance Group (Group)**. An outside investor will be selected through court 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 Policyholder Committee has recently demanded an increase in the proposed dividend due to the passage of time since it was filed.

RECEIVERS' ACHIEVEMENTS BY STATE

District of Columbia (Alan N. Gamse, State Contact Person)

Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*	
Capital Casualty Ins. Co.	$200,000.00	(GA)

Illinois (Mike Rauwolf, State Contact Person)

Use and distributions made to policy/contract creditors and Early Access

Receivership	*Amount*
Amalgamated	$34,788.00
Amreco	$1,821,157.00
Centaur	$136,640.00
MedCare HMO	$175,175.00
Merit	$30,442.00
Millers	$2,177,924.00
Pine Top	$13,678.00
Prestige	$220,097.00
State Security	$785.00
United Equitable Life	$2,105.00
Total	**$4,612,791.00**

Louisiana (Michael R.D. Adams, State Contact Person)

Receivership Estates Closed	Year Action Commenced	Licensed	Category	Dividend Percentage
Arist National	1991	Y	P&C	28.72% Priority I
New England Int.	1989	Y	P&C	100.00% Priority I 56.93% Priority 2
Fidelity Life Ins. Co.	1991	Y	Life	100.00% Priority 1 44.44% Priority 2
First Fidelity Life	1990	Y	Life	100.00% Priority 1 8.82% Priority 2
Champion Ins. Co.	1989	Y	P&C	46.47% Priority 1

(Continued on page 16)

(Continued from page 15)

Use and distributions made to policy/contract creditors and Early Access

Receivership	***Amount***	
Arist National	$600,000.00	EA
	$78,894.65	
New England Int.	$1,680,269.49	EA
	$13,894.82	
	$4,145,237.00	
	$115,632.50	
	$69,918.43	
Fidelity Life Ins. Co.	$482,959.52	
First Fidelity Life	$118,221.86	
	$75,412.66	
Champion Ins. Co.	$13,665,200.00	EA
	$2,343,855.94	EA
	$122,487.83	EA
	$73,960.69	
Total	**$24,585,945.39**	

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

Receivership	**Amount**
Grangers Mutual Ins. Co.	$20,555.06 (MD)
	$2,383.35 (DC)
	$548.00 (GA)
	$310.48 (TN)
Total	**$23,796.89**

Pennsylvania (W. Franklin Martin, Jr., State Contact Person)
Use and distributions made to policy/contract creditors and Early Access

Receivership	**Amount**
Rockwood Ins. Co.	$5,085,518.00
Westmoreland Casualty Co.	$4,986,194.00
Total	**$10,071,712.00**

Tennessee (Jeanne Barnes Bryant, State Contact Person)

Receivership Estates Closed	**Year Action Commenced**	**Licensed**	**Category**	**Dividend Percentage**
United Physicians	1992	Y	Risk Retention/ P&C-Med. Mal.	40.00%

West Virginia (Betty Cordial, State Contact Person)

Use and distributions made to policy/contract creditors and Early Access

Receivership	***Amount***	
George Washington Life Ins. Co.	$9,623,900.31	50% - Class III pol./clmts
	$600.00	100% - Class II Emp.
	$2,217,000.00	70% - Early Access
Total	**$11,841,500.31**	

NEW DEVELOPMENTS ON UK SCHEMES OF ARRANGEMENT

by Nigel Montgomery and Philip Singer, CIR

The London Market has used Schemes of Arrangement for many years to provide a timely and cost effective closure for both insolvent and solvent insurers with discontinued business. As many readers will know, schemes require the involvement of the court as well as the consensus of a majority of creditors.

This article reports on the scheme of The Hawk Insurance Company Limited (the Hawk). The Hawk is a small insurance company which originally wrote motor business and subsequently expanded to general business in the early 1970's. It ceased to write new business in October 1976 but the burden of substantial claims in the ensuing run-off proved too much for its reserves. In 1995 the directors presented a winding-up petition and sought the appointment of provisional liquidators, Philip Singer and Chris Hughes of PricewaterhouseCoopers.

As the Hawk has limited assets, the provisional liquidators decided to construct a simple scheme of arrangement in order to return assets to creditors expeditiously. In larger cases, the valuation of IBNR and outstanding claims is frequently done by actuaries, using complex and relatively costly methodologies. For the Hawk it was necessary to devise a much less involved process which scaled back IBNR and outstanding claim amounts by 50 percent and 25 percent respectively.

Background

Three stages are involved in the implementation of a scheme of arrangement. In the first stage, the provisional liquidators convene meetings of the creditors whom the scheme is intended to bind. In the second stage, the provisional liquidators obtain the support for the scheme of a majority of creditors in number constituting three fourths in value of those attending and voting at the meeting (or if more than one, at each meeting). In the final stage, the court files an order sanctioning the scheme with the Registrar of Companies.

In the Hawk's case, the provisional liquidators successfully negotiated the first two stages of the implementation process. All the Hawk's creditors who attended and voted at the meeting voted in favour of the scheme. At the court hearing, however, Mrs. Justice Arden, refused to enter the order sanctioning the scheme. She raised two concerns.

First, the judge felt that the creditors should have met in three class meetings, rather than one, to vote on the scheme. As a result, the court had no jurisdiction to sanction the scheme. She was also concerned about the dispute resolution procedure set out in the scheme. In order to ensure that the valuation mechanism operates speedily but fairly, the scheme requires the appointment of a named independent adjudicator whose role is to give a final binding decision on disputes between policyholder-creditors and the scheme administrator about the value of creditors' claims. This procedure avoids the considerable time and expense which would be involved in arbitration and court proceedings. At this hearing, the judge did not want to exercise her discretion to sanction a scheme adjudication procedure which excluded the jurisdiction of the court. She feared that the procedure was contrary to public policy. She also feared that the adjudication procedure might breach the UK Human Rights Act 1998, which came into force on 2 October 1998. Article 6 of the Act provides that public authorities, which include courts, should not act in a manner which is inconsistent with rights conferred on individuals by the European Convention on Human Rights. Under Article 6 of the Act, parties have the right to a fair and public hearing by an independent and impartial tribunal established by law.

The Hawk's proposed scheme is a simple cut-off scheme, involving valuation of contingent claims

A Question of Class

The Hawk's proposed scheme is a simple cut-off scheme, involving valuation of contingent claims. Given that the estate is small, the provisional liquidators could not justify the costs of designing and implementing a sophisticated actuarial methodology for valuing contingent claims. The scheme therefore allows the scheme administrators and the creditor concerned to agree on the value of contingent claims. If agreement cannot be reached within a certain period, the parties refer the disputed matters to a scheme adjudicator, whose decision is final and binding on the parties. The valuations achieved by this process are less accurate than the valuations resulting from a more sophisticated procedure and the scheme provides for the resulting valuations to be weighted. Dividends are paid on the basis of the weighted amounts. At least one other scheme has already used this process successfully.

Contingent claims fall into two categories: (1) those claims regarded as being the least likely to accrue due (IBNR) and (2) those claims slightly more likely to accrue (Outstanding Losses). Accordingly, claims for Outstanding Losses are to be scaled back to 25 percent, and those for IBNR to 50 percent. Although the discounting varies according to the type of claim, the treatment of all creditors is essentially the same.

The judge wanted three separate class meetings, one for creditors with claims which had accrued due, another for creditors with claims for Outstanding Losses and yet another for creditors with claims for IBNR. She perceived three different groups of creditors with different rights, because those with contingent claims, in the judge's words "have, or are treated as having, no accrued debt due, and they are to be scaled down, for

(Continued on page 18)

NEW DEVELOPMENTS ON UK SCHEMES OF ARRANGEMENT (Continued from Page 17)

distribution purposes." She also felt that each creditor had a competing interest in ensuring that his claim received as high a weighting as possible, and those of other creditors as low a weighting as possible. In addition, creditors with contingent claims were to have their claims assessed by a valuation process different from the process typically used in a winding up, even though no set formula exists for estimating contingent claims of insurance and reinsurance companies.

The judge's analysis fails to recognise that in most, if not all cases, the three separate class meetings would each have been attended by the same creditors because they have claims falling into each of the three different classes. In addition, the weighting process actually forms part of the valuation of the creditors' claim for a dividend. In many ways, the weighting process is the short-form equivalent of the widely accepted and more sophisticated calculations that are built in to actuarial methodologies used in other cut-off schemes for valuing contingent claims. Courts and policyholders in the past have accepted the treatment of creditors having accrued claims and creditors having claims which are to be valued under the scheme, as a single class. Although the Hawk's case involves a particularly simple form of estimation, if the judge's decision applied to schemes which use sophisticated actuarial valuation techniques, the provisional liquidators would have to call an impossibly large number of meetings. Every claim would be different and therefore the discount applied would be different. It is the authors' view, however, that the court's judgment should be seen as restricted to the type of valuation used in the Hawk. In any event, the provisional liquidators have appealed the decision to the Court of Appeal and, given that at least two further Hawk-type schemes are in preparation, they are asking the Court of Appeal to expedite the hearing.

The Dispute Resolution Procedure

The judge resolved her concerns about the dispute resolution procedure at a further hearing on January 24, 2000 when time allowed her more reflection. Her public policy concern arose because of the rule laid down in Lee v. Showmen's Guild of Great Britain 1952 2 Q.B. 329 that an agreement to exclude the jurisdiction of the courts on matters of law was contrary to public policy and therefore void. However, no case law or rule of public policy prevents parties from agreeing to submit some issues involving questions of fact or law or of construction to the final and binding decision of an expert. The case law also makes it clear that, notwithstanding the parties' agreement that the expert's decision shall be final and binding, it can still be challenged when the expert is guilty of fraud or bias or has acted outside his instructions and therefore his contractual remit.

The scheme's dispute resolution procedure falls squarely within this exception. The scheme only refers valuation disputes to the scheme adjudicator. No other disputes can be referred to him. The valuation issue necessarily involves questions of fact and probably the construction of the policies concerned. The Judge accepted that, in light of the case law, and since the procedure was only intended to deal with disputes on valuation of claims, it was not contrary to public policy. She did suggest, however, that the scheme did not make the limitation on the matters that could be referred to the scheme adjudicator sufficiently clear. Confusion could arise as to whether issues such as the interpretation of the scheme or resolution of a claim against the adjudicator in negligence, could be referred to the adjudicator. She therefore required an amendment to clarify this point.

The scheme also contains a provision preserving the legal rights of creditors to challenge the decision of an adjudicator in cases of breach of trust, negligence and bad faith. The provision is not a qualification to the final and binding nature of the adjudication on value, but rather it provides recourse against the scheme adjudicator. However, the judge felt that the scheme needed to be clearer on this issue as well.

Finally, the judge required new wording stating that the scheme adjudicator's decisions are final and binding only insofar as the law allows.

The judge did not call into question the provisional liquidators' interpretation of the provisions. Instead, she wished to emphasise their interpretation to ensure that creditors without the benefit of legal advice would understand the scheme's effect. Usually the explanatory statement required by statute to be circulated with the scheme gives a relatively user-friendly explanation of the important points of the scheme. The judge did not order any amendments to the Hawk explanatory statement but only minor amendments to the scheme. The provisional liquidators intend to accept these ordered changes and will not seek appeal of this portion of the judge's ruling. The creditors have already approved the scheme together with any amendments approved or imposed by the Court. Thus, the provisional liquidators need not convene a second meeting to approve the scheme as ordered by the court.

Dispute Resolution - A Star Chamber?

At first sight, the scheme's closed adjudication procedure may appear to violate the public hearing requirements of Article 6 of the European Convention on Human Rights. However, the decision of the European Court of Human rights in the case of DeWeer v Belgium 1980 2 E.H.R.R. 439, makes it clear that the right to access to a court under Article 6 may be waived, provided there is no unfair pressure or compulsion. The judge accepted that the scheme adjudication procedure had not been foisted on creditors. The scheme, although it was not in fact a contract, was a consensual document and creditors could therefore be said to have agreed to waive their rights under Article 6. The court's function was to protect the non-assenting, non-attending and unknown creditors. The judge was convinced that the provisional liquidators had taken every step to ensure that the Hawk's creditors were aware of the scheme, and had been given ample opportunity -- both at the meeting of creditors and at the hearing before the judge -- to object to the

adjudication procedures. None of the creditors objected. She saw the commercial advantages of the adjudication procedures and, because they were not intended to go further than the law allowed, she had no objection to them, as well.

Lessons to be Learned

As anyone who has been involved in formulating a scheme is aware, the correct identification of classes of creditors for the purposes of voting on a scheme is of the utmost importance if the scheme is to be successfully implemented. Unfortunately, it can involve considerable difficulties. The consequences of getting it wrong are rendered more dire by this Court's decision to treat the creditor class question as a jurisdictional issue. The law is not clear whether the court may treat this as a prerequisite to its ability to sanction the scheme. This approach nonetheless leads to some very unsatisfactory results from the point of view of the company's creditors. In the Hawk's case, this approach thwarted the wishes of creditors who voted on and unanimously supported the scheme, dissipated assets from an already very small estate in order to appeal the decision, and further delayed the return of assets to creditors.

Leaving aside the appeal against what the authors believe was an incorrect decision, it is our contention that the question of whether classes were properly constituted should be viewed in the light of all the surrounding circumstances. The court should sanction a scheme when (as in the Hawk) no potentially oppressed minority exists which should have been invited to vote as a separate class. In the Hawk, had the creditors who attended and voted at the meeting of creditors voted at separate class meetings, the outcome would have been the same. However, because the question was treated as a jurisdictional issue, the judge felt unable to give any weight to these factors.

From the point of view of those drafting schemes, some of the emphasis usually dealt with in the explanatory statement should now appear in the scheme itself, in order to guard against a similar judicial approach to the novel one adopted by the Court in this case.

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SHIFTING THE BLAME:

WHY A REGULATOR OR RECEIVER'S CONDUCT IS NOT A DEFENSE
PART I

BY GAETAN J. ALFANO and GREGG W. MACKUSE[1]

I. INTRODUCTION

A. Overview

When a company is placed into receivership, the receiver is charged with evaluating the causes for the failure. In a number of instances, the insolvency can be traced to fraud or other wrongful conduct on the part of management, as well as conduct by third parties, such as accountants, attorneys and investment advisors. Accordingly, in an attempt to marshall the assets of the failed institution, the receiver may initiate litigation against the wrongdoers who were responsible for the insolvency.

In response, defendants have attempted to shift the blame to the Insurance Department. Specifically, defendants argue that if the regulator had monitored and/or investigated the company's business practices, the insolvency might well have been avoided or lessened.

In addition to raising a claim of "regulatory negligence," defendants also argue that any recovery by the receiver should be barred or limited due to the receiver's alleged failure to maximize the assets and/or minimize the liabilities of the insolvent entity. Under this argument, any damages claimed are alleged to be excessive and should be reduced, or avoided, by the receiver's failure to mitigate damages.

Such arguments consistently have been raised as affirmative defenses in insurance insolvency litigation. Most courts addressing this issue have held that regulator/ receiver conduct may not be used to escape liability.[2] Accordingly, in the event such defenses are pled in any action brought by a receiver, a receiver should vigorously challenge the availability of such defenses.

B. Decisions Concerning The Availability Of Affirmative Defenses Based Upon The Conduct Of The Superintendent or Commissioner as Regulator

1. Insurance Insolvency Decisions

a. Van Schaick

In the area of insurance insolvency, defendants have attempted to raise regulator conduct as an affirmative defense. For example, in the early New York case of Van Schaick v. Cronin, 237 A.D. 182, 261 N.Y.S. 358 (N.Y. App. Div. 1932), the Superintendent of Insurance, as liquidator of an insolvent insurer, sued former management seeking, inter alia, "judgment for damages sustained by the

Gaetan J. Alfano

corporation as a result of the waste, malfeasance, misfeasance and nonfeasance which caused the insolvency of the corporation." Id. at 358. One of the defendants asserted that the Superintendent of Insurance "made periodic inspections and constant visitations" to the insurer and "did make no complaint or criticism" of the affairs of the insurer. Id. at 359. As such, "the Superintendent of Insurance ratified the acts of the directors of the [insolvent insurer]." Id.

The court rejected this attempted affirmative defense, holding that:

We find nothing in the nonfeasance of the Superintendent of Insurance to protect the defendant Cohen from the consequences of his own nonfeasance.

* * *

A director of a moneyed corporation cannot rest entirely upon the vigilance of the Superintendent of Insurance. Such reliance constitutes no answer to a charge of nonfeasance.

Id. at 359-60.

b. Ideal Mutual

In In the Matter of the Liquidation of Ideal Mut. Ins. Co., 140 A.D.2d 62, 532 N.Y.S.2d 371 (N.Y. App. Div. 1988), the liquidator of an insolvent insurer sued its former officers and directors, "charging that they breached their fiduciary duty to the company by mismanaging its affairs." Id. at 373. In response, the defendants raised a number of affirmative defenses, including an allegation that the "culpable conduct by the Superintendent would, at the least, reduce the amount of defendant's liability on the basis of comparative negligence." Id. at 373. The defendants alleged "that the Department of Insurance dictated the course of action of Ideal's [the insolvent insurer] business, in effect taking de facto control of the company and bringing about its demise." Id.

The court held that the alleged acts of the Insurance Department, as regulator could not support the affirmative defense of comparative negligence, holding that:

The precise capacity, or status, in which the Superintendent appears as plaintiff herein is critically important with respect to the defense of contributory negligence. That defense relates to the negligent conduct of a Party to the action, the plaintiff. (See, e.g., CPLR 1411; Prosser and Keeton, Torts § 67 [5th ed].) The allegedly negligent acts of the Superintendent that the defendants here rely upon as the basis for his comparative negligence were committed by his Department, exercising its regula-

tory function, prior to the time he became the liquidator of Ideal. Consequently, those acts cannot be charged against him as the Plaintiff liquidator of Ideal, a separate and distinct legal entity from the Superintendent of Insurance as regulator of the industry. Since the conduct involved was not that of this plaintiff, it cannot constitute his contributory negligence and the defense of comparative negligence must be stricken. Id. at 374 (emphasis added).[3]

In another action involving the insolvency of Ideal Mutual, Corcoran v. National Union Fire Ins. Co., 143 A.D.2d 309, 532 N.Y.S.2d 376 (N.Y. App. Div. 1988), the Superintendent of Insurance, as liquidator, sued the liability insurance carrier of the insolvent insurer. The liquidator alleged "a breach of contract by National Union (the liability insurer] and a breach by National Union of a duty of good faith and fair dealing owed to Ideal [the insolvent insurer]." Id. at 377. In response to the suit, the defendant raised a series of affirmative defenses and counterclaims based on the "alleged conduct [of plaintiff] as regulator." Id. The liquidator moved to dismiss the defenses as "impermissibly directed to his role as regulator." Id. Although the trial court denied the liquidator's motion to dismiss, an appellate court held that the trial court had "misconstrued the applicable law." Id. As held by the court:

The Superintendent as liquidator is subject only to defenses that could be raised against Ideal, since it is in that capacity he brings this action. He holds legal title to the property of Ideal on behalf of its creditors and policyholders, not on behalf of the State or the general public [citation omitted]. The final fund held by the plaintiff for the benefit of these creditors and Policyholders should not be reduced simply because their representative is alleged to have contributed to the loss, acting in a different capacity and role.

* * *

The affirmative defenses which are directed against the Superintendent as regulator and public official are in effect irrelevant in this action by him as liquidator of Ideal seeking to enforce a Policy on behalf of Ideal (see, National Bank v. Duramark, Inc., 97 AD2d 816). Consequently, the first and second counterclaims and the second, third, fourth and ninth affirmative defenses, which are concerned with the plaintiff's role and conduct as regulator, fail to state cognizable causes of action or defenses against plaintiff as liquidator. Id. at 378 (emphasis added).

Gregg W. Mackiuse

c. Beacon

In North Carolina ex rel. Long v. Alexander & Alexander Services, Inc., 711 F. Supp. 257 (E.D. N.C. 1989) ("Beacon"), the North Carolina Commissioner of Insurance, as rehabilitator of Beacon Insurance Company, brought suit "alleging that the defendants caused Beacon to become insolvent through various unfair and deceptive acts in violation of state law and the federal RICO statute, 18 U.S.C. § 1962.11 Id. at 259. In response to the Complaint, several defendants asserted counterclaims based on the conduct of the Commissioner of Insurance as regulator and rehabilitator. As stated by the court:

The second through sixth counterclaims are against the Commissioner as rehabilitator or his deputy in both name and effect. The second counterclaim alleges that the rehabilitator and his predecessor in office have "willfully, wantonly and recklessly managed] the Beacon's affairs and estate" in violation of their fiduciary duty. The third counterclaim alleges that "[t]he predecessor to the current Rehabilitator, and thus the current Rehabilitator as his successor in interest, has, upon information and belief, acted negligently and possibly fraudulently" by destroying or attempting to destroy "an unknown number of documents potentially beneficial to the Beacon and to the Alexander Parties' defense." The fourth counterclaim alleges that the rehabilitator "negligently monitored the activities of the Beacon Insurance Company, before the Beacon Insurance Company sought voluntary rehabilitation, as the Plaintiff was statutorily required to do." The fifth counterclaim alleges that "Melvin Dillon, both in his personal capacity and as the rehabilitator's deputy, has tortuously, willfully, wantonly, and recklessly interfered with contractual agreements between the Alexander Parties and other parties to the detriment of the Alexander Parties and their rights." The sixth counterclaim alleges that "[t]he Rehabilitator and his predecessor Rehabilitator, acting on behalf of the Plaintiff State of North Carolina, has been negligent in the handling of the rehabilitation of the Beacon Insurance Company." Id. at 261 (emphasis added).

The court, relying on Corcoran and Ideal Mutual, dismissed the defendants' counterclaims. Id. at 264.[4] As held by the court:

[A]ny award made to Beacon cannot be set off by counterclaims against the Commissioner, since the Commissioner is only a party to this action as Beacon's representative. The Commissioner is therefore, even in his official capacity as rehabilitator, not an opposing party who can be counterclaimed against.

* * *

The Commissioner as rehabilitator suing on behalf of Beacon is similarly subject only to defenses that could be raised against Beacon. The first and seventh counterclaims are such defenses, since they arise out of Beacon's alleged conduct. The second through sixth counterclaims are not. Whether they seek to recover from the State or to merely set off any recovery by Beacon, the second through sixth counterclaims arise out of the Commissioner's alleged conduct, not Beacon's, and are thus irrelevant to this action.

Id. (emphasis added).

Thus, Beacon represents addi-

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SHIFTING THE BLAME

(Continued from page 21)

tional authority for the argument that defenses or counterclaims based upon regulatory conduct are unavailable as a matter of law.[5]

d. Stamp

In Stamp v. Brown, No. 81 C 1475, 1991 WL 169377 (N.D. Ill. Aug. 28, 1991), the Director of Insurance for the State of Illinois, as liquidator of Reserve Insurance Company, sued several defendants for allegedly fraudulent conduct. In response, the defendants asserted affirmative defenses based upon the actions of the Illinois Insurance Department. As stated by the court:

In essence, the plaintiff alleges that the defendants engaged in a fraudulent scheme to misrepresent the financial condition of Reserve Insurance Company ("Reserve"). Based on these misrepresentations, the plaintiff alleges, the Illinois Department of Insurance ("IDI") approved Reserve's continued operation past the point of the corporation's insolvency, plunging the corporation further into debt.

In response to the plaintiff's allegations[,] the defendants assert many affirmative defenses. The plaintiff objects to any affirmative defenses which contend that IDI's [the Illinois Department of Insurance's] conduct shields the defendants from liability.

Id. at *1 (emphasis added)

The court granted the liquidator's motion to strike the defendants' affirmative defenses, holding that:

The conduct of a regulatory body will not shield defendants from their own culpability. Schacht v. Brown, 711 F.2d 1343, 1359 (7th Cir. 1983) (... "the fraudulent operation of ARC was surely the alleged progenitor of Reserve's damage, regardless of whether the state regulatory authority was a necessary instrument in the accomplishment of that end"). See also Federal Deposit Ins. Corp v. Blackburn, 109 F.R.D. 66, 71-72 (E.D.Tenn. 1985) (affirmative defenses cannot be based on regulator's failure to sound alarm, as the regulator had no duty to protect the corporation); Federal Deposit Ins. Corp. v. Renda, 692 F. Supp. 128, 135 (D. Kansas 1988) (regulatory negligence is not a defense to fraud, duty to discover fraud lies with the institution's officers and directors); Federal Deposit Ins. Corp. v. Niver, 685 F. Supp. 766, 768 (D. Kansas 1987) (negligence defense against regulator is stricken). Therefore, if the defendants are found to have acted fraudulently, IDI's [the Illinois Department of Insurance's] actions in approving Reserve's operation will not Protect the defendants from liability.

Id. at *2 (emphasis added).[6]

e. Rockwood

A similar result was reached in Foster v.. Rockwood Holding Co., 632 A.2d 335 (Pa. Commw. Ct. 1993). In Rockwood, the Insurance Commissioner of the Commonwealth of Pennsylvania, as liquidator of Rockwood Insurance Company, sued the former directors of Rockwood Holding Company. The liquidator alleged that, due to the fraud and mismanagement by these officers and directors, Rockwood Insurance Company suffered losses in excess of $140 million dollars. Id. at 336. In response to the complaint, the liquidator argued that:

[T]he defendants aver or indirectly suggest in their respective new matter that they are not liable for claims asserted against them in the amended complaint because the Insurance Department and/or Insurance Commissioner knew or should have known the true financial condition of RIC [the insolvent insurer] and/or should have stopped the illegal and fraudulent conduct at an earlier date.

Id. at 336-37. Accordingly, the liquidator moved to dismiss the affirmative defenses, which were based on the regulatory conduct of the Insurance Commissioner.

The court rejected the defendants' attempt to use the regulatory conduct of the Insurance Commissioner to support affirmative defenses.[7] As stated by the court:

This court also rejects the defendants' argument that the Insurance Commissioner should be subject to the pleaded affirmative defenses, because it is alleged that the Insurance Commissioner and the Insurance Department performed a poor lob managing the assets of RIC [the insolvent insurer] before RIC was placed into receivership.

Id. at 339 (emphasis added).

As succinctly stated by the court, "the defendants should not be permitted to assert regulatory negligence to offset their own alleged culpability." Id. at 338 (emphasis added).

f. Clark

Finally, in Clark v. Milam, 891 F. Supp. 268 (S.D. W.Va. 1995), the court held that a regulator's negligence cannot be used to reduce, or defeat, a receiver's claims against wrongdoers. After a Jury award in favor of the receiver on claims of breach of fiduciary duty and professional malpractice, the receiver moved to alter the jury verdict. Id. at 270. As stated by the court:

The Receiver moved to alter partial final judgment on the jury verdict pursuant to Rule 59(e), Federal Rules of Civil Procedure. The Receiver asks the Court to restore the amounts offset from the judgment for the jury's apportionment of fault to the Receiver in his capacity as Insurance Commissioner and regulator. The Receiver argues any negligence attributed to him in his capacity as Insurance Commissioner and regulator cannot be applied to reduce the verdict he obtained in his capacity as Receiver.

* * *

As an affirmative defense, the Defendants asserted the Insurance Commissioner had been negligent in his duties toward them. The jury found the Insurance Commissioner, as regulator, contributorily negligent on both counts. In the partial judgment the Court applied the negligence of the Insurance Commissioner to reduce the jury award by one-third (33%) on Count III and by forty percent (40%) on Count IV.

Id. (emphasis added).[8]

The court, relying on the Rockwood, Beacon, Corcoran and Ideal Mutual decisions, granted the receiver's motion, holding that:

The Receiver's argument not to reduce the Judgment by the Insurance Commissioner's negligence is compelling.

* * *

Although the Supreme Court of Appeals of West Virginia has not passed on this issue, this Court believes the West Virginia Court would follow other courts and hold any negligence of the Insurance Commissioner as regulator could not be attributed to his representational capacity as Receiver. See Foster v. Rockwood Holding Co., 158 Pa.Cmwlth. 258, 264, 632 A.2d 335, 338 (1993) (defendants cannot assert regulatory negligence to offset their alleged culpability to receiver); State of N.C. ex rel. Lona v. Alexander & Alexander, 711 F. Supp. 257, 264 (E.D.N.C. 1989) (any award cannot be set off by counterclaims against the Commissioner, since the Commissioner is only a party as insurance company's representative); Corcoran V. National Union Fire Ins. Co., 143 A.D.2d 309, 311, 532 N.Y.S.2d 376, 378 (N.Y.App.Div.1988) (Superintendent as Liquidator subject only to defenses that could be raised against insurance company); In the Matter of the Liquidation of Ideal Mutual Ins. Co., 140 A.D.2d 62, 66?67, 532 N.Y.S.2d 371, 374 (N.Y.App.Div.1988) (negligent conduct of Superintendent as regulator is not conduct of the Superintendent as Liquidator).

Accordingly, the Court is now of the opinion that the jury's finding of negligence by the Insurance Commissioner cannot be used to reduce its award to the Commissioner in his capacity as the Receiver for George Washington Life. Negligence attributable to the Commissioner as regulator is not attributable to George Washington Life nor to the Receiver as GW LIFE's representative. The Court GRANTS the Receiver's motion to alter partial final judgment on the jury verdict and VACATES its Partial Final Judgment on the Jury Verdict insofar as the Court reduced the jury award to the Receiver by the percentage negligence of the Insurance Commissioner.

Id. at 271-72 (footnote omitted) (emphasis added).

In sum, in the particular area of insurance insolvency, a growing number of decisions explicitly reject any attempt by a defendant to cite regulatory conduct to support affirmative defenses against receivers. In the second part of this article, the authors will discuss attempts by defendants to raise affirmative defenses based on the conduct of the Insurance Commissioner as receiver, as opposed to regulator.

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1 Messrs. Alfano and Mackuse are shareholders in the Philadelphia firm, Miller, Alfano & Raspanti, P.C.

2 In addition to raising claims of "regulator or receiver negligence," particular defendants, such as accountants, attorneys, and investment advisors, also argue that the cause of the insolvency was the conduct of the institution's former management. Under this argument, management's misconduct must be imputed to the receiver, who is alleged to "stand in the shoes" of the insolvent entity, thereby defeating or limiting recovery. The defendants' inability to impute the conduct of former management to a receiver will be discussed in a separate, forthcoming article.

3 In Ideal Mutual, the court, however, did permit the defendants to pursue the theory that the Superintendent of Insurance's regulatory conduct, which occurred subsequent to the alleged acts of misconduct of the defendant, constituted a "superseding cause" of the insurer's insolvency. Ideal Mutual, 532 N.Y.S.2d at 374-75.

4 The court also dismissed the counterclaims based on the conduct of the rehabilitator and his staff during the rehabilitation. Thus, Beacon is also authority for the unavailability of defenses or counterclaims based on the conduct of the Superintendent and/or Commissioner during the receivership.

5 Although the Beacon court was addressing the viability of counterclaims, its analysis is equally applicable to affirmative defenses.

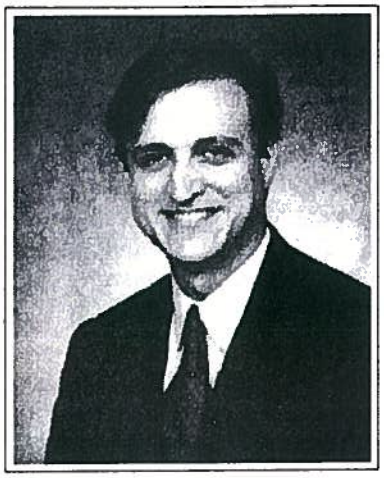
6 In reaching its decision, the Stamp court referred to an earlier decision in the same case by the United States Court of Appeals for the Seventh Circuit in Schacht v. Brown, 711 F.2d 1343, 1359 (7th Cir. 1983), cert. denied, 464 U.S. 1002, 104 S.Ct. 509, 78 L.Ed.2d 698 (1983). In Schacht, although the court was addressing the sufficiency of allegations concerning an alleged violation of the federal RICO statute and not affirmative defenses, the opinion states that regulatory conduct will not shield a defendant from liability for wrongful conduct. The remaining decisions relied upon by the court in Stamp relate to banking insolvency and are discussed in detail infra.

7 The court also rejected any attempt by the defendants to base affirmative defenses on the conduct of the Insurance Commissioner as receiver. Rockwood, 632 A.2d at 338-39. This aspect of the Rockwood decision will be discussed in detail, infra.

8 This subsequent decision in Clark is significant because, in an earlier decision, the court had refused to strike the affirmative defenses based on regulatory conduct. See Clark v. Milam, 152 F.R.D. 66, 72-73 (S.D. W.Va. 1993).

TUCSON 2000 INSOLVENCY WORKSHOP MANAGED CARE: A Different Millenium Bug

by Tom Clark



All around the cobbler's bench,
The monkey chased the weasel.
The monkey thought 'twas all in fun,
Pop! goes the weasel.
A penny for a spool of thread,
A penny for a needle.
That's the way the money goes,
Pop! goes the weasel.

Rufus has the whooping cough,
And Sally has the measles,
And that's the way the doctor goes,
Pop! goes the weasel.
A penny for a spool of thread,
A penny for a needle.
That's the way the money goes,
Pop! goes the weasel.

Children's Rhyme of unknown origin, ca. 17th Century

With apologies to the dedicated health care professionals out there, but after exploring the nuances of managed care insolvency for two days in Tucson, somehow this nonsensical children's rhyme seems to just sum up the managed care industry now poised and ready to just go Pop! Such was the theme of the managed care solvency arena surveyed during the Tucson Joint IAIR/NAIC conference held in Tucson, Arizona.

Leading off the conference was Nat Shapo, the self professed officially-no-longer recently-appointed Illinois Director of Insurance, who set the theme for the conference as one in which the new challenges presented by MCO insolvencies, which include the impact of a Patient's Bill of Rights, price constraints resulting from consumer expectations, tension between providers and payors, must be addressed with vigor, dedication and enthusiasm bracketed by wisdom and experience.

Next up with a defining overview of managed care was Eric Marshall, fresh from Florida's most recent action. The core issues: the determination of medical necessity, the varying entity structures and models, the veritable "alphabet soup" of Managed Care Organizations, were all presented in a fashion as to focus the discussion on how these various nuances affect and control the manner in which an insolvency is addressed. With the acronyms of IPA, MSO, IDS, GPWW, MSO, EPO, AWP, and a host of others, each begging the question - are all these acronyms really necessary or just a marketing ploy to confuse regulators and employ more attorneys and consultants? (ed. Note - if so, Thanks!). Regardless, a helpful glossary of terms was included in the materials.

After addressing the structure, the conference detailed how the standard safety net for insolvencies, a guaranty fund or association, is not available for the vast majority of jurisdictions in the United States. Only Alabama, Florida, Illinois, Maine, West Virginia and Wisconsin have enacted any semblance of a guaranty fund or association; however, the majority of even these structures do not provide complete assumption of coverage. However, the Illinois structure was presented by Dan Orth of the Illinois HMO Guaranty Association. Enacted in 1987 and patterned after the NAIC Life and Health Insurance Guaranty Association Model Act, the Illinois HMO Guaranty Association Law has been activated nine times. Under the Illinois Law, upon entry of an insolvency, the Association guarantees the covered benefits of Members of the insolvent entity, assures payment of the contractual obligations of the insolvent organization to covered persons, and makes payments to providers, or indemnity payments to covered persons, to assure the continuation of substantially similar benefits. In a pinch-hitting spot, Paige Waters ably brought out another hidden problem which Guaranty Associations help to resolve - the issue of balance billing. While typically prohibited by contract and statute, many providers seek to recover from the patient what they have already agreed to waive. Additionally, the application of the old priority scheme is proving to be like actual hand-me-downs - ill fitting and out of style. One negative result of the priority scheme is that out-of-network claims get paid in full before in-network claims; yet without payments to in-network providers, maintaining your network for any length of time is difficult, if not impossible.

So, before proceeding further, ask whether managed care organizations are really insurance entities after all? If not, bankruptcy must be considered. If so, proceed as normal. As a general rule, state law makes the determination for us; thus, on the face of it, the question

should seem easily resolved. However, see reference above to the alphabet soup of entities, many of these entities are not addressed by state or federal law. As such, bankruptcy as an option retains its relevance. The rule of thumb with which we were left was that jurisdictional conflict will be resolved in the state's favor when the state regulatory scheme is highly evolved and capable of addressing the challenge.

Randi Reichel of the American Association of Health Plans next outlined the federal and state regulatory matrix. In short, there are 43 of 50 states with insurance departments or divisions with primary regulatory authority, 6 health departments with primary authority, and 1 corporations department with primary authority; yet 37 states maintain another agency with secondary regulatory authority. Combine this with Health & Human Services/HCFA and its oversight under HIPAA and Medicare+Choice and the Department of Labor and its oversight under ERISA, COBRA and HIPAA. To quote Ms. Reichel - "Too many cooks in the kitchen."

The question - how do you get 200+ insolvency practitioners to remain in a darkened room when they could be enjoying lunch on the veranda on a beautiful sunny Tucson afternoon? The answer - ask Tom Foley, David Meadows and Frank Nicholson to lead a panel discussion on "Why MCOs Fail." Unfortunately, the content of this discussion could fill a complete issue, much less a single article. In short, the full scope of the reasons for MCOs failure seems to be summed up into two categories - insufficient capital and inadequate management. Most revealing though was their assessment of the impact of MCO insolvency on provider groups, which are failing at a rapid rate. What is occurring is that all of the inadequacies of the provider group structures, which arguably may have always been present (e.g., inadequate or excessive management, inappropriate reimbursement schemes, improper adoption of managed care risk contracts, etc...), are now being illuminated from reduced profit margins and increased competition. However, let us not forget the consumer's role in this equation. The consumer, whose expectations as usual greatly exceed the willingness to part with the appropriate contents of his or her bank account, was best exemplified by the anecdote tattooed in everyone's memory of the young bride demanding a scrip for Claritin to ensure a spring wedding in a meadow overflowing with flowers...just like the one in the commercial.

Pat Cantilo had the dubious challenge of leading the post-lunch presentation, possibly subtitled - What's a monkey do with a weasel once he's caught it? Well, first, familiarize yourself with the coverages in place probably including variations of all sorts of products, determine what's making money (if any), be certain that you've contacted all providers (who probably haven't been paid in 90 or so days for services rendered 180 days ago OR have a capitated contract that they have just realized is grossly inadequate OR they have good contracts with lucrative withholds that haven't been paid) and make sure they want to work with you, assess all cash, receivables, long term and short term investments, call the federal authorities and make sure that the aforementioned provider network remains intact so you don't violate your obligations under your HCFA contract, then make sure your non-provider creditors are willing to work with you. Okay that's enough for your first day. Get a good night's sleep. You'll need it. Get the idea?

Next up, we heard from Harold Horwich (see, "Talk is Cheap" in this issue), Rodney Moyer and John Black, who addressed the MCO counterpart to the riddle of the Sphinx: How does an MCO keep providing services to your Membership once you go into Receivership? While there is no easy answer, if you communicate with everyone, then you stand a greater likelihood of maintaining your network long enough to continue services to your membership until you can either sell the MCO, rehabilitate it, or find a new MCO to serve your membership.

Closing out the first day was a presentation by Tim Lee and John Black on the Rehabilitation of an MCO. If a troubled MCO is reached quickly, a true rehabilitation is possible. However, even if rehabilitation and release cannot be accomplished, rehabilitation is probably the only way to achieve the goal of landing it softly. Rehabilitation gives you the time to transfer the membership and preserve assets for creditors. While the means and methodology are familiar to insolvency practitioners; the difference is the time frame - you're talking weeks, not months, to effect a successful rehabilitation, and the implementation.

Opening the second and final day were Bob Greer and Steven Foster, who outlined the assessment process when its time to pull the plug, because the MCO no longer shows signs of life. Luckily, once this decision is made, there is the traditional receivership structure to fall back upon. But as was shown in Hank Sivley and Lew Hassett's presentation, it looks the same going in, but it sure doesn't respond the same.

Hank Sivley's presentation on Designing a Liquidation Plan, which could be the Answer to the question posed to Pat Cantilo - So what do you do with the caught weasel - Bury it, because it's dead. Using the fictional, "Get Well Quick d/b/a Bad Choice" managed care organization, Hank adeptly illustrated the all too common problems encountered with liquidating an MCO - little to no capital to fund ongoing expenses, problematic claims systems, no guaranty fund, alienated providers, etc... While the situation appears [and probably is] hopeless, it seems that you progress to a solution, because there is no alternative. There ultimately will be a solution, it just may not resemble the orderly plan you sought to enact when you accepted the assignment.

Lew Hassett added the exacerbating legal considerations to assess in your design process and reminded the attendees of the biggest bugaboo - tort claims against the HMO. At this time, the law is in complete flux with various versions and amendments making their way through Congress. While it appears that something may happen, anyone accepting an appointment should be watchful of the enterprising Plaintiff's attorney seeking to test the waters against the Company. So make sure the language in your Liquidation Order is airtight.

Next up were Mark Bennett and Phillip Tremonti, who addressed the difficulties

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inherent in Asset Marshaling, Litigation and Special Liquidation Problems. Phillip summed it up when he reminded all that well-intentioned consideration and a kind word will help you more than any legal maneuver or tactic...and oh yes, make sure that PWC gets paid.

Closing out the seminar was Paige Waters, who provided a concise checklist of the vital yet tedious task of closing down the estate. Of notable interest to an MCO insolvency are the overriding concerns of medical record maintenance subsequent to closure. However, just as with any other insolvent estate, the key is in being comprehensive in your request for an Order of Closure.

And so ended the seminar. Unfortunately, this article only scratches the surface of an incredible mountain of information presented. If you weren't there, you really missed a great one. We all owe a hearty thanks to the Planning Committee: Pat Cantilo, Dan Orth, Steve Durish, Jim Stinson, and Mike Surguine, who compiled a panel of luminaries and an agenda that provided a comprehensive, yet meaty survey of the issues associated with handling an MCO insolvency, as well as the multitude of issues that provide the fertile ground in which MCO insolvencies thrive. All of this was presented in a climate that had the majority of the attendees investigating the price of housing and questioning whether it really was necessary to be physically present in their offices for the months of January and February each year. In summary, it was a fantastic job in a fantastic location. What more could you want to assist you with tackling that next MCO assignment? That is, other than the requisite industrial size bottle of Excedrin?

CHICAGO MEETING RECAP

(Continued from page 4)

that the group finishes up with a report which not only lists the identified issues and trouble spots, but also catalogues and assesses the net improvements.

One final thought: if you care about the next round of action in insurance insolvency, make some time to think about Gramm-Leach-Bliley. To quote Jack and Larry's excellent précis,

What is "insurance?"

"Any product regulated as insurance as of January 1, 1999" [and any product regulated as such after 1-1-99] if the state determines it shall be regulated as insurance and it is not a specified bank product.

One of those nine new working groups got the charge of defining "insurance" so that it would be clear which "functional" regulator was responsible for a given problem. According to E&Y's meeting recap,

The insurance industry has survived a long time without a clear definition of exactly what constitutes the business of insurance. The blurring of the lines of separation between insurance, banking, and investment products [not to mention health insurance, health care, and health care finance. MCV] has further clouded the issue.

Driven by GLB and dazzled by the idea of convergence between finance and insurance, it is going to hard for the Commissioners to remember that there are other fields affected by those definitions, and that it is not only the baptisms of new products that the definitions apply to but also their funerals. Receivers need to make themselves heard, loud and clear, to accomplish two things:

1. to make sure that the definitions include all of the things we are likely to be expected to liquidate: notably HMO's, entities affiliated with insurers, intermediate holding companies, and what have you; and

2. that we are not saddled with definitions under which we have apparent responsibility to handle entities as to which there is neither the political will or the regulatory muscle to do the job right (notably provider groups on capitation plans, banks selling enterprise risk products, or just about anyone assuming fortuitous risk for a fixed fee paid in advance.)

I guess before we can do that, we need to figure out what we think ourselves about these issues.

A parting shot. According to a survey presented to the "Underwriting Reinsurance Pools Working Group" by the AIA in the wake of the Unicover mess, 755 of the responding workers comp insurers ceded carve-out business to life insurers. 10% of the same group thought it was important to maintain this capacity. Can anyone spell "opportunistic?"

ex rel Gerber v. Central Cas. Co., 37 Ill.2d 392, 226 N.E.2d 862 (1967) (scope of liquidation court's jurisdiction); In re Knickerbocker Agency, Inc., 4 N.Y.2d 245, 251-54, 149 N.E.2d 885, 889-91 (1958) (liquidation court's jurisdiction); Georgia Insurers Insolvency Pool v. Moore, 175 Ga. App. 430, 433, 333 S.E. 2d 383, 385-86 (1985) (definition of claim); Langdeau v. United States, 363 S.W.2d 327, 332 (Tex. Civ. App. 1962) (allowance of post-petition interest on a claim); In re Liquidation of Integrity Ins. Co., 231 N.J. Super. 152, 159-60, 555 A.2d 50, 53-54 (1988) (formation of creditor constituency committees). See Trustees of Amalgamated Ins. Fund v. McFarlin's, Inc., 789 F.2d 98, 101 (2d Cir. 1986); In re Armorflite Precision, Inc., 43 B.R. 14, 16 (Bankr. D.Me.), *aff'd* 48 B.R. 994 (1984).

5 See Trustees of the Amalgamated Ins. Fund v. McFarlin's, Inc., 789 F.2d at 101; In re Mammoth Mart, Inc., 536 F.2d 950, 954 (1st Cir. 1976); In re Cardinal Indus., Inc., 151 B.R. 833, 836-37 (Bankr. S.D. Ohio 1992); In re Armorflite Precision, Inc., 43 B.R. at 16-17.

6 See Denton & Anderson Co. v. Induction Heating Corp., 178 F.2d 841, 843-44 (2d Cir. 1949) (commission earned pre-filing but payable post-filing not entitled to administrative expense priority); In re Fagel's Corp., 1995 Bankr. LEXIS 1582 (No. 95-60545, Bankr. N.D. Ohio, Sept. 22, 1995) (agent's commission for pre-petition sale not administrative expense because it relates to pre-petition services); In re Dynacircuits, L.P., 143 B.R. 174, 177 (Bankr. N.D. Ill. 1992) (sales commission not administrative expense when sale made prior to filing); In re Precision Carwash Corp., 90 B.R. 34, 37-38 (Bankr. E.D.N.Y. 1988) (fact that payment may be dependent on post-petition contingency is "irrelevant").

7 See In re Sherman, 627 F.2d 594, 595 (2d Cir. 1980) (trustee of bankrupt agent had no right to commissions where insurer had right of setoff to commissions by virtue of pre-bankruptcy mutuality); In re Tomer, 147 B.R. 461, 472 (S.D. Ill. 1992) (right to commissions clearly rooted in pre-bankruptcy past and thus not excluded from property of the estate as earnings for post-petition services); Mutual Trust Life Ins. Co. v. Wemyss, 309 F. Supp. 1221, 1230-32 (D. Me. 1970) (trustee would be entitled to renewal commissions from bankrupt agent but insurance company had right of setoff); In re Fahys, 18 F. Supp. 529, 530 (S.D.N.Y. 1937) (Patterson, J.) ("Commissions due the bankrupt on premiums received by the insurance company on policies placed by the bankrupt [agent] before bankruptcy pass to the trustee in bankruptcy, and it does not matter that the premiums were received after [the agent's] bankruptcy . . ."). See also Bigbie v. Bigbie, 898 P.2d 1271, 1273-74 (Okla. 1995) (right to renewal commissions is property of agent's marital estate and part of pre-divorce history); Niroo v. Niroo, 313 Md. 226, 235-237, 545 A.2d 35, 39-41 (1988) (renewal commissions "part of compensation package developed during the marriage"); Pangburn v. Pangburn, 152 Ariz. 227, 230, 731 P.2d 122, 125 (1986) (right to renewal commissions is earned during coverture and constitutes community property); Skaden v. Skaden, 19 Cal. 3d 679, 687-88, 566 P.2d 249, 253 (1977) (agent's termination benefits are form of deferred compensation for services rendered and are part of property subject to division).

8 See, Liberty National Ins. Co. v. Reinsurance Agency, Inc., 307 F.2d 164 (9th Cir. 1962); Myers v. Protective Life Ins. Co., 342 So.2d 772, 777, 778 (Ala. 1977); Security National Bank v. Educators Mut. Life Ins. Co., 265 N.C.86, 143 S.E.2d 270 (N.C. 1965); Palmer v. Peoria Life Ins. Co., 376 Ill. 517, 34 N.E.2d 829 (1941).

9 The Cockrell case could more plausibly have been decided on the theory that the rehabilitator had implicitly ratified the agency agreements by continuing to enjoy the premiums for such a long period. While this theory also has certain problems, it would have been a better basis for the decision. Also, it should be noted that the decision rests on General American Life Ins. Co. v. Roach, 179 Okla. 301, 65 P.2d 458 (1937), which has been widely rejected. In that case, the Oklahoma Supreme Court held that an agent had a property interest in commissions based, in part, on provisions in the agency agreement which required the Company to separate premiums from commissions. The Oklahoma federal district court rejected Roach in Roush v. National Old Line Ins. Co., 453 F. Supp. 247, 252-53 (W.D. Okla. 1978). Outside Oklahoma, Roach was rejected in the Protective Life and Educators Mutual Life cases cited earlier in the main discussion, and the reasoning in Roach has been rejected by other courts as well. See, e.g., Canada v. Allstate Ins. Co., 411 F.2d 517, 519 (5th Cir. 1969) (under Florida law agent has no vested right to commissions); Wallman v. United Cas. Co., 147 F.2d 636, 637 (3d Cir. 1945) (no vested or property right to commissions and distinguishing Roach); Quist v. The Guardian Life Ins. Co., 453 F. Supp. 842, 844 (D. Ariz. 1978) (no vested interest in commissions after termination); Anderson v. Farm Bureau Mut. Ins. Co. of Idaho, 112 Idaho 461, 469-70, 732 P.2d 699, 707-708 (1987) ("Well settled that an insurance agent has no vested right to compensation under an agency contract after termination"); Wallace v. Hatem, 29 Md. App. 237, 243, 348 A.2d 879, 883 (1975) (agent contract creates debtor creditor relationship).

10 See, Frontier Ins. Serv., Inc. v. Nevada, 109 Nev. 231, 849 P.2d 328, 332-33 (1993); Superintendent of Ins. of New York v. Baker & Hostetler, 668 F.Supp. 1057, 1060 (N.D. Ohio 1986), *aff'd*, 826 F.2d 1065 (6th Cir. 1987); In re Consolidated Indem. & Ins. Co., 38 N.E.2d 119, 120 (N.Y. 1941); See also Charles W. Virgin Ins. Agency, Inc. v. Alabama General Ins. Co., 114 So.2d 524, 525 (Fla Ct. App. 1959).

11 See, e.g., Insurers Rehabilitation and Liquidation Model Act §§ 16, 18E; Health Maintenance Organization Model Act § 21A.

12 See, e.g., 1999 Conn. Legis. Serv. P.A. 99-9 (to be codified), amending Conn. Gen. Stat. § 38a-194(c)(3).

13 See Neblett v. Carpenter, 305 U.S. 297, 304-305 (1939) (plan must provide creditors at least as much as they would get in a liquidation), *aff'g* Carpenter v. Pacific Mut. Ins. Co., 10 Cal. 2d 307, 335-336, 74 P.2d 761, 778 (1938) (plan does not improperly discriminate if creditors get as much as they would in liquidation); Foster v. The Mutual Fire, Marine and Inland Ins. Co., 531 Pa. 598, 613, 614 A.2d 1086, 1093-94 (1990) (creditors must fare at least as well in a rehabilitation as they would in liquidation), *cert. denied* 506 U.S. 1080 (1993); In re Executive Life Ins. Co., 32 Cal. App. 4th 344, 356, 475-76, 38 Cal. Rptr. 2d 453, 459, 471-72 (1995) (rehabilitator's discretion in rehabilitating insurer must be exercised in the public interest and in a non-arbitrary and non-discriminatory way); Smith on Receivers, § 602 at 1695 ("With general creditors of the debtor . . . as with the members of every other class of receivership claimants, the general rule is that 'equality is equity.' The court will not permit one general creditor to obtain an inequitable or unlawful preference over other general creditors").

14 See Bank of America Nat'l Trust & Sav. Ass'n v. 203 North LaSalle St. Partnership, 119 S.Ct. 1411 (1999); Case v. Los Angeles Lumber Products Co., 308 U.S. 106, 115-117 (1939) (rule of "absolute priority" prohibits favoring one class over a more senior class in equity receiverships); Louisville Trust Co. v. Louisville N.A. & C. Ry., 174 U.S. 674, 684 (1899) (preferring stockholders over unsecured creditors would be "a travesty upon equity proceedings"); Minor v. Stephens, 898 S.W.2d 71, 78 (Ky. 1995) (priorities must be observed to advance policy of rehabilitation statute — protection of policyholders); Bohlinger v. Zanger, 306 N.Y. 228, 234, 117 N.E.2d 338, 341 (1954) ("Upon insolvency, assets must be equally distributed among general creditors without preference or priority."); McConnell v. Industrial Indem. Co. (In re Interstate Indem. Co.), 219 Cal. App. 2d 809, 815, 33 Cal. Rptr. 418, 422-23 (1963) (insurance company conservator must pay claims according to statutory priorities); cf. United States v. Noland, 517 U.S. 535 (1996) (courts cannot upset statutory priorities); White v. Alaska *ex rel* Block, 597 P.2d at 176 ("Absent inequitable conduct of a claimant, a court is without power to consider the general requirements of equity in setting priorities among creditors").

15 See In re FCX, Inc., 60 B.R. 405 (E.D.N.C. 1986) (allowing payment of pre-petition wages because priority established by Congress but not allowing payment of other general non-priority unsecured claims). See also, Official Committee of Equity Sec. Holders v. Mabey, 832 F.2d 299, (4th Cir. 1987) (creation of emergency treatment fund for Dalkon shield claimants, prior to allowance of claims of women who would benefit from the fund, and prior to confirmation of debtor's plan of reorganization, was a violation of the Bankruptcy Code which could not be justified as an exercise of court's equitable powers). See also, In re Chateaugay Corp., 80 B.R. 279, 280 (S.D.N.Y. 1987) (allowing the payment of certain pre-petition wages, salaries, expenses and benefits); see also In re Sharon Steel Corp., 159 B.R. 730, 736-37 (Bankr. W.D. Pa. 1993).

16 See, Russell A. Eisenberg & Frances F. Gecker, The Doctrine of Necessity and its Parameters, 73 MAEQ. L. Rev. 1, 2-5 (1989).

17 Id. at 3.

18 See In re Ionosphere Clubs, 98 B.R. 174, 175 (Bankr. S.D.N.Y. 1989) (holding that the payment by federal bankruptcy debtor of pre-petition wages and benefits of its active employees did not mean debtor must also pay same claims of its striking employees); see also In re NVR L.P. (Bankr. E.D. Va. 1992) (holding that pre-plan payment for ongoing consulting services not essential to federal bankruptcy debtor's operations and so not authorized).

19 See Health Maintenance Organization Model Act § 13D; see also, Conn. Gen. Stat. § 38a-193(c) (1999).

20 Insurers Rehabilitation and Liquidation Model Act § 18A; Health Maintenance Organization Model Act § 21.

21 See 11 U.S.C. § 365(b) (providing that a trustee may not assume an executory contract that is in default unless the trustee cures and compensates for any such default, and provides adequate assurance of future performance under the contract to the nondebtor). See also In re Superior Toy and Manufacturing Company, Inc., 78 F.3d 1169 (7th Cir. 1996) (trustee must demonstrate the ability to cure defaults and make future payments under the contract).

22 The Insurers Rehabilitation and Liquidation Model Act does not require the receiver to obtain court approval of a decision to affirm or disavow a contract. This differs from 11 U.S.C. § 365 which requires a bankruptcy trustee to seek court approval before assuming or rejecting an executory contract.

23 See NLRB v. Bildisco & Bildisco, 465 U.S. 513, 531-32 (1984). See also, In re Village Rathskeller, 147 B.R. 665, 671 (Bankr. S.D.N.Y. 1992); see generally Stewart Title Guaranty Co. v. Old Republic National Title Ins. Co., 83 F.3d 735, 741 (5th Cir. 1996).

24 See City of Covington v. Covington Landing Ltd. Partnership, 71 F.3d 1221, 1227 (6th Cir. 1995) (holding that 11 U.S.C. § 365 should not apply strictly when other parties to the contract negotiate and agree with the debtor to modify its terms).

25 See In re Lumber Exchange Bldg. Ltd. Partnership, 968 F.2d 647 (8th Cir. 1992) ("There is some authority for the proposition that a plan may classify trade creditors separately from, and treat them more generously than, other creditors if doing so is necessary to a debtor's ongoing business."). See also, Hanson v. First Bank of South Dakota, N.A., 828 F.2d 1310, 1313 (8th Cir. 1987); In re Greyston III Joint Venture, 995 F.2d 1274 (5th Cir. 1991); In re Hillside Park Apartments, L.P., 205 B.R. 177 (Bankr. W.D.Mo. 1997).

26 See, e.g., In re Wabash Valley Power Ass'n, 72 F.3d 1305 (7th Cir. 1995), *cert. denied*, 519 U.S. 965 (1996).

27 See In re Boston Post Road Ltd., 21 F.3d 477, 481 (2nd Cir. 1994) *quoting* In re Greystone III Joint Venture, 995 F.2d 1274 (5th Cir. 1991).

28 See Conn. Gen. Stat. § 38a-907(a)(1)(1999).

29 See, e.g., In re Gunter Hotel Associates, 96 B.R. 696, 700 (Bankr. W.D. Tex. 1988); In re El Paso Refinery, L.P., 196 B.R. 58, 72 (Bankr. W.D. Tex. 1996).

30 See, e.g., In re Stanndco Developers, Inc., 534 F.2d 1050 (2d Cir. 1976).

31 See Fed. R. Civ. P. 65. See also In re Eagle-Picher Indus., Inc., 963 F.2d 855, 858 (6th Cir. 1992).

32 See David S. Meyer, et al. v. DayMed Health Maintenance Plan, Inc., No. 99 CVH03 01866, Ohio Comm. Pls., Franklin Co.

33 See id. at 336.

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