The INSURANCE RECEIVER

Promoting professionalism and ethics in the administration of insurance receiverships.

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The International Association of Insurance Receivers

1991 - 2001

10th Anniversary

President's Message

By Robert Craig

Robert Craig

After this publication our readers will have to settle for the bad sentence structure and misspelled names to be found in my occasional substantive articles. In its wisdom the IAIR board has elected Liz Lovette to serve as our 2001 president. Clearly a step forward.

By way of statistics for the few of you who may not know Liz, she is the chief guru of the Indiana Insolvency Division. For the past two years Liz has served as Chair of IAIR's Accreditation and Ethics committee and has managed to shepherd through the restructuring of the accreditation program itself.

As for me, I've moved on. Having passed the presidential baton, I've also departed my firm of thirty years to establish a smaller practice with offices in Omaha and Atlanta. Although the transition caused me to miss the annual insolvency program in St. Pete, I should be back in stride by Nashville.

Now that I no longer wear the mantle of the presidency, I know that I'll miss Joe Scognamiglio's offers to kiss my ring. I'll miss the captive audiences who have tolerated my twisted sense of humor and the chance to slip pictures of my kids into power point presentations. I'll miss the opportunity to wax eloquently at board meetings on why IAIR should initiate certain projects, with board members hanging on my every word just before they summarily reject my suggestion.

All this being and not to sound trite, but my two years as president have been a gas. The opportunity to meet a lot more of our members. The opportunity to represent IAIR before the American Bar Association, the NAIC and the International Association of Insurance Fraud Agencies. The opportunity to speak in London and Brussels to introduce IAIR to those on the other side. And, much more.

Thank you.

Get involved.

A SPECIAL THANK YOU

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

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The ***INSURANCE RECEIVER***

Volume 9, Number 4

Winter 2000

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Washington Other News & Notes

By Charles Richardson

The White House Condition

As this article is being written, President Bush is enjoying a honeymoon of sorts, built upon his attempt to reach out to Democrats and Republicans alike in a spirit of bipartisanship not seen in Washington for several years. By the time you read this article, that honeymoon may have ended in a bitter divorce, but at least for now, there seems to be more of a genuine dialogue about pubic policy and less attempt by partisans to chop each other up. Of course, the President is helped by the continuing missteps by former President Clinton, Senator Hillary Clinton, and members of their respective families. Members of the Bush team must be thanking their lucky stars that President Clinton didn't leave quietly.

Big Changes on Capitol Hill

To the surprise of even those inside the Beltway, the House of Representatives approved radical changes in committee jurisdictions. Insurance and securities were moved from the House Commerce Committee (which assumed its previous name, the House Energy and Commerce Committee) to the newly formed House Financial Services Committee. Congressman Michael Oxley (R-OH) followed, becoming chair of the Financial Services Committee. Insurance, securities, and government sponsored enterprises were placed in a "super" subcommittee to be chaired by Richard Baker (R-LA). Republican committee members have been named and the remaining subcommittee chairs selected - check out the Committee's home page, www.house.gov/banking. Democrats are expected to follow soon. Chairman Oxley has indicated his agenda for this session and has stated he will be examining the issues surrounding state regulation of insurance and federal chartering.

Passage of Client's Bill of Rights

With the Bush Administration, we may soon see the passage of a federal patients' bill of rights, including the right to sue HMOs. During the presidential debates, Mr. Bush indicated his support for comprehensive patient protections, including the right to sue HMOs. Under his watch, Texas enacted a law that guaranteed independent review of insurers' decisions on medical necessity. Patients used that Texas law to challenge the decisions of HMOs and insurers 996 times from November 1997 to July 2000. The independent reviewers reversed the insurers' decisions in 50 percent of the cases, overturned parts of the decisions in 7 percent of them and upheld the decisions in 43 percent of cases. A federal appeals court struck down that Texas law, but another federal appeals court upheld a similar law adopted in Illinois. With conflicting court decisions on state patient protections and the Bush Administration's support for comprehensive patient protections, congressional lobbyists are now saying that the question is no longer whether Congress will make it easier for patients to sue HMOs, but how to define the new right.

More Privacy Regulation

Under the Gramm-Leach-Bliley Act's new threshold privacy requirements, financial institutions must provide customers with written privacy policies and allow customers to opt out of information sharing. On top of this regulation, which commentators have characterized as "particularly stringent," states are allowed to impose additional requirements. The NAIC's new model privacy regulation (Privacy of Consumer Financial and Health Information Regulation), if adopted by states, will require affirmative consumer consent for disclosure of protected health information and substantially expand the definition of a "consumer". There is a competing model being touted by the National Conference of Insurance Legislators as being "the more balanced, cost effective and less bureaucratic approach" to consumer privacy. In short, the debate over privacy regulation at the state level will continue throughout ***2001.*** And, Congress itself may way in with changes at the federal level in the soon-to-be effective GLB requirements.

IAIR Roundtable Schedule

NAIC Meeting - March 24 - 28, 2001
Nashville, TN
IAIR Roundtable
March 24, 1:00 - 4:00 p.m.

NAIC Meeting - June 9 - 13, 2001
San Francisco, CA
IAIR Roundtable
June 9, 1:00 - 4:00 p.m.

NAIC Meeting - September 22 - 26, 2001
Boston, MA
IAIR Roundtable
September 8, 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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Boston Meeting Recap

By Mary Veed

I had some trouble with this quarter's recap. as I was settling down to write it (late, as usual), my doctor's office called and said that my sore wrist (caused by a sudden and unwelcome encounter with the garage floor, during the first of our superfluity of chicago snowstorms) in fact contained a broken little bone, which they proposed to cast. so now I can only capitalize things on the right half of my keyboard, and then only at half speed, and it looked to be a long, slow project. but while I was trying to cope with my frustration, I heard a rustling sound from the chaos that normally dominates my desk.

that's where i decided to make an appearance. my name is archy iv. my great-great-grandfather was archy the cockroach who lived in a pile of forgotten sheets of half-written poetry on the desk of don marquis, a poet and columnist in the new york evening sun during the '30's. like me, he did his typing by leaping onto the typewriter keys. he couldnt write unless marquis left a piece of paper in the machine when he went to bed. lucky for me the computer screen never runs out of paper. he was a poet; i am an insurance observer. but neither one of us goes in for capitalization -cant hit two keys at once-or punctuation - too far to jump unless absolutely necessary.

this time i caught a ride to boston in the totebag of an insurance receiver but he dumped me out while he was searching for the changes to the printed program sheet in a vain attempt to figure out where the iair annual meeting went. I found more peaceful quarters in marys bag-she never looks in the bottom - and was only discovered because with the cast on her hand she couldnt pull out her boston file without turning the bag upside down. once she got over the shock i asked her what she was writing.

well, the roundtable didn't meet, the bigwigs were distracted with election politics, and Meg fletcher will have already written about carfra and Narab. They held a terrific seminar about gLb, but steve durish will be writing about that.

what should i write about boston, archy?

maybe you should let me explain what is really going on behind all that glitter and tinsel at the naic, and why it displays such a remarkable degree of durability in spite of all rational objection. for years now, you've watched your colleagues get vaguely shifty-eyed when the subject of rationalizing insurance regulation came up.

great idea if you can do it. Insurance is obviously a national, not to say international business. It's nonsensical to chop up its regulation into fragments, as we do. It would be so much more orderly and organized to create a single regulatory body that could apply simple, straightforward rules, streamline the process, and encourage a neat and tidy exchange of premium and risk. bancassurance, post gLb, almost calls out for such a solution. so why don't we quit dodging and ducking, and capitulate to the inevitable?

of all the attempts to explain your reluctance to hop on the federal bandwagon, the one that is nearest the truth is rarely articulated - that it just wouldnt make any difference. contrary to the delusions of dirigists around the world regulation does not control the insurance market. at best it influences it; at worst it is irrelevant. with thousands of companies billions of buyers and hundreds and hundreds of different products constantly adjusting in the ceaseless struggle for market share and a good underwriting ratio insurance is not so much an industry as a marketplace.

as with any market, one counts his

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Insurance Insolvencies: The Reinsurer's View

By Jack Cuff

Introduction

The relationship between a reinsurer and a cedant is meant to be a mutually beneficial partnership. It is characterized by a high degree of trust and good faith dealings. But when the reinsured company gets into financial difficulty and ultimately fails, that relationship can change overnight. The bond is loosened; the benefits are no longer mutual; and, the level of trust between the parties often declines.

For most of those involved with the insolvent reinsured-its policyholders, employees, investors, brokers, officers and directors-the failure of the company is an unmitigated calamity quite apart from any changing relationship with the company's reinsurers. Coverages, jobs, investments and careers are lost. To those directly involved with the sinking enterprise, whether the company has a strong relationship with or can recover from its reinsurers is of secondary importance, and best left to the appropriate regulator to address.

For the reinsurer of the insolvent, on the other hand, the significant change in the relationship can be a mixed blessing. No reinsurer deliberately begins a relationship with a cedant that is clearly headed towards liquidation. But the failure of the ceding company can surprisingly bring some financial benefits as well as the expected headaches.

In the following section, we discuss the storm clouds that gather over the reinsurer when its cedant fails. Later, some unexpected silver linings are pointed out.

The Storm Clouds Gather

Once the ceding company is declared insolvent and a receiver for the estate is named, the company is transformed. It has changed from an ongoing insurance enterprise to a ghost of its former self, under state supervision with the receiver standing in the shoes of the insolvent.

To the reinsurer, the cedant isn't the same cedant anymore. Before insolvency, it investigated and mitigated policyholder claims; now that it has become insolvent, it is sometimes perceived as searching for claims . Before the cedant asked for money only when it actually paid a claim; now it asks for reimbursement even though it has not actually paid anything. Once the cedant tried to commercially resolve disputes with its reinsurers informally; now litigation and arbitration are commonplace. Previously, the cedant protected the reinsurer from excessive financial shocks; nowadays it tries to engineer a commutation of the entire reinsurance contract. Formerly, the cedant would not draw down on a letter of credit; now it may threaten to do so.

Previously, the companies could set off losses against premium; that has changed-the insolvent may now want to hold on to any premium for as long as possible but have the reinsurer pay all losses as well. To sum up, before insolvency the cedant was a business partner of the reinsurer; now it is a cash flow drain and a burdensome administrative strain.

There are other drawbacks for the reinsurer. Valuable resources, such as time, staff, office space and money for travel costs, are devoted to winding down obligations under the terminated reinsurance contracts. These resources would otherwise be better used for working with continuing profitable active cedants. Trust and agreement between the parties is often at low ebb, so more expenses are incurred to monitor claim handling and litigate or arbitrate disputes.

Reserves stay on the reinsurer's books longer because of inherent delays and uncertainty and because the liquidator needs more time to get organized. There is also a danger of damaging the reinsurer's reputation as a dependable, promptly paying partner because of the increasingly public and antagonistic disputes with the insolvent reinsured. In short, the environment is less predictable and more hostile for the reinsurer.

Involvement with a failed ceding company leads the reinsurer from the familiar world of private enterprise to the alien environment of government regulation, politics, and close public scrutiny, where all the rules seem to be turned on their head.

With normal cedant/reinsurer relationships, the goal of both parties is to have a longstanding mutually profitable relationship. With insolvency, the goals diverge. The receiver is seeking generally to (1) fix the estate's liabilities; (2) marshal its assets; and, (3) wind down the estate as promptly but as fairly as possible. The reinsurer, on the other hand, is trying to become disentangled from the estate with the least damage in losses and expense costs.

The Reinsurer's Silver Lining-Paying Less and Paying it Later

For the reinsurer, there can be a brighter side: lower settlements and delayed payments. These often are the advantages of a cedant's failure. For many insolvencies, especially those with long tail exposures, it is certain the reinsurer would have paid more money more quickly if the company had survived. The ceding company's failure generally throws a monkey wrench into the process, creating confusion and discouraging claimants from filing their claims in the first place or at least dampening their enthusiasm to pursue their claim.

Lower Payments. Policyholder settlements with receivers are often lower than they would have been on an identical claim with a solvent company. Reinsurers, of course, benefit from this phenomenon. Here are some of the reasons:

- Liquidations impose claim bar

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Boston Meeting Recap

(Continued from page 4)

own venture into that market a success if he obtains what he, in particular, needs, when he needs it, at a price he considers fair. so you see a market is built of millions of individual uniquely motivated transactions, which only form a pattern if viewed from some distance. up close theyre like the dots in my great-great-grandfather's newspaper picture or the pixels on this computer screen -- unrelated, dissimilar, and meaningless static.

all the same the pattern is real. take health insurance. recently it has gotten more and more expensive -- expensive, people thought, out of proportion to its economic value - i.e. the sum of the prices of the medical services people used it to buy. buyers became reluctant and sellers were compelled to offer terms which were at least different, if not better.

regulators natually responded to market pressures by relaxing constraints to permit those different terms, and so was born the hmo. but the problem was that the fundamental conflict between what health care was actually costing and what buyers thought it ought to cost was still there and no amount of structural legerdemain could resolve it. what ensued was what the mathematicians call a process of approximation, as the managed care folks attempted one form or another of offering less product for the same money. some of their initiatives were reasonably well tolerated - the market considered the exchange good value for money. some were not - drive through deliveries, limited formularies, limits on intensive treatment. those ended up on 60 minutes, and more or less promptly disappeared from the managed care arsenal. the market held that money saved by those techniques was money better spent. look at what happened when they tried to control medical decisions without legal - read malpractice - responsibility for the consequences. buyers were unhappy but lacking a more practical outlet to express their disapproval went to legislatures and congress in an attempt to obtain a better product.

Of course each of these issues was eventually addressed by regulatory and legislative initiatives.

sure but by the time those took effect they were already redundant - today's hmo's advertise that they let the doctors make the treatment decisions and let patients select the doctors even though those measures undoubtedly add to medical costs, and represent a relinquishment of part of the capacity to "manage" care that is supposed to be their unique advantage.

I guess from the insurer's point of view, these debates have served the useful purpose of narrowing the gap between cost of health care and perceived value: by reminding people of how much they dislike having to do without a particular feature, these attempts at reduced service have caused buyers to assign increased value to health insurance products that do have the feature in question. Or to put it in plain english, now that they know how important these things are, they are willing to pay more to get them.

the same thing happened to insurer credit quality in 1985 and 1991 when buyers discovered that cheaper insurance was not always better.

fair enough, but what does that tell us about the NaIc, and the process of state regulation in general?

don't newcomers to these meetings always grouse that so little seems to get done in the meetings themselves? the action is all in the hallways. and it is curious that so much effort is expended on the creation and improvement of model laws almost ignoring the fact that they will only take effect if adopted intact by dozens of state legislatures. you could say that the naic process is a gigantic waste of time better spent at home.

but still they come. why?

i think the naic is doing exactly what it ought to be doing and doing it well. it is busy governing the insurance market in the only way that will actually get the job done - by developing consensus and shared understanding. at these meetings legions of insurance department staff and even larger legions of company representatives are busy passing on their understanding of how the insurance market works - what's new what works where the tricky parts are who's capable who can't be relied on what the looming trouble spots are. at the same time they are exerting their influence over each other - regulators communicate their biases suspicions and sensitivities while companies demonstrate both the practical impact of whatever is suggested and what they are willing to offer to address the concerns of the regulators. at the same time the companies are learning what their competitors are prepared to do in the same cause and all are deliberately and otherwise exchanging information about what they think their consumers think of it all.

Once in a while, a customer even appears in propria persona, but no one pays much attention.

one customer doesnt prove much any more than one pixel does. really though, the regulators and companies represent consumers by proxy - the regulators both because they are consumers themselves and because they and their legislative bosses receive complaints and suggestions, the companies when they detect and try to meet a consumer need.

It all makes sense. In the last 15 years, the guiding principle of the NaIc has changed from protection of the ignorant consumer through rigid rules and regulations to a full disclosure/assumption of the risk approach which seeks to put information in the hands of insurance consumers and relies on them (and their advisors) to judge whether proposed insurance is fiscally responsible, has suitable terms, and is fairly priced. with the greatest respect to the decisionmakers, I don't see that solely as the result insurance regulatory leadership. It has happened because the market, having experienced deregulation in other fields, demanded it, and continues to demand it, in insurance. More sophisticated, better educated, that market has insisted on the right to decide for itself whether rates are excessive, or whether insurance from a wobbly insurer at a bargain price is better than expensive insurance from a stable one. the same market has relentlessly pressed for the capacity to purchase insurance on its own terms, even though in so doing it may forfeit the security and predictability of tried-and-true policy forms that simply

don't fit the need.

but surely there's an easier way for the market to learn the value or lack of value of insurance than the draconian school of the marketplace? Must we have recurrent nationwide solvency crises to prevent people from buying underfinanced life insurance?

of course not --because in the hallways and working groups of the naic they've conducted dress rehearsals of every scenario, and in early adopter states they have tried their new creations off-broadway before rolling them out nationwide. they still make lots and lots of mistakes; they just don't make many big ones.

by the time a new idea is ready for wide regulatory application, most of the bugs have emerged and been dealt with, and, if the idea is a good one, the market has adopted it long before the regulators require it.

right, except i think you mean glitches. and that is why, to come around to the original question, it is a waste of time to develop new model laws by contentious votes and executive session meetings, and why for successful model law efforts the actual legislative adoption of the model always seems anticlimactic.

and of course its also the reason why a federal insurance regulator would not change much. a federal insurance czar would be faced with the same chaotic market and would understand or rapidly learn about the economic distortions that result from trying to compel the insurance market to go where it does not want to go. like todays commissioners the insurance czar would have to find ways to conduct dress rehearsals and pilot runs, to elicit feedback, and most of all to develop consensus. if they killed off the naic in the process of building a federal insurance system the insurance czar would have to reinvent it.

Obviously, you've learned a lot from the bottom of that totebag. the "orderly" market so beloved of proponents of rate regulation (as well as currency controls, milk price supports, and the european agricultural Policy) is really an oxymoron. efficient markets are messy, and a federal insurance law wouldn't make them any less so.

so what was the best part of the meeting, from your point of view?

that's easy. hal horwich's health care task force meeting with that great lunch. you mixed enough breadcrumbs and cookies in your notes to feed my family for a week exclamation point and the discussion was terrific. its amazing how much more sophisticated the group has gotten since it was formed just a short while ago. mind if i tag along to nashville question mark.

absolutely. I bet you'll see lots of friends there. and I want to congratulate (and extend sympathy to) the new IaIr officers and board members, and thank bob craig and the retiring board members for their hard work.

"Reserve The Date"

The NCIGF Legal Seminar has been scheduled for August 23-24, 2001 at the Hyatt Regency Hotel, Fishermans Wharf, San Francisco. This seminar will provide a forum for presentations on critical legal issues and challenges currently facing the property and casualty guaranty funds.

AUDIENCE & SPEAKERS: This seminar is of interest to guaranty fund managers, attorneys with an insolvency or guaranty fund practice, receivers and others who are involved in insurance insolvency matters or who would like to know more about this topic. Presenters will be lawyers and other professionals with extensive experience in these areas.

CONTINUING LEGAL EDUCATION: This program is expected to qualify for Continuing Legal Education credit. The requisite forms will be available at the seminar.

To assist in estimating the number of attendees we ask that you indicate your interest in attending this seminar by notifying by telephone, fax or email Kelly Barr, National Conference of Insurance Guaranty Funds, 10 West Market Street, Suite 1190, Indianapolis, IN 46204, Phone: 317-464-8187 Fax: 317-464-8180

Email: kellyncigf@aol.com

Please include your name, address and phone number in your fax or email. Registration material will be forwarded to you in June. ***Please pass this information along to others you feel may be interested in attending this seminar.***

ANNUAL MEETING
June 14 and 15, 2001
Budapest, Hungary

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News From Headquarters

Happy 10th Anniversary, IAIR

The International Association of Insurance Receivers is celebrating our 10th anniversary in 2001. Formed on September 6, 1991, we held our first official meeting at the December 1991 NAIC meeting. During the upcoming year we will mark this auspicious occassion with a special 10th anniversary logo, a special section in the newsletter for "Remember When" stories and photographs, and special displays at the quarterly meetings. Then at the December meeting in Chicago, we will have an anniversary dinner. Karen Weldin Stewart, CIR-ML, of the Weldin Group is chairing the 10th Anniversary Committee. She was a founding member and IAIR's first president. If you would like to work on this committee or if you have old photos for our use, please contact Karen at kws-weldingroup@home.com.

2001 Officers & Directors

At the 2000 annual meeting in Boston the following members were elected:

President - Elizabeth Lovette, CIR
1st VP - I. George Gutfreund, CIR, CIP
2nd VP - Daniel A.Orth, III
Secretary - James Gordon, CIR
Treasurer - Mark Femal, CPA, CPCU

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Robert F. Craig
Richard Darling, CIR
Steve Durish
Patricia Getty
Robert Greer, CIR
Michael Marchman, CIR
Dale Stephenson, CPA
Vivien Tyrell

Congratulations to each of you and thank you for agreeing to serve the organization.

Reminder

Annual membership dues must be received by March 31st to be included in the Membership Directory. Please remit your dues as soon as possible.

The recruiting discount and group discounts are still in place. For each new member you recruit during 2001, you will receive a 20% discount on your 2002 dues. If you recruit 5 new members, next year's dues will be free.

The group discount applies to firms with more than three members from the same country and is structured as follows:

4 - 6 members - $135 per member;
7 - 10 members - $100 per member;
Over 10 members - $25 per member.

Take advantage of this discounted membership rate to increase your firm's involvement in IAIR. This also qualifies your employees for the discounted registration rates at IAIR sponsored programs.

Congratulations!!

Jay Deiner

of Ormond Insurance & Reinsurance Management Services, Inc.

and

Paula Keyes

of Paula Keyes & Associates

have obtained the AIR designations.

Insurance Insolvency in the United Kingdom and the United States Compared and Contrasted

By Philip J. Singer, CIR - ML

As a frequent visitor to this fair land for many years, I have always been received here with warmth and courtesy, even in New York, and I've made a lot of good friends here. Therefore, as you read this offering, you might think that my remarks perhaps hint of a little criticism and/or possibly a degree of chauvinism. Instead, please recognize that it is drafted in a spirit of friendship and cooperation between friends and colleagues.

History

As to the issue before us, it is clear to me that the winding up of insurance companies is handled quite differently in the United States compared with the United Kingdom. Those of you who have had the experience of insolvencies of insurance companies in the UK will, I think, agree that there is certainly some merit in the way in which we handle things. So, how did our system develop? Well, it started with the Victorians. That's not the Victorians in Australia nor the Victorians in British Columbia, but my forebears of one hundred or more years ago in the United Kingdom.

Their image is of a staid and stuff generation, repressed and hidebound by rules of social convention, and generally dull and boring. But that really is a false image. The Victorians were exciting, adventurous and on the leading edge of technology. They built roads and railways, tunnels and bridges, iron ships that floated and, while they were at it, they created the largest Empire the world has ever seen.

I think the Victorians have had a pretty poor press and I'd like to do a little to correct that image. In doing so, it is inevitable that I have to observe that it is a truth universally acknowledged, that God is an Englishman.

One need only consider the blessings that he has bestowed upon England to demonstrate that fact. He has given us cricket, rugby, warm beer and a system for winding up the affairs of troubled companies that is the envy of the civilised world. Indeed much of the civilised world, including the United States, Canada, Bermuda and Australia, base their insolvency procedures broadly on the UK's.

So back to the Victorians, they really did some quite stunning things. For a start they recognised that the insolvency of a corporate body ought to be handled differently from the insolvency of a warm body and therefore in 1849 or thereabouts they introduced the idea of liquidation for companies, with corporate insolvencies being dealt with under the Companies Acts, and leaving the bankruptcy statutes in place to deal with the insolvency of private individuals.

Gentlemen called Official Assignees handled the bankruptcy of such individuals and to say that they were a pretty rough and ready bunch would be perhaps understating things. Not to put too fine a point on it, many of them were frankly corrupt and, indeed, things got so bad that no gentleman would handle bankruptcy work.

Now, since all lawyers are gentlemen, they abandoned the practice of insolvency in the United Kingdom leaving a bunch of ruffians who called themselves accountants to carry on the trade. A move may I say that has not been mirrored in the United States but is one that in the UK the lawyers have regretted ever since.

The accountants themselves, or at least the more respectable of their number became quite worried about things and so they banded together in an association, which in 1880 was granted a Royal Charter, and the Charter in describing their business says "... the profession of Public Accountants in England and Wales is a numerous one and their functions are of great and increasing importance in respect of their employment in the capacities of liquidators acting in the winding up of companies and of receivers under decrees, and of trustees in bankruptcies or arrangements with creditors, and in various positions of trust under Courts of Justice and also in the auditing of accounts of public companies and of partnerships and otherwise". That association is called The Institute of Chartered Accountants in England and Wales and many chartered accountants would be surprised to learn that their great and glorious institute was founded on the practice of insolvency rather than auditing.

In 1883, there was the great reforming Bankruptcy Act, the principles of which remain very much the same today. The Act introduced a new public official called as the Official Receiver who acted under the directions of a Government department known as the Board of Trade. The Official Receivers were there to administer bankruptcies and later on, all insolvencies, whether corporate or personal and the cost of administering the new system was met by a fee levied on each insolvent estate, plus what was supposed to be a small percentage of the assets collected and the interest earned on those assets.

A few years earlier, in 1869 and 1870 to be precise, two life companies, one called the Albert and the other called the European, collapsed, leaving the life savings of tens of thousands of policyholders in jeopardy. The legislation then in existence simply couldn't cope with the complexities of these two insolvencies.

My Victorian forebears came up with a remarkable solution. They passed a special Act of Parliament creating a special arbitrator, with near dictatorial powers to do whatever he thought was necessary to sort out the problems created by the two insolvencies. The arbitrator was a gentleman called Lord Cairns.

Can you imagine Parliament or Congress doing such a radical thing as that today?

This really was leading edge stuff.

It took Lord Cairns 20 years of his life to sort out the mess, and in doing so he created a lot of case law, most of which still holds good today.

Something else happened as a result of

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Creditor Committees, Constituencies and Constitutions

by Douglas Alan Hartz

(Please refer to the charts and graph on pages 19 and 20.)

I was asked to a reply to the article in the last issue of The Insurance Receiver on creditor committees ("CCs"). This is not quite a reply. It is, however, a further inquiry in regard to the work of the Insurers Rehabilitation and Liquidation Model Act Revision Working Group ("MARG") in relation to the points raised in that article. There were many points covered that may be of importance to the MARG where many of the members of IAIR are, as should be expected, very involved. These points deal with certain core principles for insurer receiverships, reflective of constitutional principles[1], which deserve consideration.

Before going further, my "mandatory disclaimers" are that this does not represent the opinion of any department of insurance, receiver or receivership estate that I am or have been connected with in any capacity. To some extent, in relation to raising issues for discussion, this may not even represent my own opinion. I have received some comments on the article on CCs by Tom McCarthy and some of the strong positions taken therein. In regard to this, I should note two things. First, I have also taken strong positions in many an IAIR article, usually to raise issues for discussion and, second, I have recommended to several departments of insurance his law firm and its many fine lawyers who have great expertise in receivership law.

Taking some editorial license, some of the points raised in the article on CCs, roughly in the order raised, are as follows.

1. The wisdom of having the same domiciliary insurance regulator ("DIR") charged with solvency regulation also charged with winding up the receiverships of insurers.

2. The judiciousness of having the DIR (or CC?) "supervised to a greater or lesser degree by the state courts."

3. The advisability of requiring licensed professionals (these could be contract Special Deputy Receivers ("SDRs") or the management in permanent offices (like the OSD in Illinois) to run insurer receiverships for the DIR or CC.

4. If these licensed professionals would be better supervised by the DIR or CCs.

5. If the primary goal of the DIR or CCs is or should be paying claims (as opposed to closing receiverships, maximizing assets or controlling costs) and whether our insolvency codes or statutes impede this goal.

6. If creditors (through CCs or otherwise) should have a say about how an insurer is liquidated (or rehabilitated?).

7. If the DIR or CCs would be more likely to release too much information to the detriment of the estate (for example in reference to commutations and employment contracts).

8. If investment policy and decisions would be better supervised by the DIR (with statutory constraints) or CCs (especially in avoiding speculative investments and potential losses of principal).

9. Whether the DIR or CCs will more readily recognize that each receivership is unique and adjust plans and policies to pay claims, close the estate, maximize assets, and control costs accordingly (especially as to claims estimation, employee retention and long tail reinsurance collection).

10. Whether the DIR or CCs will be more susceptible to criticism (especially as to claims estimation and employee retention).

11. Whether state agencies (the DIR) or CCs are better suited to dealing with what is "clearly a private affair utilizing only private funds."

12. Whether CCs (or the DIR, SDR and those working under them) should "enjoy judicial immunity, as long as they serve as officers of the court under the direction of the supervising judge."

Practically all of the above points were addressed by the NAIC in reviewing the Uniform Receivership Law ("URL") and will need to be addressed further by the MARG. Many of these points relate to some of the core principles the MARG should consider in regard to incorporating the better concepts in the URL into the Insurers Rehabilitation and Liquidation Model Act ("IRLMA").

The Creditors as Directors (Points 6, 8 and 9)

Overall, in the NAIC review of the URL, allowing more participation by creditors (and other interested parties) was shown to be one of the core principles of the URL[2]. What was proposed in the article on CCs though goes beyond mere participation and holds that CCs should govern the receivership in the manner of a board of directors "with true supervising authority" in place of the DIR. The core principle here is that insurer receiverships should be governed - with the creditors having either a voice or the only voice - in a manner that best reflects their nature, probable exigencies and objects. FP-23, 31, 34 and 41.

There are situations where CCs so constituted would be useful. For example, suppose an estate where millions of dollars of loss on speculative investments (highly leveraged) could be avoided by meeting a cash call for as many millions as were originally invested. I never have and never would make such an investment or defend its being made. Albeit, if subsequently confronted with this situation, I would seek to form a CC representing the largest part of the creditor's dollars to approve (or decline) taking such an inherently risky action. Assuming it is a general rule (by statute and case law) that a fiduciary should not even risk a loss of principal on any investment, having a CC consent may be the only way to avoid the certain loss that would result by not meeting the cash call.

On the point about recognizing the uniqueness of each estate and planning accordingly, a CC that is representative of all of the creditors, could provide useful direction. However, there are dangers of factions or a

majority benefiting their interests at the expense of the other or minority interests. FP-10.

Perhaps the MARG should consider revising the IRLMA to specifically allow for a representative role to CCs in insurer receiverships. These CCs should be vested with not just an "advise role" but also with a "consent role" to serve as an additional check[3] and balance to the wide discretion that the DIR or SDR must have in serving the executive role in administrating the estate. FP-9, 48 and 70. For example, another area where the consent of the creditors could be useful is in the area of the appointment and retention (yes, these are new concepts) of the SDR. Receiverships are different from regulation. They are projects with a definite end (like building a bridge) and the SDR as a licensed professional, barring some impeachable offence (like refusing to apply to make distributions), should be able to see the project through to its end and not be subject to removal on a whim or merely because the DIR has changed. FP-71. However, the concept that the DIR should have no role, abrogating entirely to the CC, after an insurer goes into receivership, eliminates checks and balances and seems contrary to the common sense that it is the state that takes over failed insurers and is responsible in some way for winding up their affairs.

The DIR as Receiver (Points 1, 5, 10 and 11)

The state's role in liquidations (and rehabilitations) through its DIR is historic, based on experience, and is grounded in sound public policy considerations. In 1967 in relation to Wisconsin Section 645.04, providing that only the commissioner may commence an insurer receivership, the following comment was provided.

"This section places control of delinquency proceedings in the commissioner and eliminates the possibility of private receiverships or liquidations of insurers, which have historically been wasteful and inefficient. Furthermore, it guarantees that regulatory controls are not cut off or impaired at the very moment of most urgent need, when an insurer is in trouble."

Earlier, in 1939 the drafters of the Uniform Insurers Liquidation Act (UILA) noted that private equity type receiverships of insurers resulted in inefficiencies. The UILA made it a requirement for reciprocity that the DIR be in charge of any insurer liquidations. This was adopted in the Wisconsin Act that served as the first NAIC Model Act and it has been retained in every subsequent NAIC Model and was made a requirement for accreditation of state insurance departments by the NAIC in 1991. That we have been trying to address the problems of the wasteful and inefficient private receivership for a very long time is reflected in the following from the 1876 Annual Report of William S. Relfe, then Missouri's DIR.

...the mode prescribed by law for winding up the affairs of insurance corporations is one which could be vastly improved by proper legislation in the interest of policy-holders. A receivership is almost as fatal to the policy-holder as to the company itself ... The appointment of [a committee of receivers] with their retinues of attorneys, counselors, clerks and stenographers ... constitutes an army of occupation, the costs of whose maintenance is more to be dreaded by the policy-holder than mismanagement on the part of the company's officers. The trust funds accumulated for the old and infirm, the widow and the orphan, are first depleted and reduced by dishonest officers of the company in violation of law, and afterwards consumed, or at least very largely impaired, by the officers of the court according to law."

Insurer receiverships are subject to abuse. The states rely on each other (and require that the DIR must be the receiver for a state to be considered reciprocal and accredited) to guard against such abuse. The states are accountable to do so for many reasons.

First, the primary goal of the regulation of the "business of insurance" is to assure the payment of claims. This is the goal for both solvent ongoing insurers and those in receivership where the need for the assurance is "most urgent." The goal in insurer receiverships is still the regulation of the business of insurance - assuring the payment of claims. The insolvency codes do not impede this goal, but the execution of those codes too often does.

Second, the public in general holds the states accountable based on the common sense that it is the state that takes over failed insurers. Insurance is an industry imbued with a public trust. A strong faith in its integrity is critical to the economy. This is in large part why the states regulate insurers from cradle to grave.

Third, an insurer receivership is a uniquely broad use of state power that is probably not delegable to private interests. This use of state power would possibly not carry into other states if the state through the DIR as statutory receiver were not a party to the exercise of that power. The statutory receiver "is an officer of the State, and as such represents the State in its sovereignty while performing its public duties connected with [an insurer receivership] ... [whose] authority does not come from the decree of the court, but from the statute."[4]

The office of statutory receiver is distinct from the office of the DIR as regulator of the business of insurance. Each office has a different constituency. The office of the DIR as regulator has a constituency generally only in the DIR's state. On the other hand, each estate has its own creditors as the receiver's constituency generally in several different states - which is why the states depend on each other to guard against abuse and protect their policyholders and other creditors.

Based on this interstate constituency, states that do manage their insurer receiverships cannot be expected to look too kindly on states that do not effectively manage their insurer receiverships. Insolvencies affect other state's resident policyholders, third party claimants, state guaranty funds ("SGFs") and ultimately other state's taxpayers. That there can be a detrimental interstate effect is reflected in the positive effect occurring because of the distributions of hundreds of millions of dollars out of the Transit Casualty estate. Guaranty fund assessments that would otherwise be necesswary for newer estates are not being made because of

(Continued on page 18)

Meet Your Colleagues

THOMAS W. ABELL

Tom Abell is the Principal of T. W. Abell & Associates, an insurance consulting firm specializing in procedural and underwriting reviews. Mr. Abell has spent over 40 years within the insurance industry, with experience ranging from Underwriting, Management of Companies, Underwriting operations, Agency and Brokering operations and applicability of Captive Insurers. He has prepared operational reviews and Underwriting Manuals, implementing them to provide Underwriters with a third party independent review. He has knowledge of problems arising from insurance company operations and has consulted with various financial entities as to insurance company operations.

T. W. Abell & Associates works with insurance companies in pre-approving agents and brokers for underwriting authority, and also for periodic reviews of compliance with such granted authority. Mr. Abell works directly with Insurance Companies to develop underwriting manuals and guidelines to enable a better control of the authority given to agents and brokers. In addition, he has developed training manuals for agents and their staff.

Mr. Abell has worked with Regulators and Law Enforcement throughout the world, providing clarification as to Statutes and Regulations and how they should be applied to the local situation. In addition, Mr. Abell has consulted with licensing authorities and regulators as to acceptable standards for insurance company and managing general agency operations. He has reviewed insurance company operations to provide an independent third party review for Regulators.

The business has developed principally from the United States and the Caribbean Basin, and also from Eastern Europe.

Mr. Abell is a member of the International Association of Insurance Receivers and also of the International Association of Insurance Fraud Agencies. He spent part of his career with Marsh & McLennan, which followed insurance company experience both in the United States and Canada. He has been a Named Underwriter under binding authorities from Lloyd's of London and U S Domestic companies.

Mr. Abell was educated in England and has completed various Masters degree level courses in Finance, Management and Communication. He has developed extensive connections both in Europe and the Americas. He contributes periodically to the trade press on matters of local and national interest. He and his wife Susie enjoy living in South Florida, and also visiting their daughters in California periodically.

MICHAEL J. BARATTA

Mike Baratta is a member and president of Vector Consulting, L.L.C. Vector is a management consulting firm that works with underperforming companies in re-positioning operational, financial and management functions. As a Certified Fraud Examiner, Mike has also helped company stakeholders in restructuring financial records by utilizing forensic accounting methods. Additionally, he has considerable experience with assisting in the sale of an entity's stock or assets. Mike has served as a business consultant and as an Assignee for the Benefit of Creditors for insolvent companies.

Over the past fourteen years, he has also worked with state insurance receiver's financial departments. This work included the identification of recoverable assets for insolvent estates to assisting in the development of financial department personnel.

Mike resides in Naperville, Illinois, a suburb of Chicago, though his assignments usually find him somewhere else in the United States or occasionally abroad. He has a Masters Degree in Finance from the University of Chicago's Graduate School of Business and a Bachelors degree in Accounting from Southern Illinois University. He is a Certified Public Accountant, Certified Turnaround Professional and as stated above, a Certified Fraud Examiner.

Mike enjoys attending motor racing and basketball events. He tries to stay in shape by running several days a week and when possible rides his bicycle on weekends. He is currently training to run the Chicago Marathon this fall. His goal is to survive the race and finish and hopefully recover for the winter holidays.

JOSEPH F. SCOGNAMIGLIO

Joseph F. Scognamiglio, President of Quantum Consulting, Inc., has over 23 years of experience in the disciplines of insurance and reinsurance. His company offers reinsurance consulting services to the industry, and he acts as an investment advisor, manager and principal in the acquisition of claims and portfolios against solvent and insolvent insurers and reinsurers.

Early in his career, Joe worked for American International Group (AIG) as a special services auditor. After AIG, Joe became a senior auditor with Skandia America Reinsurance Corporation. From Skandia, Joe provided consultancy services to the New York State Insurance Liquidation Bureau where he led a reinsurance recoverable team in the Midland Insurance Company run-off, forming the basis for his interest and expertise in the field of insurance and reinsurance insolvencies. Thereafter, in 1992, Joe formed Quantum Consulting to provide management and financial consulting expertise to the insurance industry.

Quantum Consulting provides services for treaty contract audits and underwriting compliance reviews, MGA and broker audits and reviews, treaty commutation accounting and analytical support, reinsurance recoverable collection assistance and analysis, liquidation accounting, litigation support, premium audits, forensic accounting and run-off management.

The investment services and claims acquisition program offered by Quantum were added in 1996. These services are a very active part of Quantum's business and provide an opportunity for Joe to speak and fight for creditor rights in insurance insolvencies. In 1998, Joe published an article in Global Reinsurance regarding current developments in the insolvency industry, with particular emphasis on short-term creditor interests.

Joe has been a member of IAIR and its predecessor organization since 1993 and serves on IAIR's marketing and HMO committees. Joe appreciates the forum provided by IAIR for the exploration of issues affecting insurance liquidations and maintains an active role in those discussions.

Joe was born in Naples, Italy and spent eleven years of his childhood there. In 1968, Joe's family immigrated to the United States. Upon his arrival, Joe had to learn to speak English while adjusting to a completely new environment and culture. In 1981, Joe received his B.A. in business administration and accounting from Rutgers College. He speaks fluent Italian and is a talented cook.

KRISTINE M. WILLIAMS, FLMI

Ms. Williams is currently engaged by FitzGibbons, Tharp & Associates, Inc., an executive management organization that concentrates on insurance company insolvencies including receivership and rehabilitation management. Her responsibilities as an estate administrator include estate and project management, liaison with guaranty associations, and coordination of legal and administrative aspects of receivership activities, including proof of claim processes.

Kristine has worked in the insurance industry for the past twenty-six years. Prior to her current involvement in the regulatory field, her experience included management of claims, customer service, new business and policy issue departments, and policy and contract development for life, annuity and accident and health products as well as regulatory compliance for the products.

Ms. Williams received her Bachelor of Science Degree from Northern Arizona University and a Masters in Business Administration (with Distinction) degree from Keller Graduate School of Management. She also earned a Fellow, Life Management Institute designation (FLMI) from the Life Office Management Association, an association dedicated to the educational development of insurance professionals.

As well as her professional association with IAIR, Ms. Williams holds memberships in the National Association of Managed Care Regulators, and the Association of Life and Health Administrators (ALHA). She currently serves as the Phoenix Chapter President of ALHA.

Kristine is also an active member and volunteer of the Girl Scouts of America and currently manages a Girl Scout neighborhood with approximately 35 troops with 400 girl members and 150 adult members. Her greatest accomplishment in life has been the parenting of her two children, Corrine, a senior at Massachusetts Institute of Technology and Thomas, a freshman at Northern Arizona University.

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 for the second quarter of 2000 is as follows:

Mark Tharp (AZ) submitted the following information for Pacific Marine Insurance Company of Alaska. As of the third quarter, 2000, the court has discharged the Receiver of Pacific Marine Insurance Company of Alaska. All claims accepted into the estate were paid at 100% plus pro rated interest. All legal actions have been resolved. After payment of court approved interest, a post liquidation trust was established to pay administrative costs related to storage and taxes.
Additionally, on June 30, 2000, the Receiver for Premier Healthcare of Arizona, Inc. filed with Superior Court Petition 25, Petition for Order for Approval of First Interim Report of Receiver setting forth a status of the HCSO receivership inception to date. In that report, the Receiver states that as of May 1, 2000, all remaining members of the failed HCSO were successfully transitioned to alternative carriers. The report further states, that as of June 1, 2000, the Receiver has processed and paid approximately $12 million of post receivership claims pursuant to the Plan for Risk of Insolvency. The formal Proof of Claim process will be initiated during the third quarter of 2000.
Mark also reports on AMS Life Insurance Company. The Receiver for AMS Life Insurance Company settled all claims against Harbourton Reassurance, Inc. (fka NRG America Life Insurance Company). The Receivership Court approved the settlement on March 3, 2000 resulting in a payment to AMS of approximately $1 million. The Receiver's claim arose out of a Surplus Relief Reinsurance Agreement between NRG and AMS Life.
Further, on June 13, 2000, the Court approved the Receiver's second early access distribution pursuant to Order Re Petition 238 for Azstar Casualty Company. With distribution of this approximate $2.284 million to the affected guaranty associations of Arizona, Florida, Maryland, Nevada and Pennsylvania, all guaranty funds claims have been satisfied in whole.
Mike Rauwolf (IL) continues to report on American Mutual Reinsurance, In Rehabilitation (AMRECO), currently managing the reinsurance run-off of their business. Total claims paid inception to date; Loss & Loss Adjustment Expense $30,449, Reinsurance Payments $133,757,419, LOC Drawdown disbursements $9,613,386. For Centaur Insurance Company, In Rehabilitation, also under OSD supervision while they manage the run-off of their business, total claims paid inception to date; Loss & Loss Adjustment Expense $51,735,580, Reinsurance Payments $4,945,493 and LOC Drawdown disbursements $13,876,555.
James Gordon (MD) continues to report on collections for Granger Mutual Insurance Company, which total $3,309.15 for the second quarter of 2000.
Further updates received from Frank Martin (PA) on the progress of Fidelity Mutual Life Insurance Company (FML), in Rehabilitation. Policyholder death benefits and annuity payments continue to be paid 100%. Crediting rates are at or above policy guarantees. As of 9-30-00 FML showed a statutory surplus in excess of $117,000,000.
In June of 2000, the Rehabilitator filed an Amended Petition to Approve Policyholder Dividends and Declared Interest Crediting Rates which increased the previously proposed rates to approximately $70 million in dividends for policyholders (from $60 million) and approximately $15.5 million in interest credits both over a 12 month period following approval of the new dividend scale. After receiving a report on the claims filed prior to the Claims Bar Date of 6-30-00, the Court approved the dividend/crediting rates and distribution/application of those new rates will begin in January 2001. Many policyholders will receive a substantially increased dividend in 2001 as a result of the surplus accumulated by FML. The dividend scale and crediting rates will be reduced to more ordinary levels for 2002.
The Third Amended Plan and all related documents have been negotiated over the last two years with the court appointed Policyholders Committee. The plan proposes that Fidelity Life Insurance Company (FLIC), a stock life insurance company, will assume and reinsure FML's obligations under all of its life insurance policies and other insurance 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. Hearings on the Third Amended Rehabilitation Plan and the accompanying Stock Allocation Report concluded in September of 1999. Subsequent to that the Court issued an

order for a Claims Bar Date of 6-30-00 and delayed ruling on preliminary approval of the Third Amended Plan until information was available about what claims were filed.

The Commonwealth Court authorized payment of all approved creditor claims if the creditors are willing to waive any interest or penalties that may be applicable. This included payment of guaranty association assessments and settlements with taxing authorities for premium taxes. Only 3 appeals were filed from the 73 notices of determination that were mailed denying claims filed prior to the Claims Bar Date of June 30, 2000. Only 2 claims were approved.

Betty Cordial (WV) reports that an Order has been entered directing that all Class II claimants, consisting of the former subscribers or policyholders, medical providers and the United States, receive a 50% distribution of their approved claim in the liquidation proceedings of Blue Cross Blue Shield of West Virginia, Inc. $10,661,378.08 was distributed to 21,344 claimants on October 26, 2000. An additional distribution to subscribers will be made if the remaining litigation case is resolved in favor of the Receiver.

RECEIVERS' ACHIEVEMENTS BY STATE

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

Receivership	***Amount***
Alliance General	$1,835.00
Amreco	$2,162,704.00
Centaur	$406,420.00
Coronet	$1,326.00
First Oakbrook	$102,655.00
Pine Top	$807,736.00
Distributions were made on an additional 4 estates under $500.00	
Total	**$3,482,901.00**

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

Receivership	***Amount***	
Grangers Mutual Insurance Company	$15,929.22	(DC GA)
	$6,541.00	(GA Ins. Pool)
	$37,397.01	(MD P&C Guar. Corp.)
Guaranty Funds	$18,544.50	(TN GA)
	$8,115.12	(MD)
Policy/Contract Creditors	$2,803.70	(DC)
	$4,291.00	(GA)
	$267.31	(TN)
Total	**$93,888.86**	

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New York (F.G. Bliss, State Contact Person)
Use and distributions made to policy/contract creditors and Early Access

Receivership	*Security/Guaranty Funds*	*Policy/Contract Creditors*	*Other Creditors*	*Total*
Consolidated	$116,617.00	$0.00	$0.00	$116,617.00
Cosmopolitan	$216,334.00	$0.00	$0.00	$216,334.00
Horizon	$356,453.00	$157,500.00	$0.00	$513,953.00
Ideal Mutual	$3,668,818.00	$43,195.00	$0.00	$3,712,013.00
Northumberland Trust	$21,760,147.00	$0.00	$0.00	$21,760,147.00
Whiting	$5,056.00	$0.00	$0.00	$5,060.00
Total	$26,123,425.00	$200,695.00	$0.00	$26,324,124.00

Pennsylvania (W. Franklin Martin, Jr., State Contact Person)

Receivership Estates Closed	Year Action Commenced	Licensed	Category	Dividend Percentage
United Surety & Financial Guaranty Ins. Company	1980	Y	P&C - Surety	17.40%
Paxton National Ins. Company	1989	Y	P&C	100% Policy Claims 75.9% Gen. Creditors

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

Receivership	*Amount*
Quaker City Ins. Company	$4,524,899.00
Proprietors Ins. Co.	

these distributions. In turn this means insurers will not be taking premium tax offsets which results in more dollars left in the state's general revenues. This interstate dependency is pervasive. It does not matter whether or not there are SGF payments or if the SGFs are in states that allow premium tax offsets (only about 1/3 for P&C, but most states for L&H), if there are none, then there still will be effects on policyholders and creditors in other states for any insurer that did business in more than just one state.

Effective management by each state matters because each dollar spent on administration (as well as dollars not collected from debtors to the estate) is a dollar that will not be distributed to the policyholders, SGFs and other creditors of the estate in other states. See prior articles on the importance of the ratio of administrative expenses to distributions and the achievement report for Missouri through 1999, which should be in this issue and should be updated for 2000 by the next issue.

The Court as Supervisor (Point 2)

In many past efforts to revise the IRLMA, it has been suggested that insurer receiverships would be more expediently run if they were purely administrative proceedings without court involvement. While revisions have been made to increase the probability that the court would have some background in the unique aspects of insurer receiverships, we have not changed much in the IRLMA to limit the role of the court. We have recognized that there are sound reasons for some degree of court supervision. Another comment in relation to the Wisconsin Section 645.04, regarding exclusivity, is instructive.

"This subsection makes this chapter the exclusive law for all delinquency proceedings in the courts of this state ... There is no good reason to permit general equity receiverships ... The rules of this chapter are carefully worked out with special reference to the insurance context, with which courts are not generally familiar, and the courts should not have the option of applying other rules developed in connection with other problems. Adequate discretionary power remains in the courts within the framework of the chapter to deal with any special problems that arise."

Note that the Wisconsin Code was based in large part on the federal Bankruptcy Act that had the court act as supervisor of the proceedings. The Bankruptcy Act was replaced with the Bankruptcy Code in 1978. The IRLMA was based on the Wisconsin Code, but the NAIC generally has not revised the IRLMA to correspond with the improvements made in the federal Bankruptcy Code.[5] One improvement that has not been incorporated into the IRLMA is the elimination of the dual capacity of the

Insurance Insolvencies: The Reinsurer's View

(Continued from page 5)

dates - in most states, 18 months or less after liquidation unless specially extended. Policyholders with long tail claims can find their claims have been barred before they were even asserted. When extensions are available, discouraged claimants don't always apply for them.

- Even if they get past the bar date problem, insureds are not familiar with the protracted insolvency process and are, therefore, not as diligent or effective during the negotiations in maximizing their recovery and protecting their interests. Also, they may not invest sufficient time and effort to maximize their recoveries because they are doubtful they will ever recover much from the insolvency;
- Many large insureds abandon or ignore their claims against the estate completely, believing they would be throwing good money after bad in pursuing a small recovery in the insolvency court;
- Guarantee funds and receivers can play hardball in the negotiations with the policyholder, knowing threats of a bad faith claim are remote;
- In environmental and toxic tort claims, which can trigger many policies, policyholders ordinarily seek first to maximize recoveries from all solvent carriers and later seek discounted reimbursements from insolvents; and,
- In environmental and toxic tort claims, liquidators are not involved in costly coverage and defense litigation. Once it has been declared insolvent, all actions against the liquidated company are ordinarily stayed. The cost of this litigation can be quite considerable.

This is not a one-way street though. There can be instances where the insolvency itself may increase the amount of the reinsurer's claims payments. For example, solvent insurers can at times resolve long-tail claims for less than the ultimate loss exposure by settling with the insured on a present value basis. The reinsurer may benefit from this lower settlement. Policyholders are generally not willing to give any credit for the present value of money in negotiations with the insolvent since it will not pay the insured any part of a settled allowance until a court approved distribution from the estate is made (which can be many years in the future.) The reinsurer in this case may pay more on an identical loss because of the insolvency.

The reinsurer of an insolvent may also pay a higher amount more quickly, if the receiver estimates the ultimate value of the claims against the estate and demands immediate payment on these estimates from the reinsurer. Some states have provisions in their statutes that allow the receiver to do this. The proposed Uniform Receivership Law (URL) also has a claim estimation provision with some limitations allowing what amounts to an arbitrated forced commutation. Reinsurers contend that these estimates can be unreliable and often are too high. They also argue that accelerating reinsurance recoveries breaches the fundamental terms of the agreement with the ceding company. On the other hand, claim estimation based on projections of past experience may understate the cost of late-developing claims. By "cutting off the tail" of long term liability policies, estimation may save reinsurers significant sums.

Delayed Payments. Liquidation slows the entire claim evaluation and disposition process, frequently to a crawl, sometimes to what appears to be a standstill. There are instances of insurers taken over by receivers in the 1970's, which are not yet, in the new millennium, finalized. Reinsurers may benefit when the day of reckoning is postponed (or never reached.) The interest that a reinsurer can earn on years of postponed reimbursements can be significant.

Several factors, unique to the insolvency of the company, impede the flow of money from the reinsurer to the cedant to the policyholder to the claimant. Here are some of the common ones:

- Many years can be spent just locating and organizing the records of the failed insurer. Insolvents' accounts are often found by the receiver to be disordered, incomplete, kept in diverse places, or difficult to decipher. Disorganized records are often the reason why the company got into trouble in the first place, or else a consequence of the chaos that preceded its failure. With many of the original employees quickly leaving the insolvent, the receiver has a difficult time finding and reconstructing basic information, including insurance policies and reinsurance contracts.
- Unless appropriate financial and employment incentives are put in place, the receiver's staff can slow the process, consciously or not. Faced with the prospect of losing their jobs once the estate is finalized, they may not be in a hurry to speed things along. They deserve to be given a financial or other good reason why a swift winding down of the estate is in their best professional and personal interest. Many estates have done this, but others have not.
- Policyholders often drag their heels in submitting timely and complete information to the receiver. Ordinarily, they are not acquainted with the receivership claim process, which includes completing a proof of claim and cooperating with the liquidator. They lose time just understanding what they must do to recover. Often may they become active only when they learn that the estate is going to pay an interim dividend or that the bar date is imminent.
- Reinsurers cause delays by scrutinizing settlements and coverage decisions more closely. Since the insolvent is no longer a business partner, the reinsurer is less likely to be overly accommodating, or to view a questionable claim with magnanimity.
- In the case of latent injury claims, which often trigger numerous policies, insureds usually first seek recovery from solvent carriers. Afterward, sometimes many years later, they may actively pursue their claim against the receivership, if they are not time barred.

As the reinsurer of a very unprofitable insurance company it is, in some ways, a stroke of luck and good fortune that the cedant is declared insolvent. For the reinsurer, the ceding company's insolvency tends to diminish the damaging effects of unprofitable underwriting.

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Creditor Committees, Constituencies and Constitutions

(Continued from page 11)

bankruptcy judge under the former Bankruptcy Act. In the legislative history to the Bankruptcy Code it was noted that, "problems arise because of the inconsistency between the judicial and administrative roles of the bankruptcy judges. [Under the former Bankruptcy Act this] inconsistency places [the judge] in an untenable position of conflict, and seriously compromises his impartiality as an arbiter of bankruptcy disputes."[6]

Generally, the judicial department has "no direction either of the strength or of the wealth of the society, and can take no active resolution ... having neither force nor will but merely judgment," (FP-78) yet in equity receiverships the courts do take title and directly supervise the receiver and control the operations. Equity receiverships are usually of a completely different nature than statutory insurer receiverships in duration, the regulated nature of the underlying business, and in interstate scope. In revising the IRLMA, we need to account for the above while keeping in mind that our statutory receiverships are not just another "case in controversy" for our courts. Using CCs may provide for a better representation of the creditors' interests that may allow for the court to serve in more of a purely adjudicative role. However, there are many facets to insurer receiverships where the independent decision-making and review of the court serve as a useful check and balance on the actions and plans of the DIR and SDR.

The DIR as Contractor (Points 3, 4, 7 and 12)

Recalling the analogy that receiverships are projects like building a bridge, as to using licensed professionals, governments do not usually contract a caterer to build bridges. They contract with construction companies that have very specific capabilities. As to supervision, some branch of the executive department is usually the contractor that administers these contracts. In insurance receiverships, the DIR is this contractor. Wisconsin Section 645.46, on the powers of the liquidator, has the following comment.

"Though power to liquidate is nominally given to the commissioner, he is not usually the active party in handling the liquidation. Liquidation and rehabilitation are usually performed by a special deputy appointed for that purpose. This section is included to make clear that the special deputy has the power of the commissioner for liquidation."

A similar comment is provided as to the powers of the rehabilitator noting that what is needed is expert management. SDRs or the management in permanent offices like the OSD should be the licensed professionals to provide that expert management. IAIR is aiming towards providing for this with its CIR and AIR accreditations. However, the role of the SDR has many aspects that are quite different from that of a construction company contractor building a bridge. While the estate is not a governmental agency, and the creditors own the funds in the estate, those funds would not be there but for the exercise of state power in taking over the insurer, and the nature of its contracts and the public trust placed in insurance require it to be a quasi-governmental entity. In rehabilitation the insurer is being shielded and managed by the state, and in liquidation its very existence is taken over by the state.

Building a bridge also does not involve the fiduciary duties that exist in any receivership. The role of the SDR is quasi-governmental and the fiduciary duties are augmented by the public trust placed in insurance. The SDR is appointed by the DIR, subject to approval by the court, because of this unique role. It is a difficult role, requiring not only great management skills but also governmental skills in representing the interests of all of the parties in interest to the estate. An appropriately representative CC could be useful to assuring that all of the sometimes very divergent interests are fully considered in the actions and plans of the DIR and SDR. As to being subject to criticism, this is much the same as being accountable. This is why we put executives in charge of the administration of matters both private and public. We want an individual that will be accountable - one that we can criticize. There is, as was covered above, an interstate interest in there being some accountability for the management of insurer receiverships.

As to the release of information that may be detrimental to the estate, because these are not government agencies supported directly by general revenues of the state, the estates should not be subject to freedom of information laws. This is something that does need to be addressed in the revision of the IRLMA. Further, among the rights and liabilities that are fixed by a liquidation order, and that remain intact when the insurer is in rehabilitation, are the privacy interests of those that dealt with the insurer and the proprietary and intellectual property interests of the insurer. Both the DIR and a CC should be expected to recognize and protect these interests.

As to immunity, such does not seem to be applicable to a purely "private affair utilizing only private funds," but certainly official immunity seems appropriate in the execution of quasi-governmental matters and judicial immunity should attach to decisions and plans that are subject to full hearings with due process to those with interests.

Conclusion

The allowance for and use of CCs as representatives of the creditors in insurer receiverships may provide useful checks and balances to the executive and judicial functions of the DIR and the court. It is apparent that the creditors, and especially the SGFs, have an increasing desire to have a voice in how the insurer receiverships that affect their interests are managed. This should be carefully considered in the upcoming revisions to the IRLMA. *(Please refer to chart and end notes on next page and graph & chart on page 20.)*

Douglas A. Hartz is Receivership Supervisor at the Missouri Department of Insurance. He has been a member of IAIR since 1992 and served as its President in 1998. He is also a past Director of IAIR.

Creditor Committees, Constituencies and Constitutions

MISSOURI RECEIVERSHIP GENERAL STATISTICS (1999)

Receivership Name	*Current % Being Paid on Allowed Class 2 or Approved Claims*	*Incept to Date Pyt On Class 2 & Secured Claims*	*Incept to Date Pyt on Class 3 & Lower Claims*	*Incept to Date Pyt on Class 1 Admin. Exps.*	*Incept to Date Ratio of Admin. Exps to Pyt on Claims*
Transit Casualty Co. (Liq.)	*39%*	*$405,563,594*	*$ 0*	*$292,712,690*	*72%*
Holland America Ins. Co. (Liq.)	*75%*	*$ 36,827,901*	*$ 0*	*$ 20,854,247*	*57%*
Mission Reinsurance Corporation (Liq.)	*100%*	*$ 0*	*$42,202,781*	*$ 6,017,192*	*14%*
Integral Ins. Co. (Liq.)	*100%*	*$ 99,003,111*	*$33,068,722*	*$ 4,107,525*	*3%*
Bel-Aire Ins. Co. (Liq.)	*N/A*	*$ 0*	*$ 0*	*$ 328,277*	*N/A*
Amer. Finan. Security Life Ins. Co. (Rehab.)	*100%*	*$ 15,472,927*	*$ 0*	*$ 4,651,633*	*30%*
Casualty Indemnity Exchange (Rehab./ Closed)	*N/A*	*$ 40,138,037*	*$ 0*	*$ 6,858,873*	*17%*
Commonwealth General Ins. Co. (Liq.)	*70%*	*$ 8,565,812*	*$ 14,635*	*$ 2,869,750*	*33%*
Professional Medical Ins. Co. (Liq.)	*100%*	*$ 21,477,428*	*$28,827,080*	*$ 5,199,697*	*10%*
Professional Mutual Ins. Co. RRG (Liq.)	*100%*	*$ 3,425,965*	*$ 3,970,400*	*$ 829,935*	*11%*
U.S. Physicians Mutual RRG (Liq.)	*52%*	*$ 7,068,603*	*$ 0*	*$ 4,529,691*	*64%*
M&M Companies (Liq.)	*N/A*	*$ 0*	*$ 0*	*$ 1,075,179*	*N/A*
Ozark Benefit Assoc. Life Ins. Co. (Rehab.)	*100%*	*$ 161,700*	*$ 0*	*$ 52,983*	*33%*
Lutheran Benevolent Ins. Exchange (Liq.)	*65%*	*$ 2,663,129*	*$ 0*	*$ 1,144,508*	*43%*
Inter. Finan. Services Life Ins. Co. (Rehab.)	*100%*	*$ 84,210,829*	*$ 0*	*$ 418,551*	*0%*
Gen. Amer. Mutual Holding Co. (Rehab.)	*N/A*	*$ 0*	*$ 0*	*$ 352,728*	*N/A*
Total or Average	**83%**	**$724,579,036**	**$108,083,618**	**$352,003,459**	**42%**
Transit Casualty Co. Projected in 2000	*50%*	*$ 518,863,594*	*$ 0*	*$292,712,690*	*56%*
Transit Casualty Co. Projected Cumulative	*N/A*	*$1,100,000,000*	*$ 0*	*$350,000,000*	*32%*

Notes regarding Transit: Payment on Class 2 & Secured Claims for Transit includes $78,566,000 paid in January, 2000 and $5,442,925 paid on secured claims (which was shown as an admin. expense). The Projected Cumulative amounts are estimates provided by Transit personnel.
General Notes: Some of the amounts include expenses and payments to claimants that occurred during rehabilitation. All of the amounts are subject to revision based on reviews and audits of reported amounts.

End Notes

[1] In the interest of keeping these endnotes to a minimum, as there are many concepts applied, I will refer to some of the Federalist Papers by number as FP-#. I would also recommend for a mere $7 or so a copy of The Federalist Papers, Clinton Rossiter, Ed. (1999), http://www.penguinputnam.com.

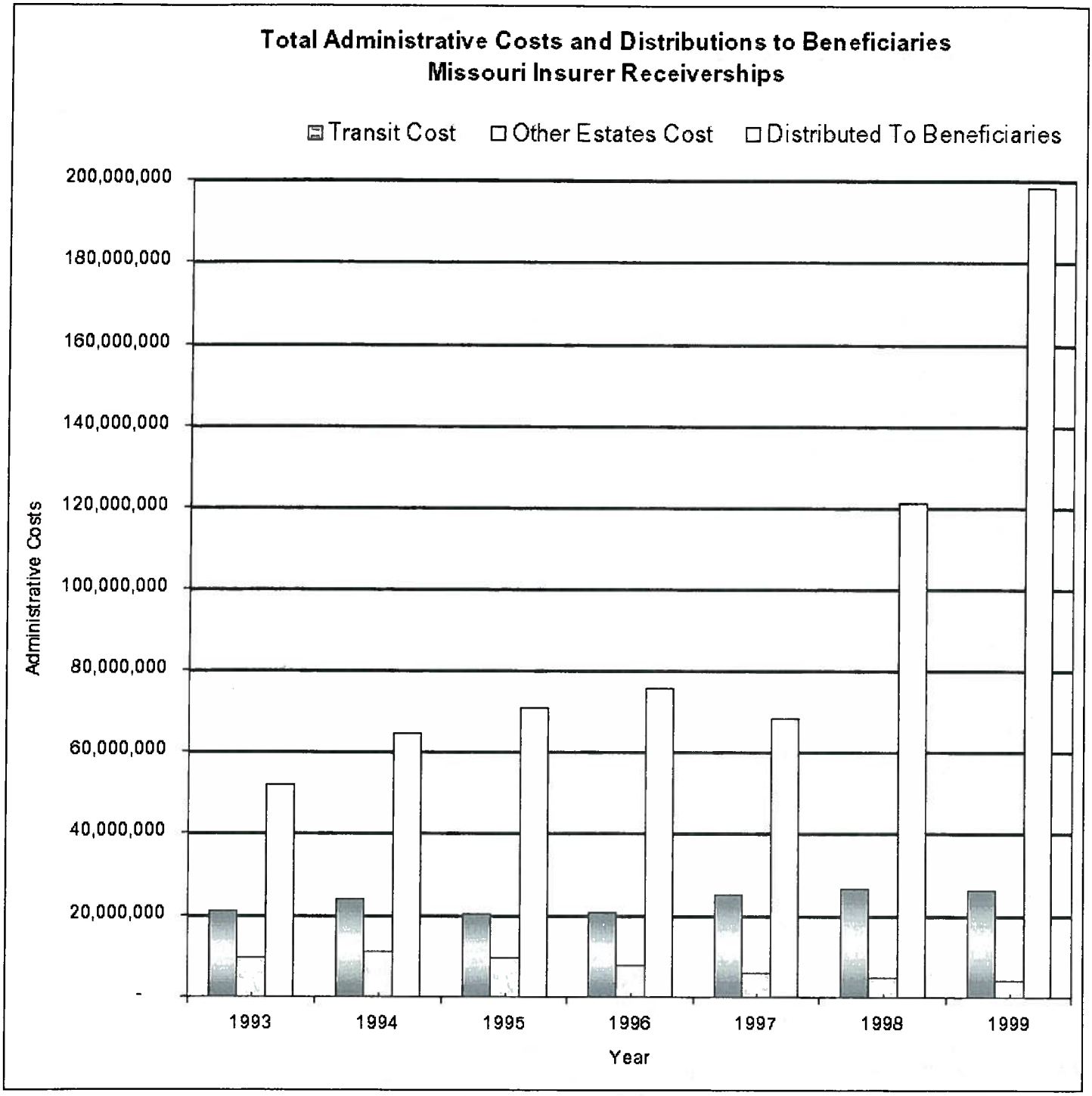
[2] See, The Uniform Receivership Law: A Synopsis - Robert F. Craig, Insurer Insolvency Revisited: 1999, ABA/TIPS. Page 10 regarding "party in interest" and rights to appear and be heard are especially applicable.

[3] In The UK Model - Johnson, Sharp and Edison, Insurer Insolvency Revisited: 1999, ABA/TIPS, at page 27, it is noted that CCs are not mandatory in the UK but are "always used as a check on the powers and activities of the Scheme Administrators who can be required to consult" the CC on various matters.

[4] Relfe v. Rundle, 103 U.S. 222, 26 L. ed. 337 (1881).

[5] The URL does in large part use concepts from the Bankruptcy Code, but it did not incorporate much that would limit the administrative role of the court.

[6] Bankruptcy Reform Act of 1978, Pub. L. No. 95-598, Hearings, pt. 1, at 591-93; Commission Report, pt. 1 at 93-94.



ANNUAL ADMINISTRATIVE COST AND DISTRIBUTIONS TO CLAIMANTS

Year	Transit Cost	Other Estates Cost	Totals	Distributed To Beneficiaries	Ratio
1993	21,093,000	9,703,980	30,796,980	51,913,343	59%
1994	23,999,245	10,921,631	34,920,876	64,517,689	54%
1995	20,168,646	9,646,062	29,814,708	70,582,648	42%
1996	20,688,105	7,828,759	28,516,864	75,594,795	38%
1997	25,223,207	5,814,271	31,037,478	67,988,032	46%
1998	26,439,416	4,886,876	31,326,292	121,049,494	26%
1999	25,983,076	4,202,529	30,185,605	198,087,847	15%

Insurance Insolvency in the United Kingdom and the United States Compared and Contrasted

(Continued from page 9)

those two insolvencies. Impacting as they did on the voting public, Parliament decided that life assurance business ought to be regulated, and so they passed the Life Assurance Companies Act of 1870. This introduced some novel ideas such as the need for a margin of solvency and an annual audit. For those of us who have been brought up since 1870, these ideas are obvious and commonplace. In 1870, they were little short of revolutionary.

Who said the Victorians were unadventurous?

Subsequently all forms of insurance in the UK came to be regulated through successive legislation, which was consolidated as recently as 1973 and is currently enshrined in our Insurance Companies Act 1982. Corporate and personal insolvency legislation was consolidated even more recently by the Insolvency Act 1986. All of which means that we now have what is in effect a single body of legislation to deal with insurance insolvency.

You may wonder why I am bothering with this history lesson but hopefully all will become clear shortly.

Now I wouldn't like you to think that the British are the only ones with a little bit of history and may be the odd skeleton in the cupboard (or closet as you would say). I have always been very impressed by the way in which the founding fathers of the United States of America sought to establish a system based on fairness and equity, the objects of which were expressed so eloquently in the words of Thomas Jefferson, John Adams, Roger Sherman and Robert Livingstone and adopted on 4 July 1776 by the Second Continental Congress.

What they said was:

"*We hold these truths to be self-evident that all men are created equal.*"

Stirring words indeed and focussing very clearly on the self-evident truth of the need to treat people equally.

On 25 May 1787, fifty five delegates from the then thirteen States met in Philadelphia (the City of Brotherly Love) to discuss the drawing up of a constitution to take the place of the Articles of Confederation.

A gentleman by the name of George Washington, an Englishman incidentally, presided and after a long struggle and many compromises, the resultant document was referred back to the States for their consideration on the 28th September, 1787.

By 21 June 1789, nine out of the thirteen States had ratified it and the new Federal Government was established in New York on 30th April, 1789.

The preamble to that historic document reads:

"*We, the People of the United States, in Order to form a more perfect Union, establish Justice, Insure domestic Tranquillity, provide for the common defence, promote the general welfare and secure the blessings of Liberty to ourselves and our posterity, do ordain and establish this Constitution of the United States of America.*"

Now why should an Englishman draw the Constitution of the United States to the attention of this meeting. Well, you will all be familiar with subsection 4 of section 8 of article 1 of the Constitution, which reads:

"*the Congress shall have power ..... to establish uniform laws on the subject of Bankruptcies throughout the United States.*"

In 1868 for reasons best known to it, the Supreme Court of the United States of America chose to consider a case entitled ***Paul v Virginia***. In that case the Supreme Court took the view that the business of insurance did not involve interstate commerce and was therefore beyond the power of Congress to regulate. That seems something of a bizarre decision when you recall that insurance was invented specifically to facilitate international trade, much less inter state trade. I haven't looked into their reasoning but it may be that the Justices took a narrow view of the definition of commerce and thought that perhaps commerce involved only chattels rather than an intangible product such as insurance.

Whatever the reasoning, in 1944 in a case called ***United States v Underwriters Association***, the Supreme Court finally reversed itself on the specific question of whether there was constitutional authority for federal regulation of insurance. Of course, by that time, all the States had enacted their own legislation covering insurance, including provisions for dealing with insurer insolvency. By passing the McCarran-Ferguson Act, Congress perpetuated a division of authority that had evolved under an obsolete constitutional interpretation.

To complete the history lesson I would observe that Congress made two attempts prior to 1896 to establish a workable federal bankruptcy code, both of which failed. At that stage Congress did the obvious and sensible thing, they broadly adopted the Bankruptcy Act then in operation in Britain. That perfectly adequate piece of legislation remained on the statute books until 1978 when Congress enacted a new Federal Bankruptcy Act.

So that is perhaps a long winded way of saying the principal difference that I would identify between the UK and the US way of handling insurance insolvencies, is that in the UK we have one single body of legislation dealing with the conduct of insurance and the conduct of insolvency with some very specific rules for the conduct of insurer insolvencies, whereas the United States has some fifty-five different codes covering both insurance and insurance insolvency. Whether or not that is a sensible approach, I can only leave you to judge, but I would suggest that if you were starting with a clean sheet of paper today you would not end up with the system you've currently got.

Democracy and Representation

The rallying call of the Boston tea party was "no taxation without representation" and indeed the desire for representation and the colonists' frustration at a lack of representation, is recorded at length in the diatribe against poor old King George III, contained in the declaration of independence. As any of you who have seen the film "The Madness of King George" will know, poor old King George suffered from mental illness and was hardly responsible for the wicked things alleged against him.

So here we have a desire for representation so strongly felt that it led to a

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Insurance Insolvency in the United Kingdom and the United States Compared and Contrasted

(Continued from page 21)

revolution, and yet what happens when an insurance company goes into liquidation? In the United Kingdom there is an election at which the creditors vote for the liquidator of their choice. They can also vote for a creditors' committee to supervise the conduct of the insolvency by the liquidator.

In the United States when an insurance company goes into liquidation there is no election, instead the State Insurance Regulator is appointed liquidator. This might be convenient but it doesn't strike me as being terribly democratic, especially as the person appointed liquidator is also the person who was in charge of the regulation of the company, which may conceivably have failed as a result of a failure of regulation, but I guess it saves the cost of an investigation.

Only in very rare cases is there ever a creditors' committee appointed.

Now that is a very significant difference between the two systems, and one that frankly surprises me in view of the US's desire both for democracy and representation. Thinking back to the Boston Tea Party I wonder whether the clarion call should not have been, "no liquidation without representation." It does seem bizarre that having started a revolution and fought the War of Independence in order to achieve the benefits of representation, that creditors should be so firmly excluded from having a say in what happens to their own money.

I have certainly had very many expressions of appreciation from US creditors in English insolvency proceedings about the level of openness and access to information and participation that they have found there.

In the UK, the liquidator may apply to the Court for directions when he is uncertain quite what he ought to do; however, typically, there is no further involvement of the Court once the liquidator and creditors committee are appointed. The liquidator and his committee make all decisions.

In the United States by contrast, the liquidator of an insurance company repeatedly has to return to the Judge on all sorts of issues concerning the conduct of the liquidation.

Since members of creditors' committees in the UK are not paid for being on the committee, holding a committee meeting is a very cost-effective exercise. On the other hand repeated applications to the Court are, in my experience, very expensive.

In the United Kingdom for someone to act as a liquidator or a receiver or a trustee in bankruptcy, he must be a licensed insolvency practitioner. He needs to train and qualify by examination as an insolvency practitioner before he can take an appointment.

Once appointed he may be entitled to an indemnity out of the estate, but not for his own negligence or misfeasance and unlike many liquidators in the United States he had no immunity from action, for instance, by an aggrieved creditor.

By contrast the liquidator of an insurance company in the US may very well appoint a special deputy to actually manage the winding up of the insolvent estate, who may have no experience whatsoever of either bankruptcy or insurance insolvency. This is one of the reasons why the International Association of Insurance Receivers was founded - to improve standards among those who work on insurance insolvencies.

Policy Holder Protection

In both the United States and the United Kingdom there is an understandable concern to protect the interests of policyholders. In the United Kingdom, the Policyholders Protection Act became law in 1974, and provides a mechanism to ensure that private policyholders or partnerships of private individuals have protection in the event of the failure of their insurance company. The protection does not extend to corporations.

Any policyholder is entitled to receive back 90% of the value of their claim from the Policyholders Protection Board, or 100% where the class of insurance is compulsory, such as Employers Liability or Third Party Motor. There is no limit to the amount of compensation that the Board may pay to any individual claimant.

The day to day running of the board is handled by a part time secretary and in the event of an insolvency the PPB will look to the liquidator to adjudicate claims, so the administration of the PPB is both streamlined, efficient and cheap.

In the United States there are at least two guarantee funds in every state and I am told sometimes three, which means that you have somewhere well in excess of one hundred guarantee funds to do the work of the PPB and its part-time secretary. In addition, those guarantee funds seem to have staff and frequently claims handling is conducted by the guarantee funds rather than the liquidator, which is in complete contrast to the way things are handled in the UK. I also understand that there are limits on the amount of compensation that may be paid, which vary from state to state as does who may be protected. In some states I gather even corporations may make claims.

Bar Dates

Another area where there is a complete contrast is with bar dates. Typically in the UK there are no bar dates. When a liquidator pays a dividend he calls on creditors to put in their claim before a date certain and, if they do not, then they are at risk of not receiving that particular dividend. If of course it is the final dividend and the creditor has failed to come forward by the date the final distribution is made, he will find that there are no funds left in the estate to pay a dividend to him, and for which he has no recourse.

Schemes of Arrangement

However, in the United Kingdom in recent years there has been a tendency not to place insurance companies into liquidation but to handle their winding up under the terms of a scheme of arrangement. Now I am aware that in the US the word 'scheme' is a pejorative, so let me hasten to say that in this context 'scheme' means 'plan' not 'scam'.

Now a scheme of arrangement is not an insolvency proceeding, it is actually a corporate reorganisation provision to be found in our Companies Act at Sections 425, 426 and 427 and the entire legislation governing schemes covers less than three

pages. Schemes are a very simple and a very effective tool, but you may wonder why we now have schemes instead of liquidations for insurance companies.

If you care to cast your minds back to the great bankruptcy reforms of 1883 that I mentioned earlier you will recall that a new public official known as the Official Receiver was created and that his department was funded by fees levied on insolvent estates.

In those days a typical bankrupt's estate would have been very small and the charges modest, but subsequently fees came to be levied on corporate estates as well.

With insurance companies where the estates can be quite large, those fees can add up. In the case of the KWELM companies it is estimated that the fees avoided by having a scheme instead of a liquidation will amount over the period of the winding up to some £200 million. A not insubstantial sum, and that is why we have schemes.

Estimation

The other thing that the scheme provides is flexibility and again you will probably be aware that in the United Kingdom we have had a number of schemes, which have provided a mechanism for putting a present value on future claims. In other words, estimation.

The scheme provides a vehicle for creating an agreed mechanism with creditors for the estimation of their claims. The estimation methodologies have now become extremely sophisticated and surprisingly accurate. In a recent report, that I published in connection with the winding up of two Singaporean companies, ICS Re and RMCA Re, under schemes of arrangement, there is a chart that compares actual development against projected development for five large losses, CAT 24, CAT 87J, CAT 90A, Hurricane Alicia and Hurricane Hugo. In nine out of the ten cases the estimates are within one or two percent of the actual development. Whilst in the tenth case the degree of accuracy was only around the 80% mark because of some unexpected development through the Marine account, but that's not bad and creditors have made it very clear that they would rather receive dividends within a few years on the basis of estimates than wait for ever for actual development to take place.

We make no attempt whatsoever to bind reinsurers into these arrangements, but to date have experienced very little difficulty in making collections from them on the basis of our estimates. A somewhat different situation from the Mission and Integrity plans where there has been an attempt to bind reinsurers into the process.

Contractual Obligations

Another area of difference is that in the United Kingdom the liquidator or scheme administrator accepts that the insolvent company is contractually bound to the terms of the policies that it issues and the contracts of reinsurance into which it enters.

For reasons that I simply do not understand things seem to be rather different in the United States where typically receivers argue that they are not, for instance, bound to the arbitration clause in reinsurance agreements and that all disputes should be remanded to the Liquidation Court. I was interested to see the recent decision involving Integrity and Munich Re where the Third Circuit US Court of Appeals has ruled that a dispute should be arbitrated in accordance with the terms of the contract.

Equality

The Declaration of Independence may say that it is "self-evident that all men are created equal", but if that man happens to be a Name at Lloyd's on a Lloyd's syndicate reinsured by an insolvent US insurer, then he will find that he had not been created equal, that in a US insurance insolvency, some creditors are more equal than others. In other words policyholder creditors have a priority over reinsurer creditors, presumably because reinsurance companies do not have a vote.

In the UK there is no policyholder preference, the only preferential creditors being employees for wages and the Inland Revenue for some taxes due.

Comity and Cross Border Cooperation

One of the really great contributions to international insolvency is to be found in Section 304 of the United States Federal Bankruptcy Code. This is a contribution, probably without equal anywhere in the world and one of which Americans can feel justifiably proud.

Simply stated, Section 304 permits a liquidator or a scheme administrator from a foreign jurisdiction to have his administration recognised by the Courts of the United States and to gain the protection afforded by the US Federal Bankruptcy Code.

Understandably a foreign liquidator must first demonstrate that US creditors will not be unfairly prejudiced by submitting to the foreign insolvency proceedings, but that is hardly onerous. Needless to say a liquidator from a foreign jurisdiction that does discriminate against overseas creditors need not apply.

Things are not quite so clear or well developed in the UK but the Co-operation of Insolvency Courts Order 1986 does enable liquidators in 17 Commonwealth Countries (including Australia, Bermuda and Canada) to enlist the aid of the UK Courts, pursuant to Section 426 of the Insolvency Act 1986, in having their administrations recognised in the UK.

A US liquidator seeking recognition in the UK would have to apply to the Courts for recognition under what are called principles of international comity. This I fear would create difficulties for the liquidator of a US insurance company because by having policyholder preference he would find himself at odds with UK insolvency law, which has no such preference, so that there would be a failure of comity.

By contrast, the English Liquidator of an insurance company could apply for relief under the Federal Bankruptcy Code since that Code covers foreign insurance companies even if it doesn't cover US domiciled insurance companies.

[Note. Since this talk was given in Dallas on 9 September 2000 there have been two significant developments.

On 30 November 2000 the Royal Assent was given to the Insolvency Act 2000, Section 14 of which allows the Department of Trade to introduce the UNITRAL Model Law on Cross-Border Insolvency into the United Kingdom, and which is likely to be carried through in the near future.

On 7 December 2000 the Senate passed HR2415, the bankruptcy bill conference report, sending the bill to President Clinton.

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At the time of writing (12 December 2000) it remains to be seen whether the President will veto the bill, which also incorporates the UNICTRAL Model Law on Cross-Border Insolvency.]

There is now the prospect that in the near future there will be harmonisation of US and UK law as regards Cross-Border insolvency.

Commencement

In the UK, any creditor whose claim hasn't been paid may institute winding up proceedings. I think I am correct in saying that in the US proceedings for the winding up of an insurance company may only be instituted by the State Insurance Department.

Contingency / Conditional Fees

In the United States if an impecunious liquidator feels that he has a good cause of action against another party he can retain a lawyer to prosecute his action on a contingency fee basis. What's more, if he loses, he doesn't have to pay the other side's costs.

In the UK, until very recently, such contingency fees would have been regarded as champetous and typically a loser pays a large part of the winner's legal costs. Until recently this would have meant that that an English liquidator who did not have access to funds would probably have no remedy against say, a miscreant director or a debtor.

Very recently however, there has been a change in the law so that now a limited number of litigants, typically private individuals or insolvency practitioners, can enter into what are called conditional fee arrangements with their lawyers under which the lawyers may charge reduced, or even no, fees for their legal work but take an enhanced fee if the case is successful. There is a limit to the amount of that enhancement so that maximum uplift the lawyer concerned could get would be 100% i.e. he would be charging double his normal costs.

That still leaves the problem of loser pays and the liquidator's exposure to adverse costs, but there are now a number of insurance facilities available so that he can actually insure that risk too. Of course he still needs enough money to pay that premium and he needs to satisfy the insurers that the case is more likely to be won than lost. It may not be a perfect system but it is a helpful move in the right direction.

Insolvency Clause

There are a number of other differences many of them relatively minor such as the Insolvency Clause. UK contracts do not have insolvency clauses and so until recently it was open to reinsurers to argue that payment of the underlying loss was a condition precedent. In other words, the wording in the ultimate net loss clause that limited a reinsurer's liability to sums "actually paid" actually meant what it said.

Until recently I had not actually experienced any great difficulty in making collections from reinsurers because I could normally point out that the arbitration clause contained wording along the lines that the arbitrator should treat the contract as an honourable engagement and that he need not take an overly legalistic interpretation of the wording. I could also point out that every time the point had been arbitrated the liquidator had won.

Things changed a few years ago when I became provisional liquidator of the Charter Reinsurance Company. I was suddenly faced with the problem that Lloyd's Claim's Office were refusing to process my paper because the underlying claims hadn't been paid. I was thus faced with the prospect of arbitrating hundreds and hundreds of identical cases none of which would have any precedential value, in order to recover from reinsurers, and that would have been both time consuming and very expensive.

I therefore took the case ultimately to the House of Lords (our Supreme Court) where their Lordships agreed with my argument that the actual words "actually paid" didn't actually mean "actually paid" but actually meant actually "liable to pay". This was rather different from the result obtained in 1937 by Fidelity & Deposit Company of Maryland, against a company called Southern Surety Company of which Superintendent Pink was acting as liquidator. Having lost, Superintendent Pink changed the law, which led to the creation of the insolvency clause.

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Conclusion

In concluding, it is clear to me that the UK system of winding up of insurance companies is quite different from the United States system of winding up insurance companies. While I'm not going to be so bold as to say we do things better, even if that's what I think, but I would certainly admit that we do things differently. I leave you to draw your own conclusions.

The remarks made herein are those of the author alone and are not to be attributed either directly or indirectly to PricewaterhouseCoopers.

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PRESERVING THE DELIVERY SYSTEM IN FINANCIALLY TROUBLED HEALTH PLANS

By Dennis Mihale

Recently, I have been asked to speak before state regulators regarding an issue that should be important to physicians: how to preserve the provider delivery systems in financially troubled plans. These talks include national meetings as well as individual state meetings. Three things to note: Regulators are focusing on this issue (this is good). In some states there is little protection for physicians when a plan encounters financial trouble (this is bad). Most physicians and managed care professionals are not aware of the rules and overestimate the protection that physicians have (this is very bad).

Before everyone panics, there are actions that can be taken and many states are beginning to take these actions. I am very pleased and pleasantly surprised that our regulators are taking such proactive steps. It is a credit to our regulators; the contractors that work with them and the many other groups that provide input. The key message is that the going forward payment plan, paying the physicians after the date of insolvency, is critical to maintaining the provider network.

Some of the areas of focus include:

1.Making sure that the majority of premiums received by a health plan are distributed to the providers for services rendered.

2.Working with health plans before financial problems become serious to avoid catastrophic results.

3.Developing guarantee funds to provide payment for services rendered.

4.Working with insurers to acquire failing health plans and thus provide payment for services rendered.

Even with all of these steps, there is more that can be done. First and foremost is educating physicians on the rules or statutes. Many physicians are surprised that even though they have provided services to the members, they are often number four or five on the priority list with respect to getting paid. Almost all physicians are unaware that in most states the rules for paying doctors before the date of insolvency are different from the rules for paying them after the date of insolvency. Still others are unsure as to how to deal with non-payment of services from a tax and accounting standpoint. This last point represents an opportunity for physicians. I believe that continuing to provide services to members is so important that the Federal Government should enact some form of tax credit when a health plan is unable to pay for contracted services which were provided.

There are a number of other steps that can be taken. The critical next steps include educating physicians relative to this issue; forming action committees at the state medical society level to push for protective legislation and working with state regulators to push for policies and procedures that will help minimize the occurrence and impact of failing health plans.

Introduction

One of the key roles of the regulator is to preserve the provider delivery system. The realities of insolvency and impairment are many:

·When a plan is insolvent, members are often the most vulnerable group.

·Even sophisticated members (benefit administrators) believe they have more protection than they actual have.

·For regulators, following the rules and paying claims may not be good enough to preserve quality health care

·Some providers will terminate and fail to provide continued access to health care, regardless of the actions taken by the regulator.

Preventing insolvency may require a mental shift on the part of the HMO executives and regulators. This is a result of the current system in which insolvency never happens if everything goes according to plan. While we know that things do not always happen according to plan, HMO executives are paid to make things happen according to plan. Further they are by nature, success oriented individuals and have little reason to suspect adverse events. In essence, they are not compensated or rewarded to plan for insolvency. It is up to the regulators to instill a need to do so and to assure that the contingency plan is developed long before insolvency, i.e. now.

There can be any number of goals and objectives in a case of impairment or insolvency. The following list is meant to serve as a starting point rather than the absolute best answer:

·Continuity of care

·Preserving the delivery system

·Accepting the facts, i.e. facing the reality of the situation

·Educating doctors and providers about insolvency

·Working with other carriers/HMOs to minimize the impact of an insolvency

·Maintaining trust and confidence

There are several assumptions regarding insolvency that can help improve the process. These assumptions come from observation rather than scientific study.

·Doctors do not understand insolvency

·Doctors do not understand guarantee funds

·The payment of claims will be delayed

·The rules to pay claims before insolvency usually differ from the rules for paying claims after insolvency

·A good strategy, good communication and the proper use of outside resources will often help improve the situation

·After key information is gathered and the situation is understood, making timely decisions is essential to minimizing the impact of insolvency

·Assets are less and liabilities are more, but not always.

·There is no super funding source, i.e. no silver bullet for insolvency

·Revenue growth will not solve the problem

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·Acquisition by itself is not the answer

·Personal agendas add complexity

·Acceptance of the situation, a plan of action and implementation must happen quickly, maybe in as little time as a few weeks.

There are several reasons why doctors terminate and understanding them can help the regulator take appropriate action both before an insolvency occurs and during insolvency.

·Doctors feel betrayed

·Doctors are reacting to a history of late payments and the insolvency is seen as the ultimate late payment scenario

·Doctors believe they are the patsies. They believe everyone else will get paid, the receiver, the HMO executives, the government, but not them.

·Doctors do not usually understand their contractual obligations

·Doctors do not understand the protection they have

·There is a general feeling they will be working for free, so why should they do it.

·Doctors may believe that threatening termination may accelerate their payments.

Preserving the Delivery System Requires Several Strategies, including strategic, regulatory and legislative action.

Strategic Action

Strategic action includes meeting with medical societies, hospital associations, physician hospital organizations, large provider networks and e-health organizations before there is a crisis. This includes forming alliances designed to protect providers in the event of a financial crisis at an HMO. It also includes educating the parties on what can and what cannot be done under current rules and regulations.

Legislative Action

Anything that will provide additional income or reduce losses for the physicians will help preserve their participation. Examples include federal income tax credits for monies not paid. This approach would require a special bill, since most physicians are on a cash basis, i.e. have not booked the income and their cost is only the time they have invested. The overhead of the office is already being counted as a business expense. What legislators have to understand, is that the physician's budget and financial forecasts were based on that lost income and that a credit for those fees will help encourage the physician to continue to see the patients during the transition period.

Guarantee funds can help assure that physicians are paid for services provided either before or after the actual date of insolvency. It is important to note that most guarantee funds or programs only guarantee payments before or after the date of insolvency, but never both.

Mandating electronic claims payments, which is coming thanks to HIPAA, will help reduce the impact on physicians since reimbursements will be much more timely.

Regulatory Action

Probably the best regulatory approach, which was suggested and used in Tennessee, is to guarantee that all premiums paid after insolvency are used to pay for medical services first, i.e. 80% of premiums must go to pay physicians, hospitals and providers for services rendered. To assure fairness, payment should be at a set rate such as 80% of Medicare Allowable, for everyone, including non-par providers.

Other approaches include bargaining or negotiating with providers to pay them a set amount up front in return for continued participation. Another tactic is to utilize the guarantee funds or assuring payment for future services (see above). Understanding what the fund allows regulators to do, the limitations, if it applies to services before or after insolvency are important. But most important is to communicate - communicate - communicate with the physicians. In this day of e-mail and broadcast faxes, it is easy to communicate to a large population. Don't forget to provide a contact person (that means a name and number). A department with a general number may prove frustrating to the doctors and do more harm than good. Remember, they will find out the truth so it is best for you to tell them the bad news along with how you intend to minimize its impact on them. Part of this means educating the doctors regarding the law, their rights and what the state is doing to help them get paid. Most physicians do not understand the law and will assume the worst. As bad as things are, they will probably assume they are worse.

Providing the Receiver with specific deliverables and dates with respect to physicians is a critical task. Communicating how much the physician is owed; when the first payment will be received, and how will the physician be paid on a going forward basis (after the date of insolvency) will help preserve the delivery system. Providers need tangible results such as: an introductory letter from the Receiver in 30 days; a statement of their account in 60 days; a first installment in 90 days. While there can be many restrictions on how the physician is paid before the date of insolvency, regulators should have some flexibility regarding how they can be paid after the date of insolvency. It is this going forward payment plan that can help preserve the delivery system. The last approach is to utilize technology.

The Internet May Provide Solutions

The Internet with its great capabilities may solve many of the problems implied in this article. Since the Internet is beyond the scope of this subject, I will offer just one example of what the Internet might do. Suppose someday soon, the Internet would allow physicians to be paid real-time for their services. At the time a patient is seen, their ID card is swiped and their co-payment amount is paid to the physician in the same manner as a visa transaction. At the same time, the system automatically adjudicates the claims and the amount due from the HMO is paid to the physician in a similar fashion. The payment is actually received from VISA or some other entity that bills the HMO. The physician pays a 2% transaction fee to the bank for these services. The physician would of course be happy to pay 2% to assure immediate payment. VISA would also be happy. How much is 2% of $1 trillion dollars? Answer: $20 billion. Think there are interested parties? And this is

just one idea explained in one paragraph. A follow up article on the Internet is planned.

Accounting Review: Things may be better than you think

The old adage that assets are less and liabilities are more is still true most of the time. But it is not always true. One of the reasons is that many financial officers of HMOs and insurers grew up with Generally Accepted Accounting Principals and still have trouble converting to Statutory Accounting methods. The differences can at times cause assets to be understated and liabilities to be overstated. Correcting this can add significant net worth and available cash to the plan. Counting on it would be foolish while searching for it would be prudent. Examples of items that may provide additional net worth include:

·Accrued rental liabilities

·Over 90 day collectibles from State agencies

·Refunds of claims overpayments which may not have been properly credited

·Guaranteed future collections from state of federal agencies

·Excess claims reserves (for claim periods greater than 12 months)

Regulatory Responsiveness

One of the critical factors in managing a plan in financial difficulty is often the state's ability to respond to the situation with:

·The right person

·At the right time

·At the right place

By working now to create a virtual agency using the Internet and e-mail capabilities, the State can provide an environment to do just that. This can allow the state to take fast action. Some of these actions might include:

·Eliminating denial at the state and HMO about the seriousness of the problem

·Halting losses

·Ceasing sales and marketing activities which will not save the plan at this time

·Putting all employees on paying claims and providing service

·Obtaining a credible actuarial study

·Stopping all special projects except those preventing insolvency

Working with Doctors

Working with the doctors means thinking about it from their perspective: how to make sure they get paid. A couple of thoughts:

·Guarantee payments for services going forward

·Reduce future administrative expenses quickly

·Work with largest providers

Summary

·Preserving the delivery system is Job #1

·Providers & members do not know the rules

·Education and communication is critical

·Doctors will terminate for good business reasons and bad emotional reasons

·Try to guarantee payments going forward

·Search for understated assets and overstated liabilities

·Stop denial by the HMO and the State

·Put everyone on paying claims and providing service to members & providers

·Remember that no one wins in receivership

·Don't forget to use technology

·Start meeting with doctors and hospitals now, before a plan is in trouble.

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Insurance Insolvencies: The Reinsurer's View

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Conclusion

The reinsurer's difficulties with an insolvent cedant are well documented and easily understood. The benefits, meager as they sometimes are, can be overlooked or discounted.

The reinsurer needs to accept the new, sometimes harsh, realities stemming from the insolvency of a cedant and develop a pragmatic and cost-effective exit plan. Understanding why things are suddenly turned on their head is the first step towards these goals. The second step is to meet all obligations under the reinsurance contracts in this challenging new environment so that the situation does not go from bad to worse.

Developing a close and supportive working relationship with the receiver's claims operation will ensure that defendable claims are skillfully handled. Communicating and cooperating in general with the receiver makes good business sense.

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