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INSOLVENCY Special Edition

This Insolvency Special Edition is another outstanding issue prepared by volunteer special editors. AIRROC's Publications Committee openly welcomes the assistance of new special editors to garner authors and articles discussing a unifying, relevant theme. The views expressed do not reflect those of the editors, authors or their employers.

– Peter A. Scarpato, Editor and Vice Chair

Message from Special Editors Mark Megaw and Constance O'Mara

AIRROC Insurer Insolvency Review: A Tapestry of Dusty Dreamers

This *Insolvency Special Edition* is intended to be a valuable tool. In addition to the sobering reminder that it provides about key property and casualty company collapses, the edition reanimates some of the debates about the legendary downfalls. For insolvency veterans the edition provides recent data that will allow for some quantitative comparisons.

As editors, we have enjoyed seeing several themes develop from this diverse collection of contributors. Each study points to a dream of grandeur that was destroyed by the realities of ill-designed or ill-timed business plans. Readers might imagine a dusty odor as they open the cedar chest that starts Jonathan Rosen's description of the Home's time capsule. The first of the repeated themes from the grave is that these iconic companies once held visions of great success. Similarly, Debbie Cohen spins her tale around Reliance, with hints at the gilded boardrooms that preceded its great collapse. Bruce Friedman reminds us that even Mission, with its ethical lapses, once had a business plan as grand as Enron's.

To our surprise, a related thread weaves through the stories of the affected caretakers: estate-managers dream too, but modestly. Connie O'Mara's interview on the topic of Integrity demonstrates that Dick White fought for a practical resolution to the challenge of delayed reinsurance collections. In their related world, Mark Peters and Mia Finsness re-awaken the debate over how liquidators might handle long-tail losses efficiently.

Yet for all of its focus on the history of yesterday's failures, this Special Edition's focus is amazingly timely. Shortly before this Special Edition was published, the Department of the Treasury established the Federal Advisory Committee on Insurance to assist and support the Federal Insurance Office as established by the recently passed Dodd-Frank Act. Similarly, there is activity at the state level. Fred Pomerantz highlights the recent decision of the Rhode Island Supreme

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Message from CEO and Executive Director

AIRROC Intelligence


Trish Getty

Reflecting on the subject of this AIRROC Matters special edition, I recall the ten years that I, along with colleagues, spent managing the reinsurance administration of over eleven estates in liquidation, both life and health as well as liability insurers. During that time, I spent six years on the International Association of Insurance Receivers' ("IAIR") Board of Directors including one year as IAIR President. The issues have recirculated time and time again. In my opinion, more underwriters should participate in IAIR meetings to understand the liquidation process and operation of the guaranty funds. This edition will shed light on the various processes, both receivers and guaranty funds, as may concern some reinsurers. We thank our knowledgeable authors for their time dedicated to this effort.

While certainly not at the bottom of the food chain, we are pleased to report that the Dispute Resolution Procedure ("DRP") has proved to be a cost-saving, smart solution for contract and claims issues. Bill Littel of Allstate gave quite interesting testimony on March 3 of the usage, considerations and cost (under $2,000 in their first usage) to resolve an issue. We encourage you to consider using the DRP process. Just let us know if you would like a hard copy mailed to you. Get smart about addressing your legacy/run-off books to save expense.

Spring and summer reflect a new and growing time not only in our gardens but at AIRROC. Leah Spivey and Colm Holmes have taken a firm grasp on "AIRROC Matters" as co-chairs of the Publications Committee. Should you have an interesting topic and wish to author an article, as Ross Perot said, "I am all ears!" Look forward to our September edition with focus on our management of legacy books.

We look forward to seeing you at the next meeting of AIRROC set for July 14 at the offices of Dewey & LeBoeuf in midtown, NYC. We at AIRROC seek solutions™!■

Ms. Getty has been active in the insurance/reinsurance industry for over forty years, her keen experience in reinsurance claims, both inwards and outwards, harking back to 1972 when she began her experience in that sector of the industry with Berkshire Hathaway/National Indemnity Re. Trish has been employed in most fashions of the reinsurance industry, the majority as reinsurance claims manager, which led her to AIRROC and understanding its members' histories and today's needs. Trish readily recognizes the great value that AIRROC brings to its members at such a crucial time in the worldwide run-off industry. She can be reached at trishgetty@bellsouth.net.

Message from Special Editors *(continued from page 1)*

A Tapestry of Dusty Dreamers

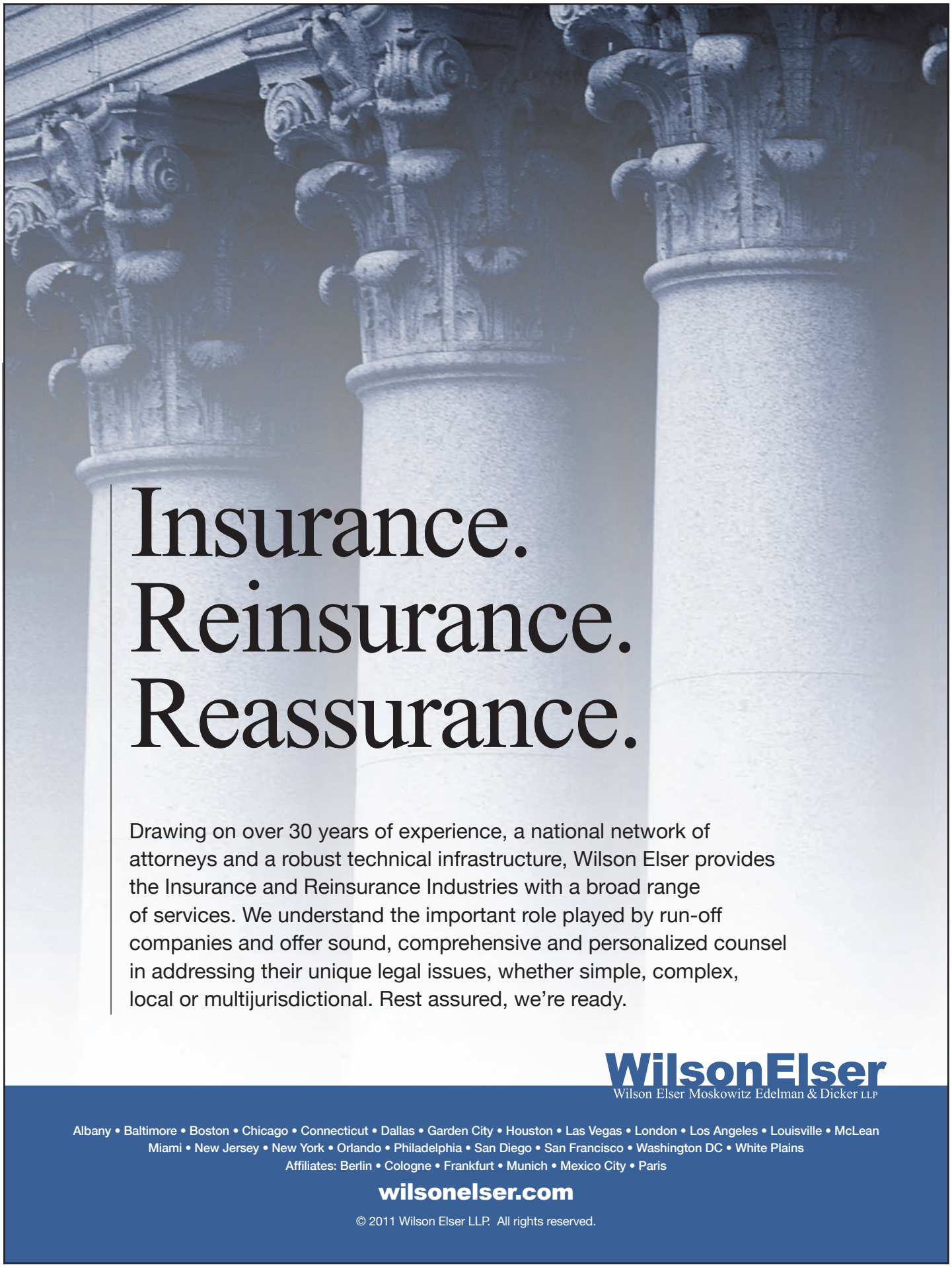
court which just blessed the first-ever US solvent scheme of arrangement. Some industry veterans have felt that the Highlands, as profiled here by Stephen Schwab and Carl Poedtke, provide a regulatory baseline for GTE Re's success. Similarly, although this Special Edition focuses on older insolvencies, new ones continue to arrive. Most recently, Atlantic Mutual, an insurer that had paid a hull loss on the Titanic, could not weather the losses of the early 21st century. These pasts continue to inform the future.

Finally, as our guide to tools for the future, Jim Veach provides us all with an interview of the NAIC's David Vacca. Mr. Vacca illuminates the NAIC's national database of receivership information. The GRID (Global Receivership Information Database) allows regulators to better understand and disclose information to consumers and regulators.

Our thanks go to all of the contributors who have made this Special Edition so valuable. By providing these studies they serve our industry today—and for years to come. ■

Ms. O'Mara is an ARIAS-US Certified Arbitrator. Formerly President and Chief Legal Officer of Brandywine Division of the ACE Group, she has over 25 years of experience in the P&C direct and reinsurance fields. Her current practice includes arbitrations, mediations, and expert review. She can be reached at connie@cdomaraconsulting.com.

Mr. Megaw is the Director of Reinsurance Litigation for ACE Group Holdings. He has been active in the reinsurance disputes field for over 20 years, having worked in London, Bermuda or Philadelphia during that time. He can be reached at mark.megaw@acegroup.com.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The Home Insurance Company – A Brief History of Time

On the outside is an invitation to "your president to drink a toast to our president on September 17, 2044." Unfortunately, that toast will never be realized, but the cognac will be drunk and, no doubt, a toast offered to the legacy of the felled giant that so long ago graced the Chicago skyline.


Jonathan Rosen

By Jonathan Rosen

On September 17, 1944, the President of The Home Insurance Company ("Home") created a time capsule in a sealed cedar chest. With the chest he addressed a message to his hoped-for successor, the President of Home on September 17, 2044. In his message, the President observed:

> Many physical and economic changes have taken place in this nation, as well as within this organization, since its founding in 1853. The war that we know as World War II seems destined to end in our complete victory in the not too distant future… We can foresee that the advances of science and the changes in the world during the next hundred years will be inconceivably greater than the changes that have taken place during the first century of The Home's history.

These were truly prescient words. However, Home's President could not have foreseen that the changes ushered in by the post-World War II boom would have such a drastic effect on Home's underwriting direction. A half century later, Home, once the largest fire insurer in the United States, and once the owner of the world's first "skyscraper" in Chicago, was reeling as a viable entity. Its liquidation followed less than five years into the twenty-first century.

*Jonathan Rosen is the former Chief Operating Officer of The Home Insurance Company In Liquidation, with whom he currently enjoys a consulting relationship. Jonathan is an ARIAS*US certified arbitrator and umpire, in which capacities he presently serves the insurance and reinsurance industries. He is also the former Chairman of the AIRROC Board of Directors. He can be reached at jonrosen55@aol.com. The views and opinions expressed in this article are those of the author and do not necessarily reflect those of The Home Insurance Company In Liquidation, its Liquidator or its Special Deputy Liquidator.*

Home survived the Great Chicago Fire of 1871 and the stock market crash in 1929 and emerged as a leader in property underwriting.

Home was formed in 1853 to write business nationwide through a network of local agents. Its $500,000 in capital was twice that of any other New York company and, within eighteen months of operation, 140 agents were conscripted and the company leapt into being. The Great Chicago Fire in 1871 nearly proved a death knell, but Home survived and prospered. By 1902, with annual premiums of $7.3 million and a policyholder's surplus of $9.5 million, Home had become the nation's largest fire insurer. Financial woes, however, struck again with the 1929 stock market crash. Home survived those with the help of across-the-market regulatory relief and was able to reemerge as a leader in property underwriting, its core discipline. It was in this context that the President of Home sent his bi-centennial successors a greeting that marked the end of a venerable institution's first century of operation.

In 1962, with property coverages constituting almost all of Home's business, Home's executive management made a fundamental change to Home's business model. Home decided to enter the burgeoning United States casualty market. By the late 1970s, over half of Home's premium came from casualty business and Home had established itself as a prolific market participant, underwriting the liability risks of many Fortune 500 companies as well as participating in a number of significant underwriting pools with the industry's leading property and casualty insurance companies, both domestically and abroad.

The 1980s saw Home's continued prominence as a casualty underwriter on the US national stage. Home's general liability portfolio expanded into specialty lines, including professional liability and D&O exposures, and Home set up a regional field office network across the country. Home wrote risks on its own paper and/or that of its affiliates, City Insurance Company, The Home Indemnity Company, The Home Insurance Company of Indiana,

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The Home Insurance Company of Wisconsin, The Home Insurance Company of Illinois and Home Lloyd's Insurance Company of Texas. Home also established a professional reinsurer in US International Reinsurance Company and had a Syndicate on the New York Insurance Exchange, in addition to maintaining branches in the United Kingdom, Canada and Hong Kong and captive reinsurance operations in Bermuda. But despite this growth, all was not well on the Home front.

By the mid-1980's…Home's significant book of working layer umbrella and excess general liability policies lay horribly exposed.

Acquired by City Investing in 1968, Home's overly conservative investment portfolio in the late 1970s failed to capitalize on the high yields of that period. To make matters worse, by the mid-1980s, asbestos had reared its head and with the advent of Superfund, which created retroactive liability for environmental clean-up, and Home's significant book of working layer umbrella and excess general liability policies lay horribly exposed. Add to that the massive pharmaceutical losses and other mass tort exposures being confronted (such as Agent Orange), it came as little surprise that Home was put on the selling block, but no buyer could be found. Home was then spun-off by City Investing to AmBase Corporation where it continued operating until it was sold, in 1991, to Scandinavia's largest insurer, Trygg Hansa.

As an integrated part of Trygg Hansa's acquisition of Home, Home purchased stop loss financial reinsurance protection from Centre Reinsurance, amongst others. This arrangement provided a limit that was twice the premium paid, and attached when Home's aggregate losses breached $4 billion. While Home continued to write new business through the early 1990s (with the casualty book accounting for 75% and the property book for 15% of $2 billion in written premium in each of the three years preceding run-off), Home's mounting long-tail exposure became increasingly apparent. These looming exposures culminated in rating agency downgrades towards the end of 1994 that had significant ramifications. Perhaps most importantly, as Home neared the end of 1994 its rating no longer met the minimum risk management guidelines of many policyholders, seriously exposing Home's franchise value.

Trygg Hansa sought an exit strategy, and found a suitor in a group led by Fund American Enterprises. In early December 1994, Trygg and Fund American reached a tentative agreement that called for a $420 million addition to surplus as a means of restoring Home's rating. That agreement was not, however, consummated. It was replaced by a competing deal from Zurich Insurance Company, whose Centre Reinsurance subsidiary had found itself exposed under the stop loss arrangement in a far shorter time period than it had anticipated. A complex transaction thus ensued which was embodied in a Recapitalization Agreement that contemplated the merger into Home of its various affiliates (other than US International Re), required Home to cease underwriting new and renewal business, transferred Home's renewal rights to Zurich and replaced the Centre Reinsurance stop loss arrangement by expanding it to a $1.3 billion cover and extending the $4 billion aggregate trigger to an "out of cash" attachment point. As part of the transaction, Zurich created Risk Enterprise Management Limited (REM) to manage the Home run-off.

The Recapitalization Agreement was subject to intense regulatory scrutiny. Originally domiciled in New York, in 1973 Home redomesticated to New Hampshire while maintaining New York as its principal place of business. Because it was licensed and did business in all states, the magnitude and spread of Home's liabilities, estimated at that time to be in the order of $3 billion, attracted national regulatory attention, with New Hampshire leading the application process. The novelty and complexity of the Recapitalization Agreement in relation to an entity in a weak financial position, with limited post run-off funding sources and a modest margin for adverse loss development, was an obvious regulatory concern. The New Hampshire Insurance Department appointed a representative to act as on-site monitor of Home's operations and obtained various rights of access into Home and REM.

Home's undiscounted financial condition was pummeled by this 63% surplus reduction to $230 million.

At year-end 1995, some six months after Home went into run-off, much of Home's already diminished surplus and available reinsurance protection was used to offset large additions to undiscounted environmental and asbestos reserves, which were strengthened to achieve industry parity. Home's undiscounted financial condition was pummeled by this 63% surplus reduction to $230 million. At the same time there were positive signs. REM established a dedicated and experienced management team, improved claims handling with centralized oversight and

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Reliance Insurance Company (In Liquidation) – One Decade Later

With nearly $10 billion in liabilities in fifty states and several foreign subsidiaries as well as a Canadian branch operation, Reliance's liquidation was predicted by many to be the largest and most challenging property casualty insolvency in history.


Deborah F. Cohen

By Deborah F. Cohen

Less than one month after the terrorist attack of September 11, 2001, the *New York Times* succinctly reported that Pennsylvania state regulators "are shutting down the Reliance Insurance Company" to be liquidated "under a court order."[1] Thus, the turmoil of that momentous day both partly prompted and partly obscured the quiet demise of the on-going business of a 184 year old icon.[2] With nearly $10 billion in liabilities in fifty states and several foreign subsidiaries as well as a Canadian branch operation, Reliance's liquidation was predicted by many to be the largest and most challenging property casualty insolvency in history. "In perspective, the magnitude of Reliance liabilities approaches the combined total of all payments by all IGAs [Insurance Guaranty Associations] for all receiverships from inception of the IGA system to date."[3]

…the magnitude of Reliance liabilities approaches the combined total of all payments by all IGAs [Insurance Guaranty Associations]…

At the time, the press painted Reliance's collapse as the result of "massive debts the company incurred … and an ill-fated aggressive expansion during the 1990's, in which the company wrote billions of dollars in high-risk policies at bargain prices, then found itself responsible for massive unexpected losses."[4] Business media commentators blamed the high-flying and ill-advised personal and professional financial dealings of Saul Steinberg, the chairman of Reliance Group Holdings, the parent of Reliance (itself filing bankruptcy on June 12, 2001). Others emphasized the impact of "Unicover," the workers compensation carve-out debacle. As *Forbes* summed it up,

> There was no single catastrophic event to cause the demise, just garden-variety mismanagement, albeit in a big way. The company was eager to expand and it wrote policies too cheaply. This brought in cash—the better to pay dividends in the short run, but led to massive payouts in the long run, a fundamental error in the insurance game. The huge sums the company paid Steinberg and his brother didn't help.[5]

The confluence of these circumstances, among others, ultimately resulted in significant downgrades by A.M. Best's, which simply killed the company due to the fact that Reliance's core business included several classes of customers (*i.e.* sophisticated buyers) and lines (*i.e.* regulated buyers) that were sensitive to its ratings.

Rating Agency and Regulatory Reactions

Reviewing Reliance's businesses, conducted through its twelve operating insurers, Best's noted that, as a group, Reliance "ranks among the 30 largest property/casualty insurers in the United States, with nearly $2 billion of net premium writings supported by nearly $1.5 billion of surplus at year-end 1997."

Reliance's demise was a massive and speedy fall from its halcyon days. Just two years prior, in 1999, Reliance's Best's Rating was A- (Excellent). Best's lauded Reliance for its "successful specialty commercial strategy, excellent operating performance, product and geographic expansion, improved asset quality and reduced debt obligations." Reviewing Reliance's businesses, conducted through its twelve operating insurers, Best's noted that, as a group, Reliance "ranks among the 30 largest property/casualty insurers in the United States, with nearly $2 billion of net premium writings supported by nearly $1.5 billion of surplus at year-end 1997." A snapshot of

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1998 BUSINESS PRODUCTION AND PROFITABILITY ($000)

Product Line	Premiums Written Direct	Net	% of Total PW	Pure Loss Ratio	Loss & LAE Res.
Workers' Comp	775,291	365,599	15.7	46.3	590,830
Comm'l Auto Liab	412,809	255,892	11.0	7.3	351,393
Com'l MultiPeril	338,673	234,513	10.0	37.5	290,035
Oth Liab Occur	634,066	209,660	9.0	35.5	514,202
Surety	215,459	176,281	7.5	15.3	67,240
Priv Pass Auto Liab	130,315	170,155	7.3	57.6	93,629
Auto Physical	174,724	171,551	7.3	75.5	23,257
Oth Liab Cl-Made	446,356	167,686	7.2	39.5	287,275
Group A & H	191,233	118,417	5.1	70.1	45,025
Allied Lines	31,709	78,354	3.4	78.8	64,307
Ocean Marine	97,824	79,604	3.4	84.1	72,240
Reins-Property	…	70,280	3.0	41.2	29,975
Reins-Casualty	…	48,477	2.1	42.3	123,457
Inland Marine	126,392	43,006	1.8	112.7	41,806
All Other	299,903	145,435	6.2	64.3	226,435
Totals	3,874,753	2,334,911	100.0	53.6	2,821,106

Reliance's business before its demise is reflected in Best's summary of Reliance's 1998 production and profitability (see table above).

Reliance was repeatedly downgraded and went from A- in June of 2000 to E by January of 2001; by May of 2001, Reliance was formally placed into rehabilitation.

Best's also commented favorably on Reliance's financial performance, including strong earnings and underwriting results.[6]

This same report, however, contained several prescient caveats. For example, Best's highlighted Reliance's high leverage in four critical areas: underwriting, investment, financial and reinsurance utilization. Similarly, it noted that the group had historically low surplus generation, lagging capitalization as compared to its peers, and sizable dividends required from the insurance group. So, the risks were described, even as they came packaged with some favorable news. For Best's however, the announcement of a significant reserve strengthening that was likely to be taken in the next quarter was enough to begin what became a downward spiral. Best's removed its positive outlook on Reliance's rating in June of 1998. Increasing concerns about these issues, and new ones, worked their way through Best's subsequent ratings actions and the Pennsylvania Insurance Department's regulatory oversight, and trace the demise of Reliance over the next two years: Reliance was repeatedly downgraded and went from A- in June of 2000 to E by January of 2001; by May of 2001, Reliance was formally placed into rehabilitation.

By the end of rehabilitation, Reliance had only five days worth of funds on hand to pay its obligations.

For this entire time period, in its attempt to save the company, Reliance variously attempted to sell itself, to sell business units and assets, to shore up its core businesses and shut down peripheral operations and offices to shed costs, to shift from an active company into a runoff entity, for the parent to refinance its bank facility or declare bankruptcy. None of these efforts, or others, were sufficiently successful or lucrative to turn the company around. "The financial condition of the company was clearly worse than what we had thought when we took over," stated then-Commissioner Koken, when she filed her petition to liquidate Reliance in the Commonwealth Court. It was not just the ratings, the deteriorating financial condition or the reserve position of Reliance that required termination of rehabilitation; significant

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The Rise and Fall of Mission Insurance Company

This paper seeks to add to the scholarship on the Mission insolvency by providing a litigator's perspective on some portions of the management and regulatory design failures that could continue to haunt the insurance industry.


Bruce M. Friedman

By Bruce M. Friedman

The downfall of Mission Insurance Company ("Mission"), to use common insurance phrases, was "sudden" and "unexpected" from many perspectives. In the years preceding Mission's entry into conservation in October 1985, its results had been very favorable, even though the most major players in the industry—with the exception of AIG—had long since been reporting combined ratios in excess of 100%. Its parent, Mission Insurance Group, Inc. ("Mission Group"), was a darling of Wall Street, with stock that continued to outperform.

How could something so good become so bad so fast? Its legendary implosion is set out in infamous detail in a 1990 Congressional report now known as "the Dingell Report," which was titled by its authors as "Failed Promises." Despite its 20-year age, the Dingell Report, which also analyzes the Transit Casualty and Integrity insolvencies, questions aloud an issue that continues to resonate today: Can states handle the regulation of insurance companies?

The Dingell Report identified certain factors that were believed to be common to each of the insolvencies that it investigated.

> These included rapid expansion, over-reliance on managing general agents, extensive and complex reinsurance arrangements, excessive underpricing, reserve problems, false reports, reckless management, gross incompetence, fraudulent activity, greed and self-dealing.[1]

This paper seeks to add to the scholarship on the Mission insolvency by providing a litigator's perspective on some portions of the management and regulatory design failures that could continue to haunt the insurance industry.

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Mission's Game Plan

As will be described, Mission's managing general agents were encouraged—or left alone—to engage in all of the activities that the Dingell Report found to have contributed to its insolvency. Mission was motivated to have its MGAs write business until smoke began coming from their stamps because the commission income went directly to Mission's bottom line. Mission set ambitious premium targets for its MGAs despite soft market conditions that made them reasonably unlikely to generate an underwriting profit. Mission, however, extensively reinsured its business, thereby appearing to reduce its risk associated with the poor underwriting results.

Mission was motivated to have its MGAs write business until smoke began coming from their stamps because the commission income went directly to Mission's bottom line.

The author's fifteen year adversarial relationship with Mission began in 1984. At the time, our client's focus was on a single component of the Mission organization—i.e., the operations of the Mission Group-owned managing general agency, Pacific Reinsurance Management Corporation ("PRMC"), which operated a reinsurance pool. Consequently, the overarching problems at the group level were not immediately obvious.[2]

Mission's Macro Design

On paper, the Mission model, though fraudulent, was achievable for a short term: it hoped to outrun the long-term casualty tail by continuing to generate an increased premium volume year after year,[3] while understating reserves. Mission also bought extensive reinsurance. During the time that Mission was insuring underpriced

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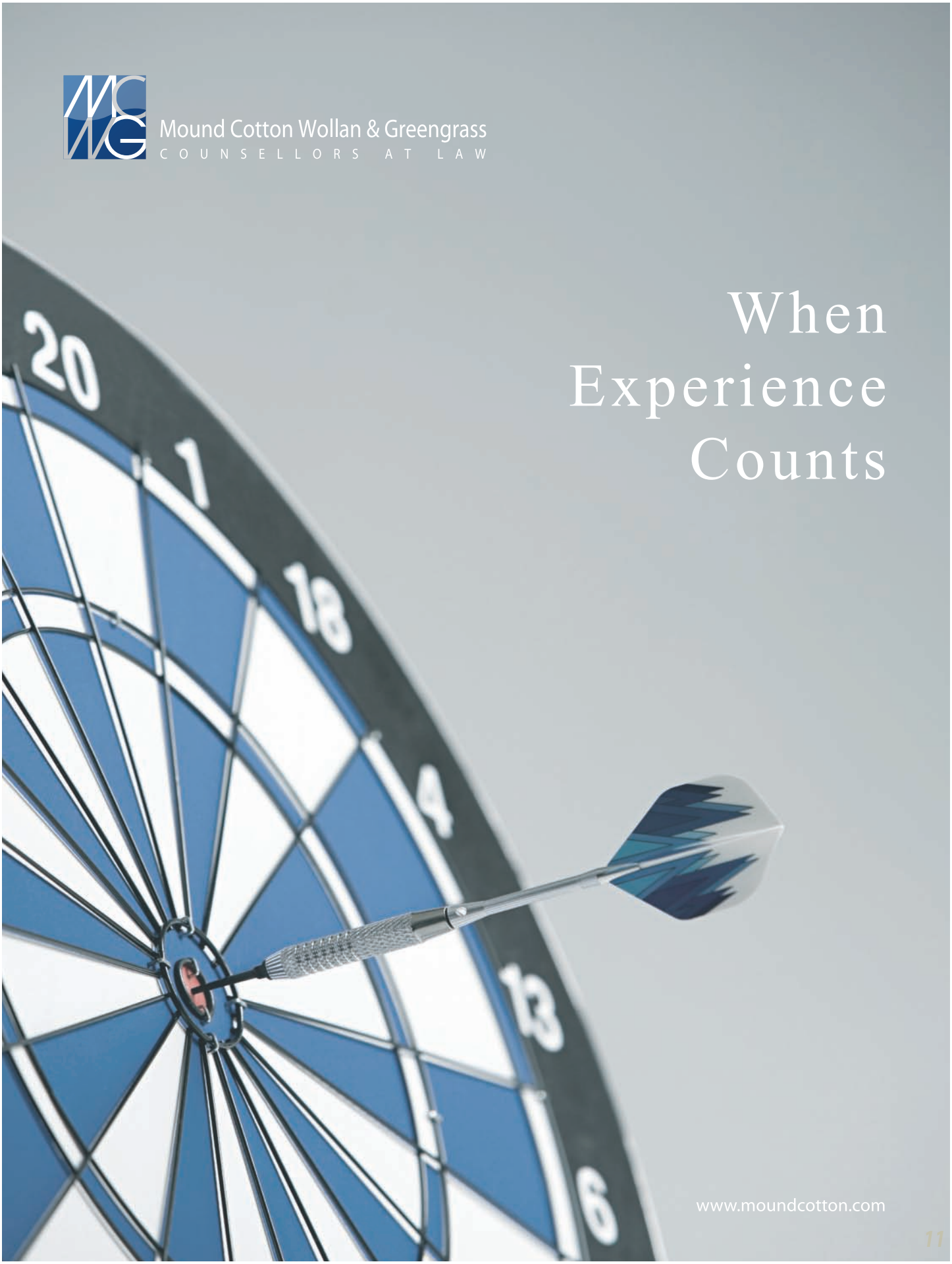
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The Rise and Fall of Mission Insurance Company *continued from page 10*

casualty business, segments of its group were generating management fees on this business through the operations of its wholly-owned MGAs, PRMC and Sayre & Toso ("S&T"). These MGAs contributed to its bottom line. Taking full credit for its reinsurance, Mission was able to understate its risk exposure, while at the same time Mission Group was fully recognizing its commission income.

Mission also placed a crucial bet that the insurance market would harden within a 3 to 5 year period, at which point real underwriting profits might have arrived. If that occurred, Mission's plan was to dramatically cut back—or even eliminate—its reinsurance support and keep for its own account the lion's share of these pure underwriting profits. The plan failed, in part, because the market failed to turn. Mission could no longer outrun its tail—its premium income could not be maintained, and the reinsurance payment stream started to wane.

During the 1970s and up to the time it was taken over, Mission had a great track record as a California and regional workers' compensation carrier. Its workers compensation business was reasonably profitable, and unlike other lines, it was largely retained net by Mission. However, Mission was able to use its market penetration in the workers compensation area to also offer far riskier casualty protections for which extensive reinsurance had been purchased.

A Crack Appears — The Beginning of the End

Mission formed PRMC in 1970. PRMC operated as an MGA for assumed property and casualty business. In 1974, a change in management at PRMC spawned what would become one of the most dysfunctional reinsurance operations imaginable.

With rare exception, from 1974 onward PRMC enticed small and/or foreign insurers to participate as members of the PRMC reinsurance pool. By and large, these companies followed Mission's reputation, but were not sophisticated in the ways of the US casualty reinsurance marketplace. As part of the sales pitch, PRMC regularly touted that a Mission Group subsidiary was the largest pool participant. What was not publicized was the fact that PRMC was using its Mission affiliate to front the reinsurance business that was assumed by PRMC. Pool members would be billed for their loss shares, not appreciating that they were technically reinsuring Mission (as one of the pool members).

In 1984, the accounts started to show markedly poor results. Pool members were receiving calendar year results, although they were led to believe that the figures were actually stated on an accident year basis. Thus, pool members would never see adverse deterioration in the prior years' results.

By regularly increasing premium volume on an annual basis and by understating and manipulating reserves, PRMC was able to mask adverse development: all newly reported losses would be lumped into the current year rather than being assigned to the contract year to which the loss should have been assigned. The increased premium volume was able to absorb all newly reported losses in the current year, thereby permitting PRMC to report "another profitable year." Internally, PRMC's management maintained underwriting year statistics which showed repeated deterioration in every prior underwriting year with each new underwriting year. That deterioration was scrupulously concealed from the pool members and from regulators.

One pool member—Ohio Re—engaged Tillinghast to conduct an analysis of PRMC's loss reserves. Gross underreserving across the board—case and IBNR—was found. Word of these findings spread quickly to all other PRMC pool members, who then partnered with other reinsurers to engage lawyers and auditors. The audits resulted in extensive findings of wrongdoing. Pool members then ceased payment of their PRMC pool obligations.

By this time, many of Mission's reinsurers on large books of casualty business had ceased making payment to Mission.

Mission is Placed into Conservation

Some of Mission's reinsurers proceeded to engage in arbitration with PRMC. That arbitration was in progress in October 1985, when Mission was placed into conservation. Then California Insurance Commissioner, Roxanne Gillespie, appointed as a special deputy insurance commissioner a lawyer from the same firm that had served as counsel for Mission. By this time, many of Mission's reinsurers on large books of casualty business had ceased making payment to Mission. Because approximately 90% of the assets of the Mission liquidation estate were reinsurance recoverables, Mission's special deputy soon recognized that if Mission was to be rehabilitated, rather than liquidated, it needed to push hard for collections from its reinsurers. There was very little incentive for the receiver to align with the reinsurers.

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Integrity Insurance in Liquidation:

Interview of Richard White, Deputy Liquidator Integrity Insurance Company

Integrity Insurance Company was a property and casualty insurer licensed to transact business in every state. Integrity was declared insolvent in December 1986 by order of the Superior Court of New Jersey and placed into liquidation a few months later, on March 24, 1987. The Court appointed the New Jersey Commissioner of Insurance as Liquidator. Richard White has been the Deputy Liquidator since 1995. The estate's website is: http://iicil.org

By Constance D. O'Mara

Connie: *By way of background, you recommended that I read* Failed Promises, Insurance Company Insolvencies, A Report by the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, US House of Representatives *(sometimes called "the Dingell Report"). In this report, they discuss Mission, Transit Casualty and Integrity; the section regarding Integrity is entitled "Going for the Gold at Integrity". To begin with, I note that the Integrity deputy liquidator testified before this subcommittee—that was* not *you, right?*

Richard: Correct. That was Mike Miron.

Connie: *Well, based on his testimony, the report describes Integrity, like Mission, as "a story of rapid growth and even more rapid calamity through extensive reinsurance and reliance on MGAs". I note there were allegations of "fraud". First of all, the State of New Jersey pursued the executives of Integrity based on misstatements of financial condition. It also appears various reinsurers accused Integrity of fraud in an attempt to avoid coverage under reinsurance contracts. Where those actions still going on when you started working on the estate?*

Richard: There was a D&O action going on when I came on the scene and it was settled during my early years here. I do not recall any actions by reinsurers concerning fraud.

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They said to Integrity "Look, you are making a lot of money and have an 'A+' rated company, you really should start writing the general liability lines and utilizing reinsurance to reduce exposure."

Connie: *Please describe what brought Integrity down.*

Richard: Essentially, what happened was that Integrity was a nice quiet company that wrote specialized auto and related specialty lines. They were approached by 2 MGAs, both of them well regarded. One was Alexander Howden out of Atlanta, originally the Irby Sewell Agency acquired by Alexander Howden, and the other was George Folkes out of Morristown, NJ who was originally with Gen Re, and he too was a well-regarded reinsurance broker. They said to Integrity "Look, you are making a lot of money and have an 'A+' rated company, you really should start writing the general liability lines and utilizing reinsurance to reduce exposure." Integrity's response was that "We aren't familiar with reinsurance markets for such business; what reinsurance we have is unique to our specialized auto and mobile homeowners lines of business." The reinsurance brokers said "don't worry" because "we have the reinsurance capacity—you won't need to worry about developing reinsurance markets". That was accurate because the brokers did have access to such markets and it was, for the most part, a first class group of reinsurance companies. Integrity was not doing anything much different than many of its competitors. It was not an unusual situation, circa 1980, for a cedant to take a small retention and lay off, say, 95% of the risk.

Connie: *Well, from my experiences the late 80s was a time that the asbestos and environmental losses were starting to*

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be billed through to the reinsurers and they did not know what to make of these losses because they were new and unique, raising trigger and allocation issues. I imagine that was a factor that impacted Integrity as well.

Richard: It is not clear to me that it was the newness or uniqueness of the losses that brought Integrity down. What brought Integrity down was the *weight* of those losses on certain of its reinsurers. So while Munich Re, American Re, and Employers' Re who were major reinsurers of Integrity, could withstand the significant volume and severity of toxic tort and environmental losses, companies like Mission, Transit and Midland could not. These companies failed and particularly when Mission failed, Integrity did not have the capital to absorb the incapacity of those reinsurers.

So while Munich Re, American Re, and Employers' Re who were major reinsurers of Integrity, could withstand the significant volume and severity of toxic tort and environmental losses, companies like Mission, Transit and Midland could not.

Connie: *Do you have any numbers, percentages of insolvent reinsurers, etc.?*

Richard: I don't.

Connie: *Given that Integrity was writing through so many MGAs (and the Dingell report says 80) did you have trouble finding all the reinsurance contracts?*

Richard: Not so much finding the reinsurance contracts but setting up the record keeping for transactions. It was not uncommon in insolvent estates to have a disorganized back office. But our initial dispute with reinsurers who were receiving our paid loss notices, estimates of outstanding, and so on, was whether the claims we were allowing were adequately supported. When it came to billing the reinsurers, they naturally had a lot of questions and the challenge was to answer all those questions. Integrity had to do major records reconstruction and that took place in those early years. Ultimately it was done and thereafter we really did not have a lot of difficulty collecting from solvent reinsurers. Certainly, when I got here, there was still work to do but we did not have major disputes and there was not a history of arbitrations or lawsuits by the liquidator with reinsurers over collections. We have a rich history of lawsuits here but it's on the issue of the early closing initiative requiring estimation of losses and IBNR.

Connie: *When I read the Dingell report, I noted that it says that Integrity did not have a centralized system for keeping track of what the MGAs wrote, so it must have been difficult to get policy records and reinsurance information together since they had so many MGAs.*

Richard: It was difficult, but I don't think it was so much attributable to the MGAs as the confusion at the time of going into rehab and then liquidation. (The rehab period was very short—three months). You know when that happens key people leave and there is a certain amount of disruption. I would not want to fault the record keeping of the MGAs because I had occasion to go back to them well *after* that period and they were always able to satisfy my requests. It may have taken them a while because they were searching warehouses, etc., but they were always able to turn up documents in response to my requests. I think sometimes we did not have the right people asking the right questions of those people but we had to undertake major efforts to put a system in place that was responsive to what was needed in liquidation.

Connie: *Who did what to put the company in liquidation?*

Richard: In late 1986 the Company endeavored to raise capital through a stock sale but that proved futile. Thereafter Integrity cooperated with the then NJ Department of Insurance (now the Department of Banking and Insurance) for an order of rehabilitation to protect the assets and discontinue writing business. It was *not* a situation where the management objected to Department involvement.

Connie: *In the Liquidation, what were the key issues?*

Richard: When I came on board, I would say the first order of business was to complete what was started in regards to records reconstruction. Much work had been done under Mike Miron's leadership, but there was a reliance on PC based systems that needed to be consolidated into the legacy systems that supported the work of the liquidation more seamlessly. Secondly, there was the major task of dealing with guarantee fund distributions. The estate, by that time, was 8 years old and the guarantee funds had been disbursing money as claims emerged from creditors and they had little reimbursement for their efforts. As you know from the Dingell report, Integrity was licensed in every state, so there was a lot of effort on our part to determine how much we could pay to each Guarantee Fund and we managed to do a distribution in that first year that not only increased the GA (Guarantee Association) distribution but also provided the first interim distribution to non-GA creditors. And finally, you may recall that Mission came out with a plan to estimate claims near the end of '94 and there was considerable litigation in California on that. So, the Commissioner tasked me with figuring out what Integrity should do. I responded that there were two choices: we

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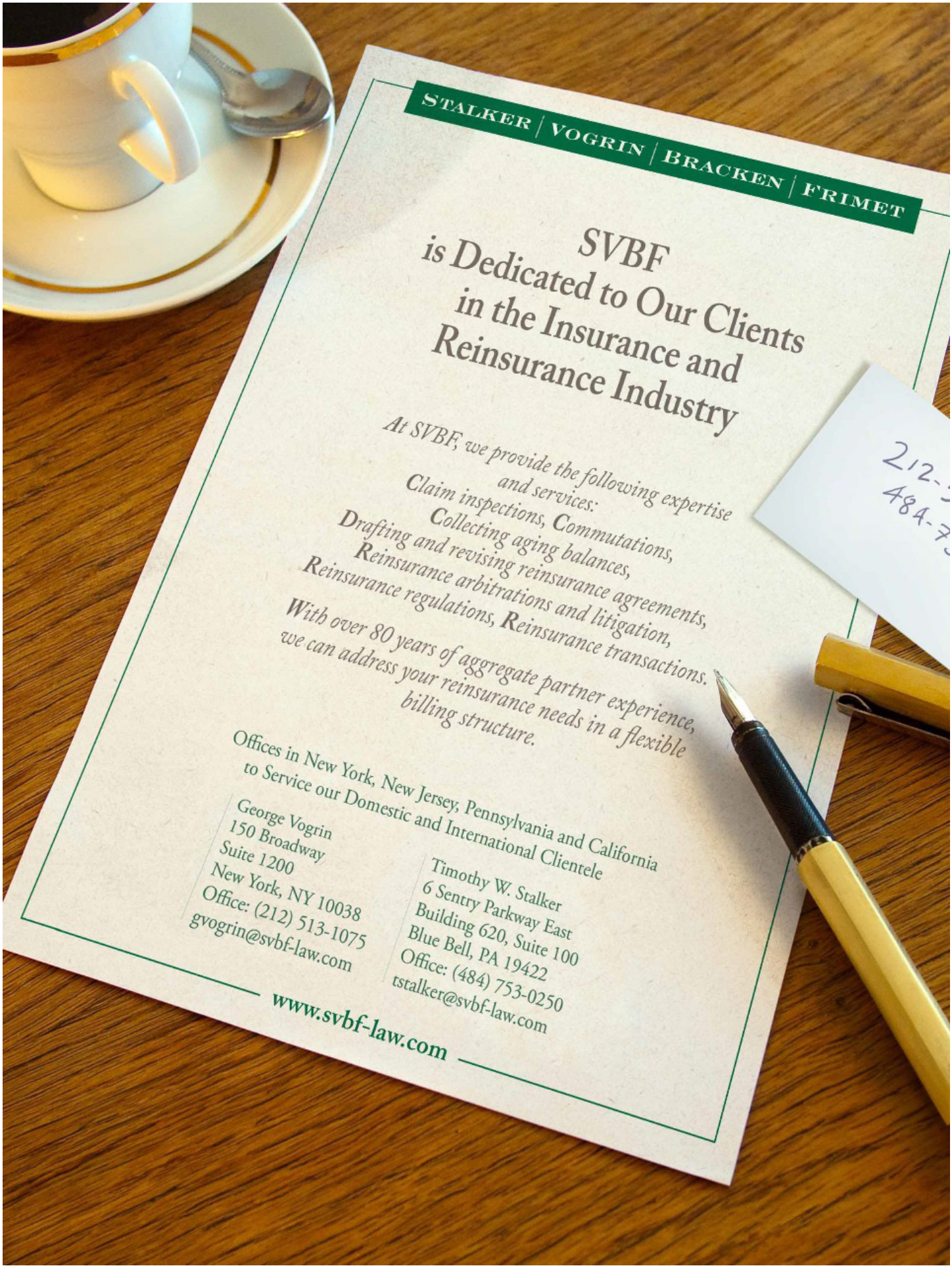
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Midland: New York's Approach to Running Off a Company with Long-Tail Claims


Mark G. Peters

By Mark G. Peters and Mia Finsness

It has been twenty-five years since Midland Insurance Company was placed into receivership by the New York Supreme Court yet the liquidation process is still ongoing. The problems faced by the New York Liquidation Bureau ("NYLB") in handling of the Midland run-off are indicative of the general difficulties associated with running off companies with long-tail claims. Midland's long and ongoing run-off period suggests that government receivers generally may need to re-think their strategy for running off companies with long-tail claims.

The History of Midland

Midland Insurance Company was incorporated under New York law as a stock casualty insurer in 1959. Under its charter, Midland was authorized to transact business in all 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands and Canada. As a multiline carrier, Midland wrote a substantial amount of excess coverage for Fortune 500 companies that began to face significant environmental, asbestos and product liability claims in the 1980s.

Midland was unexpectedly faced with claims on policies that were in effect many years earlier and the company was rendered financially impaired as a result of its inability to pay out on all of the claims.

Like many other insurance companies at the time, the explosion of asbestos litigation in the 1980s presented unexpected delayed claims for Midland. Asbestos-related diseases are progressive diseases and the courts have generally held that the injury begins at inhalation of the asbestos fibres and continues until the disease actually manifests itself. Since it took years from the date of inhalation for asbestos-related diseases to manifest themselves in plaintiffs with potential claims against Midland's insureds, all of the Midland policies in effect from the date of inhalation to the date of manifestation were triggered in each case. The result was that Midland was unexpectedly faced with claims on policies that were in effect many years earlier and the company was rendered financially impaired as a result of its inability to pay out on all of the claims.

As a result of these difficulties, on April 3, 1986, the New York Supreme Court placed Midland into liquidation. The NYLB then assumed control of the company's operations and began planning its run-off.

Midland's Early History in Receivership

After the court placed Midland into liquidation on April 3, 1986, the policies were terminated on May 4, 1986. The proof of claim filing deadline was set for April 3, 1987, one year after the liquidation order. In 1994, the New York Supreme Court approved a procedure proposed by the NYLB, for the disallowance of claims. Claimant objections to the NYLB's recommendations were directed to a referee. In 2006, certain major policyholders, the NYLB, and reinsurers, requested the court to create a more efficient procedure to address the objections to the NYLB's recommendations. The court approved a Petition and Distribution of Assets Plan submitted by the NYLB. The Petition and Plan recommended that the Midland insolvency proceedings remain open until all the creditors' claims were adjudicated. In addition, the Plan required that all disputes with creditors be resolved and that all reinsurance and assets be distributed to the creditors. The NYLB also received permission from the court to make additional, periodic distributions of assets in the future. At the time of the Petition and Plan, approximately 1,110 Class 2 creditors (policy-related claimants) qualified for the first disbursement of 10% of the claim amount allowed.

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Legal Issues Presented

In handling the Midland claims, an issue arose before the New York courts as to whether New York substantive law governed the interpretation and application of the Midland insurance policies, or whether the court had to conduct a choice-of-law analysis for each policy in order to determine which jurisdiction's laws applied. In Re: Liquidation of Midland Ins. Co., 2010 WL 89525 (N.Y.A.D. 1 Dept. Jan. 12, 2010). In relying on the case of Midland LAQ, 269 A.D. 2d 50, 709 N.Y.S. 2d 24 (N.Y.A.D. 2000), the New York Appellate Division held that "'[i]n order to assure that all Midland creditors are treated equally and in accordance with conflict of law principles, it is necessary that the court apply New York law in ascertaining' when coverage is triggered." Id. Consistent with the reasoning of Midland LAQ, the court concluded that there was an overriding state interest to apply New York substantive law so that all creditors in the liquidation proceeding would be treated equally. On April 5, 2011, the New York Court of Appeals reversed the Appellate Division's decision and held that for each Midland policy in dispute, an individual choice-of-law analysis must be conducted to determine which jurisdiction's law should apply. Matter of Midland Ins. Co., No. 38., Slip Op. No. 2011 (NY Apr. 05, 2011). In making this determination, the court held that "[t]o the extent that Midland LAQ stands for the proposition that New York substantive law must apply to all claims in the Midland liquidation, that holding…is no longer good authority." Id. Needless to say, the need to do an independent choice of law analysis for each policy will add additional complications and potential delay to a traditional process of winding down this estate.

By 2007, it was clear that the initial plan proposed by the NYLB in 2006 was not sufficient and the Midland case was presenting challenges for the traditional receivership model.

While the ongoing issue of governing law was being determined by the courts, the NYLB was faced with the challenge of addressing the long-tail claims at issue in the Midland run-off. By 2007, it was clear that the initial plan proposed by the NYLB in 2006 was not sufficient and the Midland case was presenting challenges for the traditional receivership model. In particular, the long-tail claims involved in Midland were difficult to estimate since many of the policyholders would not realize that they had a claim until years after the initial exposure. Additionally, there was considerable litigation about the claims and reinsurance process that further added uncertainty. Unlike the United Kingdom, there is no procedure in New York that allows for a scheme of arrangement to deal effectively with a book of long-tail claims. As a result, the NYLB had to begin to seriously consider new ways to effectively handle the Midland run-off.

The First Attempt to Sell Midland

The solution put forth by the NYLB was to sell Midland to a private company. The initial attempt at a sale, almost ten years ago, fell apart when the NYLB, instead of opening up the sale to competitive bidding, engaged with a sole buyer. In the absence of competitive bidding or some other system to ensure a fair bid, policyholders were concerned that Midland was not being sold for an adequate price and they lodged objections to the sale. As a result, the transaction was not consummated.

The Second Attempt to Sell Midland

A. The Model

After the first failed attempt at selling Midland, in 2007, the NYLB decided to take a different approach. The Bureau's goal was to expedite the distribution of Midland's assets to its policyholder claimants while maximizing those distributions. To address the policyholders' concerns emanating from the first attempt at a sale, the NYLB brought in Milliman Inc. to conduct a liquidation analysis and determine how much policyholders would be paid if the Bureau itself were to handle the run-off over 20 years. The NYLB then proposed to use this number as the start of a formal bidding process for buying Midland. These steps were designed to alleviate concerns held by policyholders that a private company would not handle their claims in a fair manner.

In 2009, the NYLB unveiled its proposed public bidding process for Midland. Under the terms of the proposed sale, the buyer would grant a guaranteed distribution to policyholders with resolved claims. The buyer would also pay policyholders a pro rata percentage of any profits made. As part of the bidding process, the buyers had to disclose what percentage they would give to the policyholders through the guaranteed distributions and profit sharing. Competition among the bidders was to be based on these percentages. The proposed plan, if successful, would be the first time an American insurance company in liquidation was purchased by private investors in this way.

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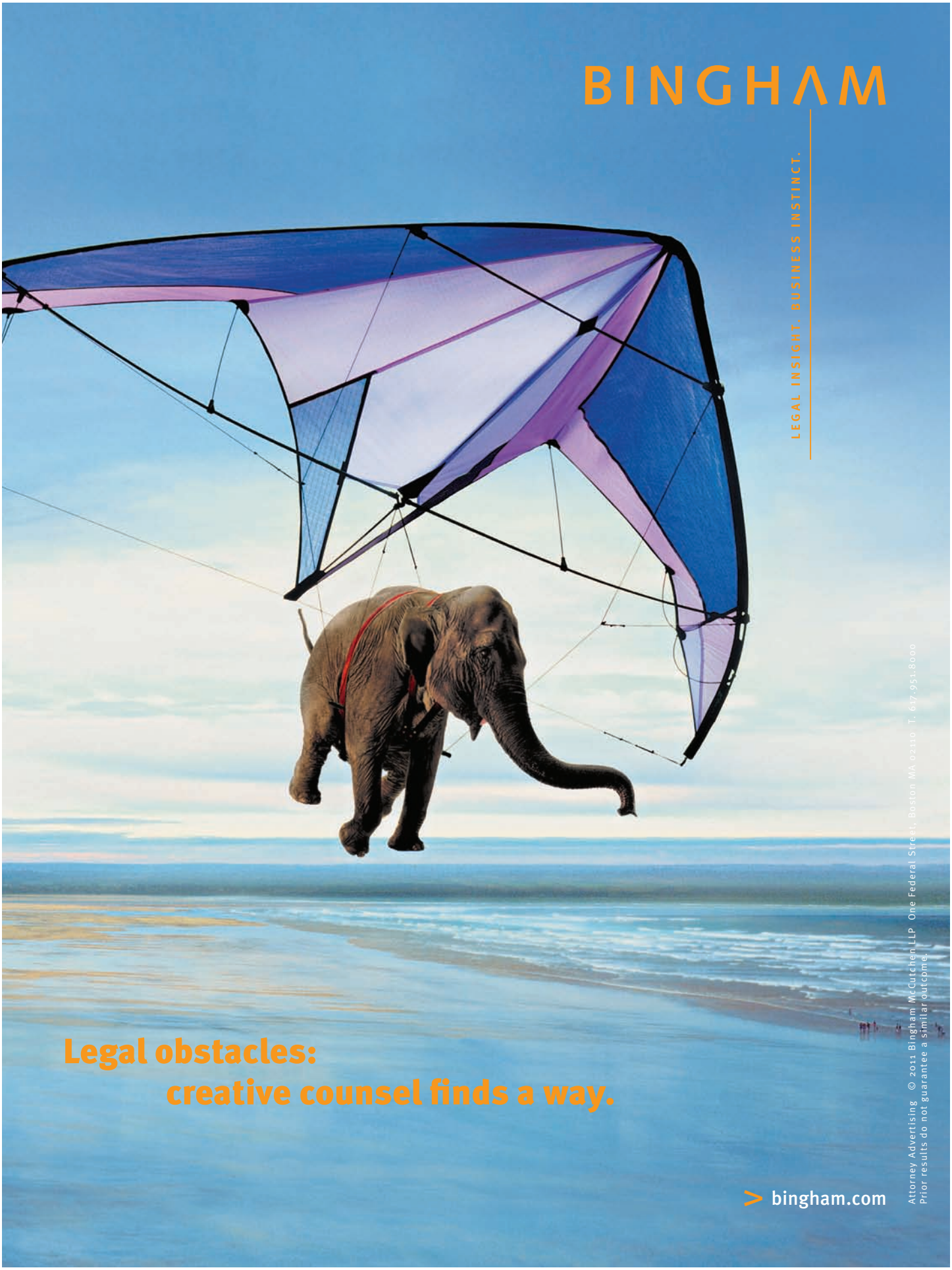
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Regulatory Developments

Rhode Island Commutation Plan Filed by GTE Re Upheld by the State's Superior Court

The first Rhode Island solvent commutation plan under a recently enacted statute has withstood constitutional challenge at the trial court level, under the Contract and Due Process Clauses.

By Frederick J. Pomerantz, Wilson Elser Moskowitz Edelman & Dicker LLP

The first Rhode Island solvent commutation plan under a recently enacted statute has withstood constitutional challenge at the trial court level, under the Contract and Due Process Clauses. The new law, Chapter 14.5 of the Rhode Island Insurance Laws, entitled Voluntary Restructuring of Solvent Insurers (the "Voluntary Restructuring Act"), delineates the procedure by which a solvent Rhode Island domestic commercial lines insurer or reinsurer attempts to withdraw from the market while extinguishing its past and future outstanding liabilities. This procedure is similar to the longstanding, well accepted process known as a "solvent scheme of arrangement" in the U.K. and Bermuda.

This procedure is similar to the longstanding, well accepted process known as a "solvent scheme of arrangement" in the U.K. and Bermuda.

After a meeting of GTE Re creditors held on November 30, 2010 to determine whether there was sufficient support to implement the plan 87% of the creditors, constituting 97% of the value of GTE Re's liabilities, voted in favor of the plan as originally presented. However, as we reported in our Spring 2011 edition, at a court hearing held in late 2010, one of GTE Re's creditors objected to the value ascribed to its claims against GTE Re. The objecting creditor opposed GTE Re's motion to confirm the prior vote of the creditors in favor of the plan, challenging the legitimacy of the Voluntary Restructuring Act and contending that the voluntary commutation process deprives creditors of the right to enforce GTE Re's contractual obligations under the Contract Clause of the United States Constitution, which provides in part that: "No State shall … make any … Law impairing the Obligation of Contracts. . .."

On January 11, 2011, a second creditor, also affiliated with the objecting creditor, objected, alleging that the reserving methodology employed in the plan violated the creditors' due process rights by allegedly inadequately addressing their potential exposures.[1]

On April 25, 2011, the Superior Court of Rhode Island issued a 44-page decision addressing these constitutional challenges. Noting at the outset that the party challenging the constitutionality of state law has to establish "beyond a reasonable doubt that a specific provision of the United States or Rhode Island Constitution has been violated," the Court refused to hold the statute unconstitutional. In doing so, the court applied the United States Supreme Court's three-part test to determine whether a contractual relationship has been substantially impaired.[2]

The court summarized the three-part test as follows:

1. Whether there is a contract;
2. Whether the law in question impairs an obligation or right under that contract; and
3. Whether the impairment is substantial.

The Court then added:

> But even if the new law constitutes a substantial impairment, it still will not be deemed unconstitutional as a violation of the applicable contract clauses, if it is reasonable and necessary to carry out a legitimate public purpose. *Retired Adjunct Professors,* 690 A. 2d at 1345 n.2….

There being no doubt that a contractual relationship existed between the objecting creditors and GTE, the Court proceeded to analyze whether any contractual rights under the objecting creditors' treaties were impaired.

The Court agreed that several contractual rights and obligations within the objecting creditors' treaties were altered or impaired, including: 1) indemnification by GTE Re for the actual value of all present and future claims; 2) the arbitration and choice of law provisions; and 3) the bilateral nature of the treaties.[3] Nevertheless, the Court

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Rhode Island Commutation Plan Filed By GTE Re Upheld by the State's Superior Court *continued from page 21*

maintained that impairment alone is not sufficient to violate the Contract Clause and that complete destruction of the rights of a contracting party is required to find an impermissible impairment.

The Court also stated that previous regulation of reinsurance made the impairment foreseeable and affected the parties' reasonable expectations:

> Indeed a party's expectation of future regulatio0n is important in determining whether contractual rights are substantially impaired because parties bargain for contractual terms based on those expectations; if those expectations are fulfilled, the court will not relieve parties of their obligations.

The Court, again citing *Retired Adjunct Professors*, 690 A.2d at 1345, invoked the state's limited police power in stating that where a state establishes that the regulation is justified by a significant and legitimate public purpose, a state statute will be deemed constitutional despite any substantial impairment of contractual rights.

Finally, the Court rejected the objecting creditors' due process claims, stating:

> Even if the Restructuring Act were interpreted as being retroactive legislation, having already passed constitutional muster under the Contract Clause, the statute would unquestionably survive a due process challenge.[4]

We will report future developments in this column as they arise. ■

Notes

1 The Objecting Creditor acted on behalf of and managed claims for its affiliated insurers.

2 *Citing Retired Adjunct Professors of R.I. v. Almond*, 690 A. 2d 1342, 1345; *see also General Motors Corp. v. Romein*, 503 U.S. 181, 186, 112 S. Ct. 1105, 1109 (detailing the U.S. Supreme Court's substantial impairment analysis).

3 *See* Mar. 16, 2011 Hearing Tr. 9-13

4 *Citing Liberty Mutual Ins.Co. v. Whitehouse, 868 F. Supp. 425, 434 (D.R.I. 1994)* (explaining that the standard applicable to a court's review of an economic legislation under due process is less exacting than under the Contract Clause); *see also Mercado-Boneta*, 125 F. 3d at 13 (noting that the Contract Clause inquiry is more searching than the rational basis review employed in a due process challenge).

Highlands Insurance Company, *In Receivership*

Over the last 25 years, a few enterprising regulators have exercised their discretion to fashion rehabilitation plans that avoid the negative consequences typical of liquidation, including triggering guaranty associations, the insolvency clause in reinsurance agreements, and balance sheet adjustments, even though the company will never return to independent operation. The rehabilitation of Highlands Insurance Company ("Highlands") is the latest case in point.


Stephen W. Schwab


Carl H. Poedtke III

By Stephen W. Schwab and Carl H. Poedtke III

Introduction

In most cases, rehabilitation of an insurance company is undertaken either as a "pit stop on the road to liquidation"—an opportunity for the domiciliary regulator to "look under the insurer's hood" and determine if liquidation is necessary—or when there is a reasonable expectation that the insurer can be "put back on the street" and returned to independent operation. Over the last 25 years, however, a few enterprising regulators have exercised their discretion to fashion rehabilitation plans that avoid the negative consequences typical of liquidation, including triggering guaranty associations, the insolvency clause in reinsurance agreements, and balance sheet adjustments, even though the company will never return to independent operation. The rehabilitation of Highlands Insurance Company ("Highlands") is the latest case in point.

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Unsuccessful Runoff and Entry into Receivership

Highlands was incorporated in 1957 by Kellogg, Brown & Root to serve as its wholly- owned captive insurance company. Halliburton later acquired both Kellogg, Brown & Root and Highlands. Highlands is a Texas domiciled property and casualty insurance company. It held licenses to transact business in all 50 states, the District of Columbia, Guam, and Puerto Rico, but its principal place of business was in New Jersey. Highlands had various affiliates in and outside the United States, including a company that operated in England and later found itself in English administration proceedings, as well as a Delaware corporation that ended up in US bankruptcy court.

In the late 1960s, it began issuing excess and umbrella coverage to large corporations…exposing Highlands to environmental and mass tort ("EMT") liabilities…

Highlands underwrote primarily commercial (including worker's compensation, general liability, and commercial automobile), specialty, marine, and personal lines coverage. In the late 1960s, it began issuing excess and umbrella coverage to large corporations. The commercial lines, umbrella and excess covers were embodied in occurrence liability policies, exposing Highlands to environmental and mass tort ("EMT") liabilities, such as asbestos and pollution. The asbestos exposures included amounts billed to Highlands by its former parent, Kellogg, Brown and Root.

In the 1990s, Highlands was incurring significant loss development, particularly in its commercial, excess and umbrella lines. In 1996, Halliburton spun off Highlands and in 2001, the company began to request, and received, regulatory approval for non-renewals in

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Highlands Insurance Company, *In Receivership* *continued from page 23*

all states. Highlands effectively moved into runoff, albeit operating under close regulatory scrutiny. In February 2002, it was placed in confidential supervision. In August 2002, the Texas Commissioner found Highlands to be in a "hazardous condition" and ordered it to rectify its condition. Circumstances deteriorated.

In November 2006, the State of Texas filed a court application for permanent injunction and an order appointing a receiver, citing:

- a $186 million decrease in statutory net worth from 1998 until June 30, 2003, when it landed at $7.6 million;
- negative net income, with a negative cash flow for operations of $158,624,622 as of December 31, 2002, and $99,598,209 as of June 30, 2003;
- under-reserving of estimated ultimate losses;
- insufficient risk based capital;
- negative unassigned surplus (which reflects historical earnings of the company) of $116,663,162; and
- entry of a $57.4 million final judgment against Highlands in California state court.[1]

The court entered the requested order on an agreed basis and appointed the Commissioner receiver "for the purpose of conserving the assets of [Highlands] and rehabilitating the business."[2] Although the State filed a petition to liquidate Highlands only weeks later due to a dispute with the $57.4 million judgment creditor, that dispute was resolved and the State elected not to pursue liquidation.

The Plan for Rehabilitation and Related Litigation

In June 2005, Texas became the first state to adopt a then unfinished version of the National Association of Insurance Commissioner's Insurer Receivership Model Act.[3] The new law went into effect September 1, 2005, substantially changing the law applicable to Highlands' rehabilitation. As required under the new law, the Receiver, through his Special Deputy (the "SDR"), developed a rehabilitation plan and in July 2006, the SDR applied for court approval. The proposed plan intended to effect a managed "runoff" of the company's liabilities; there was no intention to return the company to independent operation. The plan's lynchpin was an "Economic Cash Flow Model" ("ECFM") which the SDR proffered to demonstrate that the reasonable likelihood that Highlands' policyholders would have all of their claims paid in full—at least at a level greater than would be achieved in liquidation.

Opposition to the plan was fierce. At least 10 creditors — including major corporate policyholders — some in Chapter 11, "mom and pop" insureds, cedents, reinsurers and even some of Highlands' affiliates[4] — objected on multiple grounds, asserting, among other things, due process violations, that the plan was a *de facto* liquidation without guaranty fund protection and other liquidation "benefits" for policyholders, that the SDR had not demonstrated that policyholders would receive at least as much under the plan as they would receive in a liquidation—indeed that the plan discriminated in favor of workers compensation claimants as against all other policyholders, and that the plan did not demonstrate that there were adequate means to support it. An extensive hearing (spanning nine months, seven formal evidentiary hearings involving the testimony of numerous expert witnesses, closing argument, and thousands of pages of motions and briefing materials) followed before a Special Master in Austin, Texas, during which the SDR presented various financial and actuarial projections and analyses in support of the plan.

In April 2007, the Special Master issued a 37-page memorandum opinion recommending denial of the proposed plan.

In April 2007, the Special Master issued a 37-page memorandum opinion recommending denial of the proposed plan. The Special Master concluded, among other things, that the inherent risks in estimating EMT claims over many years called for a more conservative approach in developing projections, but even under such an approach, the SDR could not meet its burden to support the application. Among the Special Master's findings was the SDR's failure to demonstrate that the plan would pay all Allowed Class 2 (policyholder) Claims equally and in full over the life of the plan. The Special Master found in the SDR's favor on a few key points—notably the permissibility of implementing a managed runoff in the context of rehabilitation — but concluded that the proposed plan could not satisfy the new legal requirements. However, the Special Master gloomily commented that "the SDR has not established (and likely cannot establish) by a preponderance of the evidence in this Estate that all Allowed Class 2 claimants from now through closure of the Estate will receive 100% of their Allowed claim in rehabilitation."[5]

Despite the objectors' initial victory, the SDR petitioned the state court for a trial *de novo*. Among other things, they

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Highlands Insurance Company, *In Receivership* *continued from page 24*

collectively contested the Special Master's allocation of the burden of proof and his interpretation of the Act, as well as his findings and conclusions. Meanwhile, the SDR was revising the plan to overcome the Special Master's damaging findings. Substantial briefing and discovery followed, as well as settlement with Highlands' UK affiliate (which had been the SDR's most vociferous opponent).

The receivership court conducted a four day trial in May 2008. Unlike the Special Master hearing, very few interested persons participated or even observed.

The receivership court conducted a four day trial in May 2008. Unlike the Special Master hearing, very few interested persons participated or even observed. After considering evidence from the prior hearing, as well as new expert actuarial testimony establishing the reasonableness of the plan's financial projections, the court approved a Second Amended Plan of Rehabilitation ("Plan").

In reaching its decision, the court noted the size of the Estate's liabilities: $650 million of policy claim liability in all 50 states, of which approximately $110 million was for worker's compensation claims, $360 million for EMT claims, and $180 million of "other" claims. Upon its review of a new ECFM, the court concluded:

> The ECFM is based on assumptions concerning income and claim payments that are reasonable and reliable. Based on these estimates, the Estate should have sufficient funds to pay allowed administrative and policyholder claims as they become payable. As of the tenth anniversary of the ECFM, for example, the Estate reasonably anticipates having a cushion in excess of $140 million available to pay remaining policyholder claims and then non-policyholder claims. This cushion is more than 20% of the total estimated claim liability of $650 million. At the end of the anticipated payments to policyholders, the ECFM reasonably projects that significant funds will be available to pay lower priority non-policyholder claims.[6]

The court was further persuaded by the Estate's substantial reinsurance (approx. 90%), and general success in collecting reinsurance (approx. 82%). On balance, the court found that rehabilitation was likely to prove more effective than liquidation, particularly when considering the limited coverage of guaranty funds, and the impediments which liquidations cause (e.g., encumbrances in reporting data to reinsurers).

The Estate's Performance to Date

The SDR reports quarterly to the Special Master on the managed runoff of Highlands' liabilities. Per Special Master order, the SDR developed a four-phase monitoring plan to assess the Estate's performance, which includes:

- review of investment rates of return, recovery of assets, actual versus projected claims payouts, and administrative expenses;
- updated claims liability analyses;
- updated actuarial analyses; and
- processing of information through the ECFM.[7]

On July 19, 2010, the SDR orally reported to the Special Master that the updated ECFM and actuarial analysis confirm that the SDR's decision to support the rehabilitation continues to be reasonably and rationally based. The updated ECFM projects over time (through 2032) that all Class 1 and Class 2 claims will be paid in full as they become due. Per the analysis, the SDR reported there would be no impairment of cash and invested assets. The SDR also reported improvement in the Estate's gross claims liability. Prior reports indicated the Estate faced $650 million in claims liability; by July 2010, the number had reduced to approximately $399 million. The total claims paid out to date were slightly higher ($10 million) than prior projections, but reinsurance collections were $24 million higher, and cash and invested assets were $27 million ahead of ECFM projections.

Per the analysis, the SDR reported there would be no impairment of cash and invested assets.

As of April 11, 2011, total assets equaled $220,638,733, while total liabilities inched up slightly to $401,043,427 (including multiple liability classifications). The SDR's quarterly financial reports may be viewed at the Highlands Docket Website.

Conclusion

Highlands confirms the flexibility of rehabilitation in the hands of a creative regulator. Time will reveal the Plan's relative success. Various disputes and issues involving interested parties continue, but the Estate is proceeding to address claims and operate under the platform set in place several years ago. Highlands teaches that, to the extent done within the bounds of the law: (i) a managed runoff

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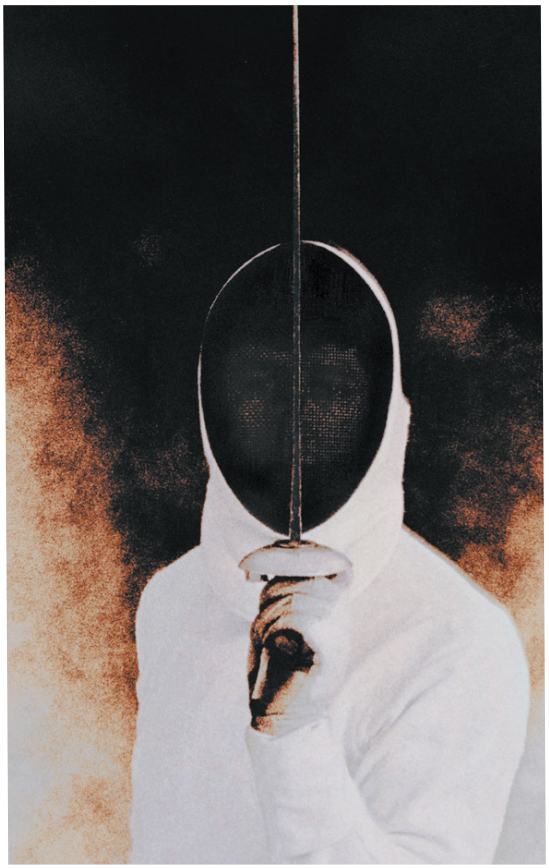

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The NAIC's Global Receivership Information Database (GRID):

A Consumer-friendly Resource for U.S. Insurance Receiverships

We interviewed David Vacca, Senior Financial Analysis & Receivership Manager with the National Association of Insurance Receivers, with respect to an NAIC database opened to the public three years ago. The GRID remains a work in progress, but constitutes one of the few central sources for information on U.S. insurance (and reinsurance) company receiverships.

By Constance D. O'Mara and James Veach

James: *Connie and I know that you are busy. We appreciate your taking time out for us. Could you tell us a little bit about your position with the NAIC?*

David: I am a CPA. I work with—among other committees and task forces—the NAIC's Receivership, Technology, and Administrative Working Group (RTA Working Group) chaired by Wayne Johnson. Mr. Johnson is the Division Director of the Florida Office of Rehabilitation and Liquidation.

I am also the assistant director of the NAIC's Insurance Analysis and Information Services Department that operates within the Regulatory Services Division. My department is responsible for financial analysis generally and works closely with the Financial Analysis Working Group (FAWG), an early warning system for troubled companies. My department also publishes information and reports on data generated by our financial analysts. We also oversee the NAIC's receivership activities.

I assist the RTA Working Group on various technology and administrative projects. For example, we are now dealing with electronic proof of claim procedures. The RTA Working Group is also addressing claim assignment and petition issues.

James: *How did you become involved with the GRID?*

David: Douglas Hartz, an attorney in the NAIC's in-house legal unit, brought me in to help him and others on what was to become the GRID. I have an accounting background and the GRID raised many accounting issues.

> *When Mr. Hartz left the NAIC, I stayed with the project because of my accounting background and also because of my work for FAWG.*

For example, most insolvent insurance company estates operate on a cash basis, but some use statutory accounting concepts. Mr. Hartz asked for my input on how to address these differences. When Mr. Hartz left the NAIC, I stayed with the project because of my accounting background and also because of my work for FAWG.

As a staff person working with FAWG, I was often one of the first to know of a potential receivership. I would advise those working on the GRID project that we might soon have another estate to add to the database that Mr. Hartz wanted to build. That's more or less how I became—and have remained—involved.

Connie: *Please give us a thumbnail description of the GRID.*

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Constance D. O'Mara is an ARIAS-US Certified Arbitrator. Formerly President and Chief Legal Officer of Brandywine Division of the ACE Group, she has over 25 years of experience in the P&C direct and reinsurance fields. Her current practice includes arbitrations, mediations, and expert review. She can be reached at connie@cdomaraconsulting.com.

James Veach, a Partner at Mound Cotton Wollan & Greengrass, is a "recovering litigator" and an ARIAS-U.S. certified arbitrator who has tried reinsurance cases to juries. Mr. Veach now focuses his practice on run-off. He can be reached at jveach@moundcotton.com.

The NAIC's Global Receivership Information Database (GRID) *continued from page 29*

David: Over the years, state insurance regulators have been pushing for greater transparency and ease of consumer access to insurance receiverships. The GRID provides a national database for that receivership information. The GRID allows regulators to better understand and disclose information to consumers, regulators, claimants, and other interested parties.

The GRID allows all of these parties to access the receivership process and, specifically, the data that regulators have made available on a state-by-state basis. Most important: the GRID brings all of the receivership data that we have collected at the NAIC under one roof.

James: *When did the GRID get off the ground?*

> *We did a lot of scrubbing, tweaking, and screen redesigning because we couldn't get a majority of the receiverships to provide the same information we needed for a uniform fifty-state database.*

David: In 2004, we began to build the GRID and populate it with regulator information. We opened the GRID to the general public in August 2008. We did a lot of scrubbing, tweaking, and screen redesigning because we couldn't get a majority of the receiverships to provide the same information we needed for a uniform fifty-state database.

Connie: *Please give our readers an idea of the kinds of information they can find in the GRID.*

David: The GRID provides receivership contact information, including receivership contact persons, docket numbers, e-mail addresses, and phone numbers. The GRID also sets out information relating to the estate, including:

- reinsurance recoveries;
- reinsurance arbitration;
- litigation;
- recovery of assets;
- distribution of assets;
- Federal super-priority issues;
- sale of shells; and
- Federal tax issues.

The GRID provides company information. This includes, among other things, lines of business written. The GRID sets out information about licensing and identifies the states in which the company wrote those lines.

The GRID also sets out the failed company's post-claim activities, including:

- claims deadlines;
- claims moratoria;
- hardship exemptions;
- cancelled policies;
- non-renewed policies;
- business activities; and
- state deposits.

Finally, the GRID describes the history of the estate or the "path of the receivership."

James: *The "path of the receivership"?*

David: By that I mean: did the company go from active insurer directly to liquidation. Or did the company begin under supervision and then move to conservation or rehabilitation and THEN liquidation. We want to understand how the receiver came to control the company. Put differently, we want to know how and why the company failed.

James: *How many receiverships does the GRID cover?*

David: The GRID provides information on 1,200 receiverships.

Connie: *Can an AIRROC member access the GRID?*

David: Any consumer and any other person can access the GRID. You can log on by going to the NAIC website at www.NAIC.org. When you open the page click on Consumer Information Source and look on the right hand side of page for the Global Receivership Information Database (GRID). Or you can go directly to https://I-site.naic.org/grid/gridDisc.jsp. Of course, you must agree to the GRID's "terms of use".

Connie: *I have looked at a few of the companies covered in the GRID and I have a copy of the balance sheet for Integrity Insurance Company. I know that this receiver's financial statements have a number of notes, but I didn't see that information in the GRID entry for Integrity. Is there more information on the GRID that I'm not seeing?*

David: You may have additional balance sheet details that don't appear on the GRID, but remember that insurance consumers are our primary focus and audience. For that estate, you may not find the same accounting details, but you will find considerable detail showing moneys paid by the estate's receivers to policyholders and other claimants.

In other words, you may not find the same level of balance sheet detail, but the GRID essentially reveals how much the estate was able to pay policyholders and creditors and how actively the estate is being managed. We want to show the consumer and other regulators that we are making substantial distributions.

continued on next page

We are still phasing in the GRID. We are roughly through Phase I and in a Phase II mode in which we want to provide a minimum level of information for every estate.

Under Mr. Johnson's direction, we just mailed letters to receivers that had not yet produced their 2010 data. That information was due on April 1, 2011 for year-end 2010. Over time our expectations for information will be higher. At this point, we just want to see that the estates are being worked and payments are being made.

James: *I have seen certain estates that have almost no summary report information.*

David: The RTA Working Group chair has been writing and pressing for additional and better information. I can't talk about a particular state or estate, but at the NAIC Spring Meeting in Austin, James Mumford (Iowa) addressed a new Financial Analysis Working Group—the Receivership—FAWG.

We have just adopted a PDF mechanism for inputting and transferring this information and I believe this will help the RTA Working Group considerably.

With this increased scrutiny, state receivers will have even more incentive to produce detailed information, particularly with respect to nationally significant estates.

We have just adopted a PDF mechanism for inputting and transferring this information and I believe this will help the RTA Working Group considerably. As I just mentioned, states have until April 1st of each year to supply data. Lots of information came in over the past few weeks as the states tried to meet their April 1st deadline.

James: *Does failure to provide information hurt a state seeking accreditation?*

David: No; a state's GRID response does not affect accreditation, at least directly.

James: *How many hits are you getting?*

David: We get 24,000–30,000 hits per quarter. We have, however, been subject to a lot of data mining that has skewed these numbers. We are addressing this problem because our primary focus continues to be the consumer.

James: *I see that you have links to other data sources, such as the National Organization of Health and Life Guaranty Associations.*

David: Yes, using the GRID you can also go directly via email to the contact person for the individual estate. If anyone at AIRROC wants to comment on the GRID and offer their comments and suggestions, please let us know.

Any consumer can access the Global Receivership Information Database (GRID) on the NAIC website at www.NAIC.org

Direct link: https://I-site.naic.org/grid/gridDisc.jsp

James: *We can see the value of having this data in one place.*

David: We have come a long way and the accuracy keeps increasing. Of course, many states are operating under budget constraints or hiring freezes. The NAIC's staff works with these states to avoiding burdening them.

Connie: *I did note that some of the estates have posted considerable detail, including balance sheet information. For example, Reliance Insurance Company, in liquidation in Pennsylvania, has posted a tremendous amount of information available on the Reliance estate.*

David: Yes, the Reliance estate is particularly complete, a gold standard of sorts for receivership information available through GRID. The Florida estates are just as detailed and quite complete. But we want to stress that we are always looking for suggestions to improve the GRID.

If I get a request for information about the GRID from a state that hasn't had any recent experience in receivership, I often suggest they look at the Reliance entries or the information available on almost all of the Florida estates.

Connie: *Yes, once you work through one estate, you begin to see how this works per state.*

David: Estates and states also vary with respect to their technological capabilities. NAIC staff persons often enter hard copy data onto the GRID themselves.

Connie: *David, we know you have a lot to do and that you were tied up most of this week with visiting regulators. We wanted to thank you for your time today. This has been a great interview.*

James: *Absolutely. We could continue all day, but we know that you can't. AIRROC appreciates your time. We invite Wayne Johnson and you to address an AIRROC education session at some time and hear from our members.*

David: You're both welcome. We are excited about the GRID and want to talk about the successes we have seen with our receiverships. At the same time, we recognize the need for improvement and welcome AIRROC's input. ■

Integrity Insurance in Liquidation *continued from page 16*

could run the Estate off until substantially all the claims were reported or we could to do an early type of closing utilizing claims estimation. The Commissioner ultimately approved the early closing option. So we developed a plan and figured out how to do it using actuaries and so on. As you know claims estimation was resisted by reinsurers and the litigation over it continued until 2007 when the NJ Supreme Court in a 3-2 decision (with two recusals) ruled against claims estimation.

(Note from the author: For information on the litigation over this aspect of the Integrity Bankruptcy please see *In The Matter of The Liquidation of Integrity Insurance Company,* 193 N.J. 886, 935 A. 2d 1184 (12/13/2007)].

Connie: *Over the period of your work with Integrity did you see adverse development in claims and estimates? Was there a need to redo IBNR based on trends?*

Because so many uncertainties faced the industry in environmental as well as asbestos exposures, there was an element of conservatism built into these estimates.

Richard: Yes. The early estimate of Integrity's impaired statutory surplus was approximately $140 million. This increased to almost $900 million as claims emerged. With commutations and investment results our year-end 2009 estimate is approximately $400 million. In the early years of the insolvency, the entire industry was alarmed with environmental losses. The courts had determined that liability existed under a series of policies going way back and that the insurance industry was liable for these losses and getting one's arms around these exposures was very difficult. Because so many uncertainties faced the industry in environmental as well as asbestos exposures, there was an element of conservatism built into these estimates. Estimates prior to liquidation, in 1985 or 1986, of course, were incredibly deficient, but once Mike Miron, his staff and outside advisors completed the records reconstruction, they had pretty good insight on the exposures. Thereafter the actuarial studies providing estimates still reflected conservatism and I like to think that when the day finally comes closing this estate—hopefully it will not be that far away— *those* estimates will prove to be redundant.

Connie: *When I read the Dingell report I get the impression that the management of Integrity did not put the necessary resources into the business to conduct it in a way that made sense from an operations standpoint and that many of the costs that were being incurred in the insolvency were for resources that should have been spent in the ongoing business in the first place. Is that a misguided impression?*

Richard: Yes. It is. I would say reflect on your own experience in the solvent world of the pre-liquidation Integrity. In that period, the industry was just not equipped to foresee the extent of the APH (asbestos, pollution and health hazard) claims. Integrity was no different and arguably less equipped than companies that had their own production staff and their own agents. Integrity went into liquidation around the time the rest of the industry was starting to grapple with how to estimate these claims and the rest of the industry was spending money and effort to figure out how to handle these losses. Integrity was not a division of a behemoth like CIGNA or AIG. It went into liquidation right as others were getting their act together and the resulting loss of personnel and the systems deficiencies exacerbated the problem related to the excess and umbrella book of business. The fault of prior management related more to increasing leverage than to insufficient resources. They should have understood the leverage they were introducing into their balance sheet.

Connie: *In terms of how NJ operates insolvencies, are there financial statements available to the public?*

Richard: Yes, what we have done for many years is file with the Liquidation Court comprehensive financial statements. They are a little different than those filed by an active company, but they include a balance sheet, statement of receipts and a detailed set of footnotes that explain what is going on with respect to reinsurance, lawsuits, distributions, and so on. We have retained independent accounting firms over the years to do a review and they issue a report which is, not surprisingly, called an "accountant's review report" and I can send it to you and it will give you a pretty good sense of how much has been marshaled and spent and background on these various questions.

Connie: *Do these statements contain numbers as in number of claims submitted? And I understand that people count claims differently.*

Richard: We have totals broken down by guarantee associations and policyholders but beyond that we don't report number of claims.

Connie: *So, what happens next in the estate?*

Richard: Well after the NJ Supreme Court said our plan seemed like a good idea but inconsistent with the state statute, we went back to the concept of filing a more traditional type closing plan, commonly called a cut-off closing plan wherein we would pay losses submitted through a closing date, in this case June 30, 2009. Under

continued on next page

Integrity Insurance in Liquidation *continued from page 32*

that plan, the liquidator had until January 31, 2010 to value those claims that were submitted, which we did. Thereafter, creditors have some period of time to object to the liquidator's determination and that was the $64,000 question—would there be extensive objections? In the 15 years I have been at Integrity, there were not a lot of objections to our allowances/disallowances. There were disputes over support for a claim and allocation issues, but we always worked them out. So, we did not have a sense of what would happen with the claims submitted as part of the closure plan. It turned out that over 60 claimants objected to the liquidator's determination.

Connie: *What percentage was that?*

Richard: Well, it was not a significant percentage in terms of the number of claims, but the dollar value was not insignificant. So we went back to court and suggested appointing a special master to hear these objections, make a determination and submit the determinations to the court for approval/disapproval. The court agreed and appointed a special master. So we are scheduling them and as I sit here today, I would expect that by the end of June all of the special master's determinations will have been made and the court may even have ruled to affirm or disaffirm those determinations. Thus by the end of June we *should* have a good idea what our liabilities are; we will certainly know what our assets are, but I cannot tell you that we are going to declare victory and go home. Those creditors whose claims have been determined by special master and affirmed/disaffirmed by the court have the right to appeal. The results of one or more appeals could affect where we end up depending on the value of the underlying claims. I would like to think that the New Jersey Appellate Division, knowing the long history of this estate, would move quickly but there is no guarantee on that and there could be another year as we wait to learn what the final liabilities will be. So, best case, sometime around the first quarter of 2012, worst case, end of the summer 2012 but those are guesstimates.

The results of one or more appeals could affect where we end up depending on the value of the underlying claims.

Connie: *The Dingell report says Integrity's "ultimate net cost will be $300 million." How does that number look now?*

Richard: As I indicated earlier, our 2009 capital deficiency (excess of liabilities over assets) is approximately $400 million, so the number mentioned in the Dingell report was not a bad early estimate. ■

Midland: New York's Approach *continued from page 19*

B. Legal problems presented

Before the sale can be accomplished, however, certain legal obstacles need to be overcome. The primary legal issue that arises relates to Midland's reinsurers: if Midland were to be sold and taken out of liquidation, the reinsurers' obligation to pay 100 percent of allowed claims, rather than simply the percent actually paid out, could disappear. This in turn would reduce the assets of Midland significantly.

The challenge for the NYLB is to find a legal way to take Midland out of liquidation while still forcing the reinsurers to pay 100 cents on the dollar.

The challenge for the NYLB is to find a legal way to take Midland out of liquidation while still forcing the reinsurers to pay 100 cents on the dollar. The proposed solution is, in essence, to sell only part of Midland. In accordance with this plan, claimants could opt out of the sale and their claims would remain in a shell company in liquidation. The reinsurers would have the same option: they could either opt into the sale and agree to pay 100 cents on the dollar while waiving their rights to contest, or they could opt out of the sale and stay in liquidation, in which case they would still pay 100 cents on the dollar. The advantage for the reinsurers of choosing the sale option is that they will gain rights of association, which they are not entitled to in liquidation.[1] If the choice is between voluntarily agreeing to pay 100 cents on the dollar outside of liquidation, or remaining in liquidation, no reinsurer will have standing to bring a challenge before a court.

As of today, the proposal is still under consideration by the NYLB and the Midland saga continues. Ultimately, the present leadership of the NYLB will need to decide whether to adopt this new approach or continue its 25-year march onward with traditional run-off. ■

Endnotes

1 Rights of association are something typically denied to reinsurers once a company goes into liquidation in New York. Even where such a right existed pre-receivership, the NYLB as a operational matter does not grant such rights once it takes over the company. Moreover, where the NYLB determines that a claim should be paid, such determination is subject to approval by the receivership court. As such, the reinsurer's only practical option is to object to that court order allowing the claim, a far less useful course than association. This is especially so given the strong deference shown to the receiver in court proceedings. Given these realities, the proffered right of association at the opening stages of the claims process could prove a real advantage to the reinsurers.

Reliance Insurance Company (In Liquidation)—One Decade Later *continued from page 9*

among the factors dooming rehabilitation was Reliance's cash position. By the end of rehabilitation, Reliance had only five days worth of funds on hand to pay its obligations. According to the Commissioner, the decision to liquidate Reliance was precipitated, but hardly caused, by the anticipated impact of 9/11 on the large reinsurance companies that Reliance relied upon. This horrific loss, and its implications for reinsurance recovery and cash flow, was the last straw.


David Brietling


Keith Kaplan

On October 3, 2001, the Honorable James Gardner Colins, then President Judge of the Commonwealth Court of the Commonwealth of Pennsylvania, granted the Department's petition to liquidate Reliance. According to the Liquidation Order, Judge Colins terminated Reliance's rehabilitation and declared Reliance "insolvent" pursuant to the Pennsylvania insurance insolvency statute, Article V of the Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, added by Section 2 of Act of December 14, 1977, P.L. 280 as amended, 40 P.S. §§ 221.1 – 221.63 ("the Act"). Judge Colins appointed the Pennsylvania Insurance Commissioner, and her successors, as the Statutory Liquidator of Reliance, and vested the Statutory Liquidator with title to "all property, assets, contracts and rights of action ("assets") of Reliance, of whatever nature and wherever located, whether held directly or indirectly, as of the date of the filing of the Petition for Liquidation." Pursuant to the Act and the liquidation order, the Commonwealth Court became the supervisory court overseeing the estate of Reliance and the Statutory Liquidator's efforts to finally wind up the business of Reliance.

There were 80,000 to 100,000 outstanding claims, and information on over one million policies in Reliance's systems.

This was no small task. From the perspective of administering "the estate of Reliance" as a single entity, Reliance was a worst case scenario. Prior to liquidation, Reliance had a decentralized business model. It was run through competing profit centers, there were nine statutory entities, there were 175 third-party administrators and program managers, many reporting through dissimilar data systems, and there were over 1,000 offices and locations (inclusive of TPA offices). There were 80,000 to 100,000 outstanding claims, and information on over one million policies in Reliance's systems. The claims had to be physically transferred immediately and supporting data and information supplied electronically to 60 guaranty associations ("GAs"). Reliance estimated at that time that it faced nearly $10 billion of liabilities.

During that same time, Reliance had to create an infrastructure to keep current with claims handling by GAs, proofs of claim filed in the estate, and claims evaluation, both in terms of statutory priority and value in accordance with the Act. In addition, procedures needed to be developed for the resolution of issues and disputes as the liquidation process ensued. To date, over 160,000 proofs of claims have been filed against Reliance. In addition to the administrative and operational nightmares, Reliance needed to address the legal issues raised by liquidation. Reliance needed to simultaneously separate itself from far-flung Reliance-related companies that were not part of the liquidation and to withdraw from multiples of on-going coverage litigations across the country. And it needed to monetize and collect nearly $5.5 billion dollars in reinsurance, by far the most significant—and challenging—asset of the estate, which was critical to provide the funds to pay for administrative services, early access to GAs, and ultimately pay distribution to creditors. There was also over $1.6 billion in collateral maintained to support exposures on deductible and retro policies.

Both Brietling and Kaplan recalled the early days of being inundated with complexities that arose from the mechanics of transitioning an operating insurer into a liquidation.

Two individuals on the Reliance front line were David Brietling and Keith Kaplan. In April of 2001, following a career as an executive at both insurance and reinsurance companies, Brietling was appointed by the Pennsylvania Insurance Department as the on-site monitor of the daily operations of Reliance. When Reliance was placed into liquidation, Brietling was made its Chief Liquidation Officer. Kaplan, a long-time employee of Reliance in several senior capacities, continued as the Executive Vice President of Reinsurance. To them, their company management and staff, under the active guidance of the Pennsylvania Insurance Department, fell the daunting task of complying with the dictates of the Act to "protect the interests of the insureds, creditors, and the public generally… through … enhanced efficiency and economy of liquidation…[and] the equitable apportionment of any unavoidable loss."[7]

continued on next page

Transitioning from Insurer to Liquidation

Both Brietling and Kaplan recalled the early days of being inundated with complexities that arose from the mechanics of transitioning an operating insurer into a liquidation. But at the same time, they felt the need to make critical up-front policy decisions that would provide overarching guidance as to how the estate would unfold. As both Brietling and Kaplan remember, the first and most important decision was that they would operate the Reliance liquidation "just like an ongoing business." As Brietling described it, all decisions would be made based on well-known business principles, only after thorough analysis including, where appropriate, a thorough cost-benefit analysis, seeking efficiency and effectiveness and evaluating the performance of the estate based upon defined and clearly articulated goals and annual targets. For example, early-on, Reliance invested in technology, establishing an electronic imaging system for claims with significant capabilities for workflow assignments and controls, which now has over 90 million images. This allowed Reliance to handle claims internally in an efficient manner and to exchange documents freely with reinsurers and permitted virtual reinsurance audits. Then, as now, the transformation to electronic imaging "is a big positive," according to Kaplan. "It goes a long way in keeping reinsurers in the loop" and reduces issues arising because of a lack of information.

Another early policy decision by Brietling and Kaplan was to emphasize communication and transparency. "To reach out," as Brietling explained, "to all stakeholders who had an interest in the on-going operations of the liquidation." Reliance kept in communication with the insurance and reinsurance community to determine what their concerns and issues were. For example, knowing that the issue of how the Act's provisions for offsets were to be applied would be a very significant financial concern to reinsurers, Kaplan engaged in discussions with industry leaders before the formulation and issuance of a written directive that identified how setoffs would be applied in various common scenarios. The wisdom of providing clear and definitive standards for the application of setoffs is reflected in the fact that setoff disputes are rare. There was also extensive communication with reinsurers on how claims would be processed in liquidation, both at the GAs and through the proof of claim process within Reliance. Also of significant importance to reinsurers was the related claim oversight and review by Reliance staff and the reporting process to reinsurers. Kaplan covered all these topics in his meetings with various reinsurers.

Reliance's commitment to being transparent in its post-liquidation business was reflected in its frequent and extensive disclosure. The majority of documents pertaining to the Reliance estate can be found on a public docket, www.reliancedocuments.com ("The purpose of this website is to provide interested persons with access to pleadings and other documents of the Liquidator of Reliance Insurance Company filed with the Commonwealth Court of Pennsylvania in the Civil Action No. 269 M.D. 2001 (Pa. Cmwlth. Ct.). The official docket may be obtained from the website of Pennsylvania's Unified Judicial System. Also, additional information about the Liquidation of Reliance Insurance Company, and Liquidation in general, may be obtained from the website of the Pennsylvania Insurance Department and the website of Reliance Insurance Company (in Liquidation)."). The Statutory Liquidator's Quarterly Reports to the Court with financial and operational information are also publically available. The Statutory Liquidator's Quarterly Reports to the Court with financial and operational information are also publically available.

Similarly, the Commonwealth Court has been an active participant in creating a clear framework within which the estate operates.

Similarly, the Commonwealth Court has been an active participant in creating a clear framework within which the estate operates. Working with the Statutory Liquidator, the Court has established comprehensive rules and procedures, most notably for filing proofs of claim and for the claims process itself, establishing timeframes for responding to proofs of claims filed in the estate as well as for when claim determinations were to be issued. The Court also provided a dispute resolution forum for claimants, creditors and reinsurers allowing them to have an opportunity to be heard by way of a referee process, arbitration (when appropriate), or intervention (if necessary) in the formal liquidation proceedings.

Legal Issues Abound

Given the size and complexity of the liquidation, it was unavoidable that there would be considerable activity before the Commonwealth Court and in reinsurance

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Reliance Insurance Company (In Liquidation)—One Decade Later *continued from page 35*

arbitrations, particularly because Reliance presented legal and financial issues that had never been confronted before in Pennsylvania, or, in some instances, in any insurer insolvency. Among the unique and difficult issues raised were whether, and under what circumstances, policyholders could "cut through" to Reliance's reinsurers, how large deductibles should be treated in the estate, what priority classification should be assigned to unusual products issued by Reliance (such as trade credit contracts, film finance policies, financial guaranty and warranty products), the operation of the Act's cancellation provisions, and choice-of-law issues for coverage determinations. Even now, Brietling remarked, new legal challenges continually confront the estate.

Conclusion

Over the last ten years, Reliance has fulfilled the prediction of being "the largest and most challenging property casualty insolvency" in history.

Ten years in, Brietling and Kaplan feel that significant progress has been achieved in reaching the overall goals of the liquidation. Distributions to class (b) claimants approved by the Court are now 30%. The GAs have received over $2 billion in early access funds, which is 65% to 70% of what the GAs have paid to date and represents over 50% of what the GAs have estimated will be their total incurred liabilities on Reliance claims ($4 billion). The GAs have agreed to refund any early access funds in excess of the ultimate distribution percentage. 96% of the proofs of claim filed with Reliance have been processed and have received notices of determination. Over $800 million of those claims have been afforded "(b)" priority status. However, the Pennsylvania statutes allow for late filed claims in the estate and the long-tail business written by Reliance will result in substantial future losses. Reliance has collected $3.4 billion in cash from reinsurers and granted $258 million in reinsurance offsets. The ultimate reinsurance recoverable remaining is down to $1.1 billion, net of estimated bad debts and offsets. Reliance has successfully commuted approximately $1 billion of ceded reinsurance liability. Although it is difficult to compare the results of different liquidations, by any definition, this is certainly "significant progress."

Over the last ten years, Reliance has fulfilled the prediction of being "the largest and most challenging property casualty insolvency" in history. Detractors may say that Reliance's expenses have been high, with over $1 billion incurred to date, including $253 million paid to GAs for their administrative fees. Critics also complain that the process of distributing assets and closing the estate will take too long. But Brietling counter-poses these comments: "What would be the total costs and time frame in the context of a voluntary solvent company runoff for a $9 billion dollar plus book of liabilities with related reinsurance recoverables of over 50%"? One other factor to consider: "although the GA overlay may add certain costs to the liquidation, it is also true that several hundreds of millions of dollars of liabilities were absorbed by other carriers by using GA statutory defenses." In sum, Brietling observes,

> Is liquidation the best model there is? I don't know, although there are some obvious inefficiencies. But this is the model we are required to use under the law, and we've tried to do the best that can be done under some difficult and unusual circumstances in order to maximize the ultimate payout to creditors in a shorter time frame than other large scale property/casualty insolvencies. ■

Notes

1 10/5/01 *New York Times,* "Pennsylvania Is Closing Insurer."

2 Reliance Insurance Company had seven affiliates that were merged into Reliance the January before it closed its doors to active business. Those companies are Reliance National Indemnity Company, Reliance National Insurance Company, United Pacific Insurance Company, Reliance Direct Company, Reliance Surety Company, Reliance Universal Insurance Company of New York and Reliance Insurance Company of Illinois.

3 2001 Annual Report, Texas Property and Casualty Insurance Guaranty Association.

4 10/3/01 *Philadelphia Inquirer*, "Reliance Insurance Declared Insolvent."

5 6/18/01 *Forbes,* "Forbes Face: Saul Steinberg." The *New York Times* actively followed both Mr. Steinberg's generous charitable contributions as well as his "infamous … 'let them eat cake' extravagances." 5/27/00 *New York Times*, "Selling the Farm, Park Avenue Style; For a Pair of Socialites, It's Out with the Ormula," Commenting on Mr. Steinberg's million-dollar parties and his 19,000 square foot Park Avenue penthouse, the *Times* gave a taste of Mr. Steinberg's excesses: "As for the furnishing, well, … if it wasn't gold, the Steinbergs did not own it. Unless, perhaps, it was ormolu-encrusted, bronze-mounted, rose-strewn, fringed, tasseled, brocaded, or covered with gilded sphinxes and sea serpents. Or someone else's family crest." In a later article, the *Times* reported on Mr. Steinberg getting sued by his own mother, because he owed her millions of dollar. "[T]imes are tough… [because] the insurance company that provided their lavish standard of living is on the brink of bankruptcy." 9/9/00 *New York Times,* "Sorry, Mother, But Get in Line For Your Money; Suit Says Steinberg Sons Failed to Repay Loans."

6 1999 *Best's Insurance Reports – Property-Casualty.*

7 The Act, § 221.1.

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The Rise and Fall of Mission Insurance Company *continued from page 13*

Within months of his appointment, the special deputy commissioner issued so-called "pay or die" letters to Mission's reinsurers. Reinsurers were instructed to pay what was owed, and told that disputed amounts could be the subject of downstream discussions. Reinsurers were also warned that their failure to pay could result in regulatory reprisals. Stated another way, notwithstanding the Mission-driven fraud allegations, the conservation team had decided to focus on recovering the reinsurance bills.

> *…eventually, the regulators themselves realized that large portions of Mission had been a fraud.*

Despite these pressures, most reinsurers continued to withhold payments, and by February of 1987, it was clear that Mission's insolvency was incurable. An order of liquidation followed. Whether there were ever any serious plans to resuscitate Mission will never be known, although the controlling shareholder of Mission Group—Carl Lindner's American Financial Group—did make cash infusions in an effort to support its balance sheet and to temporarily allow Mission to make loss payments to policyholders. Senior management, armed with knowledge that the end was near, cashed out,[4] and some went on to other ventures—which met similarly insolvent fates.[5] There were very few left to pick up the pieces. And, eventually, the regulators themselves realized that large portions of Mission had been a fraud. This operation was not worth rehabilitating.

Mission's Liquidator takes the Offensive

Shortly after being placed into liquidation, the special deputy came out with guns blazing. Lawsuits were filed against Mission's reinsurers seeking to recover reinsurance balances. The lawsuits also included counts for unspecified punitive damages against reinsurers for having caused or contributed to the liquidation of Mission by withholding reinsurance balances.

In the litigation in the liquidation court, the special deputy took many positions that were eventually rejected by the courts—but only after bizarre favorable initial results in the liquidation court. For example, the special deputy contended that:

1 reinsurers could not assert setoff rights against the Mission estate and had to pay balances in full. Like all other jurisdictions, the California Supreme Court rejected that position—though the special deputy's position had been upheld by the liquidation court.[6]

2 reinsurers could not assert fraud or any other defense to payment that would have the effect of reducing the amount of reinsurance balances due the estate; and

3 Mission had the right to accelerate future losses, thereby requiring reinsurers to make immediate payment for reserves in respect of incurred but not reported losses ("IBNR"). California appellate courts rejected that position as well—but, once again, only after it had been adopted by the liquidation court.[7]

The PRMC Arbitration Hearing Uncovers a Laundry List of Transgressions

The PRMC arbitration hearing commenced in September of 1987 and ran for almost 50 hearing days. The testimony revealed every imaginable MGA-related transgression, including the following.

1 The writing of business that was excluded by the applicable management agreement. For example, facultative business and foreign business were excluded from PRMC's underwriting authority. Yet a large percentage of all the business underwritten by PRMC between 1977 and 1984 fell into these two excluded classes.[8]

2 Misrepresentation about business actually being underwritten. For example, pool members were told that PRMC would generally avoid writing working (lower layer/higher frequency of losses) casualty business. Yet, PRMC actively targeted such accounts, particularly in the later years, so that it could continue increase its premium, year on year, even though the rates on such business could not support the risk. Thirty-two percent of all business accepted by PRMC in 1981-82 would qualify as "working casualty."[9]

3 Misrepresentation about the size of lines being accepted on incoming contracts — PRMC represented to pool members that PRMC subscribed to a conservative underwriting philosophy and would be taking small lines on a large number of accounts. In fact, PRMC began operating as a lead, which allowed it to further its agenda as a commission merchant. Large blocks of premium were derived from a relatively small number of accounts.

4 Concealing that most (bad) business was coming from the same production sources. See #3 above.[10]

5 Misrepresenting the mix of business between property and casualty. This trouble was sneakily problematic. Where the inward treaty consisted of both property

continued on next page

and casualty business, PRMC would code the treaty as one or the other. Thus, a treaty deemed to contain more than 50% property business would be coded by PRMC as property. That distinction mattered greatly because PRMC did not apply IBNR to property treaties. Thus no IBNR was assigned to the sometimes vast casualty components of "property" treaties. As the vast majority of exposures under these "property" treaties was actually casualty, this coding practice further contributed to enormous reserve deficiencies.

6 Intentionally concealing accident year development from participants by reporting calendar year figures only once.

7 Underreserving for losses. PRMC secretly utilized a formula-driven IBNR reserve—applied only to casualty—which assumed that all losses would be fully developed in 5 years. This formula was applied on a straight declining-balance basis, even though PRMC's internally-maintained loss statistics revealed adverse development long beyond the fifth year after a contract incepted.[11]

8 Prohibiting claim handlers from putting up additional case reserves, even when reported reserves were known to be inadequate.

9 The maintenance of undisclosed pools within the pool so that the perceived cream business could be siphoned off for "Mission Only."

PRMC's Discretionary Reserve Fund

But, we saved our favorite for last—the so-called Discretionary Reserve Fund ("DRF"). The DRF was uncovered during discovery in the PRMC arbitration.

PRMC recognized that calendar year reports would reflect results that were too good to be true, particularly where there were too few prior underwriting years.

PRMC recognized that calendar year reports would reflect results that were too good to be true, particularly where there were too few prior underwriting years. This could arouse pool participants' suspicion, because pool members believed that they were looking at accident year figures. To mask "exceptionally good results," PRMC maintained a "dummy file" for these so-called discretionary reserves. The President of PRMC, Ron Bengtson, would sit with his accounting manager and would decide how much of the discretionary reserves should be added to or deleted from accounts sent to participants in any given year. As related in the Dingell Report (at 18), Mr. Bengtson's pre-determined objective was to add or subtract discretionary reserves, so that he could report a combined ratio of around 99% to pool participants on an annual basis. The use of these discretionary reserves were not tied to actual losses or loss development, and thus, could not be justified as a bulk reserve. The DRF enabled PRMC to smooth out what would otherwise be seen as large disparities in the loss reports from year to year, which might prompt inquiry from participants. As new losses began to pile up the DRF was completely depleted, and unavailable to be used by PRMC when reserve strengthening was needed most.

The various affected reinsurance disputes concluded with mixed, and telling results that may have been affected by the forum selected. Some arbitrating reinsurers were ordered to pay, while rescission *ab initio* was awarded before a panel of retired judges. The arbitration awards were, however, challenged in federal court and were never confirmed.

The political pressure to collect reinsurance in the Mission liquidation was palpable. And it rewarded some public policy objectives: those collections allowed Mission to pay significant dividends to policyholders and other creditors. However, the political pressure also pointed to one of the major flaws in the regulatory/ liquidation process—i.e., that the task of administering the liquidation estates often falls to the same people whose regulatory oversight missed the bad acts of the regulated entity. As observed in the Dingell Report,

> With no real incentive to discover management fraud, and with a strong financial reason not to find it, the receiver is not in a position to issue a credible determination regarding the existence of fraudulent activity by senior management at Mission…[12]

Learning from History

Have the industry and its regulators learned the lessons of the Mission estate? Clearly, this question merits additional debate. Two points, however, provide this author with a source for optimism.

First, a Mission repeat experience is unlikely in this era of technological advances and information dissemination. Today, it would be far harder to contain sensitive details and information within a small enough control

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group to keep the Mission failures under wraps for such an extensive period of time.

> *Today, it would be far harder to contain sensitive details and information within a small enough control group to keep the Mission failures under wraps for such an extensive period of time.*

Second, had a "Mission-like" company arisen during the past few years, it seems likely that the governmental and regulatory responses would have been stronger. The existence of the Dingell Report and the increased role of regulatory and prosecutorial oversight would inevitably allow for greater political pressure to proceed civilly and criminally against senior management. That reality, in turn, would make management less likely to be willing to take such risks. ■

Notes

1 Dingell Report at 2.

2 The Dingell Report observed that PRMC was able to convince approximately 75 reinsurance companies to join the pool and remain members over a period of several years. There was deliberate misrepresentation involved; however the Subcommittee's investigation has shown that anyone with a basic knowledge of insurance could have detected the wrongdoing. (Dingell Report at 21).

3 Cash flow underwriting in the soft market was made possible by double digit interest rates that prevailed during the late 1970s and early 1980s.

4 Mission had an executive compensation program that was geared to Mission's financial performance as compared to other companies in the industry. Key management personnel were awarded stock options and bonuses as rewards for superior results. The Mission Group chairman sold a large amount of his shares in early 1984, before the house of cards came tumbling down. PRMC senior management left in early 1983 and similarly sold stock before the full extent of Mission losses were made publicly available. (Dingell Report at 15-16).

5 Superior National was formed by former members of Mission Group senior management. Superior National ultimately collapsed as well. PRMC's senior management left to start their own reinsurance MGA, Continuity Re. Continuity Re had the pen for Integrity. Sadly, the only "continuity" was that Integrity also failed, just like Mission.

6 *See, Prudential Reinsurance Co. v. The Superior Court of Los Angeles County*, 3 Cal.4th 1118 (1992).

7 *See, Quackenbush v. Mission Ins. Co.*, 46 Cal.App.4th 458 (1996); *Quackenbush v. Mission Ins. Co.*, 62 Cal.App.4th 797 (1998).

8 (Dingell Report at 19.)

9 (Dingell Report at 19.)

10 PRMC wrote a number of contracts in favor of Integrity. Soon, Mission became the largest reinsurer of Integrity. When PRMC management left PRMC in 1983 to start up Continuity Re, Integrity not only gave them its pen, but also loaned them the money to finance the start up of Continuity Re's operations. PRMC pool members were laden with enormous losses on Integrity business.

11 Dingell Report at 17.

12 Dingell Report at 62.

Highlands Insurance Company, *In Receivership*

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remains a viable option for receivers; and (ii) receivership modes and practice will continue to evolve as receivers seek innovative ways of balancing the best interests of policyholders, other creditors and the public. ■

Notes

1 *See* Plaintiff Original Petition and Application for Permanent Injunction and Order Appointing Receiver, Nov. 6, 2003, *available at* http://www.sdrtx.com/documents.asp?Company=Highlands (hereinafter "Highlands Docket Website".

2 *See Id.* Agreed Permanent Injunction and Order Appointing Receiver (Filed November 3, 2003).

3 *See* Tex. Ins. Code § 443.001 *et seq.*

4 Meanwhile, creditors of Highlands' UK affiliate initiated proceedings in England to place the company in receivership, thus embroiling the SDR in litigation on both sides of the Atlantic at the same time that included jurisdictional challenges as well as disputes over applicable law.

5 Highlands Docket Website, Memorandum Recommendations and Finding of Fact and Conclusions of Law, at 31 (April 18, 2007).

6 Highlands Docket Website, Findings of Fact and Conclusions of Law Regarding Application for Approval of Rehabilitation Plan, ¶ 25 (June 6, 2008).

7 See SDR's Monitoring Plan for the Second Amended Plan of Rehabilitation for Highlands Insurance Company (September 3, 2009) available at www.highlandsrehabilitationplan.com.

The Home Insurance Company – A Brief History of Time *continued from page 7*

the importation of specialized engineering and economic disciplines to assist in the environmental and asbestos claims resolution arenas. REM also accelerated expense reductions to keep pace with projected and regimented downsizing. Because of a combination of these various steps, almost from the outset, Home reached favorable settlements on its environmental and asbestos exposures.

Entry into run-off also posed challenges in relation to Home's extensive ceded reinsurance book, the collection of which was critical to staying afloat. Home had over 600 reinsurers situated world wide involved in complex arrangements that spanned the gamut of conventional risk spreading techniques. With collections in disarray, over $300 million in aged recoverables remaining unpaid and new billings proving controversial, coming to grips with this book was essential. The collection story is worthy of its own tale, but suffice to say REM's efforts were a huge success, with Home ultimately achieving a 90% collection rate, pre-liquidation, on over $2.5 billion billed.

At the end of 1995, when Home's asbestos reserves were strengthened to achieve industry parity, it was the conventional wisdom that the industry had moved to the down side of the bell curve in anticipated asbestos exposure. The following year, however, saw a significant spike in asbestos loss activity that thereafter continued unabated. Despite REM's best efforts, the tide could not be turned. From a statutory accounting perspective, as of year-end 1996, Home's adjusted capital was less than its mandatory control-level risk-based capital, resulting in Home entering formal regulatory supervision in early 1997.

Thus ended the active life of a mainstay of the United States insurance industry in the year of its 150th anniversary.

Notwithstanding the favorable loss settlements and high reinsurance recovery rates obtained, in addition to good returns on investment assets, Home's losses over the following years exhausted the $1.3 billion Centre Reinsurance stop loss arrangement and produced a continual decline in Home's surplus. Based on year-end 2002 results, the New Hampshire Commissioner petitioned for Home's rehabilitation and that request was granted by order dated March 5, 2003. The rehabilitation was followed in relative short order by a petition for liquidation, which was granted by order dated June 13, 2003. Thus ended the active life of a mainstay of the United States insurance industry in the year of its 150th anniversary.

While the run-off years succeeded in resolving a large portion of Home's book, considerable exposures remained. Over twenty thousand proofs of claim were filed in the Home estate. These proofs asserted billions of dollars in contingent liability. In order to deal with these challenges, Home's Liquidation Court designated Pete Bengelsdorf as Special Deputy Liquidator. Through his efforts and those of his staff, Home has accumulated an asset base that is presently in excess of $1 billion. There have been 14,217 determinations (complete and partial), with $1.1 billion of allowed claims in the process. Among the more important relationships developed in liquidation, has been Home's strong working bond with the National Conference of Insurance Guaranty Funds, collectively Home's largest creditor. Those funds have yielded approximately $200 million in early-access distributions.

Home has also been notable in developing new legal authority. In a case of first impression,[1] the New Hampshire Supreme Court upheld a Scheme of Arrangement for Home's United Kingdom Branch which reinvigorated Home's prospects on what otherwise might have been an unused reinsurance asset.

Simultaneously, Home's Liquidator made prompt decisions about its other operations. Home closed its Hong Kong and Canadian branches expeditiously. Similarly, various state ancillary proceedings, primarily involving statutory deposits, have largely been resolved. In addition, early on in the estate Home's Liquidator commissioned an external asbestos reserve study which revealed a significant reserve deficiency. This conclusion hastened the Liquidator's decision to post additional case reserves on a majority of exposures, which gave the Liquidator greater certainty in the estate's ultimate exposure as well as supporting the validity of Home's outwards commutation proposals. As a result, the Liquidator has concluded scores of reinsurance commutations, including commutations with a number of Home's largest reinsurers.

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The many initiatives undertaken in the last eight years of liquidation have brought the estate into a stable adulthood, which augurs well for its normalized and efficient maturity. Aside from handling a complex and complicated insurance operation, the execution and closure of the many trappings associated with the Home organization

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The Home Insurance Company – A Brief History of Time

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have been effectively managed. Home's investment portfolio has performed efficiently and administrative expenses for running the estate have dropped from a high of $26.9 million in the first year of operation to the present $19.8 million load.

Through these efforts, the Home estate offers useful lessons to the world of insurance company liquidations. While it is not yet known when and the extent of creditor distributions that will be forthcoming, the dedicated team that handles the estate is well directed in their goal of ensuring that those distributions will be optimal.

Buried within the cedar chest that was bequeathed by one Home President to his successor is a bottle of cognac from then newly-liberated France.

One asset, however, will not be distributed in the normal course of business. Buried within the cedar chest that was bequeathed by one Home President to his successor is a bottle of cognac from then newly-liberated France. The cognac was a part of a liquor supply in a German warehouse that was captured in World War II and was later auctioned for the benefit of injured and destitute civilians in Paris. On the outside is an invitation to "your president to drink a toast to our president on September 17, 2044." Unfortunately, that toast will never be realized, but the cognac will be drunk and, no doubt, a toast offered to the legacy of the felled giant that so long ago graced the Chicago skyline. ■

Endnotes

1 *In re: the Liquidation of the Home Insurance Company*, No. 2008-407, 2009 WL 1228565 (N.H. Sup. Ct. May 7, 2009).

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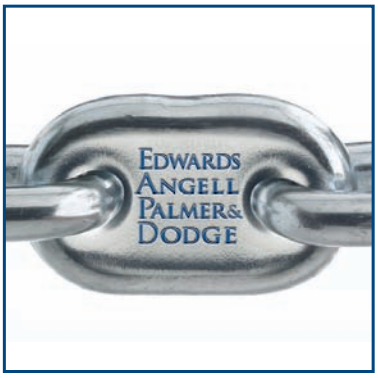

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