The

The Insurance Receiver

Promoting professionalism and ethics in the administration of insurance receiverships.

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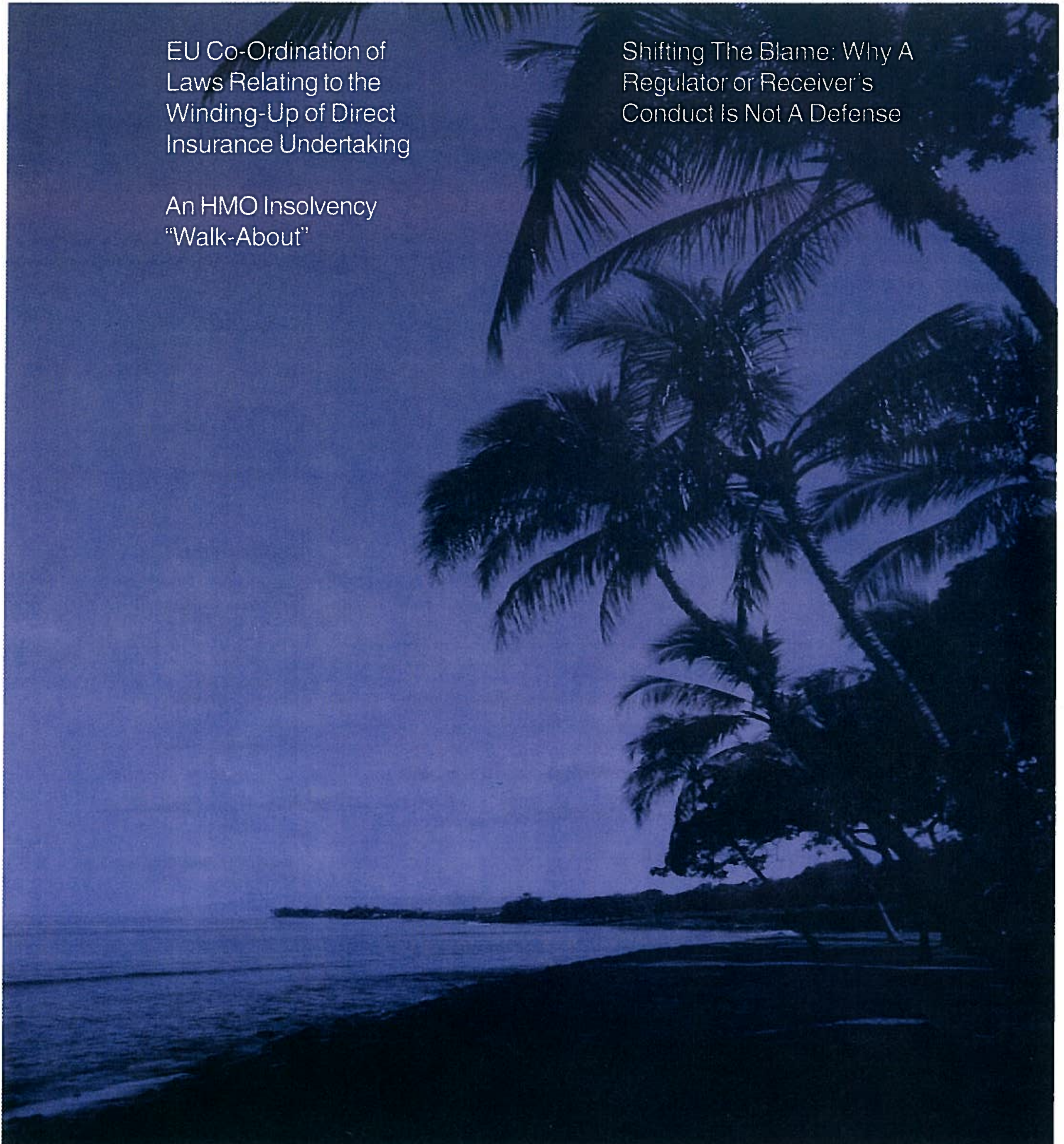

President's Message

By Robert Craig, Lamson, Dugan, & Murray

Robert Craig

It seems a given that if a regulator could access internal company operations and data on a more timely basis, more companies could be turned around. This appears to be especially true in the managed care arena. A number of IAIR's members are already involved in the process of providing management analysis for troubled companies and the regulators who oversee them.

During its June meeting, the IAIR board authorized the formation of a taskforce to look into ways that IAIR and its members can provide "early access" reviews of companies that are generating more than their share of member/policy-holder complaints at the Commissioner's office. The taskforce is being headed up by Kristine Bean of Navigant Consulting in Chicago (175 West Jackson, Suite 1700 Chicago, IL 60604 Tel: (312) 583-5713; Fax: (312) 583-5701). Kristine and her group will be working with the Health Care Insolvency Taskforce to develop this program. The group's initial meeting is tentatively scheduled for sometime during the upcoming Dallas meetings. If you are interested, please contact Kristine by e-mail at KBean@pcit. Watch IAIR's web site for more details.

On August 2nd and 3rd Mealey's presented its program HMOs in Crisis 2000. Once again the faculty consisted largely of IAIR members including a number or our board members, thanks in good measure to board member Jim Stinson of Sidley and Austin. Although the report card has yet to be issued, comments from those in attendance were very positive. If you get the chance, be sure to congratulate Robert Loisseau for his memorable rendition of a concerned HMO regulator. Rumor has it he may be looking to follow any of a number of other performers who find it profitable to be known only by their stage name. "Cher", "Sting", "Deputy Bob".

Get involved.

A SPECIAL THANK YOU

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

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The INSURANCE RECEIVER
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In this Issue

Feature Articles

Pages 6-8:
EU Co-Ordination of Laws Relating to the Winding-Up of Direct Insurance Undertaking *by Geraldine Quirk*

Pages 9 and15-17:
An HMO Insolvency "Walk-About"
by Dan Orth

Pages 18-23:
Shifting The Blame: Why A Regulator or Receiver's Conduct Is Not A Defense - Part II
by Gaetan J. Alfano and Gregg W. Mackuse

Departments

Page 2:
Message from the President
by Robert Craig

Pages 3:
Other News & Notes
by Charles Richardson

Page 4:
IAIR Roundtable Schedule

Page 5:
IAIR Association Information

and

A Recap of the Mealey's Roundtable
by Paula Keyes

Pages 10 - 11:
Meet Your Colleagues
by Joe DeVito

Pages 12 - 14 and 17:
Receivers' Achievement Report
by Ellen Fickinger

Other News & Notes

By Charles Richardson

As this article is being written on Memorial Day 2000, the terror of the Love Bug Virus (it was with some degree of jealousy that I was not among those who received an "I love you" message on May 4) had been replaced by the curiosity of the first Marty Frankel sighting and continuing upheaval in the post-GLB world of Federal v. state insurance regulation. The once sleepy insurance world is being pushed, pulled and shaped by dynamic legal and economic forces that will trickle down the food chain to present an ever-changing cornucopia of challenges for the receivership undertakers in IAIR.

Cyberrisk and the Love Bug

The so-called Love Bug virus which hit on May 4, along with several other Web site disruptions that have grabbed worldwide media attention, is driving buyers to seek new Internet insurance products and causing insurance companies to evaluate "cyberrisk" from at least three angles. First, property/casualty insurers are wondering what existing business interruption coverages might be applicable to the estimated $10 billion worldwide damages caused by the Love Bug. Second, the publicity generated by the Love Bug has increased the market's interest in new coverages to deal with Internet-related risks. And, finally, insurance companies, regulators and others interested in the modern financial services industry can't avoid speculating about how dependent we have all become on technology and the Internet, with the corollary addition of cyberrisk to the list of key threats to the industry's well-being. Just as the insurance industry and its regulators focused resources relentlessly on Y2K, the same must be true of computer security. If a single pathetic hacker in the Philippines can come close to bringing the commercial world to its knees with a simple "I Love You" message, what threats to our financial safety are there from other financial terrorists?

Frankel Sighting: A Reversal of Fortune

And speaking of pathetic, Martin Frankel, the rogue financier who allegedly embezzled more than $200 million from seven insurance companies before fleeing the United Sates last year, broke his silence on May 12 in an interview with ABCNEWS' 20/20. Speaking from the German prison where he has been detained since last September, Frankel denied that he is a master thief, saying that the lengthy sentence he faces in America is "inhumane." "There is no violence, no one is murdered, no one is killed, no one is physically harmed," he said.

Wearing a scraggly beard and dressed in the same clothes he was wearing when he was arrested nine months ago, Frankel met with ABCNEWS at the German prison. Among the pearls (diamonds) Frankel gave during the interview were his statement that, "I wish that I didn't have this incredible ability to predict things in the markets because then I never would have gotten into this position," and his insistence that he wanted to make money "to feed all the hungry people in the world."

Tell that to the 130,000 policyholders you screwed, Marty. And tell it to the juries that will hear your criminal cases here in the United States and the juries that will hear the civil RCO case filed May 9 in Mississippi federal court by the insurance company receivers in Mississippi, Missouri, Tennessee, Oklahoma and Arkansas.

Financial Modernization

Since the Gramm-Leach-Bliley Act was signed by President Clinton on November 12, the future of insurance regulation has been the focus of intense discussions among the NAIC, state regulators, the national trade organizations, and companies.

Here are some of the key events:

- At the NAIC's Spring National Meeting in Chicago in March insurance commissioners of 48 states signed the Statement of Intent: The Future of Insurance Regulation. The Statement creates the framework for several new NAIC working groups: Speed to Market, Definition of Insurance, Financial Holding Company Analysis/Examination, Consumer Protection, Treatment of National Companies, Privacy, MARAB, and NAIC/Industry Liaison. Reflecting the importance of these topics, only the state insurance commissioners themselves may serve on the working groups but industry input has been requested. These working groups are in full swing.
- NAMIC released on April 22 an impressive report on the future of state regulation with suggestions for a framework of national standards.
- The ACLI Board of Directors was scheduled to meet in June to consider a national charter approach.
- New privacy legislation continued to be discussed at both the state and federal levels, although the federal regulators delayed the effective date of the GLB privacy provisions 8 months to July1, 2000.

IAIR Roundtable Schedule

NAIC Meeting - September 9-13, 2000
Dallas, Texas
IAIR Roundtable
September 9, noon - 3:15 p.m.

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

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

***The* Insurance Receiver**

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

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A RECAP OF THE MEALEY'S ROUNDTABLE

By Paula Keyes

The April meeting in Scottsdale had something for everyone from workers compensation to life reinsurance, from alternative dispute resolution to arbitration, from multi-jurisdictional insolvencies to HMO insolvencies. The one and a half day seminar was interesting, informative, and very beautifully located.

The first day started with a review of the Unicover case which was a workers compensation carve out pool with losses reported in the $2 billion range and many disputes about whether reinsurance covered this business. Solutions included premium and exposure caps, flat dollar compensation and simply not writing the business along with others.

The alternative resolution dispute session was an introduction to the Industry Task Force of 1997 and some background on how ADR is used.

A provoking key note lunch speech by Ajit Jain of the Berkshire Hathaway Group about exit strategies from the reinsurance market offered a challenge to insurance companies to see him first because he felt he offered the best solution.

The way reinsurance claims are handled in the UK market differs from the American system and *An American Cedent In London* demystified the British system with a step-by-step explanation of how claims submitted to Lloyd's and to London Market companies handled.

The first day finished with two panels discussing multi-jurisdictional insolvencies. They provided an overview of the demographics and causes of insolvencies in various parts of the world. It was interesting to learn that 10 years ago Russia had 2 insurance companies and they now have 2,000. I wonder how many will be with us in another 10 years.

The Arbitration panel that started day two illustrated the differences between the U.S. and the U.K. systems via several skits. In the final analysis of differences, it was decided that most have disappeared with time, with the exception that U.S. arbitrators do not provide an explanation of their decisions.

The *Contract Wordings* session provided an in-depth analysis of "follow the fortunes" and offset clauses. There was also an optional Life Reinsurance session, but I must admit the climate was too beautiful to spend any more time indoors (my apologies to the panelists.)

Although the Saturday session was only half of a day, it was full of exciting information. The first session provided some insight into the future of reinsurance. The industry will look quite different in 50 years with very little need for traditional reinsurance due to the consolidation of insurance companies, alternative sources of risk capital, and a change in the relative size of the reinsurance market. The products needed will change as will the way in which they will be marketed.

An update on Year 2000 claims and the ability to recover remediation expenses under the Sue and Labor clause concluded that this clause was probably not the proper venue for these claims, but a careful analysis of existing case law may reveal some novel approaches.

Unfortunately, most attendees had departed prior to the closing panel, which was a timely and important topic, *HMO Insolvencies and Their Impact.* This session discussed what happens when an HMO becomes insolvent, what parties are impacted and what can be done to mitigate some of the damage to those injured parties. HMO insolvencies are the "new kids on the block" and the issues are so foreign when compared to insolvencies of the past. This session provided insight into what to expect and how to deal with the issues.

The Roundtable provided a lot of useful information, a good group of people with whom to network, and a wonderful location. If you missed this one, be sure to make up for it next year in Scottsdale.

Philip Singer, Trish Getty and Nigel Montgomery enjoying themselves at the Presenters' Dinner for the Market Run-off Seminar

IAIR's 2000 Educational Events

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

For more information about this program or to register for the seminar, visit our website at **http://www.iair.org/jointseminar**

A SPECIAL THANK YOU

IAIR extends its sincerest thank you for organizing and sponsoring the London Market Run-Off Seminar which was held on May 25th in London, England to:

Philip J. Singer, CIR-ML — Vivien Tyrell — Nigel Montgomery

Honorable mention goes to Trish Getty of Paragon Reinsurance Risk Management Services, Inc. for her presentation on the International Association of Insurance Receivers.

The Presenters' Dinner the night before the London Market Run-Off Seminar

EU CO-ORDINATION OF LAWS RELATING TO THE WINDING-UP OF DIRECT INSURANCE UNDERTAKING

By Geraldine Quirk

Background

On 25 May, the Council of the European Communities reached a common position on the amended proposal for a Directive on the co-ordination of laws, regulations and administrative provisions relating to the compulsory winding-up of direct insurance undertakings. The Directive applies to all insurance undertakings which come within the scope of the First Non-Life Co-Ordination Directive (73/239/EEC) as amended by the Second Non-Life Directive (88/357/EEC), and the First Life Co-Ordination Directive (79/267/EEC). Essentially, therefore, it applies to undertakings writing direct life and non-life business, although it does contain references to reinsurance business.

The objective of the directive is to provide a coherent framework for the compulsory winding-up of direct insurance companies in the European Community. To this end, it envisages a single set of proceedings, which would be commenced in the Member State in which the relevant undertaking had its head office and would be carried out in accordance with the laws of that "home" Member State, and which would be recognised in all other Member States in which the undertaking has branch offices or assets. Certain contracts and rights, however, would continue to be dealt with in accordance with the law which governs them, as opposed to the law of the home Member State in which the insolvency proceedings have been commenced. These rights include employment rights. In addition to affecting winding-up proceedings in relation to EU insurance undertakings, the Directive also has implications for undertakings which are not being wound up, and for non-EU undertakings with branches or agencies in EU Member States.

Implications Outside of Winding-up Proceedings

The Directive obliges every insurance undertaking to keep a register of certain assets in each Member State in which it has its head office, or an agency or branch. The assets represent the technical reserves corresponding to direct insurance transactions and reinsurance acceptances managed by the relevant office, agency or branch, irrespective of the country in which the policyholder is normally resident, or in which the risk is situated.

Separate registers have to be kept in relation to non-life business and life business. The assets referred to in these registers will be ring fenced on the commencement of a special compulsory winding-up, and will constitute the life and non-life asset funds which will be used for the payment of life and non-life insurance creditors.

Effect on Winding-Up Proceedings in the European Community

The Directive provides that an insurance undertaking is to be wound-up automatically where its authorisation under the First Non-Life Co-Ordination Directive and the First Life Co-Ordination Directive is withdrawn, or where conditions for the withdrawal of authorisation are fulfilled. The Directive envisages two types of compulsory winding-up:

1. Normal compulsory winding-up, which applies where the undertaking is solvent and will occur unless a special compulsory winding-up is ordered.
2. Special compulsory winding-up, which will apply in cases of insolvency.

Once a compulsory winding-up of either type has been instituted, the undertaking may no longer be wound-up voluntarily. The winding-up takes effect in all Member States, and precludes the commencement of winding-up proceedings in relation to any branch or agency of the undertaking in any other Member State.

Normal Compulsory Winding-Up

Normal compulsory winding-up can be administered by the undertaking itself, under the supervision of the supervisory authority in the home Member State. However where the supervisory body is not satisfied with the undertaking's conduct of the winding-up, it may appoint an administrator to take over the role. In order to protect policyholders, publication of the withdrawal of the authorisation and where appropriate, the appointment of an administrator, must be advertised in the Official Journal of the European Communities and by two nationally circulated newspapers in any Member State where there are creditors.

Normal compulsory winding-up does not automatically terminate insurance contracts, although it does preclude their automatic renewal. A policyholder may, however, terminate the contract when the annual premium falls due.

The Directive does not contain any specific provision relating to the order of payment of creditors or distribution of assets in a normal compulsory winding-up. Instead, it is envisaged that the winding-up will be concluded following a combination of termination, surrender or expiry of all contracts; payment of all incurred and reported claims; transfer of reserves to deal with IBNR to a trustee, who will deal with those claims as they fall due; and the transfer of the portfolio. The supervisory authorities concerned have an obligation to ensure that the undertaking seeks possible transfers of portfolios or exercises existing rights to terminate contracts in order to conclude the winding-up.

EU CO-ORDINATION OF LAWS

Where an undertaking becomes insolvent during the course of a normal compulsory winding-up, the supervisory authority must transform, or request the courts in the home Member State to transform the normal compulsory winding-up into a special compulsory winding-up.

Special Compulsory Winding-Up

A special compulsory winding-up is to be ordered by the supervisory authority of the home Member State or by the courts of that state at the request of the supervisory authority or after consulting with it, where it appears that the assets of the undertaking are no longer sufficient to cover its existing liabilities or where the undertaking is insolvent or has ceased to pay its debts. It will, therefore, be possible for creditors to initiate the winding-up procedure by applying to the Court.

Unlike a normal compulsory winding-up, a special compulsory winding-up is conducted by liquidators appointed by the competent authorities in the home Member State. Assistant liquidators may also be appointed in other Member States. The decision ordering the special compulsory winding-up is to be advertised, as is the nomination of liquidators who will deal with the winding-up, in the Official Journal of the European Communities and in two nationally distributed newspapers in Member States where there are creditors.

A special compulsory winding-up automatically terminates existing non-life insurance contracts 30 days after publication of the order commencing that winding-up, provided the contracts have not been transferred during that period. The period can be extended where there are genuine negotiations on-going concerning the transfer of an entire portfolio. Life assurance contracts are not automatically terminated. However, the liquidators may reduce the obligations of the insurer particularly with a view to effecting a transfer of a portfolio, and if this is not possible, may terminate the contracts. The permission of the supervisory authority of the home Member State, or of the courts of that state after consulting the supervisory authority, is required for both a portfolio transfer and termination. The Directive also provides that contracts by virtue of which the undertaking being wound up accepts reinsurance risks shall not be renewed after an order has been made commencing a special compulsory winding-up.

The Directive envisages the transfer of portfolios in a special compulsory winding-up, subject to the prior authorisation of the supervisory authority of the home Member State or the courts of that state following consultation with the supervisory authority. The Directive also envisages transfer of part only of a portfolio where this will not prejudice the interests of insurance and reinsurance creditors. Unlike the position with a normal compulsory winding-up, the Directive also contains provisions dealing with the ring-fencing of assets to pay certain claims and the order of payment of claims.

Life and Non-Life Asset Funds in a Special Compulsory Winding-up

Once a special compulsory winding-up has been ordered, the composition of the assets contained in the asset registers cannot be altered, other than to correct technical errors. Premiums received in respect of the class of business concerned have to be added to the assets relating to that class of business until a portfolio transfer is effected, or, in the case of non-life business where a portfolio transfer proves not to be possible, until either the expiry of 30 days after the publication of the order for special compulsory winding-up or the termination of any extension to that period allowed under the Directive in order to negotiate a portfolio transfer.

Where a portfolio transfer cannot be effected, the assets entered in the registers must be realised and distributed to creditors. Further protection for creditors is given by the proviso that, if a liquidator realises an asset for less than the amount at which it was valued in the register, he has to justify this to the supervisory authority of the home Member State or the courts of that state.

Claims relating to life business will be paid out of the life asset fund, and claims relating to non-life business will be paid out of the non-life asset fund. Non-insurance claims arising after the opening of the special compulsory winding-up and relating to the winding-up operations are paid first, followed by specified types of insurance claims, claims resulting from reinsurance acceptances, certain claims in respect of wages and salaries and claims in respect of the unused portions of premiums paid. The claims of the non-insurance creditors, other than those already mentioned, will be paid out of general assets in accordance with the laws of the home Member State.

The liquidators are allowed to set aside a sum to satisfy contingent claims, which can be lodged with a trustee who will be responsible for paying those claims as they fall due, provided they do so within a period prescribed by the supervisory authority.

Where the assets held in the relevant funds are insufficient to meet claims in full, the insurance creditors can claim against the undertaking's general assets for any unsatisfied portion of their claim. Where there is a surplus in either of the funds, that will be added to general assets.

Implications for Non-EC Undertakings

The Directive also applies to non-European Community undertakings which have established agencies or branches in Member States. Where such an agency's authorisation is withdrawn by a supervisory authority, a normal compulsory winding-up will follow. The supervisory authority in the relevant Member State can also order the commencement of a special compulsory winding-up, as can the courts of that state, after consulting the supervisory authority or at that authority's request. In addition, the commencement of a special compulsory winding-up in one Member State obliges the other Member States in which the undertaking has agencies or offices to withdraw the undertaking's authorisation. This is not the case with a normal compulsory winding-up.

(Continued on page 8)

EU CO-ORDINATION OF LAWS

(Continued from Page 7)

Comment

This Directive forms part of a general initiative to harmonise the operation of insolvency proceedings in Europe, which has gained momentum as a result of the increase in cross-border activities of undertakings. A Directive dealing with mutual recognition and co-ordination of insolvency proceedings in general has also been proposed, as has a directive on the reorganisation and winding-up of credit institutions. It is hoped that these proposals, once implemented, will prevent undertakings from transferring assets between jurisdictions to obtain the benefit of a more favourable insolvency regime, and will also ensure equal treatment of creditors in different jurisdictions. The Directive may be implemented before the end of the year.

Geraldine Quirk is an associate in the Insurance and Financial Services Reconstruction Group of DLA. She has extensive experience in this field, advising on the preparation of Schemes of Arrangement under section 425 of the Companies Act 1985 for both solvent and insolvent insurance and reinsurance companies, advising insolvency practitioners of insurance and reinsurance companies and mutuals, solvent insurance and reinsurance companies in relation to closing discontinued business and unlocking capital and solvent members of underwriting pools in relation to problems arising following the insolvency of one or more pool members.

DLA is one of the UK's top ten law firms, and a founding member of DLA & Partners, an international association of law firms comprising firms in France, Belgium and Spain.

KWELM

The 6th annual report of the KWELM companies was issued on 24th May. In it Chris Hughes and Ian Bond, Scheme Administrators of the KWELM companies, announced that they have increased the latest average payment percentage to creditors by 4% to 23% (ranging from 20% to 33% across the five KWELM companies compared with 16% to 26% a year ago). The enhanced distribution payments were made in the last week of May.

When the KWELM scheme of arrangement was established in 1993 the ultimate payment percentage was projected as 35% on average. Hughes and Bond state in the report that they are confident, on the basis of the current position, that the eventual recovery will exceed the original 35% estimate.

Hughes and Bond report that the good progress made in 1999 has continued into 2000, with a commercial resolution having been reached with Equitas that resulted in a substantial inflow of funds to KWELM.

Highlights of the annual report issued to creditors:

- A further $129m of reinsurance was recovered in 1999. Reinsurance recoveries now total more than $1.1bn.
- The funds available for creditors increased by $235m to $1.8bn.
- A further $275m of claims were processed and agreed in 1999. Cumulative claims agreed now exceed $2.2bn.
- Overall liabilities are now estimated to be $8.1bn ($8.8bn in 1998), including a prudent "special margin" of $3bn.

The payment percentages across the five companies are now as follows:

Company	Revised payment percentage%	Increase%	Previous payment percentage%
Kingscroft	30	6	24
Walbrook	20	4	16
El Paso	33	7	26
Lime Street	33	7	26
Mutual	20	4	16
Average	23	4	19

AN HMO INSOLVENCY "WALK-ABOUT"

by Dan Orth

We're going to take a walk in and around a hypothetical insolvent HMO to get a look at it from the viewpoint of those most affected by it. So grab your bush hat and sunscreen and let's go waltzing Matilda.

THE LAY OF THE LAND

HMOs are not insurers. They are a "hybrid", with some of the attributes of insurers. Unlike insurers, HMOs are not automatically regulated by state departments of insurance, so our hypothetical requires that we make some underlying assumptions. We'll assume our HMO is a domestic organization of a state (like Illinois) that treats an HMO as it would a domestic insurer, i.e., as an entity that the state has assumed the responsibility to regulate "as an insurer" through its department of insurance. We'll assume the HMO is also classified as an insurer by its domestic state for purposes of rehabilitation and liquidation under the state's department of insurance, and that the liquidation laws recognize a priority for the claims of enrollees. Finally, we'll assume that the domestic state has established, by statute, an HMO guaranty association which (again, like Illinois) has as its purpose to protect enrollees of health care plans who reside in the state (and their beneficiaries, assignees, etc., subject to limitations) against failure in the performance of contractual obligations due to the impairment or insolvency of the organization.

Our assumptions, you should note, track along with the considerations that have been taken into account by federal courts when they have been asked to decide the question of whether an HMO may seek the protection of the Bankruptcy Code, 11 U.S.C. §§ 101-1330, or whether it should be excluded therefrom. (Section 109(b) of the Bankruptcy Code provides that "A person may be a debtor under chapter 7 [or chapter 11] of this title only if such person is not - ...(2) a domestic insurance company...." See 11 U.S.C. §109(b), (d). Note, the Code does not define "domestic insurance company".) Congress has recently confirmed the right of the states to regulate HMOs as insurers, if the states affirmatively act to do that. (See Gramm - Leach - Bliley, Financial Modernization Act of 1999, PL 106-1022, 113 Stat. 1338, 1999, specifically §§ 302(e) and 336(2), which define "insurance" as "any product...defined or regulated as insurance by the appropriate State insurance regulatory authority.")

OUR WALK-ABOUT BEGINS ON THE HIGH GROUND

The Regulator's View ... of His Own Responsibilities

We start in the company of the state's insurance regulator, (our hypothetical regulator is of the male gender with the title of "Director of Insurance") who has statutory responsibilities that affect the interests of multiple parties impacted by an HMO insolvency. Significant parties are:

a) the directly-affected public (in the persons of the enrollees who hold certificates issued by the HMO);

b) the creditors of the HMO, (principal among them "contracted" or "network" medical service providers, promised to perform services for the HMO's enrollees at a discounted rate on the promise of referral of enrollees and payment by the HMO, but other creditors, as well);

c) the other licensed HMOs in the state (who are, by law, members of the state's HMO guaranty association, and who, in the event of an insolvency, may be assessed, pursuant to a statutory scheme under which the solvent HMOs in the state provide the funds immediately needed to cover a portion or all of the cost of protecting the enrollees of a failed HMO); and,

d) the less-directly-affected tax-paying public that bears the cost of state action, (which includes the involvement of a department of state government, and a state court, and a decrease in state

premium tax revenues, reduced by tax offsets taken by the assessed HMOs.)

... of the Insolvent HMO

There are many ways a regulator may become aware that an HMO is "financially troubled", but the most likely is the recognition of a trend reflected in periodic examinations or in required financial statement filings. Common reasons for HMO failures are under-capitalization, too-low premium rates, an insufficient number of enrollees, rising drug and medical costs, mandated benefits or products, inadequate data systems, inexperienced or incompetent management and, on occasion, outright dishonesty. If the HMO has less capital and surplus than is statutorily required, but is still above zero, it is "impaired". If the HMO's capital and surplus is less than zero, it is "insolvent". Before deciding whether an involuntary liquidation was necessary, a regulator would first explore other alternatives with the equity owners of the HMO, including cash infusion or bringing in new, experienced, management. For its part, the HMO would consider a sale of its single most valuable asset, its list of enrollees, (while that asset retained value) to another or several other HMOs that might have an interest in expanding their membership and possibly their network of providers in the service area. That would provide the best chance

(Continued on page 15)

Meet Your Colleagues

DOUGLAS L. HERTLEIN

Doug is the Chief Deputy Liquidator for the Ohio Insurance Liquidation Office. As such, Doug oversees the liquidation of all Ohio domestic insurance companies that are placed in liquidation. Currently there are six P & C insurance companies and three HMO's being liquidated by the office.

Doug was appointed as Chief Deputy Liquidator by Ohio's Superintendent of Insurance, J. Lee Covington, on July 6, 1999. Prior to that, Doug was in private practice as an attorney with the law firm of Thompson Hine & Flory, LLP in Columbus, Ohio. His practice consisted primarily of bankruptcy and commercial litigation. Doug obtained his law degree from the University of Cincinnati in 1988 and in addition to being admitted to practice in the State of Ohio, he is admitted to practice in the District Courts in the Northern and Southern Districts of Ohio and the U.S. Sixth Circuit Court of Appeals.

Like many people, Doug had a life prior to law school. He obtained a Bachelor of Science Degree in Agricultural Economics from the Ohio State University in 1978. Following college, Doug was the owner/operator, in partnership with his father and brother, in a diversified farming operation. During those years, they produced about 1,000 acres a year of grain crops and raised hogs and beef cattle.

Doug has been married to his wife, Lori, for 19 years and they have three teenage sons. When not at work, Doug is usually involved in activities revolving around the boys; scouting, sports, family camping, etc.

In addition to having recently joined IAIR, Doug is a member of the Ohio State Bar Association, the Columbus Bar Association, and the Christian Legal Society.

LYNDON NORLEY

Lyndon Norley is a partner in the London office of Cadwalader, Wickersham & Taft, a pre-eminent US law firm with a head office in New York. Lyndon holds a degree from King's College London and trained with UK solicitors, Clifford Chance. Lyndon joined Cadwalader in 1997 and assisted in the establishment of Cadwalader's London office.

Lyndon has advised on a variety of financial restructuring matters. In particular, Lyndon's work has focused on insurance insolvency, bond restructuring and general insolvency work, both contentious and non-contentious. Work has included advising on the KWELM, English & American and the ACC Pool schemes of arrangement as well as advising groups of bond holders on the Barings collapse, One Finsbury Circus and Alpha Shipping.

Lyndon has pioneered the use of solvent schemes of arrangement to facilitate the early conclusion to an insurance company's run-off, including solvent schemes for Scottish & Commonwealth, Osiris and Trent.

Lyndon Norley also advises on the acquisition, disposal and reorganisation of insurance companies, brokers and insurance service providers.

Lyndon participates in a number of sports, in particular golf and running. He is also a keen traveller and has travelled extensively throughout Europe, Asia and Africa.

JOHN C. McKENNA

John McKenna is a partner with Ernst & Young in Bermuda. He qualified as a Chartered Accountant in Canada in 1979 and has been a resident of Bermuda since 1981. He is a member of the Institutes of Chartered Accountants of Canada and Bermuda and holds a Bachelor of Commerce degree from Dalhousie University in Halifax, Nova Scotia.

John joined Ernst & Young as a Partner in 1994 and leads its Corporate Recovery practice. He is responsible for overseeing the day to day management of a number of large reinsurance insolvencies, including the New Cap Re Group and The Bermuda Fire & Marine.

John is a Member of the Chartered Institute of Arbitrators and holds the Associate in Reinsurance (ARe) and Associate in Risk Management (ARM) designations from the Insurance Institute of America. He is also Secretary of the Bermuda Branch of the Institute of Directors.

When his work and travel commitments permit, John tries to play enough tennis to stay just ahead of his 14 year old son. Despite the expert coaching of his 8 year old daughter, he fears his dominance is about to end.

FREDRIC MARRO

Fredric Marro, is founder and president of Fredric Marro and Associates, Inc. as well as Westmont Associates, Inc. Both firms are located in Haddonfield, New Jersey. Mr. Marro is a member of the American Bar Association, the New Jersey Bar Association, the Camden County Bar Association, the Washington D.C. Bar Association, the Federation of Regulatory Counsel, the Federation of Insurance and Corporate Counsel, the International Association of Insurance Receivers, and an associate member of the Society of Financial Examiners. He obtained his law degree from Seton Hall University School of Law, and his undergraduate degree from Manhattan College. He has over 20 years of experience in the insurance industry. Prior to attending law school, Fred was an underwriter with St. Paul Companies and later a surplus lines broker. He served as transition chief to a newly-elected insurance commissioner and as corporate counsel for a multinational insurance holding company.

In addition to the insurance regulatory, corporate and merger and acquisition work performed by his law firm, Fred currently serves as Deputy Receiver for Consumers United Insurance Company (in liquidation) and as acting General Counsel and a Deputy Receiver in regard to National Heritage Life Insurance Company (in liquidation).

Mr. Marro's consulting firm specializes in insurance regulatory services including: rehabilitations and liquidations, agency/agent licensing, company formations, company licensing, form rate and rule filings (all product lines/states), legislative/regulatory analysis and review (Federal and State), along with support services such as; claims management, due diligence, forms drafting, litigation, reinsurance commutations, risk purchasing groups, and underwriting and compliance audits. As President of Westmont, Mr. Marro oversees all operations of the corporation, while specializing in the legal aspects of insurance regulatory and industry concerns.

Fred and his wife, Gail, have three children, Courtney, Logan and Meghan. Mr. Marro spends a large amount of his leisure time coaching his children's soccer, basketball and baseball teams or relaxing at the Jersey shore.

Receivers' Achievement Report

by Ellen Fickinger

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

Our achievement news received from reporters is as follows:

Mark Tharp (AZ) submitted the following information for **Premier Healthcare, Inc. d.b.a. Premier Healthcare of Arizona (Premier)**. On November 16, 1999, **Premier** became subject to the "Order for Appointment of Receiver and Issuance of Permanent Injunction" (Order) issued by the Court. The Order includes both a finding that **Premier** is insolvent, and Consent to Order, executed by **Premier's** former Chairman, Charles F. Barrett. **Premier** is an Arizona domiciled health care services organization (HCSO) providing health care services through health care plans and is licensed and operating only in Arizona. **Premier** is a wholly owned subsidiary of **MatureWell, Inc.**, a Delaware Corporation.

Premier was first licensed by the Arizona Department of Insurance (ADOI) in 1995. It was originally owned by eight regional physician/hospital organizations (PHO's). The PHO's contracted with **Premier** to provide health care to its then and subsequent enrollees, up through the date of closing of the Stock Purchase Agreement. On or about February 10, 1999, the PHO's entered into a Stock Purchase Agreement, by which the former shareholders (PHO's) agreed to sell one hundred percent of the stock of **Premier** to **MatureWell, Inc.** The Stock Purchase Agreement closed on or about March 23, 1999.

At the time of the entry of the Order by the Court, **Premier** was doing business with the U.S. Health Care Financing Administration (HCFA), providing an HCSO product, known as "Medicare+Choice" plan, to persons entitled to Medicare benefits. **Premier** also engaged in "commercial", or non-Medicare business issuing health care plans to various groups in the private market. **Premier** operated throughout Arizona and as of the date of Receivership had approximately 75,000 enrollees of which approximately 20,000 were Medicare enrollees.

Pursuant to Arizona law, each HCSO licensed in Arizona is required to have a Plan for Risk of Insolvency which provides for (i) continuation of benefits for the duration of the enrollee or group contract period or for sixty days from the date insolvency is declared, whichever is longer, and, (ii) continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge. **Premier** had such a plan in place and such plan was implemented as of November 16, 1999. Arizona law does not provide guaranty fund coverage for obligations of an HCSO. Under the plan, post-receivership claims are being processed as they become due; a pre-receivership claims process is pending.

Mike Rauwolf (IL) reports that under OSD supervision, **American Mutual Reinsurance, In Rehabilitation (AMRECO)** is mangaging the reinsurance run-off of their business. Total claims paid inception to date; Loss & Loss Adjustment Expense $30,449, Reinsurance Payments $130,249,893, LOC Drawdown disbursements $9,613,386. An additional company under OSD supervision, **Centaur Insurance Company, In Rehabilitation**, also continues to manage the run-off of their business. Total claims paid inception to date; Loss & Loss Adjustment Expense $51,271,555, Reinsurance Payments $4,945,493, LOC Drawdown disbursements $13,876,555.

James Gordon (MD) has reported that **Trans-Pacific Insurance Company, et al** was closed on December 27, 1999. A Liquidating Trust was created to effectuate continued collections pursuant to judgements against principals of the companies. To that end, collections during the fourth quarter of 1999 totaled $1,037.50. For **Grangers Mutual Insurance Company**, total collections for the fourth quarter were $82,345.89.

James Gerber and **Pat McGuire (MI)**, deputy receivers for **Cadillac Insurance Company**, advised that on December 8, 1999, Judge William Collette approved a liquidation dividend representing administrative expenses paid by various guaranty funds from the inception of the **Cadillac** insolvency through December 31, 1997 totaling $5,909,815. This represents the first distribution from the **Cadillac** estate. Further, on November 17, 1999, Judge Collette approved a $300,000 liquidation dividend representing administrative expenses from the **Lincoln Mutual Casualty** estate. During 1999, **Lincoln Mutual** paid out $600,000 in liquidation dividends. In total, during 1999 Michigan receivership estates distributed in excess of $12,000,000 to various guaranty associations.

More updates received from **Frank Martin (PA)** on the progress of **Fidelity Mutual Life Insurance Company (FML), in rehabilitation**. Policyholder death benefits and annuity payments continue to be paid 100%. Crediting rates are at or above policy guarantees. As of 12-31-99 **FML** showed a statutory surplus in excess of $133,000,000.

The Commonwealth Court authorized payment of all approved creditor claims if the creditors are willing to waive any interest or penalties which may be applicable. Most approved creditors have accepted that settlement and have been paid; however, a handful of the general creditors have chosen to wait and see what interest rate will be approved in the rehabilitation plan for payment at Closing. All of the guaranty associations settled for immediate payment of outstanding

assessment claims. However, the Louisiana Guaranty Association has appealed the denial of their expense claim and briefs have been submitted by both sides to a claims referee. No guaranty associations have ever been asked to fund any aspect of **FML** obligations. They are also in the process of working out settlements with the taxing authorities that will allow them to retroactively credit the paid guaranty association assessments against any premium tax owed. This involves preparing and filing amended returns from 1993 forward for each state with an offset provision. So far there are only two states who allege that they are not allowed to waive interest and five states who cannot allow retroactive application of guaranty association credits.

In response to a petition filed by the Rehabilitator, the Commonwealth Court recently established a Claims Bar Date of June 30, 2000. In contrast to the previous claim filing deadline, this process will forever bar any claims against **FML**, related subsidiaries, their officers and directors (during rehabilitation) and Pennsylvania Insurance Department employees.

Hearings on the Third Amended Rehabilitation Plan and the accompanying Stock Allocation report concluded on September 21, 1999. The hearing process was unusual in that direct testimony and objections to that testimony were all submitted to the Court in writing. The hearings only consisted of cross-examination of the witnesses who had filed testimony. Just prior to the beginning of the hearings, all **FML** rehabilitation matters were reassigned to a different judge. The new judge has indicated that he will want to see what claims are filed during the Claims Bar Date period before a preliminary approval order is issued for the Third Amended Rehabilitation Plan.

The Third Amended Plan and all related documents have been negotiated over the last two years with the court appointed Policyholders Committee. The plan proposes that **Fidelity Life Insurance Company (FLIC)**, a stock life insurance company, will assume and reinsure **FML's** obligations under all of its life insurance policies and other insurance contacts. No reduction will occur in cash value, death benefits, dividend accumulation or policy loan accounts. Substantially all of **FML's** assets will be transferred to **FLIC** to support these obligations. The plan proposes that creditors with approved claims will receive payment in full, in cash, with simple interest at 6% per year. Policyholders will receive both common and convertible preferred stock in the holding company for **FLIC, Fidelity Insurance Group (Group)**. An outside investor will be selected through court approved Bid Procedures to contribute additional capital to **FLIC** through the purchase of **Group** Stock. The investor will purchase a slight majority of the common stock and appoint the majority of the board of directors. The petition for approval of a new dividend scale would distribute, through a one-time dividend and increased crediting rates, approximately $90 million to policyholders over a 12 month period while maintaining minimum capital and surplus levels and meeting risk-based capital requirements for **FML**. The Policyholder Committee has recently demanded an increase in the proposed dividend due to the passage of time since it was proposed and the Rehabilitator has finalized negotiations for an increase.

RECEIVERS' ACHIEVEMENTS BY STATE

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

Receivership Estates Closed	Year Action Commenced	Licensed	Category	Dividend Percentage
Amalagamated Labor Life Company	1989	Y	Life and A & H	Class A - 100% - $927,528 Class D - 21.29% - $2,854,219

Receivership	*Amount*
Amreco	$2,061,815.00
Centaur	$257,032.00
Equity General	$86,580.00
Heritage	$2,035,624.00
Medcare HMO	$64,939.00
Merit	$7,614.00
Millers	$176,726.00
Optimum	$2,500,000.00
Pine Top	$13,475,010.00
Distributions were made on an additional 8 estates under $5000.	$6,892.00
Total	**$20,672,232.00**

(Continued on Page 14)

(Continued from Page 13)

Kansas (Daniel L. Watkins, State Contact Person)

Receivership	***Amount***	
West General Insurance Company - Early Access	$1,536,016.00	(GA Class I Expenses - 100%)
	$6,570,218.00	(GA Class 3 Policyholder Claims - 40%)
Total	**$8,106,234.00**	

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

Receivership	**Amount**	
Trans-Pacific Insurance Company	$250,000.00	(100%+ Interest - Policy Claims)
Grangers Mutual Insurance Company	$92,127.80	(MD)
	$4,493.95	(GA)
	$310.48	(TN)
Total	**$346,621.75**	

Michigan (James Gerber, State Contact Person)
Use and distributions made to policy/contract creditors and Early Access

Receivership	**Amount**	
Cadillac Insurance Company	$35,899.00	(FIGA)
	$91,629.00	(GA Insolvency Pool)
	$199,434.00	(IN GA)
	$116,082.00	(LA GA)
	$14,389.00	(MI L&H GA)
	$4,430,961.00	(MI P&C GA)
	$72,097.00	(NV GA)
	$480,400.00	(OH GA)
	$151,185.00	(OH L&H GA)
	$317,739.00	(TX P&C GA)
Total	**$5,909,815.00**	
Lincoln Mutual Casualty	$600,000.00	

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

RECEIVERSHIP	SECURITY/GUARANTY FUNDS	POLICY/CONTRACT CREDITORS	OTHER CREDITORS	TOTAL
Consolidated	$247,799.17	$0.00	$0.00	$247,799.17
Cosmopolitan	$961,891.68	$0.00	$0.00	$961,891.68
Dominion	$0.00	$7,684.39	$25,154,928.27	$25,162,612.66
Galaxy (Early Access)	$5,245,332.00	$0.00	$0.00	$5,245,332.00
Horizon	$560,024.00	$241,677.04	$0.00	$801,701.04
Ideal Mutual	$28,941,892.68	$844,847.63	$624,439.67	$30,411,179.98
Interamerica Re	$1,080.00	$96,558.13	$30,649,121.00	$30,746,759.13
Long Island	$29,209.00	$0.00	$0.00	$29,209.00
New York Ins. Exchange	$0.00	$0.00	$1,497,848.87	$1,497,848.87
Northumberland Reg. 41	$0.00	$611,782.28	$0.00	$611,782.28
Pine Top Syndicate	$0.00	$16,232.32	$2,735,149.80	$2,751,382.12
Realex Group	$0.00	$2,303.41	$29,438,810.81	$29,441,114.22
U.S. Capital (Early Access)	$2,410,940.17	$0.00	$0.00	$2,410,940.17
Whiting Nat'l	$28,083.00	$0.00	$0.00	$28,083.00
Total	$38,426,251.70	$1,821,085.20	$90,100,298.42	$130,347,635.32

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

Receivership	**Amount**	
PIC Insurance Group, Inc.	$1,500,000.00	(GF)

(Continued on Page 17)

AN HMO INSOLVENCY "WALK-ABOUT"

(Continued from Page 9)

for a smooth transition for enrollees, and would cut losses, but would require the HMO's owners to quickly accept the conclusion that the HMO could not be saved. None of that happened here.

In our hypothetical the Director initially determined the HMO to be impaired and sought to be (and was) appointed by a state court of equity as Conservator, to get a closer look inside the HMO. There has been no infusion of new capital, whether from the existing equity holders or new venture capitalists, nor an acceptable plan to bring the entity back to financial health. There is a huge deficit of assets to liabilities, which includes a large claim backlog. No payments to certain network providers for non-contracted services nor to out-of-network providers have been made in several months. In the past, the HMO had made several acquisitions of smaller HMOs (in an effort to gain size and achieve the benefits of economies of scale). The HMOs records are a mess. The data systems of the various acquired HMOs were incompatible with the acquiring HMO and with each other. The personnel of the insolvent HMO, including its senior management, lacked the expertise or experience to deal with problems of the nature and magnitude of those which had arisen since the acquisitions. The Director concluded that the HMO was significantly insolvent, and that other parties would suffer even greater injury if it continued to do business.

... of the Court

The Director files a petition for liquidation in the appropriate court (a state court of equity) when he concludes that no other reasonable alternative exists or, at least, can be agreed to. As the state's chief officer in charge of the regulation of the business of insurance, (recalling that this state considers HMOs to be the business of insurance), the Director's petition for liquidation is entitled to great deference by the court under the state's scheme of regulation. He seeks to demonstrate that the continued availability of medical care to enrollees (by providers who may not have been paid for weeks or even months) sooner or later will turn in the balance, so he argues that a speedy hearing by the court is essential to the interests of the covered enrollee portion of the public. The court must consider how long enrollees will continue to receive care once contracted providers are aware the HMO is in trouble. Keep in mind that enrollees will receive no protection from the guaranty association until the guaranty association has been "activated" under its statute, which (except under special circumstances) occurs only when there exists a final order of liquidation together with a finding of insolvency. This can occur quickly if the HMO acquiesces to the Director and agrees to the entry of the order. It could be a prolonged and drawn-out process if the court does not hear and decide the Director's case with dispatch, and a much longer process if the HMO contests the proceeding and/or appeals from it. In our case the court, after evidence is presented at a hearing, finds the HMO to be insolvent and enters an order of liquidation. This same court will continue to deal with future questions arising in this insolvency.

... of the Providers and Other Creditors

When an HMO becomes delinquent in its payments to providers, the debt can quickly mount, creating the liabilities that result in insolvency. Once discovered and confirmed, how long can a regulator responsibly allow a condition to exist, and to worsen, while providers continue to extend credit, unaware that they have no reasonable expectation of payment? Providers, and other creditors, presumably have some right to rely on a regulator to perform basic regulatory tasks, such as to require timely filing of financial statements, to conduct appropriate examinations and to protect the public (which includes creditors) by taking action reasonably promptly when statutory solvency requirements are not being met.

A provider's acceptance of the business risk of "slow pay" from a solvent HMO is very different than the risk of "no pay" from an insolvent HMO. For a provider that is owed money, an HMO's insolvency amounts to a certain loss. This is especially the case where the claims of providers and other creditors are heard in the forum of a state insolvency proceeding (which gives priority to the claims of enrollees, above that of the claims of creditors), as contrasted with a federal bankruptcy court (where such diverse claims are treated equally). Good regulation requires a balance between the diligence to duty to give reasonably prompt notice of insolvency to the public, and the patience and caution needed to resist "pulling the trigger" too quickly and causing a panic that takes down a company that could be saved.

... of the Other HMOs

The Director's obligation to other HMOs in the state may appear to be less direct than his obligation to enrollees or providers, but it is similar in that it can result in a direct financial impact. If the Director liquidates an HMO, that liquidation is likely to cause the state's HMO guaranty association's governing board to assess its members in order to fulfill the association's statutory obligation to protect enrollees. An assessment has a negative financial impact upon the other HMOs in the state. Under a law like that in effect in Illinois, that assessment is divided among and collected from the members according to the percentage that the premium each of the member HMOs collected in the state in the calendar year prior to the insolvency bears to the total premium collected by all HMOs in the state in that calendar year. (The legislature in Illinois did provide that assessments should not be collected from a member HMO if the collection would cause the financial impairment of an HMO not otherwise impaired.) The assessed HMOs may receive a reduction in taxes, referred to as a tax offset, but as guaranty associations typically work, the offset is only able to be taken over five years, in amounts equal to 20% each year of the amount paid, for the five years following the year in which it was paid. The Director has an obligation to the continued

(Continued on Page 16)

AN HMO INSOLVENCY "WALK-ABOUT"

(Continued from Page 15)

financial health of the state's HMOs, so that even if the guaranty association law will not permit an assessment to be the sole cause of an HMO becoming impaired, the fact remains that every assessment is a drain on profits and ultimately on capital and surplus in an industry with already thin profit margins.

... of the Taxpayers

The Director must also keep in mind his obligation to the general taxpayers of the state who ultimately bear most of the financial burden of his execution of his duties. When the Director does put down an insolvent HMO, the taxpayers bear some immediate burden of the cost of state action. Many Department of Insurance personnel must become involved. The court and its support personnel are required to devote time reviewing the petition and briefs, scheduling and hearing arguments and monitoring the process after an order is entered. Finally, as noted earlier, the state's taxpayers ultimately bear the longer-term burden of the cost of tax offsets for amounts assessed against solvent HMOs. (In Illinois, only the portion of assessments paid in excess of a $3,000,000 threshold amount in a single calendar year is eligible for offset.)

... of the Politics

A final area of impact for a regulator is political fallout. No regulator wants an insolvency to occur on his or her watch, even though frequently the situation is an inherited one, holding over from one or even several prior administrations. The political impact can vary depending upon whether the regulator is elected or appointed, and on the timing, but it is rarely, if ever, seen as a good thing, even when it is absolutely the right thing to do.

THE "OUTBACK" OF INSOLVENCY AS SEEN BY ENROLLEES AND PROVIDERS

Enrollees

When an HMO collects premium (from its enrollees or from employers or from government entities for the benefit of enrollees) that premium is the consideration that supports a contract under which the HMO is bound to provide certain benefits that are spelled out in the certificate issued by the HMO. Liquidation disrupts that relationship. When the HMO is ordered by a court to be liquidated, the effect is that the operating HMO ceases to exist. The HMO's "provider network", as it had existed, will eventually disappear. Neither the "primary care physician" (PCP) assigned by the HMO nor the network of providers available to the enrollee will any longer be paid a fee every month to care for the

HOME AGAIN

Our "scenic" walk-about is over, mate, so sit back with a cold beer and relax and reflect But don't get too comfortable - another insolvency lies ahead. As will the urge to take a closer look at it.

P|A|R|A|G|O|N

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Daniel A. Orth, III was in-house counsel to an Illinois-domiciled life and health insurer for 27 years. During that time he represented his company on two state guaranty association boards of directors (Oregon for 17 years; Illinois for 5 years) and served on the Board of Directors of NOLHGA over the years 1990, 1991, 1992 and 1993. He has been Executive Director of the Illinois Life and Health Insurance Guaranty Association and the Illinois Health Maintenance Organization Guaranty Association since 1993.

FREMONT INSURANCE COMPANY (UK) LIMITED
(SCHEME OF ARRANGEMENT)
Notice of Declaration of a Second Interim Dividend
NOTICE IS HEREBY GIVEN that a second interim dividend of 5% of Scheme Creditors' Ascertained Scheme Claims has been declared in the above matter bringing total dividends declared to date to 30%. Dividend cheques in respect of those claims that have been agreed will be despatched to Scheme Creditors shortly.
P J Singer & C J Hughes, Joint Scheme Administrators
Fremont Insurance Company (UK) Limited, Plumtree Court, London EC4A 4HT, United Kingdom
Dated this 27th day of June 2000

RECEIVER'S ACHEIVEMENT REPORT

(Continued from Page 14)

LONDON (Philip J. Singer, International Contact Person)

PricewaterhouseCoopers reports the following dividend payments:

KWELM Companies	
Kingscroft Insurance Co. Ltd	Increased from 24% to 30%
Walbrook Insurance Co Ltd	Increased from 16% to 20%
El Paso Insurance Co Ltd	Increased from 26% to 33%
Lime Street Insurance Co Ltd	Increased from 26% to 33%
Mutual Re Insurance Co Ltd	Increased from 16% to 20%
Andrew Weir Insurance Company Ltd	Increased from 20% to 26%
Bryanston Insurance Company Ltd	Increased from 25% to 31%
London and Overseas Insurance Company Ltd	Increased from 25% to 30%
OIC Run-Off Ltd (Formerly Orion Insurance Co. plc)	Increased from 25% to 30%
Trinity Insurance Company Ltd	Increased from 47.5% to 52.5%
Fremont Insurance Co (UK) Ltd	Increased from 25% to 30%
C Rowbotham & Sons Limited	First and final dividend 2.9%. The liquidation of this Lloyd's Broker is now closed.

SHIFTING THE BLAME:

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

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

Defendants charged with wrongdoing in an insurance insolvency frequently assert that their liability should be barred, or reduced, due to the receiver's conduct. The most common arguments are that: (1) the receiver has failed to maximize asset recovery, thereby exacerbating the insolvency; and (2) through mismanagement of the insolvent assets, the receiver has failed to minimize losses.

These arguments typically are couched as the affirmative defense of "failure to mitigate damages." In response, courts have held that such an affirmative defense is insufficient as a matter of law.

INSURANCE INSOLVENCY DECISIONS

Foster v. Rockwood Holding Co., 632 A.2d 335 (Pa. Commw. 1993), is the major decision on this issue. In Rockwood, the court not only rejected defenses based upon regulatory conduct but also addressed whether defendants may assert, as a defense, the receiver's actions. The Rockwood court first noted that, in the area of banking insolvency, "federal courts have held that The Resolution Trust Corporation and the Federal Deposit Insurance Corporation may not be subject to affirmative defenses and claims of regulatory negligence as receivers for failed banks under federal banking laws." Rockwood, 632 A.2d at 337. The court also noted that:

"In the cases cited by plaintiffs, the federal courts have specifically held that a receiver owes no duty to manage a bank or to bring to the attention of its officers and directors any wrongdoing during its regulatory activities and that, as a matter of law, regulatory conduct cannot stand as a basis for direct claims, affirmative defenses and counterclaims against federal banking regulators."

Id.[2] (citations omitted). The Rockwood court, relying upon federal banking decisions, then held that the defendants could not assert defenses based upon the receiver's conduct:

"Although not controlling, the court finds persuasive the reasoning of the federal court cases cited by plaintiffs. The purpose of Article V, Suspension of Business--Involuntary Dissolutions, of Pennsylvania's Insurance Act is to protect the interests of insureds, creditors and the public generally. 40 P.S. § 221.1. To effect this purpose, the Insurance Commissioner is empowered under the Act with the authority to petition this court for an order authorizing her to rehabilitate or liquidate an insurer. 40 P.S. § 221.15; 40 P.S. § 221.20.

w w w

In light of the purpose of the Act to protect the public good, the Insurance Commissioner's power to recover damages for any wrongdoing should not be encumbered by an examination in court of the correctness of any specific act of the Insurance Commissioner in its receivership. Furthermore, the defendants should not be permitted to assert regulatory negligence to offset their own alleged culpability.

w w w

The defendants' interpretation of select parts of the Act, specifically sections 520(d), 523(13), and 532, ignores the overall purpose of the Act and would result in a frustration of that purpose of protecting the public generally, as well as the insureds and creditors. Under the defendants' interpretation of the Act wherein the Insurance Commissioner wwould be subjected to certain affirmative defenses such as waiver, etc., the Insurance Commissioner would be forced to defend each act of regulatory conduct in any action the Insurance Commissioner brings to recover damages for wrongdoing. As a result, the efficiency and expediency with which the assets of the insolvent insurer are converted to cash to repay the losses incurred by the creditors and the insureds may be impaired thereby harming the public good.

w w w

Accordingly, defendants' affirmative defenses of failure to mitigate damages, negligence, contribution, estoppel and waiver will be stricken as to the Insurance Commissioner in her capacity as liquidator of RIC[.]

Rockwood, 632 A.2d at 338-39 (emphasis added).[3]"

Gaetan J. Alfano

BANKING INSOLVENCY DECISIONS

The area of banking insolvency has yielded numerous decisions on this issue. Once again, with few exceptions, courts consistently have rejected defenses based on receivership conduct.

The seminal decision is Federal Savings and Loan Ins. Corp. v. Roy, No. CIV. JFM-87-1227, 1988 WL 96570 (D. Md. June 28, 1988). In Roy, the FSLIC brought suit against former officers and directors of a failed financial institution. Id. at *1. The FSLIC moved to strike the affirmative

defenses of contributory negligence and assumption of the risk. Id. The court granted the motion, holding that because the alleged wrongful conduct of FSLIC took place after the wrongful conduct of the defendants had occurred, the defenses were insufficient as a matter of law:

"The narrow issue formally raised by FSLIC's motion may be easily resolved. The gravamen of the claims asserted by FSLIC, as the assignee of First Federal, is that defendants were negligent in that they failed to have independent underwriting conducted by First Federal's own personnel before recommending and approving the subject loans and, instead, relied solely upon information supplied by brokers hired by the borrowers in makin[g] their loan decisions. The alleged conduct of FSLIC underlying the affirmative defenses occurred well after the loans were made, when FSLIC assumed supervisory control over First Federal. Thus, simply as a conceptual matter, this alleged conduct does not constitute "contributory negligence" or "assumption of risk" to the wrong alleged. Therefore, the affirmative defenses are insufficient as a matter of law, and FSLIC's motion is proper on that ground alone.

*Roy, 1988 WL 96570, at *1"* (footnote omitted).

The most significant aspect of the Roy decision, however, was the court's further holding that the defendants could not assert that the FSLIC's conduct was the proximate cause of the alleged losses. As stated by the court:

"If this were an ordinary tort case, defendants' argument would have merit. In that event, if the evidence were to show that FSLIC's own negligence (either in connection with general management matters or in working out specific loans) had caused or contributed to its losses [sic], its claims would be barred or reduced. However, this is not an ordinary tort case. Rather, it is one which arises within a special context, invoking special considerations of public policy.

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FSLIC has been created for the purpose of preserving the integrity of the national banking system by providing an insurance fund to cover the deposits of failed and failing institutions. FSLIC owes no duty to those institutions or to those whose negligence has brought them to the brink of disaster. Self-evidently, it is the public which is the intended beneficiary of FSLIC, just as it is the public which is the beneficiary of

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the common law duty imposed upon officers and directors to manage properly the institutions entrusted to their care. Thus, nothing could be more paradoxical or contrary to sound policy than to hold that it is the public which must bear the risk of errors of judgment made by its officials in attempting to save a failing institution -- a risk which would never have been created but for defendants' wrongdoing in the first instance.

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In summary, this Court finds that defendants' affirmative defenses of contributory negligence and assumption of risk should be stricken. Further, the Court finds that FSLIC's own alleged negligence is immaterial to any of the issues presented in this case, and that discovery should be restricted accordingly.

*Roy, 1988 WL 96570, at **1-2"* (footnotes omitted) (emphasis added).

Several district courts have cited Roy in striking "receivership conduct" affirmative defenses as a matter of law. For example, in Federal Deposit Ins. Corp. v. Carlson, 698 F. Supp. 178 (D. Minn. 1988), the FDIC moved to strike the former officers' and directors' defense of contributory negligence. Id.[4] Relying upon Roy, the court then dismissed the defense of contributory negligence:

The court finds that the reasoning of Roy is sound notwithstanding defendants' arguments to the contrary. The defense of contributory negligence is ordered DISMISSED.

Id. at 179.

In Federal Deposit Ins. Corp. v. Greenwood, 719 F. Supp. 749 (C.D. Ill. 1989), the FDIC moved to "exclude any evidence purporting to diminish the FDIC's right of recovery by virtue of decisions made by it in connection with the collection of the assets of the Coffeen National Bank." Id. at 750.S Relying upon Roy and Carlson, the court granted the FDIC's motion:

"The Court agrees with the position taken by the district court in Roy. Public policy concerns mandate a finding that the duty of FDIC to collect on assets of a failed institution runs to the public and not to the former officers and directors of the failed institution. Thus, the decision of the FDIC that it would be more cost effective to sell certain loans as part of a bulk sale rather than incur the considerable expense involved in collecting certain assets cannot be the basis of reduction of FDIC's claims.

Federal Deposit Insurance Co. v. Carlson, 698 F. Supp. 178 (D. Minn. 1988), is in accord with this holding.

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Evidence purporting to diminish the FDIC's right of recovery by virtue of decisions made by it in connection with the collection of the assets of the Coffeen National Bank is immaterial to the issues in the case at bar. Thus, Plaintiff's motion in limine will be allowed.

Id. at 750-51" (emphasis added).

Similarly, in Federal Deposit Ins. Corp. v. Oakes, CIV.A. No. 89-2261-S, 1989 WL 151954 (D. Kan. Nov. 3, 1989), the FDIC moved to strike the affirmative defenses of, inter alia, comparative/contributory negligence, negligence, breach of fiduciary duty, waiver and laches raised by the defendant officers and directors. Id. at *1. The defendants argued that the "no duty" rule did not apply to receivership conduct. Again, as stated by the court:

"Defendant ... argues that even if FDIC owes no duty for its pre-bank closing activities, FDIC may be liable for its post-bank closing activities, as in the

(Continued on Page 20)

SHIFTING THE BLAME

(Continued from page 21)

present case.

Id.

The Oakes court, however, relying upon Carlson and Roy, rejected the argument:

Upon examination of this contention, the court finds no logical basis for distinguishing between pre- and post-bank closing activities of the FDIC. [Citation omitted] At both time periods, the FDIC's duty is owed, not to bank directors, officers or even shareholders, but to the insurance funds it is charged with protecting and to the banking public.

*Oakes, 1989 WL 151954, at *2"* (citations omitted) (emphasis added).

Accordingly, the court granted the FDIC's motion.

In Federal Deposit Ins. Corp. v. Arceneaux, CIV.A. No. 89-2576, 1990 WL 357532 (W.D. La. Sept. 14, 1990), the former officers, directors and their insurer raised a series of affirmative defenses including *"estoppel; waiver; unclean hands; failure to mitigate damages; fault actions; omissions; negligence; and/or conduct of the FDIC ...." Id. at *1*. The court, however, relying on the Roy, Carlson, Greenwood and Oakes decisions, rejected the argument and dismissed the defenses:

"As a growing line of jurisprudence points out, the public policy considerations which guide the courts' decisions to deny various defenses to former officers and directors of a failed bank, apply equally whether those defenses are based on the FDIC's pre-closing or post-closing activities. This court finds the reasoning and results reached in several of these decisions particularly persuasive.

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The FDIC's purpose, that of stabilizing the banking industry and promoting public confidence in the banking system, presupposes an ongoing effort to minimize losses and maximize recovery to the insurance fund. The cost of litigation undermines that effort by reducing the ultimate recovery benefitting the fund. That cost would substantially increase if the former officers and directors of a failed institution were permitted to question and scrutinize every action taken by the FDIC in its recovery efforts. Accordingly, the imposition of a duty on the FDIC to former officers and directors of a failed bank would severely strain, and be inconsistent with, the FDIC's efforts to minimize losses and maximize recovery to the insurance fund.

*Arceneaux, 1990 WL 357532, at *2-*3"* (footnotes omitted) (emphasis added).

The rationale for extending the "no duty" rule to receivership conduct was set forth in Federal Savings and Loan Ins. Corp. v. Burdette, 718 F. Supp. 649 (E.D. Tenn 1989). In Burdette, the FSLIC moved to strike the following categories of defenses: (1) those alleging that the FSLIC was contributorily negligent in actions as receiver of the failed institution; and (2) those alleging that the FSLIC had failed to mitigate damages in collecting the assets of the failed institution. Id. at 662. In support, the FSLIC relied upon the Roy, Carlson and Greenwood decisions. Id. at 662-663. The defendants, however, argued:

"... that these cases are distinguishable, that as to the mitigation of damages defenses these cases do not apply, and that these cases constitute bad policy, alleging that they are based on the assumption that the officer and director defendants are indeed guilty of wrongdoing even before that issue is decided by a jury.

Burdette, 718 F. Supp. at 662."

In resolving the issue, the court voiced several reasons why defendants should not be permitted to avoid liability through the attempted use of "receivership conduct" affirmative defenses:

"In cases of the failure of a savings institution, it is important to the public that the receiver rapidly and efficiently convert the assets of that institution to cash to repay the losses incurred by the insurance fund and the depositors for deposits not covered. Suits by the FSLIC as a receiver to recover assets, or to recover damages for wrongdoing, should not be encumbered by an examination in court of the correctness of any specific act of the FSLIC in its receivership. The rule that there is no duty owed to the institution or wrongdoers by the FSLIC/Receiver is simply a means of expressing the broad public policy that the banking laws creating the FSLIC and prescribing its duties are directed to the public good, and that every separate act of the FSLIC as a receiver in collecting assets is not open to second guessing in actions to recover damages from wrongdoing directors and officers. If there is no wrongdoing by the officer or director, there can be no liability, but if wrongdoing is established, the officer or director should not be allowed to set up as a defense a claim that would permit the detailed examination of the FSLIC's action as a receiver.

Burdette, 718 F. Supp. at 663-64" (emphasis added).

Finding the authority of Roy, Carlson and Greenwood persuasive, the court struck the affirmative defenses:

"As a result, the court believes that the cases cited above are soundly decided and applicable to the instant case. The affirmative defenses at issue should be struck, as these defenses would require the public to bear the possible errors of judgment by the FSLIC as receiver rather than the persons found to be guilty of wrongdoing, and removing these defenses will help the court and the jury focus on the real issues presented in the pleadings. To hold otherwise would invite a flood of evidence as to every FSLIC discretionary decision concerning the collection of Knox assets, and could easily distract the jury from making the primary determination of liability or the lack thereof of the defendant officers and directors.[5]

Burdette, 718 F. Supp. at 664" (emphasis added).

Banking Insolvency Decisions

In addition, there are three federal appellate court decisions that hold that a defendant may not assert affirmative defenses based upon receivership conduct. See Federal Deposit Ins. Corp. v. Oldenburg, 38 F.3d 1119 (10th Cir. 1994), cert. denied, 516 U.S. 861, 116 S.Ct. 171,

133 L.Ed.2d 112 (1995); Federal Deposit Ins. Corp. v. Mijalis, 15 F.3d 1314 (5th Cir. 1994); Federal Deposit Ins. Corp. v. Bierman, 2 F.3d 1424 (7th Cir. 1993).

The first was the Seventh Circuit's decision in Bierman. In Bierman, the defendant officers and directors appealed the district court's entry of judgment against them. Id. at 1426. On appeal, the defendants argued that the district court failed to reduce the judgment based upon the FDIC's alleged failure to mitigate losses. Bierman, 2 F.3d at 1438. Relying upon the rationale of the Roy, Greenwood, Burdette and Isham decisions, the Seventh Circuit held that the FDIC had no obligation to mitigate damages:

"We believe that these cases take the approach most compatible with the congressional scheme when that scheme is viewed in its totality. An action against directors and officers who allegedly have breached their duties to the bank is an asset purchased by the FDIC in its corporate capacity. It is the duty of the FDIC to manage such assets in order to replenish the insurance fund that has been used to cover the losses allegedly caused by the directors and officers. When the FDIC undertakes this task, it must act in the public interest.

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Therefore, when the FDIC acts to replenish the insurance fund through the disposition of assets of the failed bank, including the right of action against the officers and directors, it has no duty first to attempt to mitigate the damages attributed to those individuals by seeking other, and perhaps less sure, avenues of relief.

Bierman, 2 F.3d at 1439-40" (emphasis added).

In Mijalis, the Fifth Circuit, relying upon the Bierman holding, similarly held that the defense of a failure to mitigate damages could not be asserted against the FDIC in its corporate capacity:

"After careful consideration, we agree with the Seventh Circuit's cogent analysis of the issue in Bierman. See id. at 1438-41. For the reasons stated in that case, we hold that the FDIC is not subject to the affirmative defense of failure to mitigate damages when it sues former directors and officers in its corporate capacity to recover losses sustained by an insolvent financial institution and covered by the national insurance fund.

Mijalis, 15 F.3d at 1324" (emphasis added).[6]

Finally, in Oldenburg, the Tenth Circuit addressed whether the affirmative defenses of failure to mitigate damages and contributory negligence could be asserted against a receiver. The defendant contended that: "[t]he district court erred by refusing to permit him to introduce evidence of the post-receivership conduct of the FDIC with respect to Park Glen." Id. at 1120-21. The court rejected the defendant's argument, relying upon Bierman, Mijalis and Roy:

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"[W]e hold that when the FDIC sues to recover on the assets of a failed financial institution, the responsible officers and directors of such institution may not assert the affirmative defenses of contributory negligence and mitigation of damages against the FDIC. The district court therefore did not abuse its discretion when it refused to permit Mr. Mandel [the defendant] to introduce evidence of the post-receivership conduct of the FDIC in an attempt to reduce his liability for damages sustained as a result of the Park Glen transaction."

Oldenburg, 38 F.3d at 1121-22 (citation omitted). This trilogy of decisions from federal appellate courts further supports the argument that any potential defendant may not raise the Receiver's conduct in an effort to avoid liability for its wrongful conduct.

As is apparent, the area of banking insolvency provides substantial authority for the position that a receiver's conduct may not be used to support affirmative defenses.[7]

Decisions In Third-Party Professional Liability Actions

Affirmative defenses based upon regulatory or receivership conduct typically have been prohibited in actions against former officers and directors of the failed institution. Based on this fact, several courts have held that the "no duty" rule regarding receivership conduct is inapplicable to third-party professionals.

For example, in Resolution Trust Corp. v. Holland & Knight, 832 F. Supp. 1532 (S.D. Fla. 1993), the RTC sued a law firm for legal malpractice and breach of fiduciary duty. Id. at 1533. In Holland & Knight, the RTC moved to strike the affirmative defenses based upon the conduct of the RTC. Id. at 1536-37. The court, however, rejected the argument, holding that the prohibition against such affirmative defenses did not apply to actions against third-party professionals:

"[T]he Court concludes that public policy considerations are irrelevant to actions involving third-party professionals and should not bar third-party professionals from asserting affirmative defenses against the RTC. In other words, the Court will treat the RTC as an ordinary private plaintiff in this action.

Holland & Knight, 832 F. Supp. at 1536-37, 1540" (footnote omitted).

Similarly, in Federal Deposit Ins. Corp. v. Cherry, Bekaert & Holland, 742 F. Supp. 612 (M.D. Fla. 1990), the court held that an accounting firm could raise the defenses of a failure to mitigate damages and comparative and/or contributory negligence in an action brought by the FDIC in its corporate capacity. Id. at 614 ("the corporate FDIC's disposal of assets falls outside its public policy role"). See also First Financial Savings Bank, Inc. v. American Bankers Ins. Co. of Florida, Inc., 783 F. Supp. 963, 969 (E.D.N.C. 1991) (refusing to extend public policy rationale of Burdette decision to action by the FDIC against an insurance company).

Many courts, however, have refused to adopt this restrictive view. This distinction was articulated in Federal Deposit Ins. Corp. v. Ernst & Whinney, Civ. No. 3-87-0364, 1992 WL 535605 (E.D. Tenn. May 19, 1992), an action against an auditor:

"[T]he court concludes that the status of the defendant in this civil action as an independent auditor does not make a difference for this purpose. [citation omitted]

The reason why this does not make a difference is one of public policy. '[P]ublic policy militates against judicial second-guessing of FDIC's actions or requiring the public at large

(Continued on Page 22)

SHIFTING THE BLAME

(Continued from page 21)

to bear the costs of FDIC dealing with the intricacies of disposing of the assets of a failed bank." [citation omitted] This policy applies regardless of whether the defendant in any particular lawsuit brought by FDIC was an insider with respect to the closed institution which is the source of the cause of action, such as a director or officers, or an outsider, such as an auditor.

*Id. at *3*" (emphasis added).

As also stated by the court in Resolution Trust Corp. v. Moskowitz, Civ.A. No. 93-2080, 1994 WL 229812 (D.N.J. May 24, 1994):

"Considerations of public policy compel the Court to conclude that the defenses of contributory/comparative negligence should be stricken. It would be absurd to permit a defendant who is responsible for a bank's losses to defend against the RTC by alleging that the RTC somehow contributed to those losses while attempting to recover them. By asserting such defenses, the retained professional defendants would distract the fact finder's attention from their misdeeds to the actions of the RTC.

*Id. at *20*" (citation omitted) (emphasis added).

Similarly, in Federal Deposit Ins. Corp. v. Cheng, 832 F. Supp. 181 (N.D. Tex. 1993), the court stated:

"The Court finds no meaningful distinction between defendants who are officers and directors of a failed banking institution and defendants who are third parties such as attorneys, accountants, or, in this case, stockbrokers.

Cheng, 832 F. Supp. at 186 n.3" (citing to Ernst & Whinney).[8]

Finally, many courts, without discussion, repeatedly have applied the prohibition to actions against third-party professionals.[9]

In sum, while a third party professional defendant may argue that the regulatory/receivership conduct prohibition applies only in actions against former officers and directors, substantial, contrary authority undercuts such an artificial distinction. Further, the public policy rationale that warranted development of the prohibition in the first instance remains the same, regardless of the defendant's particular status. Given the receiver's duty to the public, and the public policy concerns associated with any insolvency, a defendant, regardless of status, should not be permitted to base affirmative defenses upon the conduct of the regulator or the receiver.

In any action brought by a receiver of an insolvent company, potential defendants will likely plead, as affirmative defenses, that the Insurance Department, during its examinations, failed to assess properly the financial condition of the company, thereby contributing to its ultimate insolvency. Defendants also will likely plead, as affirmative defenses, that the Receiver, during the receivership, has failed to maximize the insolvent estate's assets and/or minimize its losses.

There are a number of decisions holding that such defenses, based upon regulatory or receivership conduct, are insufficient as a matter of law. Accordingly, in the event such affirmative defenses are pled, a receiver should consider challenging their legal sufficiency at the earliest possible time. Such an approach, if successful, not only will prevent the use of such defenses but also may limit the time and expense spent in pre-trial discovery on these irrelevant issues.

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

[2]The court also discussed in great detail the decision in Federal Savings and Loan Ins. Corp. v. Burdette, 718 F. Supp. 649 (E.D. Tenn. 1989).

[3]A contrary decision was reached in Clark v. Milam, 152 F.R.D. 66 (S.D. W.Va. 1993). In Clark, the court refused to strike affirmative defenses based upon the conduct of the Insurance Commissioner as receiver because, under a West Virginia statute, the Insurance Commissioner, as receiver, is given only qualified immunity. Clark, 152 F.R.D. at 71. Accordingly, the court held that it could not rely upon the same federal banking decisions. While Clark reaches a different result than Rockwood, its holding can be distinguished because the result was mandated by a particular West Virginia statute that limited a court's ability to adopt, as a matter of common law, the rationale of Rockwood and those of the federal banking decisions. See also Williams v. Continental Stock Transfer & Trust Co., 1 F. Supp. 2d 836 (N.D. Ill. 1998) (striking affirmative defense of contributory negligence and noting that, under Delaware statutory law, Commissioner protected from actions undertaken in good faith).

[4]As stated by the court, the defendant's defense of contributory negligence was that "the FDIC as receiver of the Bank failed to maximize the recovery available on a number of bad loans after the Bank's failure." Carlson, 698 F. Supp. at 179.

[5]See also Federal Deposit Ins. Corp. v. Healey, 991 F. Supp. 53, 55-60 (D. Conn. 1998) (striking affirmative defenses of failure to mitigate damages and contributory negligence); Federal Savings and Loan Ins. Corp. v. Shelton, 789 F. Supp. 1367, 1369-70 (M.D. La. 1992) (dismissing defenses of failure to mitigate damages and estoppel based on regulator's operation of the failed bank); Federal Deposit Ins. Corp. v. Crosby, 774 F. Supp. 584, 586-87 (W.D. Wash. 1991) (striking defenses of contributory negligence, failure to mitigate damages, ratification, waiver and estoppel based on actions of the receiver); Federal Deposit Ins. Corp. v. Stanley, 770 F. Supp. 1281, 1309 (N.D. Ind. 1991) (in entering judgment in favor of the FDIC after a bench trial, court held that "in determining the amount of the FDIC's recovery, the court will disregard evidence that was introduced in an effort to diminish the FDIC's right of recovery as a result of decisions it made in connection with the collection of the [insolvent bank's] assets"), aff'd, 2 F.3d 1424 (7th Cir. 1993); Federal Deposit Ins. Corp. v. Stuart, 761 F. Supp. 31, 32 (W.D. La. 1991) (striking affirmative defenses based upon actions taken by FDIC as receiver); Federal Deposit Ins. Corp. v. Eckert Seamans Cherin and Mellott, 754 F. Supp. 22, 24-25 (E.D. N.Y. 1990) (striking affirmative defenses based on a failure to mitigate damages); Federal Deposit Ins. Corp. v. Coble, 720 F. Supp. 748, 750 (E.D. Mo. 1989) (striking affirmative defenses of contributory negligence and mitigation of damages based upon actions undertaken by FDIC as

receiver of a failed bank).

[6]In Mijalis, the court also rejected the defendants' challenge to the district court's ruling that "no evidence would be permitted concerning the activities of the FDIC in its efforts to manage and collect on loans that were owed to the Bank at the time it was closed," holding that "the defendants were also not entitled to attack the causation element of the FDIC's case by showing that the FDIC's acts and omissions caused the damages it sought to recover from the defendants." Id. at 1327-28 (emphasis added).

[7]Some courts have questioned the continued viability of these decisions in light of the United States Supreme Court's decision in O'Melveny & Myers v. Federal Deposit Ins. Corp., 512 U.S. 79 (1994). See, e.g., RTC v. Massachusetts Mut. Life Ins. Co., 93 F. Supp. 2d 300, 2000 WL 385426, at **4-5 (W.D.N.Y. Feb. 22, 2000) (collecting cases). Other courts, however, still follow the rationale of these banking decisions. Id. at *4 (collecting cases). Regardless of the debate, the underlying rationale of these decisions is analogous in the insurance insolvency context -- a defendant should not be permitted to examine the conduct of the receiver as a defense to his own alleged misconduct.

[8]See also Resolution Trust Corp. v. Heiserman, 839 F. Supp. 1457, 1468 (D. Colo. 1993) (rejecting rationale of Holland & Knight in action against a law firm); Federal Deposit Ins. Corp. v. Baker, 739 F. Supp. 1401, 1407 (C.D. Cal. 1990) (holding that "appraiser defendants should be treated no differently").

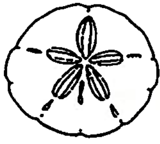
[9]See Resolution Trust Corp. v. O'Bear, Overholser, Smith & Huffer, 886 F. Supp. 658 (N.D. Ind. 1995) (attorney and appraiser); Resolution Trust Corp. v. Thomas, No. CIV.A. 92-2084-GTV, 1995 WL 261641 (D. Kan. April 25, 1995) (attorney); Resolution Trust Corp. v. KPMG Peat Marwick, 845 F. Supp. 621 (N.D. Ill. 1994) (accountant); Resolution Trust Corp. v. Farmer, 823 F. Supp. 302 (E.D. Pa. 1993) (attorneys); In re Sunrise Sec. Litig., 818 F. Supp. 830 (E.D. Pa. 1993) (auditors); Federal Deposit Ins. Corp. v. Benjes, 815 F. Supp. 1415 (D. Kan. 1993) (attorney); Federal Deposit Ins. Corp. v. Lowe, 809 F. Supp. 856 (D. Utah 1992) (attorney); Resolution Trust Corp. v. Aycock, No. CIV.A. 92-0761, 1993 WL 278455 (E.D. La. July 14, 1993) (attorney); Federal Deposit Ins. Corp. v. Marsiglia, Civ.A. No. 90-4999, 1992 WL 348454 (E.D. La. Nov. 18, 1992) (attorney); Federal Deposit Ins. Corp. v. Eckert Seamans Cherin & Mellott, 754 F. Supp. 22 (E.D.N.Y. 1990) (attorney).

WILLIAM M. SNEED WINS THE 2000 JOURNAL OF INSURANCE REGULATION ARTICLE AWARD

The National Association of Insurance Commissioners ("NAIC") announced during the Opening Session of the Association's Summer National Meeting that IAIR's own Bill Sneed won the 2000 award for his article titled "The McCarran-Ferguson Act and Insurance Insolvency: Judicial Developments Since United States Department Treasury vs. Fabe".

Bill's article looks at the conflicting issues between state insurance insolvency laws and the federal laws. Because of the McCarran-Ferguson Act, state laws pre-empt the federal laws and his article discusses the recent court cases that have been involved in the further development of this conflict.

Bill Sneed is a partner in the Chicago office of Sidley & Austin and has been a member of IAIR for two years. Our congratulations to Bill for this prestigious award!



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