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ANALYSIS OF AN INSURANCE COMPANY INSOLVENCY: A CASE STUDY

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MR. STANLEY B. TULIN: The case study that we are here to discuss is Baldwin-United, which is something that probably everybody here has heard of. The panel that we have recruited includes people who are actively involved at various points and at various levels in the Baldwin-United disaster and rehabilitation. Jeff Liebmann is an Associate of the Society of Actuaries and is therefore here not as a guest, although his function in Baldwin -- in fact, his way of making a living now -- is not actuarial, as he is a partner with the law firm of LeBouef-Lamb in New York, specializing in insurance law. He has specifically represented the Indiana commissioner of insurance in the Baldwin-United rehabilitation and the matter preceding it. John Montgomery is the

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Chief Actuary and Deputy Commissioner of the California Insurance Department. John was active in the oversight committees of the NAIC that were active in following the Baldwin problem before it went into rehabilitation and then was very active in the NAIC options committee and worked extensively with the rehabilitators and their consultants in the process of putting together the rehabilitation plan and analyzing it. Linda Garner was the Insurance Commissioner of Arkansas who took the three Arkansas companies into rehabilitation in July of 1983 and obviously was very close to the matter as the rehabilitator who took the rehabilitation plans to the Arkansas court and worked extremely closely with the NAIC groups and a host of other people during the whole process. The panel has obviously specialized in an intense experience on this matter. I unfortunately have as well, because we have been consulting actuaries to both rehabilitators, as well as consulting actuaries immediately prior to that to Baldwin-United Corporation.

I first got involved in the matter of Baldwin-United in mid-June of 1983. I had been reading about it in the press, but really kind of minding my own business and doing other things that seemed much more interesting at the time. I got a call from what turned out to be Victor Palmieri, although I don't remember who the first call came from, but Victor Palmieri wanted a little bit of help for this little problem that he had, with the bigger problem that he had being with Baldwin-United. The little bit of help he wanted was on the life insurance companies, which he did not really think were a big problem. In fact, I did not know whether they were or weren't. Shortly after getting involved, I met with all of the people here who were at various parts of this NAIC oversight committee that was following Baldwin and was looking to Palmieri, who was the new management of Baldwin-United, to come up with a plan of survival for the life insurance companies. Shortly after that I think we all concluded that there wasn't any such plan that would be forthcoming.

One thing that is very important to understand about any crisis, or at least any insurance crisis, as I have come to understand it, is that no one knows anything about the numbers. In the three weeks prior to the order's being entered, all of the numbers that we were getting from all of the parties that we were dealing with were jumping around in hundred million dollar swings. No one knew whether or not the assets that were shown in the company's

balance sheet, particularly the affiliate securities, which we may discuss more as this discussion goes on, were worth anything. We were told by the company, or some people in the company, that they were worth something. Then we were assured by Palmieri that they weren't worth anything, or at least they could not be counted on to be worth anything. There were conflicting data moving around the entire system, so that one of my early warning systems, and I mean this seriously, has become lack of confidence in the numbers.

One thing that I think everybody needs to understand about this case study, at least, is that things were much more difficult than, in retrospect, may be apparent, because nobody knew what the real numbers were. It took us many, many months, even though there were a lot of us who worked very closely with it, to get any confidence in what the underlying values of the securities were, and to some extent, for us even to get much confidence in what the real liabilities were. So we were dealing with something that might have been a problem and might not have been a problem, and we were getting conflicting reports. That is very important to understand.

The Baldwin process is one that gave rise to a lot of people, and three of them are here, but there were many, many more involved. At one point or another during this thing there were probably twenty meetings going on in twenty different places with all the people who were involved in it. The Baldwin matter touched at least four major courts that I can think of: the Indiana rehabilitation court; the Arkansas rehabilitation court; the Cincinnati bankruptcy court, where the bankruptcy of the parent was filed; and the New York multi-district litigation court, where the suits against the brokers and anybody else who got sued all got lumped together. The final solution involves an integration of all of those courts and jurisdictions, which don't want to have anything to do with each other, and a lot of legal issues and many other complicated things.

What we're going to try to develop in this discussion is how some of these things work together and, specifically, how that rehabilitation plan came about and why the rehabilitation plan looks the way it looks.

PANEL DISCUSSION

MS. LINDA N. GARNER: I am going to talk a little bit about the crisis and how it all developed. Actually the crisis had begun prior to my becoming involved when I became Insurance Commissioner of Arkansas in January of 1983. Much of 1982 had been spent by former Commissioner Bill Woodward in the companies in Arkansas, which made us 70% of the Baldwin in trust business which was in rehabilitation, and there were approximately four of the top staff, as well as two examiners, working on that. The Commissioner released an examination report of December 31, 1982. I became Commissioner January 3, 1983, just as it hit the press, I got three hundred calls that day, and the calls intensified from that point.

The *Wall Street Journal* had begun carrying some articles about the Baldwin crisis in late 1982, and they really intensified during the first part of 1983. So what that did, of course, was cause even more calls. There were some 336,000 policyholders from the Arkansas and Indiana companies, and the Arkansas companies actually sold and marketed the business from the Indiana companies, so that was the number that most of the Indiana policyholders at least initially started calling, until we told them that they needed to talk to the Indiana Commissioner about the Indiana companies. During 1983, until I put the companies in rehabilitation, I continued to have the four top people in my department working on Baldwin about 75% of our time, and that included very long hours, because there were other things we had to do. The Baldwin crisis was so large and so complex that it would require our top people, and it required much of our time.

As you can imagine, with every state in the nation involved, there were regulators calling, as well as policyholders, press, brokers who had sold about 80% of the business, and agents. The calls were so intense that I had, at various times, from four to seven people on my staff just answering calls. I myself took many of those calls, and at one point, I had to have my secretary line up calls by time zone. I could not return calls every day, but I would have her line up calls and start at 7:00 a.m. central time calling on the east coast trying to return calls. Then I would call until 7:00 p.m. my time out on the west coast. When that did not work, I even asked her to start asking people if they would like to leave home phone numbers, and if they did, I would stay until I could not return calls anymore. Also, at one time, I tried to use two

or three staff members who would simply read or prepare a statement. That was very unsatisfactory for people who were calling and wanting to talk and ask questions -- to have somebody not respond other than to simply read a statement -- but I think you can imagine the enormity of trying to disseminate information at the same time that the amount of material that was coming into the department, as well as the calls, was enormous.

Early in 1983, I required the Arkansas companies to receive prior approval from me on all significant financial transactions and, in particular, the affiliate transactions. As you can remember, I'm sure, one of the major problems with the companies was that 20% of all their assets were invested in Baldwin-United stock or bonds, at one time or another, and the complexity of Baldwin in the inter-company transactions was incredible. I have heard some people who have been much more experienced, from attorneys to accountants to tax people and actuaries, say that they have never seen anything with the complexity of the transactions that were put together in the Baldwin case. In trying to unravel those and determine exactly what was there, exactly the value of all these assets, there was a great deal of material that had to be reviewed. I am sure you can appreciate that the people who were most knowledgeable were also those people who every day were either meeting with company people or trying to review material and work out all these problems.

When I became Commissioner, unfortunately I thought that the former Commissioner had spent all of 1982 working with the companies and that my role was going to be a monitoring role. Things had been straightened out, and I was just going to have to watch these other affiliate transactions that were going to be coming in from Mr. Thompson and Baldwin people. That was not the case, and the real crisis actually intensified. I guess the crisis that we know as the rehabilitation actually did not occur until 1983. There were no more affiliate transactions that I allowed in 1983, but at the time I took office, 20% of the assets were already in affiliates, so the problem was there, and it had to be dealt with.

The NAIC formed a committee in March of 1983 that specifically dealt with the Baldwin problem. Stan talked about some of the many meetings that we attended, and it seemed like somebody was always wanting a meeting almost every other

day, and justifiably so. The coordination of the Baldwin matter is one that I think we can look back on and be proud of, yet at times I felt that the meetings were too intense; I didn't have time to actually work on the problem, because somebody was always wanting to have a meeting. When you think about 50 regulators who are responsible for 300,000 policyholders and some $4 billion in assets (for example, Florida had $150 million in liabilities, or Texas had $350 million), you can understand why they would be intense and would want answers. We were able to keep the regulators, except for two, from filing receiverships; from going off on their own and developing their own rehabilitation plans, draining funds from the estate by hiring their own attorneys and actuaries and accountants. We were able to keep the matter fairly coordinated in Arkansas and Indiana, and I think that is something that we can be proud of.

At the time the companies were placed in rehabilitation in July of 1983, I pulled most of my staff, except my Deputy Commissioner, off the case. I hired outside consultants at that point: Mr. Tulin's firm of actuaries and the accounting firm of Ernst and Whinney, outside attorneys, and investment bankers. I then utilized that expertise, which I think was essential. Indiana did the same thing, and we coordinated. Don Miller (the former Insurance Commissioner of Indiana) and I spoke probably at least once a day, if not several times.

Some of the major problems and crises dealt with the rehabilitation plan which we developed. We tried to get insurance companies to come in right away and assume this liability. They took a look at it and kind of laughed at us and said we were crazy, that there were too many problems, and too many uncertainties. We needed to do something first, and maybe after we got all of those problems straightened out, somewhere down the road they could come in and help us. This is what happened in the end.

The accountants had to try to evaluate the assets that were in Arkansas. I had the accountants physically count all of the assets that the bank had and then go through terms and documents, to try and see if the 80% of the assets which were not Baldwin related were really free and clear. When we developed the rehabilitation plan, it involved trying to develop a plan that gave

policyholders access to their accounts, as well as gave us this opportunity to strike out all of these complexities.

There were settlement agreements and affiliate transactions that I mentioned to you and that were very complex. There were probably 300 major creditor groups that had to be dealt with. Major banks in New York and all over the country were involved. Later on the attorney generals became involved. The brokers were involved, because they had sold about 80% of the annuity business. Agents were involved; even the Securities Commissioners around the nation were involved to a lesser degree. All of these people, of course, had meetings to keep updated and needed to have input to the process. I felt that it was important, even though I was advised against it, to talk to policyholders. That's why I accepted so many of the calls. I felt it was important that the rehabilitation plan that we developed resemble what policyholders felt was most important.

The timing was really interesting on developing all of this as well. For example, the accountants told us that it appeared, on a first look, that 80% of the assets were free and clear; they were fairly good. As for non-liquid assets, where the affiliate money was just totally in question, we did not know how much they were really worth. The way that the transactions were intertwined, we were not sure of the value, and certainly the liquidity was not there. As the rehabilitation plan was developed, we actually filed a plan in October of 1983 for a hearing in January. The accountants had not really done the review at the time that we filed the plan. We were simply operating on the assumption that at least the first look meant that 80% of the assets were clear. We could deal with those, we could develop a rehabilitation plan around those, but we would simply set a time-frame and some way we would meet it. We filed the plan based on that assumption, and the accountants really finished their report almost the night before the hearing, in January of 1984, and told us 80% of the assets could be dealt with. That is what we based the rehabilitation plan around.

It was interesting that at one point one of the regulators told me that it would really help if I would just pick up the phone every day and call every regulator and keep them up-to-date on what had happened that day. I was just

floored. This was a person who had worked closely with me, but I could hardly answer all of the calls that came in, much less take time to call 50 regulators and keep them up-do-date on what was happening every day. Truly there were things happening every day. It was that intense; it was that complicated; there was that much material that had to be reviewed and had to be sorted out in some way.

There was a crisis in the schedule, since we tried to develop a rehabilitation plan first so that policyholders could have access to their money. Then we had to try address the other issues -- e.g., How much of these affiliate assets were there really? Could we settle with the creditors and with Baldwin-United? So, as soon as the rehabilitation plan was approved by the court, we had to develop the implementation of that plan, get it developed, and then start out on the affiliate assets. At the same time we had the gang go back to the insurance community and the brokers and say, Now that we have a rehabilitation plan, won't you start thinking about coming in and looking at some type of global enhancement plan? So at the same time that we had begun the negotiations with Baldwin and the creditors, we had also begun working with the insurance industry, as well as the brokers, on the enhancement plan.

The settlement with Baldwin and the creditors evolved around those Arkansas-Indiana rehabilitation courts, as well as the bankruptcy courts. I think there was something like $30 billion of claims filed in the bankruptcy court. We had actually filed $3 billion of those for the policyholders' interest and the Arkansas and the Indiana companies' interest. That settlement occurred in January of 1985, after numerous meetings and negotiations. The enhancement plan actually is not fully complete yet, but continued after the major settlements with Baldwin and creditors occurred. As this whole process has evolved it has gone from a situation where there were many questions. There was very little that we could hang our hat on. Little by little, we have answered questions and been able to resolve those numerous issues that had to be dealt with, and that helped bring about the enhancement plan that I think is close to being resolved. There have been hearings in both Arkansas and Indiana, and this whole matter may soon be over.

Still, the interesting thing about the crisis was that there were really no guidelines for me or Commissioner Miller in Indiana to utilize, even though the actuaries, accountants, and lawyers had worked on receivership. They had certainly worked on matters that were similar to this, but had never worked on anything quite like this. This matter was much larger than anything that had ever been seen in the insurance industry. It was much more complex, so even regulators who might have been in office ten or twenty years did not assist that much, because they had never been in anything quite like this. It was a design project from the beginning. I've heard Stan say several times that the "Stan Tulin model," which is now one of the most famous sayings from the Baldwin rehabilitation, is one that he developed specifically for our project. When I look back and I can see the kind of troubles and complexities there were, it is kind of a marvel that everything has fallen into place as well as it has, given the crisis that we have been through.

MR. TULIN: The model that was kind of labeled the Tulin model that we created to deal with Baldwin was so specific because the problem was so specific. I think this is also probably symptomatic of crises, because no one knew about the numbers, and there was so much political pressure. I don't think anybody has given you the base numbers. There were $4.5 billion in liabilities in June of 1983 and what turned out to be $3.6 billion dollars of assets in June of 1983, so we ended up with what might have been a $900 million hole.

The conclusion that we reached -- and "we" was I, but also a number of other people -- was that we would have to have a model that was, first of all, very, very accurate, and secondly was not annual in nature like most actuarial models. The Baldwin model is monthly, and it creates monthly statutory statements and monthly statutory projections, so that we could actually talk about where the results would move from month to month and actually monitor them on a very precise basis on a month-to-month basis. The reason this became critical, I think you'll see from both Jeff and John, is that, with all the meetings going on, if you did not have a basis that you could talk about relatively on a monthly basis, you just couldn't deal with the politics of the situation.

MR. JEFF S. LIEBMANN: I am a lawyer and actuary, but I have functioned as a lawyer primarily for the last ten years now. A rehabilitation is inevitably a legal proceeding, and, as such, you inevitably deal with lawyers and courts, which is both one of the joys and one of the difficulties of this whole thing. The solution to the Baldwin situation, or one of the solutions, was the developments by Indiana and Arkansas (by the Commissioners, their lawyers, and their actuarial consultants) and by the NAIC, as John will describe, of a rehabilitation plan. This was done in late 1983. It was done over a period of perhaps 4 to 5 months, which, given the complexity of the problem, was really a very short time frame and was a considerable achievement.

What I would like to do, as one of the primary architects and the primary drafter of this rehabilitation plan is to give you some idea of what's in it and why it's there, particularly from a legal perspective. I think it's useful for two reasons. First, the rehabilitation plan itself has stood up very well to the passage of the last three years. We've really had to modify it very little, and it seems to function quite well. Second, I believe it can serve as a model for other insolvencies of a large scale on the life insurance side of the fence. I should just tell you that a rehabilitation is a court proceeding, as opposed to a supervisory status that a regulator might put a company in after the court proceeding. This is actually a receivership, and typically in most states there will be two types of receiverships. One will be a rehabilitation, and one will be a liquidation. A rehabilitation is, if you're familiar with bankruptcy context, like Chapter 11 reorganization; the goal is to bring the company out of the proceeding and functioning again, as opposed to simply liquidating it and sending the assets out to policyholders and having the company dissolve. So we are talking here about a rehabilitation. One of the things I will be describing a little later on is why this was a rehabilitation as opposed to liquidation, which is one of the topics dealt with in the plan itself.

The plan begins with something very typical in this area, which is a statement of consent on the part of the companies. Rehabilitation and liquidation involve grounds. A regulator goes into the court and seeks them and petitions those statuses to be established. You need grounds to do that. If the company consents, you don't need to prove those grounds, the company simply says yes, I

consent that I need a rehabilitation. That avoids a very, very nasty initial hearing, and normally a regulator in a troubled situation seeks such consent. There is absolutely no doubt in this particular situation that the condition of these companies was hazardous in terms of the well-being of the policyholders, so the consent was forthcoming. So the plan begins with that statement.

Then the plan goes on to state the causes of rehabilitation in rather simple terms. Again, this is a typical pattern in the rehabilitation. The need for rehabilitation arises from causes, so it would be natural to state those causes and to give the whole proceeding some general direction. In this particular case, just two causes were stated, but there were many others. The first cause was the severe negative spreads that these companies were running. These companies were large writers of single premium deferred annuities. The crediting rates were substantially in excess of the investment income of the companies. Generating large negative spreads is an unstable situation if it continues over a long period of time. In addition, these companies had large portfolios, as Linda Garner said, of what we termed affiliate securities. These were securities that other entities in the Baldwin system had issued and had sold to the insurance companies. I recall the figure was approximately $900 million that had been spent for these securities, but their value was far less than that. So obviously, in any kind of wave of surrenders of these insurance companies, if you went through the body of good assets, you would come into trying to liquidate the affiliate assets, which would turn out to be an impossibility. This too is a condition that is clearly hazardous to policyholders and was another cause for rehabilitation.

The plan then goes on to justify itself by stating and outlining in general terms what possible solutions there are to something like this. Normally, if a regulator comes upon a clearly insolvent company -- and I'm not kidding you that these were clearly insolvent companies -- liquidation is the thing that first comes to mind. How do you turn something like this around in a meaningful way if you can't print money? It's better, normally, simply to face up to the problem. Liquidate the company, distribute out what you have and get it done with; trigger the guaranty funds and get it done with. In this particular situation that was impossible for a number of reasons.

I think it's a credit to everybody who is involved in this situation that we all sat down and did realize that liquidation would have been a total disaster. There were several reasons not to liquidate. First, liquidation requires a marshalling process. You have to marshal your assets for distribution. That marshalling process would have realized all the unrealized losses in this system, in a manner that would have been uncontrolled, which is clearly not the way to go. If you allow yourself some time in a complex situation, you can often find ways to work out deals, to work out transactions that will increase value. That perception was made, and that was one of the key reasons not to liquidate. Another reason was the potential for complex litigation in this system. Baldwin-United, in its infinite wisdom, had concocted a scheme of reinsurance transactions among these various issuers of single premium deferred annuities that was really byzantine; it was an extremely impressive series of very difficult and convoluted reinsurance arrangements where the companies essentially attempted to split the mortality and investment elements of the SPDA, and put the mortality risk in the one company and the investment risk into another. This was part of an overall tax scheme. Whether it would hold up for IRS purposes no one will every know, since there has been a settlement with the Internal Revenue Service on these issues. In any case, what it involved was running reserves all over the system from one company to another in these rather extensive chains. In particular, there were two direct writers, one in Arkansas and one in Indiana. Substantial amounts of Indiana sales had been run through the Arkansas system and were residing in the Arkansas companies for the reinsurance arrangement.

One of the peculiarities in this entire area, and it is also on the property-casualty side, is the way the priority structure is set for the liquidation. Direct policyholder obligations had a priority over reinsurance obligations. That is, the Arkansas company, as a reinsurer of the Indiana companies, would pay the Indiana companies after it had addressed its own policyholders. That would be the normal result. Now this situation was, like everything in this entire deal, more complex, in that the Arkansas companies weren't merely holding Indiana funds; they were holding them in restricted asset accounts, which may or may not have been secured arrangements and may or may not have given them priority over the Arkansas policyholders -- it was very unclear. In any case, to liquidate would have required an immediate resolution of that

issue and would have likely generated litigation between Arkansas and Indiana, which would have made any solution totally unworkable, other than to push ourselves to the brink on that issue through a liquidation. Again, rehabilitation gave us time to work out that issue in an equitable fashion, which was later accomplished and which I'll describe very briefly.

The other reason not to liquidate these companies was the guaranty fund problem. There are, I believe, 36 life and health guaranty funds in the United States. They have limited assessment capacity. In a liquidation, when a company has insufficient assets to meet its obligations, normally those policyholders who were residents in the guaranty fund state will get guaranty fund coverage, with the guaranty funds' attempting to make up the shortfall. In addition, Arkansas does not have such a problem, but Indiana does; also, the Indiana statute was one step further, so that not only would Indiana residents be covered, but, for the Indiana direct writer, all of the policyholders nationally would be covered by the Indiana fund. Thus, if you carried this through, and you looked at the numbers at the time, the Indiana fund was exposed to hundreds of millions of dollars in liability. That same fund had assessment capacity on the order of $10 million per annum. It was clearly an impossible situation. Liquidation would have triggered all those funds, and what would have happened would have been a monumental regulatory meltdown. The guaranty fund system would have failed and would have been, frankly, a national scandal -- just horrifying. This was another reason not to immediately jump with liquidation. That's why we went into a rehabilitation: it's a much, much more flexible form of receivership. Rehabilitation does not trigger rights and liabilities immediately. It allows considerable flexibility to work out a rehabilitation plan and I think, in retrospect, given the way things have developed, was truly the right way to go.

After justifying itself in this way, the plan goes on to state its basic principles, which acted like a constitution in this matter and really stood up extremely well. The first principle is that the financial confirmation of the plan should be independent of whatever happens with third parties, particularly Baldwin-United. In other words, the plan uses the assets of the companies in two pools. First are the non-affiliate assets, which are the traditional assets -- the bonds, the cash equivalents, the marketable and liquid assets

held by the companies. The financial confirmation of the plan is based on the performance of the non-affiliate assets; the plan said that people who continued with an SPDA were projected to receive a rate of return of 5.5% per annum over a 3.5 year period. That was based on the non-affiliate assets. Assuming anything about what the affiliate assets would generate would be crazy. On top of that, assuming anything from Baldwin would be crazy, too. So we based the plan on the non-affiliate assets, so that there would be no false expectations, and the confirmation of the plan would be based on what we actually knew was there. We did not want to be in the business of making false promises, which was one of the problems in this entire situation in the first place.

The second basic principle was that all participants would participate equitably in the affiliate assets, and whatever value was generated by those affiliate assets would be distributed across policyholders in a fair way up to a market rate of return, if we ever got that far, which unfortunately we did not. In addition, the plan calls for the establishment of plan options, and this is where the actuaries became extremely important and really did the bulk of the work. We did have money in these estates; it's not that there wasn't anything there. In fact, there were considerable assets in these estates, which allows us, even in rehabilitation, to make funds available. We had approximately 82 cents on the dollar available to pay out. We couldn't pay that out in its entirety, obviously. We couldn't drain the estate in its entirety, but we certainly could pay out 75% of the accumulated value. Thus one of the options per the plan is 75% withdrawals. Other options allowed policyholders to annuitize or maintain their SPDAs. The actuaries were instrumental in helping us to design those options and in maintaining them on what we term an actuarial equivalent basis, namely, that the present value of the cash flows generated by each of the options, using an appropriate discount rate, will be equal. Thus no one would be cheated by electing one option or the other.

In addition, one of our basic plan principles was that policyholders would be treated the same way, irrespective of which company they bought their policy from, how they had been treated through reinsurance, etc. This required us to establish something that was really unique in this particular transaction, and

I think it made the whole thing possible. We established a pooling agreement wherein Arkansas and Indiana agreed, even though all the SPDA companies were separate companies, that they would be treated as merged entities. They would never actually be merged in the legal sense, but would be treated as merged, and cash transfers would be permitted among the companies so that, at the end of the day, each policyholder would get the same dollar per dollar of liability as any other policyholder. This involved cross liens and cross pledges, and I know of no other arrangement like it. But the establishment of that pooling agreement at least gave Indiana, which was the poorer system in this arrangement, the courage to go forward and work with Arkansas jointly in a number of areas, including the joint plan of rehabilitation and joint investment management. I think it's been important in allowing us to proceed together as opposed to litigating with one another.

I should just point out one or two additional aspects of this plan which are of interest and are pretty typical in this area. This plan maintains injunctions; one of the first things you do in one of these situations when you go into a rehabilitation or liquidation court is seek a state court injunction which says that locally (you try to say nationally) any actions brought with respect to the estate must be brought in a particular rehabilitation and liquidation court in which you are operating, in an attempt to control the estate. One of the weaknesses of the estate regulatory system, which is the regulatory system involving insurance, is that the state court injunctions do not always hold up; injunctions cannot be respected by federal courts, and sometimes not by sister states, but you certainly attempt to get respect. This plan also goes through erratic complex arrangements of stating that it involves interim orders as opposed to final orders. This is a technicality that I have never seen used in another plan except this one, but I think you are going to see more and more of stating that the plan is an interim plan and it operates in an interim manner. You avoid a final setting of rights and obligation, and thereby you avoid triggering, in certain cases, guaranty funds, setting up a whole bunch of disastrous consequences that you can't deal with if you operate under final orders.

Finally, this plan has very specific provisions dealing with statutory composites and ancillary receiverships. One of the big threats, when you are working

in a state receivership in this context, is that other regulators in other states are going to attempt to set up receiverships in those other states with respect to your company. If they have any assets in that state, they grab them for the use of local policyholders. In addition, they may be holding statutory composites that they may attempt to grab. This plan has provisions which attempt to tell the other regulators, "If you grab our assets, we are simply going to reduce the benefits available to policyholders in your states, so there is simply no point." These provisions have never been tested, but I think that the threat has done some good in terms of keeping hands off of our assets.

MR. TULIN: One thing about this plan that Jeff did not cover because he was being a lawyer is that the plan itself, from an actuarial point of view, is fairly primitive, as maybe any plan in a situation like this has to be. We had 82 cents of money that we were relatively sure about per dollar of liability that we were sure about. We used the idea that if we could earn more on the 82 cents than we credited on the dollar, eventually someplace out there these two lines would cross. The question became how far out there those lines would cross. In fact, there was a conversation in the Arkansas Insurance Department one night when all kinds of exciting things happened; I asked, "How far out can that line be? Ten years? How long is this rehabilitation going to last?" That determines how you set the rates, and the answer was 3 years. How we got the 3.5 years is funny. I mentioned that the numbers were bouncing around a little bit at that time. We started with a 3 year plan and did all of these rates. This has never been admitted publicly before. We did a 3 year plan with all these rates. The *Wall Street Journal*, through some source that none of us know, or at least I don't know, got ahold of the rates and had a scoop on the plan of rehabilitation that was going to be a 3 year plan with a 5.5% rate for some people and 3.6% for others. The paper wrote a big article on it. All the rates were out on the street and we confirmed them. Then we found out on the September balance sheets that they were $75 million off of their tax amounts, which is hard to imagine, but the balance sheets were $75 million shorter than we thought they were. We either had to change all of the rates (obviously, if it was going to be a 3 year plan) or do something else. I concluded that it would be easier to solve for the amount of time that we had and go longer with the rates we had than it would be to change all of the

rates. Maybe nobody would ever notice that we had gone from 3 to 3.5 years, where in fact we really just changed everything by $75 million. So that's how we ended up with a 3.5 year plan. Now John will tell you how the NAIC functions in all of this.

MR. JOHN O. MONTGOMERY: In the view of most stock insurance companies, the company has a right to fail, and if its management is so stupid as to allow that to happen, I really cannot dispute this view. However, for a mutual company, the Board of Directors and top managements of the companies pledge to the policyholder not to allow that company to fail. Now the regulator has different goals. He's bound by public responsibility not to allow the company to fail to the extent that the policyholders will not lose what was guaranteed to them. In other words, we try to give back to the policyholders in a rehabilitation and a liquidation what was guaranteed to them. It may not be all at one time, but it should be there somehow. It's not possible in all cases, particularly where the regulator has not adequately monitored what was actually guaranteed. However, it really is the duty of the regulator to keep incompetent managements from shooting themselves in the foot.

I would like to point out that these are my recollections and observations, and they may not be those of all regulators or even all of the regulators in the California Department. Most of the basic facts concerning the Baldwin-United Corporation bankruptcy are in a document prepared February 1985 by the National Association of Insurance Commissioners. Some of you may already have a copy of that, but that gives a chronology up to that time. Some things have happened since then, as you already have been told.

Up until March 1983, I had been aware of the crisis through the Insurance Regulatory Information System (IRIS) test and working with the oversight committee. There were numerous meetings of that committee talking about it, but it didn't reach crisis proportions until 1983, when the exam oversight committee of the Task Force of the NAIC called a special session on Baldwin-United. At that time, a working group was appointed, which later became the Options Committee, and I was designated as representative of that group for California. California had the largest amounts of deposits behind Florida, Texas, and Ohio. This is a significant number. However, in California we had

a very large number, probably the most of any state, of deferred compensation benefits -- mostly with public employees with a lot of government jurisdiction. There was intense government employee interest in this resolution, so that they would not lose their fund.

The first job we had as a working group was to untangle the insurance web that already has been referred to. Actually, the Texas Department had done a very good job on finding out all the various relationships, and it was the duty of the working group merely to put it together. Most of the work for that was done by the examiners in the Texas Department. I want to point out that many states did different things. Texas did a lot of things, the Wisconsin Department did a great deal, and the Illinois Department did a great deal.

We had a series of meetings after that that went on until July of 1983, when the Insurance Department placed six of the SPDA companies into rehabilitation. Then that's when a subcommittee of that working group was organized to assist the actuaries acquired by the rehabilitators to develop a plan of rehabilitation. This is the group that worked with Stan Tulin. Members from the NAIC were myself, Larry Gorski of the Illinois Department, and Lew Nathan of CNA, who represented the guaranty funds. Stan was of particular assistance, and two others who did a tremendous amount of work were Pete Deakins and Bruce Ogg. They really must have worked around the clock, because they did a tremendous amount of work. I was always coming up with new scenarios, and they had to run them off all the time, using Stan's system, which really was a tremendous help. It has been a model for this type of operation. If anything was one of the basic rewards (if you can call it that) of having this occur, it is the fact that we got ourselves into a whole new view on how to regulate the business.

The basic premise of the rehabilitation was to devise a series of options which were actuarially equivalent in a period of projection to the culmination of the rehabilitation plan, assuming that the assumptions as to interest, mortality, and expense would not vary in the period. Each option was tested, assuming that all policyholders could elect that option, so we could determine the actuarial equivalence. Then those options were designed to be actuarially equivalent in those situations. I won't go into any more detail, but there was a tremendous amount of detail. A stack of runs is a tremendous volume of work.

We tested the resulting plans for about thirty or forty different scenarios, assuming various patterns of change in interest rates, election of various options, and conditions as to the amounts available from sources outside the non-affiliated company assets. All these projections were basically using non-affiliated assets, as has been mentioned, and the projections for those of an anticipated class arose from comparing non-affiliated assets to liabilities, with the deficiencies of assets over the liabilities estimated at the end of the period in the future. Does this sound familiar? I think you are already aware of what's happening with all of our discussion of matching assets and liabilities and cash flow projections, which has been going on almost ever since this occurred. From these scenarios optimum investment policies were also devised. The First Boston Corporation was appointed to manage the asset portfolio.

At the same time all of this work was under way, class action suits against the securities dealers who sold most of the SPDA business were progressing, finally culminating in the litigation of the New York courts, as has been mentioned. In addition, there was an enhancement plan involving the remainder of the contract holders. This enhancement plan almost started at the time the rehabilitation plan did, but it just took a lot of discussion and arm twisting to get the thing going. I did the arm twisting. Eventually we did get them together. We got a group of companies led by Metropolitan Life. This plan and all of this work that the companies have done is now in its final stages. We're waiting for the last judge's decision. All of the other courts have made their decisions. Two major securities dealers have not agreed to this enhancement at this time and still are willing to appear to conduct separate litigation. Incidentally, under these plans it looks as if everybody is going to get close to what was originally guaranteed in the policies, which goes back to what I said in the beginning: what we'd like to do is to make sure all the guarantees in the policies are there and are satisfied, and that's what we're hoping to get out of it.

The Baldwin-United crisis has developed a whole new phase of regulation. The techniques employed in the development of this plan and subsequent enhancement have already started to produce results. At least half a dozen other insurers writing such business have been rescued from the brink of disaster by more

knowledgeable regulatory action. I think this is a significant development. Surveillance systems much more sophisticated than the current version of IRIS are in the process of consideration. Work is progressing on better reporting of affiliate transactions, holding company operations involving insurance entities, reinsurance activities, investment matrices, and the analysis of business. The 1986 blank was just approved by the blanks committee in Boston, and it does have an investment matrix by maturity. Now we have one by quality, as well, so we will have a quality matrix in the financial reporting blank.

Another basic tool emerging is the developing of computer software to develop financial reports, either annual or interim, directly from ledger and memo accounts according to specifications prepared by the NAIC. The 1986 blank has been revised to facilitate the preparation using computers, and where you have write-in, those are all listed in a separate table at the bottom of each page that they write-in. I have a feeling that it may be complicated; it may have to go on a separate page for companies that have a large number of write-ins, but anyhow we will know the details of all the write-ins directly in the blank. However, we still have some problems with respect to the bonds and private placements. I think this is being worked on, and I think within the next year or two, we should get that straightened out. So that is the only part of the computer reporting preparation of financial blanks that is not covered, but we will get that worked out in the next year or two.

Now this computerization of financial reporting is going to make possible the preparation of software to generate financial reports for surveillance purposes. The present recording blanks formats are useful for traditional verification of the profits of the various ledger and memo accounts. I don't feel that the present blanks are adequate at all for surveillance purposes. They're only adequate to verify accounting, and so I feel that we have to have some surveillance reporting system. This has to require some changes in financial reporting, of course, because there are some details we still can't pick up to do this. For smaller and medium size companies, a full blown surveillance report is obviously not going to be practical, so we have to make adjustments for that and see how we are going to handle it, but this general report form could be prepared for each of them.

The reason why we need a surveillance report is that both problems we now have with, or had with, Baldwin-United now appear to be coming with Universal Life, Single Premium Whole Life, Term Life, and Health Insurance. Then there's also the possible and anticipated mortality and morbidity, which we are much concerned with. We feel a large number of companies have not been adequately prepared for these in that they may not have enough surplus. For some reinsurers this may be a critical problem. I don't believe reinsurers have surplus enough to withstand possible losses on yearly renewable term business reinsurance because of AIDS. I am talking about the AIDS epidemic reaching into the current population of policyholders. I am not talking about underwriting future things. I am talking about business you have on the books and you can't do anything about; you are trapped. So we've got to figure out how that's to be taken care of. This is one of the projects that the actuarial task force has been assigned at the meeting this week in Boston.

What is solvency in the surveillance reports system? One of the major problems of that is determining empirically the market value of liabilities corresponding to the market value of assets. By simplified grouping of all lines of business into one of four basic risk structure groups, part of this analysis might be facilitated. At least we'll investigate it and see how it can be done. Also needed is a corporate operations group not directly related to any insurance operations, but under all indirectly, either possibly through reinsurance and other transactions or through a function as a source of backup funds for any of the risk structures that cannot match their assets and liabilities. Under this reasoning, the surveillance report would be in five segments. First is insurance risk not primarily involving investments. Then there are three groups which do involve investments. One is short term, and I am not sure what I mean by short term, because I have to explore what that means. I said ten years, but maybe it's seven years -- whatever we decide. Third are long term investment risks with a significant disintermediation factor. Fourth are long term investment risks with no significant disintermediation factor, and fifth is the corporate operation.

Table 1 shows how the various plans of insurance would go with that. It's too complicated to put on the Vector thing, but it is in the surveillance report. How are we going to implement this? First of all, computerization of financial

TABLE 1

Lines of Business Versus Risk Structures

	PRIMARY RISK STRUCTURE			
	Insurance			
	Non Investment	INVESTMENT		
		Short Term	Long Term	
			Termination Risk Added	Other
Industrial Life				X
Ordinary Life				
Term Insurance	X			
Permanent - 10 Years or less		X		
- Other				
Universal Life		X	X	
Modified Guaranteed Life				X
SPWL			X	
Endowments		X	X	
Other		X	X	X
Variable - General Acct.			X	
- Separate Acct.				X
Individual Annuities				
- Immediate				X
Modified Guar. Annuities				X
- Deferred with CSV		X	X	
- Deferred, No CSV				X
Supplementary Contracts				X
Credit Life - Single Prem.		X		
- Monthly or Annual Prem.	X			
Group Life				
Term		X		
Permanent		X	X	
Universal		X	X	
Variable - General Acct.		X	X	
- Separate Acct.		X		X
Group Annuities				
Deferred - General Acct.			X	
- Separate Acct.				X
Immediate				X
* Group A&H	X			
Credit A&H - Single Premium		X		
- Monthly or Annual Premium	X			
* Other A&H	X			

NOTES:

All reinsurance related items have multirisk features.

*Some features of health insurance, such as long term disability claims, and guaranteed renewable and noncancellable plans, may involve an investment risk.

reporting is currently under way in the work of the NAIC data base entry project. I might point out that one-third of all insurance companies, both life and casualty for the 1985 report, prepared their financial statements using computer software. We anticipate that by the end of this year, by the 1986 blank, it will be two-thirds, and by the 1987 blank it should be practically all companies. The reason is that the software really facilitates things, particularly in small companies. It is greatly to their advantage to use this, because the software systems are really terrific and are all done to specifications that the NAIC has set up. The time saving and the work saving in the preparation of the blank are just tremendous. So I think it's a real breakthrough for getting an expanded data base and also to reduce the charges for the IRIS monitoring, because we won't have that big expense of $300 or $400 thousand to collect all the data manually. I anticipate that this is going to be a big savings all the way around. However, any financial reporting system or solvency surveillance system has to be maintained until we run through it a number of years, so we can really test it out to see what is practical and what isn't. It may take until the turn of the century before we really get this all together. I don't know whether any of this will be around, but that's what has to be done.

I'm going to just briefly tell you the problems that we have with the surveillance system. First, segmentation of assets; second, the segmentation of liabilities; third, the average remaining duration -- the use of or exploring the use of Macaulay duration. Incidentally, that is one of the items that will be reported. Segmentation of transactions by risk group requires the revision of exhibits that have to do with deposits. The regulators have discovered that the deposits are not thoroughly reported in the current blank. We don't even know the interest credited on deposits. So that is going to be done for the 1987 blank. Then, on reinsurance, there are a number of things that have to be pulled out and run separately. These again will be done separately for the 1987 blank in revising certain schedules and things to make sure that the old reinsurance items that we do have will be better identified. As to failure of company items, we probably are going to need shadow blanks or shadow pages of 2, 3, and 4 to be filled just for the affiliate companies, showing just what their relationship is.

The American Academy of Actuaries, together with all the other professional actuarial groups, has set up an interim board of actuarial standards which is to become a predecessor of the actuarial standards for it. This is extremely important in the revision of financial reporting.

The meeting just concluded with the NAIC is very important. The actuarial task force has been authorized to completely revise the standard valuation law and standard non-forfeiture laws to go from basic principles. Into that will be incorporated all this stuff we have been talking about as actuaries. The statute has to define the minimum requirements for documentation of an actuarial report, as well as the conditions under which those requirements are mandatory and the conditions under which they may be optional. The statute must define a change in the process of reporting that may define minimum requirements for assumptions used in the scenarios, much as the current law defines minimum reserve requirements. Those parts of it could be in regulations to keep the basic law flexible. All of this is really needed if the valuation actuary is to function unhampered by company management issues. Whether or not the statutes can be drafted and enacted will depend on industry cooperation or antagonism and on a course of events involving possible future appearances of a Baldwin-United or Equity Funding situation.

MR. TULIN: As John just started to develop, the interesting part about Baldwin is that Baldwin was caused not by a C-3 problem, but a C-1 problem, and the Baldwin solution or rehabilitation plan involved a big C-3 Analysis. This was really where all of the concepts that I think now are kind of becoming routine in the valuation actuary process developed, which was an interesting learning experience. All this interest that developed nationwide, in terms of the idea of the Baldwin rehabilitation's being able to work or not work, revolved around interest rate change risk. Consequently, a lot of interesting work was done in terms of being able to demonstrate how to make that work, and finally how to implement it through portfolio management.

MR. ARNOLD A. DICKE: One thing was troubling all of us, even before it became obvious that there was a real big problem. Other companies were trying to compete in the marketplace against Baldwin. They found it to be stiff competition, and I remember a lot of our agents in the company I was with at the time

asking, "Why don't you credit those kinds of rates?" We kept telling them that if we do, the company can be in trouble. Their answer was that the guaranty funds will take care of all that. The whole structure is still something like that, but right now you could probably find people out in the hallways discussing certain companies, and whether or not what they are doing is really sound. The real problem here is that at the one end we lose business to these companies, and then later on we have to kind of bail them out -- bail policyholders out. If we are really going to let the market work, then maybe we shouldn't be bailing them out as much. What is your reaction to that?

MR. TULIN: First, I think that the level of bailout from the industry in this matter, relative to the overall level of performance is somewhat *de minimis*. However, I recognize that from time to time the industry mentions bailout and thinks of it as more inspirational. We put a lot of time into bailout, but we haven't gotten very much money. Second, the whole question as to the guaranty fund's structure and how it operates is one that I think came dangerously close to being exposed for what it is or isn't during this process. It is a question that I think we all have to think about very carefully -- I think there is some work being done on that. I think we have to decide that we either do bail the companies out (in which case, maybe likening to what you are saying, there would be a much more substantial regulation of standards of financial safety and much more control then there now is), or we go to an environment where we say there is no guaranty fund at all. In the second case, if you put your money in life insurance with a company that fails, then you can expect, as you do in many things that you put your money in, you might lose all your money. It's something that the banking industry obviously worried about, and the FDIC came out of it. It was a federal organization; it was independent and had money. What we had with the guaranty association are state organizations that are not really federally regulated or even state regulated -- intramural clubs almost -- and they don't have any money. So we've got, on the one hand, the FDIC, and on the other, the guaranty associations which have been compared with the FDIC, with these same agents who say that the guaranty associations will pick the failures up. I used to say "guaranty funds," until I found out there was no money. Then I started saying "association," and I think that's a fundamental issue, and that's why I wanted to jump on it. I think that there is a true lack of understanding as to what it is that the

guaranty associations promise and even a bigger lack of understanding, maybe even resentment, about whether or not, as an industry, we should promise anything. I think that whole issue needs developing.

MR. MONTGOMERY: Along those lines I would like to point out, as I mentioned briefly in my discussion, that the revision of Exhibit 10 with the deposits will include all deposits in there. As part of that will be developed the average rate of interest credited by line of business. For these deposit funds, we'll also probably take page six or get an average rate of tabular interest. We'll have these average rates of interest credited or tabular interest to be compared with the investment yield of the whole thing and from that develop a series of surveillance tests which would point out when companies are getting dangerous in their spreads. I think this could be a significant regulatory tool. There may be some bugs in it, but I think this could go a long way in helping us. As a matter of fact, on that whole item of supporting deposits, I had been running tests of the tabular interest to the net investment income, and they weren't working right at all -- they were totally inconsistent. So I looked at one that was really out of whack -- it had $7 billion of life reserves and $3 billion of health reserves, and then tucked away down under other liabilities, miscellaneous liabilities was $18 billion, and there was totally no way of recording the interest credited. It is not reported in the financial reporting blank, so we have a hole big enough here to drive an $18 billion liability through.

MR. TULIN: One of the problems here in this whole regulatory question, going back to the part of Arnold's question that plagues me, is that the solution you really get to the question of whether the industry should bail out these renegades, to put is viscerally, is one of control and regulation. You can't have what many of us would have (and I'm a guilty party): the notion that only renegades would be regulated. The problem is that we all have a different list of who the renegades are. The price that is ultimately to be paid is we will all be regulated. Obviously, the company that John just described is probably not a renegade. It would be my guess it would be an actuarial exam large eastern mutual -- or an actuarial exam large stock company. $18 billion is probably going to be a fairly large company, and the truth is you can't find out anything in its financial statements about it. If it were a Baldwin-United, you'd

never be able to tell. That is part of the problem with the blanks in the regulatory process right now. It still seems to me that the fundamental issue is the level of control that links up with the level of bailout. I think that both have to be addressed by the industry, by the public, and by a bunch of other people.

MR. MICHAEL G. WARREN: We heard a lot about the rehabilitation scheme, but I would like to have heard something about how the company got into trouble, because consulting actuaries who have to do the valuations of the companies that may not be in trouble would like the benefit of hindsight. Would Stan Tulin like to say something about the warning signals, maybe things that should have been done earlier? What the actuaries in a company should have picked up on, and these kinds of things?

MR. TULIN: Certainly as to the latter, I don't think this was an actuarial problem. Certainly under the opinions that were required in the early 1980s, the actuaries really couldn't touch most of the asset side of the house. In fact, those opinions which I've read I don't think are unreasonable. The problem of Baldwin in effect was fraud, which is scary to me, because it seems to me that fraud is something that you might never be able to stop, no matter how hard you try to regulate it. The essential fraud at Baldwin was that only one man knew what was going on. Those of us who have tried to trace the transactions have found things that are literally written on the back of envelopes; the people who were parties to transactions did not know about things that would change the entire economics of it. You can see that fraud is the best way to describe it.

In terms of the major element of early warning, I would say that I would become extremely skeptical about pyramid kinds of organizations, just as a general rule. I would really want to understand the financial solidity of large amounts of intra-company transactions and large amounts of intra-company paper. That's not to say that it may not work, but clearly, in Baldwin what sunk us in the end was that $928 million left the life companies in the form of cash and reappeared in the life companies in the form of things like the famous E-1 Preferred, which is my favorite story. When I first got involved, there was something called the DH Baldwin, DHB - E-1 Preferred Stock, a piece of paper.

The SVO (Servisco) was valuing it at $118 million, but it was marked down. It was like a firesale at $118 million, because it had been marked down from something like $183 million. I felt, in this first period when I got in, that it just got knocked down from $183, so $118 must be good. About two weeks after that it didn't pay its dividend, and Commissioner Garner marked it down, appropriately, to zero. We kept on having discoveries that the DHB - E-1 Preferred was backed by some assets that were in turn pledged to three or four different parties that all probably had better claim on them than the life companies. Fraud is the only way I can describe it. Maybe it's creative accounting; maybe it's creative financial management; but in the end it's fraud. So I think that the early warning system is that you have to watch out for fraud. I don't think that the departments, as they are currently structured, can deal with that kind of financial finagling.

I think that another fundamental issue, going back to Arnold's question about the bailout, that the industry has to deal with is the level of control and regulation it wants. I don't think the Arkansas department had the ability to trace all those transactions, and deal with all the other companies that it was statutorily responsible to deal with. I always concluded, in effect, that that's the price we are paying for the regulation that we have.

MR. GARNER: I don't think we really want the kind of regulation that would be required to try and prevent any Baldwin-United or any insolvency -- I think it may be impossible. What you would be requiring is that a regulator manage every single company in the United States, and that every investment decision and every write-off policy be evaluated by a full staff of actuaries, accountants, and investment people. That is impossible, in my opinion, and I'll want to move further from regulation, but it seems like the few people that you have to regulate very closely make you move more toward more regulation.

There are some things that I think we can do. The types of assets that can be used against or reserved against policies have to be looked at and can be regulated and limited. Certainly affiliate transactions, in my opinion, should not exceed at least a portion of the surplus. I think that there are too many opportunities for those non-marketable assets to have problems to allow them to exceed just a portion of the surplus. When we value an affiliate asset, we

have to do it in a more stringent way. The amount of liquid assets backing a non-marketable asset has to be reviewed, and hopefully there will be some regulations on that value, and the SVO will start valuing those affiliate transactions severely.

The whole matter of valuation actuaries is something that has come out of Baldwin-United and the fact that we have to look more carefully at the type of match between assets and liabilities -- not only the type of assets, but the duration and the quality and maturity and many other aspects of investment. When there is a scheme in terms of the spread and the margins that have to be there, such as Baldwin-United used with the tax allocation agreements, I am not sure that those (even though it is very time consuming and the companies will scream and yell) should not have a more specific approval from the IRS, especially when a scheme is something that has never been tried before. The IRS should have to approve those kinds of schemes that are very unique and could put the policyholders in a difficult situation. So we can improve to some degree, but I don't think we'll ever do it to the degree to fully prevent fraud or imaginative kinds of transactions, because we simply cannot regulate it that fully.

MR. TULIN: It's a question of control. All those were things that relate to additional controls. I would like to say that, although I don't think the actuarial opinions had any problems at the time, and I would not point to this being a situation where there were really actuarial problems, the actuarial valuation opinion as it's now being discussed could not have been signed for this company. The reason, as Linda alluded to, is that it had affiliate securities that would have had imponderable cash flows. If you read that opinion that we're all talking about, there's no way in the world you could sign it today, which is one of the reasons why I think that notion is a very important way of warning of situations in the future.