The Insurance Receiver

PROMOTING PROFESSIONALISM AND ETHICS IN THE ADMINISTRATION OF INSURANCE RECEIVERSHIPS

FALL 2003

Volume 12, Number 2

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President's Message

Robert L. Greer, CIR-ML

Dear Colleagues

Welcome to IAIR in the 21st century! You are either reading this on-line or have printed out a copy. The Insurance Receiver is now electronic to bring you news more quickly, and to use the organization's financial resources more productively. Please give us your comments on the new look and email delivery.

As you know, much of our activity at the IAIR organization occurs in connection with the NAIC meetings – and the June 21–24 meeting in New York was a particularly full and interesting one.

Successful Roundtable

First, IAIR hosted an excellent Roundtable on Saturday afternoon with attendance of over 100. Thanks to Frankie Bliss of New York for hosting; we had the opportunity to hear from Superintendent Serio and Special Deputy Superintendent Jim O'Connor of New York. A newsletter article summarizes the Roundtable presentations. These Roundtables are designed to provide 30–45 minute updates on emerging topics; your response to content and format has been excellent. If you have not joined us in the past, please do so at the next Roundtable on Saturday, September 13 at 1:00 when Rick Bingham, Claims and Reinsurance Director of the Illinois OSD, will be the host in Chicago. The location details and agenda will be posted on our website, *www.iair.org*, in August.

IAIR Designation Program

The NAIC Insolvency Task Force is focusing on improving the overall administration of insolvent insurers. One element of that improvement is establishing a minimal standard for professional management of the insolvency. Responding to comments from some associated with the industry, the Insolvency Task Force will undertake to define the professional management standard as part of the accreditation process. We are pleased that the Task Force will be analyzing IAIR's Designation Program for consideration as a basis for that standard.

Enhancing the Designation Program

At the same time, the Board voted to enhance our Designation Program. A revised Code of Conduct will be presented to the Board for review, discussion and deliberation later this year. The Code applies to Certified Insurance Receivers (CIR) and Associate Insurance Receivers (AIR), but is relevant to any professionals practicing in the insolvency field.

In addition, we are exploring a more structured education and testing process for obtaining a Designation. The Board is contemplating issuing a Request for Proposal to determine how an experienced education and testing consultant can help us develop an insolvency syllabus and examination protocol.

Building the Core of Designated Professionals

We are pleased that more than 40 professionals have applied for and become certified as CIRs and AIRs. There are many more of you, however, with the background and experience to qualify for the Designations. Please log on to the website, *www.iair.org*, to review the requirements and print off the documents. We look forward to receiving your application.

We are committed to enhancing the competence and knowledge of professionals so that they in turn can help states meet their obligation to protect policyholders and other creditors through an insurance insolvency. We welcome your comments and ideas for improving IAIR.

Robert Greer
President
greerlaw@aol.com

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.

The Insurance Receiver is published quarterly by the International Association of Insurance Receivers, 174 Grace Boulevard, Altamonte Springs, FL 32714, Tel: 407.682.4513, Fax 407.682.3175, Email: IAIRHQ@aol.com.

Paula Keyes, CPCU, AIR, ARe, CPIW, Executive Director; Jeanne Lachapelle, Assistant Director; Jaime Mills, Office Manager; Gregg Burga, Administrative Coordinator.

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LEGAL COUNSEL:
William Latza and Martin Minkowitz of Stroock Stroock & Laven LLP.

ACCOUNTANT:
Stephen Phillips, CPA, FLMI, AIR of Cunningham, Porter & Phillips.

View from Washington

Charlie Richardson

I've mentioned in this column several times before how interested Congress, particularly the House Financial Services Committee, is in insurance issues these days. The House Committee's laundry list of 20 insurance hot spots it intends to examine before this session of Congress ends 15 months from now is as I said last time, almost breathtaking in its depth and breadth. The Committee's agenda can be found on the Web at *http://financialservices.house.gov/media/pdf/oplan108.pdf*.

You will find elsewhere in the Receiver a superb summary by Letitia Chambers (of Navigant Consulting) on Congress' new interest in asbestos reform and the asbestos trust legislation that has moved to the top of the litigation improvement heap. But market conduct has moved to the *regulatory* improvement heap.

Market (Mis)Conduct

The stage was set on May 6 when a key subcommittee of the House Financial Services Committee held a hearing in Washington on "Increasing the Effectiveness of State Consumer Protections." Subcommittee Chair Sue Kelly (R-NY) began the hearing by saying that the key question was whether state regulators are up to the task of serving consumers better. She said that good ideas like those of the NAIC only go so far, but that real "success" comes when there is concrete action in individual states to improve the patchwork of market conduct protections across the country. She said Congress wants to put pressure on the states to do that.

There were six witnesses, including Oregon insurance commissioner Joel Ario for the NAIC. All of the members of Congress present zeroed in on the lack of uniformity among the states, the inefficiency of the market conduct procedures generally, and the need for the states to get their collective act together. Each of the witnesses talked, in some way, about the shortcomings of the current system, and none provided a top to bottom defense of it, not even Commissioner Ario representing the NAIC.

A representative of the United States Government Accounting Office testified on "States' Oversight of Insurance Market Conduct Behavior." The GAO's main points were that (a) the states don't consistently use the recommendations in the NAIC Handbook, (b) there are too frequent exams by multiple states against some companies, and (c) the NAIC's efforts to improve have been very slow. In short, the GAO concluded that there need to be consistent nationwide market conduct exam standards so that one state is able to rely on another state's work. You can find a copy of the testimony at *http://financialservices.house.gov/media/pdf/050603rh.pdf*.

A witness from the National Conference of Insurance Legislators gave the Congressional Committee a heads up on an NCOIL report that addresses the current deficiencies in the market conduct system and recommends a holistic approach to surveillance focusing on coordination between regulators and companies, plus self-policing and self-certification. You can find that report at *http://www.ncoil.org* (see the May 6, 2003 news release).

Commissioner Ario did a commendable job in defending the need for improvement at the state level without jumping into a federal regulatory regime. He said a couple of times that you won't get the job done of producing more consistent and predictable market conduct practices around the country by trying to fashion a one size fits all federal solution. He outlined the improvements that the NAIC had been pushing in the market conduct area, including better standards for scheduling exams, conducting pre-exam planning, procedures for conducting the exams, and making reports more uniform. He said over and over again that efficiency and effectiveness are not mutually exclusive. He also gave statistics about the number of complaints handled by state insurance departments each year (3.5 million) and how important it was that consumer protection stay at the state level.

Other Hot Topics in Washington

Leveling the Playing Field – Interstate Compact Could Help Make Life Insurers' Investment Activities Competitive

Since many life insurance products are now marketed as investment vehicles, life insurers are competing directly with banks and securities firms. Unlike their competitors, life insurers are constrained by the regulatory process, which varies from state to state. In contrast, banks and securities firms are able to offer new products on the market more quickly and at less expense. In response to life insurers' current competitive disadvantage, the NAIC's Interstate Compact Working Group continues its work to create an interstate compact, a national, state-based approach to insurance regulation. Regulators believe that this sort of compact would allow for a more efficient review of life insurance and annuity products while maintaining the necessary consumer protections.

View from Washington

Charlie Richardson

Senate Committee Hammers Out Compromise on Genetic Discrimination Bill

The Senate Health, Education, Labor, and Pensions Committee continues negotiations on legislation banning discrimination by insurance companies and employers based on genetic information. The Committee has focused on imposing penalties for the misuse of genetic information and strengthening privacy protections. Conflicts have arisen between Republicans and Democrats on the Committee over whether the proposed penalties provide greater protection for persons with genetic predisposition for certain illnesses than the protections available for people who have existing illnesses or disabilities. Questions also remain over whether a private right of action should be permitted to individuals whose genetic information is misused.

Damn the Torpedos – Association Health Plan Bill Plows Ahead

Despite criticism by the NAIC, insurance groups and consumer groups, the Association Health Plan bill (H.R. 660) is expected to move quickly in the House with more than 150 co-sponsors for the bill in the House. Association health plans are intended to reduce the cost of health coverage for small businesses by enabling them to pool their buying power and obtain coverage exempt from state benefit mandates. The Small Business Health Fairness Act of 2003 (H.R. 660) would allow small businesses to join together to purchase health insurance at lower costs through federally certified association health plans. AHP legislation has been introduced in the Senate (S. 545) as well. Support for this legislation comes from groups that include the National Federation of Independent Business, the U.S. Chamber of Commerce, and a number of small business associations.

Congress is "Off to the Races" on FCRA Preemption Renewal

Renewing the Fair Credit Reporting Act's (FCRA) preemption provisions is among the most significant tasks on Congress' plate for the remainder of 2003. A number of hearings have been held this year on the FCRA and its impact on consumers, the financial services industry, and the states. Consensus for renewal may not come easily, since there is disagreement on the importance of key issues, such as credit scoring, identity theft, and the accuracy of individuals' credit reports. The FCRA preemption provisions (there are seven) will sunset if Congress fails to renew them before January 1, 2004. House Financial Institutions and Consumer Credit Subcommittee Chairman Spencer Bachus (R-AL) introduced on June 26 the "Fair and Accurate Credit Transactions Act of 2003" (H.R. 2622), and the administration signaled its support of FCRA preemption renewal June 30. Senate Banking Committee Chairman Richard Shelby (R-AL) has indicated he wants special attention paid to identity theft and affiliate-sharing provisions in the context of FCRA reauthorization.

charles.richardson@bakerd.com

News from Headquarters

Paula Keyes, AIR

The IAIR Fall Quarterly Meetings will be held on September 13 and 14 at the Chicago Hilton and Towers in Chicago, IL. The meeting schedule is as follows:

Saturday, 9/13

Board Meeting: 9:00 am–noon
Conference 4M, 4th Floor

Roundtable: 1:00 pm–4:30 pm
Lake Michigan Room, 8th Floor

Sunday, 9/14

Committee Meetings: 8:00 am–5:00 pm
Conference 4M, 4th Floor
(Individual committee meetings will be posted to the IAIR website)

Reception: 5:30 pm–7:30 pm
Lake Ontario Room, 8th Floor

Note:
This is a joint reception with the National Conference of Insurance Guaranty Funds. We look forward to seeing you in Chicago!

SAVE THE DATE

"The Challenges of Contested Receiverships"

IAIR's Annual Insolvency Workshop

February 5 & 6, 2004
Miami, Florida

For more information, please contact the Event Chair, Paige Waters at *pwaters@sonnenschein.com*

The Hatch Bill: Is an End to Asbestos Litigation in Sight?

Mary S. Lyman and Letitia Chambers [1]

Among the many pieces of legislation that Congress will face when it returns from its summer recess in September, is legislation aimed at a decades-old problem: the asbestos litigation crisis. A solution is within sight that will provide fair and certain compensation to workers injured by exposure to asbestos, while preserving the economic viability of the companies charged with the liability for their harm. The question is whether Congress will have the courage to abandon party politics, retreat from extreme positions staked out on both sides, and let the solution happen.

Late in the evening of July 10, the Senate Judiciary Committee completed a markup process that had lasted several weeks and reported out the Fairness in Asbestos Compensation Act (FAIR Act, S. 1125), originally authored by Committee Chairman Orrin Hatch (R-UT). The bill was approved on almost a straight party line, by 10-8 with Senator Jon Kyl (R-AZ) abstaining and all Democrats except Dianne Feinstein (D-CA) voting no.

The good news is that the bill made it through the Committee. Despite the partisan vote at the end, a great deal of bipartisan effort and compromise went into the legislation as it made its way through the Committee process. The bad news is that not all the compromises were good ones – several amendments to the bill threaten to undermine the viability of the new system if not changed – and crucial parties are still widely separated on some issues.

During the Congressional recess, both Congressional staff and advocates of the bill will be busy with two critical tasks. The first is working to seek compromise in the remaining areas of controversy and to make needed changes and clarifications to rectify any mistakes.

The second task is putting together a sufficient number of Republicans and moderate Democrats to get the bill passed by the full Senate, whether through persuasion or by making further changes. The bill as it now stands has lost the support of the insurers, has not won the endorsement of Labor, and is unacceptable to the far wings of both parties. Some conservative Republicans believe that the bill is too generous to claimants and creates too much government involvement. Liberal Democrats, including Senators Leahy and Kennedy, believe (as does Labor) that the bill does not go far enough in compensating claimants, particularly those with cancer. These Democrats are overrepresented on the Judiciary Committee and do not necessarily represent the sentiments of all Senate Democrats. Passage by the full Senate will require putting together a coalition of Republicans and moderate Democrats. While this will take hard work by the bill's supporters, it can be done; and at this point, we put the odds of a successful bill at above 50%.

The following is a description of the bill as it now stands and the procedures that it would establish for resolving asbestos claims. Issues that are currently points of contention among the various participants and stakeholders are noted.

The New Claims System

The legislation takes all pending and future asbestos claims out of the tort system and moves them to the U.S. Court of Federal Claims ("the Court") under an Office of Special Asbestos Masters (OSAM). [2] Claims examiners appointed by the OSAM will conduct eligibility reviews, and Special Asbestos Masters, appointed by the President to four-year terms, will make determinations on claims. Compensation to claimants will be made from an Asbestos Injury Claims Resolution Fund ("the Fund") financed by defendants, insurers, and the existing asbestos trusts and administered by an Administrator of the Office of Asbestos Injury Claims Resolution ("the Administrator").

Claimants have four years from the date they are diagnosed with an asbestos-related condition to file a claim; those with pending claims will have two years from date of enactment. Claims will be resolved on a no-fault basis, with no need for claimants to identify specific defendants whose products caused their harm. A detailed work history, a description of the claimant's asbestos exposure, a history of tobacco use, and other relevant information must accompany the claim.

The Court must develop medical audit procedures and, if an audit finds that medical evidence submitted by a physi-

[1] Mary S. Lyman, Esq., is a Senior Engagement Manager in the Washington, D.C. office of Navigant Consulting, where she provides research and analysis of legal and legislative issues for the firm's product liability practice. Letitia Chambers is founder and CEO of Chambers Associates, a public policy and litigation consulting firm, which was acquired by Navigant Consulting in 2001. She serves as a Managing Director at Navigant, where she leads a team of economists, lawyers, and political scientists in analysis and estimation of mass tort litgation.

[2] The original Hatch bill would have established a new Asbestos Court to handle these claims. The Democratic members' dissent to the Hatch Committee Report states that while the system adopted is an improvement, it lacks sufficient administrative structure and would better have been housed within an administrative agency.

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cian or medical facility does not meet medical standards or the Act's legal standards, evidence from that source may be considered unacceptable. The Court must also provide a legal assistance program for claimants with a list of qualified attorneys who have agreed to provide pro bono services. All attorneys are required to inform their clients of the legal assistance service and that a lawyer is not required in order to file a claim.

After review by a claims examiner, claims go to the SAM, who must determine within 60 days the amount of the award to which the claimant is entitled. The determination will include findings of fact and an acceptance form. If the claimant does not seek additional review, the Fund is notified to pay the claimant's compensation.

Decisions may be appealed to a panel of three SAMs, which may reverse the original decision only on the basis of new and material evidence or clear error. Appeal from the SAMs is to a panel of three judges from the Court of Federal Claims, which may set aside only those findings found to be arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with the law. Decisions may be appealed to the U.S. Court of Appeals, which must uphold the decision unless it determines that the decision was arbitrary and capricious if it so finds and remands the case. The Court of Appeals decision is final, except for review by U.S. Supreme Court.

Criteria for Compensation

To qualify for compensation, every claim must meet the following elements:

- Medical criteria,
- Diagnostic criteria,
- Exposure criteria, and
- Latency period.

Medical Criteria and Values

The medical criteria for determining whether a claimant has an eligible condition, and the value paid for each qualifying disease, are the most essential elements of the new system. The strictness or laxity of the medical criteria will determine how many claimants are eligible for compensation. That and the values will determine how much is paid out and whether the funding provided to the new system will be adequate.

The medical criteria in the Hatch bill are a compromise. Some Republicans feel that they are too lax and will compensate claimants who do not have a condition caused by asbestos exposure – notably those with nonmalignant disease that may have been caused by other substances, those with lung cancer which is not accompanied by asbestosis, and those in the "other cancer" category.

To qualify for compensation, claimants must meet the medical criteria of one of ten disease categories shown in Table 1 below. There are five categories of nonmalignant disease and five of malignant disease, including three lung cancer categories. The lung cancer categories, which as noted were a particular item of contention, increase in value based on the progressively greater likelihood that asbestos exposure caused the cancer. Within each lung cancer category, claims are further divided by smoking status, and will be divided by age and by level and duration of exposure according to a matrix to be promulgated by the Administrator.

Claimants in the first nonmalignant category, asymptomatic or unimpairing nonmalignant disease (Level I) do not receive monetary compensation but only payment for medical monitoring. Medical monitoring includes reasonable costs to the claimant not covered by health insurance for x-rays, physical examinations, and pulmonary function tests every three years.

The claim values, which are detailed in the table below, continue to be a source

Table 1

DISEASE CATEGORIES AND VALUES

Level	Category	Compensation
I	Asbestosis/Pleural Disease A	Medical monitoring
II	Mixed Disease with Impairment	$20,000
III	Asbestosis/Pleural Disease B	$75,000
IV	Severe Asbestosis	$300,000
V	Disabling Asbestosis	$750,000
VI	Other Cancer	$150,000
VII	Lung Cancer One	Smokers: $25,000 - $75,000
	(15 years weighted exposure)	Ex-smokers: $75,000 -$225,000
		Nonsmokers: $225,000 - $600,000
VIII	Lung Cancer With Pleural Disease	Smokers: $125,000-225,000
		Ex-smokers: $400,000-$600,000
		Nonsmokers: $600,000-$1,000,000
IX	Lung Cancer With Asbestosis	Smokers: $300,000
		Ex-smokers: $550,000-$800,000
		Nonsmokers: $800,000-$1,000,000
X	Mesothelioma	$1,000,000

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of great contention. Senator Hatch has been adamant about holding the line on the overall cost of the Fund, and some Republicans feel that it is already overly generous. Many Democrats, on the other hand, feel that the values are still too low because they do not reach the average awards found in the tort system – although as Senator Hatch has pointed out, this ignores both the value of immediacy and certainty of compensation and the fact that up to 40% of any tort system award goes to the plaintiff's attorney.

The values shown below represent the compromise adopted by the Committee. All values will be indexed for inflation.

Diagnostic Criteria

All claims must meet detailed diagnostic requirements. These include a physical examination from the doctor providing the diagnosis for living claimants, and for deceased claimants, a physician's report based on a review of the medical records. For nonmalignant diseases, there must be an x-ray reading by a certified B-reader and, for living claimants, pulmonary function testing for categories requiring impairment. Malignant diseases must be diagnosed by a board-certified pathologist.

To ensure that the evidence provided is credible, claimants may be required to submit additional information. All submissions must meet recognized medical standards. Claims will be randomly assigned for confirmation of submitted x-rays by an independent certified B reader. Claimants asserting nonsmoker or former smoker status must provide consent for the claims examiner to obtain relevant historical records, and must also consent to appropriate medical tests to confirm their assertion. The claims examiner will review the historical records of at least 5% of those claiming to be nonsmokers.

Latency Criteria

For all disease levels, the diagnosis must include a statement by a physician that at least 10 years elapsed between date of first exposure and date of diagnosis, or else a history of the claimant's exposure sufficient to establish a 10-year latency.

Exposure Criteria

For all disease levels, claimants must demonstrate exposure to asbestos or asbestos-containing products in the U.S., as an employee of a U.S. entity in another country, or on a U.S. flagged or owned ship. For Levels II-IX they must demonstrate varying numbers of weighted years of "substantial occupational exposure." Alternately, claimants may demonstrate "take-home exposure"– a claim filed by a person who alleges injury as a result of living with a person who brought asbestos home on his clothes.

In order to resolve the issue of the citizens of Libby, Montana who were exposed to asbestos emitted by an asbestos-tainted vermiculite mining and milling facility, the exposure requirement is waived for workers at the facility and those who lived within a 20-mile radius for at least 12 consecutive months prior to December 21, 2003.

The exposure criteria of Levels II-IX use weighted years of exposure to account for the different levels of exposure in various industries and in the years before and after implementation of federal regulation of exposure levels. The years are weighted as follows, based on the exposed person's primary occupation and activity during substantial portion of the work year:

Exposure Level	Definition	Each year counts as –
Moderate exposure	Work in areas immediate to where asbestos-containing products were being installed, repaired, or removed under circumstances that involved regular airborne emissions of asbestos fibers	One year
Heavy exposure	Direct installation, repair, or removal of asbestos-containing products, such that the exposed person was exposed on a regular basis to asbestos fibers	Two years
Very heavy exposure	Asbestos manufacturing, a shipyard during World War II, or asbestos insulation trades	Four years **– of substantial occupational exposure**

[3] This includes physicians who are licensed in any state; board-certified in pulmonary medicine, occupational medicine, internal medicine, oncology, or pathology; and are actively and primarily practicing medicine in a field directly related to his or her certification.

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Medical Advisory Committee and Exceptional Medical Claims

A Medical Advisory Committee (MAC) consisting of qualified physicians[3] will be established to provide appropriate medical advice and recommendations relating to review of claims. In particular, the MAC will review "exceptional medical claim" applications.

Claimants not meeting the medical criteria can apply for designation of the claim as an "exceptional medical claim." All Libby, Montana claims and all claims other than mesothelioma claims that are based on "take-home" exposure must be filed as exceptional medical claims.

An exceptional medical claim must be supported with a report from a physician meeting the diagnostic criteria and including a complete review of the claimant's medical history and current condition. The MAC will determine whether the medical evidence is sufficient to show that the claimant has an asbestos related condition substantially comparable to one meeting the requirements of one of the disease categories. If it so finds, it will issue a certificate of medical eligibility and will submit the claim to a SAM, who will determine whether the claimant meets the other requirements for compensation.

Payment of Compensation

Compensation to qualifying claimants will be paid over three years, with four years from final adjudication of the claim the maximum payout period. Guidelines will be developed for accelerated payments for living mesothelioma victims and other claimants with exigent circumstances. Claimants may elect to receive payments in the form of an annuity. Compensation will be reduced by any payments that the claimant has received or is entitled to receive from defendants and insurers from past settlements and judgments for the same asbestos-related injury.

The Asbestos Injury Claims Resolution Fund

The Asbestos Injury Claims Resolution Fund will be established immediately upon enactment of the bill, but the bill's provisions pre-empting all asbestos personal injury claims in tort and removing them to the U.S. Court of Federal Claims will not take effect until the Administrator determines that the Fund is fully operational and processing claims. Amounts paid by defendants and insurers to settle claims during the transition period may be subtracted from their required contribution to the Fund, and claimants cannot "double-dip" but must choose between the Fund and the tort system. An amendment to accelerate the start date to date of enactment is expected.

The Fund is to be financed with $52 billion contributed by defendants required to participate ("defendant participants") and $52 billion contributed by insurers required to participate ("insurer participants") over 27 years, transfers of assets totaling $4 billion from bankruptcy trusts, and the Fund's investment earnings. Additional funding may come from the "contingent call" and "back-end" provisions discussed below.

Defendant Funding

The defendants' contributions are assessed according to an elaborate system of tiers and subtiers. There are seven defendant tiers based primarily on the defendant's "prior asbestos expenditures," which are the gross amounts paid up to December 31, 2002 in settlement, judgment, defense, or indemnity costs related to asbestos claims.[4] Once a defendant is assigned to a tier, it resides there permanently, regardless of subsequent events.

Within each tier there are three to five subtiers, to which defendant participants are assigned based on the audited consolidated 2002 revenues of the defendant and all affiliated groups. In Tiers II–VI, subtiers are to contain as close to an equal number of total companies and affiliated groups as possible. The amount assessed a defendant participant is based on the subtier to which it is assigned.

Table 2 shows the seven tiers and the range of subtier assessments for each. Note, however, that both the Committee Report and the revised bill language still contain the payment levels that were set for a $45 billion defendant contribution. The numbers below will therefore need to be adjusted upwards by about 15.6% to reflect the increase to $52 billion in total contributions.

For Tiers II–VII, the annual payments will be as shown in the table for the first five years of the Fund's operation. Beginning in year 6, assuming that the Fund is financially able to meet its obligations, the payments will be reduced by 10% every three years.

Treatment of Debtors in Bankruptcy

As Table 2 shows, asbestos defendants who are debtors in a pending bankruptcy for which there is not yet a final decree (Chapter 7) or confirmed plan of reorganization (Chapter 11) are placed in Tier I. Any plan of reorganization, and any agreement or understanding regarding asbestos claims filed before the date of enactment and still subject to confirma-

[4] This includes payments made by insurance carriers to or for the benefit of the defendants, but does not include amounts paid for activities or disputes related to insurance coverage, nor those paid as a result of changes in insurance reserves required by contract.

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Table 2

TIER AND SUBTIER ASSESSMENT SYSTEM

Tier	Includes	Number of Subtiers	Range of Annual Assessments
I	Debtors with a case pending in Chapter 11 bankruptcy (at or within the year prior to date of enactment) and their affiliated groups	3	50% of unencumbered assets (subtier 3) to 1.5184% of debtor's 2002 revenues annually, declining to 0.1518% in year 27 (subtier 1)
II	Defendants with prior asbestos expenditures > $75 million	5	$15 million–$25 million
III	Defendants with prior asbestos expenditures > $50 million and < $75 million	5	$5 million–$15 million
IV	Defendants with prior asbestos expenditures > $10 million and < $50 million	4	$500,000–$5 million
V	Defendants with prior asbestos expenditures > $5 million and < $10 million	3	$200,000–$1 million
VI	Defendants with prior asbestos expenditures > $1 million and < $5 million	3	$100,000–$500,000
VII	Defendant is a common carrier by railroad subject to asbestos claims brought under the FELA and has paid > $5 million in settlement, judgment, defense, or indemnity costs related to those claims. May include defendants also assigned to other tiers.	3	$500,000–$10 million

tion of a plan under Chapter 11 is entirely superseded by the bill.

Companies that have gone through Chapter 11, created a section 524(g) trust, and emerged from bankruptcy will not be assessed as defendants. The asbestos bankruptcy trusts must assign a portion of the corpus of the trust to the Fund and transfer the funds within six months after enactment. After the transfer, the trust will have no liability to any asbestos personal injury beneficiary. The Administrator may refuse trust assets that create liability for the fund exceeding the value of the assets. Asbestos trusts that also have non-asbestos beneficiaries may not transfer assets allocable to those beneficiaries.

Exceptions and Adjustments

Companies which qualify as "small business concerns" under the federal Small Business Act as of December 31, 2002 are exempted from the contribution requirement. In addition, a defendant may seek adjustment of the amount of its contribution based on severe financial hardship or demonstrated inequity. Financial hardship adjustments are for 3 years and may be renewed. Total financial hardship adjustments for all companies cannot exceed 6% of total required annual contributions.

Inequity adjustments are subject to the Fund's financial ability to accommodate them, and annual availability of funds in the Orphan Share Reserve Account (see discussion below) are capped at 4% of total required annual contributions and must be renewed after three years. They require a showing that the contribution under the statutory allocation is exceptionally inequitable when measured against such standards as the defendant's likely liability in the tort system without the legislation and the median contribution for the defendant's tier.

The Administrator may recover any financial hardship or inequity adjustment in future years if it is found that there has been a material change in the financial condition of the company to which it has been granted or that the inequity did not exist.

Table 3

Years	Min. Agg. Contribution
1–5	$2.5 billion
6–8	$2.25 billion
9–11	$2 billion
12–14	$1.75 billion
15–17	$1.5 billion
18–20	$1.25 billion
21–26	$1 billion
27	$250 million
Total	$45 billion

Minimum Contributions

The bill requires that aggregate contributions of defendant participants reach specified minimums for each calendar year; mandatory assessments will drop as time passes in proportion to the required minimum. The required minimums set forth in the Committee Report and Table 3 are those necessary to reach the $45 billion figure; presumably they will be adjusted proportionally to reach $52 billion.

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Procedure for Determining Assessments

Defendants' assessment levels will be determined by the Administrator, who will begin by notifying all mandatory participants that they have 30 days to submit the information necessary to calculate their required contribution to the Fund. If there is no response or incomplete information, the Administrator will determine each defendant's contribution based on the best information available. Within 60 days of receiving the information, the Administrator will send a notice of the initial determination of the defendant's contribution. The initial assessment may be revised based on newly received information, and the defendant may request a rehearing on the determination. The defendant may pay in installments as long as the full amount assessed is paid each year.

Each defendant participant's required contribution to the fund is several. There is no joint and several liability, and any future insolvency of one defendant will not affect the others.

Insurer Funding

Because insurers did not reach agreement similar to that of the defendants on an allocation of assessments, the bill establishes a five-member Asbestos Insurers Commission ("Commission") to make the allocations. Commission members will be appointed by the President, with consultation with the Congressional leadership of both parties, immediately after date of enactment. The Commission will meet within 30 days after all members are appointed and make an initial allocation determination. The insurers will then have 30 days to submit their own allocation agreement to the Commission and to the House and Senate Judiciary Committees. If it is determined that the agreement meets the statutory requirements, the Commission will terminate.

Insurer participants will include both direct insurers and reinsurers, as well as any run-off entity established to review and pay asbestos claims. Like defendant contributions, annual insurer contributions are expected to decrease over time, with each insurer's proportionate share remaining the same throughout.

Insurer participants may make a lump-sum payment or expedited payments to the Fund, and direct insurers are required to pay 100% of their allocations within three years of the effective date of the legislation. Like defendants, insurers may pay in installments as long as the full payment is received each year. Any escrow that has been established by an insurer participant in connection with an asbestos trust fund that has not been judicially confirmed by date of enactment will be returned to that insurer.

Each insurer's obligation to the Fund is several and is not affected by the future insolvency of any other insurer participant.

Mandatory insurer participants are those that have incurred at least $1 million in defense and indemnity costs for asbestos injury claims. In allocating assessments among these participants, the Commission must apply the following factors:

1. Historic premium lines for asbestos liability coverage;
2. Recent loss experiences for asbestos liabilities;
3. Amounts reserved for asbestos liabilities;[5]
4. The likely costs to each insurer participant of its future liabilities under applicable insurance policies; and
5. Other factors the Commission deems relevant and appropriate.

The Commission must also determine the respective shares that will be paid by U.S. direct insurers and by other insurer participants. Insurer participants may seek an adjustment in the amount of their contribution based on severe financial hardship. The procedures for providing notice and for determining and revising assessments are similar to those for defendants.

Within a year from the date of enactment, the Commission must submit a report to the Court of Federal Claims and to the House and Senate Judiciary Committees which contains the amount that each insurer is required to contribute to the Fund and the payment schedule for the contributions. It will terminate within 60 days after submitting its report.

The Administrator may require insurer participants to make payments to the fund before the Commission has established an allocation formula. These payments must be assessed on an equitable basis and should equal in total the funding obtained from defendant participants in the same period of time. The Administrator may also pursue a civil action against any reinsurer that fails to comply with its obligations under the Act and request treble damages, and may seek relief against the direct insurer if unable to collect from the reinsurer.

Captive insurance companies are exempted from contributing to the Fund, except to the extent they have liability for asbestos claims other than those of its parent and those affiliated with its parent. A captive insurance company is defined as one incorporated before 2003 which is entirely owned by a defendant participant or the ultimate parent of the defendant's affiliated group, and whose primary commercial business from 1940 through 1986

[5] The reserves of a U.S. licensed reinsurer are included as part of the direct insurer's reserves when the reinsurer's financial results are included as part of the direct insurer's U.S. operations in its financial statements or filings with the National Association of Insurance Commissioners.

The Hatch Bill: Is an End to Asbestos Litigation in Sight?

Mary S. Lyman and Letitia Chambers

was to provide insurance to its ultimate parent or affiliated group.

Guarantees of Sufficient Funds

One of the concerns continually expressed in debate over the Hatch bill is the possibility that the Fund could have insufficient funds to pay all claimants, either in a given year or on a long-term basis, leaving the remaining claimants without recourse. The legislation contains several provisions to guard against this contingency, including:

- Authority for the Fund to borrow each year amounts up to the level of anticipated contributions to the Fund for that year.
- A guaranteed payment account, funded by a surcharge on each participant in addition to its required contribution, which will be used to pay claims to the extent the Fund contains insufficient funds due to nonpayment by any participant.
- An Orphan Share Reserve Account, to which total participant payments exceeding each year's required minimum are directed and which provides protection against nonpayment or reduced payments by participants. The money in the account will be used only if 1) a participant files for bankruptcy and cannot meet its obligations, or 2) the Administrator grants a participant relief for severe financial hardship or exigent circumstances.
- Authority for the Administrator to establish four separate lockbox accounts – one each for mesothelioma, lung cancer with asbestosis, and nonmalignant levels IV and V – to ensure that funds are available to compensate the most severely injured claimants. The portion of contributed funds allocated to each of these "lockboxes" will be based on "appropriate epidemiological and statistical studies."
- If any participant defaults on payment, a lien in favor of the United States for the amount of the delinquent payment, plus interest, will be placed on all its property. If the participant enters bankruptcy, the lien will be treated as a lien for taxes owed to the United States. The Administrator may bring a civil action in federal district court to enforce payment, and the court may assess punitive damages, legal costs, and a fine equal to the total amount of the payment owed for a willful failure to pay.

If the above safeguards fail, there are "contingent call" provisions to ensure that the assets of the Fund are sufficient to pay all eligible claimants every year, as well as a "back-end" provision to continue assessments should funding prove insufficient at the end of 27-year statutory period. Beginning after the first five years and at the end of each three-year funding period thereafter, when assessments are due to be stepped down, the Administrator may, based on the Fund's financial situation, take one of three actions

1. Continue the assessment payments at the prior rate through the next phase – i.e., cancel the scheduled step-down;
2. Approve the scheduled step-down; or
3. Approve a step-down to a level between the prior rate and the scheduled rate.

If the Administrator does not allow the full step-down, companies may take a credit for the extra "contingent call" amount paid in subsequent years, providing the Fund has sufficient resources.

If the Administrator determines that there is a need for additional financing after Year 27, the "back-end" provision authorizes a voluntary assessment of up to $1 billion from all defendants and $1 billion from all insurers each year. Participants who do not agree to pay the assessment will be subject to asbestos tort actions, but only in the federal system in the U.S. District Courts.

Annual Reports

The Administrator must submit an annual report to the House and Senate Judiciary Committees on the operation of the Fund within six months after the close of each fiscal year. As part of the Annual Report, the Administrator must certify that 95% of eligible claimants who filed during the prior calendar year have received the compensation to which they are entitled, and that 95% of the total obligations of the Fund owed to eligible claimants in the prior calendar year have been paid. If the Administrator does not make this certification, the Administrator will have 90 days to cure the failure and submit the required certification. If this does not occur, the FAIR Act and the Fund will immediately sunset and asbestos claims will be returned to tort.

This sunset provision, added by Senator Biden at markup, has caused considerable concern, as it takes away the certainty and stability for all parties that is a principal goal of the legislation. Efforts are being made to modify it before the bill is passed by the Senate.

Ban on Asbestos

The bill prohibits the manufacture, distribution, and importation of consumer products to which asbestos is deliberately or knowingly added, other than asbestos diaphragms for use in the manufacture of chlor-alkali and, subject to a review by the EPA Administrator, roofing cements, coating and mastic utilizing asbestos that are totally encapsulated with asphalt. The EPA Administrator is also authorized to hear and grant exemptions on a case-by-case basis.

lyman@navigantconsulting.com
lchambers@navigantconsulting.com

Substantive Consolidation of Insurance Companies and Non-Insurance Companies©

Deborah L. Cotton and Robert D. Aicher [1]

A. Introduction

This article explores whether precedent exists authorizing a bankruptcy court or a court supervising the liquidation of an insurance company to substantively consolidate across industries an insurance company with an entity that is not an insurance company.[2] For purposes of this article, the phrase "substantive consolidation across industries" means a court holding that the separate existence of an entity authorized as an insurance company and an entity not authorized as an insurance company are to be disregarded so that the assets of the two companies are treated as a common pool available to pay the liabilities of both companies on a parity basis and without regard to whether such liabilities originated in the authorized insurance company or in the non-authorized company. The case law surveyed below will discuss instances in which a bankruptcy court has dealt with the assets of an authorized insurance company, and, similarly, in which a court supervising the liquidation of an authorized insurance company has dealt with the assets of a non-authorized company. However, with the sole exception of Louisiana, which has a unique regulatory regime, the authors have found no instance of substantive consolidation across industries as defined above.

B. Insolvency Proceedings of U.S.-Domiciled Insurance Companies Versus Non-Insurance Companies

At the outset the obvious should be recognized. The federal Bankruptcy Code, Title 11 of the United States Code (the "Bankruptcy Code"), provides that a domestic insurance company is not eligible to be a "debtor" under its provisions.[3] Thus we begin with the fundamental proposition that no reorganization or liquidation proceeding under the Bankruptcy Code can be instituted directly against or by a domestic insurance company.[4]

Consistent with this Bankruptcy Code rule, under the McCarran-Ferguson Act, 15 U.S.C. §1011 et seq. ("McCarran-Ferguson"), federal law generally is not applicable to insurance companies with respect to matters involving the business of insurance, including conservations, rehabilitations or liquidations of insurance companies. In enacting McCarran-Ferguson, Congress reemphasized a long-standing conviction that the regulation of insurance companies, including such conservations, rehabilitations, and liquidations, should be under the sole jurisdiction of the several states and not the federal government.[5] See *Paul v. Virginia*, 75 U.S. (8 Wall) 168, 183 (1869) (insurance is solely within the domain of the states as it is not interstate commerce), distinguished by *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), and leading to the passage of McCarran Ferguson; and *Valley v. Northern Fire & Marine Ins. Co.*, 254 U.S. 348 (1920) (reiterating the strong policy favoring the state regulation of insurance companies).

Accordingly, a conservation, rehabilitation or liquidation proceeding instituted with respect to an insurance company is primarily considered under and governed by the insolvency provisions of the insurance code of the insurer's state of domicile

[1] Deborah L. Cotton is counsel in the Chicago office of Sidley Austin Brown & Wood LLP; Robert D. Aicher is a partner at the same firm. The authors gratefully acknowledge the research assistance of Joshua G. Urquhart in the preparation of the article and the comments of Jim Stinson, Mike Goldman, and T.K. Khan. *Nevertheless, the views expressed in this article are those of the authors alone. They do not necessarily reflect the views of Sidley Austin Brown & Wood LLP, any of its individual partners, counsel or associates, or its clients.*

[2] This article does not examine the question whether a court supervising the liquidation of an insurance company could substantively consolidate two or more insurance companies.

[3] Section 109 (b) of the Bankruptcy Code.

[4] This article does not examine whether a foreign insurance company (by which is meant an insurance company organized under the laws of a government other than the states that comprise the United States) could become subject to a proceeding under the Bankruptcy Code, or the rules of consolidation related thereto.

[5] Both statutes presuppose that one knows when an entity is and is not an "insurance company." However, this is not always clear. When ambiguity of this type occurs it is possible that either a bankruptcy court or a court proceeding instituted to deal with an insurance company insolvency may find itself faced with the primal question of whether the entity before it is or is not an "insurance company." Compare *In re Grouphealth Partnership, Inc.*, 137 B.R. 593, 597 (Bankr. E.D. Pa. 1992) (holding that an HMO insolvency should be adjudicated by a Federal bankruptcy court, where authorized by the commissioner of the relevant Department of Insurance) with *In Re Medcare HMO*, 998 F.2d 436 (7th Cir. 1993) (HMO is classified as an insurance company under Illinois law and therefore is not eligible to be a Bankruptcy Code debtor; Chapter 11 petition against such insurer must be dismissed). Other than noting the issue, this article does not explore in detail the case law examining whether an entity constitutes an "insurance company" under §109(b) of the Bankruptcy Code or McCarran-Ferguson. See *Note: HMO Eligibility for Bankruptcy: The Case for Federal Definitions of 109(b)(2) Entities*, 2 Am. Bankr. Inst. L. Rev. 425 (1994) and *Note: Insurer Insolvency: Problems and Solutions*, 20 Hofstra L. Rev. 727, 732-741 (Spring 1992).

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(the "Insolvency Code(s)"). While the language of the Insolvency Codes varies, such Insolvency Codes often are stated to be applicable to "all insurers that are doing, or have done, an insurance business in [the particular State]."The National Association of Insurance Commissioners ("NAIC") Model Laws, Regulations and Guidelines, Insurers Rehabilitation And Liquidation Model Act (the"NAIC Model Act") or a version thereof, has been adopted in a majority of states. Under the NAIC Model Act, the entities subject to the scope of such laws and to which such provisions are applicable generally are limited to entities engaged in an insurance business in a specified state. The NAIC Model Act does not by its terms subject entities that are not doing an insurance business, or non-insurance companies, to its provisions, even if such entity is an affiliate of the insurance company.

C. The Concept of Substantive Consolidation

The traditional equitable doctrine of substantive consolidation as developed under the Bankruptcy Code permits a court in a bankruptcy case to disregard the separateness of two or more entities and to consolidate the assets and liabilities of those entities as though held and incurred by a single entity. See, e.g., *Chemical Bank New York Trust Co. v. Kheel*, 369 F.2d 845, 847 (2nd Cir. 1966). The power to consolidate is derived from the general equitable powers of a bankruptcy court, which since 1978 have been set forth in Section 105 of the Bankruptcy Code: "The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this title." See 11 U.S.C. § 105(a). Substantive consolidation was accomplished in early cases by "piercing the corporate veil" of the debtor, i.e., by finding that the entity with which consolidation was sought was the "alter-ego" or an "instrumentality" of the debtor which was used by the debtor to hinder, delay or otherwise defraud creditors. Modern bankruptcy courts, however, almost uniformly rely on federal bankruptcy precedent rather than state corporate law doctrine when ruling on substantive consolidation motions.

The reasons justifying substantive consolidation have been traditionally stated as one of the following: either the companies were managed so as to confuse creditors concerning their separate status, or the books and records are so hopelessly confused that the cost of sorting out the respective assets and liabilities of the two companies outweighs the benefits to the respective groups of creditors in doing so.

D. What the Case Law Reveals

With the exception of proceedings in the State of Louisiana,[6] the authors are unaware of any instance in which an insolvent insurance company has been

[6] Louisiana has a statutory framework that allows state courts to substantively consolidate a authorized insurance company and a non-authorized affiliate of the authorized insurance company. See *Brown v. Automotive Casualty Insurance Company*, 644 So.2d. 723 (La. App. 1994) (under statutory provision subjecting "any related entity" to insurer's insolvency proceedings, two related subsidiaries were declared a "single business enterprise" with the insurer and were ordered liquidated with the insurer); and *Green v. Champion Insurance Company*, 577 So.2d 249 (La. App. 1991) (under statute permitting trial court to "declare rights, status, and other legal relations," court declared affiliated entities to be a "single business enterprise" with insurer; such finding "automatically vests the Liquidator with the ownership of property belonging to this single business enterprise for purposes of the liquidation"). This regulatory scheme appears to allow substantive consolidation across industries by a court supervising the liquidation of a Louisiana insurance company, subject to the criteria that the entities be related. But see, *Note: The Single Business Enterprise Theory of Louisiana's First Circuit: An Erroneous Application of Traditional Veil-Piercing*, 63 La. L. Rev. 75 (Fall, 2002).

In addition to Louisiana, it appears that the State of Illinois also may have a legislative framework that could permit substantive consolidation across industries. In 2001, the Illinois legislature revised Section 5/187 of the Illinois Insolvency Code to include within the defined term "company," and thus to include within the list of entities subject to the scope of such Insolvency Code, the following persons or entities:

> "agents, managing general agents, brokers, premium finance companies, insurance holding companies, and *all other non-risk bearing entities or persons engaged in any aspect of the business of insurance on behalf of an insurer* against which a receivership proceeding has been or is being filed under this Article, *including, but not limited to, entities or persons that provide management, administrative, accounting, data processing, marketing, underwriting, claims handling, or any other similar services to that insurer*, whether or not those entities are licensed to engage in the business of insurance in Illinois, *if the entity or person is an affiliate of that insurer."* (Emphasis added).

The additional entities now included within the defined term "company" in the first clause above must be "engaged in" some aspect of the business of insurance, must be so engaged "on behalf of" the insurer and must be an affiliate of the insurer. As a result, it does not appear that the Illinois statute authorizes full blown substantive consolidation across industries. Under the traditional substantive consolidation doctrine as developed under the Bankruptcy Code, assuming other criteria are met (overlapping boards, overlapping officers, commingling of funds, administrative difficulty is separating assets, confusion of identity among creditors, etc.), the entities do not have to be engaged in a common line of business. By contrast, even if all the traditional bankruptcy substantive consolidation criteria are met, the Illinois statute does not appear to permit an insurance company to be consolidated with a company in a line of business unrelated to insurance. Under the bankruptcy analysis this fact alone would not be determinative. Perhaps, however, ultimately, the requirement of being engaged in some aspect of the insurance business will be read so broadly as to become meaningless. The statute itself seems to suggest this result. By including as being in the "insurance business" the particular listed businesses, such as accounting, data processing and marketing, none of which is considered to be conducting an insurance business per se, the language opens the possibility that "engaged in the insurance business" may mean little more than providing services to an insurance company.

As the revised Illinois statute has not yet been tested in the Illinois courts, there has, of course, been no definitive judicial statement regarding its meaning, scope, or efficacy. As such, the above discussion is little more than speculation on the part of the authors, and should be treated accordingly by the reader.

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substantively consolidated with a non-insurance company under a theory based on either state insurance law or federal bankruptcy law.[7]

Notwithstanding the dearth of substantive consolidation cases, there are numerous examples in which a bankruptcy court in a proceeding involving a non-insurance company debtor has dealt with or affected an insurance company affiliate. Likewise, state insurance company insolvency proceedings can and do affect non-insurance company affiliates.

For example, in certain limited instances, courts overseeing the conservation, rehabilitation or liquidation proceedings of insurance companies have exercised in rem jurisdiction over certain of the assets of an affiliated entity. Such an approach generally has been based upon substantial identity of the entities, concepts related to "alter ego" or "piercing the corporate veil" principles. See, e.g., *Garamendi v. Executive Life Ins. Co.*, 17 Cal. App. 4th 504, 523 (Cal. Dist. Ct. App. 1993) (partnerships owned 92% by insolvent insurer were "identical in interest with insurer" and the court could exercise in rem jurisdiction over assets that were "nominally partnership property" for purposes of enjoining actions affecting those assets and to adjudicate claims to those assets), related proceeding, *Morgan Stanley Mortgage Capital Inc. v. Commissioner*, 18 F. 3d 790, 794 (9th Cir. 1994) (wherein the court noted that "state insolvency courts must necessarily have jurisdiction somewhat analogous to the jurisdiction enjoyed by bankruptcy courts to attach the assets of entities closely affiliated with an insolvent debtor" and the plaintiff's argument "falls short of saying that the Bankruptcy Code's exception of insurance companies from the exclusive jurisdiction of bankruptcy courts strips state insolvency courts of all jurisdiction over the assets of entities that are not themselves insurance companies"). Also to this effect is *In re Mutual Benefit Life Ins. Co.*, 609 A.2d 768 (N.J. Super. Ct. App. Div. 1992) (restraining orders may be issued by a state court overseeing the insolvency proceedings of an insurance company to prevent indenture trustees from foreclosing on real estate financed with bonds for the benefit of insurer's related non-insurance affiliates). However, a careful reading of these cases does not reveal that the assets and liabilities of the entities were pooled. Rather, these cases stand for the proposition that the state insolvency court may exert jurisdiction over the non-insurance company assets to prevent a precipitous liquidation of the assets.

Additionally, courts in insurance insolvency proceedings have at times subjected non-insurance company affiliates to orders of the insolvency court in order to provide compensation to the insurance company for damages caused by non-insurance companies. See *Four Star Insurance Agency et. al. v. Hawaiian Electric Industries et. al.*, 974 P.2d 1017 (Haw. 1999) (liquidator of three insurance companies sued and obtained cash settlement with parent non-insurance company based upon parent's mismanagement and draining financial assets from insurers); *Corcoran v. Frank B. Hall & Co.*, 149 A.D.2d 165 (N.Y. App. Div. 1989) (liquidator of insurance company sued parent holding company to recover full amount required to pay claims against the insolvent estate, alleging that holding company acquired insurance company and operated it for the sole benefit of the parent and parent's other subsidiaries, causing insurer's insolvency; liquidator had authority under New York Insurance Law to bring rights of action of the insolvent insurer). Receivers also have filed suits for damages against the officers and directors of insolvent insurers, alleging negligence and breach of fiduciary duty, see, e.g., *Koken v. Steinberg*, No. 421 MD Pa., 2003 Pa. Commw. LEXIS 370 (Pa. Commonwealth Ct. 2003), and *Covington v. Pipoly*, No. 02CV 435 (Ct. of Common Pleas of Franklin County, Ohio 2002), in attempts to recover funds to place in the insolvent estate. One court recently noted "a trend toward recognizing 'deepening insolvency' as a cause of action against a party who creates the false appearance of solvency in an insurance company or other financial institution." See *Florida Department of Insurance v. Chase Bank of Texas National Association*, 274 F.3d 924, 935 (5th Cir. 2001). Significantly, such actions, to the authors' knowledge, have not included actions for substantive consolidation of affiliated entities.

In at least one instance, a bankruptcy court has subjected an insurance company or companies affiliated with the bankruptcy debtor to orders of the bankruptcy court, but once again the court stopped short of substantively consolidating the companies across industries. See *In Re Equity Funding Corp.*, 396 F. Supp. 1266, 1275 (C.D. Cal. 1975) ("Congress sought to prevent bankruptcy or reorganization courts from interfering with comprehensive state insurance regulations and with the rights of insureds protected by such regulations (citations

[7] We note that in Weil and Horwich, *Substantive Consolidation in Insurance Company Insolvency Proceedings*, Newsletter of the International Association of Insurance Receivers 10, 12 (Winter 1997), in addition to noting the line of Louisiana cases, the authors refer to unpublished trial court orders in a Missouri insurance insolvency proceeding in which the court ordered the substantive consolidation of three alien insurers and three non-insurer affiliates with the insolvent insurer, based on alter ego findings, and *permitted the liquidator to "treat the assets and liabilities of the Defendants which he determines to be derived from the insurance business of the Defendants* as belonging to a single business enterprise…" (Emphasis added).

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omitted). As the language of Section 4 [of the Bankruptcy Act of 1898, the predecessor provision to Section 109 of the Bankruptcy Code] suggests, Congress determined that interference with state insurance regulations would not occur as long as bankruptcy courts did not reorganize insurance companies or adjudge them to be bankrupts. … Since the exercise of this power [to adjudicate certain claims against the insurance subsidiary in the parent's bankruptcy proceedings] does not interfere with state liquidation proceedings, it is consistent with congressional intent to preserve exclusive state jurisdiction over the liquidation of insurance companies. … [T]his court's exercise of summary jurisdiction over these controversies will transform them from claims against the assets of the [insolvent insurer] to claims under the plan of reorganization."). Cf. In re Island Mortgage Corp., 18 F. Supp. 448, 449-50 (E.D.N.Y. 1937) (wherein the court declined to assume federal bankruptcy jurisdiction over an insurance company in a bankruptcy proceeding involving a noninsurer affiliate).

Finally, in *Shapo v. Engle*, 1999 U.S. Dist. LEXIS 11231 (N.D. Ill. 1999); and *Kaiser v. Stewart*, 965 F. Supp. 684 (E.D. Pa. 1997), motion for recon. granted in part and denied in part, 1997 U.S. Dist. LEXIS 12788 (E.D. Pa. 1997), the liquidators of insurance companies domiciled in Illinois and Pennsylvania, respectively, brought civil actions under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") statute, 18 U.S.C. §1961 et seq., against officers and directors and against parent, subsidiary, and affiliated entities of the insolvent insurers, claiming the defendants had engaged in conspiracies to divert assets from the insurance companies to the non-insurance companies and the individuals, and thus leading to the insolvencies of the insurers. While both actions were ultimately unsuccessful in meeting the requirements under the particular subsections of the RICO statute under which the liquidators were suing, in both cases the relief sought in the complaints was not substantive consolidation or even a return of the particular assets alleged to have been diverted, but monetary actual, statutory treble, and monetary punitive damages. The variety of actions brought in the cases discussed above may demonstrate that, even without substantive consolidation, a sufficient array of actions, claims, and remedies already are available to deal with assets of insolvent insurance companies and their non-insurance affiliates.

E. Policy Considerations

While an examination of the case law reveals no instance in which a court has ordered substantive consolidation across industries, there is also no definitive statement that it may not be done. Accordingly, the issue remains open to debate. As such, it may be useful to consider whether there exist unique compelling arguments in the context of insurance companies either for or against the prospect of substantive consolidation across industries.

There do not appear to be unique compelling arguments supporting substantive consolidation across industries. Nevertheless, the standard justifications offered in the bankruptcy context appear to have the same persuasiveness in the context of a potential consolidation of an insurance company and a non-insurance company. It seems apparent that these reasons, confusion of separate identities, or costs outweighing the benefits of unscrambling books and records, could be equally applicable to and compelling in the context of a similarly abused insurance company.

There are, however, unique considerations applicable to an insurance company that could argue against the application of substantive consolidation across industries even in the presence of compelling traditional arguments.

Unlike traditional debtors eligible for relief under the Bankruptcy Code, insurance companies are subject to a complex scheme of state regulation. As discussed above, the very reason that the Bankruptcy Code excludes insurance companies, and state Insolvency Codes traditionally exclude non-insurance companies, is to respect this unique regulatory environment. In substantively consolidating two entities under the Bankruptcy Code, the primary decision that must be faced by a bankruptcy court is what is in the best interests of the creditors as a matter of equity. Since either entity could have filed a proceeding under the Bankruptcy Code directly there is no need to address the reasons why one or the other was explicitly excluded from doing so. This is not the case with insurance companies. In addition to what is in the best interests of creditors, a court must also determine that it reasonable to do in an indirect way, by substantive consolidation, what the United States Congress and State legislatures have already decided could not be done directly.

The core of state regulation of insurance companies is premised upon the maintenance of the financial viability of a particular entity with the goal of assuring its particular policyholders will be paid. While it is obvious that insurance companies have creditors, it is also clear that the primary thrust of insurance company regulation is to assure that the policyholders are paid. In order to facilitate this result, the financial status of each insurance company has traditionally stood alone and unconsolidated with its affiliates, even those affiliates that are themselves in the insurance business. This is buttressed by the use of special accounting standards applicable to insurance

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companies, generally referred to as statutory accounting principles ("SAP"). The application of SAP treats each insurance company as a stand-alone entity. SAP emphasizes a determination and a presentation of the insurance company's assets and liabilities in a manner that demonstrates the sufficiency of surplus or reserves to pay policyholders. Substantive consolidation is essentially judicial equity creating a new company, the "consolidated entity," as a means of doing fairness to creditors. The problem with this is that from the point of view of the regulators and SAP, no such company ever existed prior to the insolvency proceeding. By a court's creating such a fictional consolidated entity it is possible that in seeking to do equity for creditors in the broad sense, it may be undermining the regulatory goal of assuring payment of policyholders by sweeping in assets and liabilities the regulators never envisioned as part of the regulated insurance company.

The most obvious example of potential regulatory frustration may be seen in the resulting conundrum of what scheme of priorities should be followed in the distribution of assets of the newly consolidated entity. In the event of insolvency of an insurance company, the distribution schemes of state Insolvency Codes give priority to policyholders before general creditors.[8] In contrast, the Bankruptcy Code gives priority to secured and then unsecured creditors, using a statutory distribution scheme that has evolved over many decades and that has been heavily influenced by notions of fairness held by legislators at a given moment in time.[9] It is possible that substantive consolidation of an insurance company with a non-insurance company would frustrate the purpose of both the Bankruptcy Code's and the Insolvency Codes' distribution schemes.

F. Substantive Consolidation – Conclusion

As stated above, the authors have found no published instance (other than in Louisiana) of a court holding that the separate corporate entities of an insurance company and a non-insurance company are to be disregarded so that the assets of the two companies are treated as a common pool available to pay the liabilities of both companies on a parity basis and without regard to whether such liabilities originated in the insurance company or in the non-insurance company. What has been found are a number of cases in which courts have *affected* the assets of an entity otherwise not eligible for the insolvency scheme being administered, but stopping short of a substantive consolidation across industries. This combination of a lack of case law implementing substantive consolidation across industries together with a body of case law that stops just short of doing so, in fact, simply may be the recognition of a more fundamental reality: that the substantive consolidation of an insurance company with a non-insurance company involves very difficult questions of policy that are best avoided by courts and left to legislators, if and when they see the need.

dcotton@sidley.com
raicher@sidley.com

[8] Although the Illinois Insolvency Code includes a category for secured claims within the priority of distribution statute, 215 ILCS 5/205(1)(b), and the secured creditors' category is higher than the policyholder distribution level, most other states' Insolvency Codes do not provide secured creditors' claims with a separate category in the priority of distribution of assets. See NAIC Model Act,. §47.

[9] See, for example, Sections 507, 510, 726 and 1129 of the Bankruptcy Code.

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George K. Bernstein

An attorney in Washington, D.C. and New York City, Mr. Bernstein represents investors, insurers, producers, state insurance departments, the federal government and international organizations on matters involving insurance regulation, solvency, restructuring and reinsurance. He is an expert witness in state and federal courts and before Congress and state legislatures.

He received his BA and LLB from Cornell University. He was a New York State Assistant Attorney General and was Deputy Superintendent and General Counsel and then First Deputy Superintendent of the New York Insurance Department.

From 1969 to 1974, he served as the first Federal Insurance Administrator, in the U.S. Department of Housing and Urban Development. While at HUD, he was also Administrator of the Office of Interstate Land Sales Registration. During this time he was also insurance advisor to the White House and frequently testified before Congress on behalf of the Administration.

Mr. Bernstein is a recipient of HUD's "Distinguished Service Award" and the "Torch of Liberty Award" of the B'nai B'rith Anti-Defamation League.

Since 1983, he has been Vermont Special Deputy Commissioner of Insurance in four property-casualty insurer liquidations and one successful life insurer rehabilitation.

He has served on numerous Presidential and state commissions, authored articles and studies on insurance and disaster mitigation and chaired several commissions for the Federal Emergency Management Agency. He was twice Chairman of the Insurance Committee of the Association of the Bar of the City of New York.

He and his wife, Caryl, who was formerly General Counsel of Fannie Mae, are partners in the Bernstein Law Firm.

Robert L. Brace, AIR-Legal

Robert ("Rusty") Brace is an AV rated contingency fee plaintiffs' lawyer residing in beautiful Santa Barbara, California, where he grew up. Since the early 1990's (the last hard market), Mr. Brace has been involved in representing policyholders, liquidators and independent fiduciaries of no-asset estates to recover funds to pay claims. The legal work at Hollister & Brace, his firm, includes fronting the funds necessary to operate a claims administration center.

The litigation brought by Mr. Brace has included enforcement of NAIC Standard Form Trusts, malpractice actions against thousands of insurance producers, malpractice actions against attorneys and accountants, a RICO action against a national financial corporation and claims brought against fiduciaries under ERISA.

Recently, Mr. Brace was retained to represent Thomas Dillon, a court appointed Independent Fiduciary, to prosecute a malpractice case against 400 insurance producers arising out of the Employers Mutual LLC health insurance scam which left over $50,000,000 in unpaid medical claims owed to 30,000 participants of small employer ERISA plans.

Mr. Brace received his undergraduate degree from U.C. Berkeley and a law degree from the University of Colorado. He was designated an Accredited Insurance Receiver Legal by IAIR in December 2002. He speaks frequently at insurance insolvency related functions, and he has numerous published opinions on insurance related issues.

Time off from work is spent with his wife and two children. Passions include surfing, hunting and gardening.

Meet Our Colleagues

Joe DeVito

Kenneth A. De Koven

A native of New York City, Kenneth A. De Koven is a graduate of New York University and the University of Miami School of law. He has practiced in the area of insurance and reinsurance in the New York City metropolitan area for over 20 years. He is presently General Counsel of Integrity Insurance Company. For the last nine years Mr. De Koven has headed up the in-house legal department of this insolvent estate, having supervised all of its insurance and reinsurance litigation and arbitration issues, as well as having drafted a unique final dividend distribution plan that encompasses the innovative concept of a contingent claims estimation process, allowing the estate to reach substantially earlier closure than would otherwise occur. In addition, he has been called upon to formulate proposed revisions to state insurance statutes by the New Jersey Commissioner of Banking and Insurance.

An active member of IAIR who sits on the Membership Committee, Mr. De Koven also participates in the committee work of the National Association of Insurance Commissioners, currently serving on the NAIC Model Act Revision Working Group and the NAIC Receivers Handbook Working Group. He is a contributing author to the indispensable *NAIC Receivers Handbook for Insurance Company Insolvencies* (2nd Edition).

Mr. De Koven previously served as counsel for the New York Superintendent of Insurance as Liquidator. Here, as well, he was called upon to contribute to the improvement of the relevant statutes, having drafted proposed amendments to the New York Insurance Law. Prior thereto, he was an insurance/reinsurance practitioner with a large national law firm headquartered in New York City and was Assistant Corporation Counsel for the City of New York. In a "different life," he served as Counsel to and managed a theatrical entertainment materials licensee/distributor, even pinch-hitting onstage on Broadway for several clients.

He and his lovely wife, Jo-Ann, enjoy sharing their leisure time with their beloved canine companions, MacGyver and Kira, all of whom enjoy cruising Adirondack lakes and streams in their classic 1938 mahogany speedboat, the *Jo Jo Star*.

Trish Getty, AIR-Reinsurance

Trish Getty is Director of Marketing and Senior Vice President of Randall America who offers insurance company exit strategies, primary and reinsurance run-off administration and P&C company acquisition opportunities. She began her reinsurance career 31 years ago at Berkshire Hathaway in Omaha where she served as the reinsurance claims supervisor for 12 years.

When Warren Buffett moved his reinsurance division to Philadelphia in 1984, she spearheaded the claims transition but due to family commitments remained in Omaha and began her work with Central National/Protective National of Omaha. Much to her chagrin, this company went into voluntary supervision shortly after her arrival but that event actually catapulted her into the troubled company arena that has since occupied the majority of her career. Protective National had to bring in-house the run-off of multiple MGA's requiring her to set up, staff and train the assumed and ceding facultative and treaty reinsurance claims departments. She developed her skillsets during those five years and has applied them to achieve efficiencies in run-off and liquidation reinsurance administration. Trish's personal goal is to increase the distribution to creditors through qualified, efficient administration of liquidations.

After seven years of IAIR membership, she has served on the IAIR Board of Directors for nearly three years, has chaired the IAIR Marketing Committee since its inception in June of 1999 and sits on the International, Education and Publication committees. The opportunities she most enjoys is meeting and getting to know people, many who remain lifetime friends.

Trish and her husband, Tom, reside in an Atlanta suburb, Alpharetta, where she spends most of her spare time gardening, cooking, home decorating or boating with their cocker spaniels on Lake Lanier. Trish's daughter and son-in-law, Toni and Matt, reside in San Diego where Matt practices medicine. Tom's children, Tom III and Liz, attend colleges in Georgia.

jjdevito1@cs.com

Recent Developments in European Solvency Regulation

Morag Elaine Fullilove [1]

Background on the EU Process

For readers less familiar with the government of the European Union, it is important to briefly review the structure of governance under which the new solvency laws will be developed. There are five key EU institutions which shape laws and regulations:

- European Parliament (elected by the peoples of the Member States)
- Council of the European Union (composed of the governments of the Member States)
- European Commission (driving force and executive body)
- Court of Justice (compliance with the law)
- Court of Auditors (management of the EU budget)

Of these, the European Commission which prepares legislation and ensures implementation of those laws is the driving force in the development of new solvency regulations. The Commission itself is divided into several Ministries. Insurance falls in the Financial Services section of the Internal Markets Ministry, charged with establishing a single market for financial services within the European Union by 2005. Within Financial Services, the Insurance Unit is headed by David Deacon and policies are reviewed by the Insurance Committee composed of representatives appointed by the insurance supervisory and regulatory agencies in the 15 Member States of the European Union.

The Commission itself usually follows a process comprised of the following steps when preparing proposals:

- Appointment of a Working Group or Subcommittee
- Commissioning a study to establish a framework for debate
- Agreement on principles
- Requesting additional research
- Drafting of the regulation or directive
- Acceptance of the directive
- Referral of the proposed legislation to the Council of the European Union and Parliament
- If adopted, implementation by the Member States

This multi-step process can take several years before directives are implemented. For example, the current Solvency II process which began in 2000 is not expected to be completed until 2007.

Although the Commission welcomes comments, there are no open meetings laws within the Commission and most of the insurance debate is closed until the Parliamentary stages. Actions taken by the Insurance Committee, drafts, and studies are available on line on the website Europa and then by following the path: Institutions/Commission/Internal Markets/Financial Services/Insurance *(http://Europa.eu.int/comm/internalmarket/en/finances/insur/index.htm)*

Current European Activity

The solvency activity of the European Commission began with changes to the 1970s insurance regulatory laws. These directives (one for life insurance and the other for non-life insurers) update the solvency margins, generally referred to as the Solvency I, were adopted by European Parliament Council of the European Union in 2002 and are to be in force by 2004.

In 1999, the Commission decided that a broader review was needed and over the course of the last three years has embarked on proposals addressing:

- Reinsurance Supervision
- Guaranty Schemes
- Solvency II

Reinsurance Supervision

A key piece of solvency regulation for the EU has been the establishment of a harmonized scheme of supervision of reinsurance. Currently there is no common accepted method of reinsurance supervision within Europe. A proposed directive is being prepared for the Insurance Committee and may be finalized by the end of the year. The proposal would provided for a common form of certificate for a reinsurer (Single Passport) which would allow the reinsurer to do business throughout the European Union without further approval or registration. The draft directive specifies the minimum guaranty fund requirements, solvency margins as a percentage of claims and premiums, the reinsurance reduction factor, asset coverage of the whole solvency margin, and use of the amounts set aside as equalization reserves. The Commission tested the proposals though simulation exercises. The proposal, in general, has been supported by the European insurance community.

Guaranty Schemes

In November 2001, a Working Group was appointed by the Insurance Committee to examine the problems arising from the lack of harmonization of the various Member States of the European Union. In April 2003, the Insurance Committee

[1] Morag Fullilove is the founder and principal of The Fullilove Consulting Group, a public affairs firm based in Chicago and Brussels.

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reviewed a report from the Working Group which found that although only a few Member States at the moment had guaranty systems, many more were currently considering them because of recent insolvencies and the instability of capital markets. The report also found that the current lack of harmonization among guaranty schemes led to gaps and overlaps in coverage of existing schemes, lack of protection, and lack of an equal playing field.

The Working Group recommended that there be a mandatory requirement for a guaranty scheme in each EU Member State. The requirement would define the claims to be covered, set the minimum levels of protection, define procedures, and establish rules for dealing with third country branches. The recommended directive would leave national legislation to set funding, structure and management of the schemes. Following considerable debate, the Insurance Committee did not accept the recommendations in the report at its April meeting, with several members expressing concern over the high cost of such systems and the moral hazard presented by the funds. Others were concerned that this issue should be left to Members' States, and some members did not view the issue as a priority.

The Committee did charge the Working Group to continue its research with the aim of establishing appropriate minimum protection levels in the future. In late June, the Working Group began a survey of the insurance supervisors in the Members States regarding guaranty schemes. Further debate will take place in July including presentations by Member States which have guaranty schemes. The Commission staff strongly supported the recommendations of the Working Group and is expected to represent the recommendations for a harmonized guaranty system at a future meeting.

Solvency II

In 1999, the Commission undertook a fundamental review of the overall financial position of the insurance industry and the supervision needed for that industry. The stated purpose of the project, know as Solvency II, is "to review all the prudential rules in the insurance field with a view to devising a solvency system which is more sensitive to the risks incurred by insurance companies and enables supervisors to protect policy holders' interests as effectively as possible and in accordance with common principles." The project was divided into two phases, the first one consisting of studying the solvency system (2001–early 2003) and the second, more technical phase, devoted to the details of developing the new system.

The goals as set forth by the Insurance Committee were to develop proposals which were:

- Not overly proscriptive
- Avoided undue complexity
- Reflected market developments
- Based on common accounting principles

The majority of the work on Solvency II has been undertaken by the Solvency Subcommittee and two working groups; one composed of experts from the Members' States and the other of actuaries. In addition, working parties have been established by the Conference of European Insurance Supervisors to assist in the project.

In addition, public comments have been sought in writing and hearings in December 2002. In addition, the Commission has drawn on the resources and advice of the International Association of Actuaries, the Groupe Consultatif of European Actuaries, the International Accounting Standards Board and the International Association of Insurance Supervisors in its deliberations.

In all its work, the Commission has considered the approaches taken to financial services and banking regulation in the European Union in an attempt to develop a compatible structure.

KPMG Study

In preparation for the debate, the Commission staff authorized a study by KPMG to examine:

- Technical liabilities
- Asset valuation
- Reinsurance
- Advance risk reduction techniques
- Future accounting changes
- Role of rating agencies
- Solvency margin methodologies

That study which was released in May 2002 recommended a Three Pillar Approach, similar to the regulatory structure for banking developed by the Basel 2 Accord. The three pillars are:

- Financial Resources
- Supervisory Review
- Market Discipline

Regulation for the first pillar, financial resources, would include review of the following:

- Minimum capital requirements using a risk-based approach assessed by reference to underwriting information, assets and liabilities in the financial statement
- Options for firms to graduate to scenario approaches and internal (probabilistic) models
- Group solvency requirements, taking into account additional risks at the group level
- Other prudential rules (assets and liabilities)

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The report contained a detailed review of various solvency margin requirement methodologies, including risk based capital and recommended an approach which takes into account underwriting, credit, and market risks. The researchers favored the results of the probabilistic models, but for practical reasons, they suggested that the scenario based approaches may be the model worth further development.

The second pillar, supervisory review would consist of an assessment of the strength and effectiveness of risk management systems and internal controls, including a review of exposures (and reinsurance), internal risk models, stress testing, fitness and propriety of management, and asset/liability mismatch.

The third pillar, market discipline, would require disclosure to create transparency, allowing market participants to assess key information on capital, risk exposure and management processes. Disclosure requirements would include information on risks and scenario analysis.

Sharma Report

In addition to the extensive KPMG study, research was also undertaken by the Conference of European Insurance Supervisors in a report named after the chair of the committee, Paul Sharma. This interesting report examined recent insurance company insolvencies and near-insolvencies. Through these case studies, the report attempted to identify not only the cause and effect of the failures, but produced a compendium of regulatory, detection, prevention, and intervention tools used by the various authorities. The Sharma Report, like the KPMG report, is available on the Commission's website at the address listed above.

The report concludes that market forces as well as regulatory control help protect the policyholders and that regulation must balance these two forces. This balance argues for increased disclosure and transparency to policyholders and shareholders.

The writers recommend a three part approach to regulation, similar to that outlined in the KPMG report. Regulation should address risk in three ways:

- Ensure that insurers are financially able to cope with the risk to which they are exposed
- Use a range of early warning systems and diagnostic tools to detect and correct threats to solvency before they materialize
- Pay attention to internal factors such as corporate governance, suitability of management, and risk management systems

It also advocates regulatory intervention at any stage where a problem may arise. The report suggests that triggers for intervention may vary depending upon a company's financial circumstances, although no method for calculating the triggers is defined.

Common Themes

Both the KPMG Study and the Sharma Report identified common themes which have given direction to the proposals developed for Solvency II. Signaling an expansion of regulatory focus, both studies stressed the role of corporate governance and management issues in insurance regulation. Increased transparency was also an important new theme in the reports. These conclusions suggest that the new solvency regulations will require greater disclosure to regulators and the public. The need for improved tools, both preventative and curative, was a focus of both research papers. In addition, they both suggested the use of target capital requirements to replace solvency margin standards.

Finally, the reports stressed the need to adopt international accounting standards for insurance. In this light, the Commission is closely following the work of the International Accounting Standards Board (IASB), both in the phase I regulations reflected in IAS 32 and 39 and the work on the more sweeping phase II standards to be developed next year.

Guiding Principles for the Future Solvency System

In April, the Commission presented its recommendations to the Insurance Committee based on the discussions on the Solvency Subcommittee in a report entitled "Solvency II: Orientation Debate – Design of a Future Prudential Supervisory System in the EU." This paper, available on the website, outlines the principles to be used in developing the directive.

The recommendations were designed to provide consistency between regulation of the financial sectors, especially insurance and banking, provide for better supervision of insurance groups and financial conglomerates, and allow for adjustments to future international developments.

The Insurance Committee adopted a solvency approach based on the three pillars of the Basel 2 Accord as outlined in the KPMG report. This direction was supported by all 15 Member States. The Committee recognized that the new system needs to place greater emphasis on the real risks encountered by insurance undertakings and stressed that detailed (quantitative and qualitative) rules be developed. Some observers have felt one difficulty in the implementation of existing prudential supervision rules in the EU has been the lack of regulations. The Committee also

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directed that the new supervisory system provide for adoption of international accounting standards, in principle, but indicated that additional analysis needs to be done in application of those standards to insurance, reflecting the growing debate in the insurance community of the direction being taken by the International Accounting Standards Board on insurance accounting standards. The Committee wished to make sure that supervisory requirements and other issues specific to insurance be adequately addressed.

In its debate, the Insurance Committee agreed with the Commission that under Pillar 1 (Financial Resources) two different types of capital requirements be developed: a target level which would reflect the economic capital needed by an insurance company to operate with a low probability of failure and a "safety net level" which would be the trigger for supervisory intervention. Companies would be allowed to use internal risk models for the calculation of their target capital, but not the minimum level.

In addition, the Committee asked that Pillar 2 (Supervisory Review) consist of a set a measures aimed at enhancing internal risk management with an insurance company as well as promoting convergence in supervisory practices.

There was considerable debate on the costs of the new regulatory scheme and the difficulties of standardizing internal models, especially for Pillar 2. The Commission has suggested standards for onsite inspections, principles to insure transparency of supervisory action, and a peer review process for national regulators to ensure harmonization. Some members supported a peer review process, while others thought is was premature to do so.

Current Activity

The Insurance Committee meeting in April marked the end of phase one of the Solvency II project. The Commission is now beginning phase two which will culminate in the preparation of a directive on insurance supervision.

The Commission is beginning to staff up for further development on Solvency II and has recently hired Pauline De Chattillon of the French insurance supervisors (Commissaire Controleuse des Assurances) to work on the Solvency II project.

The Conference of European Insurance Supervisors has been asked to review the Commission recommendations. The Conference has appointed a second working group to draw up principles for internal supervision of insurance companies as part of the Solvency II project.

The Commission is now preparing an outline of phase two of the solvency project, including a time line, for presentation to the Insurance Committee. An outline of a proposed directive will be completed this fall, although drafts will not be finalized for a year or more. It is anticipated that the new rules would not be in force in the Member States until 2007 or 2008.

Although these laws will directly affect European insurers, the impact of these wide-ranging changes will certainly influence the shape of insurance supervision in other jurisdictions, especially if the rules develop alternatives to a risk based capital approach. In addition, as the pressure for a more open global insurance market grows, the quality of home state regulation will continue to increase. For these reasons, all those involved with the insurance industry will find this development worth watch.

fullilovеconsulting@rcn.com

The IAIR Board of Directors Needs You!

The Nominations Committee is now accepting applications for the IAIR Board of Directors. If you are interested (or you know an IAIR member interested) in serving a three-year term, please let us know. If you are nominating someone other than yourself, you must also submit a written statement from that person that if elected, they are willing to serve. The Nominating committee does not process any nominations without this statement from the nominee.

To serve on the Board of Directors you must be a current IAIR member, you must be willing to attend all Board meetings (which are generally held at the quarterly NAIC meetings). The election will be held at the December 2003 IAIR annual meeting in Anaheim, California.

This year there are five positions expiring and two of those parties are not eligible to run again because they have served two full terms. We need at least two, but attempt to have three, candidates for each open position. We also try to have representation from all disciplines within the IAIR membership (i.e., receivership, guaranty fund, industry, etc.) as well as international and individuals with the AIR/CIR designations.

Nominees will be required to provide a brief paragraph describing their qualifications or why they would like to be elected, as well as a recent photograph, for the proxy mailing to the membership. The deadline for nominations is October 1, 2003.

If you want to submit a candidate's name, please e-mail Mike Marchman, CIR-ML, Chair of the Nominations Committee at *marchmanm@aol.com* or contact Paula Keyes, Executive Director, at *pkeyes@iair.org*.

Receiver's Achievement Report

Ellen Fickinger

Mark Tharp (AZ) reported on **Premier Healthcare of Arizona, Inc.**, an Arizona health care services organization that was placed into receivership on November 16, 1999. As a result of its Proof of Claim process, the Receiver filed *Receiver's Report of Claims, Recommendations on Claims, and Recommended Procedures Regarding Claims*, in September, 2001. Subsequently, as a result of objections filed to that Report, hearings were held on several issues, the most significant of which was whether under the Arizona statute, contract provider claims fall within Priority Class 7, Claims of General Creditors, or Priority Class 3, Claims Under Insurance Policies and Contracts. On January 14, 2003, the Superior Court, Maricopa County Arizona, issued its Order that medical providers that had contracts with **Premier** are deemed Class 7 creditors, pursuant to A.R.S. §20-629, Priority of Distribution. The Court further ordered that those medical providers not having a contract with **Premier** are Class 3 creditors. A second issue resulting from the process involves whether claims filed after the bar date can be considered timely filed rather than late-filed claims per A.R.S. §20-629.A.8 and A.R.S. §20-640. Both issues are pending appeal.

American Mutual Reinsurance in Rehabilitation, currently under OSD supervision, continued to manage the reinsurance run-off of their business per **Mike Rauwolf (IL)**. Total claims paid inception to date for Loss and Loss Adjustment Expense total $30,449, reinsurance payments total $161,619,359 and LOC Drawdown disbursements $9,613,386. Also under OSD supervision, **Centaur Insurance Company, In Rehabilitation**, continues to manage the run-off of their business as well. Total claims paid inception to date for Loss and Loss Adjustment total $53,294,688, reinsurance payments total $4,945,493 and LOC Drawdown disbursements $13,876,555.

James A. Gordon (MD) reported additional collections during the 1st quarter of 2003 totaled $448.91 for **Grangers Mutual Insurance Company**.

Further reporting received from **W. Franklin Martin, Jr. (PA)** regarding **Fidelity Mutual Life Insurance Company (FML) in Rehabilitation**. As of 12-31-02 **FML** showed a statutory surplus in excess of $98,000,000 after reserving for all policyholder liabilities and paying most creditors. Claims continue to be paid at 100% and policyholders have full access to their cash value. The Rehabilitator is paying out approximately $42.5 million in policyholder dividends in 2003. The Rehabilitator was unable to resolve certain issues with the Policyholder Committee concerning the calculation of non-guaranteed elements after Closing. Actuarial affidavits and dispositive motions have been filed with the Commonwealth Court explaining their respective positions and it is anticipated that the Court will rule on those issues this summer. Consequently the bid process for implementing the Third Amended Plan for Rehabilitation will be further delayed.

Evelyn Jenkins (TX) reported Texas receivership distributions for this period totaled $18,681,011. **Professional Benefits Insurance Company** made a final distribution of $1,778,709, including $1,422,308 to the Texas life guaranty fund. **Comco Insurance Company** made a final distribution of $15,180,975, including $2,483,902 to the Texas P&C guaranty fund. **Bankers Commercial Life Insurance Company** made a final distribution of $1,721,327, including $1,717,571 to the guaranty funds of thirteen states.

TDI Liquidation Oversight facilitated the submission of a closing application for **Texas Employers Insurance Association (TEIA)** by arranging for a related company (Employers Casualty Company (ECC) in receivership) to purchase the outstanding **TEIA** receivables.

Recoveries for this period include a D&O settlement resulting in $166,000 for **Legal Security Life Insurance Company**. **Colonial Casualty Insurance Company** recoveries include premium and claims reimbursement collections of $203,174, reinsurance recoveries of $321,012 and subrogation recoveries of $58,149 for a total of $582,335. **Millers Insurance Company** recoveries, totaling $2,177,916, include statutory deposits of $1,749,619, reinsurance of $184,430, agent balances of $138,331, subrogation of $60,700 and premium tax refunds of $44,836.

New Texas receiverships include **Guarantee Insurance and Annuities Company**, which was placed in temporary receivership on April 29, 2003. No Special Deputy Receiver will be appointed. **Western Indemnity Insurance Company** was placed in receivership in June, 2003; a Special Deputy Receiver had not been appointed at press time. Craig Koenig was appointed Special Deputy Receiver for **Millers Insurance Company**.

efickinger@osdchi.com

Receiver's Achievement Report

Ellen Fickinger

Ellen Fickinger, Chair

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); Evelyn Jenkins (TX)
International: Jane Dishman (England); John Milligan-Whyte (Bermuda)

Our achievement news received from reporters for the first quarter of 2003 is as follows:

RECEIVERS' ACHIEVEMENTS BY STATE

FLORIDA (Mary Schwantes, State Contact Person)

Early Access Distributions

Estate	Early Access Distribution to the Florida Workers Compensation Ins. Guar. Assoc. (FWCIGA)
Armor Ins. Co.	$500,000
Associated Business Owners	$500,000
Florida W.C. Fund	$1,800,000
Florida Employers Safety Assoc.	$2,000,000
FTBA Mutual	$500,000
Nova Southern Ins. Co.	$250,000
U.S. Employers Consumers SIF	$500,000
Total	**$6,050,000**

Estate	Amount of Reinsurance Recovery
Aries Ins.	$740,073
Assoc. Business & Commerce Ins. Co.	$657,914
Champion Healthcare	$117,537
First Alliance	$1,739
Florida W.C. Fund	$767,738
Fortune Insurance	$750,000
FTBA Mutual, Inc.	$508,836
Total	**$3,543,837**

HAWAII (Paul Yuen, State Contact Person)

New Estates Opened	Date of Order	Type of Order	Primary Line of Busines
Heritage Mutual Ins., RRG, Inc.	11/10/02	Liquidation	RRG Warranty

Distributions: Disbursements to General Creditors

Estate	Amount	Date	Type of Distribution
Pacific Group Medical Association	$8.2 Million	12/11/02	Partial
HIH - Hawaii	$2 Million	11/02	Partial/Final

Receiver's Achievement Report

Ellen Fickinger

ILLINOIS (Mike Rauwolf, State Contact Person)

Distributions: Disbursements to policy/contract creditors, Early Access & other funds paid to Guaranty Funds or Associations

Estate	Loss And Loss Adjustment Expense	Early Access Distribution	Return Premium	Reinsurance Payments
Alliance General Insurance Co.	0	50,544	0	0
Alpine Insurance Company	100	0	0	0
American Horizon Insurance Co.	0	0	0	4,826
American Mutual Reinsurance Co.	0	0	0	5,189,460
American Unified Life and Health Co.	0	16,073	0	0
Associated Physicians Insurance	0	39,999	0	0
Centaur Insurance Company	(26)	0	0	0
Coronet	339	499,998	0	0
Delta Casualty Company	463	41,886	0	0
First Oakbrook Corporation Synd	0	(412)	0	0
Gallant Insurance Company	8,063	0	0	0
Illinois Healthcare Insurance Co.	0	200,000	0	0
Illinois Insurance Co.	0	15,629	0	0
Inland American Insurance Co.	0	80,000	0	0
Intercontinental Insurance Co.	0	2,539	0	0
Merit Casualty Co.	0	25,000	0	0
Millers National Insurance Co.	0	3,383	0	0
Optimum Insurance Co. of Illinois	0	330	0	0
Prestige Casualty Company	0	3,606	0	0
United Capitol Insurance Co.	16,629	38,740	0	0
Valor Insurance Co.	3,628	0	0	0

NEW YORK (F.G. Bliss, State Contact Person)

Distributions: Disbursements to Security/Guaranty Funds and other Creditors

Receivership	Security/ Guaranty Funds	Policy/Contract Creditors	Other Creditors	Total
American Consumer	$2,671.00		$288.00	$2,959.00
American Fidelity Fire	$4,246.00			$4,246.00
Consolidated Mutual	$7,157.00			$7,157.00
Cosmopolitan Mutual	$257,320.00			$257,320.00
First Central Insurance Co.	$4,877,971.00		$121,631.00	$4,999,602.00
Horizon	$39,604.00			$39,604.00
Ideal Mutual	$2,447,383.00		$115,588.00	$2,562,971.00
Long Island Insurance Co.	$6,366.00			$6,366.00
NewYork Merchant Bakers	$31,546,112.00			$31,546,112.00
Whiting National	$12,106.00			$12,106.00
Total	**$39,200,936.00**		**$237,507.00**	**$39,438,443.00**

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

Distributions: Disbursements to Guaranty Funds

Estate	Guaranty Funds
PHICO Insurance Co.	$11,283,770.00

Receiver's Achievement Report

Ellen Fickinger

TEXAS (Jean C. Sustaita, State Contact Person)

Estate Closings

Estate	Amount Distributed	Guaranty Funds	Other	Percentage	Total Distribution
Professional Benefits Ins. Co.	$1,778,708.86	TX: Class 1		100%	$737,404.00
		TX: Class 2		57.31%	$684,944.24
			Class 1	100%	$13,148.55
			Class 2	57.31%	$343,212.07
					$1,778,708.86
Comco Insurance Company	$15,180,974.92	TX: Class 1		100%	$544,951.45
		TX: Class 2		88%	$2,938,950.44
			Class 1	100%	$4,421,837.04
			Class 2	88%	$7,275,235.99
					$15,180,974.92
Bankers Commercial Life Insurance Co.	$1,721,327.39	NOLHGA (TX, CO, UT, AZ, SD, OK, ND, NM, NE, MT, FL, MO, LA)	Class 1		$1,717,570.89
			Class 2	100%	$3,756.50
					$1,721,327.39

FREMONT INSURANCE COMPANY (UK) LIMITED

(SCHEME OF ARRANGEMENT)

Notice of Declaration of a Fourth and Final Dividend

NOTICE IS HEREBY GIVEN that a fourth and final dividend of 3.3 Creditors Ascertained Scheme Claims has been declared in the above matter bringing total dividends declared to date to 38.34%.

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

D N RACKHAM and M C BATTEN
Joint Scheme Administrators

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

Dated this the 27th day of June 2003

New York Roundtable Report

Jerry Capell

The IAIR Roundtable at the New York meetings on Saturday June 21 included a series of excellent presentations. The program, which was ably hosted by Frankie Bliss, Director, Creditor and Ancillary Services at the New York Liquidation Bureau, began with a presentation by Greg Serio, Superintendent of Insurance, New York, and Jim O'Connor, Special Deputy Superintendent, New York Liquidation Bureau.

Current Developments in New York

Superintendent Serio opened the presentation with a discussion of the changes in management at the Liquidation Bureau and the evolution of his commitment to attempt to rehabilitate troubled carriers. Superintendent Serio noted that not all rehabilitations will be successful, but he is hopeful that Frontier will become a model and develop a win/win proposition for policyholders and regulators. He also noted the economic hardship and displacement that can occur in a geographic area that suffers the insolvency of a large local employer.

The Superintendent also discussed the benefits of modernizing financial exams and the work the NAIC is doing to support risk based examinations and moving from a market based examination process to more of a regulatory approach. He noted that regardless of how well the industry is regulated, that insolvencies are inevitable and need to be acknowledged as part of the business. He also noted that insurers by and large have been free of Sarbannes/Oxley issues that reflect well on the regulatory community. He did express concern with respect to closely held families of companies that the current regulatory scheme may not be ready to handle.

Jim O'Connor then introduced his background as an attorney with significant experience in reorganizing and reengineering from his tenure at the New York State Fund. He hopes to build on the work of his predecessors and to open communication channels with stakeholders early in the process. Responding to challenging questions from the audience, Mr. O'Connor bravely promised a plan to address certain older estates in the near future.

Asbestos Claims Developments in the UK and Europe

The next entertaining presentation included an update on *"Asbestos Claims Developments in the UK and Europe"* by Alistair Kinley, Deputy Manager, Liability, Association of British Insurers. This presentation provided a view of the different systems and solutions, recent European cases as well as claims developments and cost estimates. Mr. Kinley noted some key and *substantial* differences between the U.S. and UK models including the treatment of mass torts, class actions, contingency fees, and cost recovery as well as punitive damages, forum shopping, and payment methods. He also reviewed several recent cases including a 2002 decision (Fairchild v. Glenhaven) where the House of Lords found for the claimants and adopted a theory of joint and several liability. As Mr. Kinley put it, a clear public policy decision.

The impact of this decision means that "void" periods have to be paid by identified defendants resulting in the need to establish a fair way to share claim costs. The ABI is developing a rules-based approach to the apportionment of claims. Although there is clearly significant uncertainty in the U.K., current estimates of ultimate asbestos exposure range as high as $8 billion with an expectation that claim development will lag the experience in the U.S. Fortunately, the belief is that many/most claims have been reserved and the only unknown exposure relates to paying for voids. Mr. Kinley also provided an overview of recent cases and developments in France, and Ireland where in the Fletcher v Commission of Public Works matter, a determination of no damages was made for fear of contracting mesothelioma.

The statistics Mr. Kinley provided in his presentation clearly depicted a worsening problem as rates of new mesothelioma cases are rising. The same appears to be true through continental Europe with 250,000 deaths expected between 1995 and 2020 with a peak occurring in the 2015 to 2019 time period. Related cost estimates range between 32 and 120 Billion Euro with costs concentrated on a select few insurers and reinsurers.

Key conclusions from Mr. Kinley's presentation included, "a significant policy drift in Europe towards compensating impaired claimants, a relatively firm control to date on unimpaired claimants, a range of different payment methods throughout Europe, and a series of safety nets and state schemes for compensating victims" – all of which clearly indicate that predicting the impact on individual insurers will be a challenging task. As Mr. Kinley puts it, "the picture that emerges is one of serious concern but not crisis (yet)."

A striking final quotation from Mr. Kinley's presentation comes from Dr. Thomas Legge, former UK Chief Medical Inspector of Factories and dates to 1934, *"Looking back in the light of present knowledge, it is impossible not to feel that opportunities for discovery and prevention of asbestos disease were badly missed."*

New York Roundtable Report

Jerry Capell

Current Status of Asbestos Reform Legislation

Bob Carlstrom, a Principal with Navigant Consulting, Inc. and veteran of Government Affairs matters in Washington D.C. addressed the legislative asbestos reform initiatives. In particular, Mr. Carlstrom provided an update on the status of the Hatch Asbestos Reform Bill that was introduced in the U.S. Senate in May of 2003. Mr. Carlstrom's presentation addressed the momentum which has gathered around the proposed legislation as a collision of interests including claimants, defendants, labor, the trial bar, insurers, and receivers. The substance of the Hatch bill is to remove asbestos claims from the Tort system and provide a no fault mechanism to compensate claimants on the basis of strict medical criteria. However, the criteria and compensation schemes are still under negotiation as are the funding mechanisms. Mr. Carlstrom described the process as dependent on the passage of a Senate Bill that will also be adopted in the House of Representatives, noting however that several competing measures have already been introduced in the House. A more in depth status of the legislation is provided in Mary Lyman and Letitia Chambers' feature article in this newsletter.

Update on NAIC Insolvency Initiatives

The next presenter, Doug Hartz, Senior Counsel, Financial and Insolvency Regulation, NAIC Legal Division, provided an update on NAIC Insolvency Initiatives. Mr. Hartz summarized a variety of priorities including judicial relations, coordinating with guaranty funds, use of the internet as well as the Global Receivership Database that comprised the majority of the presentation.

April 2003 Changes in UK Insolvency Law

Following Mr. Hartz was Vivien Tyrell, of Kendal Freeman in London who provided an excellent review of April 2003 changes in UK insolvency law. Ms. Tyrell's presentation focused on The Insurers (Reorganisation and Winding Up) Regulations 2003 and The Enterprise Act 2002.

The Insurers (Reorganisation and Winding Up) Regulations 2003 were enacted under EC Directive and were in force as of April 2003 with the intent of providing harmonization between member EU states. The Regulations have the effect of changing the priorities of an insolvency and apply to EEA insurers (continental insurers), UK insurers, third country insurers, but not Lloyd's. Entities must write some direct insurance to be covered by these regulations.

An EEA insurer is authorized by its home state and a liquidator, administrator, or provisional liquidator cannot be appointed in the UK. Ms. Tyrell did note "UK schemes can apply to EEA insurers if the EEA administrator/liquidator and competent authority do not object."

The regulations further require that notice be provided throughout the EEA concerning UK insolvencies and provide that creditors can submit their claim and observations in their native language. Ms. Tyrell also noted that UK general insolvency law will apply throughout the EEA to UK insurers with a few exceptions including employment contracts, real property, pending law suits, regulated markets among others.

With regard to changes in the priority of payments, the new regulations only apply to winding up orders or members' resolutions on or after April 20, 2003. To the extent a scheme is in place, the priorities can only be changed with court permission and under exceptional circumstances. Finally existing provisional liquidations and administrations are excluded.

Under the new regulations the priority of payments is 1) preferential debts (tax, VAT, social security, pensions, remuneration and employee benefits), 2) direct insurance debts, and 3) all other debts including the claims of reinsureds. To the extent that assets are insufficient to pay all creditors in any single class, the assets will be shared proportionately. The regulations also create separate pots of assets for long term and general business. Excess assets in either pot must be applied to cover preferential claims shortfalls in the other first, outstanding insurance debts next, and then all other outstanding debts.

Interestingly, third country insurers are subject to these regulations as if they were UK insurers if they are put into winding up/administration or their contracts are reduced by court order.

Briefly Covered – New Developments in Schemes of Arrangement

With time running out, Ipe Jacob graciously agreed to keep his comments on new developments in schemes of arrangement very brief and to hold over the substance of his presentation including updates to the next roundtable in Chicago in September.

jcapell@navigantconsulting.com

2003 Committees

Accreditation and Ethics

George Gutfreund,
CA, CIRP, CIRML, Chair
416.777.3054 or *ggutfreund@kpmg.ca*

This committee sets the qualifications for the AIR and CIR designations and reviews/interviews all applicants. They also draft IAIR's Code of Ethics. This is a very active, hard-working committee that is always looking for input from new sources.

Amicus

Philip Curley, Chair
312.663.3100 or
pcurley@robinsoncurley.com

This committee comes into action when there is an amicus brief of interest to IAIR. They review the situation and present the Board with a suggested position for IAIR to take.

Bylaws

Francesca Bliss, Chair
212.341.6225 or *fbliss@nylb.org*

This committee drafts the updates to IAIR's bylaws and periodically they review the long range planning goals of the organization based upon membership input.

Education

Steve Durish, CIR-ML, Chair
sdurish@tpciga.com

Kristine Bean, CPA, Vice Chair
312.583.5713 or
kbean@navigantconsulting.com

The education committee is responsible for all educational programs sponsored and cosponsored by IAIR. These include, but are not limited to, the annual Insolvency Workshop, the Staff Training Seminar, the Joint Guaranty Fund workshop and the quarterly Roundtables in conjunction with the NAIC meetings. This is a very active committee which requires a large number of members to present interesting and timely educational programs.

Finance

Joe DeVito, MBA, CPA, Chair
201.869.7755 or *jjdevito1@cs.com*

The finance committee assists the Executive Director in setting the annual budget and reviews the financial activity of IAIR.

International

Vivien Tyrell, Chair
011.44.207.556.4451 or
vivientyrell@djfreeman.co.uk

This committee was formed during 2000 to address the needs and concerns of IAIR's growing international membership. Since then the committee has sponsored several educational programs in London and they are working with members from other countries to determine the needs of the membership.

Marketing

Trish Getty, AIR-Reinsurance, Chair
770.754.1388 or
trish.getty@randallamerica.com

The marketing committee is responsible for developing and implementing a marketing plan for IAIR. They have been instrumental in the creation of the Resource Directory and in bringing awareness of IAIR to the Insurance Commissioners.

Membership

Rheta Beach, FLMI, Chair
801.595.8222 or *rbeach@state.ut.us*

The membership committee is responsible for setting the recruiting policy, initiating membership drives and handling promotional membership activities of IAIR. They also approve all applications for membership.

Nominations, Elections and Meetings

Michael Marchman, CIR-ML, Chair
770.621.3296 or *marchmann@aol.com*

This committee is responsible for the annual slate of officers and for handling the voting process together with the Executive Director.

Publications

Jerry Capell, Chair
312.583.5734 or
jcapell@navigantconsulting.com

This committee is responsible for publication of IAIR's quarterly newsletter, The Insurance Receiver, and the annual Membership Directory. They obtain the articles from the authors, edit, proofread, and advise the Executive Director on publication matters.

Website

Robert Loiseau, CIR-P&C, Chair
512.263.4650 or *bobl@jackwebb.com*

The website committee is responsible for the material that is included on IAIR's website as well as establishing an advertising policy for the site that is consistent with the publications of the organization.

If you have any questions about these committees, please feel free to contact the chair person of that committee or IAIR headquarters at 407.682.4513.

2003 Officers and Board of Directors

President – 2004

Robert Greer, CIR-ML
Greer Law Offices
P.O. Box 4338
Clarksburg, WV 26301
304.842.8090
greerlaw@aol.com

Vice President – 2005

I. George Gutfreund, CIR-ML, CIP
KPMG, Inc.
Commerce Court West
Suite 3300
P.O. Box 31
Toronto, Ontario, CN M5L 1B2
416.777.3054
ggutfreund@kpmg.ca

2nd Vice President – 2003

Daniel A. Orth, III
Illinois Life & Health Ins. Co. Assoc.
8420 W. Bryn Mawr Ave., Ste 550
Chicago, IL 60631
773.714.8050
ilhiga@aol.com

Secretary – 2003

James Gordon, CIR-P&C
Maryland First Financial Services
820 North Charles Street
Baltimore, MD 21201
410.539.8580
jgordon@md1st.com

Treasurer – 2005

Joseph J. DeVito, MBA, CPA
DeVito Consulting, Inc.
7000 Boulevard East
Guttenberg, NJ 07093
201.869.7755
jjdevito1@cs.com

Director – 2005

The Honorable Holly Bakke
Insurance Commissioner
New Jersey Department of
Banking and Insurance
P.O. Box 325
Trenton, NJ
609.292.5360
tcrowley@dobi.state.nj.us

Director – 2005

Kristine J. Bean, CPA
Navigant Consulting, Inc.
175 West Jackson Street, Ste 500
Chicago, IL 60604
312.583.5713
kbean@navigantconsulting.com

Director – 2003

Francesca G. Bliss
NewYork State Insurance Dept.
123 William Street, 5th Floor
NewYork, NY 10038
212.341.6225
fbliss@nylb.org

Director – 2003

Steve Durish, CIR-ML
Texas P&C Ins. Guaranty Assoc.
9120 Burnet Road
Austin, TX 78758
512.345.9335
sdurish@tpciga.com

Director – 2003

Patricia Getty, AIR-Reinsurance
Randall America
360 Oak Terrace
Alpharetta, GA 30004
770.754.1388
trish.getty@randallamerica.com

Director – 2004

Robert Loiseau, CIR-P&C
Jack M. Webb & Associates, Inc.
2508 Ashley Worth Blvd., Ste 100
Austin, TX 78738
512.263.4650
bobl@jackwebb.com

Director – 2004

Elizabeth Lovette, CIR-ML
Indiana Insolvency, Inc.
311 West Washington Street, Ste 200
Indianapolis, IN 46204
317.237.4900
liz@in-solv.com

Director – 2004

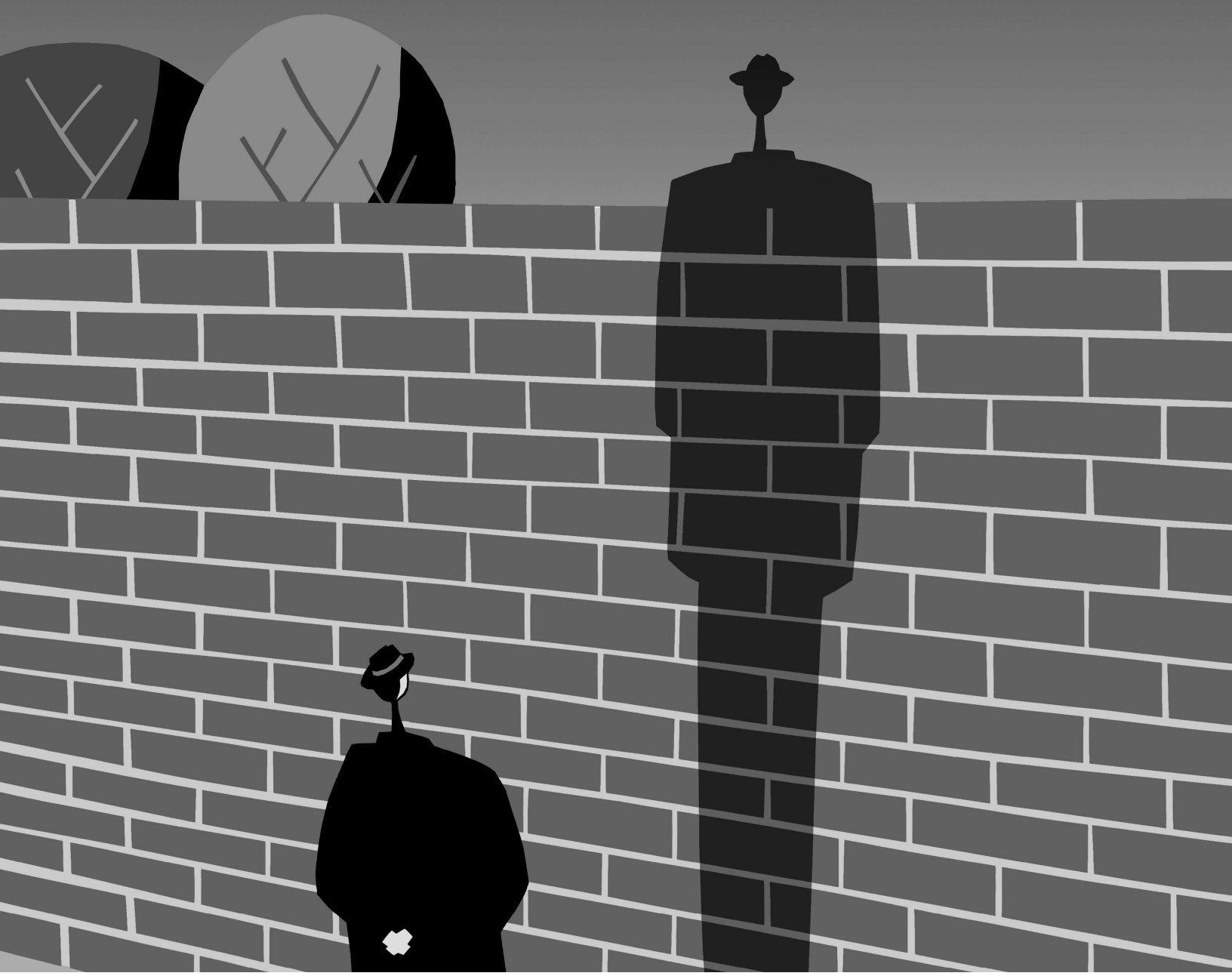
Michael Marchman, CIR-ML
Georgia Insurers Insolvency Pool &
Georgia Life & Health GA
2177 Flintstone Drive, #R
Tucker, GA 30084
770.621.3296
marchmanm@aol.com

Director – 2004

Dale Stephenson, CPA
National Conference of Insurance
Guaranty Funds
10 West Market Street, Ste 1190
Indianapolis, IN 46204
317.464.8106
dstephenson@ncigf.org

Director – 2005

Vivien Tyrell
D. J. Freeman
43 Fetter Lane
London, England EC4A 1JU
011.44.207.556.4451
vivientyrell@djfreeman.co.uk



Overcoming Obstacles

Receivers meet obstacles in countless areas of an insolvency.

Navigant Consulting professionals help them overcome obstacles in: taking over a company, finding and organizing records, evaluating processes and procedures, maximizing system effectiveness with modest investment, finding assets, tracing cash, sorting out intercompany accounts, documenting reinsurance, evaluating claims processes, collecting reinsurance, pursuing claims against officers, directors and other third parties and the other obstacles that will be new in the next insolvency.

Insolvency services for Receivers since 1990 by experienced insurance industry and technical claims, reinsurance, accounting, and systems professionals.

Property & Casualty » Life & Health » HMOs » Healthcare

Bill Barbagallo	Kristine Bean	Jerry Capell	Tim Hart
213.452.4500	312.583.5713	312.583.5734	202.481.8440

www.navigantconsulting.com

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