The Insurance Receiver

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Promoting Professionalism and Ethics in the Administration of Insurance Receiverships

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FEATURED ARTICLES

Association Manager:
Nancy Margolis, Esq.
International Association
of Insurance Receivers
610 Freedom Business Center Suite 110
King of Prussia, PA 19406
610.992.0015 | Fax: 610.992.0021
E-mail: nancy@iair.org

Dear IAIR Membership,

Summer is truly well upon us - as I'm sure will be quite evident as we gather in Indianapolis for NAIC. I can't remember the last time the NAIC was in Indianapolis… and even if I did, I wouldn't admit it as that alone might give away just how long I've been coming to these things. Anyway…. There is much to recap since the last meeting so let's get to it.

It was quite clear at our Town Hall meeting in Houston (and from previous communications) that you are looking for greater "transparency" (I hate using buzz words, but..) from IAIR, and from its Committees and Board of Directors, so our efforts have been focused on just that. Your Association has continued to work on several initiatives that are designed not only to foster that transparency, and to afford members greater access to information, but also to increase your participation and involvement in IAIR activities and events. To that end, we are working diligently to develop and sponsor programs that promote IAIR's stature as the preeminent voice for receivership expertise.

Committee/Subcommittee Restructuring

With the goal of increasing transparency, and with your collective input (for which we thank you), the restructuring of IAIR's Committees and Subcommittees is nearing finality. The proposed structure that was distributed to IAIR's membership in a March 12, 2013 memorandum from **Bart Boles** was discussed during the Town Hall meeting. After discussion and additional revisions and editing, the final version has been adopted by the Board. The adopted Committee Restructuring memorandum will be distributed to the membership and will also be posted on our website. Revisions to the IAIR Bylaws to reflect the revised structure have been drafted.

Bylaws Revisions

In addition to those revisions, other changes to our Bylaws have been proposed to enhance and clarify specific items. The Board has agreed that all changes to the Bylaws be made available for review to the full membership prior to a Board vote (even where the change doesn't technically require a membership vote). Accordingly, we have disseminated the draft revisions that

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President's Message (continued)

will be voted upon at the August 26th Board meeting in Indianapolis. Please feel free to join us during that meeting and voice your opinion.

Website Redesign

As many of you know, the redesign of the website has been a top priority for the Association. After a request for proposals process and extensive demonstrations and testing, an ad hoc committee selected MemberClicks to implement IAIR's website redesign. MemberClicks has significant experience designing websites for membership based organizations. The website redesign should significantly improve the coordination of membership records, enhance the timeliness, accuracy and security of financial transactions, and allow IAIR's members greater access to a host of information. More details will be provided as the development of the redesign progresses towards implementation prior to year end 2013. Your patience has been appreciated.

Educational Development Programs

The Education Committee, under the leadership of **Bart Boles** and **James Kennedy**, have again been incredibly hard at work to bring you the highest caliber educational programs. IAIR has continued its efforts to sponsor programs in order to share its expertise and insight to the receivership community at large. A professional development program was presented to insurance department examiners and other financial regulators in conjunction with the NAIC meeting in Houston and another is scheduled for Friday, August 23rd in Indianapolis. The focus of these sessions is to highlight areas and activities that examiners, as the early eyes present at a troubled company, might want to review a little deeper or, at least, identify for receivers and guaranty funds. Such early detection can both save significant time and expense and, more importantly, promote enhanced protection of policyholders and creditors. IAIR member presenters have drawn upon their unique experiences and the benefit of hindsight to describe the "not so obvious" warning signs and vital information within areas such as claims, information technology, accounting, reinsurance, and various other operational and managerial functions. This sharing of information from the end of the line with a troubled company to the examiners on the front lines should prove to be mutually beneficial to our common goal of protecting insurance consumers.

IAIR Events in Indy

Not to be outdone, **Kathleen McCain**, chair of the Issues Forum, has put together another stellar program with terrific panelists for Indianapolis. Also taking place will be a meeting of the Guaranty Fund Liaison Committee, chaired by **Lynda Loomis** and **Wayne Wilson**, to discuss the increasingly complicated issues surrounding data management in receiverships. Although pre-empted by our Town Hall meeting in Houston, we will have a Think Tank in Indianapolis, where you have the opportunity to tap your colleagues for their thoughts/opinions/experiences on issues with which you may be confronted. This is your forum for open exchange-use it.

Please join us at these and any Committee meetings that pique your interest. We welcome your involvement and active participation.

In This Issue

Be sure to check out the great pieces included in this issue of *The Insurance Receiver*. We have wonderful recaps of the recent events you may have missed. **Kathleen McCain** has again put together a piece about the Issues Forum in Houston. **Kevin Tullier** captured the spirit of this year's TDS program at the Mandalay Bay in Las Vegas, which was chaired by **Michelle Avery** and **Phil Curley**. (Great job guys!) We have also included a comprehensive piece by the FHLB to summarize the current state of affairs, which is a must read if you plan to attend the Indianapolis Issues Forum, where representatives from FHLB will be speaking.

Chris Maisel and **Ian Naisir** have contributed their thoughts on the practice of placing a P&C

President's Message (continued)

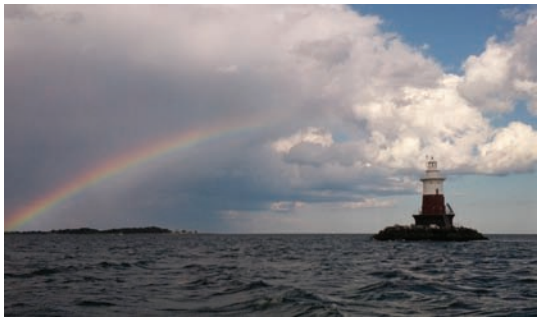
company into Rehabilitation and the concerns that can arise when the company, and its policyholders, may be better suited to Liquidation.

We also have another segment of *The Perfect Receiver*, by **Patrick Cantilo**, and update of DC goings on in the *View from Washington*, by **James Tsai**. Thank you both for your continued contributions.

Calendar Notes

Be sure to mark your calendars for the Winter NAIC meeting, which is moving back into D.C. proper to the Washington Marriott Wardman Park on December 15-18, 2013. Also, put January 29-31, 2014 on your calendar for the next IAIR Insolvency Workshop taking place at the Tempe Mission Palms in Tempe, Arizona. The Education Committee has begun planning a great program for 2014. Keep your eye out for specific details of the Workshop and save the date.

I owe more thanks to **so many**, but believe that I needed to use this message to let you know that we've heard you loud and clear and to give you an update on the adjustments we are making to get where you would like us to be.



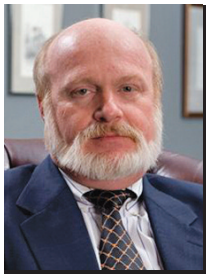
"The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails." –William Arthur Ward. This inspirational maxim pretty much sums up your Board's motivation. I sincerely hope and believe that we are headed in the right direction.

Thank you all for letting me have the helm and *happy sailing*,

frankie

The Perfect Receiver Part 9 – The Experts

By Patrick Cantilo



"Quick! Go find an expert." These are words that frequently precede a large exodus of cash and the end of easy understanding

by the receiver of the company's problems. Too often we hear the complaint that experts are too expensive and mostly complicate things, followed quickly by a resigned concession that they are indispensable. Once again, I bring enlightenment! As you consider whether you need an expert and how to get one, you must ask yourself these three questions: 1) what is an expert? 2) why do I need one? and 3) what can I afford?

Sitting on the banks of the Nile, watching the barges full of monkeys and gold float down river to the pharaoh's docks, my ancestor Al Suleiman, the first Mesopotamia-educated receiver, first penned the answer to our initial question that has been cited as dispositive ever since: "An expert is a guy from out of town with a briefcase!" All seriousness aside, an expert is an individual or firm who will enable you to understand issues of great complexity and to manage them successfully. The complexity of the issues may lie in their intrinsic nature (astrophysics, for instance), or their practical requirements (calculating morbidity rates for the U.S. population). In either case the expert possesses the tools to cope with the complexity.

For the answer to the second question, we harken back to that immortal episode of "Are You Smarter than Your Mother-in-law" in which Mabel and Gus squared off over the Pythagorean Theorem. Had Gus been able to consult an expert, he would undoubtedly NOT have guessed it was "a fishing pole for snakes", would have won the $50,000 needed to move out of Mabel's house, and bloodshed would have been avoided. In much the same way, in our world "winging it" can easily result in bad decisions or poor results. Often we

The Perfect Receiver Part 9 – The Experts (Continued)

conclude that we need experts to determine the true extent of the company's liabilities, whether our reinsurance program makes sense, whether we can effectively rehabilitate, the extent of recoverable assets, and many more such issues. But typically, we can't afford all the experts we think we need. How to decide?

For the answer to this last question I refer you back to Uncle Al Suleiman: "how much can you afford to lose because you DID NOT hire an expert?" In every case, the answer will be the result of a cost benefit analysis in which the two key factors will be the reasonably anticipated total cost of engaging the expert and the economic difference he or she can be expected to make to the matter at hand. Neither of these key determinations will be easy to make.

Experts are expensive. Their costs will include their fees, their expenses, and the cost of related staff or services. It is important to have a candid conversation with potential experts in which you learn what comparable matters have cost altogether when handled by the same expert. Be sure to include all fee and cost components. For example, many experts:

1. Bill at different (higher) hourly rates when they testify in legal proceedings;
2. Bill for their travel time;
3. Travel well (expensive hotels and air tickets);
4. Charge a premium for rendering a formal opinion;
5. May charge separately for computer modeling services, and
6. Charge for the time of support staff.

A candid conversation during the initial interview in which you explain your budget constraints and the need for economy can save lots and lots of money. Many experts are surprisingly sensitive to these matters and eager to be helpful. Those who are not may not be right for your case.

Even more difficult may be gauging the economic difference the expert's work will make to your matter. Typically, the best approach is to isolate the function for which the expert will be indispensable and make an educated estimate of how much you will gain or lose if you have to concede that function. For example, if you have a reinsurance recoverable for which you cannot prepare the necessary supporting schedules without engaging the expert, how much will you lose in likely collections?

Difficult as it will prove, the more objective and systematic these determinations are, the more reliable will be the results. There are of course additional considerations, perhaps obvious but no less important, regarding the engagement of experts. Having a clear understanding of the expert's role before interviewing candidates is essential. Acting as early as possible often helps maximize flexibility and use of the expert to best advantage. Taking more time to select the expert is usually a wise investment. Finally, sources of experts are abundant. They range from commercial services that specialize in placing experts to other people in your firm or associated with your client. It is important, however, to engage the expert for the right reasons. Experts selected as a favor to the candidate or others are very seldom among the better choices.

It is hoped that these few thoughts will help lessen the burden of one of the more difficult tasks performed by receivers. Comments and questions are always welcome.

View from Washington

By James Tsai

The mood in Washington continues to be of partisan stubbornness, matching the prototypical laconic hazy days of summer here. Since its inception, this Congress has moved very little legislation. The 112th Congress had been noted as the Congress that had passed the smallest number of bills (220) since it started keeping track of such statistics. The 113th Congress, which kicked off in January, is on track to have even fewer at this time.

Pundits give varying reasons, from a difficult House leadership, to Senate filibuster rule problems, to the effects of safe redistricting for both parties. Whatever the underlying reasons may be, it hasn't helped that Congress' attention publicly has swung from news-grabbing items such as gun control after Newtown to domestic privacy and surveillance concerns after the Snowden leaks. Immigration and the farm bill are other long-standing pieces of legislation that have been carried over from the prior Congresses as well, which have received widespread attention but precious little movement.

While little legislation has moved, that hasn't stopped Congressional hearings, agency rulemaking and other executive action to take place in the financial services world here in Washington. In fact, since the spring, quite a few things have taken place.

FSOC Names Nonbank SIFI's

The Financial Stability Oversight Council ("FSOC") has announced the designation of systemically important financial institutions ("SIFIs"), subjecting them to enhanced prudential supervision under its Dodd-Frank authority in July. This means the institutions are subject to heightened capital standards and requirements for submission of plans in case of failure.

Three institutions had been named: AIG, GE and Prudential. AIG and GE announced that they accepted the designation and would comply with the new regulatory regime. Prudential, however, announced it would challenge the designation by requesting a closed hearing before the FSOC to reconsider the designation. A thirty day window opened when Prudential made its request in early July for FSOC to schedule the appeals hearing. A final determination is then required within sixty days of the hearing. If this timeline is adhered to, a final ruling should be expected before October of this year.

June FACI Meeting

The Federal Advisory Committee on Insurance ("FACI") met on June 12 in its roughly quarterly-scheduled meetings. The FACI is comprised of fifteen individuals representing private industry, state insurance commissioners (seven of them) and academics that serve to advise the Federal Insurance Office ("FIO"). This meeting focused on two reports from the subcommittees on affordability and accessibility and international regulatory balance. The members reported back to Director Michael McRaith's inquiries on definitions and policy for access and affordability of insurance products for Americans and the effects of demographic shifts. The international regulatory balance subcommittee gave their thoughts on how American insurance companies were affected by differing regulatory regimes across borders. Both committees produced written memos that are available on the FIO website.

Director McRaith concluded the meeting by giving a brief update on international activities in which he is involved. He said that the International Association of Insurance Supervisors ("IAIS"), which he sits on, would make its first round of designations of global systemically important insurers ("G-SIIs") this summer. At the time of this writing, no designations have been made.

Director McRaith also said that the next iteration of ComFrame is due to be released at the IAIS meeting in October. Finally, the Treasury department would be hosting a US-China dialogue and he anticipated insurance being part of those discussions. Reports from the meeting indicate that there had been such discussions.

The FIO Annual Report

The Federal Insurance Office issued its first annual report to Congress on June 12, the morning of the FACI meeting and the day before a House panel on international insurance issues. The report, which is available online at the Treasury website, is a Dodd-Frank mandated one "on the insurance industry and any other information as deemed relevant by the Director or requested by such Committees." The report focused on the insurance industry's financial status and outlook, discussed legal and regulatory developments and examined current issues and emerging trends.

The report said that the financial condition of the industry was healthy with both life-health and property-casualty reporting surplus levels at record highs in 2012. The report also discussed the process of designating nonbank institutions. The report also noted the low interest rate environment, natural catastrophes, and changing demographics in the

View from Washington (continued)

United States as issues and trends that would continue to affect the industry.

As a side note, this report is not the much-anticipated state of the industry report that is overdue. At the FACI meeting, Director McRaith said that the report would be issued "soon." At the time of this writing, the report has not been issued.

Congressional Too Big to Fail Hearings and Basel III Implementation Rules

The House Financial Services Committee and Senate Banking Committee held their own respective hearings on Dodd-Frank implementation in June and July, with particular focus on the question of whether Dodd-Frank had ended too big to fail ("TBTF") or not.

The House held their hearing on June 26 and invited two Federal Reserve Presidents, Richard Fisher and Jeffrey Lacker, the current FDIC Vice Chairman Thomas Hoenig, and former FDIC Chair Sheila Bair. The hearing had a familiar partisan divide, with the Republicans calling into question whether Dodd-Frank did not end TBTF and instead had enshrined TBTF in the financial system.

During one line of questioning, Richard Fisher, President of the Federal Reserve Bank of Dallas, said that the designation as TBTF conferred a special brand to the institution from the government, giving it a special dispensation. Democratic lawmakers, including Reps. Carolyn Maloney (D-NY) and Al Green (D-TX), said that Dodd-Frank gave regulators tools to deal with large, complex financial institutions that needed to resolve, a "third option" that was not a disorderly bankruptcy (Lehman Brothers was given as an example) or a completely government-run bailout (AIG was given as that example); the Dodd-Frank tools of an orderly liquidation would be a balanced alternative approach between these two.

The Senate held its hearing on July 11. That hearing featured the head regulators of the FDIC, the Federal Reserve, the Office of the Comptroller of the Currency and Treasury Under Secretary for Domestic Finance. Here, the hearing discussed TBTF, but also focused on the just-released interim final rules implementing Basel III. While most of the hearing focused on the intricacies of capital standards for banks and the rules' implications for smaller community banks, there was a significant discussion early on regarding the rules' implication on insurance.

Chairman Timothy Johnson (D-SD) asked Federal Reserve Board Governor Daniel Tarullo about how regulators would write a rule more suited for insurance companies, as the rule did not apply to entities that had more than 25% in insurance underwriting activities. Governor Tarullo acknowledged the differences between insurance products and balance sheets and bank products and their liabilities. He said that the regulators had not wanted to hold up the process in issuing the interim rule but acknowledged that the nature of the insurance industry was still being examined and that more would be forthcoming.

James Tsai is a public policy specialist in FaegreBD Consulting's insurance and financial services practice group where he assists insurance and other financial services entities with federal legislative, regulatory, public policy, corporate, insolvency and compliance matters. James works on Capitol Hill and federal agency strategy and helps associations, companies and individuals navigate the post Dodd-Frank Act environment.

Issues Forum Recap: Houston, Texas April 2013

By Kathleen McCain

We spent the April 2013 NAIC/IAIR meeting in Houston, Texas. The convention coincided with the opening of baseball season with games just down the street from the convention center. Many of us

also watched the eco-car competition held in the park across the street from the convention center. We greeted new friends and welcomed old friends to the organization and in the midst of all of the goings on, presented the IAIR Issues Forum. We had great speakers and interesting topics. The common thread of the presentations was regulatory oversight of special deputy receivers and guaranty funds, lessons learned from regulatory mistakes, new regulatory oversight tools and how the global community is addressing resolution schemes.

Own Risk and Solvency Assessment or What Insurer Management Should Be Asking Themselves about Risk

Own Risk and Solvency Assessment ("ORSA") is part of the European Union Solvency II Directive. The NAIC has also launched its solvency modernization initiative, including similar processes and regulations as the EU ORSA, by adopting the Risk Management and Own Risk and Solvency Assessment Model Act in September 2012. This Model Act's anticipated effective date is January 1, 2015. The NAIC has also published an ORSA Guidance Manual that was updated in December 2012. Essentially, ORSA requires that insurers have a risk management process in place where they regularly assess the material risks associated with their business plans, determine the sufficiency of capital available to meet those risks and to file ORSA summary reports with their regulators. Danny Saenz, Deputy Commissioner, Financial Regulation at the Texas Department of Insurance, kicked off the Issues Forum with a discussion of the status of the United States ORSA processes. Mr. Saenz is the Chair of the NAIC ORSA (E) subgroup.

According to Mr. Saenz, the NAIC reviewed the EU solvency modernization initiatives and has taken the provisions that make sense and fit with the United States regulatory scheme and incorporated them into similar US regulations. For example, the group supervision and group capital requirements are being reviewed at an international level, while ORSA is a good fit with how the regulatory system works in the United States.

In early 2012, the NAIC began a pilot project where insurers voluntarily submitted ORSA reports. Fifteen large insurers participated and, per Mr. Saenz, the pilot program provided the opportunity for feedback by the insurers and the regulators on the implementation of the ORSA requirements. The project involved one-on-one discussions between insurer participants and the regulators regarding the ORSA reporting by the insurers and gave the insurers insight on the regulators review of the reports. Following the 2012 pilot program, reports were made to the NAIC executive committee and updates were made to the Guidance Manual. The NAIC is planning a second pilot project in 2013. In order to participate in the next pilot project, insurers will be required to prepare a full ORSA report with no redactions; the goal being an open and honest discussion of the insurers' risks.

Some issues and questions were raised by the audience regarding the ORSA requirements and how the regulators expect to supervise an insurer's investment strategy. Examples included insurers

chasing yields in their investments in order to generate revenue. Mr. Saenz responded by explaining that the goal of the reporting would be that if the insurer adopted an aggressive investment strategy, the ORSA report will allow the regulator to assess what the insurer is doing internally to assess the risk and determine the sufficiency of capital to support the risk. Another issue discussed by members of the audience related to how the regulator and the ORSA reports would assess the risk of new products and how they are brought to the market.

Mr. Saenz commented that the pilot program confirmed the fact that there is still plenty of work to do by both insurers and regulators prior to the Model Act's effective date. This involves not only educating the regulators regarding the requirements and getting their skill sets in place, but also making the insurers aware of the reporting and comfortable with the level of detail required by the regulators. Currently, there are resources and training available regarding ORSA and its requirements. The Society of Actuaries is doing training on the ORSA Model Act and several large actuarial firms and large accounting firms are also conducting training sessions.

According to Mr. Saenz, only thirty percent of the insurance industry is ready for ORSA. Further, it will fundamentally change the way Departments of Insurance conduct company examinations. Historically, examinations have involved looking backwards at what a company has done; ORSA on the other hand is a prospective, forward looking approach to where a company or group is going. ORSA is not meant to be a punitive tool but rather a management process that will allow better interaction between the company and regulator. Mr. Saenz sees it more as a process of the insurers and the regulators working together to determine how diligent the insurer is in going through the assessment of its risks. The regulators do not want failures and Mr. Saenz hopes that the ORSA requirements will allow companies and regulators to forestall another AIG type failure.

Regulatory Oversight of Guaranty Funds and Receivers or Does the Regulator Really Have Any Authority

Our panel discussed regulatory oversight of special deputy receivers and guaranty funds by departments of insurance. Pat Hughes, of Alvarez & Marsal, was the moderator and opened the discussion. He set the stage for the discussion by asking what the law allows concerning the regulation of guaranty funds and special deputy receivers. He presented some issues in the regulation of guaranty funds, including expense approval and oversight, deference by the regulator to the funds claims evaluation and coordination between the regulator and the funds in performing their duties. The panelists brought a broad array of perspective to the discussion as they included life and health and property and casualty guaranty fund representatives and a department regulator in the receivership division. The panel included Lowell Miller, Executive Director of the North Carolina Life & Health Insurance Guaranty Association, Marvin Kelly, Executive Director of the Texas Property and Casualty Insurance Guaranty Association and James Kennedy, a lawyer with the Texas Department of Insurance.

James Kennedy talked about the Texas Department's special deputy receiver (SDR) program and explained some of the basic oversight of the program by the regulator. The receiver of the company selects the SDR. The SDR is subject to extensive reporting requirements to both the court and the regulator. The receivership court sets regular status conferences that are attended by the receiver, the SDR and the insurance guaranty funds. Mr. Kennedy also briefly discussed the oversight of the guaranty funds and indicated that the receiver commonly attended the guaranty fund board meetings where, in the closed sessions, the receiver discussed issues and upcoming insolvencies. Mr. Kennedy's discussion highlighted the issue of coordination between the regulator, SDRs and the guaranty funds.

Lowell Miller then spoke about the regulation by the North Carolina Department of Insurance of the North Carolina Life & Health Insurance Guaranty Association. According to duties and powers of the Insurance Commissioner, the guaranty funds are subject to examination by the Commissioner but there has not been an examination of the guaranty fund since 1995. A planning questionnaire was issued in 1999 as the beginning steps for an examination but it has yet to be scheduled. The Insurance Commissioner approves the members of the guaranty fund board of directors as elected by the association. The Commissioner is invited to the guaranty fund board meetings but does not regularly attend them. The guaranty fund also files its audited

financial statements with the Insurance Commissioner as part of an annual report that updates the Association's insolvency related activities for the year. Finally, special deposits in North Carolina are held by the Commissioner for the benefit of the North Carolina policyholders. At the beginning of a life and health liquidation, Mr. Miller requests the deposit from the Commissioner and regularly receives it.

Marvin Kelly followed with a discussion of his role at the Texas Property and Casualty Insurance Guaranty Association and the guaranty fund's relationship with the Department of Insurance. Mr. Kelly was hired in 1992 to privatize the guaranty association and he spoke about the trials and successes in setting up and managing the fund, including the management of the fund expenses. The fund has been able to pay more than half of its expenses through investments and early access receipts. The fund has assessed its members seven times since 1992 but has been able to repay three of those assessments. He also talked about the Department oversight of the TPCIGA. The TPCIGA is one of four guaranty associations in the country that has public members who represent the interests of the taxpayers. Five of its nine members are elected through a ballot process by the insurance member companies operating in the state. The other four members of the guaranty fund board were appointed by the Insurance Commissioner. While the Commissioner had the final say as to all the members, both the guaranty fund and its board operate independently from the Department of Insurance. Additionally, the Department of Insurance audited the guaranty fund in the last year but the guaranty fund gave them permission to conduct the audits. Mr. Kelly also discussed the coordination among the guaranty funds, receivers and the department of insurance.

Mr. Hughes ended the presentation by stressing some of the key points of the discussion, including that departments are not sure whether guaranty fund oversight is a receiver function or a separate regulatory function. He also observed that the state audits of the guaranty funds may not be on a regular schedule.

Protecting Insurance Consumers: Lessons from the Recent Financial Crisis or You Can't Believe Everything You Read

Peter Gallanis, President of the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA"), shared his views on the recent financial crisis and the reporting by the media on the causes of the crisis. In his presentation, he highlighted specific errors made by the media about the insurance industry's role in the crisis.

One of the mistakes by the media was the reporting that insurance company failures were widespread when, instead, they were limited to no more than the historical average. As reported by Mr. Gallanis, six life insurance companies and five health insurance companies went into liquidation, and none of the failures were directly attributable to the financial crisis (the largest, in fact, was due to fraud by the company's owner). The liabilities of these eleven insurance companies totaled $950 million compared to Lehman Brothers nearly $750 billion in liabilities to its creditors. In contrast to the limited number of insurance company failures, many other types of financial service companies had financial difficulties or went out of business. During this same time, we witnessed the virtual elimination of investment banking, the failure of Fannie Mae and Freddie Mac, the downfall of several money market funds and banks that accepted federal infusions to stay alive.

Related to the errors in reporting on insurance company failures were the stories that the federal government rescued the insurance industry. None of the eleven insurance companies that failed during the crisis were systemically significant. All told, the liabilities of these companies were but a fraction of the liabilities of Lehman Brothers. A couple of insurance companies accepted federal aid and these monies have now been repaid. Further, there is no indication that the monies accepted by these insurance companies were necessary to stave off liquidation. Finally, while everyone looks to AIG as an example of a federal rescue, AIG is a unique company, with unique non insurance risks that caused its financial problems.

The media also reported that the AIG failure shows that insurance companies are systemically important and therefore require heightened federal regulation to prevent future harm. A systemically important financial institution is a loosely defined concept in the United States and extends beyond traditional banks to include non-bank financial institutions like insurance companies, hedge funds and other market entities. In fact, the Dodd Frank Act contains

Issues Forum Recap: Houston, Texas April 2013 (Continued)

several factors to consider in determining whether a financial institution will be regulated. These factors suggest that pre-2008, AIG would have been considered a systemically important non-bank financial institution. Today, however, there are no insurance operations that resemble the current AIG structure. According to Mr. Gallanis, both the state and federal regulators failed in the regulation and supervision of AIG.

Mr. Gallanis referred to the book Fatal Risk by Roddy Boyd concerning the failure of AIG. He specifically referred to a couple of points made in the book regarding AIG's collapse. AIG ran uniquely risky programs involving securities lending and credit default swaps; however, the collapse of the securities lending program was an effect rather than the cause of the failure. The failure of AIG was a perfect storm of events that included the massive credit default swaps program coupled with an atypical, highly risky securities lending program, and insufficient enterprise-wide risk management system after Hank Greenberg was forced out in 2005. Greenberg was essentially a one man risk management system, and Mr. Boyd doubts that Greenberg would have allowed the two programs to go forward if he had still been at the helm of the company. Finally, the AIG failure has not proven that a federal safety net was needed for insurance companies. The AIG insurance companies did not fail, so there is no clear indication that the insurance guaranty association system would not have worked as intended.

The AIG collapse also led to the assumption that the insurance guaranty associations would not have the financial capacity to handle the failure of a large insurer. As Mr. Gallanis observed, the facts point in the opposite direction because the guaranty associations have capably handled multiple large insolvencies at the same time. He pointed to the early 1990s when several large life insurance insolvencies occurred, including Executive Life, Mutual Benefit Life and Confederation Life.

Mr. Gallanis ended his remarks by reminding us that hope is not a plan – that successful liquidations involve prompt corrective action and effective intervention by the regulators.

NAIC News and Updates

Jim Mumford, First Deputy Commissioner with the Iowa Division and Chair of the NAIC Receivership and Insolvency Task Force, closed the program with his assessment of a meeting of the Financial Stability Board ("FSB") held in Switzerland earlier in the year. The meeting, attended by Michael McRaith, Director of the Federal Insurance Office, and Jim Mumford, representing the United States and the NAIC respectively, involved a discussion of various countries' resolution schemes that might be applied to Globally Significant Financial Institutions ("G-SIFIs"). The focus of the discussion at the meeting was global strategies for implementation of the resolution schemes. The global resolution strategies for G-SIFIs in play before the FSB are different from those currently employed in the United States. The FSB is looking at prefunded resolutions rather than the post funded authorities used in the United States.

Thanks to all the participants who agreed to speak at the Issues Forum and share their knowledge and expertise with the audience. We had excellent speakers and great audience participation. I often wish we had more time to accommodate all the questions from the audience and the remarks of our participants; so thanks to all for indulging me as I try to move the program along. Thanks, also, to those who helped me organize the Forum. I look forward to seeing you all at the Indianapolis Issues Forum and hope you will be able to participate in person. Check the most up to date schedule to confirm the time and location. Hope to see you there!

Kathleen is Senior Counsel in the Regulatory and Administrative group of Michelman & Robinson, LLP, in Encino, California. Michelman & Robinson is a national law firm with offices in California and New York. Kathleen assists insurance companies and related agents with various regulatory, compliance, claims and reinsurance matters.

Welcome IAIR's Newest Members!

Rich Matza

Rich is a tax partner with Calhoun, Thomson & Matza, LLP. Rich works on all of the firm's insurance clients as well as the administrative partner for CTM. Rich's experience includes over twenty-eight years of public accounting with international public accounting firms. To stay current, Rich attends the Insurance Tax Conference annually as well as numerous other tax conferences.

Rich served as an adjunct professor at the University of North Texas and also taught numerous tax and accounting courses at the University of Texas, the University of Arizona and Texas State University - San Marcos. Before joining CTM, Rich was a Tax Director with Deloitte and Touche as well as the Tax Director for Temple Inland Financial Services. Rich was instrumental in the reform of insurance taxation in the mid-80's as member of the Congressional Joint Committee on Taxation.

Rich earned his Bachelor of Science from State University of New York. He also holds a Master in Professional Accounting from the University of Texas at Austin.

Rich is a member of the American Institute of Certified Public Accountants and the Texas Society of Certified Public Accountants.

April Davis

April is a member with Jones, Otjen & Davis. She is an Appellate Team Leader and Litigation attorney in a boutique firm handling major case work in areas of civil litigation, insurance law and criminal defense in state and federal court. She is responsible for all aspects of litigation support to Receivers overseeing domestic insurance companies in receivership, both in rehabilitation and liquidation. Her representative cases have involved complex civil business, insurance and family litigation; insurance defense; civil and criminal regulatory investigations and administrative hearings; criminal litigation, and civil and criminal appeals in Oklahoma, the Tenth Circuit and the Supreme Court of the United States. She currently represents Receivers in five receiverships pending in the District Court of Oklahoma County, State of Oklahoma.

April earned her JD, with distinction, from the University of North Dakota School of Law and also holds a Bachelor of Arts, with distinction, from the University of Oklahoma.

Tamara Koop

Tamara is Receivership Counsel with the Missouri Department of Insurance, Financial Institutions & Professional Registration group. She manages, monitors, advises and reports on the operations of the Missouri-domiciled insurers in rehabilitation or liquidation. Prior to that role, Tamara was Senior Enforcement Counsel for the Missouri Department, where she litigated administrative license cases before the Administrative Hearing Commission, Department Director, Missouri circuit courts and Court of Appeals. She has also represented the Missouri Department at NAIC meetings as a member of the Title Insurance Issues Task Force.

Tamara earned her JD from the University of Missouri School of Law and also holds a Bachelor of Science, magna cum laude, from Northwest Missouri State University.

Jose Rangel

Jose Rangel is Of Counsel at Cantilo & Bennett, LLP. Mr. Rangel's practice concentrates on business litigation, regulatory matters, the insolvency, receivership, rehabilitation, and liquidation of insurers, general civil litigation, oil and gas litigation, land and real estate litigation, and civil rights litigation.

Mr. Rangel earned his JB from the University of Texas School of Law and also holds a Bachelor of Arts from the University of Houston.

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Federal Home Loan Banks

By Peter Knight,
Shaney Lokken & Jon Griffin

Federal Home Loan Banks ("FHLBanks") play an important role helping insurance companies safely and profitably meet their asset-liability management challenges.

As insurance company membership in and borrowing from FHLBanks increases, it is more important than ever for the insurance regulatory community to understand how FHLBanks operate, how they can make insurance companies stronger financial entities, and how they can be viewed as a partner by the regulators, including those rare instances where an FHLBank insurance company member goes into receivership. Strong lines of communication between a state's department of insurance with its local FHLBank will strengthen ongoing FHLBank lending to healthy insurance company members and minimize issues in the event of an insurance company member's insolvency.

This article will provide an overview of the FHLBank System and a review of how FHLBanks successfully worked with receivers in two recent cases.

What are Federal Home Loan Banks?

FHLBanks are unlike other insurance company creditors. Operating under a federal charter and established with the mission of providing liquidity to their members, FHLBanks have a very limited business line: raising funds in global capital markets at attractive rates and lending on a secured basis to members. FHLBanks are highly regulated by the Federal Housing Finance Agency ("FHFA"). While other insurance company creditors enter and exit the business of lending to insurance companies, particularly at times when they face their own liquidity pressures, the FHLBanks, as government-sponsored enterprises ("GSEs"), maintain reliable access to the global capital markets and are able to continue lending to their members across business cycles.

FHLBanks are managed and regulated to a standard that is truly unique: because FHLBanks operate on a no-loss basis, they lend on very narrow margins, passing on much of the benefit of low cost funds directly to their member/customer/owners.

Created by Congress in 1932, the twelve independently operated FHLBanks' mission is to ensure funding (FHLBank member loans are called advances) to support housing finance and community development. While commercial banks and credit unions were allowed to become FHLBank members in 1989, insurance companies have been eligible for membership from the beginning. FHLBank members rely on FHLBanks as a stable funding source across all market and credit cycles.

FHLBanks are governed by federal statute and regulations which protect members as stockholders and provide value to members as borrowers. The ability for FHLBanks to serve as unique and

The importance of Federal Home Loan Bank membership to healthy insurance companies (the overwhelming majority of the industry) has been recognized by several third-party experts.

"[I]nsurers prefer … the favorable interest rates the FHLBanks offer its members. The FHLBank System can issue bonds … at borrowing rates close to those of the U.S. Treasury. Much of the savings in reduced interest expense is … passed along to FHLB … member borrowers."

NAIC Capital Markets Special Report, December 2012, "The U.S. Insurance Industry's Exposure to the Federal Home Loan Bank System".

"Access to [FHLBank] funds aided insurance company members in navigating through the credit crisis. Insurance companies rely on FHLBank products for contingent liquidity planning, managing high impact liquidity events, and reducing risk through enhanced asset liability management."

American Council of Life Insurance, March 22, 2011 comment letter to the Federal Housing Finance Agency

valuable financial utilities for insurance companies and a resource and partner to insurance regulators stems from a few central elements of FHLBanks.

Capital Stock: FHLBank capital stock is a product of federal statute and regulation.[1] In the FHLBank cooperative, all FHLBank members are required to own FHLBank stock; and each FHLBank is charged with developing its own capital plans as approved by each FHLBank's board of directors (elected by the FHLBank's members) and the FHFA. While members must purchase more stock as they borrow more (FHLBanks are self-capitalizing), the stock is completely separate from collateral for advances and should not be considered as a compensating balance for advances.

The nature of FHLBanks as cooperatives requires that all FHLBank stockholders be treated similarly in regard to repurchases and redemptions of capital stock. This protects the interests of all stockholders. To the extent that a member has repaid its loans from the FHLBank and has excess stock, the FHLBank can repurchase such excess stock, prior to the expiration of the five-year redemption period. Most FHLBanks periodically repurchase excess capital stock from their members in this way, including healthy insurance companies who, at March 31, 2013, held $3.5 billion in FHLBank stock. Additionally, members are eligible to receive dividends on their FHLBank capital stock.

Collateral Management: Conservative management protects all stockholders from losses on loans to members and enables FHLBanks to lend on very narrow margins. By virtue of this conservative approach to collateral, FHLBanks are fully protected as secured creditors under current law.[2]

Advance Terms: Protecting all stockholders and enabling low-margin lending is also ensured by FHLBank statute and regulation that requires FHLBanks to be financially indifferent to the prepayment of an advance, even to a member in receivership. This means that, should a member take an advance that involves a prepayment fee, the terms of the contract must be followed. Members are free to take loans that do not involve these fees.[3]

Working with FHLBanks Regarding Weak or Failing Members

FHLBanks are required by FHFA regulations to follow the direction of a member's regulator (including, in the case of an insurance company, the state department of insurance) regarding lending to weak members.[4]

FHLBanks are prohibited from lending to members that do not have positive tangible capital, unless the member's regulator requests the FHLBank to do so. FHLBanks are also required to cease lending to capital deficient but solvent members if a member's regulator notifies the FHLBank that it has prohibited the member from using FHLBank advances.[5] These FHFA regulations make it imperative that the FHLBanks and the insurance regulators cooperate closely and communicate regularly when an insurance company is in a weakened condition.

During the global financial crisis, FHLBanks continued lending and providing liquidity to insurance companies when other sources dried up.

Advances to insurance company members between 2007 and 2008 increased from $28.7 billion to $54.9 billion.

The FHLBanks performed their mission throughout the crisis, never needed a penny of support from taxpayers, and, very important to a cooperative, protected their members' investments in FHLBank capital stock.

There have been two recent failures of insurance companies that were borrowers from an FHLBank.[6] In both cases, the respective FHLBanks worked with the rehabilitators to contractually confirm the rehabilitators' recognition of the FHLBanks' rights, including with respect to collateral. This contractual certainty allowed the FHLBanks to work with the rehabilitators to reach a successful outcome that involved no loss to either guaranty association or either FHLBank in connection with the FHLBank borrowings. This involved the FHLBanks working with the receivers to allow the advances

to remain outstanding to give the receiver time to favorably resolve the situation. In both of these resolutions there was no loss to policyholders or guaranty associations.

A detailed description of these two cases follows below. In both instances, it was essential that the department of insurance and the FHLBank worked closely to address the challenges raised by the failure of the company.

Shenandoah Life Insurance Company — FHLBank Atlanta

Shenandoah Life Insurance Company (Shenandoah), a Virginia-domiciled mutual life insurance company, was placed into receivership on February 12, 2009, largely due to significant impairments to Shenandoah's investment portfolio related to Fannie Mae and Freddie Mac preferred stock. At the time it was placed into receivership, Shenandoah had over $140 million of advances outstanding from FHLBank Atlanta, collateralized by agency securities. The court order included a stay of all actions by secured creditors to exercise any rights against any Shenandoah property, including pledged collateral, without the consent of the receiver. Although the FHLBanks have, unfortunately, acquired plenty of experience with bank receiverships, this was the first time FHLBank Atlanta had experienced an insurance company member failure, and more worrisome to us, this was the first time we had ever been faced with a stay of all creditor actions. Immediately pressing questions loomed: Would the receiver make the interest payment scheduled for February 17? What about the $83 million principal amounts due on March 2 and March 5? These payment dates were the result of advances chosen by Shenandoah long before the receivership date. Would the receiver honor those scheduled payment dates? Or, would the receiver instead refuse to make payments, leaving us with a default and no ability, under the stay, to access our collateral? What if this rehabilitation lasted five years? What if the financial crisis got worse and the securities collateral plunged in value while we were stuck in a protracted dispute with the receiver? Without any time limit to the stay, and without any precedent for how the receiver would proceed, we were truly nervous - one FHLBank's credit loss in an insurance company receivership and the FHFA might clamp down on all FHLBanks' ability to lend to healthy insurance companies.

Pressing questions loomed: Would the receiver make the scheduled interest and principal payments? Would this one receivership ruin the FHLBank relationship for all healthy insurance companies?

• • •

As we do in all member failures, we arranged for a prompt conversation with the receiver, to give the receiver as much information as possible about the outstanding advances, the pledged collateral, and the overall member relationship. The receiver told us of his initial plans to stabilize and rehabilitate Shenandoah. We breathed a little sigh of relief – the best result for us and for the rest of our membership is a revitalized member. In compliance with the stay, we requested the ability to debit Shenandoah's deposit account for the upcoming interest payment due; the receiver granted permission. With some trepidation, we agreed to release excess cash in Shenandoah's deposit account from our lien and we agreed to extend the upcoming principal maturity dates to give the receiver time to stabilize the company. The extension agreement gave us reassurance from the receiver that we would continue to be paid interest from the deposit account as scheduled, and it let both sides avoid a default scenario for a period of time, but we worried that we could find ourselves asking all the same questions again at the end of the extension contract.

As we do in all member failures, we arranged for a prompt conversation with the receiver to establish a cooperative working relationship and plan a course of action for the outstanding advances.

• • •

Fortunately, the receiver was able to stabilize the company and made the principal maturity payments as they came due. In turn, we released corresponding collateral amounts. When a purchaser for the company was found, we provided the prospective purchaser with information about the benefits of continuing the FHLBank Atlanta membership and assuming the remaining outstanding advances after the purchase. Upon the closing of the purchase transaction and the termination of receivership three years later on May 8, 2012, $5 million in outstanding FHLBank Atlanta advances were assumed by the purchaser, who continues as an

FHLBank Atlanta member. From our perspective, this is a common end result when a member fails. We later learned that this was an unusually successful result for a troubled insurance company. We believe that the cooperative relationship between the FHLBanks and the receivers could make Shenandoah the norm, not the exception.

Standard Life Insurance Company — FHLBank Indianapolis

Standard Life Insurance Company ("SLIC"), an Indiana-domiciled life insurance company, was placed into rehabilitation by the Indiana Department of Insurance on December 18, 2008. SLIC joined the Federal Home Loan Bank of Indianapolis ("FHLBI") in September 2006 and initiated a funding agreement program. SLIC utilized the FHLBI funding agreements for operating leverage trades, secured by agency and investment grade private-label mortgage-backed securities and reached a peak program of $550 million in funding agreements. While SLIC's trends were positive and its portfolio and capital were consistent with securing a favorable rating by the rating agencies, it encountered significant unexpected losses associated with PLMBS holdings and FHLMC preferred stock.

The terms of the rehabilitation immediately froze policyholder accounts; however, death benefits and interest distributions were not impacted. A six-month moratorium was placed on all elective surrenders, which was extended multiple times throughout the rehabilitation process. Upon notification of the rehabilitation, the FHLBI immediately scheduled an introductory meeting with the Rehabilitator and his team to open the communication channel. The meeting provided FHLBI credit management and the Rehabilitator's team the opportunity to discuss the funding agreement contracts, the securities held by the FHLBI as collateral, FHLBI capital stock and operational considerations. Through the meeting, primary contacts were established between the FHLBI and the Rehabilitator to facilitate future discussions.

Throughout the rehabilitation, SLIC substituted collateral freely pursuant to normal business operations and reinvested principal and interest cash flows received from the securities. The FHLBI provided regular reports to SLIC with details on the collateral held and coverage requirements in order to assist SLIC with ensuring the obligations remained fully collateralized pursuant to the terms of the funding agreements. The FHLBI and SLIC met regularly throughout the rehabilitation to discuss reinvestment opportunities and, through an agreement with the Rehabilitator, the FHLBI agreed to accept investment grade corporate bonds as collateral to secure a portion of the obligations. While corporate bonds are ineligible as collateral for advance borrowings, this realignment allowed SLIC's investment managers to more effectively manage its investment portfolio. Furthermore, pursuant to a separate written request from the Rehabilitator, $60 million of long-term, fixed rate funding agreements were prepaid in accordance with the terms of the agreements.

Open and regular communication was essential throughout the rehabilitation process. Conference calls and in-person meetings were held regularly with the Rehabilitator's team, and when appropriate, included other interested parties at the Rehabilitator's request. In August 2010, Guggenheim Partners began discussions with the Rehabilitator regarding SLIC. Guggenheim Partners then formed a new Indiana-domiciled stock insurance company, Paragon Life Insurance Company ("PLIC"), which joined the FHLBI as a member. Guggenheim Partners, SLIC, and the Rehabilitator entered into an Agreement and Plan of Reorganization ("Agreement") on December 15, 2010, which was approved by the Court on January 18, 2011. On March 2, 2011, the transaction closed pursuant to the terms of the Agreement, the FHLBI advances were assumed by PLIC, and the FHLBI stock was transferred on the FHLBI's books from SLIC to PLIC.

Throughout the rehabilitation process, the FHLBI worked constructively with the Rehabilitator and his team. The Rehabilitator complied with the terms of the FHLBI funding agreements, which allowed the FHLBI to exercise patience and to provide flexibility relative to the security types pledged as collateral. Ultimately, this approach allowed for a successful resolution to the SLIC rehabilitation.

1 12 U.S.C. § 1426 and 12 C F R 931.7 and 931.8
2 NAIC November 28, 2012 comment letter on the FHFA Proposed Advisory Bulletin on Collateralization of Advances and Other Credit Products Provided by Federal Home Loan Banks to Insurance Company Members
3 12 C F R 1266.6
4 12 C.F.R. 1266.4.
5 12 C.F.R. 1266.4
6 Shenandoah Life and Standard Life

Peter Knight is Director, Government Relations, Federal Home Loan Bank of Pittsburgh.

Shaney Lokken is Assistant General Counsel, Federal Home Loan Bank of Atlanta.

Jon Griffin, CFA, is Chief Credit and Marketing Officer, First Vice President, Federal Home Loan Bank of Indianapolis.

TDS IV Recap: Raising the Bar – Insurance Insolvency Litigation: Trials and Tribulations

By Kevin Tullier, CPA

This year's conference of the Technical Development Series was held over a very hot two days in Las Vegas, Nevada. Though the

temperatures outside soared to over 100 degrees, co-chairs Phil Curley and Michelle Avery provided

the packed room of attendees with two cool days at THEhotel at Mandalay Bay during which the varied cast of speakers told of trials and tribulations related to insurance insolvency litigation and beyond, including some very personal trials of their own.

The first day kicked off with a panel of Ford Huffman of Ford E. Huffman Law; Phil Collier of Stites & Harbison; Larry Johnson of Veris Consulting, Inc. and Michael Pollack of the FDIC. This conversational session was broadly focused on what occurs once an insurance company is found to be insolvent, and more importantly, who can/should be looked to pay as a culpable party. The panel of two attorneys, an expert witness and a regulator provided for some interesting and candid discussion from multiple perspectives coming from a wide range of experiences. And based on some of the back and forth between Ford and Larry, it seems some of those experiences came from both sides of the same table!

The title of the next session was "Fraudulent Transfers and Unwinding Transactions," and panel chair Joe Davis of Willkie Farr & Gallagher started it off with a history lesson – evidently, fraudulent transfers are nothing new. (1571?!) Joe and fellow panelists Jonathan Cogan of Kobre & Kim and Belinda Miller of the Florida Office of Insurance Regulation then gave a comprehensive presentation on the legal concepts of fraudulent transfers and preference claims, explained how they related to an insurance insolvency, and also gave some insight into a very current, yet un-named, receivership occurring in Florida.

The attendees of the 2013 TDS were then honored to have Scott Kipper, Commissioner of the Nevada Division of Insurance, as the keynote speaker for the lunch time presentation. Commissioner Kipper welcomed the group to Nevada and gave an update on what's going on in his state and his work at the NAIC.

The first session after lunch was the first of three case studies of actual insolvent companies presented at the TDS, and definitely the most bizarre. Many of the attendees may have heard of the fraud perpetrated by Marty Frankel – it was one of the largest insurance-related fraudulent schemes in U.S. history, involving seven insurance companies from five different states, after all – but it is doubtful anyone outside of the panelists themselves could have known the level of detail given by the panelists. (Did you know the Vatican was involved...and astrology, too?!) The panel was chaired by Betty Cordial of Vista Consulting, who was the Special Deputy Liquidator of First National Life Insurance Company of America, Family Guaranty Life Insurance Company, and Franklin Protective Life Insurance Company. Rounding out the group of informative panelists were Lee Harrell of Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C.; Alan Curley and Phil Curley of Robinson Curley & Clayton P.C. and Andrew Campbell of Wyatt Tarrant & Combs, LLP.

TDS IV Recap (Continued)

After the in-depth presentation of the unethical actions of Marty Frankel, the next presenter gave a much more personal perspective on the damaging consequences of unethical decisions, particularly when those decisions are your own. —Patrick Kuhse, a convicted felon now on the public speaker circuit after four years in prison, told his story about how he practically destroyed his life and that of his wife and two sons by a series of poor decisions and criminal actions. His story often came back to the themes of rationalizations and excuses that followed his actions and allowed him to continue. His recount of taking his family on the run to Costa Rica to avoid imprisonment showed the extent to which things can, and did, snowball. It was a thought-provoking presentation that ended the first day of the TDS on a reflective note.

The second day began with the second case study of the TDS. While surely everyone had heard of the subject of this case study – the financial services behemoth Lehman Brothers – the panelists brought new insight to the topic by relating it to insurance receiverships/-insolvencies. In the most technical session of the two days, the panelists, James McDermott, Doug Lambert and Patrick Hughes, all of Alvarez and Marsal, presented many informative historical facts and figures of Lehman Brothers' bankruptcy, particularly its banking activities. They then explained the potential implications of Lehman's failure to the insurance industry, primarily due to the (ever-evolving) effect of the Dodd-Frank legislation. Patrick ended the session by leading a discussion about "translating" what occurred at Lehman Brothers and the Dodd-Frank bill into tools and lessons for those involved in insurance receiverships.

The next session was a very interesting discussion among panelists George Krueger of Fox Rothschild LLP, Philip Anthony, of DecisionQuest and Robert Gage, Jr., Gage Spencer & Fleming, LLP about strategies and tactics for trial. The panel provided some interesting data on the general public's perceptions regarding the current economic situation and insurance companies and the challenges those views present an attorney during litigation involving an insurance insolvency. Those views, coupled with the underlying complexity of an insurance insolvency, provided the backdrop for a discussion on ways to best reach the jurors in such a trial. The old KISS mantra ("Keep it Simple, Stupid") was augmented with "KIIS" which replaces "simple" with "interesting." All panelists agreed that new technologies allow for more effective and dynamic demonstratives but can be used for innovative (and curious) new tactics such as virtual mock trials.

The last session of the TDS was the final case study that analyzed the insolvency of National Heritage Life Insurance Company (yet another tale of a shyster at work) and some of the "mistakes" that resulted in lessons learned. Fredric Marro of Westmont Associates, who serves as the general counsel for National Heritage Life, chaired the presentation. Additional insight into those lessons were provided by Fredric's fellow panelists – all

closely involved in the National Heritage Life insolvency litigation: Thomas Equels of Equels Law Firm, who served as counsel for the insurance company; George Piccoli of INS Consultants, who served as receiver; and Thomas Lindgren of Poyer Spruill, who served as counsel for George in his role as receiver.

Michelle and Phil ended the conference with a sincere thanks to all attendees and presenters. The TDS IV provided a great spectrum of information on the litigation that surrounds insurance insolvencies. We heard stories of cases that are in their final stages while learning about new strategies and tools to use in cases that are looming on the horizon. Thanks to all who worked to put on such an informative conference (and not to mention a cool respite from crazy temps in Vegas. If only my luck at the craps table was as hot….).

Kevin Tullier, CPA, CFE is a Managing Director in Veris Consulting, Inc.'s Reston, VA office. With a background in both public accounting and industry, including time as a finance officer of an insurance company, Kevin provides forensic accounting and litigation support services primarily to law firms on insurance-related matters, as well as outsourced accounting services to insurance companies. Kevin can be reached at ktullier@verisconsulting.com.

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- Space on a materials table for the Sponsor at all IAIR events.
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Beware of Rehabilitation Plans

By Iain A.W. Nasatir and Christopher M. Maisel[1]

I. Introduction

This article addresses an alarming, yet common, practice in the insurance insolvency arena, with respect to property and casualty insurance companies that are operating at or dangerously close to insolvency. That practice is the implementation of the rehabilitation plan, in lieu of liquidation. This situation occurs when an insurance company that is insolvent, or is in the zone of "mandatory control" under applicable RBC statutes, is seized by the state insurance regulator, and at the request of the regulator, a court-ordered rehabilitation is initiated. The regulator, as receiver, formulates and proposes a plan of rehabilitation. The rehabilitation plan usually provides for continuation of policyholder claims, settlements and payments at 100% when they become due.

Criticism of this practice is not directed at rehabilitation plans implemented for life and health companies, as they are completely different. For life companies, a rehabilitation proceeding, and/or a conservation order, provides the benefit of a moratorium, which protects against adverse selection and a run on the bank, while permitting the orderly sale of the life or health book of business or other remedial measures to be implemented. Rehabilitation plans for life and health insurance companies usually operate with a "live" book of premium paying business and the necessary continuation of coverage for insureds, given changing health circumstances of many policyholders. Most of the time in property and casualty insurance insolvencies, the company already ceased writing new business as its financial ratings declined, having lost policyholders who abandoned the company, taking their annual business elsewhere and leaving only the prospect for the company of running off of the remaining policies and losses. This criticism is also not directed at a true private run-off , where company management meets all statutory requirements for a solvent company, and elects to exit a book or books of business by systematically running off its book. However, implementing a rehabilitation plan for an insolvent property and casualty company that is not a candidate for a private run-off merely delays the liquidation and may be both a public and policyholder failure. As explained below, this kind of failure can and should be avoided.

II. The Regulator's Assessment of the Future of the Company

This article challenges the notion that rehabilitation of an insolvent or near insolvent property and casualty insurer is automatically always the best avenue for the regulator. It should go without saying that each property and casualty insolvency is different, and many factors, such as *monoline vs. multiline, personal lines vs. commercial lines* and *long tail vs. short tail*, can have a significant effect upon how an insolvent insurance company should be approached by the regulator. The departure point for determining the right course of action is the financial state of the company. If history has taught us anything, it is that in a troubled property and casualty company, the initial financial information, especially the reserves, are questionable at best, and even with an updated actuarial review, the losses will likely develop much worse than initially thought. For example, in the Reliance Insurance insolvency, the reserves had to be strengthened over 1.5 billion dollars from the initial estimates by its receiver. It is evident that many times even regulators fail to escape the trap management fell into; namely, using actuarial best estimates as the reserve numbers, when they actually reflect only the mid-point in a range. The mid-point usually reflects the 50/50 chance the reserves will be too high or too low. Current modeling techniques can produce a reserve that has various selected confidence levels, *e.g.* 75%, or 90%. If the regulator chose those confidence levels, it may well make it clear that rehabilitation is not viable. Because of the likelihood that the reserves of the insolvent carrier are not to be depended upon in the future as setting a cap on all loss development, it would seem prudent to question how a rehabilitation plan can be the better alternative. In addition to the uncertainty of reserves, asset values and projected reinsurance recoveries are other potential downside variables that can adversely affect the viability of a rehabilitation plan.

In the situations that concern us, it appears that the regulator reviews the financials of an insolvent, or soon-to-be insolvent property and casualty insurer, and comes to the conclusion that

there are currently sufficient assets to pay at least the policyholder obligations, and of course the administrative expenses. Based on that determination, the regulator puts forth a rehabilitation plan where at least all policyholders are to be paid when their claims come due. Moreover, if years down the road the liabilities are worse than formerly believed, or the assets deteriorate, then the regulator can simply just convert the rehabilitation plan to a liquidation.

III. The Perceived Benefits of Implementing A Rehabilitation Plan

This commonly followed approach seems to be primarily premised on three assumptions:

(1) It is more appealing or more "politically correct" for the regulator to say that he or she has a plan to rehabilitate a company, which does not suggest a failed company and the possible failure of regulatory oversight;

(2) The *rehabilitation* plan is better than an immediate liquidation, as policyholders can get paid when their claim is due; but, in *liquidation*, policyholders have to wait many years for payment of any policyholder liabilities that are not covered by guaranty associations; and

(3) Administrative expenses are higher in a liquidation, primarily because of the triggering of guaranty associations' coverage obligations, and inefficiency and delays result.

These assumptions historically have led to rehabilitation plans followed by liquidations. Some occur immediately, and some occur over many years. In either event, the authors suggest that an immediate liquidation might have been the better course of action, rather than a detour and frolic through a rehabilitation plan process, followed by a liquidation. Having said that, implementing a rehabilitation plan remains the weapon of choice for many regulators, because they perceive it as providing at least three superior benefits imbedded in the assumptions described above, when compared to liquidations. If one examines these three perceived benefits of a rehabilitation plan over liquidation, each one fails to withstand scrutiny.

a. The Political Perception

First, the politically correct nature of a rehabilitation plan becomes illusory if a liquidation follows either fairly shortly or several years thereafter. Among the questions a failed rehabilitation plan raises for the regulator is *why it has paid some creditors 100% of their claim, but those whose claims matured after the rehabilitation plan failed will only receive a far smaller percentage*. A rehabilitation plan may sound better, but it will feel much worse for those that end up holding the proverbial bag after the rehabilitation fails and it goes to liquidation. Wouldn't it be better for the regulator to explain on day one that the company was mismanaged, and that he or she immediately put it in liquidation to trigger the safety net of guaranty association(s) provided for by the state's legislature?

b. Perception of Better Treatment for Policyholders

The next perceived benefit of rehabilitation over liquidation is that the policyholders get paid when their claims come due. With liquidation comes delay, particularly for policyholders not covered by guaranty funds. The old thinking was that in liquidations, creditors will have to wait many years for a "distribution on their claim" and if they are lucky they will get an interim distribution. However, in the circumstance where the regulator has determined "for rehabilitation purposes" that there are enough assets available to pay the policyholders when the claim becomes due, then the same assets are available to pay claims in liquidation. There is nothing in the law that prevents a liquidation plan from paying losses immediately when they become due. If the regulator is so confident in his view of the numbers that he can pay claims as they come due in rehabilitation, then those numbers should also work in paying claims as they come due in liquidation. Furthermore, if the rehabilitation plan fails because the estate runs out of money to pay claims and a liquidation follows, policyholders who were paid during the rehabilitation plan in effect receive a preference, and those uncovered policyholders and/or guaranty associations whose claims get paid during the liquidation get paid significantly less than the 100% the rehabilitation plan paid. For illustration purposes only, you can have a situation where if a company went straight to liquidation, all policyholders and their subrogees receive 80 cents on the dollar. If the same company had a failed rehabilitation plan where some

policyholders were paid 100 cents on the dollar for several years, upon a following liquidation some policyholders will get only 60 cents on the dollar. This example highlights the unfair treatment of policyholders in a failed rehabilitation.

Many times the guaranty associations will have fewer assets to be paid from insolvent insurer's estate, since the rehabilitation plan paid claims with assets that would otherwise been available to the guaranty associations had there been an immediate liquidation. It is often the perspective of many guaranty associations that liquidations are preferable to rehabilitations because long, drawn out rehabilitations mean less available assets will be available upon liquidation. Moreover, unlike the Early Access Agreements between the guaranty associations and the receiver in a liquidation (which statutorily require repayment of estate distributions if there are insufficient assets to pay policyholders their liquidation percentage), the regulator has no ability to claw back payments made to policyholders during a rehabilitation who were paid in full. On the other hand, in a liquidation, if guaranty associations are paid too much in early access distributions from the estate because the distribution percentage is less than what was projected, there can be a "claw back" from the guaranty associations to ensure equal treatment of policyholder claims.

In these *rehabilitation plans*, there seems to be a practice of pressuring claimants to take a smaller settlement under the threat of "going into liquidation." Ironically, this may be occurring because of the lack of confidence that the reserves are accurate, so there is a need to settle for less than the reserves. Some have raised the question of whether a regulator should put themselves in this position because of the public policy issues raised. *See, e.g.*, Guaranty Association Perspectives, by Wayne D. Wilson, Executive Director, Cal. Ins. Guaranty Ass'n, (from the Right Choice presentation at the 2013 IAIR Workshop) (voicing the concern that some "rehabilitations use the stay powers of the court to defeat timely creditor pursuit and resolution of their claims and can be use do to 'cram down' claim values."). [2]

This problem of unequal treatment of policyholders in rehabilitations that turn into liquidations is not a newly discovered one. The NAIC's White Paper entitled "Alternative Need for Troubled Companies" (2009) ("White Paper") stated five core principles to which it was committed, providing for equal policyholder treatment in insurance insolvencies. These five principles included honoring contractual obligations to policyholders and adherence to the priority scheme, which goals are placed under substantial pressure in a rehabilitation plan scenario, but are statutorily protected in a liquidation. *See* White Paper at 22. The rehabilitation plan scenarios discussed above highlight how those goals are not reached. Rehabilitation plans do not necessarily honor all policyholders' obligations and do not provide for adherence to the liquidation statutory scheme. Notwithstanding that, few, if any, recent insolvencies have gone straight to liquidation because the regulator acknowledged the financial situation made liquidation inevitable or that the goal of equal policyholder treatment did not lend itself to a rehabilitation plan process.

c. The Perception of Cost

The final assumption regulators rely upon to favor rehabilitation plans is that liquidations cost more than the rehabilitation plan process (this assumes the rehabilitation plan process is not contested litigation, which would drive costs up materially). It is difficult to compare the costs of rehabilitation to the costs of liquidation. To be sure, there are guaranty fund loss adjustment expenses to factor in, as well as other related expenses. However, a rehabilitation plan involves the estate incurring company expenses for adjusting the claims. In the authors' experiences, in workers' compensation insurance insolvencies, guaranty associations have become quite efficient in administering claims and have vendors with favorable rates in return for a steady stream of work. Also absent from clear view are the savings a liquidation provides, because it requires the claimant to seek recovery first from all other available insurance (non-duplication of recovery provisions), and because it subordinates the claims of other insurers. In some lines of business like construction defect, this can be a substantial number. In a rehabilitation plan process, those claims are paid out of the estate's funds without regard for those limitations found in liquidations. The guaranty associations have also shown some skill in obtaining settlement of "over the cap" claims for the amount of the cap, thus resulting in a savings in a liquidation. There is no meaningful data demonstrating that the triggering of guaranty

Beware of Rehabilitation Plans (Continued)

associations in liquidation adds to administrative expenses which are not offset by other potential savings, such as non-duplication of recovery provisions, settlement of over the cap claims, and claims efficiencies of guaranty associations. The delays in transferring files can also be offset by the current practice of making sure workers' comp claims payments do not stop, and creating methods to pay critical timely payments (mostly workers' compensation claims).

IV. The Alternative?

If one accepts that the benefits of a rehabilitation plan compared to a liquidation are difficult to identify, and quantify the risk of failure, what are the alternatives? Certainly, the regulator has the ability to order a company directly into liquidation, and by-passing the rehabilitation stage. See IRMA Section 207 (permitting a regulator to "file an order of conservation, rehabilitation or liquidation" if the insurer is "impaired…insolvent…about to become insolvent… (among other grounds)). See e.g., Cal. Ins. Code Section 1016 (permitting a regulator to apply for an order of liquidation "if at the time of instituting any proceedings, under this article, it shall appear to the Commissioner that it would futile to proceed as a conservator…").

Under the circumstances we have described, there is a better alternative to a "Rehabilitation Plan." When a regulator is in a situation where, after careful analysis, he believes that an insolvent property and casualty carrier may have enough assets to pay all policyholder claims when they become due, he can implement a pro-policyholder approach with an application for an immediate liquidation. That approach would be a pre-packaged final order of liquidation and distribution plan with a finding of insolvency, coupled with an early access plan that sets up daily, weekly or monthly funding of guaranty association claims accounts by the liquidator, and provides for a standard claw-back provision, and which allows the liquidator to distribute in full the uncovered portion of a policyholder claim.

V. Conclusion

The point of this article is not to skewer the rehabilitation plan process, in general. As noted above, they are most effective in life and health insurance company insolvencies. They may have their place in other lines of insurance, including unique and rare property and casualty insurance company insolvencies. But rehabilitation plans have no place being instituted when there is not a very high confidence level (90%) of success in paying all policyholders using conservative and accurate reserving and asset valuations without a high risk of failure, and without assuming any voluntary discounts on claims. Without that level of confidence, the policyholders will likely suffer unequal treatment, which runs contrary to the stated goal of insurance regulation.

[1] The views expressed herein constitute a mixture of the authors' views and are neither a direct, nor indirect, reflection of the views of their clients, the firms with which they are associated, or IAIR. The article's theme was part of a presentation in which the authors participated as panel members entitled "The Right Choice - The Pro-Policyholder Approach," at the 2013 IAIR Insurance Insolvency Workshop in Savannah, GA, in April, 2013. The article was also based, in part, on a presentation by Mr. Maisel at the 2011 NCIGF Fall Workshop.

[2] We also note that if rehabilitation was successful due to creditors voluntarily taking, or being forced to take, pennies on the dollar, no one has addressed the question of whether stockholders should benefit from any surplus created.

Mr. Nasatir is a partner in the law firm of Pachulski, Stang, Ziehl & Jones, LLP, specializing in insurance insolvency, reinsurance, bankruptcy, and coverage disputes. He has had decades of experience with insurance holding company issues and jurisdictional disputes with the receivership courts. Mr. Nasatir has spoken at conferences and seminars and published articles for over 30 years.

Christopher Maisel holds the designation as a Certified Insurance Receiver, and has dedicated over 35 years to representing and consulting with Receivers as well as acting as a Special Deputy Receiver. Among others he has played a major role in the Mission, Executive Life and Reliance Estates.

To submit an article, please contact Michelle Avery at mavery@verisconsulting.com.

IAIR Bulletin Board

Congratulations to IAIR member Phyllis Perron, Founder and President of Phyllis Perron and Associates!

Phyllis was named one of Business Report's 2013 Influential Women in Business. The award recognizes women in the local Louisiana area who are impacting the community. The nine women selected this year come from diverse backgrounds and are influencing a wide range of companies and organizations. Phyllis Perron and Associates has developed into a major political and governmental relations and association management firm. The firm lobbies legislators and performs regulatory duties on behalf of clients—most of them in the insurance industry—as well as provides management services to professional organizations, such as the Louisiana Pharmacists Association.

One of her proudest accomplishments is her work on legislation that created the Louisiana Life & Health Insurance Guaranty Association. Formed in 1991, it's a safety net for policyholders of an insurer that may become insolvent.

Read the complete profiles of this year's honorees at http://businessreport.com/section/WIB-2013.

Congratulations to Kristine Williams the newest IAIR Designation Recipient!

Kristine M. Williams, M.B.A., serves as the Chief Operating Officer at Tharp and Associates, Inc., where she regularly provides estate administration, coordination with state guaranty associations and regulatory agencies, insurance company operations, litigation support and project management and most recently was appointed as Supervisor of a property and casualty insurer.

As a veteran of the insurance industry, her professional experience included progressively responsible management positions in managing claims, customer service, new business and policy issue departments, as well as executive level administration and compliance for life, annuity and accident and health companies.

As Chief Operational Officer and Project Manager for Tharp and Associates, Kristine has been senior staff to the court appointed fiduciary for more than two dozen insurer insolvencies which have been placed into court-supervised receivership proceedings.

Kristine is a Fellow of the Life Management Institute (FLMI); an Associate, Insurance Regulatory Compliance (AIRC), an Associate, Financial Services Institute (AFSI), and an Accredited Insurance Examiner (AIE). In addition to IAIR, she maintains memberships in the Association of Insurance Compliance Professionals and the Insurance Regulatory Examiners Society.

Congratulations Kristine on earning the designation Certified Insurance Receiver - Multiple Lines – great work!

Planning a Trip to London? Save the Date for the next IAIR Breakfast Seminar

We are delighted to invite you to the International Association of Insurance Receivers (IAIR) breakfast seminar sponsored by RPC and PwC.

Location: PwC London Office

Date: Wednesday, September 25, 2013

Time: 8:30 am registration, 9:00 -10:15 am presentations

RSVP: Jessica Simpson Jessica.simpson@uk.pwc.com

Please direct any questions regarding the program to Alice Liverton at seminars@rpc.co.uk.

If you are interested in participating as an IAIR sponsor, advertiser or wish to receive information about IAIR membership or committee participation, please contact Nancy Margolis, Esq., Association Manager, International Association of Insurance Receivers, telephone 610.992.0015 • nancy@iair.org

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December
15-18
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Wardman Park

IAIR Insolvency Workshop
January
30-31
2014
Tempe, AZ
Tempe Mission Palms

Spring NAIC Meeting
March April
29 - 1
2014
Orlando, FL
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