The Insurance Receiver

PROMOTING PROFESSIONALISM AND ETHICS IN THE ADMINISTRATION OF INSURANCE RECEIVERSHIPS

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Feature Articles

Departments

www.iair.org

President's Message

I. George Gutfreund, CA, CIRP, CIR-ML

Over the spring and summer months, your Board of Directors and Committee Chairs have been very busy promoting the goals of IAIR. First, I would like to thank Paula Keyes, our Executive Director, and her staff for the timely issuance of the IAIR Membership Directory. This is a most resourceful tool and its early publication for the current year is most helpful. Again, a tremendous thanks to you, Paula, and your staff, for a job well done.

As I mentioned in my last column, the Education Committee had issued a Request for Proposal ("RFP") for the development of an education program for IAIR leading to the accreditation of its members. Discussions were held with several potential applicants and your Board has requested additional information from one applicant as to the development of a formal program. Several issues concerning the actual implementation of an education program are being investigated and analyzed by the Education Committee and Board members. Hopefully, before the end of the year, a formal plan for the implementation of an education program resulting in the accreditation of our members will be established. The establishment of this program will greatly enhance our accreditation process and also the status of accredited insurance receivers in the insurance insolvency community.

The Accreditation and Ethics Committee was very busy over the summer months. In addition to reviewing applications received and recommending the awarding of designations to specific applicants, the Committee also looked at revising existing policies and the implementation of new policies based upon IAIR's new approved Code of Ethics. The committee presented the following proposals at the June Board Meeting, which were subsequently discussed and voted upon for implementation:

(a) Procedures for the investigation and disposition of complaints alleging violation of the IAIR Code of Ethics;

(b) Policies concerning compliance with continuing education requirements by Certified Insurance Receiver and Accredited Insurance Receiver designees;

(c) Approval of continuing education activities and accreditation standards applicable to other continuing education activities;

(d) Amendment of continuing education standards for maintaining accreditation as a Certified Insurance Receiver and Accredited Insurance Receiver.

These new policies and procedures are being posted to the IAIR website and I request that all of our members review the policies and procedures and ensure that you are in compliance with them. The implementation of these policies and procedures demonstrates to the insurance community at large that IAIR is truly concerned about preserving and maintaining its goals in the insurance insolvency marketplace.

As mentioned above, the new policies and procedures have been posted onto the IAIR website. The website over the summer months has been completely updated and reworked. The Website Committee, under the direction of Alan Gamse, has spent an enormous amount of time updating the website and making it more user friendly. Members should feel more comfortable in consulting the website to learn of upcoming events, to perform member searches, to take advantage of the links to other insurance affiliated websites and to keep current with the organization's policies, procedures and ethics. If in your review of the website you note additional improvements that can be made, kindly advise Alan Gamse or myself.

At the summer NAIC meetings, IAIR again held a "receivers only roundtable." This event was limited to 25 attendees only, and I am pleased to report that we did have 25 participants at the receivers-only roundtable. The participants welcomed the opportunity to discuss current issues with their own peer group. The participants truly appreciated this open forum and have requested that this roundtable continue in the future.

On June 22, IAIR, under the direction of Vivien Tyrell, Chair of our International Committee, and with the assistance of Kristine Johnson, Chair of the Education Committee, held the London Education Program Event. I was very fortunate to be able to attend this event, and I am pleased to report that it was a great success. It was great to see participants from both Europe and North America at this event and the subject matter and presentations were exceptional. It was also great to see so many non-IAIR members from the London insurance community in attendance. All of those in attendance were appreciative of the opportunity to enhance their knowledge and to network with fellow insurance insolvency practitioners. A tremendous thanks is owed to Vivien Tyrell and her committee for organizing this event.

President's Message

I. George Gutfreund, CA, CIRP, CIR-MIL

In closing, I would like to reiterate the comments I have made previously that IAIR is an organization composed of members who volunteer their services to enhance the organization. As a volunteer, you help to create the success of this organization. As we approach the fall months, the Nomination Committee, under the direction of Mike Marchman, is looking for members to volunteer their services to serve on the Board of Directors. This is a great opportunity for you to become involved in the evolution and management of this great organization. Please seriously consider putting your name forward to serve on the Board of Directors of our great organization. This year we will have no incumbents who will be running again, and we require five new Directors to serve for a three-year period. According to the by-laws, we need specific representations from various facets of our organization to ensure that we have a totally representative Board of Directors. In conclusion, please consider taking a leadership role in your organization by agreeing to stand for election to the Board. In discussions with those who have served on the Board in the past, this has been a most rewarding and fulfilling role.

I hope that you have enjoyed your summer months. Whether vacationing, relaxing, or like many of us, having to work over the summer months, I hope it has been an enjoyable and productive summer period. Now that the fall is upon us, we will all have to acclimatize ourselves to our busy work schedules and hopefully still have ample time to continue the great work that IAIR has done for the insurance insolvency community.

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

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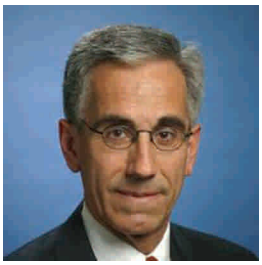
View from Washington

Charlie Richardson

The Regulatory Reform Pot Continues to Boil



I reported last issue on the Oxley/Baker Roadmap for federal insurance regulatory reform unveiled at the March NAIC meeting by Rep. Michael Oxley (R-OH), Chairman of the House Financial Services Committee. The plan was developed by Chairman Oxley and Capital Markets Subcommittee Chairman Richard Baker (R-LA). Rep. Baker held another Subcommittee hearing on March 31 to kick off the legislative process and to dig into the specifics of the plan, now that he and Chairman Oxley have laid out their basic approach.

As this article is being written in July, we still do not have the anticipated specific legislation to establish federal minimum standards for state insurance law in such key areas as rate deregulation, agent and company licensing, and speed to market. The complexity of addressing these issues has proven more difficult than staff originally thought. With few legislative days left in the 2004 Congressional session, a bill may be introduced, but real action is unlikely until Congress convenes in January 2005.

In the meantime, the NAIC laid out a Roadmap of its own at the San Francisco NAIC meeting in June. That document is a must read because it attempts to lay out a detailed framework built around – and in response to – the Baker/ Oxley Roadmap. You can read it at *www.naic.org/docs/naic_framework.pdf.*

The NAIC's roadmap document covers 15 areas where national standards can be effectively implemented, while it notes that diversity is a strength of the state regulatory system, which in certain cases requires the recognition of differing local market conditions. The issues are based on those raised during Chairman Oxley's presentation to NAIC members in March, along with other areas where the NAIC believes that national standards would be beneficial to the marketplace.

Areas addressed include:

- Market conduct uniform standards
- Company licensing
- Agent licensing
- Life insurance
- Property/casualty commercial insurance
- Property/casualty personal lines
- Surplus lines
- Reinsurance
- Antifraud network
- McCarran-Ferguson antitrust exemption and rate regulation
- State-national insurance coordination partnership
- Viaticals
- Interstate compact for health insurance processes
- Enhancing financial surveillance
- Receivership

Note that last one: Receivership! For the first time, the NAIC has itself put into the legislative debate the heart and soul of what IAIR and its members do. Rather than paraphrase, here is the text of the NAIC's discussion on the last page of its Roadmap.

NAIC Roadmap

State regulators believe effective regulatory modernization and uniformity for insurer receiverships should be achieved as follows:

- Congress should amend the Federal Priority Statute so that insurer receiverships receive the same treatment allowed to federal bankruptcy estates.
- States should be required, under Part A of the NAIC Accreditation Program, to enact laws substantially similar to the updated Insurer Receivership Model Act currently being completed by the NAIC:
  - Rights and obligations of policyholders, reinsurers, state guaranty associations (SGAs) and other claimants and debtors to the estate,
  - Commissioners and supervising court's roles,
  - Priority of distribution,
  - Special deposits being deemed to be general assets, unless to benefit of SGA's (create uniformity and consistency in the use of and access to special deposits),
  - Reciprocity and interstate cooperation,
  - Transparency and financial reporting (including to the Global Receivership Database),
  - Immunity and indemnification of receiver and others working for benefit of estate, and
  - Coordination and cooperation between the state guaranty system, receivers, and regulators.

There is already a requirement that states have "a scheme" for handling receiverships in the NAIC Financial Accreditation Program. Tightening this requirement is consistent with the concept that

View from Washington

Charlie Richardson

the accreditation process should cover more than solvency, including broader assurance that claims are paid to protect consumers and maintain confidence in the industry.

Supreme Court Stands Firm on the Exclusivity of ERISA Remedies for Medical Negligence

In a decision setting back state efforts to create legal rights for non-payment of certain expenses by health plans, the United States Supreme Court unanimously reaffirmed ERISA's expansive preemption provisions in *Aetna Health Inc. v. Davila* and *CIGNA Health Care of Texas, Inc. v. Calad,* holding that a managed care entity's decision that a particular treatment is not covered under the relevant terms of an employee benefit plan is not a decision of "medical necessity" as was the case in *Pegram v. Herdrich* but, rather, is part and parcel of administering the employee benefit plan. However, the Court's opinion included a call from Justice Ginsburg urging Congress to revisit "the unjust and increasingly tangled ERISA regime" – "fresh consideration of the availability of consequential damages under 502(a)(3) is plainly in order."

Every Little Bit Counts: Treasury Extends TRIA "Make Available" Mandate Through 2005

The Treasury Department said June 18 that it would extend through 2005 the "make available" provisions of the Terrorism Risk Insurance Act, or TRIA (P.L. 107-297). Under the federal government's backstop program, insurers must make available in their P&C policies coverage for insured losses due to acts of terrorism. A bill introduced in June 2004 by Representative Pete Sessions (R-TX), the Terrorism Insurance Backstop Extension Act (H.R. 4634), would extend TRIA from 2005 to 2007.

"Gluttons" for Punishment: Senate Leadership Continues to Push Tort Reform Initiatives (Despite Multiple Setbacks)

Medical liability legislation (S. 2061; S. 2207) may be sidelined in the Senate, but Senate Republicans continue their tort reform efforts. A bill targeting class actions (S. 2062) received renewed attention, but got bogged down over disagreements concerning legislative add-ons. S. 2062 would broaden federal court jurisdiction over multi-state class actions filed in state court. The third prong of the Republicans' tort reform agenda is asbestos litigation. House Majority Leader Tom Delay (R-TX) announced July 7 that the House intends to vote on legislation to create a trust fund to compensate asbestos victims, if the Senate fails to act (again). The Senate has voted – with no success – at least five times in the past year on asbestos, class action, and medical liability bills.

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London and the Run-off Revolution

Julius S. Bannister [1]

According to our research, around 40 percent of UK non-life insurance companies are currently in run-off, some are in liquidation, others being subject to Schemes (or Solvent) Schemes of Arrangement with their creditors. When one considers that there are only around 500 non-life insurers in the UK (including those writing both life and non-life risks), to have 199 in run-off suggests that there is something of a quiet revolution taking place. So, what is the story and has it got a happy ending?

Perhaps the most famous story about the City of London to pass into folklore is that of Dick Whittington, a young lad from many centuries ago who, as legend has it, set out from the countryside to walk to London, with express intention to make his fortune. Despite many setbacks on his journey, young Whittington persevered and completed his life journey. There is a happy ending as he eventually became Lord Mayor of London but in the process was disabused of the theory that the streets of the City of London are paved with gold.

Those in the insurance sector centred on the Lloyd's Building and surrounding streets and lanes, will tell you that today times are mostly good; a story echoed around the globe with a two year run of high rates, tight underwriting terms and seemingly for most, profits galore.

Whereas the Lloyd's insurance market traces its present origins to Edward Lloyd's coffee house, there had been a market of marine insurance dating back to earlier centuries based mostly on trade with merchants in Italy.

Today, the insurance broking market continues to remain a firm conduit for insurance business entering the London Market. Business is placed at Lloyd's and the surrounding company market from the four corners of the globe, and the risks presented for underwriting are as diverse and varied as one could imagine.

The well publicised problems at Lloyd's in the late 1980s and early 1990s have been well documented. Lloyd's pulled back from the brink of potential closure with a skilfully drafted solution that was acceptable to the London Market, the investors (The Names), the buyers of insurance and regulators from around the world. Simply said, the old year liabilities were placed by way of a reinsurance into a newly created reinsurance company that would be able to exert the economies of scale beyond the scope of the then 400 trading syndicates, and take a rational and pragmatic view to running off the old year claims.

Equitas, the name that was chosen for this rescue vehicle, has been a success; love it or hate it. Many said it would not survive five years; well, it is still here and, as far as I can ascertain still, in the market of actively negotiating the payment of valid claims.

With so much attention focused on Lloyd's, it is important not to forget that the London Market comprises more than just Lloyd's Syndicates; it also included many hundreds of insurance companies, many of whom were to share the same or similar underwriting risks as their cousins at Lloyd's. These companies included major operations, writing many hundreds of millions of pounds of premium each year, including subsidiaries of the major composite stock-market listed insurance groups, down to small operations with slender capitalisation of often much less than £10 million, some owned by UK investors and others by companies far away and overseas.

Many of these smaller companies were seen to be on the fringe of the insurance market, but were able to participate in the market picking up small lines on major underwriting slips. Some came about by being funded by local investors; capital requirements in the late 1970s and early 1980s were modest. Others were formed by the broking community (such as River Thames, Andrew Weir, Sovereign Marine or Sphere Drake) and still more were overseas companies who were persuaded to sign up to participating in the London insurance market, either by using a branch operation or by establishing a London regulated insurer.

The jet-age hastened the growth in the London Market. The many hundreds of Lloyd's broking firms were actively involved in scouting out new participants in the market, either as policyholders or as underwriting participants, and the jet-age made this task possible.

It is interesting to note how in parallel with Lloyd's, the company market also expanded. Lloyd's itself fast outgrew its staid 1958 Building, and acquired a new high-tech underwriting market across the street (Lime Street, that is) just to accommodate all those who wished to write business.

Now, with the risk of repeating the problems of the London insurance market, it is clear that a number of key

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events, catastrophes and long-tail liability claims, showed up the weakness of this huge insurance market. The spreading of the risks amongst hundreds of companies and syndicates, and the relayering of risk again and again through reinsurance, exposed the fatal flaw in the LMX (London Market excess of loss) spiral.

Disasters such as the October 1987 hurricane (Cat 87J) that left a trail of destruction across southern England, the Piper Alpha oil rig explosion (July 1988), Exxon Valdez (March 1989), Hurricane Hugo (August 1989), and the later European storms of January and March 1990 had their impact. Other losses, major losses, were also marching towards London with increasing strength; liability risks including claims for pollution and asbestos were coming to the fore.

Whereas Lloyd's was fortunate enough to be able to broker a central deal that saw the creation of Equitas, the Company market was unable to make such a neat central arrangement to deal with the run-off of old year liabilities. That said, the techniques that were developed and have naturally evolved to handle the run-off of the company market has been none the less innovative and leading edge in its approach, and in many cases more so than the Lloyd's solution.

When it comes to the run-off of an insurance company, there are traditionally just a few main options open:

1. In-house run-off of liabilities to extinction;
2. Sell the business (and liabilities) to a third party;
3. Reinsure the run-off portfolio; and
4. Place the business into a Scheme of Arrangement with your creditors.

London has examples of all these run-off options, each of which might suit the requirements of the present owners, but it would appear that only options two and four have a chance to offer the owners a clean break and finality.

Many would say that option one is an almost open ended proposition. In the UK we have several small companies that have been running off their liabilities for years, and in some cases decades. Companies in this category include the AA Mutual Insurance Company (formed 1979, ceased 1987), Community Reinsurance Corporation (1972–1984) and the Malayan Insurance Company (1979–1986).

Option three, that of reinsuring the run-off portfolio, is a more proactive strategy although whenever the issue is raised at industry conferences, it appears that no-one is offering unlimited run-off reinsurance, although in certain circumstances the reinsurance cover in place is deemed more than adequate to handle the run-off. Commercial Union, a major UK composite insurer that now operates under the Aviva name, took out a major run-off reinsurance contract with the Berkshire Hathaway-owned National Indemnity Company as part of its run-off strategy. Many others have done the same, although careful study of the reinsurance schedules of their annual regulatory returns should reveal the level of cover still in place.

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Option two provides the clean break, the sale of the business. This allows you to walk away from your past life, but at a cost. There is a vibrant market for acquiring insurance companies in run-off, and often fierce competition when a potential sale is touted. However, one must question the finer detail and if you (the original owner) are retaining the old year liabilities, what has the sale actually achieved?

Included in option two are the following recent acquisitions of companies in run-off:

- Bestpark International Ltd, formerly Trenwick International Ltd, was acquired by LCL Acquisitions Ltd.
- Aviation & General Insurance Company Ltd was acquired by Ruxley Ventures Ltd/Ruxley Investments Ltd, who successfully closed the business of City General Insurance Company Ltd in recent years.

Step forward option number four, the Scheme of Arrangement. This is by all accounts the favoured approach for many. The first Schemes of Arrangement were tried and tested in Bermuda, when several small reinsurers were dealt with by the use of a revolutionary Scheme. Once the process had been demonstrated to work, it was only a matter of time before it was applied to London Market companies as a solution to their orderly exit from the insurance market.

You can place a whole company into a Scheme of Arrangement or just a particular book of business. The Scheme has to gain the approval of a specified majority of creditors by number and value and be sanctioned by the High Court. The good news is that they work. In some recent cases they have closed a company in record time and even some of the largest UK insolvencies, the KWELM companies spring immediately to mind, are fast approaching the end of their journey under a scheme and final dividends are likely to be distributed in the near future.

PricewaterhouseCoopers regularly publish a listing of Schemes which is widely circulated in the market, so there is no need to duplicate their efforts here. One of the most recent Schemes to have been proposed is that of:

- Blackfriars Insurance Ltd, the captive insurance company of the Unilever captive, is proposing a solvent scheme to take care of a small amount of open market business written decades ago.

Many other companies have implemented schemes that are now closed or are marching on a strict timetable towards the date at which future claims are no longer eligible for settlement.

Our research shows that 199 UK non-life insurance companies are currently in run-off and that their combined assets were at the end of 2002 were at least £34.5 billion ($64bn), the majority of which related to technical provisions for future claims which were reported at a combined £27.1 billion ($50bn). A note of caution in that for certain companies that write both life and non-life insurance business in a single corporate entity, it is often tricky to ascertain the level of assets/technical provisions supporting the non-life book of business. The table shows the leading run-off companies ranked by assets.

UK NON-LIFE RUN-OFF MARKET (£ Million in 2002)

	Total Assets	Shareholder's Funds	Technical Provisions
Equitas	8,131	527	7,039
Eagle Star Insurance Company	3,112	943	1,827
Prudential Assurance Company (Non-Life)			186
Phoenix Assurance Plc (RSA)	2,013	161	55
Minster Insurance Company (Groupama)	1,368	34	1,230
St. Paul Reinsurance Company	1,285	156	998
CX Reinsurance Company Ltd (ex-CNA Re)	1,156	87	965
OIC Run-Off Ltd (ex-Orion)	881	-478	937
Lioncover Insurance Company Ltd (Lloyd's)	799	0	799
Walbrook Insurance Company Ltd (KWELM)	665	-666	862
Excess Insurance Company Ltd (Hartford)	574	23	523
Riverstone Insurance (UK) Ltd (ex-Dai Tokyo)	562	58	423
Royal & Sun Alliance Reinsurance Ltd	534	97	420
Tanker Insurance Company Ltd (RSA)	476	447	29
English & American Insurance Company Ltd	466	-321	526
Total UK Company Market Run-off *(does not include Lloyd's post-1992)*	**34,581**	**509**	**27,131**

Prudential: Unable to ascertain pure non-life data, provisions are on a net basis.

London and the Run-off Revolution

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In parallel with the large-scale reorganisation of the London/UK market, many third party run-off service providers have been formed. Many of these companies can trace their formation to specific insurance company failures or run-offs. These firms have now broadened their clientele to include many third party run-offs, the largest of these groups showing revenues in excess of £20 million per annum.

London has naturally enough developed as a centre for run-off service providers, the international reach of these companies spreading around the globe. Others in continental Europe, Australia and in North America and Bermuda are also actively involved in this sector, although for the vast majority of these service providers no financial data is placed on the financial record.

Our research into the run-off service providers shows that those filing financial returns employed at least 2,500 staff, but the worldwide total involving such run-off firms is probably twice this number. Their combined revenues in 2002 stood at £271 million ($500m), but again the worldwide total revenues of run-off service providers is probably in excess of £500 million or close to $1bn.

Market leaders include Castlewood, Claims Management, Capita, Riverstone, Randall/Cavell and Omni Whittington, this last name perhaps underlining the City of London's proud and enduring connection with its heritage?

The service providers have transformed themselves into a cohesive group, and have worked hard to develop professional standards for run-off and an effective lobbying group, the Association of Run-Off Companies *(www.aroc.org.uk).* Even more so, the International Association of Insurance Receivers (IAIR) half-day seminars in London are a "hot-ticket," always well attended, with hard-hitting presentations and full of lively debate.

The first London Market Run-Off Yearbook (LMROY) published in 2002 identified around 120 run-off entities, and for the first time brought together a comprehensive survey. This included tracking each company from when it was actively underwriting, seeking to identify the reasons why it ceased underwriting, tracking the financial performance prior to and during run-off, and listing, whenever possible, the major reinsurance relationships with likely recovery from third-party reinsurers.

LMROY provided the first report on the state of the UK market and a new report, now providing similar data on a vastly expanded 199 run-off companies, is expected to be published soon.

Fellow members of the International Association of Insurance Receivers are invited to apply for a free executive summary of this new report, listing all 199 run-offs. Please e-mail me at *news@biro.uk.*

RUN-OFF SERVICE PROVIDERS (£000s)

	2003 Turnover	2002 Turnover	2002 Expenses	2002 Pre-Tax	2002 Staff Numbers
Castlewood Holdings *(Bermuda)*	27,880	55,580	15,345	34,639	n/a
Claims Management Group	35,868	29,260	26,683	2,791	400
Capita London Market Services		21,583	17,794	3,799	n/a
Riverstone Management	18,599	20,626	20,679		122
Omni Whittington Insurance Services	18,185	19,574	18,669	983	271
Cobalt Run-Off Services Ltd *(Australia)*	21,794	17,787	16,863	924	
Aurora Corporate Services		15,442	15,438		372
PRO Insurance Solutions		15,009	12,799	2,308	245
AXA Liability Managers *(France)*	14,000				
Randall/Cavell		12,160	12,328	-27	162
KWELM Management Services	10,694	11,091	11,097		140
Downlands Liability Management *(Hartford)*		11,026	10,889	101	131
Total Market in Survey	**173,297**	**270,942**	**218,117**	**44,291**	**2,271**

Responsibility of Receivers for the Sins of Prior Management

Robert M. Hall [1]

I. Introduction

When an insurer is placed into receivership, the receiver will sometimes bring an action for fraud or other wrongdoing against the officers or directors and/or third parties who may have been in collusion with such directors or officers. The defendants in such actions may counter that any such wrongdoing is imputed to the insolvent insurer through the directors or officers who were agents of the insurer and, for this reason, the receiver, as successor to the company, is barred from pursuing such actions. Such defendants may further argue that the period of time since the receipt of such constructive notice of the wrongdoing has exceeded the statute of limitations for bringing such an action.

The receiver often counters that the innocent parties which it represents should not be barred from recovery by a technical defense such as the statute of limitations and that the wrongdoing of former directors or officers should not be attributable to the estate [2]. In effect, the receiver argues that it should not be responsible for the sins of prior management. More particularly, the receiver may assert that the control or "adverse domination" of the insurance company by individuals acting against the interests of the company should prevent these acts from being imputed to the company and should toll or delay the running of the statute of limitations.

The purpose of this article is to examine the case law concerning exceptions to the rule of imputation of the acts of directors or officers to the insurer, and, therefore, the receiver, and the implications on the statute of limitations. It should be noted that this issue is not limited to insurance company receiverships and that there is a substantial body of case law dealing with this same general issue in other factual contexts [3].

II. Cases Finding Adverse Domination or No Imputation

A. Insurance Company Receivership Cases

The court in Clark v. Milam, 872 F.Supp. 307 (S.D.W.Va.1994) defined the adverse domination exception as follows:

> *Adverse domination occurs when the officers and directors who control the rights of the corporation act adversely to the corporation's interests, usually for personal gain, to the detriment of the corporation and/or its non-officer/director shareholders* [4].

The court found that under West Virginia law, the plaintiff, who was the receiver of George Washington Life, must make a strong showing that the defendant's alleged wrongdoing constituted "some action" contributing to the adverse domination. The court concluded that the allegations of the receiver (not detailed in the decision) met this test and prevented a dismissal of the action. The court further noted that the knowledge of shareholders who bring a derivative suit ordinarily should be attributed to the corporation and not be subject to the adverse domination exception. However, the court declined to dismiss on this basis since there was evidence that the shareholders had no interest in benefitting the George Washington Life by their action and were attempting, merely, to benefit themselves at the expense of George Washington Life.

In a related case, the Supreme Court of Appeals of West Virginia was posed two certified questions by the district court. Clark v. Milam, 452 S.E.2d 714 (S.C.App.W.Va.1994). In its decision, the court confirmed that West Virginia recognized the doctrine of adverse domination and that any shareholder derivative suit must be for the purpose of correcting wrongdoing rather than protecting the beneficiaries of the wrongdoing for such a suit to negate or otherwise terminate adverse domination.

The receiver of Guarantee Security Life Insurance Company brought an action for breach of fiduciary duty against an officer in In Re Blackburn, 209 B.R. 4 (M.D.Fl.1997). The defendant sought a

[1] Mr. Hall is an attorney, a former law firm partner, a former insurance and reinsurance executive and acts as an insurance consultant as well as an arbitrator and mediator of insurance and reinsurance disputes. The views expressed in this article are those of the author and do not reflect the views of his clients. Copyright 2004 by the author. Questions or comments may be addressed to the author at bob@robertmhall.com.

[2] The argument is well stated in *Clark v. Milam*, 452 S.E.2d 714, 720 (W.Va.1994):

> When the Commissioner is appointed Receiver for an insolvent insurance company, he is charged with marshalling the assets of the company for the benefit of its policyholders and creditors. (Citations omitted). Those assets include claims against those who may have looted the insurance company as well as their possible accomplices who are either outside lawyers or accountants. (Citations omitted). After all, much more is at stake in this litigation than simply a loss to shareholder investors: we have here an insurance company that was allegedly victimized and that was allegedly looted of monies that should have been available to pay the claims of totally innocent policyholders.

[3] *See generally*, M. Dore, *Statutes of Limitation and Corporate Fiduciary Claims: A Search for Middle Ground on the Rules/Standards Continuum*, 63 Brook.L.Rev.695 (1997).

[4] 872 F. Supp. 307 at 301.

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summary dismissal of the action based on the statute of limitations. The court declined summary judgement:

> *Under this adverse interest exception, the actions and knowledge of the officers and directors are not imputed to the corporation when those agents were acting adversely to the corporation's interests. (Citations omitted). In these circumstances, there is evidence that the acts about which the plaintiff complains involve acts for the defendant's benefit and that were contrary to the interests of (Guarantee). This adverse interest exception to the discovery rule, therefore, would appear to preclude a determination that the statute commenced to run with the imputed discovery of the acts by (Guarantee) which is now imputed to the plaintiff* [5].

Schacht v. Brown, 711 F.2d 1343 (7thCir.1983) was a RICO action by the receiver of Reserve Insurance Company against officers, directors, the parent corporation and several third party defendants for allegedly continuing the company's business past the point of insolvency by looting the company of its most profitable business. In order to find in favor of the adverse domination exception, the court had to distinguish its earlier decision of *Cenco, Inc. v. Seidman & Seidman,* 686 F.2d 449 (7thCir.1982) *(see* § III C, *infra)* which ruled against adverse domination. As points of distinction, the court found the defendants looted Reserve (i.e., they were adverse to Reserve) rather than using Reserve to defraud third parties. In addition, *Cenco* court used a two pronged analysis: (1) whether a judgement in favor of the plaintiff would benefit the victims of wrongdoing; and (2) whether such a judgement would deter future wrongdoing. This analysis supported the use of the adverse domination exception since innocent creditors would benefit from the receiver's suit and directors and shareholders would be encouraged to be watchful for fraudulent activity.

In the Matter of Integrity Ins. Co., 573 A.2d 928 (Sup.Ct.N.J.1990) was a suit by a receiver against the accountants for Integrity Insurance Company. The accountant argued that the suit by the receiver was barred because the knowledge of the directors and officers of Integrity must be imputed to the company and the receiver thereof. The court rejected this defense on the bases that a culpable party is estopped from raising it and the broad remedial power of the court in the insurance company receivership context.

B. Bankruptcy Trustee Cases

There are a number of cases with similar holdings involving bankruptcy trustees. Presumably, some of the same equitable considerations attach to the role of bankruptcy trustee as do to the role of insurance company receiver.

In Tew v. Chase Manhattan Bank, 728 F. Supp. 1551 (S.D.Fl.1990), the bankruptcy trustee sued the bank on the basis that it assisted the bankrupt in fraudulent activity. The court acknowledged the adverse domination rule that the wrongdoing must be directed at the corporation rather than third parties. The court further noted that the officers and directors obtained corporate loans for personal expenses, did not repay the loans yet received huge salaries and bonuses. Based on this record, the court ruled in favor of adverse domination:

> *[T]he court finds that there is no genuine issue of material fact as to the actions of the officers and directors. They ran (the bankrupt) into the ground and robbed the corporate entity for their own aggrandizement* [6].

The court distinguished *Cenco, Inc. v. Seidman & Seidman,* 686 F.2d 449 (7thCir.1982) *(see* § III C, *infra)* on the bases that here, the bankrupt, rather than third parties, was the principle victim, the principle beneficiaries will be innocent creditors, and banks will be more diligent in similar situations in the future.

The issue of adversity to the corporation's interests was explored in *Beck v. Deloitte & Touche,* 144 F.3d 732 (11thCir.1998). The bankruptcy trustee alleged that the board of directors of a bank colluded with their accountants to misrepresent the value of an acquired bank with the result that the acquiring bank paid dividends and received regulatory approvals long after it actually was insolvent. The lower court dismissed the action on the bases: (1) that under Florida law the interests of the corporate officer must be entirely adverse to the those of the corporation; and (2) the corporation received a short term benefit from the accounting opinion. The appellate court reversed noting that the lower court used an improper baseline to determine adversity to the corporation. The trustee alleged that but for the improper accounting opinion, the acquisition would never have occurred so any short term benefit after the acquisition is not determinative of the issue. The court ruled:

> *A director's wrongful actions toward his corporation do not have to rise to the level of corporate looting (as in* Tew*) or embezzlement (as in* Golden Door Jewelry Creations, Inc. v. Lloyds Underwriters Non-Marine Assoc.*, 117 F.3d 1328 (11thCir.1997)) in order to be adverse and thereby prevent imputation, as long a the*

[5] 209 B.R. 4 at 11.

[6] 728 F. Supp. 1551 at 1559.

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> *corporation receives no benefit from the director's behavior. Therefore, we hold that the district court erred by ruling that the Trustee did not allege a set of facts that might conceivably entitle him to relief* [7].

In Re Jack Greenberg, 212 B.R.76 (E.D.Pa.1997) was a suit by a bankruptcy trustee against an accounting firm which failed to detect a scheme by an officer to inflate the value of the company by misrepresenting inventory. The trustee alleged the officer did so to tout his skills to his employer and its creditors. The court noted that Pennsylvania required that the activities of the officer have to be actuated, at least in part, by a purpose to serve the employer in order for the employer to be responsible for those activities. The court declined to dismiss the complaint on the basis that the accounting firm failed to demonstrate that officer's activities was a benefit to the employer. The fact that the fraud caused the corporation to overextend itself with customers and lenders was not a benefit to the corporation.

The same dispute came back to the same judge two years later through a motion for summary judgement by the accounting firm based on imputation of the officer's fraud to the corporation. *In Re Jack Greenberg,* 240 B.R. 486 (E.D.Pa.1999). The court observed that the beneficiaries of the trustee's action would be innocent creditors. The court then ruled that under Pennsylvania law, imputation to the corporation would depend on position of the beneficiaries of the action i.e., innocent beneficiaries would support an imputation exception:

> *Limiting those situations in which the imputation doctrine can be invoked in auditor liability cases to circumstances in which its application would serve the objectives of tort liability would ensure that the doctrine would be used only when it would produce an equitable result* [8].

In Re Sharp International Corp., 278 B.R. 28 (E.D.N.Y.2002) involved management inflating the revenues of the corporation, which allowed them to obtain large sums from lenders and investors. These sums and more were diverted to the managers involved in the fraud. Eventually, the corporation's accountants found the fraud and the scheme fell apart. A suit by the trustee against the accountants followed. The court characterized adverse domination as an exception to the rule that the acts of a corporation's management are the acts of the corporation. However, there is a "sole shareholder" exception to adverse domination: even if managers are pursing their own personal interests and not those of the corporation, the acts of managers will be attributable to the corporation if the managers in question are the sole shareholders of the corporation. The theory is that in such a case, the personal and corporate interests merge. The court found that the sole shareholder exception did not apply since an innocent 13% shareholder was on the board of directors and was active in reviewing the books. However, the court found that the adverse interest exception did apply. Even though a portion of the sums looted from the corporation came from outside investors, even more came from the funds of the corporation. The fact that managers retain some stock in the corporation does not preclude this result since it is very unlikely that they would ever receive any return on this stock.

III. Cases Finding Imputation or No Adverse Domination

A. Insurance Company Receiver Cases

Seidman & Seidman v. Gee, 625 So.2d 1 (Dist.Ct.App.Fl.1993) was a suit by an insurance company receiver against accountants who failed to discover that a major asset of the insurer did not exist. The court noted that the fraud of the company's managing director would be imputed to the corporation, and thus a defense to the accountants, if the company benefitted from the fraud. The court ruled that the company did so benefit:

> *[T]he fraud committed by the managing director was not intended to loot the corporation, but instead was designed to turn the corporation into an "engine of theft" against outsiders – policyholders… [T]he ultimate financial demise of (the company) was not the determining issue in the case before us. (The managing director's) fraudulent misrepresentation benefitted (the company) as it was the prerequisite to the (company's) approval to continue in business, and was integral to its marketing program* [9].

In *Florida v. Blackburn,* 633 So.2d 521 (Dis.Ct.App.Fl.1994), it was alleged that officers and directors looted the insurer leaving it insolvent. The defendants argued a "sole shareholder" defense on the basis that the shareholders of 100% of the stock cannot be guilty of looting a corporation which they own in its entirety. The court declined to accept this sole shareholder defense due to the presence of policyholders and other creditors. In addition, the court ruled that the activities of the officers and directors could be imputed to the corporation since "the imputation

[7] 144 F.3d 732 at 737.

[8] 240 B.R. 486 at 508.

[9] 625 So. 2d at 3.

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rule can only be invoked to protect innocent parties, and it is not available to the person who perpetrated the misconduct sought to be imputed." [10]

B. Other Receivership Cases

There are several cases with similar rulings which do not involve insurance company receivers or bankruptcy trustees. One is *Armstrong v. McAlpin,* 699 F.2d 79 (2ndCir.1983). Following an SEC investigation for securities fraud, the court appointed a receiver for an investment fund. The receiver and others sued the principal behind the fund and related entities for fraud, and the defendants raised a statute of limitations defense. The receiver argued adverse domination. The court noted that adverse domination requires that the entity be completely dominated by the wrongdoers. The court rejected the adverse domination argument on the basis that the receiver had made no showing that other officers and directors of the investment fund were part of the conspiracy or that there were no independent shareholders who could bring the wrongdoing to light. Conclusory allegations were insufficient to show adverse domination.

Federal Deposit Ins. Corp. v. Ernst & Young, 1991 WL 197111 (N.D.Tex.) was a suit by the FDIC for negligence in performing bank audits. The defendant argued that the knowledge of the bank's board chairman, CEO and sole shareholder should be attributed to the corporation thus barring a suit by the FDIC. The court noted that fraud by the corporation against third parties would be imputed to the corporation and ruled this the applicable rule of law in this matter:

> *In the present case, Woods was the sole shareholder. As a result, he was the beneficiary of his own fraudulent activity; the victims of the fraud were outsiders to the corporation – depositors and creditors. Thus, under (citation omitted), Woods' fraudulent acts were taken on behalf of Western. Furthermore, because his actions were taken on behalf of Western, his knowledge is imputable to Western* [11].

C. Other Case of Note

A case heavily cited on imputation and adverse domination is *Cenco Inc. v. Seidman & Seidman,* 686 F.2d 449 (7thCir.1982) *cert. denied,* 450 U.S. 880 (1982). Although not involving a receivership, it is included here since it is cited in many of the cases above both as support for their results or to distinguish it.

In *Cenco,* shareholders brought an action against former management for pervasive fraud and against the accountants who failed to detect it. In deciding whether to impute management's actions to the corporation for purposes of the accountant's liabilities, the court examined the underlying objectives of tort liability (i.e. whether innocent creditors would benefit) and whether future fraud would be deterred. As to the second point, the court found that future fraud by management would not be deterred by shifting liability to the accountants. As to the first point, the court observed that former management held significant stock and would benefit from the action. Other shareholders elected directors to the board who participated in the fraud and must bear some responsibility for the result. On this basis, the court imputed the activities of management to the corporation.

V. Conclusion

There is a line of cases which would: (a) allow imputation of a director's or officer's actions to the corporation and would decline to find adverse domination if the fraud was directed at third parties; but (b) not allow imputation or would find adverse domination if the wrongdoing was aimed at the corporation. This formulation of the rule may present difficulty in the insurance receivership context. The *aim* of the directors or officers may be difficult to ascertain since the *effect* may be the same i.e., an insurer that cannot pay the claims of insureds and other creditors. Moreover, a results-oriented receiver may believe that the specific aim of the wrongdoing is irrelevant to benefitting innocent parties and punishing the wrongdoers.

Receivers are likely to embrace the *Conseco, Tew, Schacht* and *Greenberg* line of cases which support the application of the imputation and adverse domination doctrines in a fashion designed to benefit innocent parties and punish wrongdoers regardless of the aim of such wrongdoers. Presumably, the formulation espoused in this line of cases would make it less likely for receivers to be responsible for the sins of prior management.

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[10] 633 So. 2d 521 at 524.

[11] 1991 WL 197111 *5.

The Adverse Impact That Unnecessary Regulatory Allegations Have Had on E&O Coverage in the Employers Mutual, LLC Litigation

Robert L. Brace [1]

I. Introduction

My firm, Hollister & Brace, is counsel to Thomas Dillon ("Dillon"), the Court Appointed Independent Fiduciary of thousands of Employee Welfare Benefit Plans ("EWBPs") that were created when small employers attempted to purchase health insurance for their employees. The health insurance was sold in 2001 to small employers across the country by licensed health insurance agents. The insurance turned out to be fraudulent and Dillon sued approximately 400 Insurance Producers who sold the insurance for malpractice and breach of the contract to procure valid insurance. There is over $25,000,000 in unpaid claims.

A substantial number of the 400 Defendant Insurance Producers had E&O insurance to cover them for malpractice. One problem encountered by us in collecting funds to pay claims is that some E&O carriers are denying coverage based upon allegations made by state insurance regulators that the Nevada corporation used by the con artists to facilitate their fraud acted like an "unauthorized insurer" or a "MEWA." That corporation, Employers Mutual, LLC, is now insolvent.

The documentary evidence, as well as the testimony of the Insurance Producers, reveals that Employers Mutual, LLC was not supposed to be acting in the capacity of the insurer or risk bearing entity, but instead was supposed to procure the health insurance from two licensed health insurers, both of which are solvent and not MEWAs. Employers Mutual, LLC did not procure the insurance as promised because the operators of the scam looted the premiums, and Employers Mutual, LLC had no contractual relationship with the admitted carriers to be able to bind coverage. The operators of the scam did have Employers Mutual, LLC pay a small amount of the claims at the inception of the fraud, the obvious purpose of which was to steal more premiums.

Several state insurance regulators inferred from the payment of some of the claims that Employers Mutual, LLC had contractually obligated itself to act as the insurer, or risk bearing entity. Because Employers Mutual, LLC was not licensed as an insurer or a MEWA, the regulators concluded that it violated the unauthorized insurer statutes and the agents who sold the product were strictly liable for the unpaid claims of their clients. Administrative complaints were filed against many of the Defendant Insurance Producers demanding that they pay the unpaid claims. Aside from access to E&O coverage, the vast majority of these agents do not have the economic wherewithal to pay the claims, which has made orders demanding payment potentially unenforceable.

Generally, E&O coverage is not available to pay unpaid claims pursuant to regulatory orders. E&O coverage is available to pay claims for damages brought by clients of the Defendant Insurance Producers provided the claims do not arise out of the placement of the clients' coverage with an unauthorized insurer, a MEWA, or an insolvent insurer. Dillon's Complaint against the 400 Defendant Insurance Producers alleges that he represents their clients pursuant to Court Order and the Defendant Insurance Producers failed to procure the admitted coverage for their clients as promised. The Complaint does not allege, and the facts do not support, the conclusion that Employers Mutual, LLC was the insurer. Notwithstanding our efforts to plead a more accurate description of the events in the case which would provide for E&O coverage, the E&O carriers have republished the regulators' allegations that Employers Mutual, LLC acted as an "unauthorized insurer" in an ongoing attempt to defeat coverage.

This paper is intended to inform regulators that in the future, they need to include in their analysis the potential adverse impact that regulatory allegations may have on E&O coverage for the damages caused to the clients of their licensees. If possible, disciplinary actions undertaken by regulators should accomplish the dual goals of the regulators of protecting the public and disciplining their agents without adversely impacting E&O coverage which is the only real source for the potential payment of claims.

II. Facts and Law of the Underlying Case Against the 400 Insurance Producers

A. Dillon's Authority to Represent the Clients of the Insurance Producers.

Dillon was appointed by the Federal Court in Reno, Nevada as the Independent Fiduciary of Employers Mutual, LLC and the"Employers Mutual Plans."The "Employers Mutual Plans" are the roughly 6,000 Employee Welfare Benefit Plans ("EWBPs") created by employers when they agreed to provide their employees with health insurance

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which turned out to be fraudulently marketed by James Graf ("Graf") and the other operators of Employers Mutual, LLC. Dillon has been charged with the duty of collecting the assets of the Employers Mutual Plans, dissolving them, and using the proceeds to pay the unpaid health expenses of over 8,000 people, which exceeds $25,000,000. In order to fulfill that obligation, Dillon hired my firm and we filed an action (the "Civil Proceeding") against, among others, approximately 400 Insurance Producers throughout the country who failed to discover the fraud and, as a consequence, failed to procure the insurance they promised to procure for their clients, the roughly 6,000 EWBPs, in exchange for the commissions paid.

B. Insurance Fraud Committed by Graf While Operating Employers Mutual LLC.

The Employers Mutual, LLC case is a case about insurance fraud. It is the writer's belief that insurance fraud is inevitable in a hard market, and therefore the first and last line of defense against it is the diligent Insurance Producer. Graf and the other RICO Defendants in the Employers Mutual, LLC case could never have perpetrated their fraud without access to the clients of the Insurance Producers, which was provided by their alleged carelessness. The fraud committed by the operators of Employers Mutual, LLC was as bold as it was simple. Graf represented to the Insurance Producers that his company, Employers Mutual, LLC, had contracts with Golden Rule Insurance Company ('Golden Rule") and United Wisconsin Life Insurance Company ("United Wisconsin"), whereby Golden Rule and/or United Wisconsin would issue individual health policies to all persons who, after being underwritten, were allowed to join one of Graf's 16 Nevada Associations. The critical problem overlooked by all of the professionals involved was that Golden Rule and United Wisconsin had no relationship with Graf or Employers Mutual, LLC. Due to their individual and collective negligence, the Defendant Insurance Producers believed the misrepresentations about the role played by Golden Rule and United Wisconsin and began placing their clients in one of Graf's 16 Nevada Associations in order for them to obtain the promised Golden Rule or United Wisconsin health insurance which was never procured by Graf or anyone else at Employers Mutual, LLC.

Graf's fraud was successful. Approximately 6,000 EWBPs paid premiums for the alleged insurance. The total number of insureds exceeds 30,000 people. Premiums amounting to $14,000,000 were paid, but only $2,000,000 in claims were paid; a substantial amount of the premiums were looted by Graf, and over $25,000,000 in medical claims of 8,000 people remain unpaid.

C. The Golden Rule Insurance.

Golden Rule is a health insurance company which is licensed in all states, except New York. Golden Rule is solvent and it is not a MEWA. The operators of Employers Mutual, LLC sent documents to the Defendant Insurance Producers which stated that the participants in the EWBPs were to be fully insured with individual policies procured by Employers Mutual, LLC from Golden Rule. One such document was a memo dated January 10, 2001which was sent to all of the Defendant Insurance Producers to give to their clients and it reads as follows:

> *"This memo is to inform you that all sixteen associations now offer health benefits to their members, which consist of a standard PPO, or Non-PPO policy with a Lifetime Maximum of $3,000,000 as provided in the Summary of Benefits. Additionally, the policy being issued to each participant is fully funded and fully insured.*
>
> *All Associations are domiciled in Nevada and all participants are enrolled through one of the sixteen Nevada Associations. The applicant's specific association facilitates the purchase of a policy from an A-rated or better insurance company; and* ***in most states the coverage is provided through the Golden Rule Insurance Company.***
>
> ***Employers Mutual is the management company providing services on behalf of the sixteen Associations. It functions as an administrator*** *and provides Network Access (PPO) contracting, Utilization Review, Quality Assurance, Pre-Authorization, and Pre-Certification, as well as verifying eligibility for its participating members. In addition, it is responsible for the day-to-day operations of the Associations."* (Emphasis added.)

Golden Rule is the alleged insurer and Employers Mutual, LLC is the manager or administrator in charge of procuring the insurance. Consistent with the representation above was the representation in the Plan Information Summary sent to Insurance Producers by Graf, which was passed on to clients as part of the solicitation effort. It states, in part, that "An insurance policy is purchased on behalf of each Participant" and Golden Rule is the insurance company.

In exchange for a percentage of the premiums paid, each Defendant Insurance Producer helped place their clients in one of the 16 Nevada Associations to obtain the coverage promised to be procured from Golden Rule. The misrepresentations about the role played by Golden

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Rule were relied upon by the Defendant Insurance Producers and by their clients. As an example, a letter from an employer, AYS Group, Inc., to the State of Florida Department of Insurance dated October 31, 2001 states as follows:

> *"On Wednesday January 24, 2001 Mr. Waddell and Mr. McKinney came into our office again with a gentleman named Mike DeBello (another agent, spokesperson for Employers Mutual, LLC). We were informed that Employers Mutual, LLC was now a "Fully Insured" plan. The plan information was as follows:*
>
> *Carrier: Golden Rule*
> *Re-Insurer: Sun Life of Canada*
> *PPO Network: Beechstreet*
> *TPA: Sierra Administration*
>
> *At that time, AYS Group, Inc. investigated all parties listed. All were legitimate entities. On January 26, 2001 Mr. McKinney and Mr. Waddell sent a Benefit Plan Summary. Per our investigation of the listed entities and agreement of rates and coverage, we signed a contract and coverage for our employees was effective February 1, 2001."*

Golden Rule never provided any health insurance to the employees of AYS or the other members of Graf's 16 Nevada Associations. Golden Rule never authorized Graf or anyone else at Employers Mutual, LLC to bind such coverage on its behalf. Ultimately, Golden Rule sued Employers Mutual, LLC to stop its operators from falsely using its name.

D. The United Wisconsin Insurance.

United Wisconsin is a health insurance company licensed in all states relevant to the case. It is solvent and it is not a MEWA. In addition to the misrepresentations about Golden Rule being the insurer, the operators of Employers Mutual, LLC also represented to the Defendant Insurance Producers that United Wisconsin was the insurer issuing the policies and bearing the risk. For example, a Memo from Employers Mutual, LLC to its Agents dated November 20, 2000 stated as follows:

> *"Dear Agent:*
>
> *We are pleased to announce that all of our Association plans being offered are* ***in conjunction with United Wisconsin Life Insurance Company.***
>
> ***Each member will receive a separate policy from the company*** *along with their Identifications Cards and Summary Plan Description booklets. United Wisconsin Life Insurance Company is rated A- (Excellent) by A.M. Best."* (Emphasis added.)

As with Golden Rule, United Wisconsin never authorized Graf to bind coverage on its behalf and no coverage was ever issued by United Wisconsin to the clients of the 400 Defendant Insurance Producers who paid premiums and joined the 16 Nevada Associations. The representations were fraudulent and Graf did not have the authority to bind the Golden Rule or United Wisconsin coverage for their clients as represented. That is what is alleged in the Complaint. There are no allegations that Employers Mutual, LLC was the insurer or risk bearing entity. Employers Mutual, LLC was, if anything, the "manager,""administrator" or "trustee." It was never the "insurer."

E. Legal Liability of Insurance Producers.

The defective health insurance was marketed across the country with the use of a Pyramid Marketing Scheme. Employers Mutual, LLC contracted with a wholesaler known as Associated Agents of America ("AAA"). The contract provided for the payment to AAA of 15% of the premiums collected. AAA, as the Wholesale Insurance Producer, had access to a stable of Retail Insurance Producers which it solicited to market the alleged Golden Rule/United Wisconsin insurance in exchange for a portion of the 15% commission. Many of the Retail Insurance Producers had access to other Retail Insurance Producers and they in turn contracted to share the 15% commission.

It has been Dillon's contention that all agents who shared in the commission taken from the premiums paid by the insured owed a duty to that insured and are jointly and severally liable for the unpaid claims of that insured. The liability of an Insurance Producer to his client, the proposed insured, for failing to procure the requested insurance is clear and is the subject matter of hundreds of cases. See the article entitled "Liability of Insurance Broker or Agent to Insured For Failure to Procure Insurance" found in 64 ALR 3d 398. The basic legal tenet is that an Insurance Producer who undertakes to procure insurance for a client and through fault or neglect fails to do so is liable to the client for resulting damages. *Washington, Inc. v. ENO and Howard Plumbing Corp.*, 348 A 2d 310 (Dist. Col. App.).

Dillon has already settled the litigation with several of the Defendant Insurance Producers. He has binding agreements which entitle him to receive over $8,250,000 in funds. He has also reached settlements with Defendant Insurance Producers whose E&O carriers have denied coverage. Those settlement agreements provide for stipulated judgments, a minimum guaranteed payment, and the assignment of rights to proceed against the E&O carriers. The litigation proceeds against the remaining non-settling defendants.

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III. Some E&O Carriers for the 400 Defendant Insurance Producers Adopted the Unproven Allegations Contained in Certain C&Ds Issued by Various State Departments of Insurance to Avoid Coverage

At the early stages of the fraud, Graf caused Employers Mutual, LLC to pay over $2,000,000 in claims. On August 14, 2001 the Florida Department of Insurance issued a Notice of Intent to Issue Cease and Desist Order and to Assess Penalty (hereinafter "C&D") against Employers Mutual, LLC and its operators alleging in part that Employers Mutual, LLC was acting as a Multiple Employer Welfare Arrangement (hereinafter, "MEWA") or an insurer, either of which required Employers Mutual, LLC to hold a Florida Certificate of Authority in order to conduct business in the State of Florida pursuant to § 624.437(2), Florida Statutes. The only evidence cited by the Florida Department of Insurance to support the factual conclusion that Employees Mutual, LLC was the risk bearing entity, and known to exist, is the fact that Employers Mutual, LLC paid a minimum amount of the claims – approximately $2,000,000 out of the approximately $27,000,000 in claims incurred. Other states filed similar Orders reaching the same conclusion. For instance, on October 4, 2001, the Texas Department of Insurance filed an Emergency Cease and Desist Order, the application of which alleged in Paragraph 9 that:

> *"Since as early as January 2001, Employers Mutual has conducted or engaged in the business of insurance in Texas as an unlicensed and unauthorized insurer and/or MEWA by selling health care coverage under what it purports and claims to be insured association/employer healthcare plans which are established, maintained and operated in accordance with ERISA."*

This writer discussed the allegations in the C&Ds with officials from the Florida and Texas Departments of Insurance who have stated that the only known evidence available to them to conclude that Employers Mutual, LLC was the risk bearing entity was the fact that some claims were paid by Employers Mutual, LLC. Dillon's expert, Robert Craig, has agreed to testify that it is his opinion that the operators of Employers Mutual, LLC paid a small amount of the claims at the early stage of the fraud in order to steal more premiums. All successful perpetrators of insurance frauds pay small claims and the claims of people who complain at the inception of the fraud in order to establish apparent legitimacy in the industry to be able to market the fraudulent insurance on a larger scale.

The inference that should not be drawn from the fact that some claims were paid out of the bank account of Employers Mutual, LLC is that Employers Mutual, LLC (as a Nevada corporation) intended to be contractually obligated as a "MEWA" or "Insurer" to provide "Insurance" coverage to 30,000 people. Taking the entity theory of the corporation seriously, it is unequivocally clear that no corporation, if truly represented, would agree to accept $14,000,000 in premiums in exchange for assuming $27,000,000 in indemnity liability, while at the same time allowing its "employees" to loot most of its premiums, leaving the corporation insolvent. That is not a business plan.

The only inference to draw from the evidence is that Graf's **purpose** was to steal premiums and Graf's **purpose** should not be imputed to Employers Mutual, LLC because Employers Mutual, LLC did not benefit from the fraud. See *F.D.I.C. v. O'Melveny & Meyers,* 969 F.2d 744 (9th Cir. 1991). The fact that Graf had Employers Mutual, LLC pay some small claims does not establish that Employers Mutual, LLC was a "MEWA" or an "Insurer" issuing "insurance coverage" to the clients of the 400 Insurance Producers. The uncontested C&Ds issued by the various Departments of Insurance do not establish facts which are binding on Dillon, the appointed Fiduciary of Employers Mutual, LLC. However, these uncontested C&Ds have been used by E&O carriers to deny coverage to their insured defendant Insurance Producers sued by Dillon.

It is understandable that regulators prosecuting Employers Mutual, LLC, an unrepresented corporation, could label it an unauthorized insurer because there was no one protecting Employers Mutual, LLC before Dillon was appointed as its receiver, and it is easier to prove the lack of a license than it is to prove fraud. However, arriving at the easy legal conclusion that the Insurance Producers were selling "unauthorized insurance" issued by Employers Mutual, LLC may not be in the best interests of the injured citizens of each state if such an unwarranted allegation has the potential of defeating E&O coverage for those producers who marketed the product to their clients.

IV. Declaratory Judgment Actions Have Been Filed by E&O Insurers Against Insurance Producers Sued by Dillon in the Civil Proceeding

Certain E&O carriers for a number of Defendant Insurance Producers have denied coverage to their insureds based upon the allegations by the various insurance departments in the C&Ds stating that Employers Mutual, LLC was an un-

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licensed insurer or a MEWA and therefore there is no coverage. Complaints for Declaratory Judgment have been filed by E&O carriers which raise the same three defenses to coverage. The three to be concerned with are:

1. *The MEWA Exclusion.* The E&O Policy bars coverage for "[a]ny claim arising from or contributed to by **the placement of coverage** with a Multiple Employer Welfare Arrangement as defined in the Employer Retirement Security Act of 1974 (and any amendments thereto)." *(Emphasis added.)*
2. *The Insolvency Exclusion.* The E&O Policy bars coverage for claims "arising out of the insolvency, receivership, bankruptcy, liquidation or inability to pay of any organization in which the INSURED has (directly or indirectly) **placed or obtained coverage** or in which the Insured has (directly or indirectly) placed the funds of a client…as a result of consultation with an Insured." *(Emphasis added.)*
3. *The Unauthorized Entity Exclusion.* The E&O Policy bars coverage for any claims "arising from or contributed to by **the placement of a client's coverage** or funds directly or indirectly with any organization, which is not licensed to do business in the State or jurisdiction with authority to regulate such business." *(Emphasis added.)*

It is our belief that all three exclusions do not apply to the facts as alleged in the Civil Proceeding because the Defendant Insurance Producers did not **place coverage** with Employers Mutual, LLC. Actual benefits under a contract of insurance have not been sought and denied by Employers Mutual, LLC. Employers Mutual, LLC was not the "insurer" providing the "insurance" coverage to the clients of the 400 Defendant Insurance Producers. One or more of the three exclusions will apply only if the risk bearing entity providing the contract of indemnity is (i) a MEWA; (ii) is insolvent; or (iii) is an unlicensed insurer. Golden Rule and United Wisconsin are both licensed, they are both solvent and neither is a MEWA. The fact that the operators of Employers Mutual, LLC did not procure the insurance with Golden Rule or United Wisconsin as promised does not, by default or implication, make Employers Mutual, LLC an unlicensed and insolvent "insurer" or a "MEWA" with whom the Insurance Producers placed coverage.

VI. Author's Recommendations

Regulators have been highly receptive to the concept of avoiding the use of regulatory allegations which have the potential of defeating E&O coverage for their licensees when the facts of the case can be interpreted in such a way that coverage is maintained and the two objectives of the regulators of protecting the pubic and disciplining its licensees are also obtained. For instance, the Texas Department of Insurance modified its position when filing disciplinary actions against its agents who sold the Employers Mutual, LLC product. At first the Texas Department of Insurance was alleging that its licensees had violated Tex. Ins. Code § 101.201, which states that:

> *"A person who in any manner assisted directly or indirectly in the procurement of the contract is liable to the insured for the full amount of a claim or loss under the terms of the contract if the unauthorized* ***insurer*** *[i.e., Employers Mutual, LLC] fails to pay the claim or loss."*

After a factual presentation was made to the Texas DOI that its producers were led to believe that Golden Rule or United Wisconsin were the carriers on the risk, it subsequently modified its position when pursuing its licensees by alleging violations of Tex. Ins. Code § 101.102 instead of Tex. Ins. Code § 101.201. Texas. Ins. Code § 101.102 prohibits entities and individuals who do not hold an insurance license or other authorization issued by the Texas Department of Insurance from directly and/or indirectly doing acts which constitute the business of insurance in Texas. The Texas Department of Insurance charged its agents with performing acts as the agents for Employers Mutual, LLC which did not have any kind of a license in Texas and which was doing acts which constituted the business of insurance by soliciting Texas employers to have their employees join the Nevada Associations to obtain the Gold Rule or United Wisconsin insurance. The change in position has allowed licensees to sign off on Consent Orders in disciplinary actions without making a factual recital or agreeing to a legal conclusion which could have the effect of precluding E&O coverage in the Civil Proceeding brought against them by Dillon.

In the future, regulators need to include in their up front analysis the potential adverse impact that regulatory allegations may have on E&O coverage for the damages caused to the clients of their licensees. If possible, disciplinary actions undertaken by regulators should protect the public and discipline agents without adversely impacting E&O coverage, which is the only real source for the potential payment of claims.

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Meet Our Colleagues

Joe DeVito

Alan F. Berliner

Alan F. Berliner is a partner in the Columbus office of the law of firm Thompson Hine LLP. Alan is a graduate of The Ohio State University Moritz College of Law and Case Western Reserve University.

Alan has served as Special Counsel to the Ohio Department of Insurance on more than a half dozen multi-state liquidations for over 20 years. In 1997, Alan took a leave of absence from private law practice and served as Assistant Director and Chief Legal Counsel at the Ohio Department of Insurance. While at the Department of Insurance, Alan led the team from the Department of Insurance in seizing control of PIE Mutual Insurance Company and the eventual placement of PIE Mutual into rehabilitation. Alan also served as Chief Deputy Rehabilitator and Chief Deputy Liquidator on a number of liquidations.

In April 1999, the Governor appointed Alan as Interim Director of the Ohio Department of Insurance. Alan returned to private law practice approximately five years ago to join Thompson Hine, which has offices throughout Ohio, in New York, Washington, D.C. and Brussels, Belgium. At Thompson Hine, Alan counsels insurance companies, reinsurance companies, trade associations and financial institutions on insurance regulation, government relations, administrative and litigation matters. Since joining Thompson Hine, Alan has participated in reinsurance arbitrations, formation of a mutual holding company, acquisitions, demutualizations, litigation and acted as general outside counsel to an Ohio domestic medical malpractice company.

Alan is a former member of the Board of Directors of Ohio State Life Insurance Company and is presently a Trustee of the Ohio State Bar Association Insurance Agency and Employment for Seniors.

Alan enjoys attending sporting events with his children, while Alan and his wife, Karen, enjoy the search for the perfect, relaxing beach vacation.

Dale C. Crawford

Dale Crawford is a sole practitioner providing specialized services in insurance and reinsurance. His practice includes arbitration, mediation, expert witness, and special project assignments. He worked in the industry for more than thirty years, evenly divided between insurance and reinsurance. In the latter, he was an offficer with nationwide responsibilities at North American Re and Bellefonte Re. His last industry job was president of National Home Insurance Company (RRG) in Aurora, Colorado. After a sale of that company and a buyout, he began his current practice. Duties to date have included service on 12 arbitration panels as both party-appointed and umpire, and more than 150 engagements as an expert witness in insurance and reinsurance disputes.

Dale's industry experience includes underwriting, marketing, claims, and administration. His career included 5+ years in senior management at Colorado Compensation Insurance Authority, a specialty writer of worker's compensation. Using that experience, he has taken part in several recent insolvencies of WC carriers, including some involving "carve out" reinsurance. An additional sub-specialty has been litigation support involving disputes between insurers, reinsurers, and managing general agencies.

His credentials include an MBA in finance, the CPCU and ARe designations. He is a certified by ARIAS US for reinsurance arbitration, and is on the ARIAS Umpires List based on completed arbitration service.

After career stops in Texas and New York, Dale and his wife live in Littleton, Colorado, a Denver suburb. They chose this location to put them close to their activities of mountain biking, tennis, cross-country skiing, snowshoeing, hiking and camping.

Meet Our Colleagues

Joe DeVito

Andrew Brannon

Andrew Brannon is a founding director of the LCL Group, which is based in the heart of the international insurance and reinsurance market in the City of London. The Group provides a wide range of specialist and high quality services primarily, although not exclusively, to the insurance market.

Andrew, who qualified as an accountant with Spicer and Pegler (which subsequently became part of Touche Ross, later renamed Deloitte & Touche) is also a Licensed Insolvency Practitioner. He has deployed this particular combination of professional qualifications to problem solving and solution finding for almost two decades as a specialist in corporate recovery and insolvency.

He has acquired a unique reputation for dealing with numerous financial services institutions, including London market reinsurance companies, Lloyd's agencies and brokers and has also implemented Schemes of Arrangement – both reserving type and cut-off schemes – for UK and Bermuda-based companies.

In 1997 he established MRC Consultants to provide Insolvency Practitioners appointed to insurance and reinsurance institutions with management and related services. These include run-off, administration, tailor-made systems solutions and recoveries. Five years later in 2002, the consultancy became a member of the LCL Group and changed its name to LCL Consulting Ltd.

Within the LCL Group, Andrew assists Insolvency Practitioners dealing with insolvent estates to assess claims profiles and exposures, recommend exit solutions and implement estimation/cut-off Schemes of Arrangement. He is also heavily involved in dealing with the run-off of the Group's own discontinued insurance and reinsurance operations.

Educated at the Kings School, Chester and the University of Kent at Canterbury, Andrew is a Fellow of the Institute of Chartered Accountants in England and Wales. He is also a Freeman of the City of London and a Liveryman of the Worshipful Company of Firefighters – offices whose origins lie in the City's medieval past.

Andrew represented Great Britain in fencing at the World Under-20 Championships and at subsequent international events. He now pursues the sport on a more leisurely basis and has been the Honorary Treasurer of British Fencing, the sport's governing body in the UK, for the past 15 years.

His other interests include travel, cricket and opera – the last involving sponsorship of the English Pocket Opera Company, a company dedicated to finding new young singers. Married to Fiona, also an accountant, they live in Barnes, West London.

John "Jack" W. Brand, Jr.

Jack Brand is a practicing attorney in Lawrence, Kansas. He is the Senior Member of a fifteen-lawyer firm, with extensive experience in receivership litigation and, in particular, in assisting the Kansas Department of Insurance.

Jack Brand served as Editor-in-Chief of the Kansas Law Review and was elected to Order of the Coif. He is a Fellow of the American Bar Foundation, is listed in The Best Lawyers in America, and in 1999 received the Kansas Bar Association Outstanding Service Award.

In regard to receivership work, Jack finds the area interesting and challenging. His receivership litigation has ranged from as far as Kansas to Florida.

Jack and his wife, Barbara, have three daughters and ten grandchildren. Besides following the Kansas Jayhawks Basketball Team, they are avid followers of their granchildrens' athletic pursuits.

Joe DeVito

San Francisco Roundtable Recap

Kristen Shikany [1]

The IAIR Roundtable at the San Francisco meetings on Saturday, June 12 included a series of interesting and thought provoking presentations. The program was hosted by **Vivien Tyrell**. Vivien is a Partner and the Head of Insurance Insolvency at Kendall Freeman in London. She is also the London Solicitors Chair on IAIR's International Committee. The program began with a presentation on recent developments in California on insurance issues by **Nettie Hoge**, California's Deputy Commissioner for Policy and Planning. Deputy Commissioner Hoge provided updates on contingent commission issues, Workers Compensation reform and other matters.

Current Developments in California

Contingent commissions are paid to brokers by insurers based on the volume or profitability of the business placed on behalf of the brokers' clients. The California Department of Insurance is investigating contingent commission arrangements. There has been only a preliminary review of the facts at this point. The best case is that brokers will be required to disclose these arrangements to policyholders.

Worker's compensation reforms were enacted in California in September 2003. Additional reforms were enacted this past April. Deputy Commissioner Hoge referred attendees to the California Commission on Health and Safety website *(www.dir.ca.gov/CHSWC/chswc.html)* which provides a good summary on California's worker's compensation reform legislation (SB 899). SB 899 was enacted April 19, 2004 and attacks the structural issues.

The bill provides for reimbursement to private employers with 50 or fewer full-time employees for worksite modifications to accommodate the employee's return to work. The program will reimburse up to $1,250 of expenses to accommodate a temporarily disabled worker or $2,500 to accommodate a permanently disabled worker.

The bill defines the treatment "reasonably required to cure or relieve" as the treatment that is in accordance with the guidelines adopted by the AD pursuant to Labor Code sec. 5307.27. Unless the employer uses a medical treatment network, the basic rule remains that the employer has medical control for the first 30 days (or longer in an HCO), and then the employee gets the right to select the treating doctor.

It defines patients' rights and provides that after the first visit the injured worker has the right to choose a doctor within the medical network. It authorizes the injured worker to obtain second and third medical opinions in an appropriate specialty within the network if he/she disputes the diagnosis or treatment prescribed by the treating physician. It also authorizes out-of-network specialist treatment if approved by the employer or the insurer.

In formulating policies and procedures to support these legislative actions, the California Department of Insurance ("CDI") incorporated the American Society of Workers Comp Professional, Inc. ("AMCOMP") guidelines and principles in their rules to raise the professional standards of practice in the administration of workers compensation benefits.

The legislature was looking to control litigation costs and believes that delays in treatment and payment drive more litigation. Employers have been forced to review and respond to claims sooner. The employer must provide medical treatment to a worker after a workers' compensation claim form is filed and until the claim is accepted or rejected. There is a $10,000 limit on liability before a claim has been accepted or rejected.

Temporary disability benefits are limited to 2 years from date of commencement of payment in most cases. Temporary disability may extend to 240 weeks aggregate within the first 5 years after date of injury for certain injuries (i.e., amputations, severe burns, chronic lung disease, etc.).

Regarding permanent disability, how the "pie" is divided has been the issue rather than the size of the pie. It provides that reports addressing permanent disability must address causation and must determine the percentage of permanent disability caused by injury and by other factors, or refer to another doctor to evaluate apportionment. It specifies that the injured employee must disclose previous disabilities or impairments upon request. The employer is liable for the percentage of permanent disability directly caused by the injury.

The bill provides that the department contract for a study of effects on workers' compensation insurance rates as a result of the 2003-2004 reforms. There is no rate regulation in the bill and no requirement to determine whether or not the savings have been passed through. The only requirement is that the Governor's designee shall examine whether savings were passed through and then contemplate whether or not there should be some type of regulatory apparatus in the future.

[1] Kristen Shikany is a Director in the Chicago office of Navigant Consulting, Inc. and co-chairperson of the IAIR Publications Committee.

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All that will be required of workers comp carriers going forward is that they file proposed rates with the California Department of Insurance every 6 months. Theoretically, they are supposed to reflect the advisory pure premium but there is no statutory requirement that they do so. The Department of Insurance has and will continue to examine filings to see whether the reforms will actually deliver the promised savings. Deputy Commissioner Hoge is hopeful that there will not be a Workers Comp III until they have sorted these things out.

A UK Perspective on the Mystery of European Insurance Regulation

Richard Spiller, head of Kendall Freeman's Corporate and Regulatory practice in London provided a UK perspective on the mysteries of European insurance regulation. His key areas of focus were on what is/is not regulated, who has access to the market, the current capital requirements and the implementation of new directives.

EU Membership

At May 1, 2004 there were fifteen member states of the European Union: Austria, Belgium, Denmark, Germany, Greece, Finland, France, Ireland, Italy, Luxembourg, Portugal, Spain, Sweden, The Netherlands and the United Kingdom. On May 1, 2004, 10 new members were added: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, and Slovenia. The European Free Trade Area (EFTA) has three members: Iceland, Norway and Lichtenstein. Together, these 28 countries make up the European Economic Area (EEA), the area within which the single regulatory market applies. Although Switzerland is not a member of the EEA, it does have special treaties that give it preferred rights in accessing and doing business in the European market.

The addition of the 10 new members does not add a significant volume to the market. It adds less than 5% of the GDP despite adding 75 million people, bringing the total number of people in the European Union to 450 million people. From an insurance premium perspective, it adds just €1 billion (or $1.2 billion US) to the existing total annual insurance premium in the European Union of €778 billion (or $930 billion US). In Germany, for example, the average premium dollars per annum is €1,500 (or $1,800 US) whereas the average in the 10 new member states is €120 (or $150 US).

Who is Regulated in the EEA?

All insurance regulation in the EEA is by the member states and there is no European level regulation or equivalent to federal regulation. Direct insurance is however, regulated on a coordinated basis. The EU Commission introduced three directives for the Life industry and three directives for the Non-Life industry that coordinate the basis of regulation for direct insurers making it basically the same in all member states. Regulation is only by the home member state (state of domicile) with very limited rights of intervention for the public good by host member states (states in which the insurance is being sold).

Regulation for reinsurers is even more limited. Regulation covers reinsurers who write direct business but it does not include carriers who write only reinsurance. Surprisingly, there are only a few member states that regulate pure reinsurers. Ireland and Belgium have no regulation for reinsurers whatsoever. In Germany and France, reinsurance regulation is on an indirect basis only via reviewing the solvency of the direct insurers. Austria, Italy, Spain and Sweden operate a limited regulatory regime for reinsurance. Only 4 states (Denmark, Portugal, Finland and the UK) have a comprehensive regime for the regulation of pure reinsurers. Of these four, only the UK has a system of regulation that is as comprehensive for reinsurers as it is for the direct industry. In April of this year, the Commission put out a formal proposal for a directive to introduce a supervisory framework throughout the EEA for pure reinsurers.

Brokers and agents are only regulated in some member states. In particular, general non-life insurance brokering in the UK is not regulated at present except on a voluntary industry standards basis. This will change in 2005, as, via a 2002 directive, all member states need to introduce regulation of insurance intermediaries throughout their individual states.

What is not Regulated in the EEA?

Premium rates and policy forms are not regulated in the EEA. In some member states, there is no regulation of direct insurance sold into the member state from abroad. For example, it is possible to sell most forms of insurance into the UK without authorization, provided you are not physically present in the UK. In other member states, there is regulation on the basis of the situation of risk. For example, if you wanted to sell a direct policy to a French policyholder out of the US, you could not unless it fell into one of the exemptions. Many member states have exemptions for lines such as marine, aviation and other specialty types of commercial insurance.

Reinsurer security is not regulated in many member states. France is an exception, as overseas reinsurers need to provide security. Regulation regarding the selling of insurance products exists in some member states but not in others. The UK, at present, does not have any legislative framework for regulating the

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sale of non-life products in the UK although that will change next year.

Entering the EEA Direct Insurance Market

There are three principal ways to enter the EEA direct insurance market. The first is through setting up a subsidiary, the second through opening a branch and the third through investing in a corporate member of Lloyd's. The EEA subsidiary route and the Lloyd's route have the advantages of gaining licenses to operate in other states. Under the single European passport, an EEA subsidiary can operate branches in its own state as well as all other member states and can sell in all other member states. However, this only applies to European companies. A US based or non-European company could not operate under a single European passport. Per Richard, the Lloyd's option is interesting in that you enter a highly regulated market but at the same time immediately gain the benefits of Lloyd's licenses throughout the world and from Lloyd's financial security rating.

Current Capital Requirements

The capital requirements for companies in Europe are quite complex and changed under the Solvency I initiative on the 1st of January this year. Each European company must have solvency capital equal to the higher of its minimum guaranty fund or its solvency margin.

The minimum guaranty fund is a fixed figure depending on class of business. It is now between €2 and €3 million. The solvency margin requirement is generally much higher and determined by calculating the higher of premium margin or claims margin. The figures are much higher than previously and will have a big impact (particularly the claims calculation) on companies in run off. The premium test is based on the most recent annual return figures and is 16–18% of annual premium. The claims calculation is based on 23–26% of annualized claims over a three-year period. An arbitrary rule, introduced on January 1, 2004, increases the premiums and the claims on all liability classes by 50%. This moves up the solvency margin further for companies that write liability business. The solvency margin calculation can be reduced by reinsurance but the maximum reduction for reinsurance is 50%. Companies that are heavily reinsured will find that their capital requirements are much higher because of the impact of the restriction on credit for reinsurance.

Lloyd's operates under a different system with its solvency calculations based on the market as a whole. Each company within the market has its solvency margin calculated according to a risk based capital system devised by Lloyd's. This system requires a minimum deposit of funds at Lloyd's of between 40% and 100% of annual premium (at times even more than 100%).

Changes Underway

The EU Commission is working on an initiative that will introduce risk-based capital across the EU. This initiative, entitled Solvency II, is estimated to be in effect in 2008. In the meantime, the UK's Financial Services Authority (FSA) is introducing a risk based capital system in 2005. The first step is the introduction of an enhanced capital requirement (ECR). This risk calibration will be calculated by applying a percentage based on premium class to an insurer's admissible assets, net written premium and net technical reserves.

The second step is to calculate the company's individual capital assessment (ICA). The insurer itself will need to determine its own stress and scenario tests covering the insured's underwriting risks, operational risks, market risks and solvency risks. These tests will produce an additional capital requirement that will be submitted to the FSA. The FSA will review, test and issue individual capital guidance (ICG) which may require the capital to be increased even further. It is estimated that capital requirements for UK companies will increase by 50–100% once the risk based capital system is introduced. The UK will then need to apply the European standard as a minimum in addition to its own enhanced capital requirement further complicating the process.

The new UK capital requirements may have serious effects on underwriters who are writing new business and do not have access to additional capital. Depending on their capital allocation, they may need to redesign their products, withdraw from capital-intensive lines of business, increase their reinsurance, diversify the lines they write or relocate to another member state. Run off companies are subject to the requirements but do not have the option of moving. This will cause a number of changes in the market. Already a number of companies in run off are being bought and consolidated. Additionally, business transfers are being proposed from one run off company to another in order to consolidate different books of business and reduce the capital requirements.

Directive to Coordinate Reinsurance Supervision Throughout the EU

The EU Commission has introduced a draft directive to introduce a single system of reinsurance regulation throughout the EU. There are a number of reasons behind initiating the directive including response to criticism from the International Monetary Fund. The EU is carrying on negotiations with the US regarding credit for reinsurance and believes that this will strengthen the EU's position considerably. The EU Commission's press release identified €50 billion in EEA based reinsurer assets as security for US cessions. It is

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clear that they will attempt to release some of those funds. The draft directive also contains a prohibition against preferred rights of access for non-European reinsurers over European reinsurers. For example, it would be illegal for the UK regulator to make it easier for US companies to come into the UK market than for French companies to do so.

The draft directive will essentially apply the standards for direct insurers to reinsurers. The solvency rules will be similar to those described earlier although the regulators will have the right to enhance the requirements by up to 50% on riskier classes of business. It is not certain at this time which lines will be affected by the increased capital requirements. This will be decided by CEIOPS, an organization of EU domestic regulators. The directive is not likely to be implemented in EU member states until 2007.

Regulation of Intermediaries

The Commission put a recommendation in place regarding the regulation of intermediaries in 1991 but it has largely been ignored particularly by the UK. The Commission introduced a new directive in 2002 that requires member states to introduce statutory regulation of insurance intermediaries in January 2005. The UK proposes to couple this with the implementation of the regulation of the sale of non-life insurance products. The regulated activities that will require authorization from the FSA include typical broker activities but will also cover administration of insurance contracts. As a result all sorts of service providers, including run off managers, will be regulated.

The proposed rules to be applied to insurance intermediaries under the directive included a series of choices for EU member states including compensation scheme, segregation of customer money, minimum capital requirements and/or compulsory professional indemnity insurance. In the UK all options will actually be adopted. The FSA has recognized that the London Market systems will not be able to handle the segregation of customer money and therefore have tabled this and are consulting further.

The minimum capital requirements for intermediaries will be based on premium. Regulation of the sale of insurance products involves the introduction of rules covering areas such as unfair inducements (including contingent commissions and PSAs), financial promotion, selling standards, cancellation rights, and disclosure of commission to commercial clients. The rules will not apply to reinsurance brokering or to wholesale brokering and they will apply at a lower level to commercial insurance than to retail insurance. The impact of this will be that brokers will need authorization and both brokers and insurers will need to bring their selling procedures into line with the new rules by January 2005.

The Reorganization and Winding Up Directive

The Reorganization and Winding Up Directive has been in force for just over a year (since April 2003). It applies to liquidation and company voluntary arrangements but not to Schemes of Arrangement. Priority for direct policyholder creditors over reinsurance and other creditors is a key aspect of this directive. It applies to all direct insurers throughout the EEA and also applies to branches of foreign insurers. If a US company had branches throughout Europe, each branch would be subject to a different procedure, as the rules of the jurisdiction in which the branch is located will apply. For European companies, the home state rules apply. This does not apply however to set off, in relation to which the rules applicable are those where the branch is located.

Presentations

Prior to the intermission, **Dan Watkins** made two presentations of IAIR accredited insurance receiver designations. **Joe DeVito**, of DeVito consulting, received a designation of accredited insurance receiver in the areas of reinsurance, claims, guaranty funds, accounting and financial reporting. **Greg Mitchell**, partner with Frost Brown Todd LLC in Lexington Kentucky, received a designation of accredited insurance receiver in the legal area. **George Gutfreund**, partner at KPMG and President of IAIR, was presented a plaque in recognition of his dedication to the Accreditation and Ethics Committee over the past three years.

Commercial Run-Off: Friend or Foe?

Michael Coutu, President of Kenning Associates spoke next on commercial run-off. Mike's goal is to find a better solution than the current solution for insolvent insurance companies. Kenning Financial Advisors was formed to manage troubled insurers and reinsurers. Kenning's working premise is that it can often maximize the value of the estate to a greater extent than would be the case under liquidation proceedings. The question is how best to harvest the value embedded in an insurance company.

Mike believes that a commercial run off can avoid many of the pitfalls of insolvency proceedings including: delays in the payment of claims that go on for many years; challenges with respect to reinsurance recoverables; and many of the additional costs associated with professionals, lawyers and others who review transactions.

Per Mike, solvency does not have much meaning. Solvency is the result of maintaining a positive capital structure.

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However, a positive capital structure does not have economic value. He believes it is more important to have enough cash with economic value to manage a run off. The bankruptcy code has two tests of solvency: 1) the traditional test - liabilities in excess of assets, and 2) inability to meet liabilities timely when due. If a company is struggling with having a positive surplus but has enough cash and investments to pay claims and collect reinsurance, Mike questions whether it should be put it into receivership simply because it does not have a positive surplus.

Mike believes there is a need to change the industry in a way that better addresses these challenges. For example, guaranty funds were created mainly for the purpose of personal lines products such as automobile and homeowners. They were not created to be the court of last resort for large commercial companies as in the Reliance insolvency where a tremendous strain has been placed on the state guaranty funds.

Mike believes there is a lot of merit in finding a better way to deal with large troubled commercial companies. There are those on the hill, such as Senator Oxley, that believe federal regulation may be beneficial at least with respect to the administration of insolvent companies. Mike believes that a catastrophe is all that is needed to crystallize action with respect to federal regulation. He believes we need to do things differently in order to control our destiny within the state regulatory framework rather than under a federal one.

Whenever Kenning formulates a run off plan, the first step is to analyze the balance sheet, cash and surplus to determine if it should be a commercial run off or liquidation. The difference between the two is that in a commercial run off, there is an expectation that there will be residual value in the estate after running it off. Another difference is that in a commercial run off, claims are discharged in accordance with their natural cycle. There is no acceleration, no discounting and most importantly, no haircut. A full dollar is paid for every dollar of liability. The other critical difference is whether or not the balance sheet will consume itself in the discharge of the obligations during the run off period. The key is whether or not there is a revenue stream to pay for expenses. As the premium line goes away, there must be enough investment income to pay for expenses so that surplus will not be drained.

Mike believes he can preserve a balance sheet via policy buy backs and reinsurance commutations. In a policy buy back, in exchange for a dollar amount, the policy is absolved of all future obligations; the contract is null and void. In a novation of policyholder liabilities, the liability is transferred to an assuming carrier. Policy buy backs have the benefit of giving surplus a lift. For example, if a policy is bought back for less than reserves, surplus can be benefited. While doing this, Mike must ensure that he does not reach a point where keeping the company up artificially produces inferior value. He also must assure that there is sufficient liquidity to administer the estate should it ultimately go down and be put into proceedings. In addition to policy buy backs and commutations, run-off plans typically call for continued expense reduction and improvements in liquidity.

Among other benefits, Mike believes commercial run-off provides for a normalized process for settling valid claims and avoids delay in the payment of valid claims. The "duty to defend" is maintained. Substantial shrinkage of reinsurance recoverables is prevented and the additional friction costs of a judicial receivership are avoided. Finally, it provides the state guaranty funds with a much-needed reprieve given the strain of the Reliance liquidation on existing funds of key states.

Mike believes it is time for change. There is work going on at the NAIC seeking to address this. It is not that liquidation proceedings themselves are wrong. Rather, it is the issues associated with them, namely timeliness, delays and cost. Many of Mike's views are consistent with those expressed in various studies including "Managing the Cost of Property-Casualty Insurer Insolvencies in the U.S.," from the Center for Risk Management and Insurance Research at Georgia State University and others.

Leaky Condominiums and New Home Warranty – The Canadian Experience

Robert Rusko, Partner at KPMG and Senior Vice President of KPMG Inc. in Canada, presented next on leaky condominiums and the insurance issues arising from them. KPMG was the trustee in the New Home Warranty (NHW) of British Columbia $200 million bankruptcy proceedings.

New Home Warranty

NHW was a not-for-profit private company incorporated by the Canadian Homebuilders Association (CHBA). The CHBA was an industry association representing builders and developers in the residential construction industry. NHW was incorporated in 1976 by the CHBA to respond to the need of consumer protection against structural problems and lack of industry self regulation. The British Columbia Warranty Program was voluntary and was used by the builders and developers as a marketing tool. Mortgage companies required a warranty as a condition for obtaining a mortgage. NHW enjoyed a monopoly in British Columbia

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until 1995. NHW was not subject to regulatory requirements under The Financial Institution Commission (FICOM). It flew under the radar screen, walking and talking like an insurance company but was not an insurance company in a financial sense.

Warranty Program

The warranty program covered all workmanship and materials for the first year. The pure warranty was only for major structural defects and only covered up to 10 years so the tail was not significant. Limitations were $100,000 per unit and $2,000,000 for common property. Builders would register with NHW and pay an enrollment fee. The builders were supposed to be risk rated by NHW, however, this did not happen. There was a fee charged per unit constructed, however, this fee stayed fairly constant even as the claims against NHW increased. NHW had very limited reinsurance, which proved to be significant later on. In summary, warranty funding was provided by registration fees, enrollment fees and interest income on reserve funds.

The "Perfect Storm"

A "Perfect Storm" of factors led to the leaky building problems. There was a housing boom in the early 1990's particularly in the condominium industry. The increase in the number of new housing starts was similar to the environment we are seeing in the US and Canada today. The housing boom created a shortage of trained construction workers and also created problems for municipal/city housing inspections. As a result, the municipalities pushed the inspection process down to the professionals requiring certifications by architects and engineers to make sure the buildings were built properly.

The new architectural designs coming out at this time also added to the problems. The public desired architectural flare and more complex designs that were unproven in multi-family dwellings. There were new building technologies such as windows without sills and face seal building construction. In addition, there were significant building code changes that caused the builders and contractors to try to design the buildings differently. For example, the FSR ratios required the overhangs to count as part of the coverage of the building. To keep profit up, the builder would decrease the overhangs causing more exposure to the walls of the buildings.

During the energy crisis in the 1980's, the building code changed in an attempt to try to retain energy requiring a vapor barrier on the inside and outside walls. The barrier did not allow moisture to evaporate which was exacerbated by British Columbia's damp climate (very similar to the UK's climate). The practice of building with green timber caused a built in problem as well since the water in the timber would never evaporate.

The buildings contained flat roof top decks and were fully exposed to the weather conditions. The windows were set right in and were uncovered. If there were any leaks, they leaked directly into the structure. The porches sloped into the buildings as the buildings settled causing the water to flow back into the building. Since the warranty only covered structural defect, a lot of the problems that needed expensive repairs were not covered by the warranties.

NHW's claim history was negligible in its early years and really began to climb in the early 1990's. By 1998, NHW was under huge pressure due to accelerating monthly claim costs. In 1999, claim costs had spiked to record levels and NHW was required to file for bankruptcy protection.

There were additional factors at work that also had impact on NHW. The government was well aware of the problems that leaky condominiums were causing in the province so new legislation required warranties specifically for water problems. They also required any warranty provider to have a proper financial balance sheet. In essence, NHW was being forced to become an insurance company.

By 1999 there was a decreasing trend in the number of housing starts. Additionally, the leaky condominium problems were causing multi-unit construction to lose popularity with the consumer. The decrease in the number of enrollments caused a decrease in enrollment revenue that could be utilized to fund warranty claims. NHW was also affected by lower yields on investments. It was the classic case of an insurance company with decreasing investment income and decreasing premium revenues facing increasing claims. In addition, NHW was facing very significant litigation costs. Since there was no legal precedent set, there was much litigation over what was covered.

Overview of Insolvency Law in Canada

Canadian insolvency laws are governed by the Bankruptcy and Insolvency Act of Canada (BIA). Similar to the Chapter 11 proceedings in the US, filing a Notice of Intention results in a stay of proceedings. Under the BIA, a proposal must be presented to the creditors within six months of filing the Notice of Intention. The process is very creditor-driven. There must be a meeting of creditors who vote on the proposal. To be successful, it must be approved by 2/3 in value plus a majority number of votes in favor. An unsuccessful proposal results in an automatic bankruptcy.

The role of a trustee in this is a bit different than the trustee's role in the US and UK. The trustee acts as a fiduciary to all of the creditors, but during this process, they are assisting the company in the development of the proposal, monitoring and reporting to the court on the process, and

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calling a meeting of creditors. The trustee ultimately needs to opine on the proposal. The test is that the offer being made through the proposal is better than what would be achieved through bankruptcy. This multifaceted role of trustee could be tricky at times. For example, the company wanted wording in the proposal that would give them protection against Director's Liability, but KPMG, as the trustee, refused this.

Development of the Proposal

The Notice of Intention was filed in March 1999 with the creditor's meeting to be held in October 1999. In between, the proposal was developed and needed to deal with a number of issues. The first issue was the difficulty caused by the 10-year warranty tail. For obvious reasons, waiting for 10 years to value and liquidate the claims would not be acceptable. The solution was to cut the tail and shorten the process by setting a claim bar date based on an analysis of historical claims' expiry dates. The bar date was originally set at August 2003 but was later extended to December 31, 2003.

Another issue was the need for representation of the IBNR claimants. Knowing future claimants were out there, the trustee did not want these claimants' rights to go unrepresented. An actuarial determination of the IBNR claims was made and the Court appointed legal representative counsel.

The cost of litigation over the $200M worth of creditor claims was an issue that could easily drain the estate, which would benefit no one. The solution was summary arbitration. Each side is given the opportunity to present its case with the arbitrator deciding (also known as baseball arbitration).

Due to the negative associations with previous management, the Directors were forced to resign and administration was by the Trustee and inspectors. To further cut administrative expenses, the court sanctioned the use of a web site for communications and allowed the various parties to communicate via email.

The proposal was simply a liquidation proposal as it was essentially the only feasible option. Assets realized were 1) cash on hand, 2) past litigation and future litigation and 3) security deposits. There was a very significant litigation portfolio. Under the warranty program contracts, they had the right to go back against the builders and developers to recoup costs. The also had a right in tort against the other sub trades.

Administration of the Proposal

The recovery actions were very complex as they involved a divided claim with two plaintiffs – both NHW and claim strata (e.g., the multi-party condominium owners and their counsel). Canadian courts do not allow for punitive damages, so there are relatively modest recoveries. As such, counsel is paid on retainer rather than on a contingency basis. Considering that each trial would take approximately 8 weeks and involve at least a dozen defendants and their insurers, litigation costs were extremely high. The legislation required people to mediate. Therefore, they were able to try to work out deals and settle which may have given up some of the recoveries but saved a great deal on litigation costs.

The buildings had to be "skinned" in order for damages to be determined. Since many buildings were not skinned, it was difficult to estimate costs. They kept a good database of case facts and became proficient at profiling buildings and estimating costs based on claims that had already been reviewed. A bar of approximately a dozen law firms represented the claimants. Ad hoc committees would present to groups to explain what was being done and how estimates were arrived at. The audiences were fairly receptive to this so they had good outcomes.

In conclusion, they have managed one interim dividend payment with another on the way this summer or early fall. This was accomplished in half of the time that it would have taken without the proposal. Administration will be complete by the end of this year with the exception of some of the litigation recovery. Although the recoveries are conservative, they have tracked other strata counsel and believe they are tracking fairly well in comparison. Finally, administration costs have been significantly less than if full liquidation had taken place.

Recent Developments in Asbestos Exposure

Linda Barber, a Director at Navigant Consulting, Inc., gave an update on asbestos exposure and its impact on insurance insolvency as well an overview on the federal asbestos legislation. Topics covered by Linda included the progress of the ongoing federal legislative efforts, state legislative reforms that have been enacted, an update on trends in claim filings, court decisions and insurer reserves.

Federal Asbestos Legislation

In July 2003, the Senate Judiciary Committee passed S. 1125, a bill proposed by Senator Orin Hatch. Various issues continue to be debated but the key issues center around the amount of funding, the disease categories, and what each claimant has to show to be entitled to funds. A new bill, S. 2290, was introduced in April 2004. Senator Diane Feinstein, a Democrat from California, was very involved, which exemplifies how very determined both sides are to achieve reform in this very difficult area.

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The key issue is the size of the fund. Labor will not go below $140B, however, to date, the highest offer from Frist and Daschle's staff is $131B with no contingency. Some of the defendants are willing to go to $140B but others refuse without an increase in insurer funding. Claim values for smokers with lung cancer are also an important issue. Labor, the defendants and the insurers are all negotiating both internally and externally on these issues.

With all of Linda's experience in the insurance industry over the past thirty years, she never imagined that federal legislation would get this far. She believes there is a chance for passage although time is growing very short, and as time passes the odds decrease. The fact that so many Senators and other stakeholders have kept pulling the bill back from the brink of failure shows the determination of all to act. The President has publicly stated the need for Congress to pass asbestos legislation. If something passes in the Senate, it is expected that the House would approve and the President would sign.

State Legislation

Efforts towards tort reform in regards to asbestos have been ongoing in many states since 1996. Legislation has been passed in Texas and Mississippi, both hot beds for asbestos litigation. Additionally, asbestos legislation passed in Ohio last month. Differences have been made in capping individual awards, in who can file a suit where, and in disease proof. Legislation regarding case management orders and inactive dockets exists in Baltimore; Cleveland; Cook and Madison County, Illinois; Middlesex County, Massachusetts; New York City; Philadelphia and Syracuse. Those who are not yet sick must wait until sickness develops before their suit can go forward. This has had a tremendous positive impact in keeping the unimpaired claimants out of the court system. Most notable of late is Michigan, as the Michigan Supreme Court is in a position to approve, however, an appeal is pending. There are similar ongoing efforts in Harris County, Texas; San Francisco, and Alameda, California.

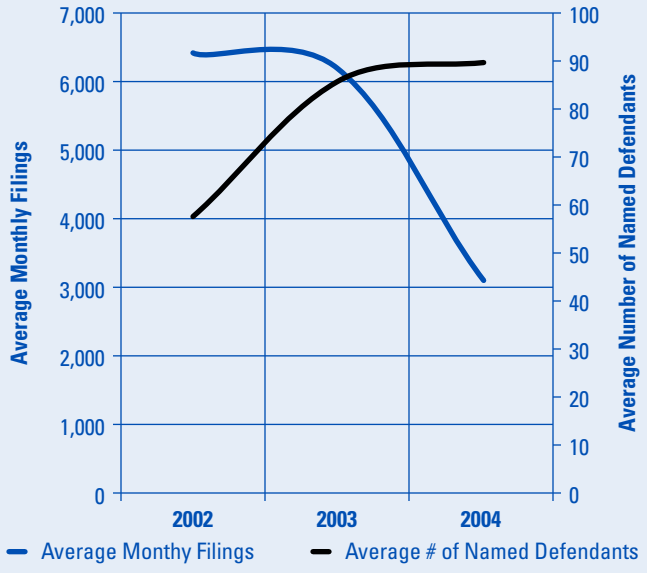
Claim Trends

After the huge ramp up in claim filings in 2001 and 2002, average monthly claim filings have decreased by 50% between 2002 and June 2004. At the same time, the number of defendants has increased dramatically. Per AM Best, the average number of defendants named in a complaint has increased by 38% (from 55–89). *Figure 1* displays the average monthly filings versus the average number of defendants. Average number of monthly filings has decreased from over 6,000 to almost as low as 3,000.

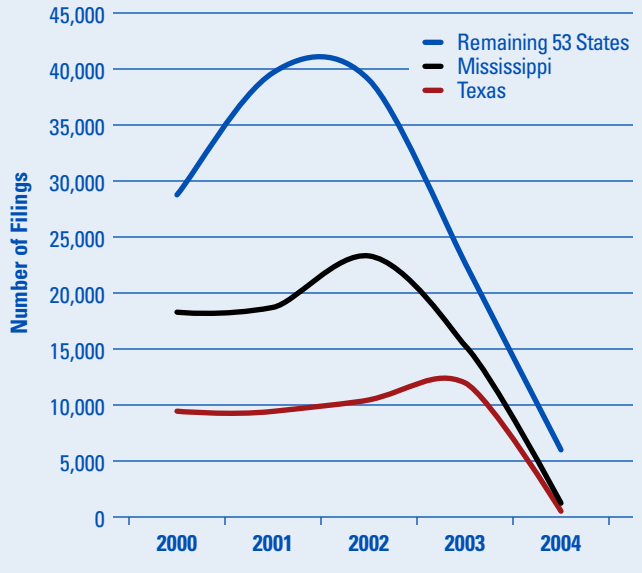
Depending on the company, there is a two to three year lag from claim filing to claim payment. Therefore, there will be an increased financial impact over the next two to three years. The increase in the number of bankruptcies may defer payments, however, insurers may still need to pay into the bankruptcy trust funds.

The bottom line in *Figure 2* displays the number of Texas filings, the middle line the number of Mississippi filings, and the

AVERAGE NUMBER OF MONTHLY FILINGS vs. AVERAGE NUMBER OF NAMED DEFENDANTS



ASBESTOS CLAIM FILING VOLUME: MISSISSIPPI AND TEXAS vs. ALL OTHER STATES



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top line is all other states. The percentage of claims in Texas and Mississippi has dropped precipitously as have the numbers across the board. In 2004, we are seeing quite a decrease in the number of filings. There are various theories regarding this. Scott Moser was quoted that he believes federal legislation has had an impact on settlements and filings. Others believe there was a ramp up in filings due to the increasing bankruptcies and/or the potential for legislation. The bottom line is that new claims have gone down.

Reserves

Despite the decrease in new filings, many companies are increasing their reserves. In June 2004, Equitas increased their reserves by $554M bringing total reserves to $7.35B. Their recent press release explains that one of the reasons they are increasing their reserves is that the cost of the mesothelioma claims has gone up. Many believe that the plaintiffs' attorneys are not seeking money for unimpaired claims but are expecting more for the malignancies. Navigator's reserves nearly doubled, increasing by $31M in February 2004 for total reserves of $78.5M. Chubb had a 34% increase in its asbestos reserves which had a negative impact on its stock price. Liberty Mutual increased its reserves but reported that much of the increase was due to the fact that they may not be able to collect their reinsurance. AM Best believes the industry is still under reserved for Asbestos and Environmental claims. They came out with an incurred to date figure of $45B for asbestos at YE 2002 but believe the reserve shortfall is in the $20B range.

Major Rulings and Developments

As more companies settle with their policyholders, more disputes are arising with reinsurers not accepting the settlements of their cedants. Courts have been split on this issue. Linda pointed to the following cases as examples:

- Insured liable for uninsured share of asbestos defense costs (CT Supreme Court, *Security Insurance v. Lumbermans,* July 2003)
- Travelers prevails in arbitration on amount of limits available for asbestos claims of AC&S (August 2003)
- Reinsurer not bound by ceding company's $257M settlement of OCF non-product claims on a single occurrence basis (September 2003)

On the bankruptcy front, there has been some positive activity for insurers. One of the reasons many companies go into bankruptcy is they believe they can better manage the claims and mitigate the uncertainty regarding these claims. A lot of the bankruptcies are pre-packaged with the plaintiffs' attorneys and the company agreeing on the plan without insurer involvement. A Delaware bankruptcy judge refused to confirm the AC&S reorganization plan. Another surprising development was that Bankruptcy Judge Wolin was recused by the 3rd Circuit due to the appearance of impropriety in the Owens Corning, WR Grace and USG bankruptcies.

Other major developments include the following:

- Halliburton announced that more claims than estimated have been received therefore the $2.775B trust will not be sufficient and the settlement will need to be revised
- There have been suits against insurers that claim the insurers failed to warn of asbestos dangers in their risk management and workers compensation services. CNA disclosed its knowledge of asbestos risks whereas Travelers recently settled.
- In January 2004, Halliburton settled with Equitas for $575M for asbestos claims.
- Travelers settled its asbestos reinsurance claims with Equitas for $245M
- Flintkote filed for bankruptcy in May 2004
- In June 2004, OCF announced that it has reached agreement with most creditors

Wrap Up

Professor Lester Brickman released a report in January 2004 indicating that asbestos lawsuits are a "malignant enterprise" that have cost the American economy more than 500,000 jobs. This is one of the reasons why Labor is willing to consider a federal bill. Professor Brickman estimates that more than 90% of claims are generated by lawyers recruiting clients and that most (e.g., 80%–90%) claimants have no medically recognized disease. Tillinghast reported that U.S. Tort costs increased to $233 billion in 2002. This was the largest single increase, 13%, in a given year and was due to asbestos.

In summary, asbestos continues to cost the US economy a lot of money. There are federal and state legislative efforts to try and change this but many believe that the legislation will only delay the pay out.

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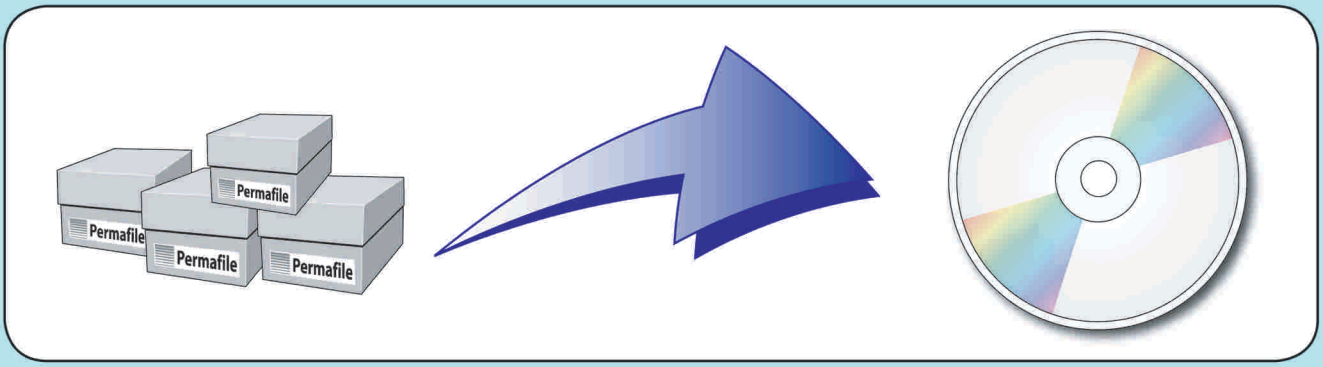

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