The INSURANCE RECEIVER

Promoting professionalism and ethics in the administration of insurance receiverships.

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President's Message

by Elizabeth A. Lovette, CIR-ML

The Fall meeting in Boston was but a few short weeks away, and I was especially anticipating seeing my IAIR colleagues, as I was unable to attend the summer meeting in New Orleans. Then the world fell apart. As I write these words, the experience of September 11 still seems to me surreal, almost as if caught in a time warp of the weirdest kind. The images of jetliners exploding into the towers of the World Trade Center were, at first, unreal but now have become so indelibly seared in my consciousness that I know I will never forget the evil that was perpetrated on so many innocent people that day.

As I write these words and reflect upon the War Against Terrorism, I cannot know how my life and the country I so love will be ultimately affected in the weeks and months to come. What I do know is that as we struggled in those darkest of days following the terrorist attacks, we as a nation woke up. We learned that the spirit of community and humanity cannot be vanquished as we watched persons of all kinds, creed and color come together in the most positive of ways under the most unimaginable of circumstances to help the victims and their loved ones. We remembered the cherished freedoms that are the foundation of our country, privileges that may have been somewhat tarnished or cynically forgotten in the pre-September 11 age. We gave thanks to our men and women in uniform recognizing their raw courage for going in to the war zone known as "Ground Zero" day after day, recognizing they truly help us sleep better at night, thankful they stand ready to take on tasks of the most horrific magnitude. We came together as Americans, united as a country, united in our resolve to protect the liberties of the world.

Thanksgiving is but a week away. This Thanksgiving holiday, more than any other in my lifetime, I am reminded how very much I have to be grateful for. I suspect for most Americans, as it will be for me, that this national holiday will be a day of reflection, remembrance and thanksgiving in its most basic sense. For despite the horrors of September 11, we Americans truly have much to be thankful for. We are united, a country standing together, and I am so very proud. Ours is a spirit that cannot be broken. As I look forward to roast turkey and mother's pecan pie, I pray that this Thanksgiving finds you and yours healthy and safe. May your table be bountiful and may you be surrounded by those you love. My friends, I look forward to seeing all of you soon. In the meantime, God bless you and God bless America.

The ***I****NSURANCE* ***R****ECEIVER*
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View From Washington

By Charles Richardson

Terrorism Insurance Legislation

After two fast-paced weeks of hearings in Congress, both the House of Representatives and the Senate are considering legislation that would assist property and casualty insurers in providing coverage for risks associated with acts of terrorism. With as many as 70 percent of reinsurance contracts coming up for renewal on January 1, 2002, there is agreement that Congress must pass legislation before recessing for the holidays. Without a federal backstop, insurers have indicated they will likely be withdrawing terrorism coverage or raising premiums considerably.

As of November 7, only members of the House of Representatives ¾ led by Financial Services Committee Chairman Michael Oxley (R-OH) and Capital Markets, Insurance, and Government Sponsored Enterprises Subcommittee Chairman Richard Baker (R-LA) ¾ have introduced legislation addressing terrorism risk. The Terrorism Risk Protection Act (H.R. 3210) was introduced November 1 and has over 30 cosponsors. H.R. 3210 is largely viewed as a temporary loan program for the industry. Ranking committee Democrats John LaFalce (D-NY) and Paul Kanjorski (D-PA) have indicated they will offer an alternative bill when the committee meets to markup H.R. 3210 November 7.

The Bush Administration has publicly stated its support for a Senate plan currently being developed by Senate Banking, Housing, and Urban Affairs Committee Chairman Paul Sarbanes (D-MD), Ranking Republican Phil Gramm (R-TX), and Senators Christopher Dodd (D-CT), and Michael Enzi (R-WY). A bill has yet to be introduced because there is strong disagreement among some Democrats about whether to allow a provision ¾ limiting an individual's right to sue private companies for punitive non-economic damages connected to acts of terrorism ¾ to be kept in the plan. The legal reform provision is a Bush Administration priority (H.R. 3210 also contains this provision.) Senate Commerce Committee Chairman Ernest Hollings (D-SC) and Ranking Republican John McCain (R-AZ) are planning to introduce a bill of their own this week, but the details remain unclear.

The following are provisions of the House and Senate Plans as of November 7, 2001:

- Under the federal cost-sharing program in H.R. 3210, private insurers are responsible for up to $1 billion in losses. H.R. 3210 sets a lower threshold "trigger" of $100 million for smaller insurers. The government would pay 90 percent of claims up to $20 billion but assesses insurers to repay the loan. Between losses of $20 billion and $100 billion, the government again pays 90 percent of the claims, assesses the industry, and recoups the loan through surcharges on policyholders.
- H.R. 3210 would allow insurance companies to set aside tax-deferred moneys to handle future terrorism claims. H.R. 3210 establishes a five-member federal commission that would study and make recommendations regarding the life insurance industry and future acts of terrorism. (The Senate plan provides for a study by Treasury, in cooperation with the NAIC and the insurance industry, to address future acts of terrorism and the life insurance industry.) H.R. 3210 sunsets January 1, 2003.
- Under the Senate plan, insurers are not mandated to pay premiums or reimburse the government for any payment of claims. The Senate cost-sharing plan requires insurers to pay the first $10 billion in claims resulting from terrorist attacks. The government would cover 90 percent of any additional claims between $10 billion and $100 billion. The Senate program would last two years and could be extended for a third year. In the third year, insurers would have to cover the first $20 billion in claims.
- Both H.R. 3210 and Senate plan would establish guidelines for coverage for acts of terrorism.

The details on the different plans are changing daily, but we believe Congress will pass something before the end of the year.

September 11 Victim Compensation Fund

The terrorism response legislation which the Congress passed in September establishes a guaranty loan program for airlines. But a larger program coming out of that bill is about to get a lot of attention. That law authorizes the Department of Justice to administer a Victims Compensation Fund which will give financial payments to the families of the deceased and those who were physically injured at the World Trade Center or the Pentagon on September 11.

The Department of Justice has released a set of questions for comment, as it is writing the regulations for this program. The Attorney General will appoint a Special Master to supervise the process, and anyone wishing filing a compensation claim will have their case decided within 120 days, but also give up the right to sue in Federal court. The bill is intended to get quick compensation to families who otherwise might have to wait years for lawsuits to be resolved.

The federal government has very little experience with this kind of mass compensation program, and many of the rules are sure to be criticized by trial lawyers and others. The comment period closes November 26, and Justice wants to start taking applications by the first of the new year.

IAIR Roundtable Schedule

NAIC Meeting - December 8 - 12, 2001
Chicago, IL
IAIR Roundtable
June 8, 1:00 - 4:00 p.m.

NAIC Meeting - March 16 - 20, 2001
Reno, NV
IAIR Roundtable
March 16, 1:00 - 4:00 p.m.

NAIC Meeting - June 8 - 12, 2002
Philadelphia, PA
IAIR Roundtable
June 8, 1:00 - 4:00 p.m.

The INSURANCE RECEIVER

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

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News From Headquarters

IAIR is very pleased to sponsor the following educational seminar:

IAIR INSOLVENCY WORKSHOP WORKERS' COMPENSATION INSURERS: TEMPORARY OR PERMANENT DISABILITY?

Plus – Other hot topics, including privacy concerns, managed health care insolvency issues, and a special report on the state of the Insurance industry after September 11, 2001

January 24-25, 2002
Hyatt Regency San Antonio
San Antonio, Texas

Workers' compensation insurers have been falling at a rate much higher than that of other insurers and recent events have heightened solvency concerns throughout the insurance industry, making this year's Workshop all the more timely and important. **Featuring six state insurance commissioners**, a highly experienced panel of senior executives and their professional advisors, the Workshop faculty will lead attendees to an understanding of the causes of today's insolvencies and the best ways to effectively deal with them. The Workshop will also focus on how the events of September 11 are affecting the insurance industry and how regulators are dealing with those effects. Privacy issues, managed care issues, and the ever-popular Legal Update round out the agenda. The Workshop will be of particular value to those whose companies or clients are affected by insolvent workers' compensation insurers, and to staff members of regulators, receivers, guaranty associations and their professional advisors.

The cost of the seminar is:

$295	IAIR Members
$345	IAIR Members (Postmarked after Dec. 11)
$495	All others
$545	All others (Postmarked after Dec. 11)

Note: Membership in IAIR is $200 annually, however, dues are pro-rated upon renewal in the 2nd year. If you submit a membership application along with your registration for this program, you may attend at the member rate ***and*** *11/12th of the $200 will be applied toward your 2002 dues.*

For more information about the seminar or to register for the program, please visit IAIR's website at www.iair.org and go to the Events & Schedules section or contact headquarters at 407-682-4513.

EVERY HEALTH INSURER'S LITIGATION NIGHTMARE:

A CASE STUDY OF HOW ONE CLASS ACTION AFFECTED THE BUSINESS OF ONE INSURER

by Michael Pennington

Michael R. Pennington, an attorney with Bradley, Arant, Rose & White LLP in Birmingham, Alabama, was counsel for Liberty National Life Insurance Company during the events described in this article. However, it was written purely in his individual capacity; nothing in the article constitutes any statement attributable to Liberty National, nor does anything in it involve any disclosure of privileged information, nor any waiver of privilege by Liberty National.

These days, most defendants would prefer to litigate class actions in federal court, where the law is more settled, justice is often seen as apolitical, and the judiciary is experienced in class action litigation. Often, however, defendants are not given that luxury. What follows is an example of the effect class action litigation in state court can have on a defendant in a particularly hostile state court environment.

The carnivorous setting

It is the early 90s -- early spring of 1993, to be exact. The magnolias are not yet in bloom in Alabama, but the torts certainly are -- especially the species known as punitive damage fraud actions. The former president of the Alabama Trial Lawyers Association is chief justice of the Alabama Supreme Court, and a majority of the justices on the court were heavily backed by that organization, financially and otherwise, in their most recent judicial races. (Coincidentally or not, the resulting incarnation of the Alabama Supreme Court creates several new species of actionable fraud every year, while simultaneously eroding virtually every defense available to defendants in fraud actions.)

Unless the defendant can show that the plaintiff actually read and understood the document, it's a matter for the jury

For example, gone are the familiar objective "reasonable reliance" and "due diligence" standards that had been applicable to fraud actions for 140 years. In their place is a much more subjective "justifiable reliance" standard. Because of this, it is no longer sufficient for the defendant to prove that the plaintiff was given a document that directly contradicted allegedly fraudulent representations made to him at the time of sale, or that supplied the very information that supposedly was not disclosed orally. Unless the defendant can show that the plaintiff actually read and understood the document, it's a matter for the jury.

The Alabama Supreme Court has also held that receipt of such documents will no longer necessarily start the "two years from time of discovery" statute of limitations for fraud under the Alabama Code.[1] Instead, so long as plaintiff does not foolishly admit he actually read the document, whether he "should have" discovered it is also a question for the jury.

Meanwhile, punitive damage verdicts in fraud cases generally, and fraud cases against insurers particularly, are growing geometrically in both size and number in Alabama; multimillion dollar punitive damage verdicts are becoming the norm, even where actual damages are slight. A plaintiff's lawyer who seems to enjoy the most success in slapping strings of zeros on the backs of insurance companies is Jere Beasley, a former lieutenant governor turned trial lawyer. Although Beasley has a formidable track record throughout the state, his favorite venues seem to be Bullock and Barbour Counties, where the only judge (Judge William Robertson) happens to be his former law partner, and virtually every potential juror seems to know him on a first name-basis.

The defense bar and the business community have not sat idly by in response to the punitive damages regularly being assessed in Alabama. They have rallied for judicial candidates and for tort reform but haven't accomplished much. They tried, for example, to create a "cap" on punitive damage awards except in wrongful death cases.[2] This led, however, to a rash of "pattern and practice" suits that left every fraud defendant facing not only the original plaintiff but also an additional 10 to 20 witnesses who would soon file their own punitive damage lawsuits. Ultimately, the Alabama Supreme Court struck the cap, finding that it unduly invaded the province of the

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Every Health Insurer's Litigation Nightmare

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jury and therefore violated the plaintiff's right to trial by jury under Article I, § 11 of the Alabama constitution.

Despite the elimination of this statute by 1993, plaintiff's lawyers had already learned the value of using pattern and practice witnesses to inflate punitive damage verdicts; they are now a standard part of every fraud case and a great way to generate business. While a lawyer is prohibited from directly soliciting new clients, it has become common practice to locate as many pattern and practice witnesses as possible to bolster a client's case. And it is inevitable that they will ask to file suit as well.

The prey

By spring of 1993, the atmosphere in Alabama had developed into something akin to a very large, very hungry school of piranhas waiting for something big and juicy to fall into the water. Unfortunately, my client, Liberty National Life Insurance Company, was the closest thing to the riverbank.

Liberty National Life Insurance Company was an Alabama success story. From small beginnings as a fraternal benefit society in the early 1900s, Liberty National had become a major part of the Alabama insurance landscape. Its parent company, Torchmark Corporation, was publicly traded and had set Wall Street records for growth and dividend performance since Liberty National's acquisition.

Liberty National had initially broken into the cancer insurance business in 1969. At that time, radiation and surgery were the primary treatment methods; chemotherapy had not yet come into vogue. Liberty National's original cancer policies provided 100 percent coverage for both radiation and for out-of-hospital medications prescribed in connection with the treatment of cancer.

Chemotherapy treatment became more prevalent during the 1970s. Even though Liberty National's original policies did not address chemotherapy at all, the company decided that 100 percent of chemotherapy charges would be covered for existing policies, and that chemotherapy would be equated with radiation treatment. Subsequent to this decision, Liberty National's old" cancer policies were amended, providing 100 percent coverage for radiation and chemotherapy for new buyers. Liberty National's pre-1986 cancer policies (which came to be known as the "old" policies) provided only scheduled or limited benefits for other costs incurred in connection with cancer treatment.

On August 29, 1986, Liberty National introduced its "new" cancer policies. These provided a host of new benefits never before offered by the company, such as a "first occurrence" benefit, hospice care, prosthetics coverage, and higher hospital room, surgery, and anesthetist benefits, among others, than previous policies. In addition, the "new" policies provided hospital confinement benefits for the treatment of various catastrophic illnesses other than cancer. The 1986-series "new" policies, however, also placed new limits on certain benefits that had previously been unlimited.

It has become common practice to locate as many pattern and practice witnesses as possible to bolster a client's case

In 1990, Liberty National introduced a second series of "new" policies, with higher benefits than provided by the 1986-series "new" policies. When both series of "new" policies were issued, many customers of Liberty National who held "old" policies replaced them with the "new" policies under a special exchange program. Customers were given the option to exchange, and most did, even though the premiums for the "new" policies were generally higher than for the "old."

Wrong place/wrong time

Although its cancer policies had been around since 1969, Liberty National faced no significant litigation over them until late 1991. At that time, Liberty National was defending against several alleged fraud and forgery cases that originated at an agency in south Alabama. Most of the claims involved life insurance policies, but a few policyholders asserted that they were fraudulently induced to exchange their "old" cancer policies (with unlimited benefits for radiation, chemotherapy, and out-of-hospital prescription drugs) for the "new" policies (which contained monetary limits on those benefits). They claimed that oral representations had presented the "new" policies as "better," and that agents had uniformly failed to tell them about the policies' radiation and chemotherapy limits. The fact that the limits were printed on the policies and in sales brochures was now legally irrelevant, they said, because the plaintiffs did not read the documents at the time of sale. (Such written disclosures had been sufficient to preclude claims based upon inconsistent or incomplete oral representations as of 1986, when the exchange programs began.)

The significance of these claims reached well beyond the individual cases. Liberty National had saturated

the Alabama market with its very popular cancer insurance product, and some 400,000 families carried them. Losing even one case in Alabama's "punitive damage lottery" litigation environment might generate massive copycat litigation. And, although the company believed it's "new" policies actually provided greater overall benefits than the "old," its labyrinthine claim system was not capable of producing data necessary to prove this.

Therefore, Liberty National chose to settle the initial phase of individual pattern and practice litigation, including the cancer exchange cases. The company could not have known that the settlement would soon fund or encourage massive additional litigation, over the same issue.

Feeding frenzy

Before the ink had dried on the "confidential" settlement papers, dozens of cancer exchange policy-holders were seeking lawyers in and around the Mobile area. Mobile was hardly a desirable venue in which to try a fraud lawsuit. The economy was depressed; a major naval shipyard had closed; unemployment was high; and punitive damages were handed out by Mobile jurors like Christmas candy.

Within the space of a few months in 1993, approximately two dozen individual cancer exchange fraud cases were filed. Most were being referred to other lawyers by the same attorney Liberty National had just settled with. He was not, however, engaged in charity -- he knew he could collect a referral fee (customarily one-third of the total contingent fee) simply by referring cases to other law firms and leaving them to do the work.

Worse yet for Liberty, Jere Beasley had gotten wind of the cancer exchange litigation, and wasn't about to sit it out. He immediately filed a class action complaint in his favorite venue: Barbour County, Alabama.[3] Roughly a week after the complaint was filed, Judge William Robertson convened a class certification hearing on plaintiff's motion. Liberty National was given additional time to prepare its case against class certification, although Judge Robertson pointedly indicated that the case seemed to him to have all of the indicia of a certifiable class action.

The litigation environment in Alabama at the time was horrendous for defendants

The next few months did not improve the situation. Beasley secured the cooperation of several former executives of Liberty National, and it seemed evident that individual cases would continue to be filed for years to come if something wasn't done. A class was going to be certified in the Circuit Court of Barbour County, sooner or later, rightly or wrongly, whether Liberty National liked it or not.

If you can't beat 'em, join 'em

In the early spring of 1993, then, Liberty National found itself in what appeared to be a no-win situation. The litigation environment in Alabama at the time was horrendous for defendants. Multimillion-dollar punitive damage verdicts outnumbered significant victories by insurance companies by quite a large multiple. The company had a statutory net worth of $ 327 million, and there were some 400,000 families included in the cancer-exchange class.

Liberty National believed that it had done nothing wrong -- that the "new" policies were better than the "old" policies in terms of providing more total dollars in benefits. Yet the company could not prove this. Liberty also believed it had adequately disclosed the limits on radiation and chemotherapy benefits for the "new" policies, both in the policies themselves and in sales brochures. Nevertheless, most trial judges allowed juries to decide whether such disclosures were adequate, and the Alabama Supreme Court was not second-guessing juries' adverse decisions when such cases were appealed.

While it might have been more valiant to go down swinging, it seemed far more prudent to try to shape the class action into something that offered at least some benefit for Liberty National. Thus, Liberty National began trying to negotiate a class action settlement with Beasley in the spring of 1993. The company made it clear that the only way Liberty National would stipulate to class treatment and agree to a class action settlement was if the class were certified on a "no-opt-out" basis.

Like its federal counterpart, the Alabama class action rule provides that a no-opt-out class may be certified if "the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." A majority of courts had held that no-opt-out certification was appropriate in such cases, so long as the predominant relief was equitable and monetary relief was simply "ancillary."

There were many reasons to insist on no-opt-out treatment if Liberty National was going to agree to class treatment and settle on a class basis. If the case were certified on an opt-out basis, this opt-out right would surely generate more litigation than it resolved (particularly true

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Cedent's Claims To Reinsurance Recoverables And Priority Of Distribution

by Robert M. Hall

Mr. Hall is an attorney, a former insurance and reinsurance executive and acts as an insurance consultant as well as an arbitrator and mediator of insurance and reinsurance disputes. The views expressed in this article are those of the author and do not reflect the views of his clients.
 Questions or comments may be addressed to the author at bobhall@qsilver.net.

I. INTRODUCTION

Veteran observers of the sometimes contentious relationships among receivers, guaranty associations and reinsurers were somewhat surprised by the recent decision of Covington v. Ohio General Ins. Co., 2001 WL 1013126 (OhioApp.). In this case, the court ruled that a cedent under a reinsurance contract has the same priority claim to assets of the estate as guaranty associations, policyholders and claimants against policyholders. The Ohio priority statute designated as Class 2 priority "all claims under policies" but did not specifically exclude cedents' claims.

After consulting several dictionaries, the Covington court concluded that a policy is a contract of insurance and that reinsurance is one form of a contract of insurance. As a result, the court ruled, the cedent's claim under the reinsurance contract fell squarely within the statute. The court further ruled that since the statute was unambiguous, legislative intent did not need to be considered. Nevertheless, if it was considered, the legislature's failure to adopt the relevant language of the NAIC Rehabilitation and Liquidation Model Act, which excludes reinsurance claims from this level of priority, is conclusive on legislative intent.[1]

The issue addressed in Covington v. Ohio General has not been a subject for debate for many years due to the case law and public policy issues addressed below. The purpose of this article is not to advocate a position but to examine this case in light of such case law and public policy issues.

II. PUBLIC POLICY ARGUMENTS

A. From the Cedents' Standpoint

It may be argued that reinsurance is merely a subset of insurance. With a few exceptions (*e.g.* rate and form filing), reinsurers are regulated in exactly the same manner as insurers. Most reinsurers write some insurance and even more insurers assume some reinsurance.

The permeable nature of the marketplace suggests several conclusions. To the extent that a receivership code attaches a certain priority to "claims under insurance policies," it is an artificial distinction to exclude reinsurance from the definition of insurance. Would we also exclude bonds?

Secondly, there is a high degree of interdependence among insureds, insurers and reinsurers. Placing cedents to an insolvent reinsurer in a general creditor category may jeopardize the financial health of additional companies. The confluence of events, such as the World Trade Center bombing and the liquidation of Reliance Insurance Company (a reinsurer of significant size), may result in a ripple effect which is damaging to many insurers and their clients. To avoid such a result, it makes sense, the argument goes, to include group guaranty associations, insurers and their clients at the same priority level.

While the desire to protect consumers is laudable, not all insureds or cedents are alike. Some insureds are multi-national manufacturing or financial institutions with sophistication and net worth greater than their insurers. Similar to the NAIC Guaranty Fund Model Act[2], a priority distinction should be made between the priority of ordinary consumers and that of sophisticated business entities.

The retort that the cedent to the insolvent reinsurer could have protect themselves by better selection procedures is off the mark. Often insolvencies result from latent exposures (*e.g.* pollution and asbestosis) that were not understood until many years later. Other insolvencies have been caused by new and ill-advised programs (*e.g.* Transit Casualty and Mission) that could not have been anticipated by those who did business with such companies before the initiation of these programs.

B. From the Receivers' and Guaranty Associations' Standpoint

Insurance is an industry touched with a public interest. For this reason, a large part of insurance regulation in the United States is oriented toward

protecting consumers who lack the resources to evaluate the financial wherewithal of insurers and the sophistication to compare insurance products.

This orientation is reflected in the receivership laws and guaranty association laws developed by the NAIC and the various states over the last thirty-five years. For instance, the limits and lines covered by guaranty associations are specifically designed to protect consumers, whether as policyholders or claimants, rather than business entities which are better able to protect their own interests. Likewise, priorities of distribution provisions in receivership laws have been structured to give a high priority to insureds and claimants while placing others at a lower, general creditor level.

While one cannot expect cedents to be omniscient concerning the future solvency of their markets, they are certainly in a superior position to consumers. Cedents can and do perform sophisticated financial analyses of those with whom they do business. If cedents choose to cede to weak or otherwise troubled companies, they assume the risk that some will fail. In addition, cedents are not without tools to protect themselves (*e.g.* setoff) should such a failure occur. Priority of distribution statutes should be construed to favor of those least able to protect themselves against the prospect of insurer insolvency.

III. EARLY CASE LAW

Receivership statutes in the United States have not always assigned priorities in the distribution of the assets in insolvent insurers[3]. However, a priorities section was inserted into the NAIC Model Insurers Rehabilitation and Liquidation Model Act adopted in 1977[4] and some version of the priorities provision has been enacted in virtually all states.

Early litigation on priorities was in the context of special deposits required of insurers to write business in particular states. Perhaps the most prominent of such litigation is Shepard v. Virginia State Ins. Co., 91 S.E.140 (Va.1917). In this case, state law required fire insurers to post a bond for the benefit of "the holders of all policies . . ."[5] When the company that made the deposit became insolvent, one of its cedents attempted to collect on the bond. The court ruled against the cedent:

The evident purpose of the Legislature, as it seems to us, and the one naturally attributable to it, was to protect property owners in their fire insurance contracts, and not to protect other insurance companies on their contracts of reinsurance. The business of insurance is in itself of such a character as to have evoked, in the public interest, much special legislation looking to its control. The average individual property owner is uninformed as to many of the details of the business, and, for this and other reasons, is not in a position to judge of the solvency of any particular company. . . .

It is true that reinsurance is a legitimate part of the business of an insurance company, and likewise true that a sound public policy would naturally lead every state to encourage and foster and endeavor to stabilize its resident insurance companies; but we cannot think the Legislature ever contemplated [a cedent making a claim on the bond]. . . .

Contracts on reinsurance are not infrequently designated as "policies," and they are doubtless properly so called; but, unless there is something in the context to indicate reinsurance, the use of the term "policy" in reference to fire insurance business naturally suggests, and will be understood as meaning, the far more usual and commonly known contract of insurance for the protection of a property owner against loss of his property by fire.[6]

The court went on to interpret legislative intent to provide this priority level to policyholders and claimants against policyholders but to ceding insurers

In accord are In re New Jersey Fidelity & Plate Glass Ins. Co., 191 A. 475 (Ct.Ch.N.J.1937); Cunningham v. Republic Ins. Co., 94 S.W.2d 140 (Comm.App.Texas1936); Aetna Casualty & Surety Co. v. International Re-Insurance Corp., 175 A. 114 (Ct.Ch.N.J.1934).

IV. MODERN CASE LAW

In re Liquidation of Reserve Ins. Co., 524 N.E.2d 538 (Ill.1988) involved a statutory priority for the claims of "policyholders, beneficiaries [or] insureds . . . under insurance policies and contracts issued by the [insolvent] company."[7] Several cedents attempted to collect balances under this statute arguing that reinsurance is a form of insurance contact. Initially, the court noted that reinsurance is different from insurance in that reinsurance is a transaction between two insurance companies and that it is unconnected with the underlying insurance policy. The court went on to interpret legislative intent to provide this priority level to policyholders and claimants against policyholders but not to ceding insurers. During the course of its opinion, the court rejected the cedents' argument that

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Cedents' Claims To Reinsurance Recoverables

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policyholders did not need to be preferred over cedents since policyholders are protected by guaranty associations:

The protection under guaranty funds is limited and does not even apply to rehabilitations. Thus, there is a real likelihood that many claims covered under insurance policies and insurance contracts will not be protected fully, if at all, under State guaranty funds. . . If anything, the Illinois Guaranty Fund Act and [priority statute] both reflect the legislature's common purpose to prefer the interests of direct insurance consumers over those of reinsureds and reinsurers.[8]

The meaning of priority language in a rehabilitation plan was the issue in State of North Carolina v. Beacon Ins. Co., 359 S.E.2d 508 (Ct.App.N.C.1987). The plan specifically excluded from coverage in the policyholder priority level "reinsureds or reinsurers." Cedents objected to the plan on the basis that it violated the relevant priority statute, which excluded only "reinsurers." The court reasoned that such a distinction was meaningless because the statute applies to claims under policies and reinsurers do not have claims under policies. The court ruled for the rehabilitator based on public policy:

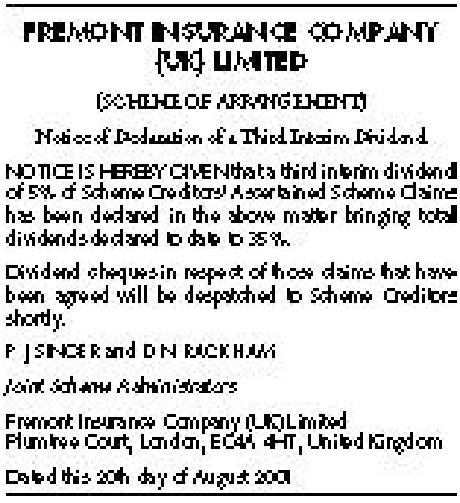
The public policy considerations favoring protection of policyholders are not as applicable, however, to the business of reinsurance. Unlike transactions between insurers and consumers, insurers who negotiate and enter into reinsurance contracts do so from a substantially more equal bargaining position. . . . (W)e believe it unlikely that the General Assembly intended, in the event of the insolvency of an insurer, that other insurers, who had ceded risks to the insolvent insurer through reinsurance agreements would be treated on a par with those who have claims under policies issued directly by the insolvent insurer.[9]

Cedents argued that their claims for reinsurance recoverables should be treated as claims under policies

The validity of another rehabilitation plan was at issue in Neff v. Cherokee Ins. Co., 704 S.W.2d 1 (Tenn.1986). The relevant statute granted a high priority to "claims for benefits under policies and losses incurred, including claims of third parties under liability policies . . . ."[9] Cedents argued that their claims for reinsurance recoverables should be treated as claims under policies. The court rejected this argument based on legislative intent:

The definition of an insurance company is found in [the receivership code], but while it would perhaps otherwise encompass a reinsurance agreement, the express inclusion of or reference to reinsurance in a number of places without doing so in this definition implies its exclusion elsewhere for the purposes of [the receivership code] as a whole. . . . Thus, the Legislature intends [the receivership code] primarily to benefit direct policyholders as these agreements are defined in that title.

Foremost Life Ins. Co. v. Department of Insurance, 409 N.E.2d 1092 (Ind.1980) involved a claim by a cedent under a priority statute, which gave a high priority to "claims by policyholders, beneficiaries and insureds, . . . and liability claims against insureds . . . ."[12] The court



FREMONT INSURANCE COMPANY (UK) LIMITED

(SCHEME OF ARRANGEMENT)

Notice of Declaration of a Third Interim Dividend

NOTICE IS HEREBY GIVEN that a third interim dividend of 5% of Scheme Creditors' Ascertained Scheme Claims has been declared in the above matter bringing total dividends declared to date to 35%.

Dividend cheques in respect of those claims that have been agreed will be despatched to Scheme Creditors shortly.

P J SINCLAIR and D N BUCKHAM

Joint Scheme Administrators

Fremont Insurance Company (UK) Limited
Plumtree Court, London, EC4A 4HT, United Kingdom

Dated this 20th day of August 2003

rejected the cedents' attempt to insert itself at this priority level stating:

It is abundantly clear that the legislature could have included "ceding" companies along with policyholders, beneficiaries and the insureds if such was their intention, and reinsurance contracts as well as insurance contracts, if they intended to include reinsurance under Class III. These are well understood terms and statutes in the insurance field and insurance law, and the legislature must be presumed to have considered them in drafting this statute.[13]

An alleged typographical error in the priority statute was the threshold issue in In the Matter of the Liquidation of Sussex Mutual Ins. Co., 694 A.2d 312 (Sup.Ct.N.J.1997). Higher priority was granted to "claims by policyholders, beneficiaries and insurers . . . and liability claims against insurers . . . ."[14] The receiver argued that "insurer" was a typographical error and that "insureds" was intended. A cedent argued that this language was intended to grant a high priority to reinsureds. The court concluded that the legislature had intended to use the language advocated by the receiver:

If the legislature had intended to contravene the settled policy enunciated in [Aetna Casualty & Surety v. International Re-Insurance Corp., supra.], and favor reinsureds along with policyholders and beneficiaries, it would have used the term reinsured not the somewhat ambiguous terms "insurers." which stands in stark contrast to the other terms "policyholders" and "beneficiaries." It is also unlikely that such a change would have been made without any indication of the Legislature's intent to make that change evident in pre-enactment history. [15]

V. CONCLUSION

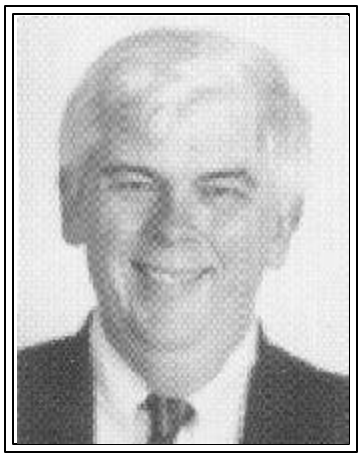
The reader must judge for himself or herself which side of this debate has the better public policy arguments. However, the case law indicates that the position of receivers and guaranty funds has prevailed thus far. The courts, certainly, have interpreted the language of priority distribution statutes, and the legislative intent behind them, against cedents. As a result, it appears likely that Covington v. Ohio General, *supra*, will be a case of limited influence that could be effectively reversed through amendments to the Ohio priority of distribution statute. Should such a legislative effort be attempted, however, consideration could be given to a consistent priority level of all sophisticated entities, be they cedent or insured.[16]

ENDNOTES

1. 2001 WL 1013126 *2 - 3.
2. Section 5 F. (3)(d) of the NAIC Post Assessment Property and Liability Insurance Guaranty Association Model Act excludes from the definition of covered claim, any first party claim by an insured with a net worth of $25 million or more.
3. The Uniform Insurers Liquidation Act used by many statutes during the early and middle portion of the twentieth century did not contain a priority provision. *See* State of North Carolina v. Beacon Ins. Co., 359 S.E.2d 508 (Ct.App.N.C.1987).
4. The legislative history to the model, which is contained in the NAIC compilation of its model acts and regulations, states: When the first drafting committee met to decide on a list of important items to include in the model, one of the most essential was establishing the order of priority of claims against the estate of the insolvent insurer. They considered it most appropriate to place policyholders, beneficiaries and claimants ahead of general creditors. 1976 Proc. II 363. The scheme adopted in 1977 remains essentially the same today. 1978 Proc. 436 - 438.
5. 91 S.E. at 140.
6. 91 S.E. at 141 - 2.
7. 524 N.E.2d at 539.
8. *Id.* at 543.
9. 359 S.E.2d at 511.
10. 704 S.W.2d at 2.
11. *Id.* at 3 - 4.
12. 409 N.E.2d at 1094.
13. *Id.* at 1097.
14. 694 A.2d at 314.
15. *Id.* at 317.
16. *See* note 2, *supra*

Meet Your Colleagues

By Joe DeVito



JACK CUFF

Jack lives in Greenwich, Connecticut, and is a Principal in the Actuarial Services Group of Ernst & Young in New York. He is married for 21 years to a Librarian and has three teenage children. Normally he likes to listen to oldies radio but is more and more losing the battle to his kids who insist on N'Sync. Not so bad.

As a member of the IAIR education committee Jack helped to plan and participate in the joint educational session with the NAIC in January in Tampa. He also contributed an article to the Insurance Reciever entitled: Insurance Insolvencies: The Reinsurer's View.

Jack was a Vice President of Claims for the US Branch of Munich Reinsurance and before that was a claim executive at General Reinsurance. He started his career at the New York lawfirm of Wilson Elser Moskowitz Elser and Dicker where he worked on professional and product liability cases as well as numerous coverage matters. Jack has a JD and a CPCU designation as well as an Associate in Management (AIM) and an Associate in Reinsurance (ARe).

He and members of his group have done work for liquidators in California, Illinois, Missouri, Texas, Pennsylvania, and New Jersey among others. He also did extensive work recently in Sydney, Australia and in Japan on a number of insurance company insolvencies. This work included loss and coverage analyses, operational management consulting as well as litigation support and expert witness testimony.

JOHN J. FALKENBACH

John J. "Jack" Falkenbach has over 30 years of diverse law and general business management experience which he applies for the benefit of his clients. Jack is a principal in WOODY & FALKENBACH, engaged in the general practice of law with emphasis on insurance and business matters. Jack is the Executive Director of the Delaware Life & Health Insurance Guaranty Association, responsible for the operations of that organization. He also regularly serves at the appointment of the Insurance Commissioner as a hearing officer in matters before the Delaware Insurance Department.

Previously, Jack was Vice President, Secretary and General Counsel of Continental American Life Insurance Company, a Provident Mutual company. At Continental American, he provided legal advice on corporate and insurance matters and managed the Law, Contracts and Compliance, Human Resources and Corporate Services Departments. He was also a member of the Senior Management and Strategic Planning Groups and was responsible for all government relations and regulatory affairs. Earlier in his career, Jack was Counsel for CIGNA Corporation where at various times he was legal advisor to their Philadelphia based direct response, group insurance and individual life insurance operations.

Jack is active in the National Organization of Life & Health Insurance Guaranty Associations (NOLHGA) where he serves on the Members Participation Council (MPC) Executive Committee, the Legal Committee and the Administrators Education Committee. He chaired NOLHGA's Year 2000 Contingency Plan Committee and also chairs The Coastal States Insolvency Task Force and serves on several other insolvency task forces.

Jack's has a B.S. in Business Administration from Drexel University and a J.D. and an LL.M. in Taxation from Temple University School of Law. He has also completed the Duke University, Fuqua School of Business, program in Managing the Corporate Law Department.

Jack and his wife, Virginia, have three children. Jack, Jr. is a student at Pennsylvania State University; their son, Jeff, is a student at Massachusetts Institute of Technology; and their daughter, Ginger, is a high school junior. Jack enjoys playing golf, skiing, racquetball, jogging and hiking.

PAUL GULKO

Paul M. Gulko is president of Guaranty Fund Management Services ("GFMS") which services the property and casualty insurance guaranty funds for Massachusetts, Rhode Island, Connecticut, Maine, Vermont, New Hampshire, District of Columbia and Virginia. Mr. Gulko has served in that capacity since GFMS was organized in 1980.

Prior to being named President, he was manager of the Massachusetts Insurers Insolvency Fund. Before his involvement with guaranty funds, Mr. Gulko was counsel to the Commissioner of Insurance for the Commonwealth of Massachusetts.

Mr. Gulko is a graduate of Northeastern University and Suffolk University Law School. He is a member of the bars of Massachusetts, the Federal District Court for Massachusetts and the United States Supreme Court.

He is a past chair of both the Public Regulation of Insurance Law Committee of the TIPS section of the American Bar Association and the National Conference of Insurance Guaranty Funds ("NCIGF") and currently serves on the NCIGF Board of Directors and Executive Committee. He chairs many of the NCIGF coordinating committees and has served or is serving on many other NCIGF Committees. Mr. Gulko has also served as chair of the Industry Advisory Committee to the Rehabilitators and Liquidators Task Force of the National Association of Insurance Commissioners.

Mr. Gulko has served as an arbitrator for guaranty fund issues and has spoken before many insurance industry groups about guaranty funds. In addition he has had various articles published through the years concerning guaranty funds.

Paul currently resides in Swampscott, Massachusetts and commutes to the GFMS offices in Boston, Massachusetts.

LOREN KRAMER

Loren Kramer began Kramer Consulting Services (located in Highland Park, Illinois) in 1981 to provide a variety of consulting services to insurance and reinsurance companies, regulators, liquidators, and attorneys involved in insurance company litigation. Formerly a partner of Arthur Young & Company (now Ernst & Young), and the Firm's national insurance industry specialist, he is a nationally recognized expert witness in insurance company litigation and arbitration matters. His work is often focused on whether insurance company audits have been performed in accordance with professional standards.

A graduate of the University of Illinois in 1963 with a Bachelor of Science in Accounting, Loren has served as chairman of two AICPA task forces and was a member of the AICPA Insurance Companies Committee. He is presently a technical resource to Illinois CPAs on statutory and GAAP insurance accounting and auditing matters. He and his wife, Vivian, have two grown children and a grandchild. An avid tennis player, he promises to take up golf when he retires or when the Cubs win the World Series, whichever comes first. Even though he considers his job interesting, his wife and daughter have an even more interesting business, Custom Tours in Tuscany, providing individual, personalized tours of Florence, Italy, and the surrounding Tuscan countryside. A side benefit, of course, is the travel to Florence, although he is still looking for his first assignment in Italy.

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); Bob Loiseau (TX); Melissa Eaves (CA)
International - Jane Dishman (England); John Milligan-Whyte (Bermuda)

Our achievement news received from reporters for the first quarter of 2001 is as follows:

Mark Tharp (AZ) provided information on several **Arizona** estates. On September 2, 1998, an Order of Liquidation in Cause No. CV98-15998 was entered authorizing the Director of Insurance of the State of Arizona, as Receiver, to liquidate the assets and business of **Ameristar Life Insurance Company**. Pursuant to the filing and entry of Order Re Petition 16 on January 2, 2001, the estate was closed with a pro-rata distribution of $276,001 to **Ameristar's** creditors.

Further, pursuant to the Court's entry of Order regarding Petition No. 26, Petition for Order of Liquidation and Order Establishing claims Bar Date and Approval of Receiver's Recommended Claims and Notice Procedures, a bar date of December 29, 2000 was set for the filing of all pre-receivership claims for **Premier Healthcare, Inc.** In response to that petition, claimants have filed approximately 3,270 proofs of claims representing in excess of 350,000 medical claims against the **Health Care Services Organization** estate. Preliminary recommendations were filed with the Court on September 4, 2001.

On December 18, 1997, litigation was commenced against former officers, directors and professional of AMS Life Insurance Company. On December 4, 2000, the Receiver settled with one of AMS' former actuarial firms. The firm agreed to pay the Receiver $2,250,000 in three installments with $1,000,000 payable on December 31,2000, $750,000 payable on December 31, 2001 and $500,000 payable on December 31, 2002 . On August 30, 2001, the Court issued a Minute Entry wherein another actuarial firm involved in the litigation was found to have liability in the amount of $17.5 million. On March 5, 2001, in the matter captioned **Charles R. Cohen, as Receiver of AMS Life Insurance Company, an Arizona Corporation, Plaintiff, v. The Hartford Fire Insurance Company, a Connecticut Corporation, Defendant**, currently pending before the Arizona Supreme Court, the Receiver filed Appellees Petition for Review. This action involves **AMS'** pursuit of the bond penalty under a $1 million Fidelity Bond issued to **AMS** by the **Hartford**.

Finally, on March 7, 2001, the Receiver filed with the Court Petition 354, Petition for Order Approving Transfer of Funds Pursuant to Early Access Agreement with regard to **Farm and Home Life Insurance Company**. On or about April 2, 2001, the Receiver transferred $26,803,350 to the Arizona Life and Disability Insurance Guaranty Fund, for a total of $78,892,602 distribution to date. The Receiver has entered into an agreement for the marketing of its interest in approximately 4800 acres of real estate in northern Georgia. Sealed bids are due no later than October 31, 2001.

Mike Rauwolf (IL) reports that, under OSD supervision, the reinsurance run-off continues for **American Mutual Reinsurance, in Rehabilitation**. Total claims paid inception to date; Loss & Loss Adjustment Expense, $30,449, Reinsurance Payments $137,118,366, and LOC Drawdown disbursements $9,613,386.

OSD additionally continues to manage the run-off of **Centaur Insurance Company, in Rehabilitation** business. Total claims paid inception to date; Loss & Loss Adjustment Expense $53,289,646, Reinsurance Payments $4,945,493, and LOC Drawdown disbursements $13,876,555.

Dan Watkins (KS) provided distribution information for **West General Insurance Company**. He advises that Guaranty Funds affected by the **West General Insurance Company** liquidation recently entered agreements with the Liquidator setting the final amounts of the Funds' Class 1 expenses and Class 3 claims in the **West General** estate. An application for distribution of assets was made to the liquidation court on August 2, 2001 and an order approving the distribution was entered September 4, 2001. A distribution of estate assets was made September 10, 2001. Detailed information regarding the distributions made to the Guaranty Funds can be found in the Use and Distributions portion of the Report.

The **West General** estate over the past two years has distributed

approximately $13,250,000 comprising the amounts for Class 1 and Class 3 Guaranty Fund claims plus $2,792,000 to non-Guaranty Fund Class 3 claimants representing 54.4% of their allowed claims. Approximately $350,000 in assets remain in the estate at this time.

There will be a final distribution in the **West General** estate after all estate administrative expenses are covered and any additional assets are recovered from bankruptcy estates of related companies in which **West General** is a creditor. Where those matters are resolved the estate will be closed.

James A. Gordon (MD) continues to provide collection information for **Grangers Mutual Insurance Company**. Collections during the first quarter of 2001 totaled $274,019.49.

Receivers' Acheivements By State

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

Receivership	Loss and Loss Adjustment Expense	Early Access Distribution	Reinsurance Payments
Alliance General Ins. Co.	3,911	0	0
Amreco	0	0	1,260,016
Back of the Yards	38,112	0	0
Centaur	9,482	0	0
Coronet	703	0	0
Illinois Insurance Co.	425	0	0
Inland American Ins. Co.	85	0	0
Millers National Ins. Co.	25,000	0	0
Optimum Ins. Co.	0	350,000	0
Pine Top	2,688	0	0
Prestige	35	0	0
River Forest Ins. Co.	0	250,000	

Receivership Estates Closed	Category	Licensed	Year Action Commenced	Payout Percentage
Kenilworth Ins. Co.	P&C	Yes	1982	Class A - 100% - $3,079,771 Class D - 16.5777% - $1,885,618
Edison Ins. Co.	P&C	Yes	1991	Class A - 100% - $5,219,252 Class D - 15.0679% - $2,392,793

Kansas (Daniel L. Watkins, State Contact Person)
Use and distributions made to policy/contract creditors and Early Access

Receivership	State GF	9/10/01 Class I Distribution	9/10/01 Class 3 Distribution	Total Class I To GF	54.4% Dist. On GF Class 3
West General Ins. Co.	Arkansas	$1,065.00	$313,499.00	$246,869.00	$1,176,800.00
	Kansas	$0.00	$125,943.00	$198,960.00	$481,025.00
	Minnesota	$0.00	$10.00	$966.00	$37.00
	Missouri	$0.00	$153,164.00	$208,758.00	$592,717.00
	Oklahoma	$818.00	$465,118.00	$587,155.00	$1,749,742.00
	Tennessee	$0.00	$49,037.00	$101,618.00	$200,323.00
	Texas	$381.00	$1,244,792.00	$197,791.00	$4,721,137.00
	TOTAL	$2,264.00	$2,351,563.00	$1,542,117.00	$8,921,781.00

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

Receivership	Amount	
Grangers Mututal Ins. Co.	$106,770.69	(MD)
	$9,768.91	(NC)

Impending Inasurance and Reinsurance Issues

Arising From September 11, 2001

by Laurie A. Kamaiko

September 11, 2001 left in its wake thousands of lost lives, massive destruction of property, and financial losses of tens of billions of dollars. Insurers and reinsurers of all lines of business will be faced with unprecedented losses. The full impact on the industry is still of unknown dimension. Coverage issues, however, are already coming to light.

The most immediate issues that will absorb insurers, reinsurers, and their counsel in the months ahead will be the scope of coverage provisions and exclusions. Also of great significance will be the number of occurrences arising from September 11, and how that will impact deductibles, retentions and limits of liability of policies and reinsurance contracts. These are just some of the issues that will arise. As the claims and factual investigations develop, so will the coverage issues.

Insurers and reinsurers must also consider the impact of September 11 on pricing, their ability to obtain reinsurance and their access to capital.

The Coverages Impacted

Property, casualty, life, health, accidental death and disability, workers compensation, aviation, and even auto insurers and reinsurers will be called upon to pay enormous losses. The impact, however, will probably spread far wider.

Insurers providing business interruption coverage to businesses in and around the World Trade Center will bear very large losses. Business interruption coverage is often included in large commercial property insurance policies. Such policies typically limit the period of interruption they cover, and require that the interruption of the insured's business be caused by damage to insured property from a covered peril.

Businesses that did not sustain physical property damage will also face financial losses. Many have already been forced or decided to close or reduce operations as a result of September 11. They will likely look for reimbursement from other types of coverages that do not require concomitant physical damage as business interruption coverage typically does. Event cancellation insurance will come into play, as Broadway shows, sporting events, conventions and events all over the world are cancelled.

The damage not just to the World Trade Center buildings, but to businesses and residences surrounding it, may bring to light defects in products and construction, and negligence in the provision of services. That will generate liability claims that will call into play the liability insurance of the targets of those claims.

Aviation insurance will probably also have a large role in the claims arising from September 11, barring the application of hijacking, terrorism or other pertinent exclusions. Aviation liability insurers of the airlines whose aircraft were involved will be called upon to defend and pay third party claims by businesses damaged, individuals injured, and families of those lost on the ground and in the aircraft. Additionally, claims may be made against the companies that provided security to those airlines and at the airports from which the hijacked flights originated. While some of these and other negligence claims may be countered by arguments that the terrorists' conduct constituted intervening acts for which the airlines and security companies are not liable, they will almost certainly result in litigation.

Trip insurance policies will also be subject to claims by the passengers of the hijacked aircraft on September 11, as will trip cancellation policies issued to passengers of flights scheduled for the days and weeks thereafter. Many passengers who planned flights, even those not cancelled, will seek to avoid flying and to invoke the trip cancellation coverage frequently sold by travel agents, cruise lines, and others in the travel industry.

E&O insurers of insurance brokers and reinsurance intermediaries will be exposed, as policyholders and cedents with large uncovered losses consider asserting claims against their insurance brokers or intermediaries for not obtaining appropriate coverage.

Clash covers will also be implicated, as insurers and reinsurers find that they have multiple policies and reinsurance contracts, perhaps on different lines of business, providing coverage for losses arising out of September 11. An insurer faced with a loss impacting several different policies will also be faced with allocation issues, particularly when it comes time to cede those losses to the reinsurers of those different policies.

Both insureds and insurers may find themselves looking for grounds to seek recovery from other arguably culpable parties, to share the burden of the enormous losses many will sustain.

The Scope of Coverage and Exclusions

The coverage issue given the most publicity in the days immediately

following September 11 has been the potential application of "war exclusions." In its simplest form, a war exclusion carves out from coverage losses arising from "war." In its broader forms, a war exclusion can carve out losses "indirectly" as well as directly arising from war, or losses arising from "warlike" acts, "undeclared" war, or acts of "foreign enemies." It is not determinative that the President of the United States or other high level officials of our government have referred to September 11 as an act of war. "War" for insurance purposes generally requires a hostile act by a sovereign entity, or at least an entity with the attributes of sovereignty. If the terrorists of September 11 were not directed by a sovereign entity, but only by a terrorist organization without even de facto governmental status, then the basic war exclusion would not apply under existing case law. Should it be determined, however, that a sovereign entity, such as the government of Iraq or the ruling Taliban of Afghanistan, did direct the terrorists who flew the four aircraft on September 11, or were involved in some other way, then insurers and reinsurers may have to reevaluate the application of their war exclusions.

"War exclusions" vary in their terms. Each must be examined carefully for language that extends its scope beyond simply "war" to other acts that might apply. Some policies and reinsurance contracts may expressly exclude losses arising from acts of terrorism or hijacking, either as part of their war exclusion or as a separate exclusion. In that event, many losses resulting from September 11 may well be excluded from coverage.

Several insurers have publicly taken the position that they will not invoke any war exclusions. Further, state insurance regulators and the federal government appear to be moving toward a position which will strongly discourage the invocation of war exclusions.

Many policies and reinsurance contracts also contain exclusions for "riot" or "civil commotion." Those are usually considered to be directed at domestic disturbances, and not incidents involving foreign terrorists such as those who hijacked the aircraft on September 11. However, looting of stores or other vandalism occurring during the days following September 11 could arguably fall within the scope of those exclusions, depending upon the timing and circumstances. Moreover, many property policies have specific exclusions for vandalism.

Other exclusions and limitations of coverage may apply, depending on the specific terms of the policies and contracts in issue. Property policies, especially those including business interruption coverage, may exclude or have sublimits for certain types of losses. While a property policy may include business interruption coverage, it will usually limit the type and duration of business interruption losses covered, as well as the amount. Insurers of large commercial enterprises often issue policies that have a complex interplay of coverage provisions, exclusions, and sublimits of liability.

Issues will arise as to whether a specific loss was caused by a covered peril or by a peril excluded from coverage under the terms of a particular policy or reinsurance contract. If a policy or reinsurance contract does not specify that the scope of a coverage or an exclusion includes losses "indirectly" caused by the peril in issue, there may be issues as to whether losses are "directly" caused by the peril for the coverage, or the exclusion, to apply. Similarly, rescue and cleanup operations may result in additional losses, and raise issues as to whether such losses were caused by a peril covered or excluded in a particular policy or reinsurance contract, or by some intervening event. As a relatively simple example, if a policy or reinsurance contract does have a terrorism exclusion, there can still be questions as to whether specific losses were caused by terrorism and thus excluded from coverage.

Moreover, reinsurance contracts, particularly catastrophe covers, may define a covered loss as one taking place within a limited time period from when the covered peril first occurred. Some of the property damage and loss of life resulting from the aircraft crashes on September 11 may actually not have taken place until days later. Thus, losses that would have been covered if they took place on or immediately after September 11 may not be covered if they did not take place within the time period specified in the reinsurance contract.

Number of Occurrences, Deductibles, Retentions and Limits

More complex and less publicized is the issue of the number of occurrences. Many millions of dollars of exposure to insurers and reinsurers will ride on whether the losses arising from September 11 comprise one or multiple occurrences. Four aircraft caused destruction and loss of life in New York, Pennsylvania, and Virginia. Of the two aircraft that crashed in New York, one of the aircraft struck one of the Twin Towers, and a second aircraft struck the other. Both towers were part of one complex of separate but interconnected buildings, the Word Trade Center. At least three buildings in the World Trade Center collapsed. Many others in and around the World Trade Center were damaged.

Policyholders' and cedents' deductibles and retentions, and insurers' and reinsurers' limits of liability, are usually on a "per occurrence," "per accident," "per event" or "per location" basis (or some similar term). It is also common,

(Continued on page 22)

Every Health Insurer's Litigation Nightmare

(Continued from page 7)

given that Alabama allowed would-be plaintiffs' lawyers to advertise for opt-outs). A "no-opt-out" class certification and settlement, to the contrary, would immediately preclude the filing of additional individual cases that were not already pending on the date of the class certification, at least under then-prevailing law. Presiding Judge Robertson made it fairly clear that, absent settlement, the case would be tried before year's end.

The settlement

On June 16, 1993, Liberty National, the named plaintiff and class counsel entered into a no-opt-out settlement, subject to court approval after notice to the class and an opportunity for any objectors to be heard. Under the terms of the proposed settlement, class counsel had extracted substantial relief for the class. However, with a class of more than 400,000 insured individuals and families and a company with a statutory net worth of $ 327 million, it was obvious that even a small cash award to each eligible class member would send the company into receivership. Class members would then lose all insurance coverage. Therefore, relief of an equitable nature was deemed most appropriate.

Under the proposed settlement, a class member who had suffered cancer, submitted proper claim forms, and received fewer dollar benefits for overall cancer treatment under the "new" policy than they would have under the "old" would receive 100 percent restitution of the difference, plus a share of each of two ancillary monetary relief funds. Even persons who had suffered cancer and had received greater benefits under the "new" policies were eligible to share in the funds, which totalled $ 4 million. Each member of the class who had exchanged to a "new" policy also received an amended policy that provided full prospective coverage for radiation, chemotherapy, and out-of-hospital prescription drugs without monetary limits. Relief was even afforded those who had not exchanged but had lapsed their "old" policies. And all class members were to receive a premium freeze through January 1, 1995 -- which equated to approximately three years of level premiums.

In addition, the settlement provided that Liberty National would be forever enjoined from replacing class members' reformed policies with any other type of cancer policy which contained any reduction in benefits, at least absent Court approval. Excluded from the class were cancer policyholders who had already filed suit prior to the date of the original class certification, March 10, 1993.

The firestorm erupts

The exclusion of class members who had already filed actions as of March 10, 1993, was a deliberate concession by Liberty National. First, Liberty National hoped this move would minimize objections to the settlement. Second, twhis exclusion met concerns that had been raised under the Alabama Code.[4]

The hope of minimizing objections to the settlement was not realized. The same lawyers who already had pending cases on March 10, 1993, were also still actively recruiting new ones. They recognized that the mailing of the class action notice would generate a great deal of publicity and the opportunity to acquire even more cases against Liberty National. Moreover, quite a few cases had been filed between the date of the original certification (March 10, 1993) and the date of the settlement (June 16, 1993). These cases had now been enjoined, and many of the plaintiffs sought opt-out status. Their lawyers held meetings with various union groups to inform them of the settlement and their right to object, and publicity and advertising on television and in newspapers generated interest in criticisms of the settlement.

The objecting attorneys also filed a class action of their own, in the circuit court of Mobile County, raising the same claims and asking the trial judge to certify an opt-out class under Rule 23(b)(3). They argued that the no-opt-out certification in Barbour County was void as a violation of due process and the right to jury trial under the Alabama constitution.

The Mobile attorneys found sympathetic ears at the Mobile circuit court. Liberty National suggested that the Mobile attorneys had violated the injunction entered by the circuit court of Barbour County and might be found in contempt. The Mobile court threatened to fine Liberty National $ 1 million a day for each day plaintiffs' lawyers spent in the Barbour County jail. The war between the two circuit courts soon caused Liberty National to file a petition for mandamus, and the Alabama Supreme Court quickly stayed the Mobile proceedings. The court ultimately issued a ruling that the Barbour County Circuit Court had exclusive jurisdiction to proceed with the class action until its conclusion, and that all actions filed after the date of class certification were to be stayed or dismissed.

Meanwhile, despite the massive adverse publicity and the side-battles, Liberty National still had to demonstrate that the settlement represented a fair compromise, and that the "new" policies were in fact better for most people who suffered cancer. As the adverse publicity generated by objectors mounted,

lapse rates for all types of Liberty National insurance products increased noticeably, and lawsuits for other types of its insurance products increased dramatically. New sales became progressively more difficult to make.

Nevertheless, an individual cancer exchange case was put to trial in October 1993. In McAllister v. Liberty Nat'l, the plaintiff was a Liberty National cancer policyholder who had exchanged from an "old" policy to a "new." Edith McAllister had never suffered cancer, nor had any-one in her family. Nonetheless, she alleged that she had been fraudulently told that the new policy was "better" and claimed that the approximately $ 800 in higher premiums she had paid for the "new" policy over several years constituted recoverable damages. In addition to these, she sought damages for mental anguish and, of course, punitive damages.

Although Liberty National believed it would prevail in McAllister, it was very concerned about the impact of an adverse jury verdict. The company feared that a substantial adverse verdict would be used by objectors as evidence of inadequate settlement in Robertson, and that a significant individual verdict might cause class counsel to back away from the settlement. However, attorneys representing McAllister also represented dozens of objectors in Robertson, and they wanted to set a precedent.

On October 21, 1993, after three weeks of trial, the McAllister verdict was returned: $ 1,000 in compensatory damages, and $ 1 million in punitive damages. The verdict, and the relationship between McAllister and Robertson, were immediately disclosed in press releases and SEC filings, in order to keep shareholders of Liberty National's parent, Torchmark Corporation, fully informed.

Wall Street gets nervous

The massive adverse publicity Liberty National had endured for months as a result of Robertson was only heightened by the McAllister verdict. Although McAllister would be appealed, stock analysts took note of the verdict and its perceived implications on Torchmark. If a single cancer exchange policyholder who had never suffered cancer could obtain a $ 1 million verdict, and there were 400,000 policyholders in the Robertson class, some theorized that any decision setting aside the Robertson settlement would have significant financial consequences for Torchmark. Shortly after the McAllister verdict, Torchmark's stock was downgraded by analysts and brokerage houses and continued to decline dramatically over the next several weeks.

The fairness hearing

Rule 23(c) provides that a class action settlement must be approved by the court, after notice to the class and an opportunity for class members to object and be heard in opposition. In January of 1994, then, a small courtroom in Eufaula, Alabama, was invaded by dozens upon dozens of lawyers and objectors; several attorneys had 100 or more objectors each. (There were in excess of 2,000 total objectors.) Despite what could have been chaos, however, Judge Robertson did an admirable job of keeping the proceedings orderly and efficient.

The fairness hearing lasted three days. Various company officials were examined, as were Beasley, an attorney for Liberty National, and an attorney representing the objectors. All of the experts who had submitted affidavits were examined as well. Objectors argued that: (1) the class should have been certified as an opt-out class; (2) certification on a no-opt-out basis was a violation of Due process under the U. S. Constitution and a violation of the right to a jury trial guaranteed by the Alabama constitution; (3) the settlement was "collusive," in that it was negotiated without consulting those who had filed individual cases after the original certification but prior to the settlement; (4) Liberty had agreed to pay up to $ 4.5 million in attorneys' fees in order to purchase Beasley's acquiescence to a no-opt-out settlement; and (5) each individual claim was worth $ 1 million in punitive damages in light of McAllister, proving that the settlement was economically inadequate.

Arguments of "collusion" and accusations of a "friendly lawsuit" were spurious, although they generated a great deal of media interest and adverse publicity for Liberty National. In truth, entering into a "friendly lawsuit" with Jere Beasley in Barbour County would have been the litigation equivalent of dropping over to Jeffrey Dahmer's house for an impromptu dinner.

The strongest objectors' argument was that the McAllister verdict had established that each individual's claim was worth at least $ 1 million in punitive damages. Obviously, no class member would receive that amount under the settlement; in fact, the vast majority of the class would receive no money at all (monetary relief being reserved for those who had actually suffered cancer).

Yet, giving each class member $ 1 million would have cost $ 400 billion. Liberty National's statutory net worth was only $ 327 million. Long before each class member could obtain recovery, the Alabama Commissioner of Insurance would

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Every Health Insurer's Litigation Nightmare

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have placed Liberty National in rehabilitation.[5] Moreover, as a practical matter, the objectors had no answer for Liberty's counter argument: that there was, according to the U. S. Supreme Court, a due process limit on the amount of punishment that could be inflicted upon a civil defendant for a given course of conduct. In short, then, the objectors had given Liberty National the perfect argument for no-opt-out treatment under the "limited fund" theory of Ala. R. Civ. P. 23(b)(1)(B), which is identical to Fed. R. Civ. P. 23(b)(1)(B).

Liberty National and class counsel quickly filed a joint motion asking the court not only to affirm the class action settlement but also to modify the certification of the settlement class, to reflect that the class was certified as a no-opt-out class under both Rule 23(b)(1)(B) (a "limited fund" class action) and Rule 23(b)(2) (a "primarily equitable" class action). Thus, rather than being the downfall of Robertson, the McAllister verdict, in the end, substantially strengthened the arguments for its approval.

The big squeeze

At the conclusion of the fairness hearing, Judge Robertson pressured Liberty National to do three things: (1) to offer the objectors a form of additional settlement funds; (2) to accept increases in the two monetary settlement pools from a total of $ 4 million to a total of $ 11 million; and (3) to increase the restitution amount from 100 percent to 150 percent for those who had suffered cancer but received fewer total dollars under the "new" policies.

Liberty did ultimately offer objectors a modest additional amount, in exchange for a general release of any and all claims, whether or not related to a cancer policy. The offer was accepted by some of the more significant adversaries Liberty National would have faced on appeal; approximately 500 objectors, however, held out. The company reluctantly agreed to increase the settlement amount. Although this substantially increased the cash portion of the settlement, Liberty still believed that equitable relief was called for, and that the settlement could be sustained as a no-opt-out class under Rule 23(b)(2). This, together with the prospect of an additional Rule 23(b)(1) certification, gave Liberty the sense that it could still buy peace, albeit at a higher-than-expected-price. The company, therefore, agreed to increase the restitution and the monetary pools.

A final "tweak" in the settlement came when Judge Robertson indicated that the premium freeze should extend until one year after final binding affirmance by the Alabama Supreme Court, rather then ending on January 1, 1995. Again, Liberty National reluctantly agreed.

The settlement was finally approved by Judge Robertson.

The appeal

The inevitable appeal followed, but before it could be resolved, an election dispute involving Alabama's chief justice virtually shut down the Alabama Supreme Court. What ensued was a political and judicial fiasco that took more than a year to resolve.

The problem for Liberty National with respect to this was that it had agreed, at Judge Robertson's insistence, to extend its premium freeze on all of its cancer policies unitl one year after final binding affirmance of the settlement. Liberty National had not had premium increases on class members' policies since 1991. Meanwhile, the cost of cancer treatment, and consequent benefits, continued to increase dramatically. Because of the election dispute, the premium freeze was costing Liberty National much more than had been anticipated at the time of settlement. The appeals process, which normally took a year or less, had been drawn out to almost two years as a result of the election dispute.

Ultimately, as 1995 drew to a close, the newly reconstituted Alabama Supreme Court did finally approve the class action settlement in its entirety. Following denial of a motion for rehearing, a petition for certiorari to the U.S. Supreme Court was granted, giving Torchmark stock analysts another jolt. The certiorari petition was, however, dismissed in March 1997. The settlement was finally complete, and all that remained was its implementation.

The aftermath

Today, the implementation process is nearly complete. However, the cost of the settlement was high, in terms of settlement benefits, defense costs, and the impact of adverse publicity. Liberty National now has evidence that the "new" policies did in fact provide higher overall benefits to the vast majority of persons who suffered cancer. (Of approximately 2,600 claimants, in fact, less than 10 percent received smaller benefits under the "new" policies.)

In spring of 1995, the individual verdict in McAllister v. Liberty Nat'l was affirmed on appeal by the Alabama Supreme Court. Even before the appeals in Robertson v. McAllister were over, a shareholder class action was filed by a disgruntled shareholder claiming that Torchmark should have predicted "the likelihood" of massive liability from the cancer exchange program even before the first lawsuit was filed. That lawsuit was quickly stayed on

procedural grounds.

In the wake of Robertson, much has changed about Liberty National's business. The debit service method of weekly or monthly door-to-door premium collection has been abandoned, and the company now conducts "RIPS" calls (recorded interviews post-sale) to ensure that there are no misunderstandings about policy being purchased.

In a further effort to limit litigation exposure in general, and exposure to class actions in particular, many insurance companies in Alabama are presently working to sustain the use of arbitration clauses in insurance policies. Recent U.S. Supreme Court decisions support this plan. However, the federal McCarran-Ferguson Act generally leaves regulation of insurance to the states, and some argue that a state statute specifically prohibiting arbitration clauses in policies might supercede the Federal Arbitration Act. Alabama's anti-arbitration statute[6] is not specifically directed to insurance, and, for the time being, the Alabama Department of Insurance has approved the use of arbitration clauses in insurance disputes.

Class actions such as Robertson have also considerably heightened the awareness of Alabama insurers to the dangers of engaging in internal policy replacements or exchanges. More and more companies are imposing severe restrictions on agents' abilities to sell new coverage to those who already have existing policies. Whether this is fair to customers is open to debate.

The Robertson no-opt-out class settlement has served as the prototype for several similar Alabama class action settlements. Rather than immediately fighting class actions with all guns blazing, business defendants often ask first whether the class action device can ward off the slings and arrows of multiple individual punitive damage cases. The possibility of a no-opt-out settlement is often one of the first considerations in formulating a class action defense strategy.

Class actions such as Robertson have also catalyzed the business community in Alabama to organize itself into a much more effective force at the ballot box. Judicial races in Alabama since Robertson have been among the most heated in the state, and, more often than not, business candidates have won.

And although it may be entirely coincidental, the law in Alabama has moved back toward the middle. Once again, for example, the objective "reasonable man" standard of reliance is applicable to fraud actions, and the receipt of written documents sufficient to put a person on notice once again begins the running of the statute of limitations.[7] Standards for punitive damage awards being set by the Alabama Supreme Court are also more stringent. Defendants hit with costly punitive damage verdicts on shaky liability theories are having success in overturning them. The Alabama Supreme Court has even adopted the mainstream view that fraud actions involving individual reliance are generally not appropriate for class action treatment.

Inevitably, however, nothing is constant or predictable. As many as six seats on Alabama's nine-justice supreme court are up for reelection in the year 2000. It is doubtful that any one factor will have a greater influence on the litigation future of insurers and others doing business in Alabama than the upcoming judicial elections.

The moral of the story

The Robertson class action settlement obviously benefited Liberty National in certain respects, albeit at a substantial cost. Does this mean that the settlement is inherently unfair or collusive? No. The class action device is not just a weapon of terror for the exclusive use of the plaintiff's bar. In appropriate circumstances, it can also provide shelter for besieged defendants. Indeed, that should be accepted as one of the fundamental justifications and one of the most important goals of Rule 23.

1. ALA. CODE § 6-2-38(1).
2. See ALA. CODE § 6-11-21 (1975).
3. Robertson v. Liberty Nat'l Life Ins. Co., CV-92-021 (Circuit Court of Barbour County, Ala).
4. For later cases addressing this issue in Alabama, see Ex parte Liberty Nat'l Life Ins. Co., 631 So. 2d 865 (Ala. 1993); Ex parte First Nat'l Bank of Jasper, 675 So. 2d 348 (Ala. 1995); Ex parte State Mutual Ins. Co., 1997 WL 772923 (Ala. Dec. 16, 1997); Ex parte American Bankers Life Assurance Co. of Florida, 1997 WL 773322 (Ala. Dec. 16, 1997); Ex parte Citicorp Acceptance Co., Inc., 1997 WL 773360 (Ala. Dec. 16, 1997); Ex parte First Nat. Bank of Jasper, 1997 WL 773364 (Ala. Dec. 16, 1997). In this series of cases, the Alabama Supreme Court initially held that, as a matter of law, individual cases filed prior to class certification could proceed, and that individual cases filed after class certification were due to be abated. In the 1997 opinions just cited, however, the Alabama Supreme Court reversed itself and held that the abatement statute (ALA. CODE § 6-5-440) had no application in class action situations, but that at least in a no-opt-out class action, the class action court had the inherent power to enjoin individual cases filed before or after class certification.
5. See ALA. CODE § 27-44-1, and ALA. CODE § 27-32-1.
6. ALA. CODE § 8-1-41.
7. Ironically, when the court went back to the objective "reasonable man" standard, it declared that the change was prospective, applying only to cases filed thereafter. Foremost, Inc. v. Parham, 693 So. 2d 409 (Ala. 1997). In contrast, when the court had abandoned the objective standard and replaced it with the subjective standard of "justifiable reliance" in Hickox v. Stover, 551 So. 2d 259 (Ala. 1989) and Hicks v. Globe Life & Accident Ins. Co., 584 So. 2d 458 (Ala. 1991), the change was not limited to cases filed thereafter.

Impending Insurance and Reinsurance Issues

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particularly in excess of loss reinsurance contracts, for all losses arising from a series of accidents or occurrences arising out of one event to be aggregated into one retention or one limit of liability.

One can debate whether there was one coordinated plan, political group, or individual that put into motion the four aircraft on September 11. Courts and arbitrators interpreting insurance and reinsurance contracts and determining if there are one or more occurrences, accidents or events, or one or more locations at the World Trade Center, may look to the more immediate physical causes of the losses in issue. Even if the aircraft crashes and resultant losses incurred in New York, Pennsylvania and Virginia are considered separate occurrences, there is an issue as to whether those at the World Trade Center comprise one or more. For example, would one aircraft alone have caused damage to all the buildings of the World Trade Center? When 7 World Trade Center collapsed on the evening of September 11, hours after the collapse of the Twin Towers, was that another, separate, occurrence? If there was more than one occurrence at the World Trade Center, to which one will the physical damage to neighboring properties from debris and smoke be attributed?

Factors to consider include the relative proximity in time and location of the acts immediately giving rise to the losses, and of the losses themselves, the type of risk (e.g., property, liability, life) and cover (e.g., catastrophe), the business purpose of the contract being examined, how premiums for the contract in issue were calculated, the case law analyzing the issue in situations that at best are only roughly analogous to the one presented by September 11 and, of course, the terms and definitions in the contracts. Unfortunately, there is no uniform application of terms such as "occurrence" that will apply across the board to all policies and reinsurance contracts. Rather, courts and reinsurance arbitrators will be called upon to make judgments based on the terms and purpose of the particular contract in issue, industry custom and practice, and case law.

Caveats

The determination of these issues will, of course, depend on the wording of the specific policies and reinsurance contracts under which coverage is sought. Choice of law issues will also have an impact on coverage disputes litigated in courts and can influence those decided by arbitrators. The interpretation of a contract will not necessarily be governed by the law of the jurisdiction where the loss arises. Here, one insurer or reinsurer could be faced with losses under one contract in New York, Pennsylvania, and Virginia. Some policies and reinsurance contracts may include a choice of law provision specifying the jurisdiction whose law is to apply to their interpretation. Should coverage litigation arise, the law of the jurisdiction in which the action is commenced will have choice of law rules that apply. Those may result in the contract being governed by the law of the jurisdiction where the contract was issued or delivered; for a national company with headquarters outside New York, that could be a jurisdiction other than New York.

Moreover, the terms of a policy, and the terms of the reinsurance of that policy, must be analyzed separately. While coverage for a particular loss may be afforded under the terms of an insurer's policy, that insurer's reinsurance contracts do not necessarily provide the same breadth of coverage. Reinsurance contracts may contain exclusions not in the reinsured policy. Reinsurance contracts, particularly those issued by alien reinsurers, may include exclusions for losses arising from terrorist acts. Similarly, a reinsured policy and a reinsurance contract relating to it may define an "occurrence" differently, or the reinsurance contract may provide for aggregation of losses in a manner different from the reinsured policy. Some reinsurers may scrutinize carefully whether the insurers ceding losses paid them out of a sense of patriotism or for a business motive apart from contractual obligation, and may deny liability for losses they consider to be ex gratia payments. Thus, insurers paying losses to their policyholders may face resistance in obtaining reimbursement from their reinsurers. Each contract along the chain of insurance, reinsurance, and retrocession must be reviewed carefully and the application of its provisions and exclusions considered. Applicable case law must be analyzed, and the developing factual record of on-going investigations of September 11 monitored.

One additional complication is that arbitrators in reinsurance disputes are generally not bound to follow strict rules of law but may, instead, look to reinsurance custom and practice, ideas of what constitutes an "honorable engagement" or their view as to what is fair under the circumstances.

Of critical importance will be the facts that develop as to the terrorists themselves and the identity of those who directed their acts. Also significant, particularly on the issue of the number of occurrences, will be the results of engineering and other

investigations as to specific losses and their immediate physical cause.

Other developments may also come into play. There has been discussion of legislation to set up a claims handling facility to handle claims arising out of September 11. While it may address some of the existing issues, it will undoubtedly give rise to others.

Impact on Capital and Ability to Transfer Risk

September 11 will have a dramatic impact on the surplus of the industry as a whole. While predictions of losses vary, certainly some insurers, reinsurers and certain underwriters at Lloyd's of London will be rendered insolvent. Reduced capital and the failure of some insurers and reinsurers is likely to result in a hardening of the market in a number of lines of business. However, the weakened surplus of surviving insurers and reinsurers may prevent them from taking advantage of a more favorable rate environment.

Reduced surplus and reinsurance capacity may force the industry to find new sources of capital and new participants to share risk. Recent years have seen increased use of securitization, protected cells and derivatives to transfer risk and to access capital in nontraditional ways. In addition, callable equity or subordinated debt have been utilized to obtain sources of committed capital in connection with large losses and catastrophes.

A hardening of rates may also lead large corporations and insureds to bypass the insurance market entirely through direct issuance of securities designed to transfer risk to investors or other alternative risk transfer strategies such as captives.

All of these factors are likely to fuel consolidation globally as stronger companies acquire weaker rivals or seek product line or geographic diversity. Even companies which may not be in the market for acquisition may find opportunities to share risk or increase market share through strategic alliances and joint ventures.

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