The Insurance Receiver

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International Association
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c/o The Beaumont Group, Inc.
3626 Tremont Avenue, Suite 203
Throggs Neck, NY 10465

Tel: 718-892-0228
Fax: 718-892-2544
www.iair.org

To My Colleagues and Friends:

It is hard to believe that two years have come and gone since I was elected as IAIR's President.

Francine L. Semaya, Esq.

As I step back and think about these past two years, I am proud of our accomplishments and frustrated by how much more I'd like to champion.

IAIR has become my home away from home and I am certainly not alone. The success of a leader depends mostly on her team – and I have been truly blessed. First, to my executive board – ready to respond at the last minute – providing sound and often challenging advice – my special thanks to my friends: Joseph DeVito, Patrick Cantilo, Hank Sivley, Lowell Miller, Mary Cannon Veed and our legal counsel, Bill Latza. We make a great team. In addition, we have had two of the most active, interested and devoted Boards of Directors. Even in these difficult economic times, this Board has taken its role seriously, has watched over our financials, has encouraged innovative growth and demonstrated continued interest and loyalty in the success of IAIR. Further, special recognition must be given to our dedicated committee chairs and members – I encourage IAIR members to get more involved.

All of us are volunteers and sometimes it amazes me how we find the time to dedicate ourselves to IAIR and other not-for-profit industry and charitable organizations. A little secret – "we couldn't do it without our dedicated administration staff. Early in my tenure Paula Keyes and Associates turned over their reigns to The Beaumont Group, (once again, many thanks to Paula for her years of hard work), and together we have worked through the rough spots and overcome some significant learning curves. Maria, I will truly miss our midnight conference calls, but I will be here for you and your team.

Whenever one steps into a leadership role, they come with dreams and goals. I am not any different. To me the success of any organization is its members and in these difficult economic times, retaining members is as difficult as recruiting new members. With hard work and perseverance IAIR continues to

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IAIR's President's Message (Continued)

grow – not only by retaining members, but also by the addition of new members. We must never lose sight of our most valuable asset – our members. I look forward to continuing my work in reaching out to our current membership and recruiting new members alike.

As I began my first term, we took a good look at ourselves and developed a broader outlook on what IAIR needs to become. We have expanded our educational programs to focus, not only on direct receivership issues, but on hot financial and regulatory issues that impact the insurance industry. We have looked within and concluded that we can be the educational resource for regulators and examiners as they work with troubled companies. Therefore, will again begin our successful road show educational seminars directed at regulators and examiners at insurance departments around the country.

IAIR's Insolvency Workshops (SAVE THE DATE – April 21-23, 2010 at the Eden Roc, Miami Beach, FL) have taken on new dimensions and this coming event, which I will co-chair with Dennis LaGory, is no different. We will also offer a 2 hour – Insolvency Primer preceding the reception to be held April 21 – for those newcomers to receiverships and for those who can use a "brush-up" course. Don't forget the dates.

Our Issues Forum (thanks to Phil Curley and Michael Cass) continue to attract excellent speakers/faculty and a growing attendance. IAIR will continue to offer these informative forums. Step up with new ideas and join our leadership team.

Last, but not least, my favorite forum is the morning Think Tank Sessions. We certainly have taken on a new dimension – guest speakers, provocative facilitators and an open and honest forum to share experiences, challenge ideas and decisions and to plan future courses of actions. As President, it has been my privilege to not only chair but also to instigate our lively discussions.

As I come to a close, it is with pride and sadness that I bid you adieu as President and proudly introduce IAIR's next President, Patrick Cantilo – a colleague and dear friend. I leave IAIR in good, capable hands – but rest assured, I remain active, loyal and challenging as we move forward.

My best personal wishes to each of you and your families for a happy, healthy, and peaceful holiday season and a new year filled with success and prosperity.

With greatest appreciation
Francine L. Semaya, Esq.
President

IAIR Welcomes New Members

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

Francine L. Semaya, IAIR President, presents James Friedman with his AIR Designation plaque

John Catlett, Jr. is an attorney for Sands Anderson Marks & Miller located in Richmond, Virginia. He is a member of the firm's Estate & Tax Planning practice group. Mr. Catlett works with people to help them preserve their estates. He is a past chairman of the Greater Richmond Chamber of Commerce's Richmond Business Council.

Joseph DellaFera is CEO of the New Jersey Property-Liability Insurance Guaranty Association located in Basking Ridge, New Jersey. He is responsible for the overall management of the organization.

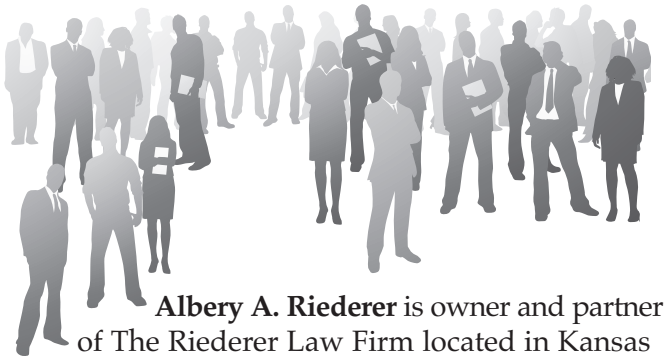
Robert Elias is with the Florida Dept. of Financial Services Division of Rehabilitation and Liquidation in Tallahassee, Florida.

Michael Gleeson is with the Office of the Special Deputy Receiver located in Chicago, Illinois.

Ben Lacey is a lawyer for Sands Anderson Marks & Miller located in Richmond, Virginia. He currently serves as Chairman of the Governmental Relations Practice Group. Mr. Lacey has experience with the regulatory and administrative process. His primary focus of work is the life, health, property and casualty insurance industry.

Thomas McCarthy is with McCarthy, Leonard & Kaemmerer LC located in Chesterfield, Missouri.

Howard Mills is a Director and Chief Advisor, Global Insurance Practice of Deloitte Touche located in New York City. He is an experienced leader in the insurance industry. Mr. Mills is a former New York State Assemblyman, twice-elected. Mr. Mills was first elected to the New York State Assembly in 1998. There, he served as the Deputy Minority Leader and sat on the Banking and Housing Committees. Mr. Mills also held the position of Superintendent of Insurance at the New York State Insurance Department prior to joining Deloitte.



Albery A. Riederer is owner and partner of The Riederer Law Firm located in Kansas City, Missouri. He focuses on representing individuals and businesses in civil litigation and in personal, family, and business transactions, and in governmental relations.

Erin Shanley is a lawyer for Stone Loughlin & Swanson, LLP located in Austin, Texas. Her areas of concentration are in general civil litigation and insurance law.

Andrew Shaffer is with Mayer Brown, LLP located in New York City. He is a member of the Restructuring, Bankruptcy and Insolvency practice. Mr. Shaffer became partner of the firm in 2009. He represents institutional creditors in bankruptcy proceedings, workouts and other situations.

Gail Pierce-Siponen is the Director of Estate Management for the New York Liquidation Bureau located in New York City. Ms. Pierce-Siponen is responsible for the day-to-day operations of the Estate Management Division.

Angel Garrett is the Director of the Rehabilitation & Liquidation Oversight for the Texas Department of Insurance located in Austin, Texas. Ms. Garrett has also participated on NAIC working groups. She is a member of AICPA.

Jemmie Russell is a Receivership Analyst for the Texas Department of Insurance located in Austin, Texas. She participates in the NAIC Working Group for Global Receivership Information Database implemation and coordinates RLO GRID input.

Rachel S. Giani is an attorney for the Texas Department of Insurance located in Austin, Texas. Ms.Giani is also a member of the Texas Journal on Civil Liberties and Civil Rights.

James A. Hall is a Consulting Actuary for Bartlatt Actuarial Group, Inc. located in Burlington, Vermont. He is a member of the American Academy of Actuaries.

Kathy Gartner is a Receivership Analyst for the Texas Department of Insurance located in Austin, Texas. She monitors the administration and progress toward closing of various receivership estates.

Fighting Against the Tide

A quiet hurricane season disguises the growing impact of coastal development on insurance resources.

By Howard Mills

After Hurricane Katrina brushed the southeast coast of Florida in August 2005 as a Category 1 hurricane, and was downgraded to a tropical storm a few hours later, many breathed a premature sigh of relief.

Howard Mills

But the Katrina story was just beginning. The once-mild hurricane re-emerged off western Florida, drew strength from the Gulf of Mexico's warm waters and became a monster. With seven states affected, the storm's aftermath caused $45.3 billion in insured losses.

Storms like Katrina–or even worse–are inevitable. Meteorologists and risk experts predict a mega-storm in a highly populated area, such as Miami or New York, is very likely in the near future. The challenge is to be prepared to minimize fatalities and reduce property damage when the "big one" hits.

Meeting this great challenge calls for a willingness to think outside of the box in finding solutions that meet the social, economic and environmental needs of all stakeholders. This is easier said than done. For example, the term "smart development" has been around a long time, and who could argue against such a sound concept? However, getting two industries with competing interests–say, risk-based pricing for insurance and controlled cost for real estate–to work together to impact policy is very difficult.

Despite repeated blows from tropical storms and total insured losses exceeding $137.7 billion from 1987 to 2006, according to the Insurance Information Institute, population has continued to grow along the nation's coasts.

In fact, the Massachusetts Office of Coastal Management notes that 53% of the U.S. population resides in coastal counties. More specifically, between 1950 and 2007, population in coastal counties extending from North Carolina to Texas grew by 247%.

But growth doesn't stop there. By 2030, Florida's population is estimated to grow by 52.2% and Texas is expected to see a 41% jump, while projected population growth in the United States as a whole is set at a comparatively modest 20.9%, according to the Institute. Moreover, in the Delaware Estuary–a highly commercialized area which includes portions of New Jersey, Pennsylvania and Delaware–population is projected to increase nearly 11%, from 4.9 million in 1990 to 5.3 million in 2020, with developed land forecast to increase 36%, according to the New Jersey Department of Environmental Protection.

Driven largely by demographics, necessity and pressures on long-term growth trends in housing, coastal real estate development is expected to continue to grow, both in the near- and long-term.

With a history of choosing warm climates in the Southeast as the ideal retirement spot, one sure buying group is expected to be the baby boomer generation. In 2008, 3.2 million baby boomers turned 62, joining the ranks of an estimated 37 million Americans who are age 65 and older, a figure that is expected to nearly double by 2030, and seems certain to raise demand for new retirement communities, apartments and single-family homes in coastal areas.

Risk-modeling company Air Worldwide Corp. summed up the issue: "There is no question that the significant increase in the number and value of exposed properties over the last decade has and will continue to contribute to increasing hurricane losses for insurers."

More Homes, More Risk

With more development comes increased risk. For coastal development and the insurance industry, increasing population numbers mean an increased risk of loss.

In fact, currently there exists $7 trillion of

Fighting Against the Tide (Continued)

insured coastal property from Maine to Texas, with commercial property making up the majority of the total, according to the Insurance Information Institute.

Coastal regions that employ sustainable land use, strong building codes and serious code enforcement measures are positioned to significantly reduce the risk of loss. One study estimated the damage of $15.5 billion (in 1992 dollars) from Hurricane Andrew would have been $8.1 billion less if the building code now in Miami-Dade County had been in effect in 1992.

Further, the Institute notes survey results that show homes in the path of Hurricane Charley in 2004 were less likely to suffer damage if they were built in 1996 than if they were built in 1995. The reason? In late 1995, new building codes enforcing high-wind standards came into play in Florida's coastal areas.

In addition to protecting against natural catastrophes, the demand for green design by government, investors, employees, homeowners, tenants and the general public is becoming a reputational necessity.

And while there may be costs attached to stricter building codes and sustainable development, planning and building in smart, ecologically minded ways are seen as avenues by which commercial real estate developers might enhance value and gain competitive advantage.

According to the Urban Land Institute, measures that are taken to protect coastal properties–such as the use of sandbags and jetties--actually serve to exacerbate erosion and habitat destruction. By keeping the beach in a natural state, the natural systems that prevent erosion are left undisturbed and buildings are better-protected from storm hazards. This allows the coastal area to hold its value longer and increases the overall development premium by driving inland values higher as well.

Furthermore, according to the Urban Land Institute, incentives are available to encourage developers to locate and cluster coastal development in less vulnerable and more resilient sites. These mechanisms include public investment, public/private partnerships for land assembly and financing, preferred treatment for timely regulatory approvals and tax incentives that add to the bottom line.

Regulatory Concerns

Yet, no matter how "smart" a coastal housing development may be, it isn't truly smart if the corresponding insurance coverage doesn't make sense.

Currently, several Atlantic coastal states are struggling with the dilemma of keeping insurance affordable enough so people don't leave. This formula can include suppressing actuarially sound prices by not allowing insurers to charge according to the true risk. Thus, another mechanism used to ensure coverage in the highest-risk areas are state-run insurers that provide coverage to those who would not otherwise be able to obtain it from private insurers. According to the Brookings Institute, 32 states have attempted to establish state-run residual markets, or last-resort insurers, for the highest risks.

Record losses in recent years have increased the insurance dilemma in coastal high-risk zones, causing some insurers to stop writing new policies and others to dramatically reduce capacity or to totally pull out of coastal regions and states.

Further, on a national level, there have been challenges related to the National Flood Insurance Program's ability to cover significant catastrophes and the argument by some that the program encourages more development in high-risk areas by charging rates that are lower than what is actuarially sound.

New Solutions

With the stakes so high, forward-thinking companies will build a competitive advantage by surveying the landscape to identify new trends and business opportunities and by searching for solutions to long-standing debates, particularly those centered on issues such as building codes and actuarially sound pricing for insurance.

To come out ahead of their competitors, companies should employ smart strategies pertaining to development along the coast.

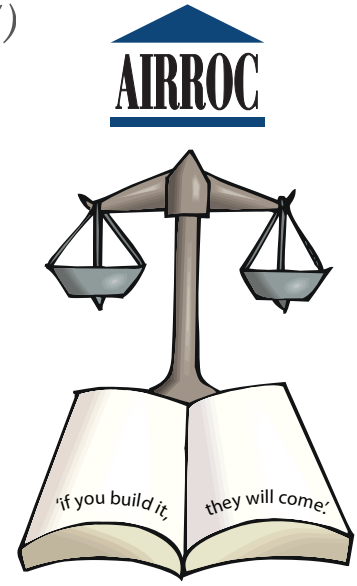
These approaches might include gaining a better understanding of the potential for future risk; creating market-based solutions and incentives to encourage appropriate development and mitigation; and designing a plan to work with regulators and legislators on initiatives regarding land use, building codes and insurance rate-making.

Source: Best's Review (November 2009 Issue)

IAIR Issues Forum Re-cap

If It Ain't Broke

OK, maybe it's not broke, but the Association of Insurance & Reinsurance Run-Off Companies ("AIRROC") decided to fix it anyway…..or at least to make it more responsive to members' needs.



Over a year ago, AIRROC sought volunteers to serve on a Small Claims Task Force to develop an expedited binding arbitration procedure. The Committee, chaired by Michael Zeller, sought to address industry concerns regarding the escalating cost and time to completion of a typical tri-partite arbitration (most often used to resolve reinsurance disputes). Although it took more than a year to produce, Trish Getty, CEO and Executive Director of AIRROC recently announced the formal launch of the *AIRROC Dispute Resolution Procedure ("DRP").**

The DRP can be used by both AIRROC members and non members. As it is consensual, both parties must 'buy into' or agree to use the DRP, which offers a high degree of flexibility. It provides for a single arbitrator at a predetermined hourly rate of $150/hour, and a $4,000 retainer ($2,000 per party, one-half of which is non refundable). The DRP uses telephonic organizational meetings, case submissions on briefs and documents only, and oral argument at the arbitrator's discretion or when requested by the parties jointly. Discovery is permitted, but only to the extent agreed to by the parties. Upon completion of the arbitration, the arbitrator is required to issue a decision within 30 days.

The DRP requires arbitrators to have at least 10 years' employment by an insurer or reinsurer, or to be ARIAS-US certified, and as noted above, they must agree in advance to the discounted fee structure. The parties are required to execute hold harmless agreements in favor of the arbitrator and AIRROC. All proceedings are confidential.

The formal procedures are relatively simple, and a proceeding can be commenced by the parties completing the necessary forms, and then agreeing on an arbitrator from the AIRROC list. If the parties are unable to agree on an arbitrator, the DRP randomly generates 15 names from the list. Any candidates having conflicts will be eliminated, and then each party will select 8 (or one more than half the names) ensuring at least one match. To the extent there is more than one matching name, the single arbitrator will be chosen by drawing lots.

The use of the DRP is free of charge to AIRROC members, and non-members must pay a nominal fee. Although originally envisioned as a vehicle to resolve small dollar disputes, there are no limits set forth in the procedure. The only requirement is that there be mutual agreement between both parties.

So, borrowing from a baseball analogy, 'if you build it, they will come', AIRROC has built it. The rest is up to you.

*A copy of the Procedure can be found in the Training Education and Materials tab on the AIRROC Web page (www.airorc.org).

IAIR Issues Forum Re-cap (Continued)

llinois Director of Insurance, Michael McRaith, along with his Special Deputy Receiver, Pat Hughes, and Mike Gleeson and Kevin Baldwin of Illinois' Office of the Special Deputy Receiver ("OSD") participated in IAIR's Fall Issues Forum, presenting A*nswering the Challenges of Receivership Modernization: How Illinois' Office of the Special Deputy Receiver has responded to the changing receivership landscape. What OSD sees for the future of managing troubled companies, and how it is positioning itself to serve regulators, consumers, and industry in the coming years.*

Redesigning receivership operations from the creditor's point of view was the opening theme of the presentation. A short description of the OSD was provided, along with an explanation of Illinois' long-standing approach to the administration of troubled company receiverships through a single special deputy with a standing receivership office. After a summary of the OSD's recently adopted business principles was provided, this portion of the presentation ended with an identification of the extraordinary advantages of Illinois' classic receivership model: no taxpayer expense, economies of scale, the development and retention of multi-disciplinary expertise, a culture of loyalty to the Director's statutory duties, and low-cost not-for-profit economics.

The presenters moved on to describe the lessons learned from OSD's 2008 internal performance assessment and the introduction of business analytics to receivership operations. Both OSD's introduction of productivity metrics for line staff as well as its renewed focus on the measurement and improvement of employee utilization and estate chargeability were discussed. Among notable achievements resulting from implementation of these measures was improvements to staff utilization and chargeability and operational productivity increases. This section of the presentation concluded with a discussion of duration (weighted average time to distribution) as an example of a receivership metric, demonstrating the dramatic monetary effects of early and frequent estate distributions.

The presentation concluded with a discussion of the fundamentals guiding OSD's modernization efforts, as well as recent initiatives and OSD's strategic vision for future service. The presenters identified the fundamentals of receivership modernization to include: (i) a consumer and creditor focus, (ii) with creative and strategic planning, (iii) delivered through a scalable, flexible model, (iv) driven by business-oriented analytics, (v) with openness, transparency and engagement with consumers, creditors and the public. The description of recent initiatives that followed demonstrated the OSD's commitment to interim distributions (both early-access payments to guaranty associations and distributions to consumers), and highlighted their development and publication of good faith estimates of the timing and amount of distributions, and implementation of various consumer-friendly claim procedures.

The presenters made clear throughout the program that the central focus of modernization involves putting receivership assets back into the economy as quickly as possible.

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Tel. (718) 892-0228.
Email: mcs@iair.org.
Maria Sclafani and Susan Barros
Executive Directors

Scottish Lion Insurance Company Limited

By Vivien Tyrell, Elizabeth Wheal, and Reynolds Porter Chamberlain LLP

On 16 October 2009 the solvent scheme of arrangement proposed for The Scottish Lion Insurance Company Limited was dismissed by Lord Glennie of the Outer House, Court of Session in Scotland.

This rejection of the scheme followed his ruling on 10 September 2009 on two preliminary issues following which he recommended that the opposing parties should seek to negotiate a compromise or amend the scheme to their mutual satisfaction. Scottish Lion did not present any proposed amendments to the scheme at the case management conference on 14 October 2009 with the result that Lord Glennie dismissed the scheme on the objecting creditors' application. Accordingly, subject to appeal, Lord Glennie's opinion on the two preliminary issues stands. Some commentators have suggested that this judgment has signalled the death knell of solvent schemes. However, rumours of the demise of solvent schemes may be premature.

The Scottish Lion Insurance Company Limited proposed a solvent scheme arrangement under Part 26 of the Companies Act 2006. The purpose of the scheme was to quantify and settle Scottish Lion's liabilities to its policyholders under or in relation to policies of direct insurance. The hearing before Lord Glennie was to consider two issues:

(a) whether the individual vote assessor had correctly valued the creditors' claims for voting purposes; and
(b) whether it would ever be fair for a court to sanction a solvent scheme in the face of creditor opposition.

Due to it being a Scottish company, the application was heard before the Scottish Courts. Lord Glennie issued his opinion on 10 September 2009. On the first issue, Lord Glennie held that in deciding what can and cannot be taken into account by a court in exercising its discretion at the sanction stage was a matter for case-by-case development. The independent vote assessor's determination of the quantum of the creditors' claims for voting purposes could not only be challenged on perversity or irrationality. It is Lord Glennie's judgment on the second issue which is of particular significance and has led the insurance run-off market to re-evaluate schemes as an exit strategy.

A scheme of arrangement is a mechanism used by corporate lawyers for many different purposes. The essential features of a scheme are that the court convenes meeting(s) of creditors and if the creditors present and voting at the meeting(s) either in person or by proxy vote in favour of the scheme by a 75% majority in value and a simple majority in number, the scheme will then proceed to the court sanction stage. The court then decides whether the scheme is fair and if it does will sanction it. If the scheme is approved then all creditors of the company are bound even if they did not vote or if they objected to the scheme. Objectors are entitled to raise objections at both the first court hearing and the final sanction stage.

Some commentators have suggested that, as a result of Lord Glennie's opinion, if a solvent scheme is to be sanctioned it is now necessary to obtain unanimous support for the scheme from all the creditors. However, is that really correct?

Lord Glennie accepted that the court's power to sanction a scheme of arrangement is unfettered. However, he drew a distinction between schemes which were intended to resolve a "difficulty or problem" in the company and those where the arrangement was ultimately for the benefit of the

Scottish Lion Insurance Company Limited (Continued)

company's shareholders. One of the key issues for Lord Glennie was the financial position of the company. There was no question that Scottish Lion was not financially sound. Accordingly, in the ordinary course each of its creditors could expect to be paid as and when it made a valid claim on its policy of insurance. The judge did acknowledge that where a company was in financial difficulties there may be an incentive for creditors to seek to make some compromise with a company. There was no such imperative for Scottish Lion.

The judge considered that a scheme of arrangement would only be fair and "creditor democracy" should operate where there is some "problem" that needed to be addressed. The obvious example would be where the company is facing financial difficulties and may become insolvent. In such circumstances, Lord Glennie thought it was easy to see why the creditors must be required to act together and be bound by the majority. A dissenting minority should not be allowed to prevent a scheme coming into effect which is obviously for the benefit of a body of creditors as a whole. However, he did not see why the principle of "creditor democracy" should be allowed to prevail in all situations where a scheme of arrangement is proposed. In the case of Scottish Lion, Lord Glennie could see no reason, apart from the wishes of the shareholders, why the company should not continue with a run-off. It was solvent and able to meet it potential liabilities in the future. He stated that in a solvent scheme he would expect petitioners who apply for a scheme to be sanctioned to be able to justify why the minority should be bound by the decision of the majority.

Accordingly, it appears that in the absence of a "problem" unanimous creditor support is required. However, the "problem" need not be a financial one. Another example of a "problem" which could be solved by a scheme would be where the majority of creditors recognise that the problem is one of administering claims. The scheme would present a streamlined process and early settlement of the claims.

Lord Glennie also appeared to draw a distinction between two different types of schemes, one where the scheme is opposed and one where there is no opposition. In the case of an opposed scheme, the judge appears to apply more stringent considerations as to the existence of a problem which needs to be solved. This appears to be taking a very serendipitous approach. When a company commences promotion of a solvent scheme it will not be known into which category the scheme will fall. This cannot be what the legislation ever intended.

It has been suggested that Scottish Lion is a return to the principles espoused in the controversial decision of British Aviation Insurance Company Limited, where a scheme was dismissed in the face of opposition by creditors. Following initial caution following the BAIC decision, that decision has now become a useful set of guidelines to companies promoting schemes in considering whether their proposal is likely to be approved by a court. Subject to the issue over serendipity, Scottish Lion may come to be seen similarly. As ever, companies promoting schemes will be best served in consulting with their creditors early in the process to minimise or eradicate opposition.

At the time of writing, we understand that Scottish Lion is due to appeal the first instance decision. It has until 6 November 2009 to lodge an appeal notice and any appeal is unlikely to be heard until the middle of 2010. The run-off market will await the views of the Appeal Court with interest.

To submit an article, please contact Maria Sclafani at mcs@iair.org. The deadline for the Spring 2010 issue is February 15, 2010.

View from Washington

By Charlie Richardson, Baker & Daniels

Regulatory Reform

We talked last time about the Obama administration's proposal for systemic financial regulatory reform that was unveiled with much fanfare in June (http://www.financialstability.gov/docs/regs/FinalReport_web.pdf). It was expressly intended to "build a new foundation for financial regulation and supervision that is simpler and more effectively enforced, that protects consumers and investors, that rewards innovation and that is able to adapt and evolve with changes in the financial market." The proposal notably ventures into new areas that Treasury has not previously addressed, including insurance information gathering through a new office within the Department. While the proposal does not go so far as to push an optional federal charter for insurance companies, it potentially subjects certain insurers to greater federal regulation and leaves the door open for more.

Right after the August recess, the action on regulatory reform was eclipsed by the nationally compelling debate over health care/insurance reform – and that debate continues as the House and Senate struggle to craft a health proposal by year-end that can command a majority in the House and a filibuster-proof 60 votes in the Senate. We'll come back to that preoccupation in a minute.

As the regulatory reform action sits today in November, there has been much more activity in the House. Financial Services Committee Chairman Barney Frank (D-MA) has been dogged in scheduling hearings and mark-ups on key pieces of the Administration's wide-ranging proposal. The House Committee has kept a continuous and almost weekly focus on regulatory reform, and Frank has results to show for those efforts. Several individual items have been passed out of Committee, most along party lines:

- The Consumer Financial Protection Agency Act
- The Expedited CARD Reform for Consumers Act
- An amendment to the Fair Credit Reporting Act to exclude health care practices, law firms, and accounting firms from red-flag guidelines
- The Over-the-Counter Derivatives Markets Act
- The Investor Protection Act
- The Private Fund Investment Advisors Registration Act
- The Enhanced Accountability and Transparency in Credit Rating Agencies Act

The Senate has proven more methodical. After indicating for months that they were working on a joint bill, Senator Chris Dodd, Chairman of the Senate Banking Committee (D-CT), and Ranking Minority Member Richard Shelby (R-AL) parted ways in early November. On November 10, Chairman Dodd unveiled his own 1136 page comprehensive proposal and immediately started into hearings (http://banking. senate.gov/public/_files/AYO09D44_xml.pdf). The Dodd bill to some extent follows the lead of the Administration and the House, but differs in approach at certain key points like the authority of the Federal Reserve (Dodd wants to give the Fed less), who should regulate financial institutions (Dodd would create a single bank regulator), and on certain consumer protection issues.

So what lies ahead between now and the Christmas recess (which may start a day or two before Christmas Eve, ho, ho, ho)? First, we have no reason to believe that Chairman Frank will not push, pull, cajole and prod all elements of the Administration's plan successfully out of his Committee and on to the House floor – maybe even culminating in a House vote on the total package. Second, Chairman Dodd will try to do the same with his omnibus bill. This is far less likely, however, as are the chances of a Senate floor vote before Christmas. Third, we are likely to see both bills contain a new insurance office

within Treasury, but only after significant Committee fights over state law preemption, subpoena power and international treaty specifics.

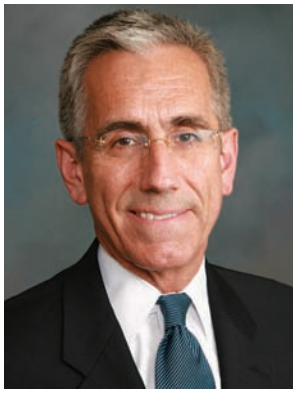
Health Care Reform Moves Forward

With the help of Senator Olympia Snowe (R-ME), the Senate Finance Committee passed its health reform plan, America's Healthy Future Act on October 13 (http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1796pcs.txt.pdf). That bill is now being merged by the Senate Democratic leadership with the Affordable Health Choices Act passed by the Senate Health, Education, Labor, and Pensions (HELP) Committee (http://frwebgate.access. gpo.gov/cgi-bin/getdoc.cgi?dbname=111_ cong_bills&docid=f:s1679pcs.txt.pdf). Senate Majority Leader Harry Reid (D-NV) will combine these bills with the goal of bringing a Senate health care reform bill to the full Senate. The Finance legislation includes government-sponsored insurance cooperatives and a mandate for all Americans to buy health insurance, while the HELP bill contains a government-run insurance plan (also known as the "public option") and a mandate for employers to provide healthcare coverage to their workers in addition to an individual mandate. Both plans would ban insurers from denying coverage due to pre-existing conditions. Once these bills have been merged and passed, resulting legislation will be sent to a conference with the House of Representatives. The House passed its legislation (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3962eh.txt.pdf) on November 7 by a vote of 220-215. Democratic leaders hope to present President Obama with final legislation by the end of 2009, but that is looking increasingly unlikely.

Antitrust Repeal Rears Its Ugly Head

Since Hurricane Katrina in 2005, some lawmakers have hit the insurance industry over the head with threats of repealing the limited antitrust exemption the insurance industry enjoys under the McCarran-Ferguson Act. In October, a few Senators started the repeal chart in conjunction with health care/insurance reform hearings at which Members mercilessly bashed the health insurance representatives. Then in November, some of my federal affairs colleagues pointed out that the big (almost 2000 pages) House health care bill has some troublesome stuff for insurers on the antitrust front. These include the modification to McCarran for health and medical malpractice insurers that has been in the press over the last few weeks (Sec. 262). The House bill also includes a provision that would restore the Federal Trade Commission's ability to conduct investigations of the insurance industry (Sec. 260).

It looks like this provision would (1) allow the FTC to investigate the insurance industry (all of it, not just health insurers) for issues rising from competition/antitrust concerns, and (2) provide the FTC's Bureau of Consumer Protection with oversight of the insurance industry. The Bureau of Consumer Protection is apparently active in areas of consumer privacy, consumer fraud, and misleading advertising and disclosures. The FTC has taken heat for not being more aggressive with the mortgage and banking industry, and as a result is likely to take any new oversight authority seriously.



Charlie Richardson

Charlie Richardson is a Partner at the law firm Baker & Daniels in Washington, D.C. where he chairs the insurance and financial services practice group. Charlie assists insurance companies and others with all types of corporate, federal legislative, regulatory, public policy and compliance matters. He practices in the area of insurance company rehabilitations and liquidations.

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As a firm, we were pleased to support your IAIR presidency, and we will continue to support you and all of our partners' roles as leaders in the insurance industry. Your involvement with the IAIR membership on issues that increase the professionalism and ethical standards of insurance receivers has continually reminded us of the importance of IAIR's mission.

As a member of NLdH, you have shown that you are focused on not only solving our clients' legal issues but on helping them grow their businesses, which makes you a perfect fit for our team. We are also extremely proud of your latest award naming you a "2009 Woman to Watch" by *Business Insurance* magazine. Knowing the energy and enthusiasm you bring to every task, we eagerly anticipate your next challenge. Again, congratulations.

All the best,

Mike

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In Major Victory For Insurance Company Receivers Illinois Appellate Court Deals Severe Blow To Imputation And In Pari Delicto Affirmative Defenses

By Robert L. Margolis

Recognizing that liquidators of insolvent insurance companies are "statutorily charged with preserving the rights of [] policyholders and creditors," the Appellate Court of Illinois recently held

that it would be "unlawful, as well as illogical" to impute to a liquidator the misconduct of an insurance company's former Board Chairman and CEO who looted the company. The Appellate Court thus reversed the dismissal of the liquidator's case against the company's former statutory auditors, which had been premised on the doctrine of *in pari delicto*. *McRaith v. BDO Seidman, LLP*, 909 N.E.2d 310, 391 Ill. App. 3d 565 (Ill. App. 2009), *leave to appeal den'd*, No. 108755 (Ill. 2009). Using language that is sure to be cited by insurance company receivers and liquidators who invariably face imputation-based affirmative defenses, the Appellate Court concluded: "the imputation doctrine does not apply to the director of the State of Illinois Division of Insurance (IDI) when acting as an insolvent insurance company liquidator under the statutory authority provided by the Illinois Insurance Code." 909 N.E.2d at 314.

The *McRaith* decision is particularly significant because, in addition to its strong stand against imputation generally, the Appellate Court recognized that (1) imputation-based defenses asserted against insurance company receivers raise public policy and equitable considerations beyond those that arise in non-regulated industries, and (2) application of the so-called "sole owner" exception to the adverse interest exception to imputation would be wholly misplaced in the context of the heavily regulated insurance industry. *McRaith* thus reaffirms and builds on principles established in cases from around the country brought by insurance company liquidators, and provides a roadmap for liquidators to avoid imputation-based affirmative defenses by third parties. It also gives insurance company auditors and other third-party service providers one more incentive to be vigilant when fulfilling their roles in the regulatory process.

I. The Facts and Procedural History of *McRaith*.

Insurance companies present tempting acquisition targets for unscrupulous individuals because they house large amounts of cash. In the case of Illinois-domiciled Coronet Insurance Company, Coronet's Liquidator contended access to cash was what motivated Clyde Engle to enter the insurance business. The Liquidator thus filed a federal RICO action against, *inter alia*, Engle and other of Coronet's directors and officers. *Shapo v. Engle*, No. 98 C 7909 (N.D. Ill.) (the "Engle RICO Action"). As the Liquidator alleged in *Shapo*, Engle systematically looted tens of millions of dollars from Coronet throughout the early-to-mid 1990s, via hundreds of complicated, multi-step transactions, misleadingly structured and papered to look like investments in Coronet's unregulated, non-insurance subsidiaries, when in fact the payments were dividends to Engle and certain of Coronet's corporate parents owned and controlled by Engle. These "disguised dividend" transactions were made at a time when, due to Coronet's lack of earned surplus, the Illinois Insurance Code prevented the payment of any dividends.

Illinois-domiciled insurance companies like Coronet must retain independent certified public accountants to audit their financial statements annually, to report on the financial statements contained within the Annual Statements, and to file the auditor's report with the Illinois Department of Insurance. This audit requirement is contained in a duly enacted regulation known as the "Audit Rule." 50 Ill.

Admin. Code Part 925. Pursuant to this regulation, BDO Seidman, LLP ("BDO"), a national public accounting firm, was retained as Coronet's "statutory auditor" during the period that much of Engle's looting scheme occurred. BDO also was the auditor and/or performed review services for Coronet's unregulated subsidiaries and corporate parents. As such, BDO was in an unique position to see Engle's scheme from the vantage point of every stage of the multi-step transactions.

After settling with Engle and terminating the Engle RICO Action, Coronet's Liquidator sued BDO in the Circuit Court of Cook County, Illinois, for, *inter alia*, professional negligence, alleging that BDO failed to adhere to Generally Accepted Auditing Standards in several respects, and thus failed to detect that the so-called "investments" were in fact sham transactions designed to disguise improper dividends.

As is typical in cases brought by liquidators (insurance and non-insurance) against third-party service providers, BDO asserted "imputation"-based affirmative defenses to defeat the Coronet Liquidator's claims. Corporations, themselves inanimate, can act only through their agents. The doctrine of "imputation" is the legal mechanism through which the conduct and/or knowledge of an agent is ascribed to the corporation (the "principal") for which the agent is acting. Imputation is based on the presumption that when an agent is acting for the benefit of a principal, the agent is duty bound to disclose facts learned while within the scope of the agency. Imputation exists so that corporations dealing with third parties cannot shield themselves from this knowledge by acting through agents. For example, a corporation cannot simply disavow a contract one of its agents enters into on the corporation's behalf, if done in the scope of the agent's authority, by claiming it had no knowledge of the agent's act. Imputation properly applied, therefore, rationally protects innocent third parties who deal with corporate agents.

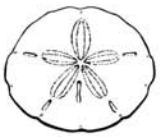
BDO sought to apply these principles to defeat the Liquidator's claims. BDO contended that Coronet acted through Engle, and because Engle engaged in misconduct, that misconduct (and Engle's knowledge of it) should be imputed to Coronet. Because, according to BDO, the Liquidator "stands in the shoes" of Coronet when bringing legal claims on Coronet's behalf, Engle's conduct ultimately must be imputed to the Liquidator, thus, BDO argued, making the Liquidator, in the eyes of the law, a wrongdoer. BDO then sought dismissal of the Liquidator's claims under the doctrine of *in pari delicto*, which prevents one wrongdoer from suing another involved in the same misconduct.

The case presented another wrinkle in the imputation analysis. When a corporate officer such as Engle is acting adversely to his company, his conduct or knowledge will not be imputed. This is the "adverse interest" exception to imputation. However, some courts (outside of the context of insurance company liquidations) have recognized an "exception to the exception," when the person acting adversely is the "sole owner" of the company. The rationale of the "sole owner" exception is that when the principal and agent are "one and the same," *In re Mediators, Inc.*, 105 F.3d 822, 827 (2d Cir. 1997), or "alter egos," Grassmueck v. Am. Shorthorn Ass'n, 402 F.3d 833, 838 (8th Cir. 2005), "the sole agent has no one to whom he can impart his knowledge, or from whom he can conceal it." *Official Comm. of Unsec. Creditors v. R.F. Lafferty & Co.*, 267 F. 3d 340, 359 (3d Cir. 2001). BDO, seizing on allegations that Engle was the "ultimate owner" of the top-level corporate parents, asserted that imputation was required under the "sole owner" exception.

The initial trial judge assigned to the case rejected BDO's argument, but when she retired and a new judge was assigned, BDO moved to reconsider and the second judge ultimately held that Engle was a "sole owner" and therefore his conduct had to be imputed to Coronet's Liquidator. He dismissed the Liquidator's claims. The Liquidator then appealed to the Appellate Court of Illinois, First District.

II. The Law of Imputation as Applied to Cases Brought By Insurance Company Receivers and Liquidators

Insurance company liquidators marshal assets for the benefit of policyholders and creditors of the insurance companies' estates. Given the public interests they serve, when liquidators sue professionals whose misconduct



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contributed to the companies' insolvency, courts from around the country typically have recognized, in the words of one federal district court in Illinois, that "it would be an absurd result to rule that the Director of Insurance as liquidator . . . could not recover damages on behalf of the [company's innocent stockholders, policyholders, and creditors] based on the improper and fraudulent acts of the officers and directors of the company being liquidated." *O'Connor v. Brown*, No. 81 C 1475, 1982 U.S. Dist. LEXIS 14419, *4-5 (N.D. Ill. 1982) (applying Illinois law and rejecting imputation defense by insolvent insurance company's former accountants against liquidator, holding the liquidator was "not bound by the allegedly fraudulent or other ultra-vires acts of the officers and directors of the corporation"). Several other courts have echoed the *O'Connor* court's reasoning.

In *Cordial v. Ernst & Young*, 483 S.E.2d 248, 257 n.9 (W. Va. 1996), an insurance company receiver sued the company's former auditors. The auditors argued that if the company itself had sued, they "would have been able to assert defenses that should have led to the dismissal of [the] case . . because the knowledge of the corporation's officers and directors is imputed to the corporation itself." Id. The court rejected the argument that insurance company receivers' rights "rise no higher than those of the corporations which they represent," because the receivers are not merely standing in the company's shoes, but "vindicating the rights of the public, including the [company's] creditors, policyholders, providers, members, and subscribers." *Id. See also Bonhiver v. Graff*, 248 N.W.2d 291, 296 (Minn. 1976) (rejecting imputation defenses when asserted against insurance company receiver; "Whether or not the company would be precluded from bringing this suit (the company was the victim of the fraud, and not the perpetrator), '[t]he receiver represents the rights of creditors and is not bound by the fraudulent acts of a former officer of the corporation'"); *Arthur Andersen LLP v. Super. Ct. of Los Angeles Co.*, 79 Cal. Rptr. 2d 879, 888 (Cal. App. 1998) (holding Insurance Commissioner, in his capacity as liquidator and acting in the public interest, is not subject to the imputation defenses an "ordinary receiver" may face: "No authority is offered for the proposition that the Insurance Commissioner acts merely as an ordinary receiver").

Based on this well-established body of law, the Coronet Liquidator argued that the trial court should have rejected BDO's imputation-based *in pari delicto* affirmative defense. Courts have recognized that *in pari delicto* is an equitable doctrine that exists "only because wrongdoers must not be permitted to profit from their wrongdoing." *In re Edgewater Med. Ctr.*, 322 B.R. 166, 178 (Bankr. N.D. Ill. 2005) (applying Illinois law). Under Illinois law, therefore, once the wrongdoer has been removed and will not stand to benefit from any recovery in the case, "the defense of *in pari delicto* loses its sting." *Scholes v. Lehman*, 56 F.3d 750, 754 (7th Cir. 1995). Thus, the Liquidator argued that imputation should not be allowed under *O'Connor*, *Cordial*, and other insurance insolvency and Illinois precedent, but even if the Court did impute Engle's conduct to the Liquidator, the *in pari delicto* defense still should fail because this case would not benefit Engle, who was long removed from control of Coronet and had waived any claims in the Insurance Companies' estates. Instead, it would harm only the policyholders and creditors who would benefit from any recoveries by the Liquidator. In fact, the only beneficiary of imputation would be BDO, itself an alleged wrongdoer which the Liquidator contended had contributed to Coronet's demise through its negligence. The Liquidator contended it would make no sense to restrict his ability to recover from culpable wrongdoers by imputing the misconduct of persons who are now strangers to the lawsuit. Further, the Liquidator argued the reasoning of the cases rejecting imputation to insurance company receivers and liquidators does not change, nor are the public interests at stake any less worthy, simply because the wrongful conduct sought to be imputed was committed by an alleged "sole owner."

III. The *McRaith* Decision

The Appellate Court began with a discussion of "Public Policy for the Insurance Industry." The Court quoted from a 1914 United States Supreme Court decision, that "the business of insurance has very [defined] characteristics, with a reach of influence and consequence beyond and different from that of the ordinary

businesses of the commercial world" and that insurance is "essentially different from ordinary commercial transactions" and "certainly in the sense of the modern world – is of the greatest public concern." 910 N.E.2d at 330 (*quoting German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, (1914)). It next noted that consistent with the general recognition of the public interest in a healthy insurance industry, Illinois "has adopted a strong policy of regulating, controlling, and supervising the business of insurance because it affects the public interest." Id. (*quoting Coronet Ins. Co. v. Washburn*, 558 N.E.2d 1307 (Ill. App. 1990)). Illinois law "recognizes that the core aim of insurance regulations is 'geared toward protecting policyholders from unscrupulous or inexperienced management." *Id. (quoting Hoylake Investments Ltd. v. Washburn*, 723 F. Supp. 42, 46 (N.D. Ill. 1989)).

The Court then highlighted provisions from the Illinois Insurance Code that further exemplify the strong public interest in insurance, including Code provisions concerning the rights and duties of insurance company liquidators. *Id.* Finally, the Court cited the Audit Rule, requiring annual audits of insurance company finances, as "another part of the goal of protection through the regulation process," and noted that the Liquidator's claim was that BDO failed "to meet the required professional standards in its performance of the annual audit examinations." *Id.*, 910 N.E.2d at 331.

Based on this strong public policy, the Court proceeded to reject BDO's argument that the conduct and knowledge of Engle should first be imputed to Coronet and then, because the Liquidator "stands in the shoes" of Coronet, bar the Liquidator's claims under *in pari delicto*. Noting that Illinois courts have "yet to address the issue of imputation of conduct in the context of . . . the liquidation of insolvent insurers," the Court turned to a Connecticut decision arising out of similar facts. In *Reider v. Arthur Andersen*, LLP, 784 A.2d 464 (Conn. Sup. Ct. 2001), the liquidator of First Connecticut Insurance Company brought negligence and fraud claims on behalf of the insolvent company's estate against the company's auditors alleging, like the Coronet Liquidator, that the auditors knew or should have known that the company's controlling shareholders had looted the company, and the auditors failed to disclose the transactions to regulators. *Id.* at 466. The Connecticut court held, "when a corporate officer or agent engages in fraudulent conduct for the distinctly private purpose of lining his own pockets at his corporation's expense, it is unlawful, as well as illogical, to impute the agent's guilty knowledge or disloyal, predatory conduct to his corporate principal." *Id.* at 470. The same result followed for the Coronet Liquidator. *McRaith*, 910 N.E.2d 332.

The Illinois Appellate Court then addressed BDO's argument that the "sole owner" exception to the adverse interest exception applied. BDO had relied primarily on cases brought by federal bankruptcy trustees, which, as the Liquidator argued, involve different public policy issues than insurance receivership cases, and also require analysis of Section 541 of the Bankruptcy Code, which several courts have interpreted to preclude consideration of the fact that trustees have replaced the wrongdoers at the helm of the company. *See e.g. Lafferty*, 267 F. 3d at 359. The Liquidator argued these cases were distinguishable on these grounds, and pointed out that even the courts hearing bankruptcy cases recognized that absent the constraints of Section 541, the better policy would be to not impute conduct to bar claims by trustees. *See e.g. id.* at 357 (recognizing rule barring *in pari delicto* defenses when the wrongdoers would not benefit from the suit "might be preferable from a public policy perspective").

The Appellate Court agreed with the Liquidator. Again relying on *Reider*, rather than the federal bankruptcy decisions on which BDO based its argument, the Appellate Court held "sole owner" simply cannot apply to an insurance company, which is not "a typical corporation." *McRaith*, 910 N.E.2d at 333. The Court's discussion of *Reider* is instructive:

> The liquidator there, similar to the Liquidator here, argued that the sole owner exception cannot apply to insurance companies because of their unique legal responsibilities to policyholders, creditors and the general public. The *Reider* court noted the separate set of rules and strict regulations that govern

> insurance companies. As in Illinois, Connecticut recognizes the need to afford insurance companies special protections to ensure the public's need for reliable insurance coverage. Annual audits of insurance companies are required and the Insurance Commissioner is given sweeping statutory powers to take action to minimize the consequences from rehabilitation or liquidation. The actions of insurance companies are heavily regulated to preserve solvency in the public interest. Considering the role of insurance companies and the special protections they require, the *Reider* court held there could not be complete unity of interest between a sole shareholder who loots his own insurance company and the company itself. "Therefore, when a sole owner seeks to loot his own insurance company, every person with a legally protected interest in the insurer's continuing solvency is not a knowing and willing participant in the owner's fraud."

Id. at 333 (quoting Reider, 784 A.2d at 474). Finding *Reider's* "holding and reasoning" to be "applicable here," the Illinois Court rejected application of the sole owner doctrine and refused to impute Engle's conduct to Coronet. *Id.* at 334. *See also id.* at 336 ("the imputation doctrine also cannot apply to the Liquidator where Engle clearly engaged in fraudulent conduct for the distinctly private purpose of lining his own pockets at the insurance companies' expense").

Once it had rejected imputation from Engle to Coronet, the court found no need to reach the merits of BDO's *in pari delicto* argument, but nonetheless rejected it, stating "the *in pari delicto* doctrine cannot apply because the Liquidator, by statutory definition, is not the wrongdoer; rather he serves to protect the insurance industry and the public interest by ensuring the victims of the misconduct can recover monies entitled to them. To equate the Liquidator with Engle under *in pari delicto* is illogical and unavailing." *Id.* at 336.

IV. The Significance of *McRaith*

The McRaith decision further solidifies the law rejecting as legally untenable affirmative defenses based on the imputation of the conduct and knowledge of adversely acting agents to insurance company receivers and liquidators. As the first appellate level decision to address head on the "sole owner" doctrine and reject its applicability to insurance company receivers (*Reider* was rendered by a trial court), *McRaith* will no doubt be a useful precedent for receivers.

To best take advantage of *McRaith's* reasoning and analysis, receivers and liquidators asserting claims against third-party service providers should take several steps. First, assuming the wrongdoers were victimizing the company, not using the company to victimize others, receivers and liquidators should highlight in their complaints how the insurance company's prior agents were acting adversely to the company, and avoid allegations that may be interpreted as suggesting some benefits to the company from the agent's actions. In *McRaith*, as in *Reider*, the liquidators were clear to assert that the wrongdoers were stealing from the companies, from which the courts could easily conclude that no benefits were conferred.

Second, receivers should place the agent's misconduct in the context of public policy-based regulatory concerns. The Coronet Liquidator's complaint alleged in detail the regulatory scheme, including the Illinois Audit Rule, that was established for the purpose of placing auditors, like BDO, in position to protect insurance companies (and by extension, policyholders and the public) from the type of misconduct Engle perpetrated. After pleading BDO's important role in the financial regulation of Coronet's solvency, the Liquidator could convincingly argue that exonerating BDO from liability for failing in that role would violate a strongly-held policy, resulting in a weakened regime of financial solvency regulation.

Finally, insurance receivers and liquidators should not be shy about asserting they are "different" from trustees or receivers in other industries, due to the "greatest public concern" in having healthy insurers. *German Alliance*, 233 U.S. at 415. That should not be a particularly difficult argument to make in the current climate where financial institution failures have wrought havoc on commerce around the world.

In Major Victory For Insurance Company Receivers... (Continued)

For auditors and other third-party service providers, *McRaith's* virtual elimination of imputation-based defenses asserted against insurance company receivers and liquidators should reinforce the need for vigilance when fulfilling professional functions on behalf of insurance companies. On balance, *McRaith* properly allocates the risks of fraud by insurance company agents against their companies to those who may be in the best position to prevent it, consistent with the policy goals of insurance regulation.

Robert L. Margolis

Robert L. Margolis is a Partner at the law firm Robinson Curley & Clayton, P.C., in Chicago, Illinois. A member of IAIR, he practices in the area of litigation. He has represented insurance company receivers in litigation throughout the country, including the Liquidator in McRaith v. BDO Seidman, achieving recoveries on a wide variety of claims, including RICO, professional malpractice, fraud, fraudulent transfer, and fiduciary breach.

Legacy Long Term Care Insurance

By Holly Bakke, Esq.

The insurance regulatory system is currently being challenged by the financial deterioration of many legacy long-term care (LTC) companies, i.e., monoline companies that began selling this new product in the 1980's. This presents two opportunities for the national state based insurance regulatory system: development of unique solutions to a unique and limited problem and improving future regulation by exploring the lessons learned from the legacy LTC experience. This article focuses on the latter, with an emphasis on the rate process.

Long Term Care Coverage: An Overview

LTC services are not just another set of traditional health care services. Meeting acute and chronic health care needs is an important element of caring for aging and disabled individuals. LTC, however, encompasses services related to maintaining quality of life, preserving individual dignity, and satisfying preferences in lifestyle for someone with a disability severe enough to require the assistance of others in everyday activities. Some LTC services are similar to other health care services, such as personal assistance with activities of daily living or monitoring or supervision to cope with the effect of dementia. Other aspects of long-term care, such as housing, nutrition, and transportation are services that are utilized daily but become an integral part of long-term care for a person with a disability.

Where one wants to live or what activities one wants to pursue affects how needed LTC services can be provided. Providing personal assistance in a congregate setting such as a nursing home or assisted living facility may satisfy more of an individual's needs, be more efficient, and incorporate more direct supervision to ensure better quality than when caregivers travel to individuals' homes to serve them one on one. Yet, those options may conflict with a person's preference to live at home and maintain autonomy in determining his or her daily activities. Nationally, spending from all public and private sources for long-term care for all ages totaled about $183 billion in 2003, accounting for about 13 percent of all health care expenditures. Private insurance, which includes both traditional health insurance and long-term care insurance, accounted for nine percent of the total, about $16 billion in 2003.

Long-term care can be expensive, especially when provided in nursing facilities. In 2006, the average cost of a year of nursing facility care in a private room was about $75,000. The average hourly rate for a home health aide in that same year was $19; as a result, 10 hours of such care a week would average close to $10,000 a year.

LTC insurance helps pay for the costs associated with long-term care services. Individuals can purchase policies from insurance-companies or through employers or other groups. As of 2002, individual policies represented approximately 80 percent of the market, with policies purchased through employers representing most of the remaining 20 percent. The average age of consumers purchasing individual policies has decreased over time from an average age of 68 in 1990 to 61 in 2005. The number of LTC policies sold has been relatively small, about nine million as of the end of 2002, with less than 10 percent of people aged 50 and older purchasing LTC in the majority of states.

Legacy Long Term Care Insurance (Continued)

The Challenge of Legacy Long Term Care: Rate Adequacy

Most people buy long-term care insurance many years before they are likely to require services. Because prices are much lower for younger purchasers, buying coverage earlier in life and paying premiums for a longer period can be a sensible investment. LTC insurers cannot increase the premium for an individual because he or she grows older or develops health problems after buying the coverage. However, the insurer may impose a general rate increase applicable to an entire class of purchasers if it can demonstrate to regulators that additional revenue is needed to cover current or future costs. If increases are large enough, many policyholders, especially those living on fixed retirement incomes, may find it difficult to continue coverage. Some may allow their policies to terminate. Those who go on paying premiums may be those at the greatest risk of needed services.

In August 2000, the NAIC adopted new model regulations intended to improve the accuracy of initial rate proposals and to set standards for approval of requests for rate increases. The model regulation sought to discourage under pricing and assure that rate increases are justified. In addition, the rules include requirements for information to be supplied to purchasers, intended to help them better evaluate the possibility of future rate increases. These changes, however, do not govern legacy long-term care rates.

Despite state oversight efforts, some consumers remain more likely to experience rate increases than others. Specifically, consumers may face more risk of a rate increase depending on when they purchased their policy, from which company their policy was purchased, and which state is reviewing a proposed rate increase on their policy. Further, consumers in some states may be more likely to experience rate increases than those in other states, because there is variation in the regulatory approval of company rate requests. Company assumptions about interest rates on invested assets, mortality rates, morbidity rates, and lapse rates, the number of people expected to drop their policies over time, also affect premium rates.

While insurers are supposed to set initial premium rates at levels sufficient to cover ultimate projected costs, it was difficult with LTC at the outset because it was a fairly new product. Policies were not widely sold until the 1980s, and most of the earliest purchasers did not begin to use services until even more recently. In addition, the type and number of services available today were not envisioned when LTC policies were first designed and priced, e.g., nursing home policies did not contemplate the development of alternative senior residential facilities such as assisted living complexes. As a result, even well-intentioned insurers did not always have sufficient experience to accurately estimate have had to seek rate increases. It has been suggested that still other insurers offered unrealistically low initial premiums to gain market share. Still, other insurance companies acquired underpriced policies from other companies and then found it necessary to raise rates. Finally, some insurers set initial prices that were apparently reasonable but failed in their underwriting. For example, industry observers suggest that underwriting was a factor in the recent financial difficulties experienced by a legacy LTC company recently put into receivership.

Setting LTC premium rates at an adequate level to cover future costs was a challenge for the first companies providing LTC coverage. Because LTC was a relatively new product, companies lacked sufficient data to accurately estimate the revenue needed to cover costs. For example, according to industry experts, lapse rates, which companies initially based on experience with other insurance products, have proven lower than companies anticipated in initial pricing, which increased the number of people likely to submit claims. As a result, many policies were priced too low and subsequently premiums had to be increased, leading some consumers to cancel coverage. As companies adjust pricing assumptions, for example, lowering the lapse rates assumed in pricing, initial premiums may be higher but the likelihood of future rate increases may also be reduced.

Legacy Long Term Care Insurance (Continued)

The NAIC's pre-2000 model stated that insurance companies must demonstrate an expected loss ratio of at least 60 percent when setting premium rates, meaning that the companies could be expected to spend a minimum of 60 percent of the premium on claims. For all policies where initial rates were subject to this loss ratio standard, proposed rate increases are subject to the same standard. While the loss ratio standard was designed to ensure that premium rates were not set too high in relation to expected claims costs, the NAIC identified two key weaknesses in the standard. First, the standard did not prevent premium rates from being set too low to cover the costs of claims over the life of the policy. Second, the standard provided no disincentive for companies to raise rates. In identifying these weaknesses, the NAIC noted that there have been cases where initial premium rates proved inadequate, resulting in large rate increases and significant loss of LTC coverage from consumers allowing their policies to lapse. Additionally, because LTC claims are typically filed years after a policy is purchased, loss ratios in early years are artificially low when compared to the lifetime of a book of business.

Although consumers will be protected by the new NAIC standards going forward, some consumer's policies are not governed by those standards, either because they live in states that have not adopted the standards, or because they bought policies issued prior to implementation of these standards.

Further, consumers who purchased policies when there were more limited data available to inform pricing assumptions may continue to experience rate increases. Regulators from seven states in the federal General Accounting Office (GAO) study reported that rate increases are mainly affecting consumers with older policies. For example, regulators from one state told the GAO that there are not as many rate increases proposed for policies issued after the mid-1990's. Regulators in five states explained that incorrect pricing assumptions on older policies are largely responsible for rate increases. Specifically, there were inaccurate assumptions about the number of consumers who would allow their policies to lapse and those assumptions led to rate increases. Officials from more than one company confirmed that mistakes in pricing older LTC policies, including overestimating lapse rates, have played a significant role in the rate increases that have occurred.

In summary, it is clear that the insurance regulatory system is aware of the challenges presented by LTC and has attempted to address them through improved model regulations. The legacy LTC rate experience suggests, however, that future regulation must address policy language provisions, especially those most subject to changes in medicine and technology, that could undercut the initial rate determinations.

September Quarterly Meeting Photo Gallery

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