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# "No One Has to Sell Insurance Here"

## Delaware Commissioner Matt Denn talks about health insurance rates, federal regulation, and the regulatory challenges facing a small state

Matt Denn took office as Delaware's insurance commissioner in January 2005. Before joining the department, Denn served as Governor Ruth Ann Minner's legal counsel from 2001 through 2003. He wrote several of the governor's major legislative initiatives, including the Patients Bill of Rights, which regulated health insurance companies. Denn also worked in the private sector as an attorney with the law firm of Young, Conaway, Stargatt & Taylor. At Young Conaway, he argued cases involving insurance disputes, personal injuries, real estate, commercial and corporate disputes, and bankruptcies. The *NOLHGA Journal* interviewed Commissioner Denn in early April 2007.


***Can you tell us a little about how you came to the Delaware Insurance Department?***

When I served as legal counsel for Governor Minner, there were some issues that I thought really needed to be addressed at the state level—first and foremost, the cost and availability of health insurance. In our state, and I suspect in many other states, that's one of the top two or three issues facing families and businesses, so it was a primary motivator for my running for office and it remains at the top of my agenda now that I'm in office.

***How are you addressing the problem?***

Some of the solutions will have to come at the federal level. What we are trying to do at the state level is use the tools that we have available to try to make some progress with respect to cost. There are two bills specifically that we've been trying to get our general assembly to pass, one of which would simply allow the insurance department to substantively review health insurance rates.


Matt Denn

We currently have the legal authority to review all the property and casualty rate filings. We have used that authority very responsibly, but in a way that we think has had a leveling effect on some of our property and casualty rates. We would like to have the same authority with respect to health insurance rates, and we've asked the general assembly to give us that authority.

*["Matt Denn Talks..." continues on page 8]*

> As a commissioner from a smaller state, I'm more open than some of my colleagues may be to the idea that there is some role for the federal government to play in insurance regulatory issues.

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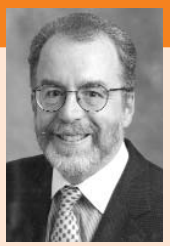
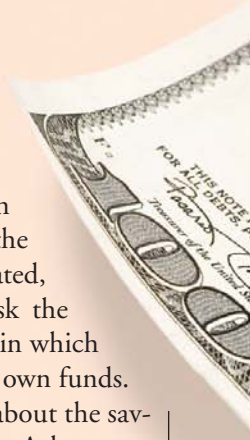


# Other People's Money



*"The one thing you can be most sure of in this life is that everyone will spend someone else's money more liberally than they will spend their own." — Armen Alchian, Professor of Economics (Emeritus), UCLA*

The sentence set out above was one of the favorite quotations of the late Nobel Economics laureate Milton Friedman. As one of history's seminal libertarians (I think he would have described himself as a "classical liberal"), Friedman's philosophy of political economy holds that institutions—especially political institutions—are most efficient and most moral when permitting individuals the greatest possible latitude in deciding how to spend their own money and labor. Conversely, systems depriving individuals of the freedom to choose how their own money and labor are spent—at least without very strong justification—tend to be inefficient and immoral.

Professor Alchian is an expert on the economics of property rights. In his writings he identifies a number of examples of how inefficient and immoral outcomes follow from permitting decisions about property rights to be made by persons other than those who have an economic interest in the subject of their decision. Chicago folk music artist Steve Goodman sang, "It ain't hard to get along with somebody else's troubles." Likewise, it is not hard to accept the risk of someone else's economic loss, particularly when you may stand to gain (without risk to yourself) from putting the funds of others at risk.

Examples of that phenomenon are easy to see in the business world—perhaps, for most of us, uncomfortably easy. Early in my legal career, I spent much time in the company of people who were successful in the business of commercial real estate. In that world, it was understood that a good real estate operator never put his own money at risk; instead, he made his investments with "other people's money." This perspective was sometimes referred to as the "OPM Principle."

Of course, the OPM Principle is hardly limited to the real estate sector. The entire worldwide system of capital markets also depends fundamentally on obtaining and applying funds entrusted by investors to firm managers they have never met. The same is true of the insurance markets, where an individual or commercial consumer entrusts premium dollars to an insurance company against the promise that the insurer will in the future deliver on a contractual commitment.

Professor Alchian's point in the quotation above is that individuals guard their own money carefully; it is human nature that even honest people tend to be less careful when guarding other people's money. Those who lost money on real estate syndication investments in the early 1980s saw firsthand the dark side of the OPM Principle: Bluntly stated, some real estate syndicators were happy to risk the money of others investing in real estate projects in which they never would have invested a penny of their own funds.

In a different arena, Professor Alchian wrote about the savings and loan industry crash of the late 1980s. A key contributing factor in the crash was that S&L managers were not risking their own money, nor even much of the money of their own depositors. The bulk of the risks taken by S&L managers had effectively been transferred to the now-defunct Federal Savings and Loan Insurance Corporation (FSLIC). In that sense, S&L managers had found the ultimate OPM—money that seemingly came from a distant and faceless bureaucracy. Having transferred the risk of loss so effectively to a distant party, managers felt free to take big investment gambles with insured S&L deposits. When the gambles proved to have been unwise for much of the industry, the federal taxpayers—that's us—became the real and final source of the OPM that had been gambled away, to the tune of roughly $150 billion of our money.

None of this is to say that there is anything illegal or immoral about investing and handling funds for others. We all know individuals who each spent a lifetime earning a reputation for being scrupulously fair, honest, and effective in handling the funds of others entrusted to them; that is likewise true of many honorable financial institutions. However, as comforting as it may be to rely upon the reputations and integrity of the persons or companies to whom consumers and investors entrust their funds, most people are yet more comfortable believing that an appropriate set of *rules* governs the behavior of those in the OPM business.

And indeed, broadly speaking, a core set of such rules has long existed, both in the common law and by statute. The rules involve two primary areas: substantive standards for how decisions involving the entrusted funds should be made and disclosure standards requiring transparency in reporting how entrusted funds are handled.

The substantive standards are best reflected in the fiduciary responsibilities imposed upon many who handle the funds of others, such as trustees of trusts and partners in a partnership. The notion of fiduciary responsibility has never been


expressed more strongly or eloquently than it was by Justice Cardozo in the 1928 case *Meinhard v. Salmon*[1], where he wrote that partners in a joint venture owe each other the highest duty of loyalty—"Not honesty alone, but the punctilio of an honor the most sensitive." A similar sentiment is reflected in the "prudent man" standard, which requires trustees of entrusted funds in key circumstances, and with respect to the subject of the trust, "to exercise such of the rights and powers vested in {the trustee}… and use the same degree of care and skill in their exercise, as a prudent man would exercise or use under the circumstances in the conduct of his own affairs."[2]

Disclosure standards are perhaps best exemplified in the federal securities laws and are aimed at ensuring that investors are provided with the information necessary for investors and the marketplace to reach properly informed decisions relating to the purchase and sale of securities, on the premise (attributed to Justice Brandeis) that "sunlight is the best disinfectant." To that end, the securities laws, in language whose power rivals the language of Cardozo in *Meinhard*, make it unlawful, in a securities transaction, "to make any untrue statement of a material fact or to omit to state a material fact necessary in order to make the statements made, in the light of the circumstances under which they were made, not misleading."[3]

Of course, the specific legal rules described above apply to particular types of transactions and relationships in particular settings, and not to *all* circumstances and settings in which innocent third parties entrust funds to another. I believe, however, that they do not stray far from the reasonable expectations that most people have of those to whom they entrust funds in virtually every case. It appears to be a common expectation than when we entrust our money to another, we generally expect that person to treat and handle our funds with the same care and skill they would exercise if they were handling their own funds. We likewise expect them to report to us all material facts relating to their engagement on our behalf and not to omit to advise us of material developments.

Those expectations apply—and *should* apply—as much in the arena of insurer insolvency as in the other fields mentioned above. An insurance company insolvency proceeding is at its heart the effort by a receiver, under the supervision of a court and with appropriate input from stakeholders, to marshal the assets of the failed insurer, reduce those assets to cash, and distribute the cash to those with valid claims against the insurer in accordance with statutory mandates.

An insurance receiver is dealing with nothing but "other people's money." The receiver's job, in the view of a claimant, is to manage the process of getting that money to claimants as quickly and efficiently as possible, using "the same degree of care and skill… as a prudent man would exercise or use under the circumstances in the conduct of his own affairs." Similarly, claimants look to the receiver—as the party entrusted with the claimants' money—to report all material facts relating to the receivership being conducted for the sake of the claimants and not to omit advising claimants of material developments.

How well receiverships serve the interests of the parties they are intended to protect—the claimants—is dependent both upon the talent and integrity of receivers and upon the rules governing the receiverships. It is perhaps the essence of Professor Alchian's work on property rights to say, "If you tell me the rules that apply, I'll tell you what outcomes to expect."[4]

Here, a critic is confronted by a less clear legal and institutional playing field than is the case in, say, securities transactions or the world of corporate trustees. For one thing, since insurance receiverships (like most of insurance law) are governed by non-uniform state statutes, there is no single national standard either for the substantive rules to be followed in a receivership

["President's Column" continues on page 11]

# MARG, IRMA & More

**From higher benefit limits for structured settlements to heightened transparency for the guaranty system, Delaware Deputy Insurance Commissioner Michael Vild's work with the NAIC touches on a host of guaranty issues**

Michael Vild joined the Delaware Insurance Department as deputy insurance commissioner after Commissioner Denn's election in 2004. Prior to that, he was an attorney with a Delaware law firm, where his practice focused on bankruptcy and solvency matters. He is the Delaware Insurance Department's representative at NAIC meetings and serves as chair of the NAIC's Receivership and Insolvency (E) Task Force. The *NOLHGA Journal* interviewed Deputy Commissioner Vild in early April 2007.


Michael Vild

***As head of the NAIC's Receivership and Insolvency (E) Task Force, what were your impressions on the development and passage of the Insurer Receivership Model Act (IRMA)?***
Technically, Commissioner Denn is chair of the task force. He delegated that authority to me. As far as IRMA is concerned, when I started in this job, the development of IRMA was already well underway. I was impressed with what I saw of the development process at the NAIC, and I think that process generated a really sound piece of solvency legislation that I hope will be widely adopted by the states. Our receivership statute in Delaware is old and woefully in need of updating, and we're hoping we can make that update soon.

***An IRMA-based receivership bill was introduced in the Delaware legislature last year. Can you tell us about the bill, its prospects, and some of the changes you made to IRMA in the proposed bill?***
We introduced a version of IRMA during the last legislative session. It passed the state Senate but didn't make it through the House before the end of the session. Probably the biggest difference between the Model Act and the Delaware version of IRMA is the removal of the provisions relating to conservation. The life industry was very concerned about those provisions, and after considering the issue, we concluded that our existing supervisory authority along with the authority we would have under the rehabilitation and liquidation chapters of IRMA would provide sufficient authority for us to carry out our job without the addition of broad conservation powers. We're intending to introduce the bill, very similar to the form in which it was introduced last year, during this legislative session.

***Could you explain the conservation provisions?***
Under IRMA, conservation is a preliminary step in the rehabilitation/liquidation path. The idea is that it's supposed to give the receiver a chance to get in, take a quick look around, see what the status of the company is, and decide whether to move forward with a more stringent receivership in the form of a rehabilitation or liquidation.

***I've heard there's still some debate on the Delaware bill regarding the large-deductible issue. Could you frame the issue for us and elaborate on your stance?***
The large-deductible issue, or as I prefer to call it, the loss-reimbursement issue, is really the only controversial aspect of IRMA in Delaware. I look at the issue through the lens of a fundamental concept of insolvency law. A basic tenet of insolvency law states that on the date the receivership court issues a receivership order, the receiver takes on all the property rights of the insolvent insurer. And to suggest, as some of the approaches to this issue have, that the collateral and reimbursement streams that support these loss-reimbursement programs are not the property of the estate of the insolvent carrier does violence, I think, to this fundamental principle of solvency law.

**"I'm not sure I'm qualified to create a new system out of whole cloth, but it does seem to me that the guaranty fund system should be better understood by consumers and should be more transparent."**

So to my way of thinking, the issue should not be whether or not the collateral and reimbursement streams are property of the estate. Rather, the issue is whether this particular "pot" of estate assets should be treated differently than all other assets in the estate and, if so, how? I think the industry has made a good argument that these assets should be treated differently. We have accepted that premise, but as usual, the devil is in the details. We think the approach we have taken is a fair balancing of the equities between the industry and those consumers who have bought policies from the insolvent carrier.

***What role did the guaranty associations—L&H and P&C—play in crafting IRMA and in the changes made in the Delaware bill?***

I know that the national associations were very active during the drafting of IRMA at the NAIC and that they participated in all the drafting sessions. It's my understanding that the process took nearly five years to be completed, and I know that NOLHGA and the NCIGF were involved all along the way.

In Delaware, Jack Falkenbach, who is the executive director of both our funds, provided very helpful comments and technical assistance as we "Delawarized" IRMA for introduction to our legislature.

***As Delaware attempts to pass an "IRMA bill," what are your views on incorporating IRMA or portions of IRMA into the NAIC state accreditation program? One Delaware State Senator wrote a letter in 2005 to the chair of the NAIC's Financial Condition (E) Committee saying that it would be unconstitutional.***

The Delaware department hasn't taken a position at this point on whether IRMA should be an accreditation standard. It's my understanding that the Financial Regulation Standards and Accreditation (F) Committee of the NAIC is going to be considering this issue over the next year or so. Frankly, we've heard good arguments on both sides of the question, and at this point, we're just planning on listening to that debate and then forming a view.

***Solvent runoffs have been the subject of recent* NOLHGA Journal *articles. What are your views on these runoffs and the effect they can have on policyholders?***

Solvent runoffs appear to be a fact of life. We have several domestic companies that are currently running off their books of business. From our perspective, the regulator's most important job in monitoring a solvent runoff is to make sure that it is actually solvent and will remain so throughout the process. It is also vitally important to ensure that the company's claims-handling processes don't change to the disadvantage of policyholders. If at any time it appears that the company ultimately will be unable to meet all policyholder obligations into the future or if it starts to manage its claims unfairly, the regulator has an obligation to step in to protect all policyholders.

***You also serve on the NAIC's Model Act Revision Working Group (MARG). What's the status of the review of the Life & Health Insurance Guaranty Association Model Act, and where do you see things going from here?***

I think it's moving along pretty quickly, and it doesn't look like there are going to be a great many changes to the Life & Health Model Act. One important issue that still needs to be addressed is how to deal with structured settlements. At the last NAIC quarterly meeting, the Receivership and Insolvency Task Force referred that issue to a new subgroup. I think many regulators believe the current claim cap on structured settlements in the Model Act is too low, and I'll be interested to see what the work of that new subgroup yields.

***Since many structured settlements are so large—in the millions of dollars—has there been any talk as to whether protecting consumers entering into such settlements can be done solely by "tweaking" the current guaranty system, as opposed to considering a more expansive approach to the problem?***

I'm not really sure how it will play out. I know that there is a view held by some regulators that this structured settlement area is really an issue that sort of transcends the Life & Health Model Act and needs to be looked at in a broader context.

**"The fact is that the caps in place now were put in place in the 1970s. As a matter of logic, it seems that simply as a result of inflation, they should be increased."**

> I think many regulators believe the current claim cap on structured settlements in the Model Act is too low.

***Do you see any potential for increasing the benefit limits in all categories?***
We've heard from the industry in the MARG meetings about the adequacy of the current caps. The fact is that the caps in place now were put in place in the 1970s. As a matter of logic, it seems that simply as a result of inflation, they should be increased. The question, if you accept that premise, is how much should that increase be? I think that's where the group is at this point. I think that some increase to the caps is appropriate, and settling on what that should be is the work that group has to tackle.

***What are your thoughts on the role NOLHGA and the guaranty associations are playing in the review of the Life & Health Model Act?***
I think NOLHGA provides a very important perspective to the regulators working on the Model Act, and we really value the input of the NOLHGA representatives who regularly appear before them.

***The Property & Casualty Model Act was recently revised. Have the two revision processes differed in any way?***
I think many regulators felt that the Property & Casualty Model Act required substantially greater revisions than the Life & Health Model Act, so it was a more drawn-out process. There are still several issues that have really divided the industry and the regulators, and we expect to take up those issues in the Receivership and Insolvency Task Force when we meet in June in San Francisco.

***On a more local level, could you describe the relationship your department has with the Delaware Life & Health Insurance Guaranty Association?***
As the primary contact between the department and the Delaware guaranty associations, I think we have an excellent working relationship with the fund boards and with Jack Falkenbach. Jack really epitomizes what a guaranty fund executive director should be. He's very easy to work with, very reasonable, and importantly, he recognizes that the guaranty funds are creatures of state law. They're created by the legislature to meet certain public policy missions, and he spends his time making sure his organizations are working to meet those needs.

***If someone were to sit down today and create a guaranty system from scratch, do you think we'd end up with the system that exists today?***
I think you wouldn't end up with what we have now. I'm not sure I'm qualified to create a new system out of whole cloth, but it does seem to me that the guaranty fund system should be better understood by consumers and should be more transparent. I'm embarrassed to admit it, but before I took this job, I'd never heard of an insurance guaranty fund.

On the banking side, the guaranty system is much better understood by consumers and is certainly more transparent, and I think most banking consumers understand that the deposits they're making in the bank are entitled to some limited protection. I'm fairly sure that insurance consumers don't have that same level of understanding.

***That seems to touch on the review of the Life & Health Model Act and its advertising prohibition, which some regulators and receivers in the NAIC MARG group have questioned. Do you think modifying the prohibition would add to the public's understanding of the system?***
I think that anything that gets more information into the hands of consumers would be a benefit.

***FDIC protection seems much simpler than some of the coverage questions guaranty association can face in an insolvency. Is there a way to make guaranty coverage easy for consumers to understand?***
I think the concept is fairly simple—the complication comes in all the details. The concept of FDIC coverage is also simple, but when you get into the details of what kind of accounts are covered and which products are covered, you can get into the same complications. But it seems to me that on a regular basis, we explain complicated concepts in layman's terms that consumers understand. This area shouldn't be any different. ✯

["Matt Denn Talks..." continues from page 1]

The other bill that we think could have a positive impact on rates is a bill to set up a statewide health insurance purchasing pool that would allow individuals, families, and small businesses to get some of the same advantages when they purchase health insurance that our large businesses already get. There are parts of that bill that are modeled on successful portions of programs in other states, with other parts that would be unique to Delaware.

***What's the status of the bills?***

Both of those bills were introduced last year, and both passed the state Senate by overwhelming bipartisan majority. But both were held up in the state House of Representatives. The bill that would allow the department to review rates was tabled twice in the House of Representatives Insurance Committee, and the bill to set up the statewide purchasing pool was released from committee but was kept off the floor of the House by the Republican caucus.

***What's driving opposition to the bills?***

With respect to the bill that would permit us to set the rates, the health insurance carriers were opposed to it. I think the reason for their opposition is that they're currently permitted to charge whatever they think the market will bear, and if this bill were passed, they would no longer have as much leeway. Which I think is the right result, but they obviously think it's the wrong result.


***What about the other bill?***

I don't know why the purchasing pool bill was held up. In Delaware, the party caucuses are not public meetings, so I was not privy to the discussion that led to the bill being held up in the party caucus and kept off the floor. The only entities that were lobbying against the bill were the state's two largest health insurance carriers, and their stated reason for being opposed to the bill is that one of the provisions to the bill requires that health insurance carriers who administer the state employee health benefit program also participate in a good-faith fashion in this new purchasing pool. That provision is in the bill because we noted at least one other state where the pool had been set up but there was an absence of insurance carriers participating in good faith in the pool. The consequence was that the bill didn't have the intended result. So that portion of the bill we think is very important, but it's the portion of the bill that has drawn the most opposition.

***What are the prospects for both bills this year?***

I am optimistic. I think the issue has become so pressing for so many families and businesses in the state that legislators are feeling a real sense of urgency to do something about the issue. They're hearing it, not just from people who are uninsured, but from people who have insurance and businesses that offer insurance but are having to go to extraordinary lengths to keep doing so—families that are spending their savings or businesses that are having to make very difficult decisions about retaining employees or even keeping their doors open based on health insurance issues. I think the legislature has reached a point where the public is demanding it deal with the issue, and these two bills are, as of now, the legislature's best opportunity for dealing with it.

Again, I think a lot of the larger solutions are going to have to come at the federal level, but these bills represent a good effort to do what's feasible at the state level within a state with Delaware's unique qualities.

***What's happening on the federal level?***

There are all kinds of discussions taking place now in Congress about federal solutions to the same problems of cost and availability that I just mentioned, and they run the gamut from national pooling-type arrangements such as those proposed in the U.S. Senate all the way down the line to expansion of the Medicare program

and other programs that look more like a single-payer program. So there's really a broad array of options being talked about in Congress, but only Congress has the ability to come up with a solution of the scope and magnitude that will deal with this problem in the long run.

***What other priorities does your department have?***

Our two overriding priorities have always been, one, rates in general, with health insurance rates being the top priority, but also auto, homeowners, workers compensation—the rates that affect families and businesses day to day. And the second priority has always been ensuring that people who do have insurance are treated fairly by their carriers when they have to submit claims on their policies.

***You mentioned the need for Congress to act on the health insurance issue. Are there aspects of the insurance industry that the federal government might be able to regulate more effectively than the states?***

As a commissioner from a smaller state, I'm more open than some of my colleagues may be to the idea that there is some role for the federal government to play in insurance regulatory issues. We have had many situations arise in which we are attempting to take what we think is appropriate regulatory action, and we've had to be concerned that we could not do so because of our status as a small state with a relatively small market. So I'm less averse than some of my colleagues may be, across the board, to there being an appropriate role for the federal government in insurance regulation.

***How did Delaware's size affect the department's ability to take regulatory action?***

No one has to sell insurance here, and for the most part, the companies we are regulating are national companies that sell in most if not all the other states. There have been situations in the past where companies have responded to statutory or regulatory changes by reducing their activity in a given state. So having a federal role in some of these issues allows you take some necessary actions without facing that type of situation. I think the challenge is identifying those issues where it's appropriate for the federal government to take an active role and which issues are still more appropriately dealt with at the state level.

***So you see a need for state-based regulation as well?***
I think you have to have a level of responsiveness from your insurance regulator that can only be provided by a state-level regulator. The primary role of regulation should continue to be at the state level. But I do think it's appropriate to have a discussion of where federal involvement is appropriate.

***Does the increasing consolidation of the industry, with larger and larger players, enhance the argument for federal regulation?***
It may for other states. For Delaware, given our small size, we didn't need the companies to be consolidated for them to be large from our perspective. But it may make a difference for some of the larger states.

***You mentioned responsiveness as a strong point of state-based regulation. What other benefits does state regulation offer?***
Responsiveness is the primary one, but that's not an insignificant factor. When I say "responsiveness," I mean to both consumers and carriers. We really pride ourselves in Delaware on being very responsive to carriers when they contact us with issues, but also on having a state-of-the-art organization when it comes to dealing with consumer complaints. And I just don't think that's something that can easily be replicated in a federal bureaucracy. Responsiveness and accessibility are the primary advantages of the state-based system.

***What challenges do you see the department facing in the remainder of your term, and what are your plans to deal with them?***
I don't think the challenges have changed significantly—they remain trying to keep some control over rates and trying to ensure that people are treated fairly. We have had, from time to time, other issues "bubble up," the most recent being coastal homeowners insurance, which is an issue we seem to share with most of our states up and down the Atlantic and across the Gulf Coast. We've been able to work through that situation more successfully than some other states have, but the two overriding goals remain the same. ✯

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proceeding nor for the disclosure that receivers must make to the claimants they serve.

I tried in a prior column to describe what I saw as a consensus view of receivership stakeholders on the attributes of a properly designed legal framework for receiverships.[5] Without reciting all the particulars, I think that particular attempt reflects the sorts of substantive standards inherent in the "prudent man" rule and the kind of reporting transparency required under Rule 10b-5.[6]

As debates over how to improve U.S. receivership practice now unfold in various arenas, some key disputed areas may usefully be analyzed in terms of how well they capture the prevailing American views on standards for the handling of "other people's money."

The most obvious substantive area raising the OPM "standards" question is the decision whether and when to place an insurance company into liquidation. Experts have noted the political incentives that exist for regulators of financial institutions to forbear placing an institution in receivership in hopes that some sort of workout scenario eventually will develop, even though such forbearance risks increasing the losses eventually borne by the institution's stakeholders[7]—a clear case of gambling with "other people's money."

Widespread regulatory forbearance of this type was thought to have played a major role in running up the eventual costs of the savings and loan crisis of the late 1980s, and Congress attempted to address the problem with the development of "prompt corrective action" legislation.[8] Although risk-based capital rules in insurance regulation have produced somewhat greater clarity in the responsibility of regulators to act in troubled insurer situations, the rules fall short of a true "prompt corrective action" standard.

Once a receivership has commenced, the lack of clear substantive standards can also lead to imprudent decisions about "other people's money" in two principal contexts: asset marshalling—bringing into the insolvency estate funds from third parties to pay claims and administrative costs—and determining how (and to whom) to distribute the estate's cash among the various claimants.

In the absence of specific governing standards for making decisions like those present in other OPM situations, receivers are compelled to choose for themselves standards that make sense by their own lights. Without questioning the integrity or professionalism of any receiver, many commentators have noted the inescapably political context in which many receiverships operate.[9] Decision-making incentives in that political context can be exacerbated by the fact that insurance receivers are appointed by and directly answerable only to the domiciliary insurance commissioner (the commissioner whose state chartered the failed company), while costs of the insurer's failure typically are "externalized" to stakeholders nationwide. In any case, when receivers may effectively choose their own substantive and reporting standards, the possibility exists that the standards chosen may end up little resembling either the "prudent man" standard or the types of disclosures contemplated by Rule 10b-5.

On the asset marshalling side of a receivership, the absence of a "prudent man" standard may result either in overly conservative asset dispositions ("fire sales") or wishful thinking about the potential recovery in value of assets held for long-term investment, possibly in connection with a plan for rehabilitation. The absence of a substantive standard may also result in overly aggressive pursuit of asset recovery litigation, such as denial of reinsurance offset rights contrary to statute, or the use of estate assets to pursue director and officer liability or similar litigation against judgment-proof defendants in order to vindicate some moral or political point that might better be served through the operation of the criminal justice system.

Likewise, on the distribution side, the absence of clear fiduciary obligations may serve as an incentive for attempts at improper discrimination in the distribution of assets to claimants, such as disparate treatment among categories of equal-ranking policy-level claimants, preference of certain general creditor claims over policy-level claims, or the preference of in-state claimants over out-of-state claimants.

Finally, the absence of clear rules requiring meaningful, timely reporting of receivership finances and key developments, especially when coupled with the lack of rules requiring notice to and permitting participation by stakeholders, magnifies the potential negative incentives provided by the lack of clear substantive standards. If claimants are neither aware of nor able to be

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heard on key receivership developments, they obviously have no way to protect their own interests. Such a result stands on its head the "disinfectant" effect of transparency so praised by Justice Brandeis.

Having served as the receiver of some 60 or so insolvent insurers of all types, I can understand the urge by receivers to resist the imposition of clear substantive and disclosure standards on the conduct of receiverships. Doubtless the imposition of a "prudent man" standard and reporting requirements like Rule 10b-5 would increase the burden on receivers and diminish their flexibility to pursue some strategies.

Nonetheless, preserving the strategic flexibility of the receiver is not, in the view of stakeholders, the highest objective served by the receivership laws. Receiverships must be understood, both in the law and in public discourse, as problems about how to handle "other people's money." The application of appropriate and well-tested substantive and reporting requirements to insurer receiverships would clarify the rights and responsibilities of all parties to the material benefit of all. ✯

*Peter G. Gallanis is president of NOLHGA.*

**End Notes**

1. *Meinhard v. Salmon*, 249 N.Y. 458 (1928).
2. American Bar Foundation, *Model Debenture Indenture Provisions – All Registered Issues*, Section 601(b) (1967).
3. Securities and Exchange Act Rule 10b-5, section (b), 17 C.F.R. § 240.10b-5 (2007).
4. *The Concise Encyclopedia of Economics*, http://www.econlib.org/library/enc/bios/Alchian.html.
5. "The Goals of Insurance Receivership Law Reform," *NOLHGA Journal,* May 2005.
6. My last column was a critique of recent proposals to adopt American "solvent runoff" schemes that focused on several ways in which such proposals fail to deliver either substantive fairness or reporting transparency and stakeholder participation. *See* "The 'New Runoff': Threat or Menace?", *NOLHGA Journal*, January 2007.
7. M. Grace, R. Klein, and R. Phillips, "Insurance Company Failures: Why Do They Cost So Much?" Georgia State University Center for Risk Management and Insurance Research (October 30, 2003) at pp. 5–6.
8. 12 U.S.C. § 1831o (1991).
9. *See, e.g.,* Grace, Klein, and Phillips at p. 20.

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## NOLHGA Calendar of Events

### 2007

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| **July 11** | **MPC Meeting<br>San Francisco, Calif.** |
| **July 12–13** | **NOLHGA's 15th Annual Legal Seminar<br>San Francisco, Calif.** |
| September 28–30 | IAIR Fall Quarterly Meetings<br>Washington, D.C. |
| September 28–October 1 | NAIC Fall National Meeting<br>Washington, DC |
| **October 8** | **MPC Meeting<br>Amelia Island, Fla.** |
| **October 9–10** | **NOLHGA's 24th Annual Meeting<br>Amelia Island, Fla.** |
| October 21–23 | ACLI Annual Conference<br>Washington, D.C. |
| November 30–December 2 | IAIR Winter Quarterly Meetings<br>Houston, Tex. |
| November 30–December 3 | NAIC Winter National Meeting<br>Houston, Tex. |

### 2008

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| March 28–April 1 | NAIC Spring National Meeting<br>Orlando, Fla. |
| May 31–June 3 | NAIC Summer National Meeting<br>San Francisco, Calif. |