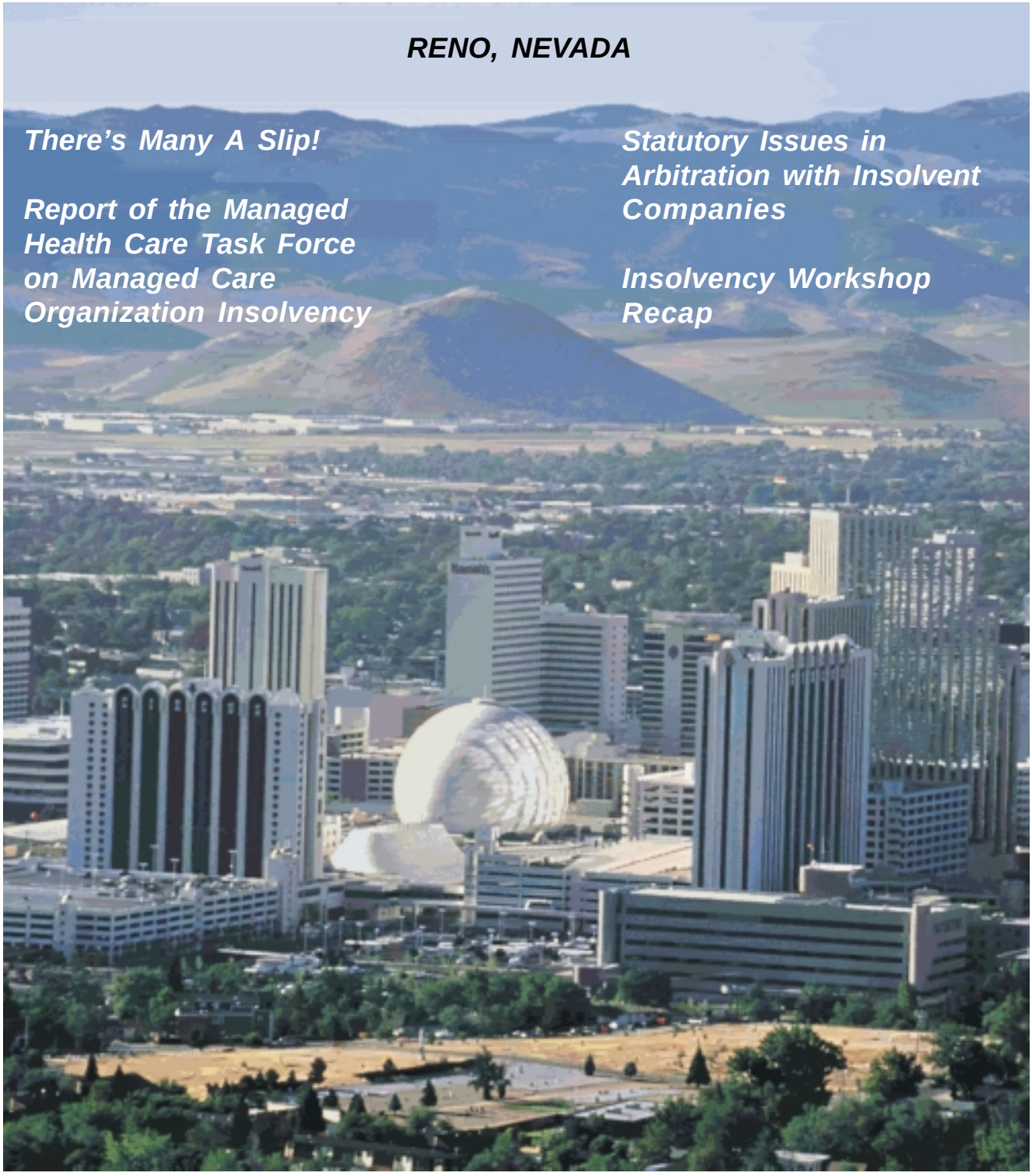
The INSURANCE RECEIVER

Promoting professionalism and ethics in the administration of insurance receiverships.

Volume 11, Number 1 **Spring 2002**



RENO, NEVADA

President's Message

by Elizabeth A. Lovette, CIR-ML

Let me begin this first message of 2002 with a resounding thank you to the membership for your support in reelecting me to the IAIR Board of Directors and to the Board for your confidence and support in appointing me President for a second term. I eagerly anticipate that this year, like 2001, will be one of notable achievements. Welcome also to IAIR's newest Board member, Bob Loiseau, CIR-P&C, President of Jack M. Webb & Associates, Inc. in Austin, Texas. And welcome back to returning board members, Bob Greer, CIR-ML, of Greer Law Offices in West Virginia; Mike Marchman, CIR-ML, with the Georgia Life & Health Insurance Guaranty Association; and Dale Stephenson, President of the NCIGF in Indianapolis. Sorely missed will be retiring board member and past President, Bob Craig, whose leadership and contributions to our organization were and will continue to be insightful and invaluable. I should clarify that "retirement" in this sense is perhaps a misnomer as I know Bob will continue to be beneficient with his time and talents.

Having just returned from IAIR's Annual Insolvency Workshop in San Antonio, my hope is that many of you were fortunate enough to have attended this stellar program. I must point out that this workshop, the eleventh of its kind, was IAIR's first effort at solely sponsoring this educational event and was, by anyone's standards, a rousing success. As Steve Durish, IAIR's Education Chair so aptly observed, a good gauge of success is when 99% of the attendees are still seated when day one concludes at 5:00 pm! Those of us present witnessed such a phenomenon. Why was this workshop such a success? Words like "dedication", "teamwork", "generosity", and "involvement" are all descriptive of what was required, but the most important ingredient in this recipe of success were the IAIR members themselves who personified all of these qualities and more in planning, preparing, and delivering the finished product. Specifically, I thank Jim Stinson, Chair of the Planning Committee, and the members of his committee: Frankie Bliss; Dick Darling, CIR-ML; Steve Durish, CIR-ML; Trish Getty, AIR-Reinsurance; George Gutfreund, CIR-ML; Paula Keyes, AIR; Mike Marchman, CIR-ML, and Tom Patterson for a job superbly done. *(Continued on next page)*

The Insurance Receiver Has Changed!

You may notice that *The Insurance Receiver* looks a little different this issue and that you did not receive a Winter 2001 issue. In our effort to improve the publication, IAIR has made a slight formatting change and added information to the newsletter. We have added a new column, *Meeting Update*, by Bob Loiseau of Jack Webb & Associates, Austin, Texas. Bob will keep us informed about what happened at the prior roundtable, board meeting and committee meetings. This will keep you up to date on how IAIR is working for you.

We are also running articles in their entirety before starting the next article. Therefore, you will not have to flip throughout the publication to read one article.

Finally, we are changing the timing of the publication to be available to members several weeks before the quarterly meeting rather than a month after it. To effect this change, it was decided to skip the Winter 2002 issue.

We appreciate your patience during this transition and hope you will enjoy these improvements.

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In a roundabout way, this brings me to the focal point of this message. IAIR is your organization. Though still in its infancy by many standards, IAIR has evolved enormously in recent years, accomplishments the likes of which would not, could not have been possible without the tireless efforts and selfless generosity of our members. Unfortunately as an organization we have continued to cull and rely upon the talents of only a small portion of our membership. I point out the members of the Insolvency Workshop Planning Committee to illustrate this point. With this practice runs the risk of going to the well only to one day find that the well has dried up. When the well has become dry, the life source of the organization is likely to die from thirst.

The close of December 2001, found IAIR with its membership at an all time high. This leads me to the obvious conclusion that there are many members, new and old alike, available to participate in IAIR activities. With the onset of this new year, all Committee Chairs have been asked to review the membership of their committees and "clean house" if necessary. A listing of each IAIR committee and its Chair are included with this publication, and I urge each of you to select a committee that appeals to your taste and talents. Plans are in the works to present at the Roundtable in Reno a short presentation describing IAIR's committees and the charges/activities of each. If you are interested in becoming more involved but are unfamiliar with IAIR's committees, this presentation will be of benefit to you.

I cannot portend to know how ultimately the events of September 11 and the ensuing recession will affect the practice of insurance insolvency. If the prognosticators are to be believed, the likes of Reliance and Enron are but a foreshadowing of what is to come. What I hope is that IAIR stands prepared to meet the demands of an economic downturn, whatever they might be and however they might present themselves, and I challenge each of you to partake in this endeavor. Apply for a designation, participate in the next Roundtable or workshop, recruit a new member, attend a board meeting, become active in a committee, let your voice be heard! For IAIR, like any other organization, is only as strong as its members. Lend your strengths today.

Thank You To The Sponsors of The IAIR Insolvency Workshop

IAIR would like to express its sincere appreciation to the following organizations for their generous support of the IAIR Insolvency Workshop held January 24 - 25, 2002 in San Antonio, Texas. It is only with the assistance of these firms that we are able to provide quality educational programs to the insurance insolvency industry. Thank you.

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And a very special thank you to the following firm for being a general sponsor as well as co-sponsoring the reception:

Volpe, Bajalia, Wickes & Rogerson

View From Washington

By Charlie Richardson

Schumer and LaFalce Float Optional Federal Charter Bills

Both Senator Chuck Schumer (D-NY) and Congressman John LaFalce (D-NY) have stepped up the debate on state versus federal regulation of insurance by drafting bills that allow insurance companies to choose whether to be regulated by the states or by a new federal regulator.

Congressman LaFalce, ranking member of the House Financial Services Committee, indicated his intent to introduce an optional federal charter bill on January 18 when he sent a "Dear Colleague" to request other Members of Congress to sign on as cosponsors to his bill, the Insurance Industry Modernization Act. This bill creates an optional federal charter for life and property/casualty insurance companies (but not health insurance companies) and allows those companies to chose between state and federal regulation. A new office established at the Department of Treasury will oversee companies that elect to become federally-chartered entities. This office is analogous to the current Office of the Comptroller of the Currency (OCC) and the Office of Thrift Supervision (OTS).

Senator Schumer's bill is similar to Congressman LaFalce's bill, although it includes health, as well as life, property/casualty insurance companies. The Schumer bill sets up a dual-system, allowing companies to chose a state or federal model of regulation and establishes an office within the Department of the Treasury, based on the OCC and OTS model, to oversee companies electing a federal charter. In addition, it provides for the chartering and licensing of federal insurance producers, while the LaFalce bill does not. Both bills require national insurers to belong to qualified state guaranty associations.

At press time, Congressman LaFalce had yet to introduced his bill, although a draft of the legislation was circulating. Senator Schumer introduced his bill in December, but at press time it had not been assigned a bill number or been referred to a committee of jurisdiction. But with legislation drafted and introduced, the debate in Congress over federal regulation is likely to heat up this session.

Oxley Orders Study

On January 16, 2002 Congressman Mike Oxley, Chairman of the House Financial Services Committee, ordered the General Accounting Office (GAO) to produce a study on the availability and affordability of terrorism insurance aftera the events of September 11 and the impact of any lack of coverage on consumers and the economy. This request comes after Congress failed last December to pass legislation that would provide a federal "backstop" for liabilities due to acts of terrorism.

Specifically, Chairman Oxley asked the GAO to examine the availability and cost of comprehensive property/casualty insurance, the impact of any lack of availability on key structures and in areas already impacted by September 11, the existing capacity of the industry to absorb future losses, and marketplace

reactions by the property/casualty insurance and reinsurance industry. In his letter to the GAO, Chairman Oxley requested that the study be completed by January 23, 2002; however no hearings on the results of the study have been scheduled, as the Committee has been focused on issues related to the collapse of Enron (which itself will have a likely $2-3 billion impact on the insurance industry).

Whether Congress will end up considering a federal program to address terrorism losses remains to be seen. Senate Majority Leader Tom Daschle has stated that terrorism reinsurance legislation will be one of his top priorities this session of Congress. The legislation failed to move last year because of a dispute over whether tort reform provisions should be included in the legislation. Business groups are now trying to come up with examples of the impact on the economy of not having more certainty in the area, as state insurance departments continue to field requests from carriers for approval of terrorism coverage exclusions.

News From Headquarters

Congratulations!!

The following IAIR members were granted designations at the December Board Meeting:

Trish Getty	AIR - Reinsurance
Daniel L. Watkins	CIR - Multiple Lines

Save This Date!!

On November 7 - 8, 2002 IAIR is co-sponsoring with the NCIGF a Joint Seminar to be held at the Hyatt in Henderson, Nevada. As more information becomes available, it will be provided both in this publication and on the IAIR website at www.iair.org under the Events & Schedule page.

Thank You To IAIR's Patron Sponsors

IAIR would like to thank the following for their support of IAIR's quarterly meetings by being a patron sponsor of the December roundtable and reception. Thank you for your continued support of our association.

Baker & Daniels, Indianapolis, IN

Cross River International, New York, NY

DeVito Consulting, Inc., Guttenberg, NJ

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IAIR Roundtable Schedule

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

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

NAIC Meeting - September 7 - 11, 2002
New Orleans, NA
IAIR Roundtable
September 8, 1:00 -4:00 p.m.
(Roundtable will be on Sunday)

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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Legal Counsel: William Latza and Martin Minkowitz of Stroock Stroock & Laven LLP.

Accountant: Stephen Phillips, CPA, FLMI, AIR of Cunningham, Porter & Phillips

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Chicago Meeting Recap

by Robert Loiseau

IAIR 10th Anniversary. IAIR's meeting in Chicago on December 8th and 9th marked a milestone in the Association's history with the observance of its tenth anniversary. Quite a number of the original organizers attended and continue to be active after a decade of involvement in promoting growth and elevating IAIR's recognition within the regulatory and professional communities here and abroad. This anniversary was formally recognized at a soirée that included libations, music and dancing. These festivities were preceded by a "ceremony " in which IAIR's former presidents were duly recognized. Recognition came in the form of a roast that was emceed by tuxedo-clad Charlie Richardson, who kept the party in stitches as he lampooned many innocent and unsuspecting members, starting with the aforesaid former presidents. Once the formalities were out of the way and the repast consumed, the party stayed in full swing until the bar closed and the DJ left the building.

Roundtable Meeting

Dan Orth of the Illinois Life and Health Guaranty Association hosted this quarterly educational program. It was a standing room only event, covering diverse and interesting topics. Vivian Tyrell of DJ Freeman in London opened the program with a presentation about the European Insolvency Directive as well as the INSOL 2001 meeting held in London. The Directive is essentially an undertaking among members of the European Community which requires them to introduce new insolvency laws affecting cross-border insolvencies of insurance and non-insurance entities. This initiative is intended to foster cooperation, rather than competition, among member states who have differing rules and practices pertaining to insolvency, policyholder protection and creditors' rights. This undertaking is akin to the NAIC's Model Act which attempts to bring some consistency to insolvency laws and practices among the fifty states. Members interested in learning more about this topic can read Ms. Tyrell's commentary article published by Mealey's in its August 23, 2001 issue.

Holly Bakke of the New Jersey Guaranty and Surplus Lines Fund spoke on an issue that affects almost every receivership: What happens when guaranty associations take over pending litigation? In Ms. Bakke's experience, many judges have little ongoing exposure to insurance insolvencies and the technicalities of guaranty association statutes relating to claims litigation. She has found that communication between guaranty association executives and presiding judges furthers the interests of claimants, litigants and the courts by enabling receivership judges to timely and effectively deal with matters such as stays of litigation, hardship cases and notices to litigants. She emphasized that these are not ex parte communications on the merits of a receivership case or pending litigation, but rather an educational process that often results in continuing coordination among the administrative staffs of the judiciary and the guaranty association.

What happens when guaranty associations take over pending litigation?

In a similar vein, Steve Durish, CIR-P&C, of the Texas Property and Casualty Insurance Guaranty Association, reported on the Joint Education Initiative of IAIR and NCIGF. This initiative aims at providing formal training about receivership and guaranty association issues to members of the judiciary. The goals included presentation of live seminars to judges funded in part by a grant from the State Justice Institute. Although grant money proved unavailable for 2002, the initiative is by no means over, and alternative efforts are under way to develop and distribute an educational program on CD-ROM which serves the same purpose, but reduces the costs and logistical problems associated with live seminars.

James R. Armetta of Arthur Andersen made a presentation focusing on the technology issues of "problem clients" as they relate to solvency issues. Not surprisingly, information systems can be one of the weakest links of a troubled company. In Mr. Armetta's view, insurance receiverships, especially managed care entities, present a wealth of unique technology problems for which there are consultation services and out-sourcing options available. His visual aids included some statistical data of particular interest to IAIR members that suggest P&C insolvencies are trending upward globally.

Next up was Phillip Singer, CIR-ML, of Tawa Associates, London, who gave a thought-provoking presentation about the magnitude of the asbestos problem facing the insurance and reinsurance industries. Mr. Singer highlighted the growth of asbestos claims and potential liability exposure, which is now estimated at $200 billion in the United States alone. He shared his views on how these liabilities will be allocated among policyholders, insurers and reinsurers. He also reported on Equitas' new requirements concerning asbestos claims and opined that other carriers will follow suit. Equitas now requires proof of impairment by a party asserting an asbestos claim rather than simple proof of exposure which heretofore has been the trigger for payment of claims. In closing, he asked rhetorically whether the property and casualty industry as a whole has the resources to deal with such massive liabilities. He also reported the view held by some prominent actuaries that asbestos claims have been consistently under- reserved, and,

coupled with losses arising from the World Trade Center attack, might lead to the insolvency of a large segment of the property and casualty industry.

Before adjourning the meeting, Dan Orth provided even more food for thought on the topic of state vs. federal regulation of insurance insolvencies, and potentially, guaranty associations. His comparison of the costs and benefits between state and federal regulation were especially topical in light of consolidation of insurance and the financial services industries fostered by Gramm, Leach, Bliley and the overlapping of federal and state regulations it created.

Board of Directors Meeting

In addition to routine activities relating to IAIR's administration and finances, a number of achievements were recognized by IAIR's Board:

- First, IAIR membership has reached 368 members, its highest enrollment yet.
- The Board accepted and approved (with considerable praise) the report of the Managed Health Care Task Force on Managed Care Organization Insolvency. This report, written principally by Harold Horwich, appears on page 10 of this issue of The Insurance Receiver. It is a concise, informative report resulting from the input and shared experiences of IAIR members dealing with managed care insolvencies, and will serve as excellent reference material for anyone coming into contact with this segment of the industry.
- The Board approved the Education Committee's recommendation to accredit Trish Getty of Paragon with the AIR-Reinsurance designation. In addition to this professional recognition, the Board acknowledged Trish's ongoing efforts to elevate IAIR's profile in the regulatory community through educational presentations about IAIR in all NAIC zones.

The Board accepted and approved the report of the Managed Health Care Task Force on Managed Care Organization Insolvency

- Likewise, the Board conditionally approved Dan Watkins' CIR-ML accreditation, subject to successful completion of the oral interview requirement. The interview was conducted by the Accreditation and Ethics Committee the next day, and Dan did complete it successfully. He will be awarded his CIR-ML plaque at the March meeting in Reno, Nevada.
- The CIR and AIR designations are even closer to becoming registered trademarks owned by IAIR, with final approval expected to occur during 2002.
- The Board finalized plans for the Annual Insolvency Workshop, which this year is being hosted solely by IAIR, as opposed to the joint NAIC/IAIR format of past meetings. As further evidence of IAIR's heightened professional status within the insolvency community, six insurance commissioners have agreed to speak at this program.
- The Board accepted the Publication Committee's recommendation to make changes and improvements in the publication schedule and content of The Insurance Receiver newsletter. This issue is the first to incorporate those changes, the overall goal of which is to better and more timely communicate the Association's activities to its members, as well as broaden the newsletter's content.
- Finally, the Board approved the educational program proposed by Trish Getty for the March 2002 meeting in Reno, Nevada and initiated the planning of the next IAIR/NCIGF Workshop which is tentatively scheduled for November 7 and 8, 2002 in Henderson, Nevada.

There's many a slip!

By Phillip McKinnon and Catherine Gamlin

The Court of Appeal reaches two different conclusions on whether the policy wording supersedes the slip and whether the slip can be used as an aid to interpretation of the policy. Two recent decisions of the Court of Appeal reaffirm the contractual orthodoxy that the intentions of the parties are paramount in each case, Although reaching opposing' conclusions on the facts, these cases hold that a slip may not, in the absence of an intention to the contrary, be used to aid the interpretation of an agreed policy wording.

The insurance contract comes into existence when the underwriter scratches the insurance slip presented to him by the broker. The slip typically sets out in shorthand the main terms of the contract of insurance. The details are filled in later by the policy wording. This fast and efficient procedure has, however, caused certain legal difficulties. There are often two documents, the slip and the policy, which potentially contain contractual wording. Sometimes, however, there will be a conflict between the two. Until the time the policy wording is issued, the contents of the slip constitute the terms of the contract of insurance.

However, once the policy itself has been issued, the traditional view is that the slip and all other external evidence, become irrelevant. This is due to the contractual rule known as the parol evidence rule. In essence this rule says that where there is a written contract in existence, no external information can be used to interpret or amend that contract.

This view is confirmed in respect of insurance contracts in the leading case Youell v Bland Welch [1992] 2 Lloyd's Rep 127. To the extent that the policy is inconsistent with the slip, a party seeking to rely on the slip must persuade the court that there has been a mistake in the preparation of the policy and that accordingly the policy should be rectified.

A new approach?

This traditional view of the slip as a document which could not be used to help interpret the policy was questioned in HIH Casualty and General Insurance Limited v New Hampshire Insurance Company & Others (unreported, Court of Appeal, 21 May 2001). In this case, the slip in question was entitled, Slip Policy. It contained a provision that the insured was obliged to comply with a particular term which was not mentioned in the full policy wording. HIH (as reinsured) argued that the court was not permitted to look at the slip, since it had been superseded by the wording.

The Court of Appeal held that the fact the slip was entitled Slip Policy was of some significance. It was the court's view that the parties intended the slip to be the underlying contract of insurance and that the detail would be contained in any subsequent policy wording. There was no intention of the parties that the policy wording was to supersede the Slip Policy. The court therefore held that the relevant clause, present only in the Slip Policy, was in fact a term of the contract.

The Court of Appeal was wary of asserting a general rule that where a slip is followed by a policy wording, the wording will invariably supersede the slip and the slip cannot be referred to as an aid to interpretation of the policy, although Lord Justice Rix did note, cautiously, that "(in) the insurance market...it may well by now be possible to talk of a general presumption that a policy is intended to supersede a slip". A presumption is rebuttable, however, and Lord Justice Rix went on to note that it was not common ground in this case that the policy wording superseded the original slip policy. Rather than an inflexible rule of law, therefore, the issue is one of construction which will depend on the surrounding circumstances.

Not necessarily!

In Great North Eastern Railway v Avon Insurance (unreported, Court of Appeal, 24 May 2001), GNER brought claims against its insurers, Avon, in respect of business interruption losses arising from a derailment of one of GNER's trains in June 1998. The losses suffered by GNER resulted from a defective wheel on a train which was due to faulty workmanship. The policy wording provided by GNER's previous brokers, Fenchurch, included an exception for damage arising from faulty workmanship. This exception was not mentioned in the slip. The slip expressly provided breakdown cover. GNER argued that the exception in the policy wording had not been agreed by the parties and that it was repugnant to the breakdown cover provided in the slip. GNER submitted that the policy wording should therefore be viewed in the light of what was actually agreed in the slip.

The Court of Appeal had to decide whether the slip could be used as an aid to the interpretation of the contract. The Court of Appeal held that the original policy had been agreed in 1996 for one year's cover and had been renewed in 1997 and 1998. No problems had ever been raised and the Fenchurch wording was expressly accepted by both the brokers on behalf of GENR and the insurers as governing the contract, a finding which GENR disputed.

When it came to a decision as to whether the slip could be used as an aid to interpretation of the contract, Lord Justice Longmore dealt with the issue summarily. He held as a matter of law, following the decision in Youell v Welch, that use

of the slip to help construe the terms of the contract was "impermissible."

It is unfortunate that in his judgment Lord Justice Longmore did not mention the HIH judgment, which was handed down three days earlier. A further clarification of the rules relating to the terms of an insurance contract would have been of general assistance. Instead he accepted that Youell v Bland Welch contained an unyielding rule of law.

The GENR decision can nonetheless be rationalised and reconciled with the HIH decision. In his judgment, Lord Justice Longmore referred several times to the numerous opportunities GNER's brokers had to review and dispute the contract wording. At no stage during the history of the policy had the brokers asked for the terms contained in the slip to be incorporated into the policy wording. All experience over the previous three years had seen the brokers and insurers discuss issues with reference to the Fenchurch wording. The court therefore

found that there was no clear intention on the part of the parties for the slip to form part of the contractual documentation.

Comment

These cases make it clear that the intention of the parties is paramount in any particular case. GENR v Avon also highlights that, despite what was widely perceived as the groundbreaking case of HIH v New Hampshire, the judiciary has not completely overhauled the existing law. In the absence of clear evidence that the parties intended the slip to form part or all of the contract or be used as an aid to its interpretation, GENR makes it clear that a judge will be reticent to declare that the policy fails to supersede the slip.

It therefore remains the case that a judge can presume, in the absence of evidence of contrary intention, that a full policy wording is intended to supersede slip wording. Insurance companies and insureds alike must therefore be vigilant to check the policy wordings when they are received and to object immediately if they disagree with any of their terms. The paramountcy of contractual intention, like liberty, is at the price of constant vigilance.

Mr. McKinnon and Ms. Gamlin are both solicitors with DJFreeman, a D J Freeman is a well-known and highly regarded UK commercial practice. This article was first published in the September 2001 issue of The Insurance Review, a publication of DJFreeman.

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STILLMAN CONSULTING SERVICES

TO: IAIR

FROM: LEN STILLMAN, ESQ.., CIR

SUBJECT: UNITED REPUBLIC LIFE INSURANCE COMPANY

DATE: 2/13/2002

I am pleased to report that the estate of United Republic Life Insurance Company was closed and the receiver discharged by order of the Third Judicial District Court in Utah on July 25, 2001. United Republic was placed into liquidation on November 18, 1994. The receiver defended extensive litigation with the former officers, directors and shareholders, including an appeal to the United States Supreme Court. Notwithstanding the litigation, all claimants, including affected guaranty associations, were paid 100 per cent of their allowed claims plus interest from the date of the liquidation order. A distribution of residual property appraised at approximately $7 million was made to shareholders. Special thanks go the Rheta Beach, assistant deputy liquidator and all others who played a role in the resolution of this particularly difficult receivership.

REPORT OF THE MANAGED HEALTH CARE TASK FORCE

ON MANAGED CARE ORGANIZATION INSOLVENCY

Harold S. Horwich

The Managed Health Care Task Force consisted of regulators and professionals who have been involved in the insolvencies and turn-arounds of Managed Care Organizations ("MCOs") throughout the country. The purpose of the task force was to share and collect its experience and expertise in dealing with troubled MCOs. The observations and recommendations of the group deal with operational issues and regulatory practices rather than statutory insolvency schemes, which differ widely from state to state.

The single most important observation of the group is that regulators should perform operational examinations on MCOs in addition to financial examinations. Operational examinations would investigate an MCO's systems and practices as compared to financial examinations that focus primarily on the organization's capital adequacy and profitability. Operational examinations are particularly important for smaller MCOs which typically have relatively thin capitalization and are susceptible to rapid financial decline if they get into operational difficulty.

Early Warnings

Detecting trouble early at an MCO is crucial to effective turnaround. This is especially so as to small organizations or organizations with weak capital. The task force identified a number of early warning signs. Many early warning signs depend on financial reporting; accordingly, the integrity of management and the diligence of outside auditors are highly important.

1. Failure to comply with risk based capital requirements. The recently imposed risk-based capital requirements provide an effective means of identifying MCOs with weak capital. However, in order to use these tools, regulators must depend on the MCO's financial reporting. This underscores the importance of the role of outside auditors in testing and verifying the financial information presented by MCOs.

2. Complaints from constituents. MCOs in trouble often generate a high volume of complaints from consumers or providers or both. While some volume of

complaints is normal, a high volume of complaints frequently signifies deeper problems. In addition, complaints that do not get resolved promptly may also be a symptom of deeper trouble.

3. Rapid growth. Small, established MCOs have sometimes undertaken rapid and large scale growth projects in order to survive in a market of larger organizations. Such growth takes management skill, excellent systems and careful planning. Organizations that are thinly capitalized have no margin for error in this high-risk endeavor.

4. Loss of enrollment or providers. Providers are usually loath to drop an MCO from their practice. Thus, a loss of a significant number of providers suggests a problem with medical management or timely payment or both. While turnover in enrollment is normal, a significant decline in enrollment may signify a fundamental problem with pricing or a failure in the MCOs delivery system.

5. Accounts receivable from providers, enrollees or downstream risk takers. A high level of accounts receivable from providers suggests an inability to reconcile balances with providers or a reluctance to resolve disputes with providers over past services. Such receivables are highly suspect. A high level of accounts receivable from enrollees suggests that either the billing system has failed or that enrollees who have terminated are being billed even though they have no coverage. A high level of accounts receivable from downstream risk takers suggests that the arrangement is not working and that the MCO is in jeopardy of having to take back the risk which has been transferred downstream. The role of outside auditors in determining the collectability of these receivables is extremely important.

6. Management agreements with affiliates. Management of MCOs through agreements with affiliates is a common arrangement, but it can be used by management to disguise financial weaknesses. In some cases, management through an affiliate has led to the siphoning of funds out of the MCO to the management company for use in other affiliates or for the principals' own use. It is in this area that insurance departments are most heavily reliant on the MCO's outside auditors. Failure by auditors to blow the whistle on trust requirements, uncollectable intercompany accounts or inadequate internal controls can hide an incipient (or even an advanced) problem from regulators.

7. Restated financial statements. Restated financial statements are often a symptom of a loss in control of financial record keeping. Again, outside auditors play a critical role in notifying the regulators of inadequate internal controls.

8. Implementation of new information systems. The acquisition of a new system may be nothing more than a sign of healthy growth. It may also be a sign that existing financial information is unreliable. Moreover, the implementation of a new system presents high risk to the organization because system conversions are almost always disruptive and often unsuccessful.

Many of these early warnings are based on financial information. As to these tests, the well-recognized financial tools are adequate, provided that management and outside auditors provide reliable information. However, other warnings will only come with operational examinations. Furthermore, the results of operational examinations are likely to reveal the true depth and nature of the MCO's problems.

Systems

Medical management, marketing and provider relations are all key elements to running a profitable MCO. However, no MCO can operate without timely and accurate financial information. MCOs run

on very thin margins. For this reason, receivables must be accurately billed and collected, claims must be accurately processed, and claim information must be assimilated periodically into the formulation of new and revised rates. Thus, the systems that maintain and manipulate financial information for the organization are critically important to its well being, and have played a significant role in the failure and near failure of many MCOs. Oxford Health and Harvard-Pilgrim are probably the two best known examples.

It was the consensus of the group that regulators do not have, and badly need, the capability to evaluate an MCO's information systems as part of their examinations. This includes both functional and ownership issues.

At the functional level, systems need to be evaluated as to their quality and reliability. There are now well-recognized systems on the market. An MCO's use of a system that was either internally built or acquired from a vendor which does not normally sell systems to MCOs may be cause for concern. Furthermore, even the best system is useless if the individuals who are using it lack the training and expertise to run it properly. Thus, the quality and experience of the information systems staff should be an area of inquiry. Reviewing an MCO's systems capability requires individuals who are sufficiently knowledgeable to watch the actual functioning of the system, including claim input, processing of claims in accordance with plan design, and generation of usable financial information. Such individuals should also be able to run tests and spot anomalies that demonstrate the strength or weakness of the system. For instance, reconciliation of actual enrollment with enrollment tapes may be done. The existence of disputes between hospitals and the MCO or large claims "in the course of settlement" suggests problems in reconciling provider information.

In addition to determining whether systems work, regulators need to understand who owns the system. In some MCOs, the management company owns the system and processes all of the data generated by the MCO. In the event of an insolvency, the receiver is faced with the prospect of continuing the arrangement with the management company (which may be in default at the time of the receivership). In other situations, the MCO uses the system, but the system is owned by an affiliate. This, too, presents problems in receiverships because the principals of the MCO's corporate family may be hostile to the receiver and make it difficult to continue to have access to the systems.

Systems defects are not invariably fatal to MCOs. However, they require extraordinary care and attention because the organization must continue to operate while the system is being repaired. Claim backlogs and unbilled receivables build if the organization does not have an alternative method of processing information in the interim. It also results in delays for rate increases and filing of financial statements. In essence, management may be required to navigate without maps or markers while systems are being repaired or replaced. Further, if the organization ultimately fails with no systems in place, the receiver will not know the financial status of the company and will be unable to pay claims. However, even the implementation of good systems is not enough to assure success of an MCO.

Turnarounds and Management

The task force observed that regulators often become involved with the affairs of MCOs and that all such involvements do not presage insolvency or failure. However, the task force also observed that the involvement of regulators in distressed situations is often ineffective because the regulators lack the expertise to deal with turnaround situations. In many departments, there is a division between individuals who conduct financial examinations and individuals who deal with insolvencies. Typically, the insolvency professionals have far more experience doing turnarounds than the examination staff. Further, where neither examination nor insolvency staff have relevant turnaround experience, it was the consensus of the task force that the regulators should bring in help from outside. / At a minimum, it appears that the regulator's insolvency professionals should become involved with the company before the commencement of proceedings. Such involvement might avoid some proceedings and would result in a smoother and more effective transition into proceedings where proceedings could not be avoided.

Involvement in turnarounds by the regulator may take a variety of forms from informal to formal supervision proceedings. States have different mechanisms for permitting involvement by regulators in the affairs of an MCO. The consensus of the task force was that where a regulator becomes aware of a need for involvement, that involvement needs to commence swiftly and requires daily presence at the company. Otherwise, intervention is both potentially ineffective and dangerous. It is potentially ineffective because management may not implement decisive action without constant monitoring. It is potentially dangerous because the company's failure at a time when the regulator is involved will reflect badly on the regulator whether or not the failure can be ascribed to the regulator's activities.

The turnaround of an MCO is a project that has both short term and long term aspects. What follows is a canvassing of issues that typically arise in MCO turnarounds.

The most immediate tasks are the assessment of systems and the husbanding of cash. The importance of systems is discussed at length above. Husbanding cash requires an understanding of the MCO's operations and obligations. It may be feasible to curtail management fees or require capital infusion. Expenses may be cut in various ways and, ultimately, it may be feasible to obtain concessions on payment from providers, but such concessions are not typically part of a short-term plan.

Claim backlogs and understated incurred-but-not-reported ("IBNR") losses are typical in troubled MCOs. Gaining an understanding of the extent and causes of the backlog and understatement is one of the key early tasks to be pursued in MCO turnarounds. Understated IBNR is often systems related. Backlogs are typically caused by systems problems, cash shortages or both. In either event, resolution of the problem is likely to take time. Investigation of systems problems may also reveal that claims have been processed badly in the past and that providers have been overpaid or paid for the same services more than once. In that case, decisions need to be made about the method of reconciling accounts: whether through reimbursement, setoff or otherwise. While systems problems are being resolved, it may be necessary to develop an alternative set of benchmarks to use in running the company. For instance, hospital days per thousand encounters may be an adequate indicator for prediction of future performance.

However, in order to keep the MCO in operation while management and the regulator are determining how best to address its problems, it is essential to keep

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Report of the Managed Health Care Tast Force

(Continued from page 13)

The Managed Health Care Task Force consisted of regulators and professionals who have been involved in the insolvencies and turn-arounds of Managed Care Organizations ("MCOs") throughout the country. The purpose of the task force was to share and collect its experience and expertise in dealing with troubled MCOs. The observations and recommendations of the group deal with operational issues and regulatory practices rather than statutory insolvency schemes, which differ widely from state to state.

The single most important observation of the group is that regulators should perform operational examinations on MCOs in addition to financial examinations. Operational examinations would investigate an MCO's systems and practices as compared to financial examinations that focus primarily on the organization's capital adequacy and profitability. Operational examinations are particularly important for smaller MCOs which typically have relatively thin capitalization and are susceptible to rapid financial decline if they get into operational difficulty.

Early Warnings

Detecting trouble early at an MCO is crucial to effective turnaround. This is especially so as to small organizations or organizations with weak capital. The task force identified a number of early warning signs. Many early warning signs depend on financial reporting; accordingly, the integrity of management and the diligence of outside auditors are highly important.

1. Failure to comply with risk based capital requirements. The recently imposed risk-based capital requirements provide an effective means of identifying MCOs with weak capital. However, in order to use these tools, regulators must depend on the MCO's financial reporting. This underscores the importance of the role of outside auditors in testing and verifying the financial information presented by MCOs.

2. Complaints from constituents. MCOs in trouble often generate a high volume of complaints from consumers or providers or both. While some volume of complaints is normal, a high volume of complaints frequently signifies deeper problems. In addition, complaints that do not get resolved promptly may also be a symptom of deeper trouble.

3. Rapid growth. Small, established MCOs have sometimes undertaken rapid and large scale growth projects in order to survive in a market of larger organizations. Such growth takes management skill, excellent systems and careful planning. Organizations that are thinly capitalized have no margin for error in this high-risk endeavor.

4. Loss of enrollment or providers. Providers are usually loath to drop an MCO from their practice. Thus, a loss of a significant number of providers suggests a problem with medical management or timely payment or both. While turnover in enrollment is normal, a significant decline in enrollment may signify a fundamental problem with pricing or a failure in the MCOs delivery system.

5. Accounts receivable from providers, enrollees or downstream risk takers. A high level of accounts receivable from providers suggests an inability to reconcile balances with providers or a reluctance to resolve disputes with providers over past services. Such receivables are highly suspect. A high level of accounts receivable from enrollees suggests that either the billing system has failed or that enrollees who have terminated are being billed even though they have no coverage. A high level of accounts receivable from downstream risk takers suggests that the arrangement is not working and that the MCO is in jeopardy of having to take back the risk which has been transferred downstream. The role of outside auditors in determining the collectability of these receivables is extremely important.

6. Management agreements with affiliates. Management of MCOs through agreements with affiliates is a common arrangement, but it can be used by management to disguise financial weaknesses. In some cases, management through an affiliate has led to the siphoning of funds out of the MCO to the management company for use in other affiliates or for the principals' own use. It is in this area that insurance departments are most heavily reliant on the MCO's outside auditors. Failure by auditors to blow the whistle on trust requirements, uncollectable intercompany accounts or inadequate internal controls can hide an incipient (or even an advanced) problem from regulators.

7. Restated financial statements. Restated financial statements are often a symptom of a loss in control of financial record keeping. Again, outside auditors play a critical role in notifying the regulators of inadequate internal controls.

8. Implementation of new information systems. The acquisition of a new system may be nothing more than a sign of healthy growth. It may also be a sign that existing financial information is unreliable. Moreover, the implementation of a new system presents high risk to the organization because system conversions are almost always disruptive and often unsuccessful.

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Systems defects are not invariably fatal to MCOs. However, they require extraordinary care and attention because the organization must continue to operate while the system is being repaired. Claim backlogs and unbilled receivables build if the organization does not have an alternative method of processing information in the interim. It also results in delays for rate increases and filing of financial statements. In essence, management may be required to navigate without maps or markers while systems are being repaired or replaced. Further, if the organization ultimately fails with no systems in place, the receiver will not know the financial status of the company and will be unable to pay claims. However, even the implementation of good systems is not enough to assure success of an MCO.

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However, in order to keep the MCO in operation while management and the regulator are determining how best to address its problems, it is essential to keep the MCO's network of providers in place. By far the most effective tool for doing this is communication with providers either directly or through professional organizations such as county medical societies. Experience suggests that providers are willing to stay involved with an MCO longer than expected, particularly if they can get paid for services rendered currently while the backlog is being resolved.

Where providers have not continued to see patients willingly, both incentives and disincentives have been successful. In some situations, the MCO has renegotiated contracts for higher rates going forward or has changed from capitated arrangements to discount fee-for-service arrangements going forward. Most provider contracts require ninety days' notice prior to termination, thus providers

Report of the Managed Health Care Tast Force

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do not have the right to refuse patients during the termination period. Some providers will continue to provide services once reminded of their contractual obligations. In some situations, medical authorities have threatened sanctions against doctors for abandoning patients during a course of treatment. In other situations, out-of-town practitioners have been brought in to see patients.

The other essential element to maintaining the operations of the MCO is to ensure that agents are receiving commissions regularly. If they are not, even though enrollees may be getting medical service, agents will have a strong incentive to move business out of the MCO.

Medical management is often one of the keys to turning around an MCO in trouble. Frequently, an MCO will fail to have systems in place to tightly control the management of medical costs. The absence of such controls is surprising to outsiders since the entire point of an MCO is to manage medical treatment. However, the absence of controls does not adversely affect either enrollees or providers. It only affects profitability and, in an organization that is being bombarded by other complaints, it is often overlooked. The implementation of medical management can be done relatively quickly and can make an enormous difference in the organization's financial results.

Pricing also has a significant effect on the profitability of an MCO. However, it takes longer to remedy inadequate pricing for several reasons. First, increases in rates must typically be approved by regulators. Second, if the MCO has systems problems, it probably lacks the data needed to make pricing decisions. In addition, in markets where there is real competition, it may be difficult to sustain an adequate base of business with significantly increased rates.

Receivership proceedings

Turnaround efforts during formal or informal supervision fail for a variety of reasons, and sometimes receivership provides a better opportunity to save an ailing MCO. The receivership court has the ability to issue orders that affect recalcitrant providers and, generally, at least slows the process of network deterioration. In addition, the receivership court has the ability to bind providers to a plan of rehabilitation which resolves their claims on a basis other than current cash payments. Such plans have provided for partial payments over time, satisfaction of claims with the issuance of stock in the reorganized MCO or the issuance of surplus notes to be paid over a long period. Typically, rehabilitations work only for large MCOs. Smaller MCOs do not typically have the revenue to support major organizational change, nor do they have the customer or provider loyalty to support the types of change necessary for rehabilitation.

When an MCO cannot be rehabilitated, the receiver typically attempts to sell the ongoing business of the MCO. Sometimes these sales can be effectuated before the commencement of receivership proceedings, but often they are after. The feasibility of a sale depends largely on the attitude of the remaining market. If the MCO fails and its enrollment terminates, the subscribers to the MCO will find alternative coverage elsewhere in the market. If other MCOs do not perceive an opportunity to increase their market share of desirable business, there will be no offers. This would be the case for business that consists largely of small groups or unprofitable groups. Sales may also be scuttled by agents and brokers who rapidly move their better cases to other MCOs promptly.

Where there is at least some desirable business maintained by the troubled MCO, a wide variety of approaches have been taken to sales. Some receivers have packaged good business with poorer business in order to ensure that all of the business gets transferred. Some receivers have actually assigned the subscriber contracts while others have sold only the customer list. Some receivers have sold to competing MCOs while others have sold to MCOs which desire to enter the market. Both privately negotiated sales and public auction sales have been used.

It was widely perceived that the presence of a guaranty association enhanced the salability of business because there was less risk that the business would dissipate while a sale was under consideration. In at least one state, there are provisions that allow the guaranty association to subsidize enrollments for up to six months in order to facilitate a transfer. There are often regulatory issues that accompany sales of an MCO's business, but these are typically overcome to accomplish the sale. It was observed that both state and federal regulators have been cooperative when sales are in prospect. It was widely recognized that selecting one among many MCOs in a region to purchase a business raised issues of regulatory favoritism. Qualification of bidders for a public sale raised similar issues.

In most other types of insurance company insolvencies, claims are handled by guaranty associations. In a few states, guaranty associations handle the claims of a failed MCO. But in most states, it is the receiver that manages claims. The management of claims is highly dependent on the status of the information systems. If information systems are fully functional, claims can be processed in the ordinary course of business. Explanations of benefits are sent to providers and enrollees, and bonders and enrollees are given a right to appeal. Claims can be submitted on customary forms used pre-receivership.

However, frequently, the receiver finds that the claim system does not function adequately and the receiver must send out proof of claim forms or develop creative alternatives. Some receivers have attempted to strip off the data from the existing system and load it into a new system to verify its accuracy. In some cases, receivers have promised providers to promptly pay their new post-receivership claims if they will assemble a bulk bill consisting of all of their pre-receivership claims. This enables the receiver to rapidly gather all of the necessary information. In some cases, the receiver has bid out the claims processing function to third parties that have the capability of managing large volumes of claims. Where the claim backlog is very severe, some receivers have avoided the task of reviewing every claim by trying to reach bulk compromises with large providers that have a high volume of transactions.

In many cases, the receiver has reason to doubt the information on the system and must undertake to reconcile claims with eligibility files by hand. Sometimes, the receiver can get help on this reconciliation by looking at the eligibility files of outside service providers such as the prescription drug vendor. In some

cases, the receiver has doubts about the identity of providers. In this case, the receiver may be able to develop a set of information from the previous year's 1099 forms filed with the Internal Revenue Service.

In developing a program for dealing with claims, the receiver must decide whether to investigate prior claims handling with a view to correcting prior errors. The correction of prior errors may give rise to rights of recovery against providers or at least rights of setoff. Unfortunately, the cases where overpayments are likely to be found are also the cases where it is most difficult to pursue them due to the deficiencies in the system.

Protection of enrollees

One of the most important issues facing regulators in MCO insolvencies is the protection of enrollees from collection actions by providers. States have a wide variety of approaches to this problem. Some states enjoin all providers from taking action against enrollees to collect bills. Some of these states have guaranty mechanisms that assure payment to providers. Other states bar only participating providers from seeking collection from enrollees. Many of these states also have a priority scheme which gives a priority to non-participating providers over participating providers, thereby making it more likely that they will get paid in full and not seek recourse against enrollees.

Downstream risk taking entities (such as medical management companies) may have recourse to the enrollees. This creates anomalous results if the downstream entity is serving an intermediary function within the MCO's network because claims with network providers are ordinarily non-recourse to enrollees. For this reason, several states have placed restrictions on an MCO's relationships with downstream risk takes. The NAIC currently has a task force studying these issues.

The contracts of an MCO with its participating providers typically contain provisions that prohibit providers from seeking to collect bills from enrollees. Most providers heed these provisions and refrain from billing enrollees. However, some do not. Receivers had a variety of approaches to dealing with this problem. Some took direct action against such providers in the receivership case. A few were able to persuade the attorney general in their state to take action. Most receivers were careful to advise enrollees of their rights and encourage them to enforce those rights. Many required providers to certify on their proof of claim forms that they had not collected from enrollees. Most receivers had poor experience inducing providers to return payments received.

It was widely observed that in each receivership there were some situations where enrollees decided to voluntarily pay providers despite their right not to. These enrollees may have believed that non-payment imposed a hardship on the doctor (particularly solo practitioners in rural settings) or would make the doctor less attentive during an ongoing course of treatment.

Task force work product

This report synthesizes the experience of dozens of professionals gleaned from over a decade of experience. The lessons learned over that period were not intuitively obvious at the time. As in other complex human endeavors, lessons come with experience (some of it adverse). This report does not imply criticism of any receiver or regulator who suffered the experiences from which we have learned.

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Meet Your Colleagues

By Joe DeVito

THOMAS F. CRONE

Tom Crone is currently the Chief Financial Officer and Director of Operations for Transit Casualty Company in Receivership, which is based in Los Angeles, CA. Over the past 14 years, he has worn a number of hats in sorting out what the 101st Congress has referred to as the "Titanic of Insolvencies;" and it was before the U.S. House of Representatives that he testified during its investigation into the causes of several large insurance failures, including Transit's. Primarily, he has assisted the Transit estate with collections of over $1.4 billion for policyholders, including recovery of nearly $1 billion of reinsurance from 840 reinsurance companies located in 32 countries.

Prior to joining the receivership, Tom was with the AVCO Financial Insurance Group where he managed the withdrawal from the group's nation-wide managing general agency operations, as well as oversaw development of data processing systems for the group's worldwide insurance operations. He also worked for several years with Ernst & Young, LLP in Orange County, CA. A Certified Public Accountant and a member of the American Institute of CPA's and California Society of CPA's, he is also an associate member of the American Society of Pension Actuaries and IAIR.

Tom lives in Pasadena, Ca. with his wife, Rennette, and their three sons, with whom he enjoys the outdoors, including spear fishing and horseback riding. He is also a member of the Pasadena Tournament of Roses Association, which stages the annual New Year's Day Rose Parade and Rose Bowl events.y.

DAVID KENDALL

David Kendall is a partner at London solicitors D J Freeman and heads their insurance department. He has acted in insurance matters since 1979 and joined the firm as a partner in 1988. His main areas of practice are insurance insolvency, reinsurance and insurance coverage. Clients include major UK and overseas insurers and reinsurers, liquidators, scheme administrators and Lloyd's brokers.

David has particular experience of advising on pool and syndicate group reinsurance programmes, particularly in cases of insolvency. He also advises on regulatory, structural and management issues affecting London market companies in run-off. He has advised the KWELM companies on reinsurance issues since 1990 and has acted for liquidators and scheme administrators of many insolvent insurers, including Sovereign, Cambridge, Focus, English & American and Independent. Reported cases include PCW Syndicates v PCW Reinsurers, Central National v D R Insurance, Munich Re v Weavers, Milano v Walbrook and HIH v Axa.

IAIR's international director, Vivien Tyrell is a partner in D J Freeman's 50 lawyer strong insurance department. Of David, Vivien says:

"David's reinsurance law expertise and understanding of the industry are a significant contribution to our work here, especially considering the fresh challenges we are all facing!"

David writes regularly for insurance publications and speaks frequently at insurance-related conferences, both nationally and internationally, including IAIR Roundtables. He is a Lloyd's panel arbitrator and is fluent in German.

When not working, David occupies himself with tennis, woodworking, his wife and 3 children, but not necessarily in that order.

JANICE F. MURRAY

Janice F. Murray is a principal at McTevia & Associates, Inc., a financial and management consulting firm in Eastpointe, Michigan, that specializes in working with companies in transition. She is a graduate of Lake Superior State University and a certified public accountant. Over the past 13 years, Ms. Murray has participated in the refinancing and restructuring of more than $3 billion of corporate debt for more than 200 companies.

Ms. Murray believes her success in negotiating settlements is related to recognizing two themes that appear in almost every case: Convincing clients there is a problem that needs to be addressed and taking the emotion out of the discussions with angry creditors.

Her experience in the health care industry has stretched throughout her 16-year career and in recent years, has been concentrated in assisting the Michigan Insurance Bureau in overseeing financially distressed HMOs. In addition to her expertise in health care, Ms. Murray also has extensive experience in a variety of other industries, including manufacturing, retail, professional services and construction. Her background includes services in the areas of corporate restructuring, bankruptcy, litigation support and forensic accounting.

In addition to her involvement in IAIR, she is on the board of the Turnaround Management Association, Detroit Chapter and is a member of both the American Institute and Michigan Association of Certified Public Accountants. When she is not working (and weather permitting in Michigan), Ms. Murray is an avid golfer and sports fan.

ROBERT O. SANDERSON

Bob Sanderson is a senior partner with KPMG in Toronto Canada and President of KPMG Inc. He is currently heading up KPMG Corporate Recovery Insolvent Financial Institutions practice in North America. He has over 33 years of public accounting experience and has specialized in the insolvency field for the past 25 years. His professional qualifications include a FCA (Fellow of the Institute of Chartered Accountants), Licensed Trustee in Bankruptcy and FCIP (Fellow Chartered Insolvency Practitioner) designation. As well, he holds a BA (Honours) degree from Simon Fraser University. He is Past Chair of the Canadian Association of Insolvency Practitioners and was recently appointed to the Executive Committee of INSOL International as Treasurer and Board member with responsibility for the insurance industry.

Originally from Vancouver, Bob came to Toronto in 1986 for a short stay that has lasted over 15 years. He has been involved in numerous multinational insolvency and restructuring assignments with a particular emphasis on financial institutions. His new and novel approaches led to the successful liquidation of Confederation Life and Sovereign Life Insurance Companies, two assignments valued at over $15 billion. Bob was also responsible for the restructuring of Central Capital Corporation, a financial holding company with subsidiaries in a number of financial services sectors.

When he is not restructuring or liquidating companies, Bob spends his leisure time on one of his other three passions: driving his Mazda Miata sports car, golfing or traveling. A number of years ago, Bob discovered an insurance conference in Arizona that takes place in early spring each year. This conference allows Bob to keep up to date on what is happening in the insurance world, visit interesting historical sites in Arizona and New Mexico and loosen up his golf swing for the coming season.

Receivers' Achievement Report

by Ellen Fickinger

Reporters:
Northeastern Zone - J. David Leslie (MA); W. Franklin Martin, Jr. (PA);
Midwestern Zone - Ellen Fickinger (IL); Brian Shuff (IN)
Southeastern Zone - Eric Marshall (FL); James Guillot (LA);
Mid-Atlantic Zone - Joe Holloway (NC)
Western Zone - Mark Tharp, CIR (AZ); Bob Loiseau, CIR (TX); Melissa Eaves (CA)
International - Jane Dishman (England); John Milligan-Whyte (Bermuda)
Our achievement news received from reporters for the third quarter of 2001 is as follows:

Mike Rauwolf (IL) continues to provide updated information on two companies under OSD supervision. **American Mutual Reinsurance, In Rehabilitation (AMRECO)** continues the reinsurance run-off of their business. Total claims paid inception to date; Loss and Loss Adjustment Expense $30,449, Reinsurance Payments $139,122,323, and LOC Drawdown disbursements $9,613,386. **Centaur Insurance Company, In Rehabilitation**, also continues the run-off of their business, total claims paid inception to date; Loss and Loss Adjustment Expense $53,289,623, Reinsurance Payments $4,945,493 and LOC Drawdown disbursements $13,876,555.

Daniel L. Watkins, CIR-ML (KS) provided information on several receiverships. During September 2001, the estate of **The Centennial Life Insurance Company, In Liquidation** distributed $24,099,632 to Guaranty Associations to reimburse 100% of reported Class 1 administrative expenses incurred and recoveries due. In addition, the distribution paid Guaranty Associations 85% of Class 3 policy related claims. In total, the **Centennial** estate has distributed $10,831,956 to Guaranty Associations for repayment of advances and for reimbursement of administrative expenses, $20,967,997 to Guaranty Associations and $5,325,237 to non-guaranty fund claimants representing payment of 85% of policy related claims. The **Centennial** estate has also paid $30,517,588 in early access payments to Guaranty Associations to fund claims, settlements and Assumption Reinsurance Agreements on non-cancelable blocks of **Centennial** business.

On a second estate, **West General Insurance Company**, Guaranty Funds affected by their liquidation recently entered agreements with the Liquidator setting the final amounts of the Funds' Class 1 expenses and Class 3 claims in the **West General** estate. An application for distribution of assets was made to the liquidation court on August 2, 2001 and an order approving the distribution was entered September 4, 2001. The **West General** estate over the past two years has distributed approximately $13,250,000 comprising the above amounts for Class 1 and Class 3 Guaranty Fund claims plus $2,792,000 to non-Guaranty Fund Class 3 claimants representing 54.4% of their allowed claims. Approximately $350,000 in assets remains in the estate at this time. There will be a final distribution in the **West General** estate after all estate administrative expenses are covered and any additional assets are recovered from bankruptcy estates of related companies in which **West General** is a creditor. When those matters are resolved the estate will be closed.

Finally, **Daniel Watkins** reports that an application was filed with the court on November 16, 2001 requesting permission to distribute approximately $17,610,000 of estate assets for **National Colonial Insurance Company, in Liquidation**. This distribution will be mailed on December 15, 2001 and will increase inception to date payments to 100% of incurred administrative expenses and 94% of policy related Class 3 claims. In total, the **National Colonial** Estate will have paid approximately $2,063,000 to guaranty funds for reimbursement of Class 1 administrative expenses and $27,866.577 to guaranty funds and to non-guaranty fund claimants representing payment of 94% of policy related class 3 claims. There may be an additional distribution in the **National Colonial Insurance Company** estate if assets are recovered from (1) the DSN bankruptcy estate where **NCIC** is the largest creditor; or (2) a disputed conservatorship account which is currently the subject of litigation in New York.

Ongoing collection information was received from **James Gordon, CIR-P&C (MD)** for **Grangers Mutual Insurance Company**. Collections during the second quarter of 2001 totaled $42,451.45. Additionally a report was received on **PrimeHealth Corporation**. This single state HMO/MCO with approximately 12,000 members was licensed and domiciled in the State of Maryland and provided services solely to the Medicaid population. It was placed in Rehabilitation in

October 1998 with a deficit of approximately $4,000,000. It was operated in Rehabilitation where it was returned to profitability in 1999 and 2000. Due to a change in the method of capitation from the State, losses were projected for calendar year 2001. After a limited bidding process, the Receiver sold the provider contracts and its certification as an MCO in the Health Choice program to another program participant. **PrimeHealth** began run-off effective May 1, 2001.

Frank Martin (PA) continues to provide updated information on Fidelity Mutual Life Insurance Company (FML), In Rehabilitation. As of 9-30-01 FML showed a statutory surplus in excess of $124,000,000 after reserving for all policyholder and creditor liabilities. The surplus went down slightly due to the booking of the $65 million policyholder dividend approved by the Commonwealth Court for 2002.

The moratorium on cash surrenders, withdrawals, policy loans and other contractual options which was imposed by the 11-6-92 rehabilitation order was terminated effective 10-1-01. Policyholders are now able to fully access their cash values. Death benefits continued to be paid and policyholder dividends and interest continued to be credited. Because of the high dividends paid in 2001 and planned for 2002, surrenders as a result of the moratorium termination are expected to have minimal financial impact. The moratorium termination order also provides that creditors with allowed claims can be paid immediately with 6% simple interest. All general creditor claims have been paid except for a few where we are awaiting a release to be returned to the Rehabilitator. Settlement of some of the premium tax claims are still pending with state authorities.

On August 14, the Commonwealth Court issued an order approving proposed dividends for 2002 in the approximate amount of $65 million. A petition for approval of crediting rates for non-traditional policies was filed in August. The petition proposed that most of the crediting rates would drop slightly. The Policyholder Committee has filed objections to the proposed crediting rates saying they are too high in light of recent decreases in the federal funds rates.

The Commonwealth Court issued a briefing schedule for argument of the legal issues related to the remaining objections filed by the Policyholder Committee against the Third Amended Plan. Hearings on the factual issues were held in August and September of 1999. Initial briefs are to be filed by all parties by December 5 and response briefs are due on December 20, 2001.

Our new Western Zone Reporter **Bob Loiseau, CIR (TX)** reported a personnel change within the Texas Department of Insurance. **Evelyn Jenkins** has been appointed Director of the Liquidation Oversight Division, where she has overall responsibility for 24 receiverships and 10 Special Deputy Receivers. Ms. Jenkins holds an MBA from Southwest Texas State University and was promoted from within the Liquidation Oversight Division where she had 5 years of experience in receivership administration. She has applied to become an IAIR member. Ms. Jenkins succeeds former Director Rosalind Conway who joined the New York office of PriceWaterhouseCoopers. In other Texas news, the **Employers Casualty Company** and **Employers National Insurance Company** receiverships made their 7th early access distributions to 45 participating guaranty associations, bringing their Class 2 (policyholder level) distributions to 80% and 50% respectively. **American Eagle Insurance Company** in receivership made its first early access distribution to 48 participating guaranty associations, representing a partial Class 1 payment of administrative expenses.

Receivers' Achievement Reports By State

Georgia (Harry L. Sivley, State Contact Person)

Receivership Estates Closed	Category	Licensed	Year Action Commenced	Payout Percentage
The Shores Group	Health	No	1992	34%

Illinois (Mike Rauwolf, State Contact Person)

Receivershipt Estates Closed	Category	Licensed	Year Action Commenced	Payout Percentage
United Fire Insurance Company Closed 6/22/01	P & C Health	Yes	1989	Class A - 100% $2,542,345 Class D - 68% $7,042,085

Use and distributions made to policy/contract creditors and Early Access

Receivership	Loss and Loss Adjustment Expense	Early Access Distribution	Reinsurance Payments
Alliance General Ins. Co.	800	0	0
Amreco	0	0	2,003,957
American Unified Life & Health	595	0	0
Back of the Yards	55,360	0	0
Centaur	(23)	0	0
Coronet	73	10,070	0
Illinois Earth Care Workers Comp	101	0	0
Illinois Electric Employers Work	592	0	0
Illinois Insurance Co.	690	0	0
Inland American Ins. Co.	0	250,564	0
Intercontinental Insurance Co.	60	0	0
Merit Casualty Co.	0	100,000	0
Optimum Insurance Co.	0	300,000	0
Prestige	0	19,983	0
River Forest Insurance Co.	0	200,000	0
State Security Insurance Co.	0	100,000	0

Kansas (Daniel L. Watkins, State Contact Person)

Use and distributions made to policy/contract creditors and Early Access

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

Receivership	Non Guaranty Fund	9/10/01 Class 3 Distribution
	Total	**$31,824.00**

Receivership	Class 1 - GA	Class 3 - GA	Early Access
Centennial Life Ins. Co.	$3,131,635.00 (100%)	$20,967,997.00 (85%)	$35,842,825

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

Receivership Estates Closed	Category	Licensed	Year Action Commenced	Payout Percentage
Pennsylvania Automobile Wholesalers' Association Trust	A & H	No	1991	17%

Maryland (James A. Gordon, State Contact Person)

Use and distributions made to policy/contract creditors and Early Access

Receivership	**Amount Guaranty Funds**	**Policy/ Contract Creditors**
Grangers Mututal Ins. Co.	$8,110.22	$1,026.75 (MD)
	$2,019.44	$636.23 (NC)
	$11,458.81	
	$3,666.90	
Total	**$25,255.37**	**$1,662.98**

Ohio (Douglas L. Hertlein, State Contact Person)

Use and distributions made to policy/contract creditors and Early Access

Receivership	***Amount***
PIE Mutual Insurance Company	$61,970,925.00
Reliable Insurance Company	$14,026,598.23

Texas (Evelyn Jenkins, State Contact Person)

Use and distributions made to policy/contract creditors and Early Access

Receivership	***Amount***	***Total***
Employers Casualty Company	$8,650,829.00	$155,743,528.00
Employers National Insurance Company	$1,930,640.00	$29,186,461.00
American Eagle Insurance Company	$5,170,842.00	$5,170,842.00
Total		**$190,100,831.00**

STATUTORY ISSUES IN ARBITRATION WITH INSOLVENT COMPANIES

by Peter T. Maloney & Jeanne M. Kohler

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Arbitration provisions in reinsurance agreements are common and generally enforceable. However, historically, when a ceding company has entered liquidation, rehabilitation, supervision or receivership, the binding effect of an arbitration clause has not always been clear. Traditionally, liquidators and rehabilitators have attempted to resist arbitration with reinsurers, based on the hopefully mistaken perception that in a given dispute, state insolvency courts will favor the insolvent cedent to the reinsurer's detriment. While the trend in U.S. jurisdictions is to enforce the clauses and require insolvent cedents to arbitrate with their reinsurers, the scope of such arbitrations remains subject to continued dispute. Liquidators and rehabilitators routinely attempt to exclude certain issues from the arbitrators' jurisdiction and keep those issues within the purview of the state courts, and reinsurers routinely attempt to maximize the arbitration process by submitting as many issues to arbitration as possible.

The Federal Arbitration and McCarran-Ferguson Acts

The starting point in deciding these disputes has been the Federal Arbitration Act ("FAA"). The FAA provides that binding arbitration agreements involving interstate commerce are enforceable. In the international field, Section 2 of the FAA, the United Nations Convention on the Recognition and Enforcement of

Foreign Arbitral Awards (the "Convention"), facilitates the enforcement and recognition of international arbitration agreements and awards. Given that reinsurance is an international industry, either the domestic or international provisions of the FAA can be called into play in reinsurance arbitration disputes.

Absent any other federal mandate, the FAA would generally require the arbitration of a dispute between an insolvent U.S. insurer and its domestic or alien reinsurer. However, in addition to the FAA, Congress has enacted the McCarran-Ferguson Act, which places limits on the preemptive effects of non-insurance specific federal laws such as the FAA and gives the states broad power to regulate the business of insurance. Therefore, the states have promulgated extensive legislation to deal with the business of insurance, including the insolvency of insurance and reinsurance companies.

State insolvency law is generally uniform and furnishes a comprehensive method for winding up an insolvent company, often vesting exclusive jurisdiction over insurer liquidations and rehabilitations in state courts. Therefore, a conflict often arises between the reinsurer's right or desire to arbitrate pursuant to the FAA and the liquidator's right or desire to resolve a ceding company's insolvency in state court under the protection of the McCarran-Ferguson Act. Because of the strong federal and international policies favoring arbitration, reinsurers typically attempt to resolve these disputes in the federal courts, which are generally made accessible in the event of international arbitration by a specific federal removal section in the Convention.

In the majority of U.S. jurisdictions, both federal and state courts have held that the statutory successor of an insolvent ceding company, whether a liquidator, rehabilitator, supervisor or receiver, may be compelled to arbitrate with a reinsurer. This is because of the strong federal policy in favor of arbitration, as exemplified by the FAA, and because the statutory successor is deemed as a matter of state law to "step into the shoes" of the insolvent company and assume its obligations, including the obligation to arbitrate.

Significantly, however, in New York that is not the case. In Corcoran v. Ardra Ins. Co. Ltd., a matter involving an international arbitration, New York's highest state court acknowledged that the Convention mandated arbitration absent preemption by the McCarran-Ferguson Act and New York state precedent prohibiting arbitration with an insolvent cedent. Therefore, the Ardra court focused on whether the Convention itself exempted the liquidator, in that case the State Superintendent of Insurance, from arbitration. The court noted that Article II of the Convention requires recognition of an arbitral agreement only when it pertains to a subject matter "capable of settlement by arbitration", and that the court may refuse to compel arbitration if the agreement is "null and void, inoperative or incapable of being performed". The Ardra court found that New York's insurance statutes, as enabled by McCarran-Ferguson, granted the Superintendent plenary powers to manage the affairs of an insolvent company, but did not authorize the Superintendent's participation in arbitration proceedings. In reaching that conclusion, the court followed Matter of Knickerbocker Agency, a 1958 case predating the formulation of the strong national policy in favor of arbitration.

The court therefore held that the arbitration clauses were "incapable of being performed" and that the claims at issue were not "capable of settlement by arbitration" within the meaning of the Convention.

Statutory Issues In Arbitration

The Ardra decision is contrary to the weight of authority supporting post-solvency arbitration. Ardra's departure

from the trend in other jurisdictions is its focus on the overall statutory scheme for the resolution of insurance insolvencies, and its implication that the scheme's failure to address arbitration must mean that arbitration is inimical to it. However, most courts have not accepted that implication, reasoning that the federal and international policies and everyday practicalities supporting arbitration would require a much more explicit statutory prohibition before they would find a conflict. While, therefore, liquidators and rehabilitators in most states may not rely upon generalized statutory antagonism towards arbitration, they nonetheless commonly attempt to exclude various specific issues from arbitration with reinsurers, arguing that those issues concern matters of statutory interpretation or relief only appropriate for determination by state insolvency courts. To some extent, these arguments reiterate arguments previously made and lost respecting the arbitrability of causes of action arising under federal statutes such as the Securities, Antitrust, RICO and Age Discrimination Acts.

Thus, historically, federal courts had been resistant to the arbitration of federal statutory claims and the U.S. Supreme Court had ruled that such statutory claims could not be arbitrated. However, over the past twenty years, the U.S. Supreme Court has held that federal statutory claims are appropriate for arbitration. Similarly, in those jurisdictions allowing post-solvency arbitrations ,issues with alleged statutory origins have been submitted to arbitration.

Quackenbush v. Allstate Ins. Co. involved the issue of whether, under California Insurance Code § 1031, a reinsurer was entitled to offset its obligations to an insolvent ceding company against debts owed by the insolvent cedent to the reinsurer under other reinsurance agreements. The Court of Appeals for the Ninth Circuit, relying on Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., supra held that statutory issues in insolvency, in some circumstances, are arbitrable. In Mitsubishi, the United States Supreme Court had held that "[h]aving made the bargain to arbitrate, the party should be held to it unless Congress itself has evinced an intention to preclude a waiver of judicial remedies for the statutory rights at issue," or "legal constraints external to the parties' agreement foreclose[s] the arbitration of claims." Based on this standard, the Allstate court noted that "Congress has not expressed an intent to prevent arbitration of this claim, and no external legal constraints counsel against arbitration. Furthermore, this claim, while it may indirectly relate to the California Insurance Code, involves contractual rights, not rights created by statute." Significantly, the Allstate decision was decided after remand from the U.S. Supreme Court, which had held on appeal that federal courts should not be overly hesitant to exercise their jurisdiction in matters involving the application of state insurance statutes, such as the California setoff statute. In that case, the Court considered whether the federal courts should refuse to exercise their jurisdiction, or "abstain," from the dispute between the liquidator and Allstate because it concerned matters of state insolvency law. The Court reaffirmed that abstention is rarely appropriate and recognized that Allstate's motion to compel arbitration implicated "a substantial federal concern for the enforcement of arbitration agreements." Therefore, Allstate is a strong direction by the Supreme Court that on removal from state court, federal courts should exercise jurisdiction even when alleged statutory issues are presented. Selcke v .New England Ins. Co. was another dispute between a reinsurer and the rehabilitator of an insolvent ceding company respecting setoff. In Selcke, each of the reinsurance contracts at issue included a clause which called for the arbitration of disputes concerning the interpretation of the contract. The rehabilitator brought suit against the reinsurer in the United States District Court for the Northern District of Illinois. The reinsurer moved to stay the action pending arbitration. The district court denied the reinsurer's motion, finding that the claim for setoff was statutory and not a dispute over contract interpretation. The Court of Appeals for the Seventh Circuit reversed the district court, noting that there is a "favorable judicial attitude toward arbitration" and that the arbitration clause at issue was quite similar to others in the insurance and reinsurance industries which were interpreted broadly. Thus, the Seventh Circuit held that the statutory right to setoff was in fact an implied term in the reinsurance contracts, and therefore was within the scope of the arbitration clauses which required arbitration of that implied "term's" interpretation.

In Koken v. Cologne Reinsurance (Barbados), Ltd., the United States District Court for the Middle District of Pennsylvania thoroughly examined the issues of whether a liquidator of an insolvent cedent could be compelled to arbitrate with a reinsurer and whether statutory claims are arbitrable. In Cologne, the reinsurer had reinsured the cedent's policies under a coinsurance agreement. The reinsurer and cedent had also entered into a stop loss agreement under which the cedent reinsured the reinsurer. The Pennsylvania Insurance Commissioner, as statutory liquidator of the cedent, brought suit in state court seeking damages against the reinsurer and a declaration that (1) the reinsurer could not invoke its right to set off one contract against the other pursuant to § 221.32 of the Pennsylvania insolvency laws; and (2) that the liquidator had appropriately cancelled the stop loss agreement but not the coinsurance agreement pursuant to her statutory powers under § 221.21 of the Pennsylvania insolvency laws. The reinsurer removed the case to the district

Authority Issues In Arbitration

(Continued from page 23)

court and moved for an order compelling arbitration. The Liquidator moved to remand and opposed arbitration claiming: 1) the McCarran-Ferguson Act preempted the FAA; 2) under Ardra, arbitration would impair Pennsylvania's statutory scheme and the federal court should therefore abstain from hearing the case; and 3) Article II of the Convention did not authorize arbitration because the arbitration agreement was "null and void, inoperative or incapable of being performed." The Cologne court rejected the Liquidator's arguments and held that "the arbitration agreement was operative and that the Liquidator stands in the shoes of the insolvent insurer and is bound by the insurer's contractual agreements...even as to arbitration." The court therefore compelled arbitration of the liquidator's claims for declaratory relief respecting setoff and cancellation of the stop loss agreement.

In In re Liquidation of Inter-American Ins. Co .of Illinois, an Illinois appellate court reversed a trial court's order which precluded an arbitration panel from deciding whether certain claims were covered under reinsurance contracts. In that case, the Illinois Director of Insurance, as liquidator, argued in the lower court that the reinsurer was obligated to compensate the cedent's living insureds for the value of the policies and that the reinsurance contracts were not executory. The reinsurer countered that the reinsurance contracts were executory, and had been rejected by the liquidator upon the company's entry into liquidation. The trial court ruled in favor of the liquidator, holding that the contracts were not executory. The reinsurer then moved to compel arbitration on the remaining issues in dispute and the liquidator opposed the motion. The trial court granted the reinsurer's motion to compel arbitration but excluded from arbitration the issues of whether the contracts were executory and whether the insureds' claims against the estate were among the benefits covered under the reinsurance contracts. The reinsurer conceded that the executory contract issue was no longer arbitrable but appealed the arbitrability of the benefit coverage issue. The liquidator argued that the reinsurer, by raising the coverage issue before the trial court, had waived arbitration on it. However, the appellate court held that merely raising the issue in court without obtaining a determination had not amounted to a waiver. Further, the court found no support in the record for the lower court's ruling that, alone among its contract defenses, the reinsurer could not arbitrate the coverage issue. The appellate court noted that "contracts...contained broad arbitration clauses, which, under the [FAA],the court has a duty to enforce". Thus, the court held that the lower court had erred in singling out the benefits issue as non-arbitrable, and ordered arbitration on it. Subsequently, the arbitration panel issued an award in favor of the reinsurer, which was later confirmed.

Conclusion

Although the statutory successor of an insolvent company may attempt to avoid arbitration with its reinsurers, the majority of courts have held that statutory successors are not exempt from arbitration simply because arbitration is not specifically addressed in state insolvency laws. Moreover, there is a developing trend within that caselaw that the mere fact that a claim or issue allegedly arises in connection with a state insolvency code does not render it non-arbitrable.

Jeanne M. Kohler *has experience representing both ceding and reinsuring companies with respect to coverage cases. She has rendered legal opinions as to interpretation of contracts, settlement agreements and commutation agreements. Ms. Kohler received her B.A. from Hofstra University and her J.D. from Hofstra University School of Law.*

Peter T. Maloney *represents both ceding and reinsuring companies in arbitration and litigation. He developed his reinsurance expertise in a wide variety of property and casualty, life and health, and financial reinsurance disputes, and has diverse experience with insolvency, coverage, licensing, and regulatory matters. He has authored several articles on reinsurance and is the American co-commentator to the English reinsurance treatise Reinsurance Law. His professional affiliations include the AIDA U.S. Reinsurance and Insurance Arbitration Society, the Torts and Insurance Practice Section of the American Bar Association, and the Committee on Arbitration and Alternative Dispute Resolution of the Commercial and Federal Litigation Section of the New York State Bar Association. Mr. Maloney is a graduate of Columbia College and St. John's University School of Law. He is admitted to practice in New York.*

Insolvency Workshop Recap

by Robert Loiseau, CIR-ML and Tom Clark

For the first time in its ten-year history, IAIR was the exclusive sponsor of the annual Insolvency Workshop held in San Antonio, Texas on January 24 and 25, 2002. The program was attended by more than 120 registrants and included almost three-dozen speakers and panelists comprised of regulators, industry representatives, receivers and other professionals active in the insurance insolvency arena. IAIR extends special thanks to Commissioners Diane Koken (PA), Terri Vaughan (IA) and Kathleen Sebelius (KS). The presence of these Commissioners, along with delegates from other states' insurance departments, contributed to a program that was clearly IAIR's best-attended and most informative Insolvency Workshop to date.

The principal focus of this seminar was the challenges facing workers compensation carriers in terms of market pressures, regulatory concerns and, ultimately, guaranty association involvement after insolvency. The perspectives of many different constituencies afforded all attendees the opportunity to learn the industry insiders' perspective, including some eye-opening statistics not readily available to the general public.

Although space limitations preclude a detailed recap of the program, the following summary will give the reader some sense of the magnitude of challenges facing workers compensation carriers, their regulators and the insolvency professionals who will deal with their failure.

The State of Workers Compensation

Panelists raised more than a few eyebrows with their description of the workers compensation market as a whole. After comparative tranquility in the late 90s, workers compensation rate increases of up to 50% are occurring, with coverage becoming increasingly harder to get in certain segments of the market. Further consolidation is expected within the industry with larger, multi-line carriers absorbing mono-line companies and weaker carriers failing in increasing numbers. Not surprisingly, the World Trade Center losses contributed to these adverse changes in the marketplace, where loss reserve deficiencies might be as great as $20 billion industry wide. Poor underwriting and aggressive expansion of operations and market share without regard to cost contributed to the current state of the industry. Poor investment returns industry-wide aggravated the already marginal performance resulting in soon to be filed annual statements that will show substantial deterioration as loss and expense ratios skyrocket and loss histories deteriorate.

Workers Compensation Failures

While this section focused on the demise of Superior and Reliance, the lessons have application to other workers compensation insurers. Mismanagement combined with predatory pricing and cutthroat competition to increase market share were all common traits. Additionally, a trend through the 90's of small carriers acquiring larger ones contributed to market instability. Not surprisingly, inadequate reserves, bad information systems and poor internal controls continue to contribute to company failures. The regulators' take on these problems is that "hindsight is 20/20," because when management appears both competent and motivated to solve looming problems, they are afforded significant latitude. Internal pressures such as holding company debt service, loose underwriting and inadequate pricing are seldom apparent until too late. As a result, guaranty associations, operating virtually without a cap, then get caught in a vise as a result. In California, cash demands for workers compensation claims exceed $58.7 million per month. Added to exposure from other lines, the California Insurance Guarantee Association is paying a staggering $79.9 million per month in claims with ultimate liabilities projected at nearly $5 billion. Clearly, workers compensation failures place an enormous stress on guaranty funds' resources. Using California as a poster child, and projecting its experience nationwide, there was consensus that a real weakness in the workers compensation industry market exists today that will be compounded by uncollectable reinsurance, insufficiently collateralized fronting arrangements and questionable intercompany transactions.

Keynote Speech on the Reliance Insolvency

The Hon. Diane Koken, Pennsylvania Commissioner of Insurance presented the keynote speech at the luncheon meeting and provided some of her own astounding statistics relating to the Reliance insolvency. All told, Reliance's burn rate is approximately $100 million per month. Moreover, a company as large and diverse as Reliance posed enormous challenges. Reliance heavily utilized TPAs (with offices in more than 1,000 locations). She acknowledged the NCIGF's valuable participation in this process, affirming that early involvement of guaranty funds in a large receivership is vital to the company's policyholders. At the time of Reliance's receivership, more than 200,000 claims were open. The proof of claim mail-out was also of a magnitude few receivers have ever seen - more than 1.6 million proofs of claim were included with a supplemental mailing of 600,000 underway.

Solutions to the Failing Workers Compensation Carrier

Early regulatory intervention was the near unanimous recommendation to save carriers. When a company is identified as troubled, management should be replaced while there is still enough cash to facilitate a merger with a stronger entity or, in some cases, to permit a loss portfolio transfer. A successful rehabilitation requires value in the company. Cash, personnel, information systems and viable reinsurance are some of the key elements without which rehabilitation is not possible. Possible rehabilitation scenarios discussed were: loss portfolio transfers and guaranteed dividend plans. For a loss portfolio transfer to work, a carrier must have cash and be exiting the market and the reinsurer or transferee of the policies must want the business. Under a "Guaranteed Dividend Plan," a third party (usually a reinsurer) assumes responsibility for a company in runoff or liquidation (under oversight by the regulator) and immediately pays a set dividend to approved claimants. As later claims are approved, they receive a similar distribution. If underlying assumptions prove wrong, the assuming party pays the downside with no opportunity to recapture

Insolvency Workshop Recap

(Continued from page 25)

dividends paid to creditors. The benefit of this type of arrangement are that it avoids the need to accelerate or estimate claims for reinsurance collection purposes, guarantees a specific dividend to creditors and reduced administrative expenses through the economies of scale. Also in this section of the program, America's practice of intervention in troubled companies was contrasted to practices in the United Kingdom. In the UK, the responsibility for dealing with troubled companies begins with the board of directors, each member of which has a legal duty to surrender control of a troubled company. Failure to do so can result in personal liability for "wrongful trading." Some panelists clearly preferred the UK model because it provides a deterrent to management's baseless optimism, which was viewed as a primary reason for delays in regulatory intervention.

Guaranty Association's Perspectives on Workers Compensation Failures

Not surprisingly, panelists in this section of the program echoed the sentiment that early intervention by the regulator is vital. Only when a company still has assets that can be used to pay administrative costs and make early access payments to guaranty associations can the impact of insolvency on the guaranty funds be minimized. California's woes (as described above) were cited again as examples of why, in the guaranty associations' view, companies should be placed into liquidation sooner rather than later.

Special Issues, Including Self-Insured Workers Compensation Pools

The topics in this section of the program show just how complicated employers and insurance companies can make a workers compensation program. Many companies choose to (or must) self-insure their workers compensation claims, which create a unique set of problems in the event of insolvency. Florida was used as a case study. In the mid 1990s, workers compensation self-insurance pools dominated the Florida market leading to their regulation by the Florida Department of Insurance in 1994. Most pools couldn't comply with the regulations, and either became insolvent, converted to stock or mutual companies or effectuated loss portfolio transfers to licensed P & C companies. As a result, Florida created a separate guaranty fund for self-insurance pools in 1995. Funding was a chronic problem as the Department of Insurance encountered resistance from member pools. Subsequently, self-insurance funds declined from 80% of the market to only 5%. The remaining five percent was viewed as necessary to prevent some employers from going without coverage altogether. Illinois' experience with self-insurance funds was similar. Although permitted for specific types of employers, members of Illinois' self-insurance funds must commit to pay the assessment when due and show a positive net worth as a prerequisite to becoming self-insured. Illinois only pays final workers compensation awards, as contrasted to pay-as-you-go medical and indemnity benefits structures, and does not provide employer liability claims coverage. As in Florida, Illinois has also encountered difficulty in collecting assessments from member associations.

The State of the Insurance Industry after September 11, 2001

Hon. Terri Vaughan, Iowa Commissioner of Insurance, made a thought- provoking presentation on changes facing the insurance industry after the World Trade Center attacks, which she characterized as the largest single industry loss ever, with estimates of $40 billion in claims liabilities. Many new issues were spawned by this event or took on greater urgency: terrorism exclusions, federal legislation affecting catastrophic losses, market disruptions such as non-renewal of policies and transfers of business to surplus lines carriers or offshore entities illustrate the sea change that has occurred. Commissioner Vaughan reported a separate terrorism coverage market is emerging with upward of $300 million in offshore capital currently available and more in the pipeline. From her perspective, the principal issues which the NAIC must ultimately address are approval of the forms of terrorism exclusions to be incorporated into commercial lines policies, complete exclusion of "first acts" of nuclear or bio-terrorism and legislative limits on future industry losses. She also noted that some forms of coverage, like workers compensation, do not permit any exclusions further compounding regulators' dilemma. There appears to be a consensus that a "Federal fix" is needed, and that the exclusions and amendments to coverage being promulgated by the NAIC should only be interim measures. Commissioner Vaughan did offer some encouragement, though, concerning the industry's ability to handle losses arising from World Trade Center attacks. The NAIC has begun to assess the overall impact, studying New York, New Jersey and Connecticut carriers as the market segment responsible for a substantial percentage of total losses. The NAIC's ongoing Financial Impact Survey, which tests such things as reinsurance, liquidity and investments, identified no specific solvency concerns and provided some comfort that even heavily-burdened carriers can handle these catastrophic losses, at least this time. Moreover, the insurance industry is evolving to address future calamities of this nature. Primary carriers are tightening their underwriting and avoiding high-risk areas, and premiums are increasing to offset additional risks. Even so, she reported that capital continues to flow into the reinsurance industry, with billions of dollars now in the pipeline. Commissioner Vaughan's presentation, perhaps more than any other, underscored the increasing linkage between the insurance industry and the Federal government.

Reinsurance Solutions after September 11

Debra Hall of RAA addressed the impact of September 11 on reinsurance. Initial responses included assuring prompt payment and waiver of war-risk exclusions allowed for the industry to stabilize despite the anticipation of massive losses that are projected to be as high as $70 Billion. While natural catastrophes can be zoned and anticipated through historical recurrence patterns, terrorism is not zonable, avoids predictable patterns, and evolves through learned experience. Thus, no easy solution is readily identifiable. Notwithstanding a substantial amount of effort to design a solution, no federal legislation has been forthcoming. In the absence of further large-scale attacks, mid-term election politics will determine whether a federal solution will be forthcoming.

Privacy Issues Affecting the Guaranty Funds

Despite substantial activity at the

federal and state levels, Guaranty Associations appear to have escaped lawmakers' notice. While both the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) can be construed to exclude GA's from application, it will be necessary to consider applicability of HIPAA whenever paying claims on behalf of insolvent health insurers or workers compensation insurers as a result of bodily injury and med pay coverage. Additionally, as the industry assimilates the mandates of GLBA and HIPAA, it will be necessary to be cognizant of regulations governing security of personal information as well as the privacy of personal information.

Privacy Statutes and Regulations Impact on Receiverships

Similar to the impact on GAs, both GLBA and HIPAA will require Receivers to reconsider preconceived notions of claims handling and dealing with company information. It is anticipated that Receivers of health insurers and HMOs will notice the most immediate impact, primarily in responding to individual's requests for information. Familiarization of staff with the time frames for responding, as well as the tracking of responses for subsequent review, should become a component of every Receiver's staff training program. Additionally, Receivership Orders and Administrative procedures should be thoroughly reviewed to ensure compliance with GLBA and HIPAA.

Status of NAIC Model Privacy Regulation

Over the past year after the adoption of NAIC model privacy regulation, 44 states and the District of Columbia have laws and/or regulations that meet GLBA's privacy standards. Of these, 16 states have regulations or laws based on NAIC model privacy regulation which protects financial and health information; 15 states have enacted laws or regulations based on the NAIC model privacy regulation's notice and opt out provisions protecting financial privacy; 13 states have retained the 1982 model privacy act on their books; and 7 states have privacy regulations pending, but have not taken final action.

Managed Care Insolvency Issues

A little bit of irony accompanied morning coffee in the form of a well-scripted presentation on HMOs. The cast of characters, well known to all involved in insolvency practice, included an active Commissioner, an astute and dogged Examiner, the anxious HMO General Counsel, and the oblivious and conflicted HMO Executive/provider. The sketch involved an HMO's executives meeting with their regulator in an effort to obtain approval for a "new" product certain to cure all of its problems only to be met with the adverse results of the financial examiner's initial assessment of the Company's operations. Unfortunately, at the conclusion of the presentation, there were no magic answers to the obvious problems that continue to plague the managed health care industry.

2002 Legal Update

While most legal updates are a necessary component to at least the lawyers in the audience and the materials ably covered developments over the past twelve months, Walter Lamkin brought a bit of levity to close the seminar by speculating about the likely cause for the aberrant Ohio General decision in which for a brief and shining/indigestion-causing (depending on your perspective) moment the distinction between direct insurance and reinsurance was eliminated. Mr. Lamkin then gave the nuts and bolts version of how differently incentive based compensation plans can look at the dawn of a new Estate and at the eve of that same Estate.

It must be noted that as the 2002 IAIR Insolvency Workshop came to a close, the tables remained full of attentive attendees, which is probably the best compliment that we can all give in addition to our gratitude to the Planning Committee and the many presenters listed below:

Planning Committee
James R. Stinson, Sidley Austin Brown & Wood - Chair
Francesca G. Bliss, NY State Insurance Dept.
Richard S. Darling, CIR-ML, Office of the Special Deputy Receiver
Stephen S. Durish, CIR-ML, TX Property & Casualty IGA
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Paula Keyes, CPCU, ARe, AIR, CPIW, Paula Keyes & Associates
Michael C. Marchman, CIR-ML, Georgia Ins. Guaranty Assn.

Presenters
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Jonathan F. Bank, Tawa Associates Ltd.
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Norris Clark, California Department of Insurance
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Anthony M. Grippa, FL Workers' Compensation Guaranty Assn.
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Kevin Harris, NCIGF
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