

The **INSURANCE RECEIVER**

Promoting professionalism and ethics in the administration of insurance receiverships.

Volume 11, Number 3

Fall 2002



President's Message

by Elizabeth A. Lovette, CIR-ML

As I sat down to pen this column this time last year, my office had just placed a very large HMO in rehabilitation, and I was operating in that "high alert" state we receivers find ourselves in at the onset of a particularly prickly insolvency. Ironically, as fate would have it, I received an order just this morning placing a sizeable MEWA in rehabilitation. I mention this for a couple of reasons: 1) first and foremost, I have a valid reason for keeping this column BRIEF!; and 2) as I began digging to find the materials on those funky creatures known as Association Health Plans and MEWAs provided by Mila Kofman, the Assistant Professor at Georgetown's Institute for Health Care Research & Policy who spoke at IAIR's recent Roundtable in Philadelphia, I couldn't help but think once again how very much I benefit from and value the resources provided by IAIR.



And on a somewhat related note, the 2003 Annual Insolvency Workshop has been scheduled for February 5-7, 2003, at the Marriott Rancho Las Palmas Resort & Spa in beautiful Rancho Mirage, California. I say related in that rumor has it that "Special Receiverships" may be the focal point of this workshop along with other as yet unnamed topics. Thanks go to Paige Waters with Sonnenschien Nath & Rosenthal who as agreed to chair this event along with the other members of her planning committee. I know this workshop will be every bit as scintillating as its predecessors, and I encourage the membership to attend. Look for more information to follow in the months ahead.

Thank You To The Sponsors of The IAIR Philadelphia Meeting

We would like to thank those companies and individuals who have served as Patron Sponsors of our quarterly round table and reception held in Philadelphia, PA. 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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INSURANCE RECEIVER

Volume 11, Number 3
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English & American Insurance Company Ltd increase Scheme Payment to 30 per cent

Following consultation with the Creditors' Committee, the Joint Scheme Administrators of English & American Insurance Company Limited ("EAIC"), Tony McMahon and Tom Riddell, Partners in the Insurance Solutions practice of KPMG Corporate Recovery, have increased the Scheme Payment Percentage to creditors from 25 to 30 per cent as at 1 June 2002.

The first distribution at the new rate was paid to creditors with Established Scheme Liabilities on 5 July 2002. Following this distribution, the total amounts paid to creditors exceed US\$51 million.

The Scheme Administrators estimate that the ultimate Scheme Payment Percentage may be in the range of 40 to 44 per cent. However, at this stage EAIC faces continuing uncertainty regarding its exposure to APH claims and to reinsurance bad debt, and therefore estimates of the final Scheme Payment Percentage cannot be given with any degree of certainty.

As at 31 March 2002 EAIC had agreed claims of US\$325 million, of which US\$180 million were Established Scheme Liabilities. Over the past two years the Scheme Administrators have made substantial progress in accelerating the agreement of claims and payment of dividends to Scheme creditors. At the same time, the Scheme Administrators continue to pursue collections from EAIC's reinsurers and since the inception of the Scheme have collected over US\$174 million in reinsurance recoveries.

Tony McMahon, Joint Scheme Administrator commented:

"The progress on EAIC to date has been very encouraging as evidenced by the amount that has now been paid out to creditors. We are working hard towards an early closure of the estate within the next five years." A meeting of EAIC creditors has been convened for 27 August 2002 at 10:30am at KPMG LLP's offices at 1-2 Dorset Rise, London, EC4Y 8AE.

Creditors should call the EAIC helpline on +44 (0)1452 782600 if they have any queries regarding the Scheme.

IAIR Educational Seminars

IAIR/NCIGF Joint Seminar
November 7 - 8, 2002
Henderson, NV
 Host Hotel: Hyatt Regency

For more information on this program, visit our website at www.iair.org. The agenda and registration brochure will be available on the Events & Schedules page within the next several weeks.

2003 Insolvency Workshop
 February 6 - 7, 2003
 Marriot Rancho Las Palmas Resort & Spa
 Palm Springs, California

Topics will include special receivership topics such as:
 Alternative Risk Transfer Vehicles
 Unauthorized Health Insurers
 Federal Alternatives
 Interstate Compact Legislation
 and
 2003 Legal Update

For more information, visit the IAIR website at www.iair.org and go to the Events & Schedules page.

View From Washington

by Charlie Richardson



We are heading into the mid term elections, with people playing the ever popular Washington political game of "what ifs" in connection with control of the House and Senate. We probably should take stock of a few issues that are going to be front and center in the new Congress.

Terrorism Insurance

We have written about that issue in several prior issues of the Receiver. As this article is being written, the Senate has just passed a bill to protect insurance companies and consumers from future terrorist attacks. Disagreements over limitations on punitive damages and other "tort reform" measures in the earlier House passed bill being pushed by Republicans may delay final legislation in conference. Business and even some labor groups, with support from the White House, will try to keep the heat on Congress to resolve their differences, if not in this Congress, then in early 2003.

Insurance Regulation

On June 4, 11 and 18 a key subcommittee of the House Financial Services Committee held hearings on the future of insurance regulation, generally, and the concepts behind proposals for an optional federal charter, specifically. The Financial Services Coordinating Council, an association of some of the principal insurance trade groups (ACLI, AIA and the ABIA) threw its support behind one plan for an optional federal charter. Under the new plan, there would be a federal insurance authority within the Treasury Department to regulate federally chartered insurers and

producers. State chartered insurers and producers would continue to be regulated by state regulators. 2003 may bring more hearings on improvements in state regulation and maybe even hearings on optional federal charter legislation. Unless there is some cataclysmic event casting more significant doubt on the existing state regulatory system, Congress is likely to take its time in making wholesale changes in that system. But you can count on the fact that the House Financial Services Committee will continue to press for incremental improvement.

Sen. Sarbanes' bill is similar to legislation he introduced in 2000

Predatory Lending

In May, Senator Paul Sarbanes (D-MD), Chairman of the Senate Banking, Housing and Urban Affairs Committee, introduced the "Predatory Lending Consumer Protection Act of 2002" (SB 2438). Sen. Sarbanes' bill is similar to legislation he introduced in 2000, although its provisions regarding tightening the definition of a "high cost mortgage" are more rigorous. The bill includes a limitation on single premium credit insurance and would prohibit the up-front payment or financing of credit life, credit disability or credit unemployment insurance on a single premium basis. It is expected that this will make it more difficult to package such products in loans. The bill contains no federal preemption of state laws. Again, look for more hearings in the predatory lending

area in 2003.

China

Also last May, the National Association of Insurance Commissioners and the China Insurance Regulatory Commission signed a memorandum of understanding on the exchange of regulatory information. Under the agreement, the NAIC will provide technical assistance to Chinese regulators on the development of model laws and regulations, examination handbooks and collection and analysis of data, and may exchange personnel to help train Chinese officials. There will be a new working group set up by China and the NAIC to facilitate communications and to carry out the agreements made in the memorandum. All of this is a way of saying that the interaction of the United States and China in the financial services sector is going to increase, and Congress is going to be watching that interaction very closely.

Philadelphia NAIC Meeting Recap

by Belinda Miller

IAIR Board of Directors Meeting

The Board met on June 8 at its regular Saturday morning time and discussed primarily the fact that at the next Quarterly NAIC meeting, the regular times will be pushed back by a day and a half. After figuring out what that meant in terms of room reservations, the Board also discussed several upcoming educational seminar opportunities. The Joint IAIR/NCIGF Seminar on November 7 & 8 will be held in Henderson, Nevada, and there are several locations under consideration for the 2003 Insolvency Workshop in January 2003. Later in 2003, there may be an opportunity to have a joint session with INSOL but plans are not final for this yet.

The Board considered several weighty financial matters. Proposed dues for next year were discussed and a hand-out was distributed. However, the Board members needed more time to consider all of the relevant information, so the topic will be brought up again in September.

On the International front, Dorothy Cory Wright standing in for Vivien Tyrell, discussed the activities of the London IAIR group. She reported that the International Committee had a successful meeting in March. In fact, the IAIR London group has had several successful events over the past year or so, and as a result, has accumulated some funds in a checking account. These funds will be included in the accounting numbers for IAIR. There was a brief discussion of whether the London group should be an affiliated organization, a chapter of IAIR, or what form would be best to encourage its growth and

development. No decisions were made on this issue, nor is there any urgency to make decisions, but in terms of planning for the future, the group will probably come back with a proposal for a recommended structure for its organization.

The only other major topic discussed at the Board meeting was the fact that at the December annual meeting, some new Board members need to be elected. Dick Darling indicated that anyone wishing to serve on the Board should send him an e-mail. Typically, there are several candidates for each Board seat, and it may take more than one try to be elected to the Board. The qualifications are that Board members are required to be members of IAIR, and must show up for quarterly Board meetings. Desirable traits include significant receivership experience.

Accreditation and Ethics Committee Meeting

The A & E Committee talked about a couple of very heavy topics. Although IAIR has had a Code of Ethics for a long time, we don't have a formal procedure for investigating or taking action if anyone were to complain of a violation of the Code of Ethics. If our organization is going to grow and gain prestige among Commissioners and others, we probably need a somewhat formal mechanism for dealing with complaints against our members. The Committee is studying disciplinary procedures from several other organizations including the Fraud Examiners, SOFE, IAIS, and the actuaries. We have a first draft of a disciplinary procedure which will be

considered by the committee before the September meeting. It is anticipated to be ready for the Board and then the general membership of IAIR hopefully by the annual meeting in December. You will receive more information on this as it develops.

The Publications Committee Meeting

The Publications Committee continues to need articles and volunteers. It does an excellent job of producing high-quality publications, and needs the help of IAIR members to keep the material fresh and interesting.

NAIC Meetings

The MARG Committees met and discussed time. There was a discussion of the need for longer sessions to get through big issues that must be decided before drafts can be finished. The subcommittees are sending in material and beginning to narrow the issues, but there are several issues that will need to be decided at the Working Group level. There may be some where consensus is not possible. The subcommittees continue to plod on, however, and work on their assigned pieces of a new Model Act. Most are comparing the URL to the Model Act and coming up with new language that, on some topics, incorporates some of the URL language. At the next meeting or two, the subcommittees will produce the rest of their drafts, and the issues will gradually move back up to the Working Group where the real shouting can begin. The good news is that there are some drafts that have been completed by the subgroups.

Philadelphia IAIR Meeting Recap

by Robert Loiseau, CIR- P&C



IAIR's June 8th Philadelphia Roundtable included a roster of speakers and topics that was simply outstanding. The program was hosted by Kristine Bean of Peterson Consulting who, after opening the meeting, allowed Chris Maesel, CIR-ML to offer some words of tribute for our colleague Lenny Minches who passed away in May of this year. Always generous with his time and expertise, Lenny "wrote the book" on insurance insolvency during his long and diverse career in the field. A brief memorial appears in this issue.

The first speaker at the Roundtable was Mila Kofman, an attorney and college professor at Georgetown University's Institute for Health Care Research & Policy, who spoke about the harm to consumers done by unlicensed, illegal health benefit plans. Ms. Kofman became interested in this topic during her tenure with the United States Department of Labor where she focused on the regulation of Association Health Plans (AHPs). In addition to providing historical information, she also sounded an alarm about legislative changes under consideration in Congress that would preempt state regulation, and may have the unintended side effect of causing AHPs to proliferate. This legislation also places oversight of AHPs with the federal government, which may not have the resources to regulate them effectively.

Prior to ERISA's enactment in 1974, AHPs were jointly regulated by the Department of Labor and state insurance regulators. After ERISA, they became federally regulated. Following a spate of insolvencies, Congress' remedy in 1983 was to permit states to regulate certain self-funded and self-insured health benefit plans, apparently recognizing they were better able to protect consumers than were their federal counterparts. Evidence of this appears in State insurance commissioners' willingness to issue cease and desist orders against the operators of these bogus plans, and in one recent case, the use of receivership

as a tool to shut them down and pay their victims.

Regardless of what name or acronym they utilize, AHPs proliferate in market environments (like the present one) where rate hikes for health insurance premiums force small businesses to look for other alternatives to traditional healthcare insurance products. With one in three small businesses (fewer than 10 employees) relying on AHPs to provide health benefits to their employees, promoters prey on these businesses by representing AHPs as legitimate ERISA health benefit plans wholly exempt from state regulation. Bogus trade or professional associations are often formed as vehicles for marketing an AHP's various benefit plans, and using a broad network of TPAs and agents, they collect substantial contributions but ultimately don't pay enrollees' claims. Ms. Kofman reported that at present, the Department of Labor has seventy civil investigations and fourteen criminal files open on AHPs.

In addition to traveling from Washington to give her Roundtable presentation, Ms. Kofman contributed a feature article on AHP regulation and legislation for this edition of *The Insurance Receiver*; it is thought provoking material.

Holly Bakke, New Jersey's Banking and Insurance Commissioner, spoke next about a medical malpractice insurance crisis in her state. The recent insolvency of FICO, {sp?} which wrote 40% of New Jersey's medical malpractice market, made replacement coverage unaffordable, and in some places not available at all. High risk specialty fields

such as obstetrics and gynecology are in a state of crisis because they can't get or can't afford coverage and up to one fourth of New Jersey's obstetricians plan to stop delivering babies altogether because of astronomical premiums. Along with FICO's failure, New Jersey's Medical Insurance Exchange also hit the skids financially, but through early intervention by the New Jersey Department of Insurance, is now operating in a solvent runoff mode and will be succeeded by a new entity. The new entity will be a reciprocal, doctor-based organization funded by physicians' contributions, rather than a for-profit stock company like its predecessor.

Commissioner Bakke emphasized the need for a long-term solution but argued that tort reform is too slow and too political to stem the current crisis. Instead, she advocates such basics as charging premiums appropriate to the risk, and offering policies with features including high deductibles, risk prevention training and even no interest installment payment plans.

Moreover, in New Jersey, the Department of Health became involved in managing this crisis, viewing it not just as an insurance problems, but also a public health issue as well: i.e. obstetricians who won't deliver babies. Again, using the field of obstetrics to illustrate the origins of the crisis, Ms. Bakke reported medical claims arising under growing number of high-risk pregnancies. These claims, she feels, arise from circumstances created outside the health care system, not within it. Among these are drug addiction leading to more premature births, growing numbers of late-in-life babies and the problems attendant to expectant mothers' obesity. At its core, the crisis comes from malpractice litigation reflecting a societal condition where "everyone feels entitled to a perfect outcome"; a result that neither the medical profession nor the health care delivery system can provide. While a complete solution to New Jersey's

problem may not be at hand, Commissioner Bakke and her counterparts at the New Jersey Department of Health are proactively dealing with an escalating crisis; a crisis about which we hope she can report her solutions at future Roundtable.

Jeff Tindall, an attorney with the Philadelphia law firm of Davies, McFarland, Carroll P.C. and a principal in Vertical Claims, a medical TPA firm, spoke about Pennsylvania's medical liability insurance crisis. Calling his own state the "Afghanistan of medical malpractice" he said that Pennsylvania has effectively been forced into self insuring many of its hospitals because they cannot buy medical malpractice coverage.

The focus of Mr. Tindall's remarks was on Pennsylvania's efforts at tort reform legislation, detailing the "M-Care Act" which imposes more risk management responsibilities and greater reporting requirements upon hospitals as well as a small measure of tort reform. In his opinion, Chapter Five of that act is central to its effectiveness. but described with a trial lawyer's skepticism certain key provisions and whether they will really change the status quo. Among these provisions are:

- new informed consent rules relating to a doctor's representation of his qualifications;
- a punitive damages limitation that is illusory;
- elimination of the collateral source rule to reduce actual damage awards;
- requirement of itemized jury verdicts which may have the unintended effect of actually increasing damage awards;
- structured payouts that cease if the plaintiff dies;
- using the present value of future earnings of an injured plaintiff to compute damages;
- stricter expert witness qualifications;
- seven year statute of repose.

At the heart of Pennsylvania's crisis is what the speaker called the "Philadelphia Problem." In that city and surrounding counties, forum shopping is

rampant and venues are so plaintiff-oriented they are "sucking the life out of the medical malpractice industry". Mr. Tindall reported that the M-Care Act does create new Venue Committee whose charge is to change this circumstance. Efforts are also underway at the statehouse to eliminate joint and several liability in medical malpractice claims in favor of something more closely approximating comparative negligence.

The next speaker was Rowe Snider of the Lord Bissell and Brook firm who

It took only three weeks before the Pennsylvania Commissioner had no choice but to put Reliance into liquidation.

gave an overview of the unique issues arising from the Pennsylvania's Reliance Insurance Company receivership. With liabilities estimated at \$8 billion and recoverable assets of between \$4 and \$5 billion, there is a fairly deep "hole" that will have to be made up by guaranty associations and high net worth insureds or borne by Reliance's creditors.

Mr. Snider gave a brief background of Reliance's five-month rehabilitation effort which ended abruptly on September 11, 2001. Until that day, Reliance's operations were largely being funded by advances from key reinsurers; after September 11th, those sources dried up, as did the availability of other credit facilities. It took only three weeks before the Pennsylvania Commissioner had no choice but to put Reliance into liquidation.

the reliance case presents liquidation challenges of unprecedented scope and complexity. Among the receiver's first priorities were dealing with the physical challenges of continuing to pay workers compensation benefits while claims files were being transferred to guaranty associations and insureds. This formidable task included distributing to the proper party more than 90,000 claims files held by Reliance's 155 TPAs in more than 1,000 separate locations.

If that was not daunting enough,

enforcement of the Pennsylvania Receivership Court's stay of litigation was rejected by some states. complications from this even spilled over to some guaranty association litigation where Reliance was a named party in pending suits.

Logistics aside, the types of insurance that Reliance wrote posed enormous challenges to the Receiver some policies and features included:

- Large deductibles (\$250,000 - \$1 million) in everything from workers compensation to commercial general liability policies. These large deductibles were customarily secured by letters of credit or cash deposits, but sometimes they only appeared to be secured.

- Reliance's use of a vast TPA network that allowed its large insureds to effectively control how the TPA handled their claims. Some TPAs had become little more than captives of large insureds, and even gaining access to their claims files and data posed an hurdle to the receiver.

- In some insurance programs, Reliance had "first dollar liability" with the insured later reimbursing it for paid losses. These were essentially programs that resembled self insurance, but took a wide variety of forms depending on the unique circumstances and bargaining power of the insured.

Not surprisingly, these facts made the guaranty associations' work much harder. Wholly apart from paying covered claims, guaranty association issues of first impression arose:

- Which party is entitled to the deductible recoveries under the above - described programs?
- Which party is authorized to administer the collection of deductibles?
- Should the guaranty association even be involved where an insured's net worth might exclude it from guaranty fund coverage?

- Who gets the collateral securing the large deductibles; who maintains it?

Mr. Snider reported that it took six months to negotiate and obtain court approval of an interim agreement on this agreement we to give guaranty associations the benefit of the large

(Continued on page 8)

Philadelphia NAIC Meeting Recap

(Continued from page 7)

deductible policies, while focusing on making sure workers compensation claimants paid. Interestingly, this interim agreement also yielded a "back door" early access plan for participating IGAs, giving them quarterly disbursements. The agreement also addresses responsibility for the use and control of funds among the receiver, the insureds and the guaranty associations. Mr. Snider pointed out that while this interim agreement is workable, it without prejudice to any party's rights to litigate in the future. Consequently, it is a safe bet that a considerable body of new receivership law will flow from Reliance's massive and unprecedented insolvency.

The Roundtable's final speaker was Scott Moser, Director of Claims-Equitas. Equitas reinsured policies issued by Lloyd Syndicates in 1992 and prior years, and one of its biggest challenges is winding up long-tailed claims, particularly asbestos claims. He reported that Equitas has paid \$20 billion in claims to date, of which \$5 billion relates to asbestos. Because of the enormity of these amounts (with no end in sight) Equitas decided to go "back to basics", as Mr. Moser put it with respect

to asbestos claims. It has adopted new and controversial asbestos claim documentation requirements, at the heart of which is the notion that valid claims must be supported by evidence of disease, not just exposure, and that the insured's asbestos products caused the claimant's disease.

Mr. Moser cited some impressive statistics about the number of major manufacturing and industrial companies (more than sixty in the past twenty years) forced into bankruptcy due to asbestos claims. He noted that the plaintiff's bar has encouraged a flood of new claims, most of which are filed on behalf of people showing no signs of asbestos related disease. He cited the state of Mississippi.

Again demonstrating the magnitude of the asbestos problem, Mr. Moser cited Equitas' undiscounted asbestos reserves of \$12 billion at March 31, 2001 comparing them favorably to aggregate reserves of \$9 billion set by the top ten solvent insurance companies with major asbestos exposure. "Are these reserves adequate, or will the well run dry?" Moser asked. Based on actuarial studies, he rates Equitas' survival ratio favorably in

comparison to most carriers, but concedes that absent a fundamental change in the claims environment, money may eventually run out.

Equitas' solution is that it will pay all valid claims but will require evidence of causation first. Mr. Moser emphatically stated that "real claimants", those suffering asbestos related diseases, deserved to be compensated promptly. But he said payments to the unimpaired claimants are another matter entirely. Equitas will continue to pay jury verdicts (whether outrageous or justified) but will not voluntarily settle claims of unimpaired claimants.

Mr. Moser also hopes for some measure of balance to return to the judicial system and that asbestos risks need to be handled differently in the future. He urged defendants to litigate claims by unimpaired plaintiffs and require proof of causation before considering any settlement. He also advocates appealing adverse verdicts until all appellate avenues are exhausted. Only then, in Mr. Moser's view, will that "measure of fairness" return to the system.



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In Memorium

On Sunday June 2, 2002 Leonard H. "Lenny" Minches passed away quietly at his home in south Florida. He will be deeply missed.

Lenny was a member of IAIR since its inception and he gave so much to the association over the years that it would take more space than we have available here to mention all of his contributions.

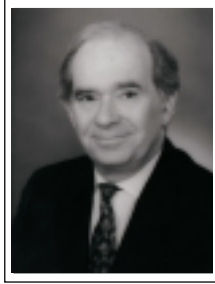
He graduated from New York University with a BA in 1952 and from the New York University School of Law in 1955. Lenny was an experienced insolvency attorney with over 40 years in the insurance industry. Prior to entering private practice, Lenny spent 20 years with the New York State Insurance Department, the last four as Special Deputy Superintendent in charge of the Department's Liquidations Bureau.

At Edwards & Angell he was counsel in the Palm Beach and New York offices. He represented clients in numerous commutation agreements involving receiverships in the United States and elsewhere. Lenny also represented insurance and reinsurance companies in regulatory matters.

He was an avid sports fan with a baseball card collection containing 75,000 cards. He and his wife, Lorraine, were enthusiastic movie and theatregoers.

We mourn the passing of our colleague and friend. IAIR wishes to extend our sincerest condolences to his wife, Lorraine, as well as his family.

Goodbye to a dear friend.



IAIR Roundtable Schedule

NAIC Meeting - September 7 - 11, 2002
New Orleans, NA
Roundtable has been cancelled due to scheduling conflicts.

NAIC Meeting - December 7 - 11, 2002
San Diego, CA
IAIR Roundtable
December 8, 1:00 - 4:00 p.m.

NAIC Meeting - March 8 - 11, 2003
Atlanta, GA
March 9, 1:00 - 4:00 p.m.

The **INSURANCE RECEIVER**

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

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The Leonard H. Minches Scholarship Endowment

The law firm of Edwards & Angell, LLP is pleased to announce the formation of the Leonard H. Minches scholarship endowment at the School of Risk Management - St. John's University (formerly the College of Insurance) in memory of friend, mentor and partner, Lenny Minches, who passed away on Sunday, June 2, 2002.

For more information, see the next issue of *The Insurance Receiver*.

Health Insurance Scams Promoted Through Associations: A Primer

by Mila Kofman, J.D.



Mila Kofman is Assistant Research Professor at the Georgetown University Institute for Health Care Research and Policy. Before joining the faculty at Georgetown University, Ms. Kofman was a federal regulator at the U.S. Department of Labor, where she worked on federal legislation affecting association health plans in addition to regulating such arrangements. Prior to joining the U.S. Department of Labor, Ms. Kofman was Counsel for Health Policy and Regulation at the Institute for Health Policy Solutions, a non-profit, non-partisan firm, where she assisted small businesses in establishing health insurance purchasing coalitions. She also worked at the National Association of Insurance Commissioners, where she researched state regulation of Multiple Employer Welfare Arrangements. Mila Kofman holds a law degree from the Georgetown University Law Center and a Bachelor of Arts in Government and Politics from the University of Maryland, College Park.

According to ABC News, Christine Sinclair has a rare and inoperable cancer. Chemotherapy each week costs \$2,000. Her treating physician has informed her that the insurance company owes him more than \$30,000 in unpaid bills and that he is not a “bank” for his patients. Christine is embarrassed and concerned that he will stop her treatment. She also worries about mortgaging her home to cover over \$50,000 in outstanding medical bills.¹

Christine was not uninsured when she incurred these bills. As a member of a professional association, she was enrolled in the association’s health plan, which was through a company called Employers Mutual LLC (Employers Mutual). Christine believed that she had insurance to cover her cancer treatment.

Christine is one of 22,000 Americans who paid nearly \$15 million in premiums to Employers Mutual, an illegal insur-

ance arrangement according to regulators. State and federal regulators shut this company down when they discovered claims were not being paid. A federal judge determined that the management of Employers Mutual depleted its assets by paying itself excessive fees and diverting funds to personal accounts.² Although court documents indicate that many of the 22,000 individuals were left with over \$6.5 million in unpaid medical bills, the extent of unpaid medical bills will not be known until all claims are filed with the independent receiver appointed by the federal court.³

Unfortunately, Christine’s experience is not an isolated case. According to the U.S. General Accounting Office (GAO) and federal and state regulators, in the past two decades health insurance scams sold through both legitimate and phony associations have defrauded thousands of small businesses and self-employed individuals.⁴ In the last six months, over 50,000 working Americans and their families have lost their health insurance coverage, and many of these victims are now faced with millions of dollars in unpaid medical bills that should have been paid by association health plans.

This primer focuses on health coverage scams promoted through real and phony professional and trade associations. Part I provides background information focusing on recently discovered scams. Part II discusses how the regulation of association health plans and other group purchasing arrangements

has evolved in the last twenty-eight years. Part III concludes by looking at one federal proposal that has recently garnered support from the Administration. It examines its potential effect on current efforts by state and federal regulators to stop health coverage scams perpetuated through associations.

PART I: BACKGROUND

Association Health Plans

Millions of working Americans — one out of every three businesses with fewer than ten employees⁵ — rely on group purchasing arrangements such as professional and trade associations, multiple employer welfare arrangements⁶ (MEWAs), multiple employer trusts (METs), employer coalitions, and alliances for their health insurance coverage. These arrangements combine resources to “self-insure or self-fund” (pay into a fund that pays medical claims) or to “fully insure” (buy insurance from a licensed insurance company). Some arrangements, including professional and trade associations, e.g., the local chamber of commerce, provide health coverage as one of many benefits to their members. Other arrangements, e.g., Health Insurance Purchasing Coalitions (HIPCAs), exist solely for the purpose of providing or buying health coverage or other types of insurance-related services for participating employers. Because federal law generally does not distinguish among different types of group purchasing arrangements, this paper uses the terms “MEWAs,” “association health plans,” and “group purchasing arrangements” interchangeably to describe an entity through which two or more employers and self-employed individuals obtain health insurance coverage.

Although many group purchasing arrangements have helped employers finance health benefits for their employees, such arrangements have

also presented opportunities for unscrupulous individuals to defraud employers and their workers. Millions of American workers and their families have been left without health insurance and with millions of dollars in unpaid medical bills.⁷

2001 - the beginning of a real crisis

State and federal regulators believe that in the last two years, the number and magnitude of association health plan scams have grown and that such "illegal operations are rapidly growing and spreading around the country."⁸ In the last year, the Texas Insurance Department shut down three illegal association health plans that had defrauded more than 20,000 Texans.⁹ Since last year, Florida's Insurance Department has shut down six arrangements covering nearly 30,000 Floridians, leaving many without health insurance and with unpaid medical bills.¹⁰ Oklahoma's Insurance Department has 60 open investigations.¹¹ In response to rapidly growing scams, Louisiana's Insurance Department recently created a MEWA Task Force responsible only for handling such scams.¹² In January 2002, the U.S. Department of Labor reported having 76 civil and 14 criminal investigations open.¹³

How does a health insurance coverage scam work?

Typically, promoters of scams target small business owners and self-employed individuals. As a way to attract a large volume of business quickly, they market health insurance scams through well-established trade and professional associations. They also establish their own associations. For example, operators of American Benefit Plans, an unlicensed entity according to court documents, sold their health plan through at least seven existing associations and four associations they created — National Association for Working Americans, National Association of Working Americans, the United Employer Voluntary Employee Beneficiary Association, and the United Employee Voluntary Employee Beneficiary Association (emphasis added).¹⁴ They enrolled over 32,000 people in forty-eight states.¹⁵

Operators of Employers Mutual enrolled 22,000 people in fifty states by allegedly selling coverage through sixteen associations they established and through existing associations.¹⁶

Small businesses and self-employed individuals buy association coverage because it is less expensive than health insurance available in the commercial market.¹⁷ For example, Employers Mutual charged a 50 year-old woman a monthly premium of \$285 compared to \$425 for comparable benefits from a licensed insurance company offered through the same association.¹⁸

Promoters claim that premiums are low because they have purchasing power when employers band together to negotiate with insurance companies. Additionally, they claim that they offer "ERISA plans" or union plans exempt from state insurance laws and that their low premiums result from this exemption. In real-

Operators of scams collect premiums without intending to make good on their promise to provide health coverage!

ity, these claims are false.

Operators of scams collect premiums without intending to make good on their promise to provide health coverage. For example, Phillip Harmon was sentenced to eight years in prison as a result of massive fraud "inducing" employers to pay millions of dollars into a trust for "nonexistent" health insurance (covering 6500 individuals, primarily ministers of various churches and their families) nationwide. According to the U.S. Department of Labor's Report to Congress, "No insurance was purchased; rather, the money went to benefit Harmon and others.... The total amount collected by Harmon through the schemes (which also included an investment scheme) was approximately \$40 million."¹⁹

Many operators establish scams collecting millions of dollars in premiums until state or federal regulators find them. While undetected, to continue attract-

ing new business and to continue receiving premiums from existing clients, they pay small claims while delaying paying large ones. Ameri-Med collected \$1.6 million in premiums and paid only \$360,000 in claims, its operator diverted more than \$900,000 for personal use.²⁰

Operators of scams often are repeat offenders. Recently the Florida Insurance Department shutdown an entity linked with an individual who, according to the state, two years ago "pleaded guilty to healthcare fraud in connection with the embezzlement of some \$8 million" through a phony union plan and a phony employer association.²¹

Double-digit cost increases and demand for alternatives

Health insurance coverage scams exist because there is an unmet demand for affordable health insurance. Criminals take advantage of small employers and self-employed individuals looking for affordable alternatives to traditional coverage.

Historically, MEWA fraud increased when premiums for health insurance increased substantially. For example, in 1988 employers faced double digit increases in premiums averaging 12.0%.²² According to the General Accounting Office, MEWA problems increased between 1988 and 1991 — MEWAs left thousands of people without health insurance and nearly 400,000 patients with medical bills exceeding \$123 million.²³

In 2001, businesses with three to nine workers paid an average of 16.5% more than in 2000.²⁴ In 2002, it is estimated that premiums increased by 15.6%.²⁵ In 2003, some analysts predict an additional 20% increase.²⁶ As employers face double-digit premium increases, they will continue seeking alternatives to traditional coverage and are at risk of being conned by scams.

Victims are financially liable for unpaid medical bills

Small businesses and their workers defrauded by association health plan fraud have few legal options. In some cases court appointed receivers find some assets. In addition to prison sen-

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tences, courts can order restitution to be paid to the victims.²⁷ However, typically there are not enough assets to pay fully all outstanding medical bills. According to the GAO, only \$9.6 million in assets were recovered, but over \$123.6 million was owed for medical bills between 1988 and 1991.²⁸ State guaranty funds, designed to protect consumers when a licensed insurance company becomes insolvent, do not protect individuals covered through unlicensed association health plans.²⁹ Ultimately, patients are responsible for paying their doctors, hospitals, and other providers for services and procedures the patient received.

The states and the federal government have tried to address the problem of health coverage scams. The next section discusses how the regulation of association health plans has evolved in the last twenty-eight years.

PART II: SHARED REGULATION

Both states and the federal government regulate association health plans, although this was not always the case.

EVOLUTION OF FEDERAL AND STATE REGULATION

When Congress federalized regulation of employee benefits by enacting the Employee Retirement Income Security Act of 1974 (ERISA), it severely restricted state authority to regulate group purchasing arrangements. Under the 1974 statute, states could not regulate group purchasing arrangements that were considered to be “employee welfare benefit plans,” an ERISA plan.³⁰ The U.S. Department of Labor became responsible for regulating such arrangements. To determine if an arrangement was an ERISA plan, a state (and in many cases a court) had to apply a very technical and complex federal standard requiring a fact intensive inquiry.

ERISA replaced state-based standards with minimal federal standards to encourage employers to provide medical benefits to their workers. Some argued that fewer regulatory requirements make it less costly for employers to pro-

vide benefits. The federal statute required ERISA health plans to comply only with fiduciary standards and reporting and

States regulate both fully insured and self-insured group purchasing arrangements

disclosure requirements, but did not require such plans to be licensed or to meet any solvency requirements.³¹

Broad preemption of state law had unintended consequences. When states tried to regulate group purchasing arrangements that were not subject to ERISA, its operators successfully claimed ERISA exemption from state law.³² However, the U.S. Department of Labor claimed not to have authority over such arrangements because most were not ERISA plans.³³ Ambiguity about whether states had authority to regulate group purchasing arrangements, minimal federal standards in ERISA, and limited oversight by the U.S. Department of Labor created opportunities for widespread fraud.

In response, in 1982 (effective in 1983) Congress amended ERISA to limit its preemptive effect on state law. As a result of these amendments, states can generally regulate group purchasing arrangements. More specifically, with almost no limitations, ERISA allows states to regulate MEWAs³⁴ – defined broadly to include all types of arrangements offering health coverage to two or more employers or self-employed individuals.

Current regulation

As a result of the 1983 amendments to ERISA, both state insurance departments and the U.S. Department of Labor regulate MEWAs. Most consumer protections are state-based, not federal-based. Also, state insurance departments have enforcement tools that the U.S. Department of Labor does not have, which affect its ability to regulate effectively.

States regulate both fully insured and self-insured group purchasing arrange-

ments. States may require fully insured arrangements to obtain a license and insurers selling coverage through such arrangements must comply with state insurance laws. States may require a self-insured arrangement to be licensed as an insurer³⁵ or in states with MEWA-specific laws, to be licensed as MEWAs.³⁶

State-based standards applicable to group purchasing arrangements are more comprehensive than federal standards. State insurance laws including licensing, solvency, benefit requirements, external appeal laws, and other consumer protections apply to group purchasing arrangements. Federal standards are generally limited to fiduciary obligations, disclosure and notice requirements, and more recently a requirement to register with the U.S. Department of Labor.³⁷ ERISA does not require MEWAs to be licensed and there are no federal solvency, external review, or other consumer protections similar to those found in state insurance law.

In addition to a broad range of state laws applicable to MEWAs, state insurance departments have enforcement tools not available to the U.S. Department of Labor. For example, state insurance departments can shut down insurance scams using administrative cease and desist authority without going to court. Cease and desist orders may be issued in an ex parte fashion in an emergency.³⁸ This authority allows insurance commissioners expeditiously to shut down a scam without having to go to court.

The U.S. Department of Labor must seek a temporary restraining order (TRO) and a preliminary injunction (PI) from a federal court to shut down a scam. A TRO and PI by a federal court require the federal government to offer sufficient evidence at a pre-trial hearing to prove that a violation of ERISA has occurred and to demonstrate that the government will probably prevail on the merits once the case is fully litigated. Unlike states shutting down illegal arrangements based on a failure to be licensed, the federal government must prove a violation of a fidu-

ciary duty, which is financial in nature requiring evidence that assets have been misused. To gather enough evidence for a successful hearing in federal court, Labor's investigations may take several years. While being investigated, operators of scams continue collecting premiums.

Although both states and the federal government regulate group purchasing arrangements, health coverage scams continue. Operators of scams continue to use ERISA preemption as a shield to avoid state enforcement actions, challenging state authority by removing cases to federal court.³⁹

Additionally, preemption ambiguities under ERISA continue to be exploited. For example, ERISA prohibits states from regulating union plans. Ambiguity over what a union plan is has resulted in health insurance scams promoted through phony unions.⁴⁰ According to the U.S. Department of Labor in one case, a MEWA called the International Professional, Craft and Maintenance Association Trust claimed exemption from state regulation as a Taft-Hartley plan. This phony union left 3000 workers with \$2.3 million in medical bills and worker compensation claims.⁴¹ The U.S. Department of Labor found another sham union called the International Workers' Guild (IWG), which left 3600 people in 32 states with approximately \$25 million in claims.⁴² State regulators believe that major impediments to effective state regulation include operators of scams using ERISA as shield to avoid state regulation and exploiting preemption ambiguities under ERISA.⁴³

The next section discusses implications for policymakers and examines one federal proposal recently endorsed by President Bush.

PART III: POLICY IMPLICATIONS

The recent influx in health insurance scams sold through associations presents significant challenges for policymakers to address. One way to eliminate fraud is to provide universal access to affordable health coverage and thus eliminate the demand.

Absent comprehensive reforms, policymakers should improve oversight

and clarify current state and federal regulatory authority. Further research is needed to evaluate the efficacy of state and federal regulation. Identifying differences among state enforcement and the federal government's approach will help inform public policy about most effective strategies to address fraud. Generally, new enforcement tools, stronger civil and criminal sanctions, and additional resources would help improve oversight. At a crucial time when incidents of fraud are on the rise, declining state and federal budgets and new priorities reflect-

The recent influx in health insurance scams sold through associations presents significant challenges for policymakers to address

ing domestic security concerns may result in fewer enforcement actions.⁴⁴

Instead of addressing the current crisis, some members of the U.S. Congress are considering federalizing the regulation of association plans by eliminating state authority to regulate such arrangements. A bill, which was added to the House-passed Patients Bill of Rights (H.R. 2563), would preempt state regulation of association health plans. President George W. Bush has actively promoted proposals to federalize association health plans.⁴⁵

Similar bills have been introduced over the past twelve years but have been strongly opposed by prior administrations. David Ball, Assistant Secretary of Labor appointed by President George Bush, told the U.S. Senate in 1990, "In concept, MEWAs would appear to fill an important void in health-care availability. In practice, they may be subject to abuse. This is because they may have inadequate reserves, and therefore, be unable to pay claims. In the worse situation they may be run by individuals who bleed them dry through extraordinarily high fees and outright embezzlement."⁴⁶ Seven years later, Olena Berg, Assistant Secretary of Labor appointed by President Bill Clinton, told the U.S. Sen-

ate Labor and Human Resources Committee, "While MEWAs may offer economy of scale advantages, their operation is often marred by entrepreneurs who market and operate them as Ponzi schemes. These operators unscrupulously promise health benefits, collect premiums from the employers for health coverage and then default on their obligations, leaving participants with thousands of dollars in unpaid claims."⁴⁷

H.R. 2563 would federalize the regulation of association health plans by eliminating state authority and state-based consumer protections from applying to such plans.⁴⁸ Additionally, the bill's preemption provisions create new ambiguity under ERISA. For example, the bill would preempt state laws that "may preclude" or merely have the "effect of precluding" entities from selling to a federally licensed association.⁴⁹ Under this vague standard, it is difficult to determine which state laws are preempted. As discussed earlier, ERISA ambiguities help criminals avoid state regulation, resulting in small businesses and their workers being defrauded.

The bill does not provide the U.S. Department of Labor with new enforcement tools to strengthen its regulatory authority. To enforce the standards in the bill, the U.S. Department of Labor has to go to federal court.⁵⁰ And as discussed earlier, it is difficult to shut down a scam expeditiously when going to federal court.

Furthermore, it is unclear whether Congress will appropriate necessary additional resources to enable the U.S. Department of Labor to enforce the new standards. In 1997, in evaluating a similar federal bill, the Assistant Secretary of Labor Olena Berg told Congress that given its resources and the scope of its regulatory responsibilities, the Department could review each health plan under its jurisdiction once in 300 years. She said, "An infrastructure adequate to handle the new responsibilities (under a similar bill), replicating the functions of 50 state insurance commissioners, simply does not exist."⁵¹ Recently, the GAO criticized the Department's ability to regulate stating, "The operational weaknesses and broader management issues

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... could affect its ability to effectively and efficiently carry out its responsibilities for enforcing ERISA's employee benefit plan provisions."⁵² Yet some policymakers believe that the U.S. Department of Labor will effectively regulate association health plans.

With limited federal oversight, more fraud may occur. Instead of replacing comprehensive state-based laws with a weak federal law, Congress should look for ways to address the current crisis of health insurance scams sold through associations, which defraud small busi-

nesses and leave thousands of working Americans without health insurance and with millions of dollars in medical bills.

¹Judy Muller, *Insecure Insurance: Unmonitored MEWA Plans Stick Patients with Unpaid Bills*, ABC World News Tonight, Mar. 6, 2002, available at ABC News.com.

²Chao v. Graf, et al., CV-N-01-0698-DWH-RAM, at 6, 15-17 (D. Nev. Feb. 1, 2002) (court issued a preliminary injunction) (hereinafter Federal Court Order Employers Mutual). See also Complaint for ERISA Violations, U.S. Department of Labor, Chao v. Graf, Employers Mutual LLC, et al., CV-N-01-0698-DWH-RAM, at 8 (D. Nev. Dec. 13, 2001) (hereinafter Complaint Employers Mutual).

³Federal Court Order Employers Mutual at 6; Complaint Employers Mutual at 4. Official sources indicate that outstanding medical bills may be in the \$20 million range.

⁴See Congressional testimony on MEWA fraud by Gregory McDonald, Associate Director, Income Security Issues, U.S. General Accounting Office, Testimony before the Subcommittee on Retirement Income and Employment, Select Committee on Aging, House of Representatives, Sep. 17, 1991 (hereinafter GAO Testimony); Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration before the Senate Labor and Human Resources Committee, Oct. 1, 1997, at 9-11 (hereinafter Berg Testimony).

⁵Stephen Long and Susan Marquis, *Pooled Purchasing: Who Are the Players?*, HEALTH AFFAIRS, Jul./Aug. 1999, at 105, 107.

⁶A federal law called the Employee Retirement Income Security Act of 1974 (ERISA) defines MEWAs broadly to include employer purchasing coalitions, trade associations, or other group purchasing arrangements offering health coverage to two or more employers or self-employed individuals. ERISA § 3(40), 29 U.S.C. § 1002. Individuals who operate such arrangements no longer use the "MEWA" label because of the large number of MEWA insolvencies and fraud since ERISA was enacted.

⁷Berg Testimony at 9-11. For a discussion of civil and criminal MEWA fraud cases handled by the U.S. Department of Labor, see U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, EMPLOYEE RETIREMENT INCOME SECURITY ACT REPORT TO CONGRESS FOR YEARS 1994 - 1999 (hereinafter U.S. Department of Labor Reports to Congress).

⁸Telephone discussion with Fred Nepple, General Counsel for the Wisconsin Insurance Department, Chairperson of the NAIC ERISA Working Group (and a leading expert on association health plans and MEWAs) (Apr. 24, 2002).

⁹Aissatou Sidime, *Health Insurance Rip-offs Rising*, SAN ANTONIO EXPRESS-NEWS, Mar. 19, 2002, at 3E.

¹⁰Gallagher Wins on Appeal Against Phony Insurer, Florida Department of Insurance, Press Release, May 8, 2002; Gallagher Orders Sixth Unlicensed Health Insurer To Stop Operations in Florida, Florida Insurance Department, Press Release, May 14, 2002 (hereinafter Florida May 14, 2002 Press Release).

¹¹One state regulator reported referring 12 cases for administrative action within one week. The same regulator indicated that she has never seen as many health coverage scams as she is seeing currently.

Telephone discussion with Dalora Schafer, Director Life, Accident and Health Division, Oklahoma Insurance Department (Apr. 22, 2002).

¹²Telephone discussion with Ron Musser, Assistant Commissioner, Office of Financial Solvency, Louisiana Insurance Department (Apr. 5, 2002).

¹³Telephone discussion with Gloria Della, Public Information Officer, U.S. Department of Labor, Pension and Welfare Benefits Administration (Apr. 2002).

¹⁴Texas Petition for Temporary Restraining Order at 5, Texas v. American Benefit Plans et al., Cause No. GV200903 (Tx. D. Travis County Mar. 6, 2002) (hereinafter ABP Petition). ABP also allegedly sold coverage through the American Association of Agriculture, Forestry, and Fishing Workers; the American Association of Transportation, Communication, Electrical, Gas, and Sanitary Workers; the American Association of Wholesale Trade Workers; the American Association of Manufacturer Workers; the American Association of Service Workers; the American Association of Construction Workers; and American Association of Professional Workers. *Id.* at 6-7.

¹⁵Telephone discussion with Jon Nogaredo, Assistant to Robert Loiseau, court appointed Special Deputy Receiver of American Benefit Plans (Apr. 4, 2002); Discussion with Dorien M. Rawlinson, Health Policy and Research Analyst, Colorado Division of Insurance (Apr. 5, 2002).

¹⁶Federal Court Order Employers Mutual at 2-3. Its operators even sold coverage to the National Writers Union whose membership includes freelance journalists.

¹⁷Operators of Employers Mutual charged below market rates. Complaint Employers Mutual at 8.

¹⁸Telephone discussion with Stephanie Goldberg, consumer covered by Employers Mutual LLC (Mar. 6, 2002).

¹⁹U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, EMPLOYEE RETIREMENT INCOME SECURITY ACT 1998 REPORT TO CONGRESS 14 (hereinafter 1998 Report to Congress).

²⁰A federal court sentenced Paul Pereira, its operator, to two years imprisonment for health care fraud and embezzlement. U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, EMPLOYEE RETIREMENT INCOME SECURITY ACT 1999 REPORT TO CONGRESS 15.

²¹Florida May 14, 2002 Press Release.

²²KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2001 ANNUAL SURVEY 14 (2001) (hereinafter Kaiser Survey).

²³U.S. GENERAL ACCOUNTING OFFICE, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40, at 2-3 (Mar. 10, 1992) (hereinafter 1992 GAO Report).

²⁴Kaiser Survey at 16.

²⁵Projected by Hewitt Health Value Initiative, HEWITT ASSOCIATES, *Annual Health Care Cost Increases National Averages* (2001).

²⁶California's public employees benefits program estimates a premium increase of between 20% and 25% next year. CALPERS, *2003 Health Plan and Premium Changes*, available at www.calpers.ca.gov (Apr. 17, 2002). A UCLA study estimates private premiums to increase by 20% in 2003. *Health Insurance: Premiums Expected to Rise 20% in 2003*, AMERICAN HEALTH LINE (Jun. 18, 2002).

²⁷Operators of the International Forum of Florida Health Benefit Trust defrauded 43,000 individuals and left \$29 million in unpaid medical bills. They pleaded guilty to embezzlements, kickbacks, and money laundering. In the plea agreement they agreed to pay \$34.5 million in restitution to the victims. Peter Kerr, *3 Plead Guilty in Insurance Fraud Case*, NEW YORK TIMES, Dec. 30, 1992, at D3.

²⁸1992 GAO Report 22.

²⁹David Randall, Deputy Director, Ohio Department of Insurance, Testimony of the State and Federal Health Insurance Legislative Policy (B) Task Force of the National Association of Insurance Commissioners Before the Committee on Labor and Human Resources of the United States Senate, July 25, 1995, at 9 (hereinafter NAIC Testimony).

³⁰ERISA § 514(a), 29 U.S.C. § 1144.

³¹ERISA § 101-110, 404-413, 29 U.S.C. § 1021-1030, 1104-1113.

³²U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT: A GUIDE TO FEDERAL AND STATE REGULATION I (1992) (hereinafter U.S. Department of Labor MEWA Guide).

³³Although there were no changes to Labor's jurisdictional authority, it now believes that it has broad authority to go after arrangements that are not ERISA covered plans when they handle ERISA plan assets, which occurs when employers covered by ERISA participate in the arrangement. U.S. Department of Labor MEWA Guide at 5.

³⁴ERISA § 3(40), 29 U.S.C. § 1002.

³⁵U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, AO 90-18A (1990) (letter to J.Scott Kyle, Texas State Board of Insurance).

³⁶NAIC Testimony at 9.

³⁷The registration requirement was enacted in 1996. Six years earlier, Labor Secretary Elizabeth Dole asked Congress for authority to require MEWAs to register with the Department. See 1992 GAO Report; David Horowitz, *Uncovered: Health Plan Fraud Leaves Workers in Lurch*, ST. LOUIS POST - DISPATCH, Aug. 21, 1990, at 6D (hereinafter Horowitz Article). In addition to these requirements, federal HIPAA portability and access rules amended ERISA and therefore apply to MEWAs.

³⁸For example, Colorado's Insurance Department issued an ex parte emergency order against American Benefit Plans, ordering its operators "to cease and desist the unauthorized and unlawful transaction of the business of insurance in the state of Colorado." Case File No. 130120, Order No. 0-02-144 (Feb. 13, 2002).

³⁹Operators of American Benefit Plans challenged Texas Insurance Department's authority by removing the case to federal court. See Texas v. Robert David Neal, et al., Case No. A-02-CA-220-SS, at 4-5 (W.D. Tx. May 22, 2002) (remanded to state court); Texas v. American Benefit Plans et al., Cause No. GV200903, at 7 (Tx. D. Travis County May 28, 2002) (ordered permanent injunction).

⁴⁰In 1991, the GAO told Congress that the U.S. Department of Labor needs to issue regulations clarifying union status. 1992 GAO Report at 9. To this date, there are no final regulations although the Department issued proposed regulations in 2000.

⁴¹Multiple Employer Welfare Officials Sued for Siphoning \$2.3 Million in Plan Funds, U.S. Department of Labor, Pension and Welfare Benefits Administration, Press Release, Aug. 5, 1996.

⁴²1998 Report to Congress at 8. See also Court Grants Preliminary Injunction, Continuing Freeze of Assets of Trustees and Administrator of New York-based Health Program, U.S. Department of Labor, Pension and Welfare Benefits Administration, Press Release, Dec. 29, 1998.

⁴³GAO Testimony 3-4.

⁴⁴For a discussion of state budgets and priorities see John Engler, Michigan Governor, Testimony of the National Governors Association before the Senate Appropriations Committee on Homeland Security Funding, Apr. 10, 2002. The Congressional Budget Office underestimated revenues for 2002 by \$80 billion. CBO, MONTHLY BUDGET REVIEW (Jun. 14, 2002). President Bush described the FY2003 budget submitted to Congress as placing "highest priority on war against terrorism overseas and at home." OFFICE OF MANAGEMENT AND BUDGET, BUDGET HIGHLIGHTS (Feb. 4, 2002).

⁴⁵WHITE HOUSE PRESS OFFICE, *Transcript: Bush Remarks on Health Care Reform*, Feb. 11, 2002; Elisabeth Bumiller, *Bush Proposes Insurance Plan to Businesswomen*, NEW YORK TIMES, Mar. 20, 2002, at A20; NEW YORK TIMES, *The 2000 Campaign: 2nd Presidential Debate Between Gov. Bush and Vice President Gore*, Oct. 12, 2000, at A22.

⁴⁶Horowitz Article (Assistant Secretary of Labor's Testimony before the U.S. Senate Subcommittee on Investigations).

⁴⁷Berg Testimony at 10.

⁴⁸H.R. 2563 § 421(b) amends ERISA § 514.

⁴⁹*Id.*

⁵⁰H.R. 2563 § 424(b).

⁵¹Berg Testimony at 6.

⁵²U.S. GENERAL ACCOUNTING OFFICE, *Pension and Welfare Benefits Administration: Opportunities Exist for Improving Management of the Enforcement Program*, GAO-02-232, at 3 (Mar. 15, 2002).

Case Study: Lawyer Liability for Failing to Prevent Insider Looting of a Corporate Client

by Robert L. Brace, Esq.



We just finished trying a professional negligence action against the outside legal counsel of a defunct insurance company known as Meadowlark Insurance Company ("Meadowlark") which owed over \$4 million in unpaid insurance claims. The lawyer worked full time for Meadowlark for five years, earning approximately \$1 million in fees. An issue worth sharing was the lack of precedent directly on point as to the obligation of an outside corporate lawyer to report to regulators the criminal activity of insiders of a corporation when it should have been abundantly clear to the lawyer that: (i) the criminal activity was for the advantage and gain of the insiders to the detriment of Meadowlark, and (ii) there were no corporate fiduciaries in place at Meadowlark to report the observed criminal activity to – in other words, the corporation was being used by the insiders solely as a vehicle to commit fraud with no gain going to the corporation.

The plaintiff's liability argument against the lawyer was that given the facts as known by the lawyer, a reasonably prudent practitioner would have concluded that: (i) the constituents were looting the premiums paid to Meadowlark; (ii) the assets of Meadowlark set aside to pay claims of policyholders and third parties were bogus; (iii) the longer Meadowlark stayed in business, the more premiums would be looted by the insiders and the deeper Meadowlark's insolvency would ultimately be; (iv) there were no fiduciaries in place at Meadowlark for the lawyer to report the news of the existence of the defalcating constituents to; (v) Meadowlark's continued operation as an insurer

made no legitimate business senses; (vi) the lawyer had the obligation to the corporation to try to prevent further losses; and (vii) one avenue of recourse which would have worked for the lawyer was to report the information he knew to insurance regulators who would have immediately shut Meadowlark down.

To support our theory of an attorney's malpractice liability to his insolvent corporate client for failure to make loyal disclosure of wrongdoing to regulators, we cited a 1998 law review article on ethics by Professor George C. Harris entitled *Taking the Entity Theory Seriously; Lawyer Liability for Failure to Prevent Harm to Organizational Clients Through Disclosure of Constituent Wrongdoing* (herein also ("Harris Article"), 11 *Geo. J. Legal Ethics* 597 (1998)). Professor Harris' article has been cited by the American Law Institute's Restatement of the Law Third, The Law Governing Lawyers ("Restatement"). See Restatement of the Law Third, The Law Governing Lawyers 96,'s Note, com. F, at 43-44 (ALI 2001) (disclosure outside the organization appropriate where the wrongdoing is clear, the injury to the client organization is substantial, and the disclosure would clearly be in the interest of the entity client).

Professor Harris concluded that once an attorney knows or should have know (i) that constituents of an

insolvent corporation are engaged in fraud or other wrongdoing and (ii) that the wrongdoing will create significant harm to the corporation (whether through liability to third parties or otherwise), the same duty to preserve the client's assets by disclosing the wrongdoing to the appropriate governmental authorities attaches to the attorney for the organizational client as to an attorney representing an incompetent ward who discovers that the ward's guardian is engaged in illegal conduct to the detriment of the ward. Harris Article, at 637-638.

The legal basis for the analogy is sound. It is beyond debate that an attorney may be liable for failing to make the necessary protective disclosures when his client is the injured ward. Harris Article, at n. 156. In addition, even where the guardian is the attorney's client, it has been held that an attorney has a duty to the ward to prevent foreseeable harm from the guardian and may be liable for failing to do so. *Id.*, citing *Fickett v. Superior Court of Pima County*, 558 P.2d 988 (Ariz. Ct., App. 1976) (holding that attorney for guardian was negligent to failing to discover and disclose that guardian had embarked on scheme of misappropriation, conversion, and improper investment); see also *Charleson v. Hardesty*, 839 P.2d 1303, 1306-07 (Nev. 1992) ("When an attorney represents a trustee in his or her capacity as trustee, that attorney assumes a duty of care and fiduciary duties toward the beneficiaries as a matter of law."); *In re Fraser*, 523 P.2d 921, 928 (Wash. 1974) (holding that because "attorney owed a duty to the ward, as well as to the guardian," attorney

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was justified in not turning assets over to a guardian who “manifested a greater interest in obtaining money for herself than in serving the interest of the ward”) (overruled on separate issue, 1999); Ronald C. Link, *Developments Regarding the Professional Responsibility of the Estate Administration Lawyer; The Effect of the Model Rules of Professional Conduct*, 26 Real Prop. Prob. & Tr. J. 1, 78 (1991) (“In representing a dishonest fiduciary, the attorney not only must maintain loyalty to the beneficiaries but also must be truthful to the probate court regarding the fiduciary’s actions... The correct response of the attorney is usually disclosure when the fiduciary’s action is fraudulent or criminal”).

In our case, full disclosure by the lawyer to state insurance regulators about Meadowlark’s failure to comply with legal requirements and the clear indications of the insiders’ deceptive and illegal activities would plainly have been in the best interests of Meadowlark. As shown by our expert’s testimony, such disclosure would have been followed by the institution of a court-supervised receivership, the only effective way to stop the insiders’ looting and mitigate Meadowlark’s damages.

Liability under the above rule will rarely be imposed because the requisite factual scenario will seldom occur. In the vast majority of instances, lawyers will resign from representation when confronted with criminal activity or, they will be able to give notice of the nefarious activity to higher-ups at the corporation who will respond to protect the corporation. Professional malpractice liability will also not be

imposed in those instances when the corporation benefits from the criminality committed by its constituents. This is so because the knowledge of the agent’s wrongdoing is imputed to the corporate client eliminating any argument that the corporation relied to its detriment on the bad advice of counsel or his failure to intervene on the corporation’s behalf.

Professional malpractice liability

In the vast majority of instances, lawyers will resign from representation when confronted with criminal activity

for failing to disclose criminal conduct of the constituents of a corporation can only occur when the constituents are clearly using the corporation as a tool to commit fraud for their own benefit thereby eliminating any agency relationships and arguments about business judgment. In those rare instances, the lawyer who represents the corporation should be liable when he acquiesces in the constituents’ wrongdoing and the wrongdoing injures the corporation.

In our case, the trial court concluded that: (i) the lawyer knew that Meadowlark’s insiders were attempting to deceive state insurance regulators, (ii) lawyers knew that Meadowlark’s financial statements regarding assets available to pay claims were false, and (iii) that the lawyer had sufficient cause to believe that the insiders “were operating Meadowlark in their own interests and not those of Meadowlark or its policyholders and third parties.” The

trial court went on to conclude, however, that before the attorney must report criminal activity to an outside agency, there must be proof that the attorney had actual knowledge that the constituents were operating the business as a criminal enterprise, and that their operation would likely result in Meadowlark’s destruction. The court awarded the disgorgement of close to \$1 million in fees, but did not impose liability on the lawyer for the \$4 million in Meadowlark’s unpaid insurance claims. We have filed a motion to amend the judgment and will file an appeal on the legal issue of the required competency of the lawyer. It is plaintiff’s contention that proof of facts showing that the lawyer knew or should have known that the constituents were operating a criminal enterprise was sufficient. Requiring proof of actual knowledge only rewards severely incompetent or crooked lawyers.

Robert Brace is a partner at Hollister & Brace, a law firm located at 1126 Santa Barbara Street, P.O. Box 630, Santa Barbara, California 93102. For over nine years Mr. Brace has been actively involved in contingency fee representation of policyholders and liquidators of failed insurance companies. To date his firm as collected over \$25,000,000 in settlements from various insurance producers, brokerage houses, banks, attorneys and accountants to pay, on a pro rata basis, the unpaid claims owed by the insolvent insurers. Documents and pleadings relevant to the above article are available upon request at (805) 963-6711 or by e-mail at rlbrace@hbsb.com.

Insurance Exit Strategies

by Robert Loiseau, CIR – P&C

Editor's Note: IAIR Member Bob Loiseau recently attended a Business Forum on Solutions for Discontinued Insurance Operations Including Reinsurance, Sale, Runoff and Solvent Schemes presented by the American Conference Institute in New York City. The Publications Committee asked him to report on this meeting, given its topicality for IAIR's members.

Introduction

As an insurance receiver attending a conference populated by industry and regulator representatives, it was interesting, (eye-opening, in fact) to hear so many non-receivership perspectives on dealing with long term problems presented by a distressed market segment or book of business. The faculty included regulators Greg Serio, Superintendent of the New York State Insurance Department, Betty Patterson, Senior Associate Commissioner of the Texas Department of Insurance and Doug Hertlein, Chief Deputy Liquidator of the Ohio Insurance Liquidation Office. Industry representatives included executives from Berkshire Hathaway, Swiss Re and CAN, and consulting firms such as Chilington International, Inc. and TAWA Associates. Professionals from Tillinghast, KPMG, Grant Thornton and Standard & Poors also made presentations. IAIR members included Jonathan Bank and Andrew Maneval who co-chaired the event, with Ipe Jacob, Doug Hertlein, James Veach and Karl Rubinstein among the faculty.

The Burgeoning Run-off Industry

Several common themes emerged about which the speakers were unanimous in their views. First is the enormity of the runoff industry globally. The dollar volume of runoff portfolios presently exceeds \$300 billion, making runoffs perhaps the fastest growing area of the insurance industry as a whole. The second principal theme is the quest for finality which is hard to achieve absent outright sale of a troubled company or

its liquidation under regulatory auspices. The third theme involved a running debate about who can best perform the services that a runoff or exit strategy requires: in-house workout departments or outside consultants. Finally, there was consensus among all speakers that the runoff industry is here to stay, and its practitioners provide highly specialized services that a wide variety of constituents require.

Why Exit Strategies are Pursued

A variety of factors motivate companies to seek exit strategies. Long term liabilities as such as asbestos and workers compensation are risks that companies want to escape. Other motivations include a corporation's desire to free up capital that is otherwise committed until the last claim is paid. Similarly, entities like holding companies sometimes find that through merger, acquisition or change in business strategy, they no longer have an appetite for involvement in the insurance industry or in a particular segment of it. With respect to large insurance companies, some have redefined their target markets and find that certain lines of business are no longer a good fit with their current business plan.

Once a decision to exit has been made, finding the way to the door often leads through a labyrinth of difficult decisions.

The Best Way Out

Needless to say, there are a myriad of exit choices available: runoff reinsurance, novation of policies by a different carrier, policy buy-backs, outright sale of the company and dissolution or liquidation are but a few of them. Each of these approaches has advantages and disadvantages which share a common denominator: Someone has to design and implement the strategy. Many major carriers created entire departments or subsidiaries whose sole function is to deal with the parents' "problem children" in terms of risks.

Outside consulting firms offer experience and skills which are significantly different from the operation of an on-going business, making them attractive to clients who lack well-developed internal capabilities. In some instances, a consultant may be engaged to devise a workout plan which the client company's existing staff then executes. Another exit path involves actions by regulators. In the UK, schemes of arrangement, whether solvent or insolvent, are favored, while in the United States, supervision, conservation and receivership are the weapons of choice for regulators once they have identified a problem company that needs to be nudged (or bludgeoned) into action.

Any exit strategy necessarily involves regulatory input or approval. But it also involves difficult decisions by senior management of the company which in turn can trigger shareholder repercussions. The mere announcement of an exit strategy or run-off plan can make ratings agencies nervous about a company's financial standing and even lead to ratings downgrades with all the negatives they entail. Even announcing a sound business decision to exit a geographic area or market segment or to run-off a line of business triggers heightened scrutiny and a measure of risk to the company making the disclosure.

Which Way to the Exit?

After making the agonizing decision to embark on a run-off plan or exit strategy, the next difficult decision a company faces is whether an outsourcing or do-it-yourself approach should be adopted. Since the attendees at this conference were primarily industry executives and consultants seeking business opportunities, it was not surprising to see sharp differences of opinion on which approach is favored. An entire article could be written on the pros and cons of each approach, so the benefits articulated by each group are

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highlighted rather than detailed below.

Internal Management of Run-Off

BENEFITS:

1. Best protection of corporate/industry relationships.
2. Greatest knowledge as to how contracts worked, business practices, etc.
3. Maximum leverages obtained from other useful relationships:
 - Ceded and assumed balances
 - Dealings with brokers/intermediaries
 - Actual or potential ongoing relationships with affiliated companies
 - Offsets and cash management
 - Knowledge and experience regarding leverage points
4. Confidentiality
5. Preserving access, in-house, to historical information and documents
6. Ability to retain quality staff for future operations
7. Better utilize opportunities for asset-liability matching in investment decisions
8. More effective expense management, less expensive
9. Record management

DANGERS:

1. Work performed with a "preserve your job" mentality.
2. Distractions from attention to company's ongoing operations.
3. Biased perspective on subject business.
4. Insufficient in-house expertise.
5. Vulnerability to unpredictable loss of staff.
6. Difficulties of investing in infrastructure for run-off operations.
7. Staff "morale" issues.
8. Danger of antagonisms from "old years" adversely affecting ongoing business.

External Management of Run-off

BENEFITS:

1. Ability to obtain the right expertise for the purposes needed.
2. Freeing up management and staff for ongoing operations.
3. Avoid complications of run-off activities impacting ongoing business relationships.
4. Fully motivated staff.
5. Valuable knowledge and experience

gained in other similar matters.

6. Possible gains in leverage with other run-offs.

7. "Run-off economies of scale".

8. Possible enhanced negotiating positions for settling inward liabilities.

DANGERS:

1. Lessened control over day-to-day activities.
2. Higher costs.
3. New systems and data entry requirements.
4. Loss of valuable in-house staff.
5. Possible impediment to resolving disputes.
6. Issues of conflicts and priority problems with other clients.
7. Harm to reputation/relationships through "outsourcing".

The British are Coming!

Schemes of arrangement, which our UK colleagues have long advocated as being superior to the American practice of receivership proceedings, are analogous to Chapter 11 reorganizations under the United States Bankruptcy Code. They require majority approval by creditors because they alter contractual benefits affecting those creditors; they also facilitate earlier payments of dividends to them. They achieve certainty and finality in terms of an exit, and they can apply to both solvent or insolvent carriers. By using claims estimation (commonly called a cut-off scheme) all policyholders' rights are determined and paid-fully or partially - depending on whether a solvent or insolvent scheme is utilized. Other common elements are the establishment of classes of creditors, the need for court approval and meetings of creditors to vote on approval of the scheme, followed by implementation of the scheme under court supervision.

So what does this have to do with the British? They have established a beachhead in Rhode Island of all places! Through that state's Voluntary Restructuring of Solvent Insurers Act, Rhode Island seeks to attract insurers who want to engage in an "Americanized" scheme of arrangement. Rhode Island's statute only addresses solvent runoffs and is modeled closely on UK schemes of arrangement. It requires a company

to redomesticate to Rhode Island for regulatory purposes, and like its British counterpart, involves court approval of the insurers' restructuring plan that is binding on objecting parties (so long as they are in the minority) and applies only to commercial lines of business. Interestingly, estimation of claims is specifically authorized by statute but is not binding on reinsurers. According to the sponsors of this legislation, it was motivated partly because of the perceived inefficiency of the United States liquidation system in comparison to its UK counterpart. It is also intended to stimulate economic development within Rhode Island by requiring redomestication and the hiring of that state's residents and professionals to implement the restructuring plans. Receivers might be well served by following the success and effectiveness of this statute, because if it produces the desired results, the logical extension would be to enact similar legislation for insolvent restructuring plans which could dramatically alter the receivership industry.

Conclusion

The rapid growth and considerable size of run-off portfolios throughout the world make this industry noteworthy. Regulators clearly favor any viable alternative to receivership, and only a few of the many alternatives available could be touched upon within this report. The caliber and diversity of the faculty and their written materials made this seminar worth the price of admission, and the heavy turnout prompted its sponsor, American Conference Institute www.americanconference.com, to consider presenting a related program in New York City this November. Those of you who attended this one, or who might attend the November program, will probably agree there is great value in learning about the tools utilized by parties wanting to solve major insurance problems in a manner that obviates the need for receiverships. Finally, the writer gratefully acknowledges the sponsor's many courtesies including permission to draw from the written course materials in preparing this article.

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 - James Guillot (LA);
 Mid-Atlantic Zone - Joe Holloway (NC)
 Western Zone - Mark Tharp, CIR (AZ); Bob Loiseau, CIR (TX)
 International - Jane Dishman (England); John Milligan-Whyte (Bermuda)



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

Mark Tharp (AZ) reported that on August 30, 2001 following a bench trial, the Arizona Superior Court, Maricopa County, assessed liability against the former actuaries of AMS Life Insurance Company in the principal amount of \$17.5 million dollars plus sanctions, costs and pre-judgment interest of \$1,537,450 for a total judgment of \$19,037,450.

Further, the Receiver closed on the sale of Farm and Home Life Insurance Company's holdings in a complex failed real estate development realizing net proceeds of \$7,516,031. As a result of litigation settlements recoveries from former officers, directors and professionals approaching \$94 million, as well as the sale of estate assets including the property referenced above,

the Arizona Life and Disability Insurance Guaranty Fund (ALDIGF) will receive a one hundred percent distribution on their total claim of \$106,091,479 and policyholders with excess claims totaling \$13,537,443 not covered by the ALDIGF will receive a pro-rata distribution on their claims of approximately 80%.

Proof of Claim recommendations on Premier Healthcare of Arizona were filed with the Court in September 2001 totaling \$56.9 million. A formal objection process is in effect wherein claimants were afforded the opportunity to object to the proof of claim recommendations. The Court will hear and consider these objections the latter part of 2002.

Subsequent to the entry of the Receivership Order on March 14, 2002 for Reliance Insurance Company, the

Ancillary Receiver has marshaled assets held in the form of statutory deposits for the benefit of Arizona policyholders and claimants in the approximate amount of \$23,030,500. The Ancillary Receiver is working closely with the State Compensation Fund to coordinate payment of Arizona workers compensation claimants affected by the Receivership.

The Receiver for Diamond Benefits Life Insurance Company finalized the sale of its holdings in the Heritage Ranch properties consisting of approximately 5,000 acres located in San Luis Obispo, California on April 3, 2002, resulting in proceeds of approximately \$6 million for future distribution to creditors of the estate.

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Receivers' Achievement Reports By State

(Continued from page 19)

Arizona (Mark Tharp, State Contact Person)

New Estates Opened	Date of Order	Type of Order	Primary Line of Business
Reliance Ins. Co.	3/14/2002	Liquidation - Ancillary	Property & Casualty Workers Comp.
Distributions	Estate	Amount	Type of Distribution
Guaranty Funds	AMS Life Ins. Co.	6,000,137.00	Early Access

Illinois (Mike Rauwolf, State Contact Person)

New Estates Opened	Date of Order	Type of Order	Primary Line of Business
Gallent Ins. Co.	2/25/2002	Conservation	P & C
Valor Ins. Co.	2/25/2002	Conservation	P & C

Distributions

Estate	Loss and Loss Adjustment Expense	Early Access Distribution	Return Premium	Reinsurance Payments
Alliance General Ins. Co	456	0	0	0
AMRECO	0	0	0	6,921,136
American Healthcare	0	1,158,433	0	0
Coronet	30	0	0	0
Illinois Earth Care Workers Comp	3,911	0	0	0
Illinois Environmental Services	810	0	0	0
Illinois Insurance Co.	4,875	0	0	0
Inland American Ins. Co.	170	0	0	0
InterAmerican Ins. Co.	10,245,186	2,907,561	0	0
Merit Casualty Co.	8,240	0	0	0

Significant Recoveries

Estate	Amount of Recovery	Type of Recovery
Alliance General Ins. Co.	17	Reinsurance
American Mutual Reinsurance Co.	1,623,072	Reinsurance
Centaur Insurance Co.	71,677	Reinsurance
Delta Casualty Co.	5,115	Reinsurance
Equity General Ins. Co.	20,000	Reinsurance
First Oakbrook Corp. Syndicate	1,385,866	Reinsurance
InterAmerican Ins. Co. of IL	170,271	Reinsurance
Pine Top Insurance Company	2,253,810	Reinsurance
United Capitol Ins. Co.	552,045	Reinsurance

Texas (State Contact Person?)

New Estates Opened	Date of Order	Type of Order	Primary Line of Business
American Benefit Plans, et.al.	3/6/2002	Receivership	Healthcare

Distributions

Estate

NAIC Summer National Meeting

June, 2002

Philadelphia

by Mary Cannon Veed and Jessica Kovrov

The NAIC Summer meeting in Philadelphia suffered from hot and sticky weather but benefitted from a great location. As a few people may have noticed, I didn't attend Philadelphia. Most of the following comes from my colleague, Jessica Kovrov, and I greatly appreciate her help. She reports that it really was possible to find an excellent Philly steak sandwich there, and that the Liberty Bell looks just like its picture. The intemperate comments in the following, are, as usual, all mine!

Gramm-Leach-Bliley, Privacy, and Modernization

The intertwined subjects of GLB, privacy and regulatory modernization continued to fascinate the meeting. There has been significant progress in efforts to modernize the business of rate and form filings and agent licensing. At last report, 44 states were using SERFF. Now, all states, and the District of Columbia are doing so, as are 509 companies. In addition, all states have implemented rate and form filing checklists and review standards. These can be conveniently accessed via the NAIC Website. Forty-four states have adopted laws that satisfy GLB reciprocity licensing mandates, and forty-nine have adopted privacy protections that meet GLB standards.

The privacy issues that followed on GLB's wake remain on the front burner. The Privacy Issues Working Group, which recently celebrated its second birthday, is charged with addressing issues that arise as states enact and enforce privacy protections, and with working toward uniformity, or at least consistency, among the states. At this point, with all states having laws on the books, the Working Group is increasingly focused on uniformity.



The higher than anticipated degree of opt-out from privacy disclosures has been the cause of some concern. One approach to combating consumer indifference is a "plain language" privacy notice. The Privacy Notice Subgroup is charged with working with interested parties in drafting such language. Along the same lines is an effort to cut down on redundant notices. The idea is that if consumers receive fewer notices, they will be more likely to read the ones they do receive. As things currently stand, a consumer who doesn't opt out, might receive several privacy notices regarding the same transaction, all of which remain unread. With the thought of reducing notice-overload, the Privacy Issues Working Group has approved language that would, in many instances, eliminate the need for an agent to provide a notice if the targeted consumer will receive the same notice from the principal. From a legal perspective, the issue is - when does an agent cease being an agent. For example, when the policy is up, and the agent shops around on behalf of the consumer, the consumer is the client of the agent, and therefore, the agent will again have notice requirements.

In the HIPAA realm, the Privacy Regulation drafting is drawing to a close. Under the final regulation, covered entities must obtain authorization from the individual for the use and disclosure of PHI, (personal health information) except for treatment, payment, health

care operations, or specified exceptions. Among the concerns in June were distinguishing those activities from marketing activities that trigger privacy rules. HHS has proposed various modifications to the Final HIPAA Privacy Regulation (which applies to electronic, paper and oral communications). One change redefines "marketing" as a "communication about a product on service with the intent to encourage its purchase or use". The proposal eliminates the always-problematic word "intent". As a practical matter, it may still be easier to say what marketing is not than what it is. "Marketing," as the NAIC sees it, does not include identifying or describing providers or a network or available services, providing information as part of a treatment plan, even if the information recommends particular name brands, sending reminder notices for appointments and providing information like advising a smoker about smoking cessation workshops, or a pregnant woman about a birth class, whether or not the provider itself participates in the workshop or birth class.

Even in marketing, authorization for the use of PHI is not required by the HIPAA draft when the marketing 1) occurs face to face; 2) concerns products of only nominal value, or 3) concerns services or products of the covered entity or a third party, the covered entity or third party and its remuneration are identified, and the individual is allowed to opt-out. The period to submit written comments ended June 30, and the working group planned to thrash out the results by conference call.

Another Interstate Compact?

Undeterred by the snags encountered by the Receivership Compact, the NAIC held public hearings

on the concept of using a compact model to handle rate and form filings, especially for life insurance products. 22 states are already participating in CARFRA, which amounts to an opt-out approach to the same target and suggests that a statutory protocol would work well. Unfortunately, there is a great gulf between a day-to-day willingness to use centralized procedures most of the time, and selling the Legislature that the state's sovereignty in this area should be abandoned. Practitioners know that much of that "sovereignty" is an illusion; if an approach is working in 49 other states, you need a darned good reason to be the holdout. But that fact hasn't kept the other Compact moving ahead...

For some reason, the life insurance industry is vastly more supportive of this thing (and more offended by the nuttiness of 50-state filing) than are the P/C and health industries. The usual mantra is that life insurance is more standardized, but the truth is that contention is circular: life insurance products are parallel because the industry wants them to be that way. But why don't the other guys? Anyway, the question is where to slot in Long Term Care insurance, which is sold by both sorts of companies. The life industry proposed including LTC in the Compact; consumers, or at least the official consumer representatives, being deeply suspicious of anything that makes life easier for an insurance company and apparently uninterested in the cost savings and competitiveness issues, don't like the Compact in the first place and really don't want it to apply to LTC. Given that the real problem is getting something put together that will take care of the easy cases, this may be an unfortunate diversion of attention.

A New Model Law

One of the interesting interfaces between insurance and ERISA has been fermenting in the area of "discretionary" health insurance clauses. ERISA provides, in a provision meant to offer lawsuit protection to employer trustees, that the benefit determinations of a plan that gave discretionary authority to the trustee are darned near untouchable. But if the plan trustee provides benefits by buying insurance, then the insurer's coverage determinations can be challenged to the same extent as usual. Taking the obvious next step, health insurers who were serving as fiduciaries anyway have been writing discretionary authority into their policies so they got the same protection as a self-funded employer did. Unfortunately, that looks, to the NAIC, suspiciously like illusory insurance – insurance that pays when the insurer feels like it and not otherwise – and they're right. A new Model Act has just been approved rejecting such clauses in insurance products. Which leaves behind the question – why is it OK for employers to offer benefits programs that pay when the employer feels like it, and did Congress really mean to say that? (A significant amount of litigation has arisen in this area, driven by claimants who thought it didn't. So far the courts are saying that Congress apparently meant what it said. Any further statement from Capitol Hill is stuck in the whole Health Care Bill of Rights morass. In the meantime, have we just created a competitive disadvantage for insurers vs. self-funded programs?)

Terrorism Exclusions

Terrorism had almost as strong a

presence at the June meeting as privacy did. The sense of urgency surrounding terrorism exclusions probably will not abate until/unless Congress acts. Because, 9 months after September 11th, Congress has still not passed a bill that adequately addresses insurers' concerns on this issue, the NAIC agreed to recommend states' granting conditional approval of terrorism exclusion for commercial lines endorsements. Such exclusions would be automatically withdrawn 15 business days after the enactment of a federal law addressing terrorism.

The NAIC and ISO (Insurance Service office) have worked out a mutually agreeable wording. P&C insurers will be allowed to exclude terrorism losses on commercial lines that exceed \$25 million in the aggregate within a 72 hour period. The exclusion may not be applied, however, to personal lines. The Limit will not apply if the terrorist act is made by a nuclear reaction, or biological or chemical warfare; these tend to be limited already by existing language. ISO has indicated that it will permit any insurer, whether or not it is a licensee of ISO policy funds, to use its copyright exclusion language.

Insolvency Task Force

The Insolvency Task Force's Receivership Model Act Revision Working Group reported that its subgroups were making progress, and may have a consolidated draft by New Orleans. One recurrent issue remains the priority of distribution of guaranty funds' administrative expenses. No doubt a few more will surface!

In New Orleans we will at least enjoy the unique sensation of meeting on company time instead of the weekend. See you there!

London Market Documentation Requirements for Asbestos Claims: Reinsurance Contract Implications

by Thomas D. Cunningham



Beset by the rising tide of asbestos bodily injury claims, Equitas Ltd. and certain unidentified London insurers (collectively, the "London Market") promulgated new documentation and claim procedure requirements for asbestos bodily injury claims from policyholders (the "Direct Insurance Requirements"), effective June 1, 2001. A copy of the Direct Insurance Requirements can be found at Section D of Mealey's Litigation Reports: Reinsurance, Vol. 12, No. 1 (May 10, 2001).

Purporting to track the standard tort elements of injury and causation, the Direct Insurance Requirements establish stringent requirements which must be met before the London Market will reimburse asbestos-related bodily injury claims. For instance, the Direct Insurance Requirements call for a specific medical diagnosis that the claimant suffers from a disease "caused in substantial part by exposure to asbestos" and sufficient evidence (including a sworn or verified statement) that the claimant was exposed to an asbestos-containing product of the insured. In addition, all asbestos bodily injury claims submitted for reimbursement (or to exhaust underlying coverages) must be accompanied by a certification under oath that the claims meet the Direct Insurance Requirements.

One obvious target of the Direct Insurance Requirements is the practice of bulk or "inventory" settlement of asbestos claims, where individual claimant information is rarely obtained: "[i]nventory settlements -- accounting for the majority of asbestos-related losses paid by the London market to date -- have created abuses in which people reportedly exposed to asbestos but with no actual injury are being paid along with legitimate claimants, according to Glenn

Brace, head of asbestos, pollution and health hazard claims at Equitas."

The Direct Insurance Requirements suggest a sea change in the London Market's approach to asbestos claims. One press report stated that "[w]hen asked why Equitas had not imposed such requirements before, Mr. Scott Moser, claims director at Equitas, said that there previously was a belief that if asbestos claims were settled with 'swift small payment' the problem would disappear and costly court battles could be avoided. But because of the significant increase in the number of claims in the past few years, that theory has been abandoned."

Following introduction of the Direct Insurance Requirements, the London Market announced that it would also promulgate requirements to apply to reinsurance loss cessions resulting from payment of asbestos bodily injury claims. These requirements (the "Reinsurance Requirements") took effect on November 1, 2001, and essentially mirror the Direct Insurance Requirements. Thus, the London Market has announced that insurers ceding asbestos bodily injury losses must show that they have "sufficient" documentation showing that the underlying claimant suffered from a disease caused in substantial part by exposure to asbestos and "sufficient" evidence (including a sworn or verified statement) that the claimant was exposed to an asbestos-

containing product of the underlying insured. As with the Direct Insurance Requirements, the Reinsurance Requirements apply to the actual claims paid, as well as to each claim asserted to exhaust underlying limits, retentions, and deductibles. In addition, insurers ceding asbestos bodily injury losses must supply a list setting forth minimum information for each individual asbestos claim (including claimant's name, jurisdiction, exposure dates, and amount of indemnity and expense paid), along with a certification that the cession and the supporting documentation meet the Reinsurance Requirements.

Whether the Direct Insurance Requirements are an appropriate response to the asbestos problem is a subject worthy of debate. This article, however, addresses the reinsurance contract issues implications of the Reinsurance Requirements. More specifically, if London Market reinsurers deny an asbestos loss cession from a U.S. cedent based on an alleged failure to comply with the Reinsurance Requirements and the cedent brings an action to recover, who will prevail?

Any actual dispute would turn on the particular reinsurance contract language at issue, precisely how the cedent allegedly failed to meet the Reinsurance Requirements, and how the parties had operated under the contract over the years. This article addresses the subject in more general terms, highlighting the contractual and legal issues that are likely to arise in such a dispute.

Typical Reinsurance Contract Provisions Implicated

Enforcement of the Reinsurance Requirements would implicate several standard reinsurance contract provisions.

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London Market Documentation Requirements

Exactly what a cedent must provide when presenting a loss cession to the reinsurer is a proof of loss issue. A reinsurer's claim that a cedent did not have "sufficient" documentation to pay an asbestos loss under its policy to the insured raises a follow the settlements issue. The very concept of a reinsurer explaining to the cedent how underlying asbestos claims should be handled calls to mind claims association or control provisions. Typical reinsurance contract language on these subjects follows:

1. Proof of Loss/Follow the Settlements

The Reinsurer agrees to abide by the loss settlements of the Company, such settlements to be considered as satisfactory proof of loss, and amounts falling to the share of the Reinsurer shall be immediately payable to the Company upon reasonable evidence of the amount paid by the Company being presented.

2. "Sole Judge" of Loss and Amount of Payment

The Company shall be the sole judge as to what constitutes a claim for loss covered under its policies and the kind or type of loss thereon and the Company's liability thereunder, and as to the amount or amounts which it shall be proper for the Company to pay thereunder. The Reinsurer shall be bound by the judgment of the Company as to the liability and obligations of the Company under its policies.

3. Claims Association

When so requested, the Company will afford the Reinsurer an opportunity to be associated with the Company, at the expense of the Reinsurer, in the defense of any claim, suit or proceeding involving this reinsurance, and the Company and the Reinsurer shall cooperate in every respect in the defense of such claim, suit or proceeding.

If the reinsurance contract at issue included Paragraphs 1 and 2 above, a reinsurer would face an uphill battle in denying a cession for failing to meet the Reinsurance Requirements. These

provisions, which minimize the proof of loss obligation and vest the cedent with control over underlying claims decisions, cannot be squared with any new requirement to provide a list of particulars respecting every individual asbestos claim comprising a settlement, much less a sworn certification. As for proof of injury and causation, Paragraphs 1 and 2 grant the cedent the right to make such determinations, with the reinsurer bound to follow. The Reinsurance Requirements would turn these provisions on their head: the reinsurer decrees what is appropriate in the direct claims context, and the cedent is bound to follow.

If the reinsurance contract contains a claims association right, perhaps the Reinsurance Requirements qualify as an exercise thereof. At least under Paragraph 3 above, however, the reinsurer's option under the clause is to become involved in the handling of an underlying claim, suit or proceeding. The Reinsurance Requirements do not contemplate such direct involvement. Rather, they impose burdens on the cedent respecting its claims decisions.

In fact, the Reinsurance Requirements substitute the judgment of the reinsurer for that of the ceding company with respect to coverage and settlement of asbestos bodily injury claims. A reinsurer pursuing that proposition should look for something more muscular than a claims association right. A claims control or consent to settle clause is needed. Such clauses, however, are atypical; and reinsurers who invoke them assume a risk of incurring direct liability to the policyholder. To support enforcement of the Reinsurance Requirements, the London Market will likely need to venture beyond the reinsurance contract and into reinsurance case law and commentary.

Case Law and Commentary

Over the past 15 years, U.S. court have granted ceding companies a wide berth when making coverage and settlement decisions. Generally speaking, as long as the cedent had a reasonable basis for its settlement

decision and acted in good faith, the reinsurer is precluded from challenging ("second-guessing") that decision. See, e.g., *Travelers Casualty and Sur. Co. v. Certain Underwriters*, 760 N.E.2d 319 (N.Y. 2001); *American Bankers Ins. Co. v. Northwestern Nat'l Ins. Co.*, 198 F.3d 1332 (11th Cir. 1999); *North River Ins. Co. v. CIGNA Reinsurance Co.*, 52 F.3d 1194 (3d Cir. 1995); *International Surplus Lines Ins. Co. v. Certain Underwriters*, 868 F. Supp. 917, 920-21 (S.D. Ohio 1994). The doctrine applies even to a cedent's good faith decision to waive potential defenses against its policyholder. *Christiania Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268, 280 (2d Cir. 1992). A cedent has a reasonable basis for its settlement decision if the cedent's payment to its insured was "at least arguably within the scope of the insurance coverage that was reinsured." *Mentor Ins. Co. (U.K.) Ltd. v. Brannkasse*, 996 F.2d 506, 517 (2d Cir. 1993) (emp. added). Bad faith "requires an extraordinary showing of a disingenuous or dishonest failure to carry out a contract." *North River*, 52 F.3d at 1216.

This formulation of the follow the settlements doctrine would not support enforcement of the Reinsurance Requirements, which can be likened to obvious second-guessing of liability and damage determinations that are historically well within the cedent's purview. See, e.g., *Ins. Co. of State of New York v. Associated Manufacturers' Mut. Fire Ins. Co. of New York*, 74 N.Y.S. 1038, 1039 (N.Y. App. Div. 1902) ("In the absence, therefore, of fraud or bad faith on the part of the plaintiff [cedent], the defendant [reinsurer], by the terms of its policy, as well as by the construction placed upon it by the admission, is in no position to object to the mode of adjustment as made by the plaintiff"). Some formulations of the follow the settlements doctrine, however, arguably refer to the quality of the cedent's claims investigation; this may be the basis for the London Market's defense of the Reinsurance Requirements.

For example, that a cedent

investigate underlying claims in a "reasonable and businesslike" manner before the follow the settlements doctrine applies is a concept that originates in English case law and has been imported into certain U.S. decisions. See, e.g., *Hartford Acc. & Indem. Co. v. Columbia Casualty Co.*, 98 F. Supp. 2d 251, 258 (D. Conn. 2000): "Consequently, 'subject to the requirements of good faith and a reasonable, businesslike investigation, the ceding company may bind the reinsurer to follow its settlement fortunes when it concedes that a particular claim falls within the scope of coverage provided by the ceding company's policy'"; see also *American Marine Ins. Group v. Neputunia Ins. Co.*, 775 F. Supp. 703, 708 (S.D.N.Y. 1991); *Curiale v. DR Ins. Co.*, 593 N.Y.S. 2d 157, 165 (N.Y. Sup. Ct. 1992). These cases all cite English authority on this point.

Conceivably, the London Market may argue that the Reinsurance Requirements merely set forth what constitutes a "reasonable, businesslike investigation" with respect to asbestos bodily injury claims. But does the "reasonable, businesslike investigation" formulation mean that the most minute details of a cedent's claim practices, such as what proof to require before satisfying an underlying claim, are always open to challenge?

The limited authority available suggests that the "reasonable, businesslike investigation" standard cannot subvert the policy that grants significant deference to cedents' settlement decisions. If it could, every cedent's settlement of a coverage dispute would be a mere prelude to a new dispute wherein the reinsurer challenges the cedent's claims-handling as not "reasonable and businesslike." The point is well illustrated in a case which involved certain London Market reinsurers, *Aetna Casualty & Sur. Co. v. Certain Underwriters*, Index No. 118676/95 (N.Y. Sup. Ct. June 9, 1997), published in *Mealey's Litigation Reports: Reinsurance*, Vol. 8, No. 4 (June 25, 1997) ("Aetna"). In *Aetna*, certain London Market reinsurers argued that their cedent's settlement "may not have been 'reasonable, in good faith, and made in

a proper and businesslike manner.'" *Id.* at *3. Without purporting to adopt that standard, the court held that under contract language similar to the clauses listed above, it "can not [sic] conclude that there is any possible issue of fact on any of these questions without running afoul of the 'follow the fortunes' doctrine.... The court does not believe that the businesslike handling standard may be used as an excuse for a full blown review of the ceding companies' settlement decision. If it were, there would be no reason for the 'follow the fortunes' doctrine, since every case would be open to second guessing after the decision to acknowledge coverage and to settle." *Id.* at *3-*4 (emp. added).

Moreover, regardless of how different

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courts formulate the follow the settlements standard, specific reinsurance contract language should control in any given case. The 'sole judge' language previously quoted powerfully refutes the notion that reinsurers can decree appropriate underlying claims practices – the contract grants that right to the cedent. Thus, there appears to be little support for the argument that the "reasonable and businesslike investigation" standard permits the London Market to dictate asbestos claims practices to its cedents via the Reinsurance Requirements.

A related argument, that the "reasonable and businesslike investigation" standard mandates proof of causation and injury before a cedent may properly settle a claim, is equally unfounded and contrary to U.S. case law. The issue of proof of causation and injury for coverage of mass tort settlements has been extensively litigated in direct insurance cases. Those cases have consistently held that a settling policyholder need not prove actual

liability as a prerequisite to obtaining insurance coverage. For example, in *Uniroyal v. Home Insurance Company*, 707 F. Supp. 1368 (E.D.N.Y. 1988), *Uniroyal*, a manufacturer of the "Agent Orange" defoliant, sought insurance coverage for its share of a \$180 million global settlement with a class of 2.5 million Vietnam veterans allegedly injured by Agent Orange. Home Insurance Company denied coverage for the claim on the grounds that, *inter alia*, *Uniroyal* had failed to prove that "actual injury" took place. *Id.* at 1378. In words that ring with equal truth here, the Court declared that:

Home's contention would place settling defendants in the hopelessly untenable position of having to refute liability in the underlying action until the moment of settlement, and then of turning about face to prove liability in the insurance action. Often the evidence needed to prove actual injury--such as the tort plaintiffs' medical histories--would be unavailable to the insured. Such a regime would markedly reduce the advantages to the insured of settling: faced with the choice of defending the tort action vigorously or settling it without hope of insurance reimbursement, insureds would tend to choose the former. Settlements expressly disavowing tort liability...would be discouraged lest the express disavowal operate as a waiver of insurance coverage claims....In times of severe pressure on courts overwhelmed with litigation, and undersupplied with resources, a rule forcing more cases to trial would be a self-inflicted wound of suicidal import.

Id.; see also *Luria Brothers & Co., Inc. v. Alliance Assurance Co., Ltd.*, 780 F.2d 1082, 1091 (2d Cir. 1986) ("In order to recover the amount of the settlement from the insurer, the insured need not establish actual liability to the party with whom it has settled 'so long as ... a potential liability on the facts known to the [insured is] shown to exist, culminating in an amount reasonable in view of the size of possible recovery and degree of probability of claimant's

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success against the [insured]”) (citations omitted) (ellipses and brackets as original).

United States courts have also recognized that cedents act reasonably in reaching compromise settlements of asbestos claims, even if those compromises, like the compromises inherent in the Wellington Agreement, do not require cedents to prove causation and injury. For example, the decisions in *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 762 F. Supp. 566 (S.D.N.Y. 1991), *aff’d in part and rev’d in part*, 4 F.3d 1049 (2d Cir. 1993), although well known for their treatment of the late notice issue, also concerned challenges to the sufficiency of proof of causation and injury for asbestos loss cessions paid in accordance with the Wellington Agreement.

The Wellington Agreement was titled the 1985 Agreement Concerning Asbestos-Related Claims. Nevertheless, it is commonly known as the Wellington Agreement for its chief mediator, Dean Harry Wellington of the Yale Law School. The Wellington Agreement was a global compromise of numerous complex issues between and among certain producers of asbestos and asbestos-containing products (“subscribing producers”) and their liability insurers. 762 F. Supp. at 575. The Wellington Agreement established the Asbestos Claim Facility (“Facility”) to handle all asbestos-related claims against the subscribing producers. *Id.* at 573, 576. Once the Facility settled a claim, the settlement amount and the defense costs were allocated among the subscribing producers according to a producer allocation formula. 4 F.3d at 1056. Under the producer allocation formula, the different asbestos subscribing producers were assigned shares based on the relative amount each producer had previously paid on asbestos claims. *Id.* Thus, for any given claim settled by the Facility and billed to a subscribing producer, it was not necessarily the case that that subscribing producer was legally liable to the underlying claimant. By the same

token, for any given claim, the subscribing producer may have been chiefly liable but ended up paying a smaller share, benefiting from the billings to other subscribing producers based on the producer allocation formula, which was a proxy for actual liability based on averages derived from past payments. 762 F. Supp. at 589; 4 F.3d at 1066.

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North River Insurance Company (“North River”) was a party to the Wellington Agreement, as was its insured, Owens Corning Fiberglas Corporation (“OCF”). After North River had paid asbestos losses to or on behalf of OCF, it sought to recover from its reinsurer Unigard Security Insurance Company (“Unigard”). Unigard denied liability based on a number of arguments, including North River’s failure to notify Unigard of its entry into the Wellington Agreement. Unigard claimed that the Wellington Agreement had significantly altered the risk reinsured by adoption of the producer allocation formula and other mechanisms. 762 F. Supp. at 588-89. The district court rejected the argument, finding as a matter of fact that OCF’s eventual withdrawal from the Facility meant that the claims North River ceded to Unigard had not been paid pursuant to the producer allocation formula and holding that Unigard was bound to follow the fortunes of North River, which had compromised its liability to OCF in a reasonable, good faith manner. 762 F. Supp. at 587.

On appeal, the Second Circuit reversed the district court’s factual finding respecting the impact of the producer allocation formula: “[T]he Wellington Agreement did affect the claims paid by North River to Owens-Corning.... The coverage principles of the Wellington Agreement were used to

compute which insurance companies would pay and how much they would pay for each claim.” 4 F.3d at 1064. The Second Circuit also held that North River had a duty to notify Unigard before entering into the Wellington Agreement, and that it had breached that duty. Nevertheless, the Second Circuit held that Unigard was bound to follow North River’s fortunes:

[B]y changing the coverage rules pursuant to the insurance-allocation formula, the [Wellington] Agreement altered North River’s liabilities, including requiring it to pay some claims and administrative costs for which it was not liable under the original policies. Nonetheless, because the reinsurer’s and ceding insurer’s interests are essentially the same as to liability, good faith coverage decisions generally do not constitute prejudice. This is so even in the radical case of the Wellington Agreement, which used automatic formulae to replace individualized determinations as to the liability of insureds and their insurers. Coverage and liability would be altered but the changes might offset each other and the total payouts by particular insurers might remain roughly the same.

4 F.3d at 1068. Although the Second Circuit’s decision in *Unigard* ultimately concerned late notice and prejudice, the court’s discussion of the Wellington Agreement in *Unigard* is instructive because it upholds the cedent’s fundamental ability to compromise underlying claims, so long as it acts reasonably and in good faith under the circumstances, even if the compromise calls for the cedent to pay some claims for which it is not legally liable. The London Market should have considerable difficulty reconciling that principle with enforcement of the Reinsurance Requirements.

Course of Performance

In addition to the pertinent contract language and the case law, a dispute over enforcement of the Reinsurance Requirements would also concern the parties’ course of performance under the

contracts. The reinsurance contracts at issue may date back decades, and prior asbestos loss sessions may date back nearly as long. In the process, the parties may have developed understandings in practice respecting appropriate proofs of loss and accepted claims and settlement procedures.

Such "practical construction" is afforded significant deference by the courts: "the interpretation placed upon a contract by the parties themselves, before a dispute has arisen, is entitled to the greatest weight." *Reconstruction Fin. Corp. v. Sherwood Distilling Co.*, 200 F.2d 672, 676 (4th Cir. 1952); see also *Thompson v. Fairleigh*, 187 S.W.2d 812, 816 (Ky. 1945) ("Show me what the parties did under the contract and I will show you what the contract means"). To the extent that the Reinsurance Requirements depart from these common understandings, the London Market reinsurers should be at a distinct disadvantage in enforcing the Reinsurance Requirements.

Conclusion

The Direct Insurance Requirements may well be an appropriate response by the London Market to the asbestos liability problem. It may also be true that other direct insurers would benefit from implementation of such claims practices. The Direct Insurance Requirements, however, involve fundamentally different issues than those raised by the Reinsurance Requirements and enforcement of the Reinsurance Requirements poses considerable contractual and legal problems.

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