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“You got to know when to hold ‘em...”

Peter A. Scarpato

Sometimes it feels like certain segments of our business are inhabited by card sharks – people hell bent on cutting the numbers and the deal to the edge of acceptability to make a buck. Or you sense that the “business partners” around the table watch the twitches in your neck muscles and read the fear in your eyes, scanning for some weakness, some perceived advantage they can snatch “before the dealings done.” And while antithetical to the mantra of utmost good faith that permeates our arcane but artful business, in these circumstances, one must hold their cards closely and measure each commission and omission carefully. Hence, the card theme of our issue.

Enter the first article, Barbara Murray, Lisa Slotznick and Donald Menzie’s *Your Deal: Large Deductible Programs*, which takes us through the accounting and regulatory changes required to maintain proper vigilance on a valuable segment of our business fraught with financial pitfalls. Next Fred Pomerantz and Aaron Aisen examine the requirements for out-of-state lawyers wishing to appear before the Connecticut Insurance Department – the famed *pro hac vice* rules (translated from the Latin “for or on this occasion only”). Those of you in this position heed carefully *Pro Hac Admission in Connecticut: Implications for Insurers and Attorneys Alike*.

And where would we be without arbitrations (no cynical responses, please)? The next piece, *Lifting the Veil on Arbitration Proceedings: Who’s Your Arbitrator: Arbitrator Disqualification*

by *the Courts*, is part of our continuing series on this pervasive segment of our business. Here, Michael Goldstein and Daniel Endick show us the latest rules on when and how courts rarely reach in and require disqualification of arbiters – words for the wary.

Our Spotlight, *Learning about Leah*, gives us helpful insights into our current dynamic Chair Leah Spivey. The last paragraph in this piece sums up why Leah is a true leader: “[I]t isn’t my idea but my ability to direct and/or assist others in bringing their ideas to fruition that makes me valuable to an organization.” Good for us! And our Executive Director, Carolyn Fahey, muses on *The Five Arms of a Starfish* and how AIRROC serves the legacy and run-off community in at least five ways. Maybe we’re more like an octopus?

Chicago, New York and Brighton, England figure prominently in our edition, with valuable information in *Educational Summaries: Chicago Regional May 25, 2016 and Summer Membership Meeting Networking and Education, NYC July 19-20, 2016*. We cover legal roundups, regulatory updates, allocation and modeling, and more. Also, in *A Game Changer or Game Over? The Grand, Brighton England, June 13-15, 2016*, we cover the Insurance and Reinsurance Legacy Association’s Annual Congress, held at the Grand Hotel. Much for everyone.

In our Resources section, we include information about and an AIRROC-member discount for the new book,

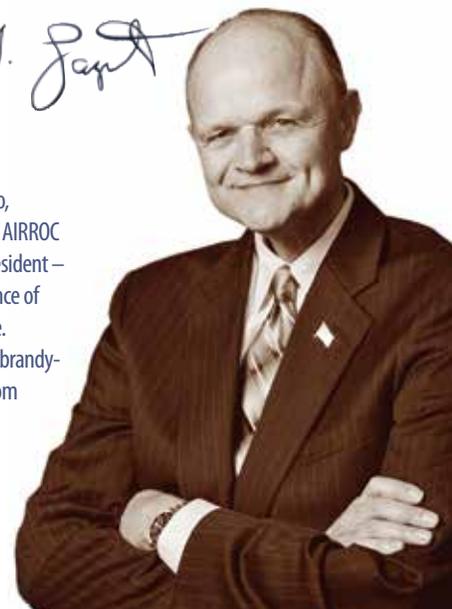
The Iskaboo Guide to Part VII Transfers. The Part VII transfer looms large as a valuable tool in the legacy run off arsenal. This book gives everything one needs to know to navigate the entire Part VII process from start to finish.

Present Value closes us out with updates on regulatory news, business news and people on the move, including but certainly not limited to our good friend Keith Kaplan who begins a new adventure as Chief Liquidation Officer for Excalibur Reinsurance Company in Pennsylvania.

We are always looking for the next big thing, the next novel idea, or just a refresher on tried and true strategies. As always, this is your magazine.

Let us hear from you.

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AIRROC matters

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EDITOR'S NOTES

"You got to know when to hold 'em..." Peter A. Scarpato 3

REGULATORY

Your Deal: Large Deductible Programs
Barbara K. Murray, Lisa Slotznick & Donald F. Menzie, Jr. 6

LEGALESE

Pro Hac Admission in Connecticut
Frederick J. Pomerantz & Aaron J. Aisen 13

LEGALESE

**Lifting the Veil on Arbitration Proceedings:
Who's Your Arbitrator**
Michael H. Goldstein & Daniel J. Endick 14

SPOTLIGHT

Leah Spivey 20

AIRROC's 12th Annual Commutations & Networking Forum 21

AIRROC UPDATE

The Five Arms of a Starfish
Message from the Executive Director Carolyn Fahey 23

• **Thanks to our Corporate Partners** 23

• **CLIP Requirements** 23

CONTINUING ED

Educational Summaries • Chicago Regional 25

Illinois Department of Insurance: *The Regulators Speak*;
Legal Roundup; Lead Contamination; RI Insurance Business;
Transfer Interactive Workshop

Summer Membership Meeting • Networking & Education 29

Forecast, Allocation and Policy Defense Modeling; Reinsurance
of ECO and XPL; Big Data

IRLA Congress and Seminar 2016 32

Iskaboo Guide to Part VII Transfers 35

Advertisers in this Issue 35

PRESENT VALUE

News & Events / Mark Your Calendar 37

Francine L. Semaya & Peter H. Bickford



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Your Deal: Large Deductible Programs

Accounting and Regulatory Changes on the Horizon



Years ago a large global insurer, working to grow its book and establish a presence in a new market, underwrote a large deductible workers compensation account that, under normal circumstances, might have either been rejected or set at a very high premium with substantial collateral to reduce the insurer's risk.

However, neither occurred because the carrier was anxious to establish its market presence. Although the account's deductible was material (over \$750,000) the carrier agreed to a cash loss fund account that would be periodically replenished rather than a fully collateralized program. It used a cash loss funding account and an LOC to "secure" the risk to ultimate value based upon actuarial projections.

Almost immediately after policy inception, the insured lapsed in cash funding the established loss fund within the deductible layer. Despite several cash infusions, the fund never reached the contractual level. Shortly thereafter, the insured, which was experiencing financial difficulties, ceased making payments while the number of reported claims and losses mounted. The carrier ultimately canceled the policy for non-payment of premium, but with the loss fund exhausted and no LOC collateral, the carrier became liable to pay all claims both within the deductible layer as well as the insured layer above the deductible. The carrier is probably still making payments today and will likely continue to do so for years, and the policy is a significant loss. Unfortunately this example is not uncommon.

This is a prime example of increased scrutiny on insurance carrier practices with respect to the treatment of large deductible accounts. Industry and regulators have extensively studied the financial risks of large deductible programs. In particular, the National Association of Insurance Commissioners (NAIC) and the International Association of Business Communicators (IABC) have formed a joint working group to study large deductible insurance and to assess the need to adjust accounting rules related to the use of large deductibles. Currently, a debate exists as to whether insurance carrier accounting treatment for deductibles should change to increase transparency surrounding the financial implications to the insurer of the credit risk associated with these large deductible programs.

We discuss below proposed revisions to the accounting rules and their associated pros and cons, and identify other regulatory changes under consideration. Before we address them, let's visit what brought us to this point: Whatever changes they implement, companies will need to address root causes to solve underlying problems tied to assessing, reconciling, securing and reporting large deductible obligations.

Defining a Large Deductible

A deductible is the amount of a covered loss retained by an insured. A large deductible plan has a per accident and/or per occurrence limit of at least \$100,000 (occasionally even higher), escalating into the multiple of millions. These plans are most common in commercial workers' compensation, auto liability, and general liability insurance. In addition to the per accident and/or per occurrence deductible, a large deductible plan also may include an aggregate deductible, which caps the total deductible payments by the insured during a defined period (defined by an insurance policy).

There are three types of liability deductibles:

- Per claim deductible – Applies separately to each claim.
- Per accident/occurrence deductible – Applies once to all claims arising from a single occurrence.
- Waiting period deductible – Expresses a straight deductible in terms of days, not dollars. The policy holder is responsible for all claims within a defined time frame.

Large deductible plans are also common in property insurance. There are four types of property deductibles:

- Flat deductible – Deducts a fixed amount from each loss.
- Franchise deductible – Pays the entire loss for any loss above a fixed predetermined amount or agreed percentage of insured value. The insured bears all losses that fall below the predetermined amount or agreed percentage.
- Percentage deductible – Sets the deductible at a percentage of value.
- Aggregate annual deductible – Requires the primary insurer to retain losses of a certain size until they accumulate to a predetermined total during a policy period.

Who Uses Deductibles and Why

The NAIC/IABC committee, in its *Draft 2015 Workers Compensation Large Deductible Study*, notes an increase in the incorporation of large deductible programs in corporate risk management. Recent numbers reflect a stable increase in the growth of large deductible policies written. The total percentage of policies written increased from approximately 3.5 percent in 2011 to almost four percent in 2013; we expect this trend will continue.

...debate exists as to whether insurance carrier accounting treatment for deductibles should change to increase transparency...

Large corporations with strong cash flow/assets usually use a large deductible program. A workers' compensation program with a large deductible, for example, allows the insured to retain a portion of each loss and transfer to an insurer any loss in excess of the defined deductible amount. Insureds enjoy many costs saving benefits under a large deductible plan, including reduced payment of certain premium components, improved cash flow, stronger incentives for improved loss control and mitigation without increased regulation.

Premium for a large deductible policy now includes premium for losses and expenses associated with the portion of an insured's losses above the deductible. Because this is only a fraction of the overall losses under a policy, the premium loading the insurer must place on the expected claims costs for state taxes, residual market loadings (amounts added to a premium of voluntary insureds to compensate insurers for losses resulting from involuntary insureds), and overhead costs is reduced and not replaced by other costs that the program covers.

Since the insured is financially responsible for losses below the deductible, large

deductible plans lower the insured's total cost of risk. An insured can maximize cash flow by paying losses through the deductible program as payments are made to claimants over the many years that it may take claims to pay out, rather than as an upfront premium during the policy's specific coverage period.

Loss control and loss mitigation initiatives with a large deductible program also can have a positive impact on total loss payments. The benefit from overseeing claims, establishing financial statement reserves, and controlling settlements allows large deductible insureds to use their own internal insights and understanding of operations and relationships when dealing with the injured party. For example, return to work programs can mitigate ultimate lost time exposures by finding opportunities for employees to return to work in a lesser capacity.

In general, lower total insurance costs through both reduced premiums and lower claim payments may help free up cash. Also, entities with large deductible programs are considered insureds under a policy and, therefore, may receive less regulatory scrutiny compared to entities which elect to self-insure.

Large deductible programs have grown significantly in workers' compensation and, in particular, Professional Employer Organizations ("PEOs"), which provide outsourced employees to clients for many functions. The PEO becomes the employer of record, assumes the payroll and is responsible to supply workers' compensation insurance for the employees. In turn, PEOs can pool employees of their various clients, leverage insurance purchasing power and receive the same premium, cash flow, and other benefits described above.

What's Gone Wrong?

In the opening, we discussed how a large deductible program can go awry. An insurer may not maintain sufficient levels of collateral for many reasons, including:



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Large Deductibles (Continued)

- Under reserving (either case or IBNR reserves) when determining the specific insured's profitability and collateral needs;
- Reducing collateral requirements to increase the chance for policy renewal;
- Failing to track collateral levels for required replenishment;
- Relinquishing control of assessing required levels of collateral;
- Delegating the tracking and seeking replenishment of collateral to third parties;
- Failing to monitor the applicability and deterioration of aggregate limits;
- Reconciliation errors that are perpetuated through roll forward accounting;
- Insufficient credit risk assessments.

Many large deductible insureds cooperate with the insurer to mitigate losses. However, occasionally, insurers have entered into formal or informal side agreements in which the insurer allows the insured to go too far in loss mitigation activities and managing claims within the deductible layer, thereby ignoring policy terms. In these cases, the insurer essentially becomes an excess carrier and does not assess or manage losses until the deductible layer is exhausted. Typically this causes delayed reserve development, delayed recognition of ultimate loss values, and potentially under collateralization and underfunded loss payment accounts. This generally occurs when the claims administration is unbundled from the insurer to an independent third party administrator. Failure to ensure accurate and timely accounting and pursuit of funds due are common challenges for insurers. Some of this may be deliberate, such as discounting collateral requirements when negotiating renewals. Other underfunding issues relate to internal insurer data management. Insurers have struggled internally with managing the data that would permit timely increases in required collateral, potentially causing the insurer to assume payment of losses under the deductible without

recourse to funds from the insured. Aggregate deductibles are difficult to monitor because many insurers' systems cannot monitor the aggregate amounts without manual interventions. Insurers sometimes have accounting errors driven by roll forward versus ground-up accounting reconciliations and failure to perform reconciliations at defined periods. Inadequate systems and controls make overcoming these obstacles cumbersome at best.

Insurers have struggled internally with managing the data that would permit timely increases in required collateral.

The insured or insurer's insolvency can be a serious problem for both parties, especially if either or both fail to maintain a robust creditworthiness assessment process. Insurers can become responsible for under collateralization and underfunded loss payment accounts if the client becomes insolvent (even leading to the insurer's insolvency). Conversely, insureds may be at risk of losing excess collateral if their carrier goes insolvent.

Current Accounting Rules SSAP 65/Annual Statement Note 31

Before addressing proposed changes to the accounting of reserves involving deductible programs, we will briefly discuss the current accounting treatment. Current accounting rules allow P&C insurers to record reserves on a net of deductible basis. Statutory Accounting Principles, as defined in SSAP 65, require the financial statement treatment for P&C reserves to be net of the large deductible, unless the deductible is deemed uncollectible. The deductible is accounted for from policy inception onward, and sums attributable to the deductible layer are treated as a credit risk. Annual Statement Note 31

("ASN 31") requires the reporting of the value of the deductible credit for unpaid claims and billed deductible amounts on paid losses on all lines, not just workers compensation. In effect, this provides the gross and net of deductible positions as a disclosure item on a Statutory accounting basis. Note that, in 2015, SSAP 65 was revised to require the reporting of individual PEO members' obligations as well as those of the group as a whole. This change indicates that greater transparency is being pursued.

There are different perspectives on the propriety of accounting for reserves on a net of large deductible basis. Those against, note that a large deductible program is not the same as self-insurance. The insurer bears the risk from dollar one and has a contractual provision to seek reimbursement for the deductible obligation from the insured. Reporting on a net of deductible basis under the current rules does not promote accounting transparency, and ultimately contributes to numerous situations of under collateralization. Carriers who attach excess of a large deductible may rely on the insured to assess case reserves within the deductible layer. If the insured under reserves, the collateral will be insufficient.

Those in favor of continuing to report on a net of deductible basis feel that ASR 31 provides the necessary gross and net of deductible position and view a requirement to report gross of deductible with an offsetting credit as cumbersome. This new process would require revisions to individual case reserves and the creation of offsetting accounting entries on an individual claim level. For losses falling entirely within the deductible, carriers will establish individual claim records where in the past these losses may not have appeared in the carrier's data. These entities also are concerned about increased costs associated with implementing any required changes in their accounting systems, meeting new

Large Deductibles (Continued)

regulatory requirements, and any related impacts on underwriting.

Changes under Regulatory Consideration

The NAIC/IAABC *Draft 2015 Workers Compensation Large Deductible Study* addresses various options under consideration:

- Revise Annual Statement Note 31: Clearly establish reporting requirements to encompass and delineate IBNR for large deductible programs.
 - Accounting for deductible reserves: Replace the existing practice of disclosing gross reserves in Annual Statement Note 31 with booking reserves on a gross of deductible basis with a separate credit for anticipated deductible reimbursements. This is similar to accounting practices used for ceded reinsurance on a GAAP basis. On a statutory basis, while loss reserves are presented net of ceded reinsurance, significant disclosures related to ceded reinsurance exist through Schedule F.
 - Risk Based Capital (RBC) Charges: Enhance charges to the existing risk-based capital (RBC) calculations associated with large deductible business to ensure that the RBC charges properly reflect the insurance risk associated with reserves that are under collateralized, the insurance risk that adverse development of reserves may result in reimbursable losses that exceed the collateral, and the credit risk associated with the underlying collateral.
 - Retrospective rating plans: Modify incurred or paid loss retrospective rating plans to align them with changes made to the accounting of deductible programs.
- Other potential, albeit longer term, recommendations include:
- Design of legislation related to financial (collateral) requirements for large deductibles;
 - Require that specific protocols be followed when evaluating the insured's credit worthiness;

- Enact legislation defining a consistent approach to treatment of collateral held for large deductible programs for insolvent carriers;
- Develop and implement a “special exam” if a carrier/company writing deductible insurance is at risk for insolvency or for being placed under supervision by its regulating body;
- Enhanced guaranty fund language to address use of collateral held on an insured's behalf;

- Enhance regulation requiring specific financial stress testing for large deductible programs.

Deficiencies in the large deductible space drive the potential changes that the NAIC/IAABC report describes. At the heart of the issue, carriers must exhibit greater focus and consistency during the underwriting process of large deductible programs. In particular, there must be increased focus on credit risk and ongoing disclosures evidencing the

Stakeholder Perspectives

When considering any change, one must recognize the different perspectives and impact on involved stakeholders. This chart depicts the key concerns various stakeholders may have if there is a move to dollar one, inclusive of the deductible, accounting.

Policy Holder	Increased regulation over deductible collateralization. Greater underwriting scrutiny with respect to credit worthiness. Potentially increased collateralization requirement and/or less ability to negotiate a reduced collateral value. Decreased access to large deductible programs as increased regulation may drive away product offering.
Underwriters	Higher scrutiny in placement of large deductible programs to ensure an appropriate and consistent assessment of risk and collateral needs. Increased pressure in negotiating collateral for IBNR.
Claims	Greater certainty that available collateral will meet long term needs in case of failing insured. Improved scrutiny over third-party administrators (TPAs) to ensure appropriate reserving.
Accounting	Increased workload to revise accounting procedures in order to implement new rules. Revisions to accounting systems to allow for contra codes/offsetting entries, and to address impact on reinsurance cession logic. Increased burden in tracking appropriate collateral and in establishing consistent approach to credit risk.
Actuaries	Greater use of actuaries in the process of selecting loss picks and the establishment of IBNR on a by account basis. Improved assessment of credit risk.
Reinsurers Regulators	Heightened scrutiny over cessions to validate if they are net of deductible. Need for increased oversight in order to monitor the collateral insureds maintained with insurers.
Guaranty funds	Greater certainty that available collateral will meet long term needs in case of failing insured. Improved transparency.
Carrier's investors	Greater certainty that available collateral will meet long term needs in case of failing insured. Improved transparency.
Rating agencies	Increased focus on underwriting assessment process, collateral requirements and securitization. Greater certainty that available collateral will meet long term needs in case of failing insured. Improved transparency.
Outside Auditors	Increased focus on assessing appropriateness of collateral and gross up value determination.

program's impact. Some carriers worry about potential legislation dictating protocols and procedures addressing financial adequacy and reporting. Each regulating body (or state) might enact unique requirements, some of which carriers may view as onerous and duplicative. Carriers of large accounts which conduct multi-state business may be required to review and sign numerous different forms representing similar, if not the same, information for each state in which the insured operates. As these accounts are more sophisticated compared to small insureds and policy proposals and endorsements clearly outline requirements under the deductible program, carriers may ask if this increased administrative requirement is necessary. However, defined and enhanced protocols would increase transparency and reduce both risks and costs associated in addressing disputes that may arise.

Moreover, given widespread reliance on legacy systems, effectuating, tracking and reporting against any changes in requirements, in particular when multi line programs come into play, will be even more challenging for many insurers. Several implementation questions might arise: Would an insurer ask for separate collateral for each deductible risk in place (WC, GL, auto, and property)?

Impact on Insurers

Implementing gross of deductible accounting treatment and the additional potential disclosure and underwriting regulatory requirements will require insurers to address the following:

- Revisions to processes, procedures and controls with respect to financial reporting;
- Underwriting changes regarding acceptable levels of collateral and associated vehicles for funding;
- Controls over acceptable forms of collateral, and evaluation of client credit worthiness;

In the interim, insurers and insureds would be well advised to promote robust accounting, credit assessment processes, data tracking capabilities, and loss funding collection initiatives with adequate quality assurance controls.

- Accounting for contra code entries that offset gross values by the corresponding deductible held;
- Logic changes to reinsurance cessions so that they remain net of deductible;
- Formalized systems and processes to monitor deductible aggregates and rate of exhaustion to avoid overstatement of the deductible asset, with special attention to programs in which the deductible applies to multiple lines of business and/or locations;
- Procedures and controls that ensure accounting reconciliations are consistent with the calculations and intervals defined in the contract;
- Increased statutory reporting requirements;
- Heightened scrutiny of required collateral levels by policyholders, brokers and actuaries;
- Revisions to IBNR assessments.

There are significant challenges to revising procedures related to and controls

over the underwriting, tracking, calculating, collateralizing and reporting of deductibles. Tracking deductible aggregates, real time deductible collateralization obligations, and the ability to provide contra codes against gross reserves on a claim basis are significant accounting challenges for many organizations and will be costly to overcome.

Conclusion

No easy answers exist to the myriad issues relating to changes in the deductible accounting rules. An organization's ability to properly track and account for gross exposures will be a significant challenge for many carriers due to system weakness (coding contra entries to represent expected recoveries and the associated held collateral), and required changes to procedures with enhanced controls will drain resources. There have been multiple committees, task forces assembled, and studies issued since 2006, all with sound, well-reasoned recommendations. What progress will be made or what will come of the various legislative efforts remains to be seen. In the interim, insurers and insureds would be well advised to promote robust accounting, credit assessment processes, data tracking capabilities, and loss funding collection initiatives with adequate quality assurance controls. Routine testing and benchmarking should be integrated in the operation to drive continual improvement in managing and securing this viable asset. ●



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Pro Hac Admission in Connecticut

Frederick J. Pomerantz & Aaron J. Aisen

Implications for Insurers and Attorneys Alike

The State of Connecticut recently revised its judicial rules¹ to require that any attorney not admitted in Connecticut be admitted pro hac vice prior to appearing on behalf of a client before any state or municipal government agency. As with any pro hac vice admission, out-of-state attorneys will be required to fill out the requisite application and retain local counsel as a condition of any appearance.

Since 1984, Connecticut Insurance Department regulations² have only required an authorized representative of a party to an Insurance Department proceeding to file a Notice of Appearance. This change will increase the overall costs to the client due to the costs associated with complying with the *pro hac vice* application process and of hiring local counsel.

Rule 5.5 of the Rules of Professional Conduct of the State of Connecticut appears to support the rule change. The rule states in relevant part:

A lawyer admitted in another United States jurisdiction which accords similar privileges to Connecticut lawyers in its jurisdiction ... may provide legal services on a temporary basis in this jurisdiction, that (1) are undertaken in association with a lawyer who is admitted to practice in this jurisdiction and who actively participates in the matter; (2) are in or reasonably related to a pending or potential proceeding before a tribunal in this or another jurisdiction, if the lawyer, or the person the lawyer is assisting, is authorized by law or order to appear in such proceeding or reasonably expects to be so authorized; (3) are in or reasonably related to a pending proceeding ... in this or another jurisdiction ... in which the lawyer is admitted to practice and are not services for which the forum requires pro hac vice admission; or (4) are not within subsections (c) (2) or (c)

(3) and arise out of or are substantially related to the legal services provided to an existing client of the lawyer's practice in a jurisdiction in which the lawyer is admitted to practice.³

Section 2-44A (Definition of the Practice of Law) of the Connecticut Superior Court Rules⁴ defines "the practice of law" stating, in relevant part, as follows: "(4) Representing any person in a court or in a formal administrative adjudicative proceeding ... in which ... a record is established as the basis for judicial review."

"... be aware of the potential ramifications of not seeking admission pro hac vice before accepting the assignment."

One question is how the state will define "proceeding," as the rule does not formally define the term. As such, the Commissioner may have discretion in how this rule is applied. For example, the Commissioner could define "proceeding" broadly to include all actions and petitions, whether contested or uncontested; formal hearings or informal meetings with the Commissioner; a written reply to a critical report on examination or a market conduct report that does not result in a formal hearing. This may also include representation of a purchaser of a domestic insurer in filing a Form A Change of Control petition or appearance at an Insurance Department change of control hearing, and so forth.

The Connecticut Insurance Department has confirmed that it is required to amend Section 38a-8-33 by January 1, 2017 to conform to the revision in Section 2-16. However, Burton Cohen, the Chairman of the Unauthorized Practice of Law Committee of the Connecticut Bar Association, believes that any out-of-state attorney who participates in an administrative proceeding now without first being admitted by the court could be viewed as engaging in the unauthorized practice of law.⁵

Mr. Cohen believes that this rule change "levels the playing field as more out of state attorneys are appearing in administrative agency proceedings without demonstrating their qualifications to practice law and without paying into the client security fund and attributing their legal fees to Connecticut for income tax purposes." In addition, the rule change may also be intended to protect Connecticut attorneys who specialize in administrative law and are competing with attorneys from New York City and Boston.

Any lawyer seeking to represent clients in a matter before the Connecticut Insurance Department is therefore cautioned to be aware of the potential ramifications of not seeking admission *pro hac vice* before accepting the assignment, particularly if the matter could involve a "proceeding," in the broadest sense of that word. ●

Endnotes

1 State of Connecticut Judicial Branch, Connecticut State Bar Examining Committee, Rules of the Superior Court Regulating Admission to the Bar, Sec. 2-16; http://www.jud.ct.gov/Publications/PracticeBook/pblj_7802_071216a.pdf at p. 3PB

2 Section 38a-8-33 (Appearance and representation)

3 Article VII – Admission on Motion of Attorneys of Other States, Regulations of the Connecticut Bar Examining Committee; <http://www.jud.ct.gov/cbec/regs.htm#VII>

4 State of Connecticut Judicial Branch, Connecticut State Bar Examining Committee, Rules of the Superior Court Regulating Admission to the Bar, Sec. 2-16; <http://www.jud.ct.gov/cbec/rules.htm#2-44A>

5 Martha Cullina Regulatory Department News: New Rules Require Pro Hac Vice Admission for Out of State Attorneys in State and Municipal Agency and Board Proceedings The National Law Review (June 24, 2016) Available at <http://www.natlawreview.com/article/new-rules-require-pro-hac-vice-admission-out-state-attorneys-state-and-municipal>.

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Lifting the Veil on Arbitration Proceedings

Who's Your Arbitrator: Arbitrator Disqualification by the Courts



In the Spring 2016 issue of AIRROC Matters, we featured Part 1 of a multipart arbitration series by Michael Goldstein and Dan Endick titled, “When Courts Peek Under the Arbitral Veil: The Role of the Courts in Managing Your Reinsurance Arbitration.” Part 2 was “Lifting the Veil on Arbitration Proceedings: Who’s Your Counsel – Disqualification of Counsel by Courts” and it appeared in the Summer 2016 issue. This is Part 3 of the series.

In addition to resignations, disqualification of an arbitrator in a pending arbitration is another remedy that is more frequently sought in the courts. Although not considered the “general rule,”¹ it is difficult to see why more litigants have not attempted to make analogous arguments as they do with resignations. *See, e.g., Ins. Co. of N. Am. v. Pub. Serv. Mut. Ins. Co.*, 609 F.3d 122, 130 (2d Cir. 2010); *WellPoint, Inc. v. John Hancock Life Ins. Co.*, 576 F.3d 643, 647 (7th Cir. 2009). A common request for disqualification asserts that an arbitrator was not disinterested or was not properly

selected under the relevant contractual provisions and therefore must be replaced. One might argue that the entire panel should be replaced because there is a potential that the newly-selected arbitrator would be tainted by the two remaining arbitrators. Although this might be a plausible argument, given the case law involving arbitrator disqualification, it seems that the courts generally respect the parties’ rights pursuant to contract to select an arbitrator and are hesitant to intervene to disqualify one.

In *Trustmark v. John Hancock*, for example, the plaintiff filed an action attempting to ask the court to declare that an arbitrator was not disinterested and therefore should be disqualified. *Trustmark Ins. Co. v. John Hancock Life Ins. Co. (U.S.A.)*, 631 F.3d 869, 871 (7th Cir. 2011). The District Court found that the arbitrator, who had acted as an arbitrator in a prior arbitration between the parties, was not disinterested because he could have been called as a fact witness about the prior proceedings. *Id.* at 871. The District Court ruled in favor of the plaintiff and granted an injunction to enjoin the arbitration proceeding. *Id.* Additionally, the court found that only a judge could determine what the

confidentiality agreement signed by the arbitrators required. *Id.*

The Seventh Circuit reversed, finding that mere knowledge of the prior proceedings was not enough to claim the arbitrator was not disinterested. *Id.* at 873. The court analogized this situation to judges, who often have knowledge of and experience with multiple suits arising from the same issue. *Trustmark*, 631 F.3d at 873. The court found that the District Court erred in concluding that arbitrators could not interpret the confidentiality agreement, as the agreement to arbitrate encompasses all arbitration disputes. *Id.* at 873-74. The appellate court found that the confidentiality agreement was “presumptively within the scope of the reinsurance contracts’ comprehensive arbitration clause.” *Id.* at 874.

Finding that the arbitrator had no financial stake in the outcome of the proceedings, the court declined to intervene. *Id.* The court noted that although the arbitrator was familiar with the parties, “[n]othing in the parties’

¹ A prior article by Michael H. Goldstein and Daniel J. Endick in the Spring 2016 Edition of AIRROC Matters discussed the “general rule” that applies in the event of the death of one arbitrator; see also *Marine Products*, 977 F.2d at 68.

contract requires arbitrators to arrive with empty heads.” *Id.* at 873. Additionally, the court stated that the arbitration panel was entitled to determine the meaning of the confidentiality agreements. *Trustmark*, 631 F.3d at 874-75. “But among the powers of an arbitrator is the power to interpret the written word, and this implies the power to err; an award need not be correct to be enforceable.” *Id.* at 874. The court held that as long as “the arbitrators honestly try to carry out the governing agreements,” the panel is within its discretion and the court should not intervene. *Id.*

Northwestern National Insurance Co. v. Insko, Ltd. is another instance where the contractual right to select an arbitrator was upheld, in a particularly contentious dispute. Arbitration commenced in June 2009, and the arbitrators made initial disclosures of possible conflicts of interest in February 2010. *Nw. Nat. Ins. Co. v. Insko, Ltd.*, No. 11 CIV. 1124 SAS, 2011 WL 1833303, at *1 (S.D.N.Y. May 12, 2011). The arbitration was “characterized by an ongoing dispute regarding the alleged failure of both party-appointed arbitrators to disclose possible conflicts of interest arising after the organizational meeting.” *Id.* This dispute led to a petition to the court in which Insko demanded the resignation of the entire panel “on the basis of evident partiality.” *Id.* This request for resignation came after it was revealed that one of Insko’s counsel was employed by an insurance company of which Insko’s arbitrator was a board member, and the Northwestern arbitrator revealed that she had been appointed as arbitrator in two previous arbitrations that involved Northwestern’s counsel’s firm. *Id.*

After the demand for resignation, Insko’s arbitrator resigned and Insko quickly reappointed a new arbitrator. *Id.* at *2. Northwestern then filed suit, claiming that the defendant did not have the authority to replace the appointed arbitrator. *Nw. Nat. Ins. Co.*, 2011 WL 1833303, at *3. It claimed that allowing a party to appoint a new arbitrator, three days before oral argument of a dispositive motion, would allow for manipulation of the arbitration process. *Id.* Insko

countered this argument by stating that it had uncovered evidence of partiality and was entitled to replace its party-arbitrator.

The court declined to intervene in the arbitration proceeding because Insko had appointed a replacement arbitrator. *Id.* The court distinguished this scenario from situations where a party refused to appoint a replacement arbitrator and tried to assert the “general rule” that was set forth by the Second Circuit in *Marine Products, Inc. v. Marine Products Exp. Corp. v. M.T. Globe Galaxy*, 977 F.2d 66, 68 (2d Cir. 1992). The fact that there was an alleged lack of impartiality, coupled with the swift action by Insko to appoint a replacement arbitrator, allowed the court to exercise its discretion by not intervening. The court believed that allowing Insko to choose its arbitrator in these circumstances would promote the underlying goals of arbitration. *Id.*

The court held that as long as “the arbitrators honestly try to carry out the governing agreements,” the panel is within its discretion and the court should not intervene.

The Sixth Circuit, in *Savers Property and Casualty Insurance v. National Union Fire Insurance Company of Pittsburgh*, recently also confronted an effort to disqualify an arbitrator mid-proceeding. In that case, a complaint was filed in Michigan state court, but was later removed to federal court, seeking to vacate an award for “evident partiality.” *Savers Prop. & Cas. Ins. Co. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 748 F.3d 708, 713 (6th Cir. 2014). After selecting the party-arbitrators, the parties selected an umpire, who at the time of his appointment disclosed that he was a personal friend of National Union’s party-arbitrator. *Id.* at 712. Despite this connection, the parties agreed to the umpire’s appointment, and the arbitration commenced.

After the panel issued a unanimous “Interim Final Award,” the plaintiff, Mead-

owbrook, filed a supplemental submission pursuant to the award, containing documents needed to calculate the final damages. *Id.* at 713. National Union’s arbitrator and the umpire, the two who had disclosed that they were personal friends, rejected the supplemental submission as not responsive to documents that were sought in the Interim Final Award. *Id.* Meadowbrook filed suit in Michigan state court, arguing that the majority showed evident partiality because they rejected the supplemental submission in the absence of Meadowbrook’s party-arbitrator. *Id.* at 713-14. Additionally, Meadowbrook argued that National Union’s arbitrator was not disinterested, because he was involved in speaking *ex parte* with National Union’s counsel during the course of the arbitration. *Savers*, 748 F.3d at 713-14.

In addition to filing a petition with the court, Meadowbrook protested the panel’s orders, asserting the same evident partiality arguments; the panel denied all of Meadowbrook’s motions. *Id.* at 714. Meadowbrook moved the state court to stay the proceeding “in order to challenge the fundamental fairness of the proceedings.” *Id.* at 715. National Union removed the case to federal court on the basis of diversity and the District Court heard the motion by Meadowbrook for injunctive relief. The District Court concluded that injunctive relief was proper because of the high likelihood of irreparable harm that Meadowbrook faced. *Id.* The court found that substantial financial liability could result, and there was a high likelihood that Meadowbrook would succeed in showing a breach of contract with regard to *ex parte* communications between National Union’s party-arbitrator and its counsel. *Id.* Accordingly, the court enjoined the arbitration proceedings and National Union appealed.

The Sixth Circuit, however, found that the District Court erred when it entertained an interlocutory attack on an arbitrator’s partiality. *Savers*, 748 F.3d at 716. The court found that a determination of whether the arbitrator was disinterested is ripe only after the proceedings have finished. *Id.* In reviewing both the FAA



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Who's Your Arbitrator (Continued)

and Michigan's arbitration laws, the Sixth Circuit concluded that there were only two stages at which a court may become involved in arbitration proceedings: at the outset and at the conclusion of the dispute. *Id.* at 717. "Between those two stages, however, the laws are largely silent with respect to judicial review." *Id.*

Placing a heavy emphasis on the procedural posture of the case, the court found that, even when there are allegations of impartiality, the court is bound by the FAA. *Id.* at 720. If proceedings are brought before the court, even in the face of an arguably tainted arbitrator, the court will respect the arbitration proceedings and not intervene in an ongoing arbitration proceeding.

Even when not dealing with whether an arbitrator is disinterested, courts seem to be reluctant to impose their authority to disqualify an arbitrator. For instance, in *IRB-Brasil Resseguros S.S. v. National Indemnity Company*, the court specifically acknowledged that its holding and reasoning could cause manipulation of the arbitration process yet respected the parties' right to select their own arbitrator. *IRB-Brasil Resseguros S.A. v. Nat'l Indem. Co.*, No. 11 CIV. 1965 NRB, 2011 WL 5980661, at *4 (S.D.N.Y. Nov. 29, 2011). *IRB* involved three separate arbitrations. *Id.* at *1-2. All three arbitration panels were being selected simultaneously, and one of the proposed umpires, after being stricken by *IRB-Brasil*, was subsequently appointed as National Indemnity's arbitrator in two of the three proceedings. *Id.* at *2. In order to get appointment of the stricken umpire as its party-arbitrator in the third proceeding, National Indemnity requested that its already appointed arbitrator, who had been in place for more than two years, immediately resign. *Id.* at *4. *IRB-Brasil* filed a petition with the court seeking an order preventing National Indemnity from changing its party-arbitrator.

IRB-Brasil argued that the original appointment by National Indemnity should be considered final in order to protect the integrity of the arbitration

process. *Id.* at *3. In coming to its conclusion, the Southern District of New York distinguished the instant case from *Insurance Company of North America v. Public Service Mutual Insurance Co. IRB-Brasil*, 2011 WL 5980661, at *3. The court found that there was a crucial distinction between the cases: the party whose arbitrator resigned in *Insurance Company of North America* did not nominate a replacement candidate. *Id.* at *4. Instead, the court found that the factual scenario in this case was similar to *Northwestern National Insurance Co. v. Insko, Ltd.*, where the court held that the request to replace a candidate cut against the overall goal of arbitration to have balanced deliberations that produce an outcome acceptable to both parties. *Id.*

...the Sixth Circuit concluded that there were only two stages at which a court may become involved in arbitration proceedings: at the outset and at the conclusion of the dispute.

The district court found that because the second arbitration had not begun, the parties were within their rights to appoint their own arbitrators under the arbitration clause of the contract. *Id.* at *5. Even while acknowledging that the process can be manipulated to allow a party to get the arbitrator it wants, the court was unwilling to disturb the contract. "It is commonly accepted that in the tripartite arbitration system, parties are entitled to an arbitrator of their choice to act as a de facto advocate for their position." *Id.* at *4.

A similar result was reached more recently by the Southern District of New York in *Odyssey Reinsurance Co. v. Certain Underwriters at Lloyd's London Syndicate* 53. 1:13-cv-09014-PAC, Slip Op. (S.D.N.Y. Oct. 9, 2015). In that case, the arbitration agreements required that each member of the arbitration panel be an officer of a

U.S. authorized insurance or reinsurance company writing workers' compensation business. Prior to the appointment of an umpire, the respondents advised the petitioner, Odyssey, that they were replacing their party-arbitrator. Subsequently, Odyssey determined that the replacement arbitrator was actually an officer of a broker rather than an insurance or reinsurance company. Respondents took the position that he was qualified insofar as his company had "corporate affiliates" that wrote workers' compensation business in the United States. Odyssey subsequently petitioned the court to direct respondents to appoint an arbitrator who meets the qualification requirements in the relevant agreements. The court, however, refused to do so, holding in a handwritten decision that respondents' replacement arbitrator "meets the qualifications" set forth in the agreements. *Id.*

Interestingly, in that same matter, the court *did* eventually intervene to break a deadlock with regard to the appointment of an umpire. Odyssey had taken the position that respondents' proposed candidates were unqualified under the terms of the parties' agreements. The District Court initially refused to intervene, holding by order of June 30, 2014 that "there has not been a breakdown in the process that justifies court intervention." 1:13-cv-09014-PAC, 2014 WL 3058377 (S.D.N.Y. June 30, 2014). On August 26, 2015, however, the Second Circuit reversed, holding that where, as here, there had been a "lapse" in the naming of an umpire, the district court had "not only the authority, but the obligation" to appoint an umpire pursuant to Section 5 of the FAA. 615 Fed. Appx. 22 (2d Cir. 2015). Accordingly, on December 2, 2015, pursuant to the Second Circuit's instructions, the district court appointed an umpire and dismissed the case. 1:13-cv-09014-PAC, Slip. Op. (S.D.N.Y. Dec. 2, 2015).

Indeed, courts will intervene if the actions taken seem intended solely to manipulate the arbitration process. In *AIG vs. Odyssey*, the New York Supreme Court was asked to intervene to solve a dispute that arose when an arbitrator was discharged

Who's Your Arbitrator (Continued)

by the party that selected him. *AIG v. Odyssey* Motion Transcripts, p. 6, Index No. 159373/14, February 10, 2015. The parties were involved in three separate arbitration proceedings. *Id.* at 4. Multiple disputes arose between the parties regarding the selection of arbitrators. In one of the proceedings, Odyssey Group sought to replace its arbitrator only a few days before an organizational meeting was held following an adverse ruling in another matter against Odyssey, in which Odyssey's arbitrator was also a panelist. See Memorandum of Law In Support of Petition to Compel, p.1, Index No. 159373/14, October 1, 2014. The other disputes surrounded the selection process for the arbitrators pursuant to the written agreements between the parties. AIG filed a motion under Section 5 of the FAA asking the court to intervene. *Id.* at 6.

As to the replacement of Odyssey's arbitrator before the organizational meeting, AIG's main contention was that the replacement of the arbitrator at that time was a "litigation strategy to most effectively manipulate the arbitration process." *AIG v. Odyssey*, Petitioners Reply Memorandum of Law, p. 9, Index No. 159373/14, Oct. 30, 2014. AIG argued that the calculated termination of the Odyssey party-arbitrator was intended to delay and frustrate the arbitration proceedings. AIG argued that Odyssey had no right under the contract to replace its arbitrator and was simply trying to do so because they were in a "no man's land of the arbitration prior to the constitution of the panels in each case." Transcripts, p. 9. AIG asked the court to reappoint the arbitrator that Odyssey had terminated.

The court granted AIG's motion, and found that the substitution of Odyssey's party-arbitrator would prejudice AIG. *Id.* at 21. The court found it was proper under Section 5 of the FAA for it to intervene, as the contract did not expressly sanction Odyssey's actions. Additionally, the court found that in this case there was no claim that the appointed arbitrator was lacking impartiality, and stated that "there is no conflict, there's no reason to substitute

that is obvious." *Id.* at 17. Holding that there was no evident partiality, the court distinguished cases like *IRB* and *INSCO*, finding that those cases dealt squarely with a claim that the arbitrator was not disinterested. *Id.* at 18-21. The court concluded that allowing a party to take this action would give it the ability to "blow [up] the arbitration" at any point in an attempt to delay the proceedings. *Id.* at 20. Hence, AIG's claim of Odyssey's attempt at deliberate manipulation of the process was vindicated.

The court then turned to the two other disputes between the parties, and found that the contracts in both arbitrations were controlling. Transcripts, p. 22. Both disputes concerned the reselection of arbitrators after an arbitrator, who was serving in both arbitrations, independently resigned. The contracts for the arbitrations stated that a list of potential arbitrators was to be submitted by both parties, and the parties were to work together to select the arbitrator. *Id.* at 23. The court ordered that the parties follow this procedure, and independently submit a list of potential arbitrators, so that the arbitration process could continue. *Id.* at 22-25.

Although a court could be asked to review the qualifications or partiality of an arbitrator, courts seem to comply with the general understanding under Section 5 of the FAA, which explicitly grants the court discretion to appoint an arbitrator only if the contract itself does not state how the arbitrator will be appointed. Courts seem to respect the party's right to choose its own arbitrator, but have become wary of situations that seem only to delay or frustrate the arbitration process.

Although the case law seems very fact-sensitive and based on when and how the parties come before the court, the Supreme Court of New York's decision in *AIG v. Odyssey* put a check on situations that indicate clear manipulation of the process. In those rare instances, although courts are reluctant to intervene, courts may step in to enforce the parties' contract and allow the arbitration to continue.

Conclusion

Courts have recently taken a more proactive role in pending, as opposed to concluded, arbitrations. Most of the litigation activity surrounds the replacement of party arbitrators. Jurisdictions differ as to the courts' authority when exercising their discretion in these situations. Some jurisdictions follow a strict rule that requires an arbitration to start anew, while others will simply appoint a new arbitrator in the middle of the process and require the new arbitrator to be integrated in the midst of an ongoing proceeding.

A growing concern is whether courts, in exercising their authority under Section 5 of the FAA, are inevitably generating more litigation through these decisions. These decisions, while sound and in accordance with the courts' authority, may be missing issues that could result in a heightened level of litigation in subsequent pending arbitrations. Although the goal of arbitration is to avoid litigation, and reach amicable agreements in a less formal setting, there is still uncertainty as to precisely what role the court should be taking in the midst of the arbitration process. While courts seem to respect the contractual rights of the parties, the broad discretion given under Section 5 of the FAA, and the various applications of the "general rule," could be expanding the courts' role, even if their final determination is that they have no authority to intervene in a particular matter. ●



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Learning about Leah

Head of Business Runoff Operations at Munich Reinsurance America, Inc.



Leah Spivey is the type of person who wanted to put her own stamp on her career, and that philosophy led her to the highest levels of the legacy sector of the reinsurance industry. Leah believes her personality—as a self-described “driver” as well as a “people person”—allows her to simultaneously produce results and build strong client relationships. Leah’s route to the top was based on an old-fashioned theory — that she could both be a career professional and pursue her passions and talents in the industry.

But Leah began her reinsurance career in the most unconventional of ways. Her first job after graduating from the University of Massachusetts with a journalism degree was as an admissions counselor for an accredited school that operated as a for-profit college. “Working this job made me realize that I wanted a

position that provided a certain level of autonomy where I could own my work product from beginning to end. The insurance industry was the perfect fit for my criteria,” she said. Leah took a claims position with an insurance company in 1984 and steadily moved up the career ladder to her current position as SVP-Head of Business Runoff with Munich Reinsurance America, Inc.

At Munich Re, Leah leads a group, which has results responsibility for all of its 2001 and prior liabilities. She manages a staff of reinsurance professionals with a portfolio of current and former clients. During her time at Munich, she has held a variety of positions in claims and account management. “My current role involves being responsible for the results of our legacy portfolio and mitigating its risk of change year over year.” We evaluate what makes sense for the group economically and try to find the best ways to meet our reinsurance partners’ needs through optimal exit solutions,” she says.

Since joining the insurance industry in 1984, her career has been filled with

interesting opportunities. “At one point, I was asked to step away from the business and design a multi-line training program for recent college graduates,” she explains. It was a creative detour that kept her engaged with the company and led her to pursue and achieve a Certified Training Designer designation. However, she longed for and returned to the business side of the industry after a fulfilling two years.

At Munich Re (formerly American Re), since 1993, Leah has enjoyed its organizational flexibility, which meant that she was able to work a four-day per week at one point in her career, though she chose to return to a full time schedule. “Work/life balance has always been important although optics and expectations have changed a great deal since I started in this industry. Today, people are insisting on more balance. I appreciate the young people, who are not afraid to take advantage of all the benefits we now have; just as much as I am thankful for those who came before me, who forged new paths and provided me with the opportunities that I have experienced,” she says.

Among the lessons Leah has learned during her career:

On Career Paths

“Get as much education as you can as early as you can because it truly benefits you. Get in a good training program, and if you find something that excites you, it can sustain you for an entire career.”

On Advice to Women Today

“There are more opportunities today than when I started. Take advantage of all the work-life balance options you have as there is no ‘right or wrong’ way to build a career anymore. You can grow in a career successfully in many ways at your own pace and in your own directions.”

On Secrets to Success

“In my younger days, I said the secret to my success was to speak your mind but never complain. I don’t believe that anymore. Now, I believe the secret is to

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do things in a way that you are always building and improving. If something isn't quite right, find a way to make it better rather than to think or say that it is wrong. Pointing out what is wrong doesn't add any value, building excitement around an idea of how to take it to the next level is true leadership."

On Succeeding

"Don't worry about getting there. You will get there. Worry stands in our way. The minute you start to relax and trust in yourself and the path you are on, that's when people are attracted to you and look to you to lead. Trying too hard is a big problem with women. It took me a long time to understand what that means. I could have avoided a lot of angst if I had listened to the wise people who told me that along the way."

On Leaders

"People want leaders but leadership isn't telling people what to do. It's supporting people to do the right things. More often than not, I find that it isn't my idea but my ability to direct and/or assist others in bringing their ideas to fruition that makes me valuable to an organization." ●

Fast Facts

Professional Career

SVP, Head of Business Runoff, Munich Re
SVP, Head of E/MT Claims, Munich Re
Vice President and Account Executive, Munich Re
Regional Manager, The Home Insurance Company

Education

B.A., University of Massachusetts – Amherst,
Journalism and Communications
CPCU Designation (Chartered Property
Casualty Underwriters)

Industry Involvement

Chair, Board of Directors, AIRROC
Member of APIW
Certified Training Designer & Developer

This profile first appeared on the Women in Reinsurance™ website in November 2015.

Mark your calendars: AIRROC's biggest event of the year will be held from Sunday, October 16, 2016 to Wednesday, October 19, 2016.

The AIRROC Board of Directors looks forward to seeing you at the upcoming networking forum at The Heldrich Hotel and Conference Center in New Brunswick, NJ.

The Heldrich is less than 40 minutes by train from New York City and boasts a large number of restaurants and shops within walking distance, as well as the full service amenities expected from a fine hotel. "We chose The Heldrich as our host again this year in response to the extremely positive feedback that we received from AIRROC's members and delegates. Not only does it offer beautiful facilities and rooms, but it is an easy commute from Manhattan as well as the major airports," said AIRROC's Executive Director, Carolyn Fahey.

The event offers many features that continue to make it an industry "must-attend". Delegates benefit from two full days of reserved networking tables on Monday, and Tuesday. "We already have more than 60 companies represented among the delegates registered," said Fahey.

TOPICS TO BE COVERED:

**Brexit: Implications and Impacts
Long-Term Health Care Runoff
Emerging Coverage Issues Driven by Sharing
Economy/Technology
Rhode Island Insurance Regulation 68:
A View In Practice
AIRROC/E&Y Survey: Results and Findings**

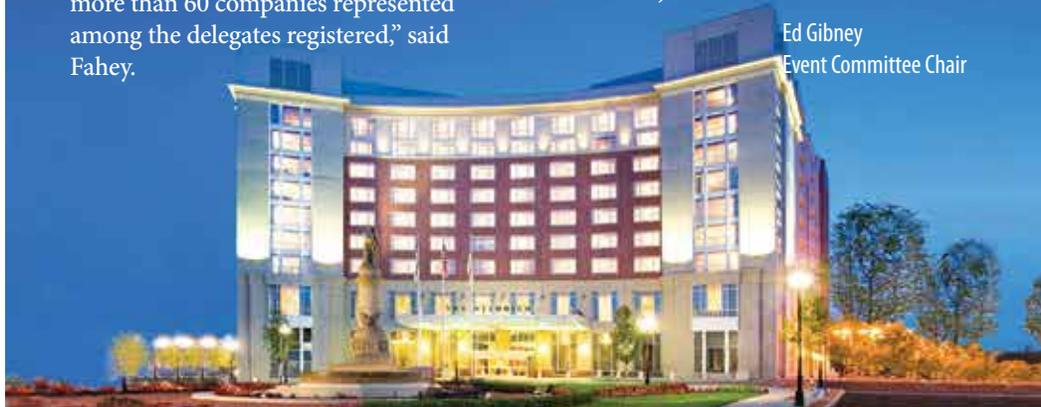
On Monday evening, AIRROC is once again hosting a wine tasting/dinner at the famous George Street Playhouse, catered by the highly-acclaimed Catherine Lombardi restaurant. Learn who AIRROC has chosen as the 2016 Person of the Year as well as meet the recipient of AIRROC's 2016 Trish Getty Scholarship. Tuesday again provides for the opportunity to schedule meetings all day with other event attendees in order to progress matters between companies. There will be a two-hour cocktail reception and whiskey tasting on Tuesday evening at INC, right around the corner from The Heldrich.

We will adjourn at noon on Wednesday.

Go to www.airroc.org and register now!!!!

We look forward to seeing you at AIRROC NJ 2016!

Ed Gibney
Event Committee Chair



2016 REGISTRATION RATES

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- AIRROC Corporate Partners can register at the member rate of only \$595
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- Monday Education Sessions only \$295 for members and \$495 for non-members
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Building a better
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The Five Arms of a Starfish

Message from the Executive Director

Most starfish – or sea stars – have five arms, but did you know that some have many more? In thinking about my column this quarter, I had recently returned from a beach vacation (think images of a starfish, sand, sun, surf.....) So why did this bring AIRROC to mind for me? AIRROC serves our industry in multi-faceted ways – at least five in fact!

Earlier this year the board adopted a new VISION and MISSION for AIRROC:

AIRROC's VISION is to be the most valued (re)insurance industry educator and network provider for issue resolution and creation of optimal exit strategies.

AIRROC's mission is to promote and represent the interests of entities with legacy business by improving industry standards and enhancing knowledge and communications within and outside of the (re)insurance industry.

Our new VISION contains in it the core values of AIRROC (our five “arms”):

- (Re)insurance Industry
- Valued Educator
- Network Provider
- Issue Resolution
- Exit Strategies

AIRROC’s board of directors has been busy on some ideas from a strategic planning session earlier this year. Maybe we will soon add even more “arms”

to AIRROC! We featured our annual Chicago Regional in May and in July the annual Summer Membership Meeting. The Who, What, When, Where, and Why (again five arms!) of these programs can be found in this issue.

Mark your calendar for these upcoming AIRROC events:

- **September 20** – A Comparative Arbitration Workshop, New York NY
- **October 4** – AIRROC / IRLA Munich Regional Education Day, Munich, Germany
- **October 16-19** – AIRROC NJ 2016 Commutations & Networking Forum, New Brunswick, NJ

The delegate list for AIRROC NJ 2016 is already on our website. Sign up today – it’s not too early to start scheduling your business meetings! I bet that you can find AT LEAST five companies that you would like to see there... :-)



Carolyn Fahey joined AIRROC as Executive Director in May 2012. She brings more than 20 years of re/insurance industry and association experience to the organization. carolyn@airroc.org

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Educational Summaries

Chicago Regional • May 25, 2016

AIRROC partnered with Butler Rubin for the annual Chicago Regional Education Day. We had great attendance and an interesting “potpourri” of hot topics!

Illinois Department of Insurance: The Regulators Speak

In a panel moderated by Dan Cotter, a Partner at Butler Rubin Saltarelli & Boyd LLP, senior leaders of the Illinois Department of Insurance (“IL DOI” or the “Department”) and the Office of the Special Deputy Receiver (“OSD”) provided attendees with insights into the workings of the Department, as well as the Department’s current areas of focus. James Stephens, Chief Deputy Director of the IL DOI, Michael P. Rohan, Deputy Director, Consumer Education and Protection for the IL DOI, and J. Kevin Baldwin of the OSD spoke about the consumer protection mandate that permeates the work of the Department, the challenges of working with regulators from other states, and the industry issues that they see on the horizon.

The OSD handles insolvencies, servicing twenty-six receivership estates in 2015. Mr. Baldwin identified the most common causes of financial distress as the failure to properly reserve and the inability to properly price particular lines of business, due to lack of a good understanding of expenses for those lines. Companies come to OSD’s attention in various ways, including liquidity problems, deterioration in the company’s Risk-Based Capital (“RBC”) ratio over successive quarters, and an increase in reserves at year-end followed by an immediate decrease during the first quarter of the following year. OSD will sometimes involve itself with a financially distressed company prior to putting the company into supervision and attempt to help the company implement various practices aimed at avoiding supervision or worse. Lastly, Mr. Baldwin indicated that the best way for a company to avoid the OSD is to reserve and price properly, eschewing blind adherence to market trends.

Mr. Rohan spoke concerning market conduct exams. Level 1 exams are conducted frequently. The results are not shared with the public, although they may be shared with other regulators. The Level 1 market conduct exam includes an analysis of general company issues, the RBC ratio, state regulatory action by other states, market share, lines of business written, premium per line of business, and existing claims. The Department looks for outliers in that information before proceeding with any further review. Only one-half – or fewer – of Level 1 exams result in further action. There is no specific trigger for a market conduct exam. Rather, a number of factors come into play, including the level of consumer complaints, regulatory action in other states, rapid growth that might outstrip the ability to service customers, and/or length of time since the last review. Cooperation with the Department and self-reporting are likely to reduce the amount of any penalty imposed as a result of any violation. A penalty may also be less severe if the business at issue is in run-off since the conduct is less likely to cause future consumer harm. Mr. Rohan suggested that, to avoid a market conduct exam, a company should do its due diligence when buying a run-off book and should be aware of any problems with TPAs.

Mr. Rohan spoke about the Department’s current view on the amendments to Rhode Island Regulation 68 permitting insurance business transfers (“IBTs”). Mr. Rohan indicated that the Department’s focus in reviewing an IBT would likely be the actuarial opinions; he speculated that the Department might want to define the actuarial process – and possibly hire its own actuary – to ensure appropriate review of any proposed IBT. He also indicated that the impact on interstate relations among regulators implicated by such a transaction remained an open issue.

Lastly, the regulators identified the industry issues that keep them up at night, including the fate of non-standard auto, the potential for a major cyber breach, Affordable Care Act issues, the impact of increased lifespans on long-term care and





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ALVAREZ & MARSAL

Chicago Regional (Continued)

health insurance, and the fact that many of the Department's employees have reached retirement age, potentially leading to the loss of significant institutional knowledge.

Randi Elias, Partner, Butler Ruben Saltarelli & Boyd LLP, rellias@butlerrubin.com

Legal Roundup: Significant Developments in the Courts and Beyond

The Legal Round-up session was divided into two subsections this year: Direct Insurance and Reinsurance. The Direct Insurance panel consisted of Jenna Buda and Marty Cillick of Allstate, Mark Deptula of Locke Lord, and John LaBarbera of Carroll McNulty & Kull LLC. Each panel member presented on current relevant matters.

The session opened with John LaBarbera discussing the recent decision in the *Matter of Viking Pump, Inc. and Warren Pumps, LLC*, (N.Y. Ct. App. No. 59 May 3, 2016). John provided the background of this case in which the Delaware Supreme Court certified two questions to the New York Court of Appeals and ruled on significant issues of allocation.

Next, Jenna Buda discussed Allocation in New Jersey and the recent decision in *Ward Sand & Materials Co. v. Transamerica Insurance Co.*, Docket No. A-1479-13T1 (App. Div. Jan. 12, 2016) which decision clarified that insolvent shares are to be removed from allocation to insurers in long tail coverage cases in spite of amendments to the Property – Liability Insurance Guaranty Act.

Mark Deptula presented on the topic of recent developments regarding successor liability and insurance. In particular, Mark discussed the background and rulings in *Fluor v. Superior Court*, 61 Cal. 4th 1175 (2015) and *Givaudan Fragrances Corp. v. Aetna Cas. & Surety Co.*, 442 N.J. Super. 28 (N.J. Super. Ct. App. Div. 2015) where courts have interpreted the enforceability of anti-assignment provisions in the context of long tail losses.

Marty Cillick presented on the status of the drafting of the American Law Institute's Restatement of the Law of Liability Insurance, which will likely be finalized in May 2017. To date, the American Law Institute

has written or is in the process of writing twenty-six restatements, including this new Restatement of the Law of Liability Insurance.

Following the Direct Insurance panel discussion, the Reinsurance panel discussed recent developments affecting reinsurance. The Reinsurance panel consisted of moderator, Neal Moglin of Foley Larder as well as panel members Julie Johnston of CNA, Dee Dee Derrig and Paul Ryske of Allstate. Neal Moglin's wit and dialog as moderator served to keep the presentations lively and interactive.

Panel member Julie Johnston discussed arbitrability of disputes and, in particular, who decides questions of arbitrability. Julie described the background and impact of case law on this topic and noted that practitioners should be mindful when drafting arbitration clauses, focusing on the intended reach of the clause.

Dee Dee Derrig presented on the topic of confirmation and enforcement of arbitration awards under the Federal Arbitration Act. In particular, Dee Dee described case law interpreting the Federal Arbitration Act's confirmation requirements as well as cases concerning whether a party's payment or compliance with an arbitration award moots judicial confirmation of the award. Dee Dee also discussed the potential impact of confidentiality agreements on the confirmation process.

Paul Ryske discussed covered agreements, and in particular, the impact of the Dodd-Frank Wall Street Reform and Consumer Protection Act on covered agreements. Paul noted that, once effective, a covered agreement could pre-empt state laws relating to reinsurance collateral.

Martin P. Cillick, Senior Attorney, Allstate Insurance Company, mcill@allstate.com

Lead Contamination: The Epidemiology and the Litigation

This year, AIRROC was very fortunate to hear from an esteemed panel of experts with regard to lead contamination, consisting of Dr. Helen Binns, a Pediatrician with Lurie Children's Hospital and a Professor of Pediatrics at Northwestern University's Feinberg School of Medicine and Patrick Connor, President of Connor Consulting. Additionally, AIRROC thanks



Chicago Regional (Continued)

Ben Blume of Carroll McNulty & Kull LLC for organizing and moderating this highly-informative panel. Dr. Helen Binns's presentation included a discussion of data related to the causes and implications of lead exposure, much of which relates to research here in Chicago. Dr. Binns noted at the outset that lead levels in children are largely the result of environmental exposures and, further, that there is no safe level of lead exposure. Elevated lead levels in blood will have an impact at all ages. The only way to bring blood lead levels down is to remove all lead from an environment. This can be hard. Here in Chicago, 86% of homes that were built prior to 1980 have lead paint and 80% of homes built in Chicago have lead service lines. These service lines were installed well into the 1980's.

Lead is used in many products. It can be found in paint, plastics, including vinyl blinds, dishes, and glassware. But the single largest amount of lead in use in society today, however, is in batteries. However, most exposures to lead are from paint. Lead was used as an additive in paint until 1976 and lead paint exposure in children is often as a result of exposure to lead dust generated from the paint. Children tend to get dust on their hands and then ingest the dust when their hands are placed to their mouths.

Lead in water is another source. The problems that caused lead in the water in Flint, Michigan, for example, are really not that different from problems that also exist in places like Chicago and Cleveland, other cities with older construction containing lead water service lines. Treatment for exposure to lead includes removing all continued sources of lead contamination in the home, including possible removal to a "safe house" free of lead, along with good nutrition. Iron is an important part of the diet because it competes with lead for resources in the blood and treating an iron deficiency will allow the body to absorb iron before absorbing lead.

The presentation by Patrick Connor, President of Connor Consulting, also included a discussion of data related to the causes and implications of lead exposure. In Maryland, more than 50% of children with higher levels of lead were exposed not from paint but from lead in other areas of their homes. Lead in gasoline is still a problem in the United States, having settled on side-

walks, roadways, and homes. A lot of lead also enters the United States in products produced in China and other countries. Many believe these sources of lead produce lead dust that represents a greater risk of exposure than chipping lead paint.

Accurately detecting the presence of lead in the home can be a challenge. While the tools used can be very sophisticated and expensive, they are often used by poorly-trained technicians with poor testing strategies. While doctors may order testing of a home environment for the presence of lead, the test results can miss the mark if generally accepted testing principals are not followed. While deteriorating lead paint should be an element of an inspection it is just one component of a broader environmental inspection that should also look beyond the presence of lead paint. When investigating a child's exposure to lead, the child's complete environment should be investigated (not just the home) because exposures could be coming from outside the home or even from imported spices, glassware, and other imported items used within the home. Consequently, exposure to lead should be examined beyond the presence of lead paint.

Martin P. Cillick, Senior Attorney, Allstate Insurance Company, mcill@allstate.com

Rhode Island Insurance Business Transfer Interactive Workshop

Attendees participated in an interactive workshop highlighting the facets of the analysis necessary to effectuating the insurance business transfer ("IBT") contemplated by the amendments to Rhode Island Insurance Regulation 68.

First, Luann Petrellis from the Insurance Advisory Services of Ernst & Young LLP provided an overview of the regulatory framework for completing an IBT. Modeled on UK Part VII transfers, the IBT is a court-sanctioned novation of a book of insurance business (other than life, worker's compensation or personal lines) or reinsurance business (other than life), to a Rhode Island insurer. The IBT can provide a number of benefits to the transferring company, including capital optimization and operational efficiency.

The transaction may be an intra- or inter-company transaction. Regulation



Summer Membership Meeting

Networking and Education, NYC • July 19-20, 2016

68 contemplates a two-layer review of any proposed transaction. The first is a regulatory review in which the transferring company, which need not be domiciled in Rhode Island, must obtain approval of a proposed IBT plan from the regulator in its state of domicile. The assuming company must also obtain approval of a proposed IBT plan from the Insurance Department of the Rhode Island Department of Business Regulation. If those approvals are obtained, then the second layer involves the assuming company filing a Petition for Implementation with the Rhode Island Superior Court for approval of the IBT plan. In order to obtain court approval, the assuming company must demonstrate, through an expert report, that the IBT will not materially, adversely affect policyholders. Notice must be given to all policyholders potentially impacted by the IBT. Any party who may be impacted by the IBT – not just policyholders – may file an objection to the plan and be heard on that objection in the Superior Court, but there is no provision in Regulation 68 that permits a policyholder to opt out of a court-approved IBT.

Following Ms. Petrellis's explanation concerning the process for effecting an IBT in Rhode Island, participants broke into teams to discuss various aspects of a hypothetical situation in which a fictional company considered how best to structure a proposed IBT. The facilitators assigned to each team included the following individuals: Dan Cotter, Randi Elias, and Teresa Snider of Butler Rubin Saltarelli & Boyd LLP; John Noone, Senior Attorney, Specialty Operations Law Division at Allstate; Marsha Papageorge, Ceded Reinsurance Manager, Treaty Premium and Claims Enterprise Risk Management and Corporate Reinsurance at CNA; and Ms. Petrellis and Peter Venetis, Manager, Insurance and Actuarial Advisory Services at Ernst & Young, LLP. Each team focused on one of four issues: (1) strategy and design; (2) expert report; (3) policyholder notice; and (4) regulators. Following in-depth – and lively – discussions during the breakout session, participants reconvened, and a spokesperson for each team reported on his/her team's analysis of the issue before it.

Randi Elias, Partner, Butler Rubin Saltarelli & Boyd LLP, rellias@butlerrubin.com



The July heatwave didn't deter AIRROC members from gathering for the Summer Membership Meeting at the offices of Chadbourne & Parke LLP.

Forecast, Allocation and Policy Defense Modeling

Panelists Ricardo Verges (Managing Partner) and Sarah Peterson (Senior Consulting Actuary) of EVP Advisors, Inc. and Benjamin Blume, Member of Carroll McNulty & Kull LLC, conducted a detailed modeling exercise to explain the benefits of modeling for exposure to an insurer (DDIC) whose policyholder had been involved with numerous claims/lawsuits arising out of the same product. The fictional scenario involved a policyholder that manufactured jeans made with a denim dyed with a formula that could cause injuries to the wearer of the jeans over frequent and prolonged use. According to a coverage chart provided, DDIC afforded primary and low level excess coverage to the policyholder from 1985-87 and 1991-92 whereas the relevant coverage block spanned 1980 to 1995, with no coverage available in 1984.

As a preliminary matter, the panel noted that modeling is a tool or guide used to predict exposure while taking into account “all moving parts” and is a multi-disciplinary approach. In the modeling exercise used, a medical expert was consulted who estimated what percentage of known consumers who wore the affected jeans would develop three different types of illnesses. The medical expert also determined the range (number of years) when symptoms will develop. Coverage counsel also assisted in identifying relevant allocation considerations including, for example: how policy terms are defined, the venue/choice of law, number of occurrences, trigger of coverage, exhaustion, and the impact of coverage gaps. The panel explained the modeling process through charts that estimated exposure. For each forecast, coverage allocation, or policy defense issue, a separate chart provided simulated results that was discussed by the panel. Some of the charts showed surprising results in terms of how an issue impacted the exposure to DDIC. Policy term considerations may include per occurrence and aggregate limits, whether multi-year policies are involved, deductibles/SIRs, the layer of

Membership Meeting (Continued)

coverage (primary, excess, or umbrella) and the treatment of expenses. Here, all claims could result out of a single occurrence (per dye formula) or multiple occurrences (per person purchasing/wearing jeans).

Trigger considerations include using the continuous trigger, triple trigger or date of first exposure (date of purchase here). Coverage gap considerations involved whether to allocate on a pro rata basis or on an “all sums” basis in which coverage caps (insurer insolvencies or lack of coverage) may receive no allocation. Exhaustion considerations included whether a horizontal, vertical, or bathtub (from dollar one) exhaustion applied.

Modeling the potential exposure to DDIC also included analysis of liability defenses to the claims against the policyholder including, in the scenario provided, an expected or intended/known loss defense (a 1986 internal memorandum stated that a chemist working for the policyholder had discovered evidence that the formula involved with the dye problem could cause skin damage) and a product warning defense (some jeans included a warning not to use a specific fragrance which would react unfavorably with the jeans).

A chart with a simple “decision tree” weighed the various factors and defenses to determine a settlement value.

Reinsurance of ECO and XPL

Joseph Holahan, a Partner in the law firm of Morris, Manning & Martin LLP, explored key issues regarding reinsurance coverage for extra contractual obligations (ECO) and losses in excess of policy limits (XPL) in a session that prompted many questions from the audience. Mr. Holahan’s experience in this area primarily comes from his involvement in the drafting of reinsurance contracts. Both ECO and XPL involve losses arising from the reinsured’s handling of a claim. However, ECO involves amounts awarded to a policyholder against the reinsured that are not covered by the original insurance policy whereas XPL involves losses covered by the policy, but only that part of a loss that is in excess of policy limits. The most common example of XPL loss occurs when the reinsured

has liability in excess of policy limits for failing to accept a reasonable settlement within the policy limits, as part of the reinsured’s duty to defend a third party claim against the policyholder.

Mr. Holahan discussed the two seminal cases that addressed ECO/XPL issues before such clauses were even added to reinsurance contracts starting in the 1970s. Such clauses are now commonly included in reinsurance contracts and he provided examples of such clauses that were obtained from the BRMA website. He noted that ECO cover may exclude loss caused by an officer of the reinsured company and that loss due to fraud is more of an issue with Directors and Officers coverage. He agreed that many reinsurance contracts may still only provide ECO coverage at 80% instead of 100%.

Many questions were raised in response to a discussion concerning a “counsel or concur” clause, which provides that a reinsurer is not liable for XCO “unless it concurred in writing and in advance with the actions of the Company which ultimately led to the imposition of” ECO. There were concerns that this type of requirement can impose an undue burden on a reinsured in various situations, such as when it may be difficult to obtain written consent quickly before settling or when numerous reinsurers have to be notified. In the latter situation, it was suggested that consent should only be required from a lead reinsurer.

There are many factors which could determine when a reinsurer will be liable for ECO/XPL, including whether the dispute is in court or arbitration. Since newer contracts commonly include such clauses, the absence of an ECO/XPL clause should lead to an inference that the clause was never intended. Other factors include how loss is defined, the impact of follow the settlements, whether applicable law prohibits punitive damage awards as against public policy, the reinsurer’s involvement in claim decisions, and the extent to which any portion of the settlement can be allocated to bad faith allegations.

Ben Gonson is a Partner in Nicoletti Gonson Spinner LLP. bgonson@nicolettilaw.com





What is “Big Data” and Why Is It Important to Insurers?



As explained during the July AIRROC membership meeting by Prudential Insurance Company of America’s Christine Hofbeck, Vice President and Actuary, Predictive Analytics, data analytics and predictive modeling have become widespread in a host of industries, not least of which is the insurance industry.



Ms. Hofbeck opened her presentation with some startling statistics regarding the ongoing “data revolution” (e.g., as much data is created each week as was accumulated from the dawn of civilization until 2003), before turning to a definition of “big data.” As there is no consistent definition, she shared five variations, including for example, “data too large to capture, process and analyze using traditional techniques in a reasonable time frame.” Ms. Hofbeck further explained that among the reasons for the insurance industry to embrace big data, are the fact that more data is available now than before and the fact that the use and analysis of that data provides a competitive advantage and optimized customer service.



Ms. Hofbeck explained that predictive analytics can be used to make predictions about future or otherwise unknown events, and provided a number of examples how various companies are employing predictive analytics. Specific to the insurance world, Ms. Hofbeck noted that several automobile insurers use telematics to harvest data regarding driving patterns, thus enabling the targeting of premium discounts to certain customers, and the identification of potentially undesirable prospective insureds. Other potential insurance applications allow the carrier to understand the drivers of policyholder behavior, analyze potential insureds’ propensity to purchase and understand what drives customer calls. Insurers can also use analytics to optimize marketing and producer segmentation, aiding in the development of niche



Membership Meeting (Continued)

products. Predictive analytics also can be used in price elasticity modeling when allowed by regulation. Finally, predictive analytics are helpful in risk selection and can be employed in underwriting when non-discriminatory.

After this overview, Ms. Hofbeck turned to an explanation of what a predictive model is and how one properly constructs such a model. She explained that in building a model, the user must determine what data is predictive and set the proper weight given to each component of that data. The key in drawing conclusions from the model is to determine whether there is a mere correlation between two data points, or whether it can be said that one data point truly causes the other. To illustrate, she noted that the *New England Journal of Medicine* related a country's chocolate consumption with the number of Nobel laureates per capita produced by that country. While there is apparently a correlation between the two, one does not cause the other (rather, it is believed that a country's level of wealth is predictive of both). Ms. Hofbeck then detailed the steps needed to develop a model – planning, data preparation, building the model, validation, implementation and reporting/refinement.

She concluded with four considerations. First, a model only has an impact if used to change the way we make decisions. Second, the model's use must be balanced – i.e., the user should not employ the model only when it suggests to discount, but must also use it for surcharge and load decisions too. Third, using a model is somewhat of a leap of faith, especially when results won't be seen for months or years. Finally, quantifying the model's impact can be difficult when the same decision would have been reached irrespective of the model and its revelations.

Joseph Monahan, Saul Ewing LLP, jmonahan@saul.com



A Game Changer or Game Over? The Grand, Brighton England, June 13-15, 2016

There was record attendance at the Insurance and Reinsurance Legacy Association's Annual Congress, held at the Grand Hotel in Brighton, England in June. Drawn by the array of excellent speakers, delegates enjoyed a lively interchange during nine panel sessions which covered a number of highly relevant topics from retrospectives over the run-off market, including technical updates such as the ARIAS fast track arbitration rules, new developments in the industry and the inevitable speculation (or should we say informed debate) over what Brexit might hold.

The main Congress kicked off with an energising and insightful Keynote address from Colm Holmes, CEO of Aviva General Insurance UK. He reflected on the rapidly changing market over the 17 years he had been involved in run-off, which only promised more change to come. It will be the agile who will succeed, embracing disruptive

forces, which are a challenge set fair to continue. Warren Buffet was there in spirit being quoted at several points throughout the two-day agenda.

As well as the panel discussions, which included views from the US and Europe as well as the UK heartland, a fresh dimension to our working lives was covered by a personal management session by Great Britain rowing medallist, Rachel Woolf.

The traditional meeting sessions fitted in well with the educational programme and the lunches and gala dinner with subsequent entertainment made for fantastic networking.

The IRLA Congress itself has changed and developed over the years to reflect changes in the run-off market and attracts delegates from many different countries. AIRROC members might wish to come over and see next year.

The event was a credit to the smooth stewardship of the Chairman, Paul Corver, and the IRLA Board as well as the excellent work of the events management team: a resounding success.

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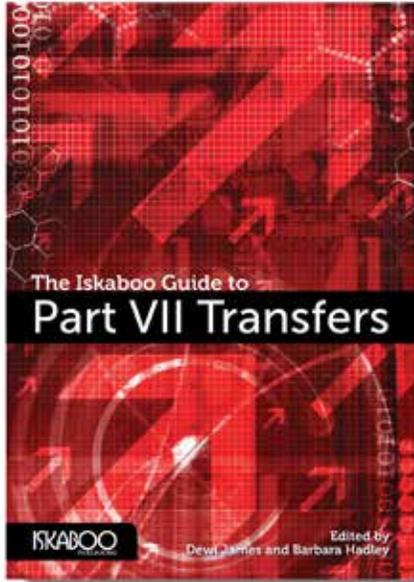
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Edited by Dewi James and Barbara Hadley with contributions from Derek Austin and Tom Rennell*

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* The original “Part VII transfers – a practical guide” was written by Nick Miles, Dewi James and Steve Goodlud and published in 2008.

Figure 1
Part VII transfers by year

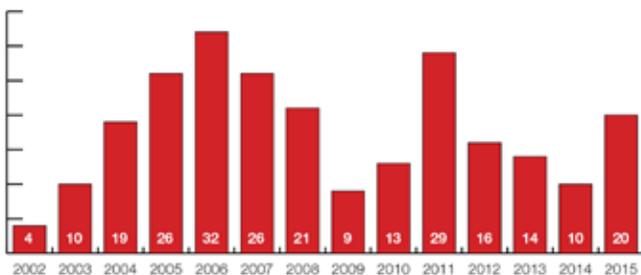


Figure 5
Part VII transfers by law firm



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News & Events

Francine L. Semaya & Peter H. Bickford

Regulatory News

NAIC

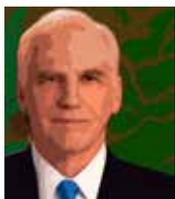
In June, the National Association of Insurance Commissioners (NAIC) adopted a recommendation that will activate principle-based reserving (PBR) starting on Jan. 1, 2017. The recommendation from the PBR Implementation Task Force followed an extensive analysis of amended Standard Valuation Laws passed by 45 states, representing nearly 80 percent of the U.S. life insurance market. To the pleasant surprise of the insurance industry, Financial Services Superintendent Maria T. Vullo announced on July 6th that the



New York Department of Financial Services (DFS) will adopt principle-based reserving (PBR) for its regulated life insurers beginning in January

2018. New York has convened a working group representing industry and consumers to assist the DFS in establishing the necessary reserve safeguards. The Superintendent has established a working group consisting of six domestic life insurers and consumer representatives to provide input to establish the appropriate reserving safeguards. A list of the working group members is available on the DFS website at <http://www.dfs.ny.gov/about/press/pr1607061.htm>.

Federal Reserve



On May 20th, Federal Reserve Board (“FRB”) Governor Daniel Tarullo delivered remarks at the National Association of Insurance

Commissioners (NAIC) International Insurance Forum spelling out the FRB’s supervisory approach to insurance and in particular the expected framework for

capital standards it will impose on the insurance companies it regulates. Tarullo emphasized that “capital and liquidity requirements for insurance companies should be calibrated differently than capital and liquidity requirements for dealer banks. Because Congress modified the Collins Amendment in late 2014, we can now tailor capital requirements for insurance companies.” Governor Tarullo stated that the FRB intends to propose two group capital approaches, one for “systemically important” insurers and one for insurers that own an insured depository institution.

On June 3rd the FRB released an advance notice of proposed rulemaking (ANPR) inviting comment on “conceptual frameworks” for capital standards that could apply to systemically important insurance companies and to insurance companies that own a bank or thrift. The standards would differ for each group.

Solvency II

Captives domiciled within the EU are required to comply with Solvency II’s blanket approach to the regulation of (re)insurance business. The capital requirements under Solvency II are designed to address problems within the commercial market and from the very beginning the EU captive market was concerned that some of the requirements are “disproportionately onerous” for captives. Solvency II is pushing more and more captive owners to put their captives into run-off due to stringent regulation, according to Paul Corver, R&Q’s Director of Insurance Investments.

Brexit

On June 23rd, the UK voted 53.6% to 46.6% to leave the European Union (EU). In order for the UK to leave the EU, the two sides have two (2) years to reach agreement on the terms of the UK’s departure from the EU, once *Article 50 of the Lisbon Treaty* is triggered.

During this time, the UK must continue to comply with all EU laws and treaties, but it no longer has a say in decision-making issues. The reasons to leave the EU are fairly easy to understand, but many question whether the departure will harm or enhance the UK economy.



No one clearly knows how the UK economy, or that of the rest of the world, would ultimately be impacted by the departure of the UK from the EU. One question raised is whether the UK will become a member of The Transatlantic Trade and Investment Partnership or whether it will need to negotiate a separate trade agreement with the United States. Of great interest to our readership is the impact on the insurance and reinsurance industry – especially its impact on Lloyds.

Industry News

In March, Hartford, Connecticut-based investment management firm **Conning & Co.** issued a report, “Global Insurer Mergers & Acquisitions in 2015, The Big Bang,” that confirmed the large volume of merger and acquisition activity last year. The report showed that the volume of merger & acquisition activity in the insurance industry more than quadrupled in 2015, to \$194.9 billion from \$43.8 billion in 2014. There were 24 transactions valued at \$1 billion or more in 2015, compared to nine in 2014. Among property/casualty insurers the aggregate value of M&A deals increased to \$39.6 billion in 2015 from \$6.7 billion in 2014. The report predicted that for 2016, “with so many of the largest insurers having entered into transactions in 2015, it is likely that activity in 2016 will involve combinations among

Present Value (Continued)

second-tier players.” Even that prediction, however, may prove to be overstated, with very little company M&A activity reported in the second quarter of 2016, with only broker mergers and acquisitions showing any significant activity.

On the run-off scene, the most interesting development is the placement of **Castlepoint National Insurance Company** (“Castlepoint”) into receivership in California. In September 2014, ten insurers owned by **Tower Group International Ltd.**, were sold to **ACP Re** and put into runoff. These ten insurers were eventually merged into one company – **Castlepoint** – and on July 28, 2016, a California Superior Court issued an order appointing the California Insurance Commissioner as its Conservator. The Commissioner has filed a proposed motion for an Order Approving Conservation and Liquidation Plan. As part of the Conservation and Liquidation Plan, **Castlepoint** and its parent **ACP Re** have agreed to commute a stop loss reinsurance agreement for a cash payment of \$200 million to **Castlepoint**. A hearing on the plan is scheduled for September 13, 2016.

On July 18, 2016, **Excalibur Reinsurance Corporation**, formerly PMA Capital Insurance Company, was placed into liquidation in Pennsylvania. **Excalibur** mainly reinsured U.S. business from 1990-2003 for commercial auto, commercial general liability, product liability and workers’ compensation. **Excalibur** was in run-off since 2003 (See also the People on the Move item for Keith Kaplan below).

People on the Move

James Wrynn has joined **FTI Consulting, Inc.** as a Senior Managing Director to the firm’s Global Insurance Services practice within the Forensic and Litigation

Consulting segment. Wrynn was the last Superintendent of Insurance before the merger of the Banking and Insurance Departments into New York’s Department of Financial Services.



Following his tenure at the New York Department, he was a Senior Partner in the law offices of Goldberg Segalla, LLP, and most recently served as Managing Director and Vice-Chair at the Guy Carpenter Global Strategic Advisory Group. Jim is based in New York and can be reached at wrynn@fticonsulting.com.

Jill Levy has joined **Mound Cotton Wollan & Greengrass LLP** as a Partner in the firm’s New York office specializing in complex insurance coverage matters. Jill currently serves as Chair of the Insurance Law Committee for the New York City Bar Association, and can be reached at jlevy@moundcotton.com.



Through his boutique advisory and management services firm, **Anselma Capital, LLC**, **Keith Kaplan** has been retained

to serve as Chief Liquidation Officer for Excalibur Reinsurance Company in Pennsylvania. Keith can be reached generally at kkaplan@anselmacapital.com and for Excalibur matters, he can be reached at c-kkaplan@pa.gov.

If you are aware of items that may qualify for the next “Present Value,” such as upcoming events, comments or developments that have, or could impact our membership, please email Fran Semaya at flsemaya@gmail.com or Peter Bickford at pbickford@pbnylaw.com

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October 19-23, 2016
**ABA/Tort Trial & Insurance
Practice Section (TIPS)
Fall Leadership Meeting
San Diego, CA
www.americanbar.org**

November 30, 2016
**Insurance Federation of New York
(IFNY) Annual Luncheon
New York, NY
www.ifny.org**

December 10-13, 2016
**National Association of Insurance
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Fall National Meeting
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