INTERNATIONAL ASSOCIATION OF INSURANCE RECEIVERS
PROMOTING PROFESSIONALISM AND ETHICS

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PRESIDENT'S MESSAGE

James Kennedy, Esq.

Since the theme of our recent workshop was Back to the Future, let's look back at the last year, and into IAIR's future…

■ We started 2017 with our annual Resolution Workshop. Around 160 colleagues joined us in Austin for a discussion of risks, regulation, and resolution, with a generous side of brisket.

■ IAIR members made return appearances at the Insurance Solvency class at the UConn School of Law, giving students insight into the insolvency process.

■ At the Spring NAIC Meeting in Denver, the Society of Financial Examiners and IAIR hosted a joint presentation on Long Term Care Insurance.

■ The Receivers & Guaranty Fund Relations Committee explored issues impacting both receivers and guaranty funds, such as federal claims and litigation in co-op receiverships.

■ The Issues Forums are always a popular event. At the summer meeting in Philadelphia, we held a joint Issues Forum with AIRROC, covering recent arbitration cases and financial regulation.

■ In October, Donna Wilson moderated a panel of IAIR members in a presentation to the Midwest Zone Guaranty Funds to discuss the challenges facing receivers in the takeover of an insurer.

■ IAIR assisted regulators on both national and international fronts by providing comments to the NAIC Receivership Model Law Working Group the International Association of Insurance Supervisors.

■ After countless hours of painstaking work, the Ethics Committee finalized its proposed designation program, which promises to bring the accreditation process to a new level.

■ And, in February 2018, program Co-Chairs Brett Barratt, Don Roof, and Kevin Tullier did a stellar job of organizing the Insurance Resolution Workshop.

And now, let's get back to the future, and some of IAIR's plans for this year:

■ Our next Issues Forum is just around the corner on Sunday, March 25.

■ On October 11-12, the Technical Development Series returns! The upcoming session will be a collaboration with UConn, and will focus on dealing with the obstacles that receivers encounter in closing receiverships.

■ And last – but certainly not least – the next Resolution Workshop is already shaping up. Join us in New Orleans in February 2019!

That's just for starters. We hope you can be a part of these events this year.

Superintendent Eric Cioppa, NAIC president –Elect, offers his keynote address at the 2018 Insurance Resolution Workshop

MARK YOUR CALENDARS FOR THESE UPCOMING EVENTS

Summer NAIC	August 4-7, 2018 - Boston, MA
IAIR Technical Development Series: Closing A Receivership	October 11-12, 2018 - Hartford, CT
Fall NAIC	November 15-18 2018 - San Francisco, CA
IAIR Insurance Resolution Workshop	February 13-15, 2018 - New Orleans, LA

SUSTAINING THE INSOLVENCY PROCESS THROUGH DISRUPTION

By Roger H. Schmelzer, President & CEO, National Conference of Insurance Guaranty Funds

The natural tension between "disruption" and "sustainability" drives the entire world today. Everywhere you look there seems to be a struggle between preserving legacies and new, simpler ways of doing things. The resolution system is not immune from these forces. From NCIGF's perspective, we have chosen to embrace the shifting business environment by *proactively and constructively* disrupting the insurance resolution world to assure its long-term sustainability.

In each of the last two years, NCIGF has hosted "stakeholder" meetings to which we invite representatives from the property and casualty industry, policymakers and guaranty funds. We have heard loud and clear the expectation by regulators and industry of a functioning and effective resolution system to provide a safety net for insurance customers necessary for carriers to compete for business. It is up to us to steward it.

Through planning and foresight, NCIGF is helping its members meet these expectations on several fronts:

- NCIGF has made great progress on digital data, both from the standpoint of security and the management of claims information relevant to an insolvency. Moving large amounts of digital information securely between insolvent company, guaranty funds and receivers is not as easy as it sounds and is essential to protecting consumers seamlessly. Working closely with insurance receivers in California and Florida, we have utilized our competencies to achieve significant successes in the Castle Point and Guarantee Insurance Company liquidations.

- Guaranty funds must be funded consistently even when there is very little insolvency activity. A common misperception I've come to understand recently is that for some the goal is to realize no company failures ever and to put the resolution professionals—both insurance receivers and guaranty funds—out of business. This misses the reality, if not the entire point; insurance is a highly competitive business and as a result, there will be companies that don't survive. While it doesn't happen often, readiness of the system is counted upon and for that reason, NCIGF members are carefully deliberating options to assure funding continuity.

- Our greatest resource is the people who make the system go! Among the NCIGF membership we are witnessing a significant turnover of experienced employees not unlike the generational shift underway throughout other industries. We have taken this trend seriously and have stepped up efforts to transfer a knowledge base developed over the last 40 years. I'm inspired to see high-performing, long-time leaders of the guaranty fund system go out of their way to share their experience and help usher in a new generation of leadership. We miss those who have already left but I am proud to say system performance remains strong.

- Continuing to be alert to regulatory changes that could impact the U.S. consumer protection mechanism remains a priority. The concept of "systemically important insurer" has lost momentum but the state resolution construct is still expected to meet its duties without the federal government looking quite so closely over its shoulder. Why? Precisely because the state system is so highly regarded. But know this: if the ball gets dropped for any reason, a full-throttle response will result that could fundamentally and unalterably change the way insurance and protection of the industry's consumers is overseen. This is an outcome worth avoiding.

- We are working to end the distraction that can be caused by isolated disputes between guaranty funds and receivers, usually over guaranty fund administrative expenses. I am leading a group of guaranty fund and receivership professionals empaneled by IAIR's Receiver and Guaranty Fund Relations Committee to foster a better understanding of a) the increased need for pre-liquidation planning in a digital environment; and b) the many factors, statutory and otherwise, that impact guaranty fund administrative expense ratios. David Wilson, chair of the NAIC's Receivership and Financial Analysis Working Group (RFAWG) laid out this challenge at the August 2017 NAIC meeting and committee co-chairs, Lynda Loomis and Wayne Wilson agreed to take it up. These issues developed over time and won't be resolved quickly; we could see preliminary results at the Milwaukee NAIC meeting with more to come over at least the next several months, if not years.

It is my very strong belief that the resolution mechanism supports the insurance promise and as such, adds substantial value to the insurance industry and its customers. Members of IAIR and NCIGF are part of this and help fulfill a giant public policy purpose. These responsibilities are embraced with vigor and passion in guaranty fund and receiver offices throughout the country and in the NCIGF headquarters in Indianapolis.

By remaining focused on our mission and the partnership between the two houses of the insurance safety net, we can disrupt what we must to establish a sustained and effective system for insurance resolution.

A MILLENNIAL'S OBSERVATION ON THE INSURANCE INDUSTRY

By Jacob Mitchell MCM

A popular topic at insurance conferences today centers around how the insurance industry can connect with the millennial generation. As a millennial working in the insurance industry, I have a personal perspective on the matter and have incorporated a few observations that I have made through my own choices in the selection of insurance and those of some of my peers. I will be covering renters' insurance, health insurance and some uses for apps. I will also forward some general ideas for changes overall.

To that end, have you ever seen the article that says millennials are killing the housing market? I will give you a hint – it is because our generation can mostly only afford to rent and not own. Thus, renters' insurance is an important market for many millennials. When purchasing traditional renters' insurance, the product offered by the larger insurance companies that most consumers get is a hollow experience of generated policies meant for a more standardized clientele. Unlike many industries, insurance has a history of being slow to adapt, and many experience this when trying to make decisions on their insurance. I was recently having lunch with one of my friends and she was complaining about how much she hated her renter's insurance. However, without knowing or understanding much about the insurance space she felt this was her best option. Like her, in many cases the overwilling nature of the market is too much, and many just latch off what their parents have for their homes.

Recognizing that millennials prefer solutions outside the way that the insurance industry has traditionally done business, some tech-savvy companies—like the app-based startup, Lemonade—are trying to fill the gap by offering easy, understandable coverage at an affordable price. The app clearly explains what you are paying for and (perhaps even more important to some millennials) explains the community of which you are becoming a part. While this concept doesn't matter to me personally, many millennials find communal membership to be an important part of their purchasing decisions. Similar to Lemonade, insurance startups are taking root all over the industry, finding niche markets where larger companies are largely set in their ways, and as a result are out of touch with this demographic.

Health insurance is something that recently has become very important to me. For the last year I have been working as a consultant, without an employer-sponsored health plan. Like many others in this situation, I looked to the state and federal health insurance exchanges, where at best the options are grim. It feels like a jigsaw puzzle where all the pieces are the same color. Many millennials face this same struggle, a lackluster experience of outdated websites, with policy descriptions that don't help you understand what you are getting. That is unless you have written the policies yourself or have studied them extensively. The entire experience is dreadful at best.

However, unlike the case of renters' insurance, I have yet to see a solution for how to improve the health insurance market. Whether the industry is unwilling to change the way it markets and distributes its products or is ignorant of the need for change, it appears to be adapting more slowly to technological advancement and evolving consumer demand than most other industries. I have faith however, that given enough time and regulatory freedom we will continue to see innovation, both from startups and major carriers in this space. This innovation could be as simple as updating the process of purchasing insurance or filing a claim, or as complex as changing how a health insurance policy is developed. I am not an expert in the field, but as an insurance professional, I can say without a doubt that changes need to be made for the industry to respond to the types of demands that millennials are proposing.

To adequately address millennial demands, the industry should start thinking outside of its traditional business model

Many in the industry misunderstand the purpose of apps and how they can add value for consumers and streamline business processes outside of the purchase process. An app does not necessarily need to be used to sell insurance unless of a short-term nature. For example, insurance apps can be used to submit claims on a policy, submit any required follow-up information, and follow the claim's progress through the entire adjudication process. Another notable example of an effective use of apps is policy management, such as paying premiums or checking coverage for specific items that someone might run into, or being able to determine whether you have coverage without needing to contact a claims department or your insurance agent directly. Such a function for the medical insurance field could add a lot to the policy in terms of usability which, in my experience, is currently lacking.

To adequately address millennial demands, the industry should start thinking outside of its traditional business model, which simply does not work for millennials the same way it has worked for previous generations. Cookie cutter policies just don't appeal to millennials. We want policies that are about us, our lives, and what we as people value in the world. There won't be just one answer to solve this problem. It will take a personalized approach from every company for us to move forward. These changes won't be easy and won't be without failure, but at the end of the day if you want to continue to grow then change is necessary.

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THE LONG-TERM CARE CRISIS: THE CAUSE AND EFFECT OF LONG-TERM CARE INSURER INSOLVENCIES

By Fred E. Karlinsky, Esq., Richard J. Fidei, Esq., Christian Brito, Esq., Greenberg Traurig, P.A.

I. Introduction

The long-term care insurance ("LTCi") market has grown significantly since the first LTCi policies were marketed over thirty years ago. In those days Americans were spending less than $20 billion on long-term care ("LTC"). Today, Americans are spending roughly $225 billion on LTC and that number is expected to grow as baby boomers reach retirement age. In the past decade alone, the market for LTCi has grown from insuring roughly two and a half million lives to now covering over seven million lives.

As illustrated in a study (the "Study") conducted by the National Association of Insurance Commissioners ("NAIC") Center for Insurance Policy and Research, there are two key social factors driving the development of LTCi—mortality risk and longevity risk. Improvements in the overall health and mortality rates of the population means that people are living longer and will need to secure resources to cover the cost of LTC for longer periods of time. Many have turned to LTCi, but some unique characteristics of LTCi have made it difficult for carriers to apply accurate rate assumptions when pricing the product. As is explained in greater detail below, state insurance laws generally require that LTCi policies may only be cancelled for non-payment of premium. In addition, products are often designed for premium stability during the life of the policyholder, and policies generally cover the actual cost of care up to a daily maximum. Lastly, where carriers' original pricing assumptions are negated by actual experience, carriers may only adjust premiums after obtaining regulatory approval. Collectively, these factors impair carriers' ability to respond to drastic changes in current and future demand for LTCi.

Many carriers that issued LTCi policies before the mid-2000s have seen adverse claims experience when compared to their original pricing assumptions. As a result, many carriers have implemented class-wide premium rate increases on their LTCi policies after receiving regulatory approval. In response, some insureds have filed putative class action lawsuits challenging rate increases imposed by their LTCi carriers. These lawsuits typically allege that carriers have breached the terms of their LTCi policies and in many instances also allege that carriers violated state consumer protection statues or otherwise engaged in fraudulent conduct.

This article provides an overview of the difficulties being experienced by the LTCi industry as carriers struggle to maintain rate stability and reserve adequacy on blocks of LTCi policies that were inadequately priced at inception. Next, we discuss recent developments at the NAIC and state levels related to LTC insurer insolvencies and the effect of those insolvencies on state guaranty associations.

II. Rate Stability and Reserve Adequacy

In 2016 the NAIC concluded a Study, titled *The State of Long-Term Care Insurance: The Market, Challenges, and Future Innovations*, to gain a comprehensive understanding of LTC and to examine the issues facing the private LTCi market in the U.S. The Study compiles the research and findings of several experts in the LTC and LTCi space, including "thought leaders and researchers in the fields of LTC and insurance, state insurance regulators and other policymakers, insurance industry executives as well as consumer advocates

. . . ." Not surprisingly, the Study discusses the crisis being faced by LTCi carriers in maintaining rate stability and reserve adequacy on in-force policies for which actual experience has been adverse to original pricing assumptions. To help understand the rate stability problem, it is useful to provide an overview of how LTCi policies are priced and regulated.

State insurance laws impose certain requirements on LTCi policies that limit the ability of carriers to respond to adverse claims experience. Specifically, in addition to requiring that initial premiums be designed to remain level for the life of the insured , state laws require that LTCi policies be guaranteed renewable, *i.e.*, the insurer cannot cancel the policy if the policyholder continues to pay premiums. Insurers are permitted to adjust premium rates on a class-wide basis only where actual experience contradicts original pricing assumptions; however, such adjustments to premium rates are subject to regulatory approval.

Counterbalancing the requirement for level premiums, the amount of claims paid per-capita does not remain constant but, instead, increases dramatically over the life of a policy. Generally, the increase in the number of claims can be attributed to four factors:

1. *Aging.* The incidence of becoming disabled or cognitively impaired (and triggering LTC benefits) increases by attained age.

2. *Underwriting selection wear-off.* Most LTCi policies are underwritten . . . based on health conditions [of the insured

at the time of policy issuance]. Claim costs [may] increase [over the course of the policy] as the effect of this initial risk selection wears off . . . .

3. *Marital status changes.* Long-term care claim costs are much higher for people who live alone [as opposed to] married couples. This generally occurs because healthy spouses will tend to provide informal care for disabled spouses. Policies issued to married couples have lower initial claims costs. When one spouse dies, however, claim costs for the surviving spouse [may increase to] the same rate as persons who live alone.

4. *Inflation protection benefits.* Many LTCi policies contain inflation protection benefits. State laws and regulations require [insurers to offer an inflation guard rider] that automatically increases benefits by 5% . . . each policy anniversary (with a level premium rate).

As a result of the disconnect between generally stable premiums and consistently increasing claims, premiums will surpass the cost of claims in the early stages of a standard policy; however, the opposite will occur for the book of business as policyholders age and the frequency and severity of claims increase. To fund the later increase in claims, insurers create a reserve by setting aside and investing the premiums received during the early policy years, which are then used to fund policies once the cost of claims exceed the premiums being collected. Accordingly, for LTCi to remain viable, original pricing assumptions must accurately gauge future claims costs so as to create sufficient reserves to fund additional claims occurring in later years. Unfortunately, the original assumptions upon which some of the older in-force policies were priced have not accurately predicted future claims costs and, as a result, the majority of those policies on the market have not generated sufficient reserves to cover actual claims costs.

Indeed, "[v]irtually all insurers issuing LTCi policies prior to the mid-2000s have observed adverse experience on these policies when compared to pricing assumptions." The historical assumptions upon which those policies were priced, and which proved to be incorrect, can be summarized as follows:

• *Low lapse and mortality rates.* [LTCi] is a lapse supported product. If voluntary lapse and mortality rates are lower than expected . . ., there will be more policies in-force at later policy durations than were expected when the policies were priced. Because of the mismatch of level premium rates and claim costs that increase steeply by policy duration, the additional premium collected from the greater number of in-force policies will not be enough to fund the additional claims occurring at later years.

• *Interest rates.* The assets held in reserve to fund future cash out-flows . . . are expected to generate investment income. If this investment income is less than expected, the assets, together with premium collected, will not be sufficient to fund . . . future benefits and expenses.

• *Morbidity.* Morbidity is comprised of three factors: (i) claim incidence rates; (ii) length of claim; and (iii) benefit utilization. While [a report by the United States Department of Health and Human Services upon which the Study relies] does not directly list specific assumptions used in earlier pricing [calculations], it does state that publicly available data sources generally were used to develop assumptions. In general, these sources did not include experience for assisted living facilities, which have become a highly utilized care setting, and which result in a longer . . . claim [duration as compared to] . . . nursing homes. Although this trend by itself generally is not

enough to have a severe impact on reserve adequacy, it can compound the level of reserve deficiency when combined with lower lapse [rates], mortality issues and lower investment earnings.

To offset future losses and attempt to restore reserve adequacy, the majority of LTCi carriers have undertaken corrective measures, such as: (i) requesting premium rate increases;

(ii) offering benefit reductions; or (iii) recognizing losses.

Premium rate increases are perhaps the most common, albeit limited, method of offsetting future losses. Rate increases are prospective in nature and generally prove less effective for older policies. "This is because the amount of premium collected in later years is much less than benefit payments and there are fewer policyholders paying premium, which causes the level of rate increase needed to restore reserve adequacy to be very large." Such high levels of rate increases are generally viewed by regulators and insurers to be unfair to policyholders and, as a result, most approved premium rate increases do not completely restore reserve adequacy by themselves.

To avoid or mitigate the negative consequences of rate increases, many insurers have chosen to offer their policyholders the option to reduce benefits. This option will sometimes be offered in lieu of, or in conjunction with, premium rate increases. This means that policyholders are given the option of reducing their daily benefit, benefit period, or other benefit options, such as inflation protection.

Finally, when all else fails, carriers may need to supplement reserve deficiencies with profits from other products or lines of business.

Taken together, the level-nature of premiums, limited ability of carriers to adjust premium rates, and limited and problematic options available to carriers who are under-reserved, have created a crisis for LTCi carriers that will only get worse as the number of baby boomers entering retirement increases. This has led to certain high-profile LTCi company insolvencies that have placed considerable strain on state-based life and health ("L&H") insurance guarantee associations and have drawn the attention of regulators and the public. Below we discuss how some state legislatures and the NAIC have reacted to those insolvencies.

III. NAIC and State Initiatives Addressing LTCi Insurer Insolvency

LTCi has historically been classified as health insurance by state guarantee associations, meaning that the responsibility of handling the policy obligations of liquidated LTCi insurers has traditionally fallen almost entirely on health insurers. Recently, the NAIC and some state legislatures have sought to expand the assessment base for L&H insurance as a response to the growing LTCi crisis.

The NAIC Financial Condition (E) Committee (the "Committee") is charged with evaluating issues related to LTCi insolvencies and the effects of those insolvencies on state insurance guarantee funds. The Committee is further charged with determining whether to amend certain NAIC model laws to address the financial challenges of LTCi insolvencies. In furtherance of the Committee's objectives, the Receivership Model Act (E) Working Group (the "Working Group") and the Receivership and Insolvency Task Force (the "Task Force") have been tasked with considering whether to amend the Life and Health Insurance Guaranty Association Model Act (NAIC Model #520, the "Model Act") and expand the assessment base.

The Working Group and Task Force proposed revisions to the Model Act that were intended to address the financial challenges of LTCi insolvencies and bring Health Maintenance Organizations ("HMOs") within the guaranty associations' protection and assessment base.

The two major changes proposed in the exposure draft included the following:

- Requiring HMOs to become members of the various state L&H guaranty associations where they do business, thus adding them to the assessment base and extending guaranty association coverage to their enrollees and healthcare providers;
- Specifying precisely how to allocate Class B guaranty association assessments relating to impaired or insolvent LTCi insurers to the then-existing two assessment accounts which were (i) the Life and Annuity Account and the (ii) Health Account, which would be augmented to include HMOs.

The core problem the Working Group and the Task Force faced is that the LTCi market is simply not large enough to bear the financial burden of guaranty association assessments for any significant LTCi insolvency. Accordingly, for the traditional guaranty association system to be viable for this challenged line, a broader premium base for guaranty association assessments must be established. Further, as discussed above, the majority of premiums received on LTCi policies are classified as health insurance premiums. Under the traditional assessment approach, health insurers bear the bulk of the related guaranty association LTCi assessment burden, even though LTCi is traditionally written by life insurance carriers. Moreover, some commenters have observed that health markets within a state may be dominated by one insurer, or a small number of insurers, which creates a situation in which only a few member insurers bear a significant portion of the assessments associated with LTCi insolvencies.

Together these circumstances have created an issue for state legislatures related to the equity of using the traditional assessment practice in LTCi insolvencies. To address the issue, the Working Group and the Task Force adopted revisions to the Model Act that established a broad assessment base for LTCi and represented a departure from that traditional approach. Specifically, the Working Group and the Task Force adopted revisions to the Model Act that provide, in pertinent part, that L&H accounts would be equally assessed (i.e., a 50/50 assessment split between life insurance carriers and health insurance carriers) and add HMOs to the types of entities that will be subject to assessments.

On December 4, 2017, the Committee voted to adopt the proposed amendments to the Model Act. During that meeting,

parties expressed concerns that the 50/50 assessment would fall disproportionately on the health insurance industry. Some commenters favored an assessment approach that would be computed using a market-share analysis approach. Others responded that the issue had been debated extensively by the Working Group and Task Force and, while it was acknowledged that 50/50 split would not be entirely equitable, it was not possible to tie assessments to market share. Ultimately, the Committee agreed that a 50/50 split was a reasonable compromise and voted in favor of adopting the proposed amendments. Those amendments were later adopted by the NAIC's Executive (EX) Committee and Plenary on December 21, 2017.

Prior to the adoption of the proposed amendments, every state, the District of Columbia, and Puerto Rico had adopted the Model Act, at least in part, or had enacted similar legislation aimed at protecting LTCi policyholders from loss due to insolvency. It is too soon to determine the extent to which states will implement the proposed amendments to the Model Act. However, given the pervasiveness of the issues affecting the national LTCi market, it is anticipated that the changes will be widely adopted by the states.

Some state initiatives pre-dated the NAIC's adoption of the proposed changes to the Model Act. HB 1273, titled "Insurer Insolvency," was filed in the Florida legislature in 2017 and would have required, in pertinent part, that assessments made for the payment of obligations under LTCi policies of an impaired or insolvent insurer be made against all health insurers and life insurers in an amount sufficient to pay all LTC obligations as they come due. Importantly, the bill provided for a market-based approach to calculating the assessment base. Specifically, the bill required that assessments for each member insurer be based on the ratio of the combined total of L&H insurance premiums written in Florida by the insurer for the 3 most recent calendar years to the combined total of L&H insurance premiums written by all member insurers for the 3 most recent calendar years. The bill did not become law, but it serves as an example of one state's approach to expanding the L&H insurance guarantee association base and addressing the LTCi crisis. Notably, the approach adopted in the bill differed from the NAIC's 50/50 split approach. If and when the Florida legislature considers whether to adopt the NAIC's proposed changes to the Model Act, one key issue will be whether Florida chooses to adopt the NAIC's 50/50 split, or whether it adopts a market share approach similar to the one that was proposed in HB 1273.

IV. Conclusion

The provision of LTC is one of the most important, yet problematic, social challenges facing our country. Overall improvements in health and longevity have drawn focus to the need to provide solutions for consumers to obtain health and senior care services at an affordable price. Due to the length of time stakeholders need to project and estimate healthcare and daily living needs, the nature and advancement in life-saving and life-prolonging medical care, and the costs thereof, it is extremely difficult to formulate and implement achievable solutions that accommodate availability and affordability needs of consumers, while maintaining insurer solvency. If LTCi is to remain viable, carriers will need to attract new consumers by offering them an attractive product design and price. Unless the consuming public is confident that LTCi provides a valuable, long-term solution, and insurers maintain a product design and pricing mechanism that will accommodate future developments in medicine, difficult issues related to the ongoing stability of this market will continue to arise.

Donna Wilson, past President of IAIR, receiving a honorary plaque at the 2018 Insurance Resolution Workshop, with Commissioners Donelon and Doak and current IAIR President James Kennedy

THE PERFECT RECIEVER: DOCUMENT MANAGEMENT

By Patrick Cantilo, Cantilo & Bennett

I am a really strong guy! I can lift 28 FULL sets of the 32 volume Encyclopedia Britannica with ONE finger. What's more, so can you. For about ten bucks you can buy a 128GB flash drive that weighs about a third of an ounce and can carry 28 full copies of this now-nearly-obsolete encyclopedia. The advent of ever-larger and more affordable digital storage options has revolutionized raw data management. The consequences are particularly important for receivers. Never shy about addressing a subject of which I know next to nothing, in this column I will explore issues in management of data and documents.

Recently, I found myself in a forest testing the hypothesis that if a husband says something alone therein, and his wife is not there to hear him, he is still wrong. While working diligently on this important scientific endeavor[1] I overheard the following conversation among some trees:

TREE NO. 1: *The good news is that with modern data communication and storage techniques the demand for paper has declined dramatically, meaning more of us will survive into adulthood and old age.*

TREE NO. 2: *Yeah but then we will have more stupid squirrels climbing all over us and filling us with pesky nuts and acorns!*

TREE NO. 3: *You are both wrong, as usual. In fact, paper use in the U.S. has more than doubled in the last two decades. I wouldn't be surprised if when I wake up in the morning both of you ignorant fools have been taken by the mean guys from the mill.*

Yep! Hard as it is to believe, tree No. 3 is right; we continue to use more and more paper! But just because the other little receivers in your class do so doesn't mean you have to. As I will demonstrate more fully in the paragraphs that follow, your life as a receiver will become more rewarding in inverse proportion to the change in the quantity of paper your receivership consumes.

This principle, known in scientific circles as Pythagoras' OTHER Theorem[2] (or "POT"), should become one of the important guidelines in your receivership planning. Pythagoras' OTHER

Theorem is expressed as $\Delta RH \propto 1/\Delta PC$, where ΔRH is the rate of change in your happiness as receiver and ΔPC is the rate of change in the consumption of paper by your receivership.

Algebraically: $\Delta RH = K/\Delta CP$, where K is the constant of proportionality. Although K may vary from receivership to receivership, massive studies by the National Enquirer suggest that it will generally fall in a range of from 3 to 9. Thus, assuming for purposes of illustration that K=6, if your paper consumption declines by 10% your receivership happiness will increase by 60%. You can see readily, then, why POT can be a key ingredient to your success as a receiver.

As you have no doubt already observed[3] receiverships inherit, generate and consume vast quantities of data much of which takes the form of paper but would be just as useful in electronic

form. Call this "Flexible Data." On the other hand, there is some data that can ONLY be in one form or the other. Call this "Rigid Data." Examples of Flexible Data are drafts of nearly anything, electronic mail[4], spreadsheets, calendars, contact lists and many more things I can't remember just this second. Examples of Rigid Data that must be in physical form are your: 1) birth certificate, 2) driver's license,[5] 3) passport, 4) marriage license, 5) divorce decree, 6) second marriage license, and 7) second divorce decree. There may be other things but I'll bet you a fraction (to be determined by me) of a bitcoin that I can make a persuasive case that NO, they really don't have to be on paper. Moreover, in time even these documents will exist only in electronic form.

Soooo, our mission is to see how much of the Flexible Data we use daily we can preserve strictly in electronic form. "Why" you ask (oblivious to the need to save trees)? Because it is much cheaper and more effective to organize, handle and store data electronically than physically. It is also much, much, much, much easier to retrieve and destroy electronic files than paper ones. Running your receivership as much a s possible in electronic form will save you money, reduce aggravation, and accelerate the decision-making process.[6]

There is almost no aspect of a company's operations (whether or not in receivership) that does not go far more smoothly if the associated data is managed in electronic form.[7] Ask anyone

who has had to go to a musty old warehouse to find the 1977 annual statement of Sans Coeur Life Insurance Company only to be confronted by: a) two rats bigger than my aunt's Schnauzer, b) a set of stacks held together by rubber bands manufactured in a Peruvian rainforest in 1921, and c) a layer of dirt 13.5 millimeters thick that makes reading any label an absolute impossibility. That is an unhappy individual! By contrast, his ever-lucky brother in-law was tasked with retrieving the same document from his computer (which he did in two minutes) and is now laying back at the bar, third Margarita in hand, inventorying all the fun ways he will spend the rest of the day while his brother in-law remains at the warehouse.

From correspondence, to event tracking, from financial reporting to claims adjudication, from lawsuit to paycheck; almost every

aspect of day-to-day operations goes much faster in digital form while saving the enormous costs of acquiring, placing ink upon, and storing paper. Moreover, data managed electronically can be manipulated far more easily. Have you ever tried to drag and drop a paragraph from the WSJ into your handwritten report? And organizing your files so that those that can be destroyed in 2018 can be found easily is much easier on your computer than in the warehouse in which Sans Coeur Life Insurance Company maintains its archives. The destruction is also much faster and cheaper.

"What's the catch," you ask? You must take extensive precautionary measures to protect your electronic data and have current back-up sets available when needed. But this is another subject completely foreign to me, so it is likely to be the subject of one of my next columns.

I hope that I have gotten it through your thick skull: STOP WITH THE PAPER ALREADY!

And don't forget the importance of POT in your receivership.

Patrick Cantilo is a very old Texas receiver who once was president of IAIR and served on its board of directors for ten years until he showed up at a meeting and they promptly booted him out! He practices law with Cantilo & Bennett, L.L.P. in Austin.

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1. While not central to this article, the conclusion of my research nevertheless is notable: YES.
2. The originator is not the more famous Ionian philosopher, Pythagoras of Samos, but rather his less well-known contemporary cousin, Pythagoras of Sybaris, or "Mini Pyt" as his friends called him. Mini Pyt became famous also for owning the first chain of Kinko's stores in ancient Greece. Those, however, proved a poor investment because the copier had not yet been invented and they had nothing to do.
3. And yet you have failed to do anything about it or I wouldn't be having to mention it now.
4. There is a special place in hell for those who religiously print their emails: they will be condemned to listen to the recorded speeches of all great conservationists for the rest of their duration - without interruption!
5. Soon to be replaced by SSP Licenses as self-driving cars take my last savage pleasure from me. SSP licenses, of course will be those issued to Specially Skilled Passengers who have demonstrated the required proficiency to lift the clear plastic cover and press the red "STOP" button whenever their self-driving cars decide that they have made enough trips to the ***Bull and Anchor Pub*** and should instead head to the nearest coffee shop.
6. Some have suggested that it will also erase the wrinkles on your face and give you the stamina of a twenty-year-old on speed. These claims remain the subject of extensive laboratory testing and have not yet been approved by the FDA.
7. The lone recognized exception being the annual Management Paper Airplane Contest, which has never been won by a flash drive, although a CD-ROM came close in 2014.

Deputy Ins. Commissioner Brett Barratt moderating a panel with Mark Sagat (NAIC), James Kennedy (TDI), Kathleen Maurer (NJDOB), Pat Hughes, (FaegreBD)

2018 INSURANCE RESOLUTION WORKSHOP WRAP UP

By Kevin Tullier, Veris Consulting, co-chair 2018 Insurance Resolution Workshop

How many movie quotes can you use in a two and a half day seminar? Attendees at the 2018 IAIR Insurance Resolution Workshop learned this and more in Scottsdale in February. The event covered a wide range of interesting topics, and was highlighted by presentations by Maine Superintendent Eric Cioppa, Oklahoma Commissioner John Doak, Louisiana Commissioner Jim Donelon, and industry experts.

As all good insurance conferences do, it started with an entertaining discussion of veterinary techniques and pragmatic solutions that Stephanie Mocatta has successfully implemented in run-offs. This was followed by an update on current regulatory issues was provided by Pat Hughes, Mark Sagat, James Kennedy, and Kristine Maurer, including the recent amendments to the guaranty association model law.

Commissioners Donelon and Doak gave personal accounts of what's new about the potential privatization of flood insurance, as well as other developments in their respective states in a panel discussion moderated by Fred Karlinsky. Superintendent Cioppa gave the keynote address, discussing his upcoming NAIC presidency and how the organization is planning to face the many challenges facing the industry.

Following lunch, John Morrison, Darren Ellingson, Michelle Avery and Steve McBrady discussed a variety of topics regarding the status of the state Co-ops and the current litigation making its way through the courts. The first day concluded with John Humphries, Wayne Johnson, and Jan Moenck teaching us that what sounds like a duck may actually be a duck-headed horse….and how that relates to a risk-based approach to analysis can prevent you from thinking it may just be a duck.

Friday morning opened with a panel moderated by Doug Wheeler, where Tom Hampton and Matt Morton were joined by Kristine Maurer and James Kennedy to discuss the troubled Long Term Care market. Craig Brookes, Beth Reeves, and Sara Bishop followed with a discussion of how to maximize efforts to recoveries when litigating on behalf of a company in liquidation. Paige Freeman and Kimberly Welsh gave an international perspective on how the new Covered Agreement is expected to change, and not to change, their business.

The Workshop ended with a cameo appearance by James Woods in the Ethics presentation by John Humphries, Eric Scott, and Bill Goddard.

Long Term Care panelist Tom Hampton of Dentons

Commissioners Donelon and Doak discussing private flood insurance, moderated by Fred Karlinsky (Greenberg Traurig)

Deputy Insurance Commisioner Brett Barratt, Workshop co-chair, addresses Workshop attendees

THE RECEIVERSHIP LEGAL REVIEW

By C. Phillip Curley and Robert L. Margolis, Robinson Curley P.C.

In August 2017, the federal district court in Alabama held that "the misdeeds and/or negligence of Colonial [Bank] employees" would not be imputed to the FDIC as Receiver of Colonial Bank (the "Bank") for purposes of in pari delicto defenses being asserted by PricewaterhouseCoopers ("PWC"). FDIC v. *PricewaterhouseCoopers LLP*, No. 2:12-cv-957-BJR, Order (M.D. Ala. Aug. 18, 2017). The significance of that ruling became apparent in December. After the liability phase of a bifurcated bench trial, the court ruled that PWC's *in pari delicto* defense barred the professional negligence claims of the Bank's holding company, Colonial Bancgroup, Inc. ("CBG"), but not the professional negligence claims of the FDIC as Receiver of the Bank. *FDIC v. PricewaterhouseCoopers LLP*, No. 2:11-cv-00746-BJR-TFM (M.D. Ala. Dec. 28, 2017) (Order on the Liability Phase of the PWC Bench Trial).

Under Alabama law, the *in pari delicto* doctrine "bars recovery by a plaintiff who is equally as guilty as the defendant in the breach of the law." *Ex Parte W.D.J.*, 785 So.2d 390, 392 (Ala. 2000). The court in *FDIC v. PricewaterhouseCoopers* in upholding PWC's in pari delicto defense against CBG found that the intentional acts of two Bank employees who had pled guilty to criminal fraud charges – senior vice president Catherine Kissick and operations analyst Teresa Kelly, who worked under Kissick – should be imputed to the Bank, and ultimately CBG, because they were acting under the "misguided" but sincerely-held belief that it was beneficial to the Bank to appease its "most important customer," Taylor, Bean & Whitaker Mortgage Corp., which at the time was perpetrating a large-scale fraud.

The court looked at evidence of Kissick's and Kelly's "incentives" in engaging in their fraudulent conduct and concluded that (i) in the initial stages of the fraud, they were motivated "not to alienate and perhaps lose their largest customer"; and (ii) in the next stages they were trying to buy time so that the Bank could be made whole. The fact that neither personally received any funds as a result of the fraud was also probative. While Kissick's and Kelly's belief that they were furthering the Bank's interests may have been "misguided," the court found those beliefs to be genuine, defeating CBG's argument against imputation. Because their conduct could be imputed to the Bank, it could also be imputed to CBG.

Under Alabama law, a receiver generally "stands in the shoes" of the failed entity he or she represents. If not for the public policy concerns the court cited in its August 2017 ruling – "the FDIC brings suit on behalf of innocent third parties" and the Bank "is in receivership and no longer exists" – FDIC's professional liability claims against PWC would likely have been barred by the same imputation argument that defeated CBG's claims against PWC. Because those public policy concerns did not apply to CBG's claims, the court found imputation against CBG to be proper based on its "requisite indicia of control over [the Bank] such that CBG is liable for Colonial's actions."

Directors of an insurance holding company may owe fiduciary duties to a wholly-owned insurance company subsidiary and its policyholders.

A regulated insurance company has constituencies other than just its parent holding company, including policyholders. *See, e.g., Meyers v. Moody*, 693 F.2d 1196 (5th Cir. 1982). Thus, courts have held that an insurance company parent owes fiduciary duties to its insurance company subsidiary and its policyholders. *In re Rehabilitation of Centaur Ins. Co.*, 632 N.E.2d 1015, 1018 (Ill. 1994) ("An action by a parent corporation injurious to its subsidiary is actionable as a breach of fiduciary duty."); *Pioneer Annuity Life Ins. Co. v. Nat'l Equity Life Ins. Co.*, 765 P.2d 550 (Ariz. Ct. App. 1988) ("As controlling shareholder, Pioneer and its officers on the [subsidiary] board owed [the subsidiary] and its cognizable communities of interest a fiduciary duty to act fairly … In our opinion, that fiduciary duty was owed to the policyholders and contract holders of [the subsidiary]."); cf. *Four Star Ins. Agency, Inc. v. Hawaiian Elec. Indus., Inc.*, 974 P.2d 1017 (Haw. 1999) (liquidator of insolvent insurance company may bring action for breach of fiduciary duty on behalf of policyholders and creditors against corporate parent); *Corcoran v. Frank B. Hall & Co.*, 545 N.Y.S.2d 278 (1st Dept. 1989) (same).

A Recent Decision Shows Public Policy Concerns, When Recognized, May Be The Difference Between Winning And Losing A Professional Liability Claim.

There is no reason to believe that these fiduciary duties to the subsidiary insurance company and its policyholders does not extend to parent company directors as well. Indeed, in *Four Star* and *Corcoran*, liquidators of the insurance company subsidiaries had sued parent company directors but settled those claims before the above decisions were rendered. State insurance codes may also contain provisions permitting parent company directors to take management roles in the insurance company. *See, e.g.*, 215 ILCS 5/131.20(b)(2) (insurance company and its affiliates may have or share "a common management or a cooperative or joint use of personnel, property, or services"). While the extent to which a parent company director assumes such a role may ultimately be a fact question, once a parent company director's role in the management of the insurance company subsidiary is established, duties to the subsidiary and its policyholders should follow.

The Receivership Legal Review is presented by C. Philip Curley and Robert L. Margolis, partners in Robinson Curley P.C. It contains general information about receivership-related legal issues and case law, does not constitute legal advice, and should not be treated as such.

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LIST OF NEW IAIR MEMBERS

Tina Arendall
Tina Arendall is an Accredited Financial Examiner with the Texas Insurance Department.

Kandi Buckman
Kandi Buckman is the Director of the Bureau of Liquidations & Rehabilitation Administration for the Pennsylvania Insurance Department Office of Liquidations, Rehabilitations & Special Funds. She was the Chief Liquidation Officer for Lincoln General Insurance Company. Kandi obtained her Juris Doctorate from Drake University Law School.

Gina Cook
Gina Cook is a Senior Consultant at Risk & Regulatory Consulting where she provides troubled company and receivership consulting services for a broad range of regulatory clients. Gina has extensive knowledge providing claims oversight for companies in Rehabilitation or Liquidation status, establishing, reporting and adhering to project timelines. She has experience in Auto, Homeowners, Workers Compensation, Medicare HMOs, Title Insurance, Mutual and Auto Warranty Receiverships and non-policy claim evaluations including government entities, company employees, general creditors and shareholders. Gina coordinates noticing activities and manages handling of receivership claims by Third Party Administrators to ensure timely adjudication, contract compliance and quality deliverables.

Guy Hohmann
Guy Hohmann of Hohmann, Brophy and Shelton, PLLLC. The practice focuses on representing or serving as a court appointed Receiver as well as securities fraud, commercial litigation, professional liability litigation and insurance litigation. Guy obtained his Juris Doctorate from the University of Houston and is also a Certified Public Accountant. He is admitted in Texas and Colorado.

Moya McKenna
Moya McKenna is an attorney with the Texas Department of Insurance. Prior to joining the Texas Department, she was employed by Reed & Associates, CPA Inc in Manassas, VA. Ms. McKenna received her Juris Doctorate from Quinnipaic University School of Law and is admitted to the bar in Texas and New York.

Belinda Miller
Belinda Miller is the President of Belinda H Miller PA specializing in insurance regulatory consulting. Previously, Belinda was Deputy Insurance Commissioner for Property & Casualty, General Counsel and Chief of Staff for the Florida Office of Insurance Regulation. She obtained her Juris Doctorate from the Florida State University College of Law.

Michael O'Day
Michael O'Day is a seasoned financial executive with over 40 years in the life Insurance and related guaranty association industries.

Michael graduated from the University of Washington with a degree in Accounting. A CPA, with a currently retired certificate, Michael has spent most of his career in financial reporting and management. He has been the Executive Director of the Washington Life and Disability Insurance Guaranty Association since 2004.

Michael and his wife have a small horse farm in Shelton, Washington where they spend most of their spare time doing chores.

James Potts
James Potts of Cozen O'Connor has more than 20 years of experience in insurance and corporate matters. He also serves on the board of governers of the Academy of Risk Management and Insurance, Erivan K Haub School of Business at Saint Joseph's University. James is admitted to practice in Pennsylvania and before the US District Court for the Eastern District of Pennsylvania, the US Court of Appeals for the Third Circuit and also the Supreme Court of Pennsylvania. He earned his undergraduate degree, magna cum laude, from the University of Florida and his law degree cum laude from Georgetown University Law Center.

Sheri Shudde
Sheri Shudde is the Deputy Receiver with the Arizona Department of Insurance. She obtained her Juris Doctor from the Phoenix School of Law and also has a Bachelor of Science in Nursing from the University of Arizona College of Nursing.

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