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RECIPROCAL OF AMERICA and THE RECIPROCAL GROUP

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For a Determination Whether Certain Workers' Compensation Insurance Policy Payments May be Made to Claimants Formerly Covered by SITs and GSIAs

CASE NO. INS-2003-00239

REPORT OF MICHAEL D. THOMAS HEARING EXAMINER

April 21, 2005

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

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Procedural History

On July 11, 2003, the Deputy Receiver of Reciprocal of America ("ROA") and The Reciprocal Group ("TRG") (collectively, the "Companies") filed an Application for Order Authorizing the Continuation of Workers' Compensation Disability Payments by ROA for Workers' Compensation Claims Denied Coverage by State Guaranty Associations ("Application") in Case No. INS-2003-00024.

On November 12, 2003, the Commission entered an Order on the Application which, among other things, assigned to a Hearing Examiner the issue of whether certain Self-Insured Trusts ("SITs") and Group Self-Insurance Associations ("GSIAs") or employers thereof that were the subject of the Application constitute "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1(ii) of the Code of Virginia.[1]

By Order entered on December 2, 2003, the Commission reaffirmed that the Hearing Examiner was to proceed with this case, notwithstanding the filing of a Petition for Rehearing or Reconsideration of its November 12, 2003, Order.[2]

By Hearing Examiner's Ruling entered on December 16, 2003, a Pre-hearing Conference was scheduled for January 15, 2004, for all interested parties to identify the documents governing the status of the SITs and GSIAs, discuss any additional discovery that may be required to develop the issue for the Commission, and agree on a procedural schedule for the remainder of the case.

On January 15, 2004, the Pre-hearing Conference was held as scheduled. Counsel presented a procedural schedule, which had been, for the most part, agreed upon by the parties, and was acceptable to the Examiner. Further, the parties discussed the scope of this proceeding and whether the hearing would be restricted to the agreements in which ROA assumed certain workers'

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[1]The Order entered by the Commission also directed the Deputy Receiver of ROA to make payments to certain claimants, whether weekly or monthly in frequency, that are indemnity or wage-replacement payments, as requested in the Application, but did not authorize physician, hospital, or other health care facility payments at the present time. *See*, Case No. INS-2003-00024.

[2]*See, id.*

compensation coverage from the SITs and GSIAs, or whether the hearing would also include the other liability coverage assumed from the SITs and GSIAs by ROA. There are nine (9) agreements covering the assumption of workers' compensation coverage and two (2) agreements covering other liability coverage.[3] The Hearing Examiner advised the parties that he interpreted his assignment from the Commission broadly, and it required him to decide the status of all agreements in which ROA assumed business, and determine whether such agreements constituted contracts of primary insurance, assumption reinsurance, reinsurance, or some other type of contractual agreement.

Counsel for the Indiana Insurance Guaranty Association, Kansas Insurance Guaranty Association, Mississippi Insurance Guaranty Association, and Tennessee Insurance Guaranty Association (the "Guaranty Associations") requested that the Deputy Receiver amend his previously filed Application to include the Liability Assumed Claims assumed by ROA.[4] The Deputy Receiver agreed to the request and indicated that the amendment to the Application would be filed on or before January 21, 2004, and served on all counsel of record.

Given the scope of this case, the Hearing Examiner advised the parties that if they were unable to adhere to the procedural schedule, they were to consult with one another and present a revised schedule to the Hearing Examiner. Any party not agreeing with the new procedural schedule was directed to file a pleading objecting to the change in the schedule and setting forth with particularity the reasons the schedule should not be changed. The Hearing Examiner scheduled an evidentiary hearing for June 1, 2004.

On January 21, 2004, the Deputy Receiver filed an amendment to his Application with the Commission. Therein, the Deputy Receiver requested, among other things, that the Commission enter an order authorizing the Hearing Examiner to consider and make a determination as to whether the Liability Assumed Claims constituted claims of "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 (ii) of the Code of Virginia. In support of his request, the Deputy Receiver stated that his amendment to the Application did not seek authority to pay the Liability Assumed Claims, rather, a determination of the underlying legal issue to prevent later re-litigation of the matters presently before the Examiner in the interest of judicial economy.

By Order entered on January 29, 2004, the Commission accepted the Deputy Receiver's amendment to his Application; affirmed the assignment in its Order of November 12, 2003, of the issue whether the Assumed Claims constitute claims of "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1(ii) of the Code of Virginia; and directed the Hearing Examiner to consider and make a determination whether or not the Liability Assumed Claims of ROA are claims of "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1(ii) of the Code of Virginia.

On April 14, 2004, the Guaranty Associations filed a Partially Assented-To Motion for Extension of Scheduling Order Deadlines and Continuance of June 1, 2004, Hearing. In support of their motion, the Guaranty Associations stated that in response to discovery requests, the Deputy

[3]The workers' compensation coverage assumed by ROA has been referred to as the "Assumed Claims" and the liability coverage referred to as the "Liability Assumed Claims." However, there are instances in the case when both coverages were referred to as the "Assumed Claims."
[4]*See*, Case No. INS-2003-00024.

Receiver had produced over 500 banker's boxes of documents. The Guaranty Associations requested an extension of the procedural schedule to review the documents and prepare for depositions, and proposed a revised procedural schedule. The Deputy Receiver agreed with the revised procedural schedule.

On April 15, 2004, the Virginia Property and Casualty Insurance Guaranty Association ("VPCIGA") filed a Motion Joining in Guaranty Associations' Motion for Extension of Scheduling Order Deadlines. In support, VPCIGA stated that it also began reviewing the documents produced by the Deputy Receiver, but because of the sheer volume it too needed additional time to complete the document review.

On April 21, 2004, the Kentucky Hospitals[5] and the Coastal Region Board of Directors and Alabama Subscribers ("Coastal") filed a Statement in Opposition to the Motion filed by the Guaranty Associations. The Kentucky Hospitals and Coastal opposed any change in the procedural schedule. They noted that this case involves a single issue of law; i.e., whether the claims for which ROA assumed responsibility at the time it acquired the assets and liabilities of certain SITs and GSIAs are "claims of other policyholders arising out of insurance contracts" under the provisions of § 38.2-1509 B of the Code of Virginia. They argued that no amount of discovery will change the essential facts of this case, which were limited in scope and well known to the parties.

On April 23, 2004, the Guaranty Associations filed a reply to the Kentucky Hospitals' and Coastal's opposition to the Guaranty Associations' request for an extension of the procedural schedule. The Guaranty Associations stated there were genuine disputes concerning the facts of this case. In particular, there might be facts which support the Guaranty Associations' claim that the claims of the SITs and GSIAs do not constitute claims of "other policyholders arising out of insurance contracts."

On May 4, 2004, a Joint Submission on Motion for Extension of Procedural Schedule was filed by the Guaranty Associations and the Deputy Receiver. In the Joint Submission, the Guaranty Associations and the Deputy Receiver stated that, after negotiations among all the parties, the parties agreed to the entry of a procedural schedule as outlined in Exhibit A attached to the Joint Submission. The parties requested that the Guaranty Associations' Motion for Extension of Scheduling Order Deadlines and for Continuance of June 1, 2004, Hearing be granted. Additionally, the parties requested that the revised procedural schedule containing the deadlines set forth in Exhibit A to the Joint Submission be adopted.

By Hearing Examiner's Ruling entered on May 7, 2004, the Guaranty Associations' Motion for Extension of Scheduling Order Deadlines and for Continuance of June 1, 2004, Hearing was granted and the revised procedural schedule containing the deadlines set forth in Exhibit A to the

[5]The Kentucky Hospitals include: Appalachian Regional Healthcare, Caverna Memorial Hospital, Clinton County Hospital, Crittenden Health System, Cumberland County Hospital, Gateway Regional Medical Center, Hardin Memorial Hospital, Highlands Regional Medical Center, Jane Todd Crawford Hospital, Lincoln Trail Hospital, Livingston Hospital & Healthcare Service, Marcum & Wallace Memorial Hospital, Marshall County Hospital, Monroe County Medical Center, Murray-Calloway County Hospital, Ohio County Hospital, Owensboro Mercy Health System, Pattie A. Clay Hospital, Pineville Community Hospital, Regional Medical Center/Trover Clinic Foundation, Rockcastle Hospital, St. Claire Medical Center, T.J. Samson Community Hospital, Twin Lakes Regional Medical Center, and Westlake Regional Hospital.

Joint Submission was adopted. The Hearing Examiner rescheduled the evidentiary hearing for September 22, 2004.

During the intervening period, there was extensive discovery conducted by the parties, and the resulting discovery disputes were disposed of by various rulings of the Hearing Examiner.

The evidentiary hearing was convened as scheduled on September 22, 2004, and continued for six days thereafter. The Deputy Receiver appeared by his counsel Patrick H. Cantilo, Esquire, Susan E. Salch, Esquire, and Christina A. Garcia, Esquire. The Guaranty Associations appeared by its counsel Gregory P. Deschenes, Esquire, and Maia H. Harris, Esquire. The VPCIGA appeared by its counsel C. Cotesworth Pinckney, Esquire, Andrew G. Mauck, Esquire, and Kevin W. Mottley, Esquire. The Kentucky Hospitals appeared by its counsel, Greg E. Mitchell, Esquire. Coastal appeared by its counsel Wiley F. Mitchell, Jr., Esquire and Michael R. Katchmark, Esquire. The Virginia Uninsured Employers Fund appeared by its counsel Brian J. McNamara, Esquire. Doctors Insurance Reciprocal appeared by its counsel Patrick A. O'Hare, Esquire. The Children's Hospital of Alabama appeared by its counsel W. H. Albritton, IV, Esquire. The Bureau of Insurance appeared by its counsel Peter B. Smith, Esquire. Eric M. Page, Esquire, made a limited appearance on behalf of Richard W.E. Bland, who had been subpoenaed to testify in this matter. Post-hearing briefs were filed timely by the Deputy Receiver, the Kentucky Hospitals, Coastal, the Virginia Workers Compensation Commission, the VPCIGA, and the Guaranty Associations. A copy of the transcript is being filed with this report.

Summary of the Record

The record in this case was developed during six days of hearings, the testimony of fifteen witnesses, prefiled and live direct testimony, the admission of hundreds of individual documents as exhibits, and lengthy cross-examination.

The Deputy Receiver offered the testimony of three witnesses: Alfred Gross, Commissioner of Insurance of the Virginia Bureau of Insurance; Mark Hyland, a second vice president with TRG; and Paul Walther, chief executive officer and principal consultant of Reinsurance Directions, Inc.

Mr. Gross provided an overview of the actions he has taken regarding the Assumed Claims and Liability Assumed Claims (collectively, the "Assumed Claims") since he was appointed the Deputy Receiver of ROA. He was appointed the Deputy Receiver of ROA and TRG on January 29, 2003, when the two entities were placed into receivership by the Circuit Court of the City of Richmond. He explained that ROA is an unincorporated association and a reciprocal insurer, which wrote professional liability insurance, workers' compensation insurance, and some ancillary coverages for its professional liability insureds. ROA also provided reinsurance to various companies, including three Tennessee Risk Retention Groups. ROA operated through its attorney-in-fact, TRG. TRG and ROA had an exclusive management and insurance services agreement, pursuant to which TRG was to perform actuarial, administrative, claims, premium collection, accounting, and records services for ROA for a fee. ROA was a member of the VPCIGA. Exs. AG-1, at 1-2; DR-1; Tr. at 52-53.

After he took control of the Companies, Mr. Gross concluded that the Companies could not be rehabilitated. On April 30, 2003, he filed an application with the Commission to liquidate the Companies. After an evidentiary hearing, the Commission ordered the Companies liquidated and ROA's policies of insurance cancelled. Mr. Gross was directed to proceed with the liquidation of the Companies in accordance with the provisions of Title 38.2, Chapter 15 of the Code of Virginia, other applicable Virginia law, and the orders of the Commission. Pending further orders of the Commission, Mr. Gross was authorized to continue making disability payments arising under ROA's workers' compensation insurance policies until such time as they could be made by the applicable insurance guaranty associations. He specifically asked for this authority believing that such disability payments were essential for daily living for the recipients in Virginia and other states. Mr. Gross was also authorized to cancel all direct insurance policies issued by ROA, to be effective on or before the last date for which claims arising thereunder would be covered by the applicable insurance guaranty associations. Exs. AG-1, at 2-3; DR-2; Tr. at 53-54.

After the Liquidation Order was entered, ROA continued to make the disability claim payments and either ROA or the claimants submitted the claims to the applicable insurance guaranty associations for payment. Mr. Gross stated most of the claims were accepted by the associations; however, the associations denied coverage for the Assumed Claims from the SITs in Alabama, Arkansas, Kentucky, and Missouri, and the GSIAs in Mississippi, North Carolina, Tennessee, and Virginia. This amounted to approximately 450 claims with weekly disability payments of approximately $125,139. The insurance guaranty associations returned the claim files to ROA. Ex. AG-1, at 3-4.

The insurance guaranty associations took the position that the Assumed Claims are not policy obligations of ROA, because they did not arise originally from ROA policies, and because of the manner in which ROA assumed liability for these claims. Mr. Gross disagreed with the position taken by the associations. He believes the Assumed Claims should be afforded the same "safety net" protection that applies to all similar claims of injured employees. When the 30-day period for which ROA was to advance disability payments was coming to a close, Mr. Gross applied to the Commission to continue making disability payments on the Assumed Claims.[6] Exs. AG-1, at 4-5; DR-3; Tr. at 54-55.

On November 12, 2003, the Commission ordered Mr. Gross to continue making indemnity and wage-replacement payments, but did not authorize him to make physician, hospital, or other health care facility payments. The order also referred to a Hearing Examiner the issue of whether the claims of the SITs and GSIAs, or their members, constitute "claims of other policyholders arising out of insurance contracts."[7] Exs. AG-1, at 5; DR-4; Tr. at 56.

The Guaranty Associations filed a Petition for Rehearing or Reconsideration with the Commission, and noticed an appeal to the Supreme Court of Virginia. The Commission granted the

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[6]The workers' compensation SITs/GSIAs assumed by ROA included the Healthcare Workers Compensation Self-Insured Fund, Arkansas Hospital Association Workers' Compensation Self-Insured Trust, Compensation Hospital Association Trust, MHA/MSC Compensation Trust, MHA Private Workers' Compensation Group, MHA Public Workers' Compensation Group, SunHealth Self-Insurance Association of North Carolina, THA Workers' Compensation Group, and Healthcare Providers Group.

[7]*See*, § 38.2-1509 B 1(ii) of the Code of Virginia.

Petition for Rehearing or Reconsideration for purposes of receiving responses from all the parties, and stayed the Deputy Receiver's payment of any indemnity and wage-replacement claims until further order of the Commission. Exs. AG-1, at 5; DR-5; Tr. at 57.

By order entered on January 8, 2004, the Commission denied the Guaranty Associations' Petition for Rehearing or Reconsideration; reinstated the Order of November 12, 2003, authorizing Mr. Gross to make indemnity and wage-replacement payments; and denied the Guaranty Associations' request for suspension of the November 12, 2003, Order pending appeal. The Guaranty Associations appealed the January 8, 2004, Order to the Supreme Court of Virginia, which subsequently dismissed the appeal.[8] Exs. AG-1, at 6; DR-6 and 7; Tr. at 58-59.

Mr. Gross filed an amended application on January 21, 2004, to include in this proceeding the Liability Assumed Claims also assumed by ROA, and to resolve the legal issue related to the liability claimants' status as policyholders.[9] He believes the issues are identical to those at issue for the workers' compensation claimants. The Commission accepted the amended application. Exs. AG-1, at 6; DR-8 and 9; Tr. at 59-60.

Mr. Gross believes the Assumed Claims are claims of other policyholders arising out of insurance contracts under § 38.2-1509 of the Code of Virginia. He believes these claims arise under insurance contracts originally issued by the SITs and GSIAs, which were later assumed by ROA. Mr. Gross believes the assuming insurer, ROA, became directly liable to the holder of the policies with respect to pending and future liabilities. He believes the Assumed Claims are covered under the various state insurance guaranty fund statutes. Mr. Gross stated to be "covered" by an insurance guaranty association, a claim must arise out of the scope of a policy covered by the insurance guaranty association act, and issued or written by a member insurer which has been found to be insolvent. Mr. Gross believes that is precisely what has occurred in this case. ROA assumed the insurance obligations of the SITs and GSIAs by stepping into the shoes of those insurers to provide direct coverage to the insureds, and ROA has subsequently been declared insolvent. He believes the standard for insurance guaranty association coverage has been met. Ex. AG-1, at 6-7.

Mr. Gross addressed the Guaranty Associations' position that there was no transfer of risk when ROA assumed the claims. He stated that existing insurance obligations were assumed by ROA. The severity and duration of the liabilities were not known at the time the transactions occurred. Mr. Gross believes ROA was responsible for those liabilities without any additional monetary payment. He believes ROA assumed the risk that the liability would exceed the assets it received in exchange for the assumption of the claims. Ex. AG-1, at 7.

Mr. Gross provided the current status of the Assumed Claims. The Arkansas and Missouri Insurance Guaranty Associations are paying the Assumed Claims. Additionally, the North Carolina Industrial Commission, in a ruling dated July 19, 2004, has ordered the North Carolina Insurance

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[8] *Indiana Insurance Guaranty Assoc. et al. v. Alfred W. Gross*, 268 Va. 220, 598 S.E. 2d 322, 2004 Va. Lexis 104 (2004).

[9] The professional liability SITs include the Alabama Hospital Association Trust and the Kentucky Hospital Association Trust.

Guaranty Association to pay the SunHealth Assumed Claims.[10] As of September 7, 2004, ROA is currently making payments on approximately 22 claims at an amount of $13,500 per month. Additionally, ROA has entered into agreements with certain employers which result in ROA making the payments, subject to reimbursement from the employers if it is determined that the Assumed Claims are not claims of other policyholders. Mr. Gross's efforts to find alternative sources of payment for the Assumed Claims have been unsuccessful. Ex. AG-1, at 7; Tr. at 62, 125-26 and 127-28.

Mr. Gross is pursuing this case because he believes the purpose of the insurance guaranty association acts was to protect insureds upon the insolvency of their insurer. He believes employees who have suffered a work-related injury, alone among all insureds, are exempted by the General Assembly from the caps and limits of insurance guaranty association coverage; their claims are to be paid in full. Mr. Gross objects to the insurance guaranty associations' singling out this group of employees for special adverse treatment. He noted that the insurance guaranty associations are not only denying the claims, but they oppose him paying the claims with assets from the ROA estate. To address this disparate treatment, Mr. Gross, in his capacity as Insurance Commissioner, proposed an amendment to § 38.2-1603 of the Code of Virginia that clarifies that claims like the Assumed Claims are "covered claims" that would be paid by the VPCIGA.[11] Mr. Gross believes the amendment makes it clear that obligations assumed by a member insurer through a merger, an assumption agreement, or other common commercial transactions would be counted as policyholder claims for coverage. Ex. AG-1, at 8; Tr. at 61, and 85-86.

On cross-examination, Mr. Gross testified that as a licensed reciprocal insurance company in Virginia, ROA was a member of the VPCIGA. He further testified that Healthcare Providers Group, a former Virginia GSIA, and the other GSIAs and SITs were not members of the VPCIGA. He confirmed that insurance guaranty associations provide a limited safety net in cases of insurance company insolvency and the limitations are established by statute. He agreed the protection afforded is limited to certain types of insurance companies, certain types of insurance coverage, and by a certain dollar amount. Although he noted there is no limitation for workers' compensation claims. Mr. Gross agreed the coverage afforded by insurance guaranty associations applies to direct policyholder obligations. He further agreed that the insurance guaranty associations are governed by the statutes under which they are created and must comply with those statutes. Tr. at 67-69.

Mr. Gross answered a number of questions related to the Virginia insurance guaranty association statute, § 38.2-1603 of the Code of Virginia. He agreed that the VPCIGA can pay a claim only if it meets the statutory definition of a "covered claim," which requires that the claim arise out of a policy issued by a member insurer which has been found to be insolvent, and that the VPCIGA cannot pay non-covered claims. He noted that there were agreements whereby ROA assumed the GSIAs' and SITs' policyholder liability and the issue in this case is whether those agreements are contracts of insurance. Tr. at 70-71.

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[10] *In re SunHealth GSIA/The Reciprocal Group*, I.C. Nos. 402156, 467439, 822818, 734242, 902560, 426774, 705360, 616611, 734300 & 944966 (N. C. Indus. Comm'n, July 19, 2004).

[11] *See*, 2004 Va. Acts 2 ch. 85. The amendments were effective July 1, 2004, but they do not apply to the Assumed Claims that are at issue in this proceeding.

Prior to stating his opinion that the Assumed Claims are covered claims under the various state guaranty fund statutes, Mr. Gross did not personally review the insurance guaranty association statutes in Indiana, Kansas, Mississippi, or Tennessee. He agreed that each state's insurance guaranty fund statutes govern claims submitted in that state. Mr. Gross was not aware that Tennessee's statutes specifically exclude any insurance issued on an assessable basis. He was aware that the alleged insurance policies issued by the GSIAs and SITs were issued on an assessable basis, but that did not change his opinion because his opinion was based on the direct obligations assumed by ROA, a member of the VPCIGA. Mr. Gross was not aware that Indiana's statutes exclude insurance written on a retroactive basis to cover known losses for which a claim has already been made and the claim is known to the insurer at the time the insurance is bound. Again, this fact did not change Mr. Gross's opinion. Mr. Gross is aware that most of the workers' compensation claims submitted to the various insurance guaranty associations have been accepted and have been paid, but he is unsure whether the associations have rejected any claims in which the insurance policy was written directly by ROA. Tr. at 72-76.

Mr. Gross testified that as the Deputy Receiver of ROA, he must comply with § 38.2-1509 B of the Code of Virginia when disbursing the assets of an insolvent insurer's estate. He relied on that statute when making the distributions in this case. He agreed that the statute requires that claims be apportioned without preference and that he cannot make disbursements that constitute a preference. Mr. Gross noted the statute did not expressly provide for any exceptions for hardship or equities. He stated that if he had legal questions concerning disbursements he may have to consult with the statutory receiver, the Commission. Before he filed his Application, Mr. Gross considered whether the payment of the Assumed Claims constituted a preference in light of the statute. Mr. Gross does not characterize his payment of the Assumed Claims a preference. He believes there is a valid dispute whether these claims were policyholder claims and he went back to the Commission to find an equitable resolution to his dilemma. He believes the effect of his action was to ensure that the Assumed Claims were paid at the same time the insurance guaranty associations paid covered claims. Mr. Gross has taken a counter position in another case, that payment of the Tennessee Risk Retention Groups' ("Tennessee RRGs") claims would create a preference. In that case, Mr. Gross does not believe their claims are policyholder claims. Tr. at 79-84.

Mr. Gross testified that GSIAs are organized and regulated differently than insurance companies. Insurance companies are regulated pursuant to Title 38.2 of the Code of Virginia, and GSIAs are regulated pursuant to Title 65.2. He agreed that GSIAs are governed by rules adopted by the Commission. Under those rules, GSIA members are required to execute an indemnity agreement. Additionally, those members agree to be jointly and severally liable for all claims of every member of the GSIA. Mr. Gross did not recall the position taken by the Virginia Bureau of Insurance (the "Bureau") in a 1993 case that HPG was not an insurance company. HPG was not licensed pursuant to Title 38.2 as an insurance company in Virginia. Mr. Gross testified he was not involved with HPG's assumption transaction or any of the other assumption transactions, nor does he recall those transactions. He is aware that the Bureau approved the HPG transaction. The transaction was approved as a distribution of surplus assets under 14 VAC 5-370-110 B and § 13.1-900 A of the Code of Virginia. Ex. AG-3; Tr. 87-91, 100 and 120-24.

On redirect, Mr. Gross testified he used the definition of "insurance contracts" or "insurance policies" found in § 38.2-100 of the Code of Virginia when he determined that the Assumed Claims were policyholder claims.[12] After reviewing the purpose for the insurance guaranty associations found in § 38.2-1600 of the Code of Virginia, Mr. Gross reiterated that his primary purpose in filing the Application was to protect policyholders. He agreed that there was nothing in the statute indicating that the insurance guaranty associations are created for the purpose of protecting the insurance carriers who fund the association, or the taxpayers of Virginia. Mr. Gross stated that the primary purpose of the insurance guaranty associations as stated in the statute is to reduce financial loss to claimants or policyholders resulting from the insolvency of an insurer. Tr. at 129-33.

Responding to questions from the bench, Mr. Gross testified he was not aware of the legal theories under which the Arkansas and Missouri Insurance Guaranty Associations were paying the Arkansas Hospital Association Workers' Compensation Self-Insurance Trust and MHA/MSC Compensation Trust Assumed Claims as covered claims. Additionally, Mr. Gross was not aware of the legal theory under which the North Carolina Workers' Compensation Commission ordered the North Carolina Insurance Guaranty Association to pay the SunHealth Group Self-Insurance Association of North Carolina Assumed Claims. Tr. at 133-34.

Mr. Hyland testified he has worked for TRG and its predecessor, Virginia Professional Underwriters, Inc. ("VPUI"), for approximately eighteen and a half years in the claims area. Currently, he is responsible for the workers' compensation claims and underwriting department. Mr. Hyland is familiar with the nine transactions by which ROA (or its predecessor, The Virginia Insurance Reciprocal ("TVIR")) assumed responsibility for the Assumed Claims from SITs in Alabama, Arkansas, Kentucky, and Missouri, and GSIAs in Mississippi, North Carolina, Tennessee, and Virginia. He is also familiar with the two transactions by which ROA assumed the Assumed Liability Claims from SITs in Alabama and Kentucky. Ex. MH-4, at 1-2.

Mr. Hyland sponsored Ex. DR-10 into the record. Ex. DR-10 includes copies of the documents relevant to each of the transactions at issue. The documents include the membership certificates of the SITs and GSIAs, indemnity agreements, and documents evidencing the transactions. Ex. DR-10 is arranged alphabetically by state, with a separate section for each of the transactions. The exhibit is divided as follows:

Tab A: Alabama	Healthcare Workers' Compensation Self Insurance Fund ("HWCF")
Tab B: Alabama	Alabama Hospital Association Trust ("A-HAT")
Tab C: Arkansas	Arkansas Hospital Association Workers' Compensation Self Insurance Trust ("AWCT")
Tab D: Kentucky	Compensation Hospital Association Trust ("C-HAT")
Tab E: Kentucky	Kentucky Hospital Association Trust ("K-HAT")
Tab F: Mississippi	MHA Public Workers' Compensation Group ("MHA Public")
Tab G: Mississippi	MHA Private Workers' Compensation Group ("MHA Private")
Tab H: Missouri	MHA/MSC Compensation Trust ("MHA/MSC")

[12]The last complete sentence in the statute provides: "[w]ithout otherwise limiting the meaning of or defining the following terms, 'insurance contracts' or 'insurance policies' shall include contracts of fidelity, indemnity, guaranty and suretyship."

Tab I: North Carolina	SunHealth Group Self-Insurance Association of North Carolina ("SunHealth")
Tab J: Tennessee	THA Workers' Compensation Group ("THA")
Tab K: Virginia	Healthcare Providers Group ("HPG")

Behind each of the tabs are the original coverage documents, and the merger or assumption agreements for each transaction.[13] Exs. MH-4, at 3; DR-10.

Mr. Hyland also sponsored Ex. DR-11 into the record. Ex. DR-11 includes copies of documents related to the approvals of the transactions by the members of the SITs and GSIAs, as well as the documents related to regulatory approval of the transactions at issue. Ex. DR-11 is organized in the same manner as Ex. DR-10. Behind each of the tabs are the consent and approval documents for each transaction for which there are such documents.[14] Exs. MH-4, at 3-4; DR-11.

Mr. Hyland testified a majority of the employers who became members of the GSIAs in Virginia, Tennessee, Mississippi, and North Carolina were direct insureds of TVIR before they became members of the GSIAs He further testified the employer members of the SITs in Kentucky, Missouri, Arkansas, and Alabama were not direct insureds of TVIR before they were members of those SITs. Mr. Hyland was not involved in the formation of the GSIAs, but he did administer the claims before and after the GSIAs were formed. He stated the GSIAs were formed to help the hospitals keep their insurance premiums low, and to ensure a constant market for workers' compensation coverage. At the time, it was believed that moving the business to the GSIAs could avoid some expenses, and allow the GSIAs to focus attention on the workers' compensation business, which might result in lower losses. Exs. MH-4, at 5; MH-5, at 19-21.

The GSIAs were formed by Specialty Insurance Services ("SIS"), a wholly owned subsidiary of VPUI. SIS was the operational management company for the GSIAs. SIS engaged VPUI to handle the claims administration for the GSIAs. For example, an injured employee would seek recovery from the employer-member, the employer-member would file a claim with the GSIA, and VPUI would then administer the claim. VPUI was also retained to handle certain financial aspects of the GSIAs, including loss development, pricing, and preparation of annual statements. The GSIAs used the same workers' compensation policy form as ROA. Additionally, ROA provided reinsurance for some, if not all, of the GSIAs. ROA did not provide reinsurance to the SITs. Ex. MH-4, at 5.

[13]For example, Tab A includes the HWCF coverage agreement, the ROA – HWCF Business Combination Agreement, and the Acquisition of Assets and Assumption of Liabilities Agreement between HWCF and TVIR.

[14]For example, Tab A includes the November 30, 2000, HWCF Unanimous Consent of the Board of Trustees, the November30, 2000, Resolutions of the Board of Directors, the November 30, 2000, and December 21, 2000, letters sent to HWCF members regarding the transaction, the HWCF member voting ballots, and the April 2, 2001, letter from the Alabama Department of Industrial Relations confirming the member approval.

Mr. Hyland testified the employer-members of the GSIAs and SITs received certificates of membership, and also indemnity agreements. Mr. Hyland was able to locate indemnity agreements for six of the transactions.[15] Although he was not able to locate them, Mr. Hyland stated that Alabama, Arkansas, and Kentucky had similar agreements. Ex. MH-4, at 6.

Mr. Hyland was able to locate sample membership certificates for nine of the transactions.[16] Although he was unable to locate them, Mr. Hyland stated that Arkansas and Missouri had similar forms. Ex. MH-4, at 6-7.

Mr. Hyland testified ROA gradually phased out of the workers' compensation business after the GSIAs were formed. However, in the 1990s, ROA sought to bring the business back from the GSIAs. Two factors influenced ROA to change its business plan: changes in the workers' compensation insurance market, and a desire to grow its business. Mr. Hyland stated there were several benefits for the GSIAs to return their workers' compensation business to ROA. These included: the financial strength of ROA; larger more varied investments were available to a traditional insurance company; additional investment income would result in lower premiums; the employers would be relieved of their joint and several liability; and increased administrative efficiency. Mr. Hyland stated that insurance guaranty fund coverage was another benefit; however, it was not a primary selling point and was not mentioned at the time of the transactions. There was some discussion among employees at TRG that the merger of the GSIAs into ROA would provide insurance guaranty fund coverage. At the time, everyone, including Mr. Hyland, thought of ROA as a growing, vibrant company that was not thinking about going out of business. He agreed that there was no insurance guaranty fund coverage for claims against a GSIA or SIT. Exs. MH-4, at 7; MH-5, at 29 and 154.

Mr. Hyland stated ROA acquired the SITs workers' compensation business with the expectation of further growing its business and possibly leading to writing additional general or professional liability business in those states. Ex. MH-4, at 8.

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[15]This included: Mississippi – Indemnity Agreement and Power of Attorney for MHA Public Workers' Compensation Group (Ex. DR-10, Tab F 1); Mississippi – Indemnity Agreement and Power of Attorney for MHA Private Workers' Compensation Group (Ex. DR-10, Tab G 1); Missouri – Indemnity Agreement for MHA/MSC Compensation Trust (Ex. DR-10, Tab H 1); North Carolina – Indemnity Agreement and Power of Attorney for SunHealth Group Self-Insurance Association of North Carolina (Ex. DR-10, Tab I 1); Tennessee – Indemnity Agreement and Power of Attorney for THA-Workers' Compensation Group (Ex. DR-10, Tab J 1); and Virginia – Indemnity Agreement and Power of Attorney for Healthcare Providers Group (Ex. DR-10, Tab K 1).

[16]This included: Alabama – Fund Coverage Agreement Healthcare Workers' Compensation Self Insurance Fund (Ex. DR-10, Tab A 1); Alabama – Alabama Hospital Association Trust – Medical Professional and General Liability Coverage Agreement (Ex. DR-10, Tab B 1); Kentucky – Compensation Hospital Association Trust Workers' Compensation Coverage Certificate (Ex. DR-10, Tab D 1); Kentucky – Kentucky Hospital Association Trust Exhibit "A" as Revised January 1995 (Ex. DR-10, Tab E 1); Mississippi – Certificate of Membership-MHA Public Workers' Compensation Group (Ex. DR-10, Tab F 2); Mississippi – Certificate of Membership-MHA Private Workers' Compensation Group (Ex. DR-10, Tab G 2); North Carolina – Certificate of Membership-SunHealth Group Self-Insurance Association of North Carolina (Ex. DR-10, Tab I 2); Tennessee – Certificate of Membership- THA-Workers' Compensation Group (Ex. DR-10, Tab J 2); and Virginia – Certificate of Membership-Healthcare Providers Group (Ex. DR-10, Tab K 2).

Although Mr. Hyland was not involved in structuring the transactions, negotiating the terms of the transactions, or drafting the agreements, he was present at the GSIA board meetings to give claim reports and was present when the transactions were discussed. Once the agreements were in place, Mr. Hyland instructed his claims personnel to handle all the claims like all other ROA claims. At the time ROA assumed the claims from each GSIA, it did not know, and could not have known, the total amount (duration or severity) of liability it had assumed. The risk transferred from the SITs and GSIAs to ROA was that the assets it acquired would be insufficient to cover the liabilities it assumed. ROA did not have the ability to pass unexpected claims or losses back to the SITs or GSIAs, or to collect additional funds for these claims and losses. Exs. MH-4, at 8; MH-5, at 19, 45-46, 71, 123-24, and 147.

Mr. Hyland provided an overview of the documents that effected the assumption of the business from each of the GSIAs and SITs by ROA, and the approvals required for each of the transactions. Employees at the Companies generally referred to these transactions as mergers, business combinations, or loss portfolio transfers. Mr. Hyland does not recall whether the term assumption reinsurance was used. Some of the transactions were structured to have an effective date of December 31, to coincide with the expiration of the GSIAs' policy coverage. Exs. MH-4, at 9; MH-5, at 23, 38, 46, 68 and 73.

The HWCF business was assumed by ROA on April 1, 2001, through an Acquisition of Assets and Assumption of Liabilities Agreement. Ex. DR-10, Tab A 3. As provided in Sections 2.1 and 2.2 of the agreement, HWCF transferred all of its assets and liabilities to ROA. The members of HWCF approved the transaction. Ex. DR-11, Tab A 4. HWCF and ROA obtained regulatory approval for the transaction from the Alabama Department of Industrial Relations. Ex. DR-11, Tab A 5. The Assumed Claims related to this transaction are not being paid by the Alabama Insurance Guaranty Association. Ex. MH-4, at 9.

The A-HAT business was assumed by ROA on January 31, 2001, through an Acquisition of Assets and Assumption of Liabilities Agreement. Ex. DR-10,
Tab B 3. As provided in Sections 2.1 and 2.2 of the agreement, A-HAT transferred all of its assets and liabilities to ROA. The members of A-HAT approved the transaction. Ex. DR-11, Tab B 3. A-HAT was a liability SIT and its claims are not being paid by the Alabama Insurance Guaranty Association. Ex. MH-4, at 10.

The AWCT business was assumed by ROA on January 1, 1999, through a Merger Agreement – Acquisition of Assets and Assumption of Liabilities Agreement. Ex. DR-10, Tab C 1. As provided in Sections 1.1 and 1.2 of the agreement, AWCT transferred all of its assets and liabilities to ROA. The members of AWCT approved the transaction. Ex. DR-11, Tab C 3. The Assumed Claims related to this transaction are being paid by the Arkansas Insurance Guaranty Association. Ex. MH-4, at 10.

The C-HAT business was assumed by ROA on November 1, 1997, through a Master Agreement. Ex. DR-10, Tab D 2. As provided in Sections 2.1 and 2.3 of the agreement, C-HAT transferred all of its assets and liabilities to ROA. The members of C-HAT approved the transaction. Ex. DR-11, Tab D 2. The Kentucky Department of Workers' Claims approved the

consolidation of C-HAT with ROA. Ex. DR-11, Tab D 3. The Assumed Claims related to this transaction are not being paid by the Kentucky Insurance Guaranty Association. Ex. MH-4, at 11.

The K-HAT business was assumed by ROA on November 1, 1997, through a Master Agreement. Ex. DR-10, Tab E 2. As provided in Sections 2.1 and 2.3 of the agreement, K-HAT transferred all of its assets and liabilities to ROA. The members of K-HAT approved the transaction. Ex. DR-11, Tab E 2. K-HAT was a liability SIT and its claims are not being paid by the Kentucky Insurance Guaranty Association. Ex. MH-4, at 12.

The MHA Public business was assumed by ROA on December 31, 1997, through a Merger Agreement. Ex. DR-10, Tab F 3. As provided in Sections 1.1 and 1.3 of the agreement, MHA Public transferred all of its assets and liabilities to ROA. The members of MHA Public approved the transaction. Ex. DR-11, Tab F 5 and 7. The consolidation of MHA Public with ROA was approved by the Mississippi Workers' Compensation Commission. Ex. DR-11, Tab F 9. The Assumed Claims related to this transaction are not being paid by the Mississippi Insurance Guaranty Association. Ex. MH-4, at 12.

The MHA Private business was assumed by ROA on December 31, 1997, through a Merger Agreement. Ex. DR-10, Tab G 3. As provided in Sections 1.1 and 1.3 of the agreement, MHA Private transferred all of its assets and liabilities to ROA. The members of MHA Private approved the transaction. Ex. DR-11, Tab G 5 and 7. The consolidation of MHA Private with ROA was approved by the Mississippi Workers' Compensation Commission. Ex. DR-11, Tab G 9. The Assumed Claims related to this transaction are not being paid by the Mississippi Insurance Guaranty Association. Ex. MH-4, at 12-13.

The MHA/MSC business was assumed by ROA on January 1, 2000, through an Acquisition of Assets and Assumption of Liabilities Agreement. Ex. DR-10,
Tab H 2. As provided in Sections 1.1 and 1.3 of the agreement, MHA/MSC transferred all of its assets and liabilities to ROA. The members of MHA/MSC approved the transaction. Ex. DR-11, Tab H 1. At the request of the Missouri Division of Workers' Compensation, ROA issued a replacement policy to MHA/MSC. Ex. DR-10, Tab H 3. The policy provided coverage retroactive to the inception date of the MHA/MSC Compensation Trust. Mr. Hyland stated ROA treated the MHA/MSC Assumed Claims exactly like all the others. The Assumed Claims related to this transaction are being paid by the Missouri Insurance Guaranty Association. Exs. MH-4, at 13-14; MH-5, at 41.

The SunHealth business was assumed by ROA on July 1, 1999, through an Acquisition of Assets and Assumption of Liabilities and Reinsurance Agreement. Ex. DR-10, Tab I 3. As provided in Sections 1.1 and 1.3 of the agreement, SunHealth transferred all of its assets and liabilities to ROA. The members of SunHealth approved the transaction. Ex. DR-11, Tab I 2. The North Carolina Department of Insurance approved the assumption of SunHealth's business by ROA. Ex. DR-11, Tab I 3. By Order dated July 19, 2004, the North Carolina Industrial Commission ordered the North Carolina Insurance Guaranty Association to pay the SunHealth Assumed Claims. Ex. MH-4, at 14.

The THA business was assumed by ROA on December 31, 1997, through a Merger Agreement. Ex. DR-10, Tab J 3. As provided in Sections 1.1 and 1.3 of the agreement, THA transferred all of its assets and liabilities to ROA. The members of THA approved the transaction. Ex. DR-11, Tab J 4. The Tennessee Department of Commerce and Insurance approved the merger. Ex. DR-11, Tab J 6. The Assumed Claims related to this transaction are not being paid by the Tennessee Insurance Guaranty Association. Ex. MH-4, at 14-15.

The HPG business was assumed by ROA on December 31, 1997, through a Merger Agreement. Ex. DR-10, Tab K 3. As provided in Sections 1.1 and 1.3 of the agreement, HPG transferred all its assets and liabilities to ROA. The members of HPG approved the transaction. Ex. DR-11, Tab K 9. The Assumed Claims related to this transaction are not being paid by the VPCIGA. Ex. MH-4, at 15.

Mr. Hyland sponsored the ROA Annual Statement Schedule Ps for the years 1997 through 2001. Additionally, he produced a set of tables which summarize changes in premiums earned for direct and assumed claims, and workers' compensation incurred losses and allocated expenses over the years 1997 through 2000. Mr. Hyland obtained this information from ROA's Schedule Ps. ROA did not treat the assets it received from the GSIAs and SITs as premium income for years 1997 through 2001. Exs. MH-4, at 16; MH-5, at 44; DR-12 and 13.

Mr. Hyland's duties did not include working on ROA's Annual Statements, or providing input for Schedule P and the interrogatories. Additionally, he is unaware of the accounting treatment given the Assumed Claims on ROA's balance sheet or income statement. Ex. MH-5, at 35, 75, 80-81, and 142-44.

Mr. Hyland testified he is familiar with the term loss development analysis, which takes a body of claims for a given year and tracks how those loss amounts change over time. ROA's actuarial staff performed a loss development analysis on the Assumed Claims. The analysis looked at paid loss amounts, incurred loss amounts, case reserves, claim count information, and also exposure information. Mr. Hyland stated ROA's loss development is reflected in Schedule P, Part 2D, Workers' Compensation. He referred to Part 2D as a loss development triangle. It tracks individual accident years and how those losses develop over time. Mr. Hyland reviewed ROA's Schedule Ps for the years 1996 to 2001, and he is familiar with how the Schedule Ps were updated to reflect the business combinations. Schedule P of the annual statement is a financial report that analyzes the premium income and loss and expense development from year to year on both an aggregate basis and according to the various line of business written by the insurer. Exs. MH-4, at 16; DR-11.

Mr. Hyland testified that in its 1998 Annual Statement, ROA restated Schedule P, Part 1D for prior year premium data for the workers' compensation line of business back to 1993. In addition, ROA restated the incurred loss and allocated expense data on Part 2D back to 1996. ROA noted in its response to Schedule P interrogatory number 8, that if the data was not restated, it was omitted. Mr. Hyland described the effect of the restatement. The restated 1998 Schedule P shows a dramatic increase in the workers' compensation business over the 1997 non-restated Schedule P for 1996 and prior years. To compare the changes from year to year, Mr. Hyland prepared Exhibit DR-13. Table 1 compares the total of all earned premiums from all lines of business that are reported in

Part One of Schedule P, and Table 2 shows this information for only the workers' compensation line of business. Mr. Hyland stated there was little or no change in the earned premiums reported in the 1996 and 1997 Schedule Ps for any particular year. However, he stated once the information was restated in 1998, there was as much as a 698% increase in the reported workers' compensation earned premium, which contributed to the 48% change in the total reported earned premium for all lines of business. Ex. MH-4, at 17.

Mr. Hyland also described how the restatement affected the incurred and paid losses and allocated expenses. He summarized the changes in Table 3 of Exhibit DR-13, which shows how incurred losses and allocated expenses for the years 1995, 1996, and 1997 were reported in Part 2D of the 1997 and 1998 Schedule Ps. He stated the 1997 and 1998 reports clearly show a dramatic change in the 1996 data. The change reflects ROA's increased incurred loss and allocated expense reserve requirements associated with the assumption of the assets and liabilities of six of the GSIAs. Ex. MH-4, at 17.

Mr. Hyland stated that in its 2000 Annual Statement, ROA restated all prior year incurred and paid loss and allocated expense data reported on Schedule P, Parts 2D and 3D back to 1991. He noted that Exhibit DR-13, Table 4 shows the changes between the 1999 statement and the 2000 statement for the information contained on Part 2D. He stated that in 2000 ROA again started reporting loss data for 1995 and, as can be seen in Table 4, it continued development of losses for the previously restated 1996 and later years. Ex. MH-4, at 18.

Mr. Hyland explained how the other business combinations were reflected in ROA's Schedule Ps. In 1999, ROA merged with two additional GSIAs, and it partially restated the prior year's data. The 1999 Schedule P was updated to reflect the combined earned premium data for all prior years; however, the incurred and paid loss and expense information was only partially updated. In ROA's 2000 Annual Statement, Parts 2D and 3D of Schedule P were restated back to 1991 to reflect the inclusion of all the GSIAs and SITs for which ROA assumed the assets and liabilities over the four years preceding the 2000 statement. In the 2001 Annual Statement, the information for Parts 2D and 3D was restated to reflect ROA's combination with HWCF and A-HAT. Ex. MH-4, at 18.

Mr. Hyland explained that once the prior year loss and allocated expense data, both incurred and paid, were properly restated to reflect the historical information on the business combinations, then as claims were evaluated and losses developed, this information was amended from year to year in the normal course of operations. He stated the information reported for earned premiums, however, is generally static and not reevaluated from year to year. Ex. MH-4, at 18.

Mr. Hyland testified the Assumed Claims were not treated any differently from other insurance claims. Once a claim was in the system, whether assumed or not, it was tracked and adjusted for loss development, and evaluated regularly to adjust its case reserves. The year-to-year adjustments based on both case reserve evaluations and loss development are reflected in the year-to-year changes in ROA's Schedule P once the prior year was fully restated. ROA treated the Assumed Claims exactly like it treated other policies that it had written directly, as direct policyholder liabilities. Ex. MH-4, at 18-19.

After the GSIA and SIT business was assumed, ROA issued new policies for coverage arising after the date the transactions were completed. The new policies did not renew existing coverage, but provided coverage on a going-forward basis. If a GSIA or SIT member decided not to become an insured of ROA, its pre-merger claims were assumed by ROA and were treated the same as all other ROA claims. Mr. Hyland was not aware whether the GSIAs and SITs made contracts of insurance pursuant to the Code of Virginia or other applicable law. Exs. MH-4, at 19; MH-5, at 40, 68 and 79.

Mr. Hyland sponsored a list of the Assumed Claims that are not being paid by the various insurance guaranty associations. He has run case-based estimates to determine the Assumed Claims' ultimate cost; however, Mr. Hyland could not remember the exact figure without consulting the report. In addition, Mr. Hyland is aware of the Deputy Receiver conducting an actuarial study of the Assumed Claims, but he was not aware of the result. When asked whether the claims would ultimately reach $35 million as stated in a pleading by the Deputy Receiver, Mr. Hyland stated that the number was reasonable. As of the time of his deposition, the Deputy Receiver was paying four claimants approximately $1,500 per month. Exs. MH-4, at 19; MH-5, at 138-40; DR-14.

Mr. Hyland explained the differences between a GSIA and a traditional insurance company. For example, a GSIA is limited in the types of investments it may have and an insurance company is not limited. The members of a GSIA are jointly and severally liable and an insurance company policyholder is not. The members of a GSIA can be assessed for adverse losses. The GSIA is limited in the types of coverage it may write and for whom it may write coverage. An insurance company is generally regulated by a state's Department of Insurance and a GSIA may or may not be regulated by the Workers' Compensation Department. Finally, there are differences in governance between a GSIA and an insurance company. Ex. MH-5, at 166-68.

On cross-examination, Mr. Hyland testified that Exhibit DR-10, Tab D 1 is a representative sample of a workers' compensation coverage certificate issued by C-HAT. The coverage provided by C-HAT was the statutorily mandated workers' compensation coverage. When C-HAT merged with ROA, ROA assumed the risk of loss back to the date C-HAT was formed. ROA allocated the premium received from C-HAT to the same years that C-HAT had received the premium from its members. In addition, he testified that Exhibit DR-10, Tab E 1 was the coverage certificate for K-HAT. The coverage provided by K-HAT included professional and general liability, healthcare, and umbrella coverage. When K-HAT merged with ROA, ROA assumed the risk of loss for these coverages back to the inception date of K-HAT. ROA allocated the premium received from K-HAT to the same years that K-HAT had received the premium from its members. Tr. at 200-02.

Mr. Hyland testified that Exhibits DR-10, Tab A 1 and DR-10, Tab B 1 are examples of the policy forms issued by HWCF and A-HAT. Mr. Hyland stated each of the agreements identified the subject matter to be insured, which would be the members of the GSIA or SIT or their employees. Each of the agreements also identified the risk to be insured against. HWCF was insured against workers' compensation risks and A-HAT professional and general liability. Each of the agreements identified the commencement and period of risk undertaken by HWCF and A-HAT. Each of the agreements identified the amount of insurance being provided by HWCF and A-HAT. Finally, each of the agreements identified the premium and the time at which it was to be paid by the members to HWCF and A-HAT. When the acquisition and assumption agreements

were entered into between HWCF, A-HAT and ROA, ROA assumed all of the liabilities of HWCF and A-HAT. Mr. Hyland stated that ROA recognized these liabilities as direct obligations of ROA. With respect to each claim that it assumed, ROA concluded that a proper entity was the subject matter to be insured, that the risk was insured against, that the commencement and period of risk undertaken by the insured was within the period, and the amounts at issue were within the amount of insurance. Mr. Hyland agreed that as far as ROA was concerned, the premiums had been paid timely for each of the Assumed Claims involving HWCF and A-HAT. He confirmed that there was no relationship between HWCF, A-HAT, and ROA before the acquisition and assumption agreements were entered. Finally, Mr. Hyland confirmed that the dates shown in the acquisition and assumption agreements were the dates the transactions were completed. Tr. 203-06.

Various documents from ROA's records were admitted into the record through Mr. Hyland. These included ROA's Annual Statements for 1996 through 2002, and other documents related to representations made by ROA's counsel to obtain the necessary regulatory approvals for the various transactions. Exs. MH-5, MH-6, VA-14, VA-31 through 37, VA 138-42, 147-52, and GA-25; Tr. at 211, and 240-62.

On redirect, Mr. Hyland testified on the risk assumed by ROA. From a claim perspective, ROA did not know whether the reserves were sufficient to pay the claims, whether there would be development in the claims, whether there would be additional surgeries, or how many claims ROA ultimately would receive since workers' compensation coverage is an occurrence policy and claims would continue to be received. He stated this is particularly true with repetitive motion injuries. Mr. Hyland further testified that based on his review of the documents there was a transfer of a risk of loss from the members to the GSIAs and SITs. Tr. at 264-65.

On further examination, Mr. Hyland stated that his answers with respect to HWCF and A-HAT (see above) applied as well to the C-HAT and K-HAT programs. He further stated that if ROA received a claim from C-HAT or K-HAT, prior to making a claim payment, ROA's claim department would review the policy to determine if coverage was in place, ensure that the premium had been paid, and ensure that the policy had not been cancelled. This was the same process employed by ROA on the policies it had written directly. Finally, Mr. Hyland confirmed that as part of the master agreement with both the C-HAT and K-HAT programs, an entity named Coverage Options Associates provided administrative services to ROA and maintained certain of ROA's books and records related to the C-HAT and K-HAT programs. Tr. at 266-68.

Mr. Walther testified he provides consulting and advisory services to address reinsurance situations. His specialties include due diligence analysis, contract analysis, reinsurance recoveries, dispute resolution, expert witness testimony, educational presentations, outsourced reinsurance functions, and arbitration/mediation services. Additionally, he serves as the editor of the *Journal of Reinsurance*, which is published by the Intermediaries and Reinsurance Underwriters Association. Mr. Walther has earned the Chartered Property Casualty Underwriter ("CPCU") and Associate in Reinsurance ("ARe") designations. He has extensive experience in the insurance and reinsurance industries. Ex. PW-7, at 1-5; Tr. at 270-75.

Mr. Walther testified he was retained as an expert to assist in preparation for, and to participate in this matter. He was asked to review 11 transactions in which ROA assumed obligations of the various GSIAs and SITs. He reviewed and analyzed documents including, but not limited to, contracts and supporting documentation detailing each of the relevant transactions, minutes of meetings, coverage documents, completed proxy forms, correspondence with insurance regulators, and other relevant documentation of the transactions. After reviewing the documents, Mr. Walther was able to formulate an opinion regarding the various transactions. His opinions are based primarily on his analysis of the terms and conditions of the contracts at issue, which are variously entitled "Master Agreement," "Merger Agreement," "Acquisition of Assets and Assumption of Liabilities and Reinsurance Agreement," and "Acquisition of Assets and Assumption of Liabilities Agreement." He stated that these agreements reflect the intent of the parties to each of the transactions at issue in this proceeding. Additionally, Mr. Walther based his opinions on his experience and training in analyzing reinsurance and/or insurance coverage documents during his 40-year career in the insurance industry. Ex. PW-7, at 5-6; Tr. at 280 and 284.

Mr. Walther opined that the titles of the various documents are not important. To determine whether insurance is involved or risk is transferred, the rights and obligations of the parties under the various agreements must be examined. He cited an example of the THA transaction. In his opinion, ROA stepped into the shoes of THA with respect to the obligations of THA to its members from an insurance perspective. The agreement between THA and ROA results in a novation and substitution of ROA for THA with respect to insurance obligations to the members of the group. Mr. Walther based his opinion on the wording of the agreement between THA and ROA. The agreement sets forth the assumption of liabilities by ROA, including insurance obligations, which were formerly the responsibility of THA, and the fact that under Section 1.3 of the agreement, there is the indication and statement that THA and its members shall not have any further liability after the closing date of the agreement. Mr. Walther referred to the agreement as an "assumption reinsurance transaction." He stated that in an assumption reinsurance transaction the "assuming company" replaces the "ceding company," which is the original insurance entity, so that after the transaction, only the assuming company is responsible to the policyholders. Exs. PW-7, at 6; DR-10 J 3.

Mr. Walther explained what he meant when stated that the agreements resulted in a novation. A novation in the insurance industry is the substitution of one insurer for another, so that only the assuming insurer has responsibility to the insured. From a ceding insurer's perspective, a novation relieves the ceding insurance company from its obligations to its insureds. From an assuming insurer's perspective, that reinsurer becomes the insurance entity which is deemed to have issued the original policies to the insureds. After a novation occurs, the insured loses the right to recover from the ceding company, but acquires the right to assert the same claims against the assuming company, which includes the right to obtain payment for losses that occurred before the assumption. The insured has the right to recover from the assuming company everything that could have been recovered from the ceding company from the inception of the original insurance obligation. Ex. PW-7, at 6-7.

Mr. Walther testified that failure to obtain regulatory approval of an assumption reinsurance agreement, under statutes such as § 38.2-136 that require consent of the policyholder, does not relieve the assuming company of its insurance obligations. In such circumstances, the policyholder may also be able to assert a claim against the ceding company. In the transactions he reviewed, ROA was the assuming company. In his opinion, ROA is still responsible for the claims of the GSIAs and SITs even if policyholder consent to the transactions was not obtained, or a novation in the traditional sense of assumption reinsurance was not achieved. Mr. Walter stated that the fact ROA's lawyers took the position that the GSIAs and SITs did not issue contracts of insurance or that ROA failed to comply with the regulatory requirements for an assumption reinsurance transaction had no impact on his opinion. Additionally, he stated that the fact ROA may not have accurately reflected the mergers or acquisitions on its Schedule Ps had no impact on his opinion. In his opinion, ROA was responsible for their insurance obligations back to the day the GSIAs or SITs were formed. Ex. PW-7, at 7-10; Tr. at 288-89, and 292-93.

Mr. Walther believes that as a practical matter anyone can enter into an insurance transaction; it is not restricted to licensed insurance companies. There are various types of insurance entities that assume risk in exchange for the payment of premium consideration. He opined that the GSIAs and SITs were recognized as legitimate insurance vehicles that had insurance obligations to their members. The members of the GSIAs and SITs pooled their obligations and entered into an insurance relationship with each other. The GSIAs' obligations to their members were created at the time the group was formed for the purpose of sharing their liabilities. Mr. Walther stated the certificates of workers' compensation coverage evidenced the insurance obligations of the GSIAs to their members. The certificates included elements of the insurance obligations, which include defining the coverage provided, putting limits on and making reference to the premiums to be charged, as well as the terms and obligations under which the entity assumed those obligations. In certain instances, the certificates referenced the National Council on Compensation Insurance ("NCCI") policy form. Mr. Walther was not aware if any of the GSIA or SIT programs were retrospectively rated. In looking at the programs, he noted that they were equivalent to a standard insurance policy arrangement whereby a premium is charged for coverage. The GSIAs and SITs used various elements of underwriting and pricing to determine the proper premium for the risk each of these entities assumed from their members. Mr. Walther identified the documents which allowed him to form his opinion. Exs. PW-7, at 7-8; DR-10, Tab A 1, DR-10, Tab B 1, DR-10, Tab D 1 through Tab K 1, DR-10, Tab F 2, DR-10, Tab G 2, DR-10, Tab I 2 through Tab K 2; Tr. at 285-88.

Mr. Walther stated each of the coverage documents he identified describe the matter to be insured, the risk insured, the commencement of the coverage period, the amount of coverage or insurance provided, and the premium or consideration, or a mechanism for calculating the premium or consideration. He also stated that the assumption agreements clearly set forth the intention of ROA to assume the insurance obligations of the various GSIAs and SITs. The assumption documents describe, by reference, the risks assumed by ROA, which were the obligations that the various entities had expressed in certificate form or otherwise to their members. The assumption documents describe by reference the amount of insurance to be provided, the commencement and period of the risk assumed, and the premium for the coverage. Tr. at 295-98.

Mr. Walther believes that by entering into the agreements, the GSIAs and SITs desired to transfer all their obligations, including their insurance obligations, to ROA, and to effect a novation or replacement of those obligations with obligations of ROA. ROA agreed to assume the insurance obligations from the GSIAs and SITs, and thereby effect a novation from the original inception date of those obligations. He also believes the transactions were intended to eliminate the joint and several liability of the members. Mr. Walther believes this transaction was an insurance transaction. There was an exchange and an assumption of risk on the part of ROA, namely, the uncertainty of loss. The consideration for assuming this uncertainty of loss was the acceptance of the assets that related to those risks. Ex. PW-7, at 8; Tr. at 288-89.

Mr. Walther identified the documents that evidenced the members' approval of the various assumption transactions. He stated that if the members failed to approve the transactions, ROA is still obligated to pay the claim, although the member may also seek recovery from the GSIA or SIT. Mr. Walther believes ROA should be considered the original insurance entity responsible for claims emanating from former members of the GSIAs and SITs. He further believes that by stepping into the shoes of the GSIAs and SITs, ROA created a direct insurance obligation to the members of those entities from the inception of the members' involvement in those entities. Any claims which occurred prior to the closing date of the assumption are claims attaching to ROA under the policy obligations, and constitute insurance obligations owed to the members of the entities and their claimants. Ex. PW-7, at 8-9; DR-11, Tab A; DR-11, Tab B 3; DR-11, Tab C through Tab I.

Mr. Walther opined that while there were certain known claims in the transactions, the ultimate duration and amount of the resulting liability could not be known at the time. Additionally, there was also the probability of significant unknown claims at issue. For these reasons, Mr. Walther believes the transactions included the transfer of risk to ROA. He further believes that, subject to the terms and conditions of the various state guaranty statutes, the Assumed Claims would be covered claims because ROA assumed insurance obligations, which became obligations under insurance contracts issued by ROA. ROA remained responsible for these insurance obligations when it became insolvent. When it entered into the assumption reinsurance or merger agreements, the effect was to issue ROA insurance contracts to the former members of the GSIAs and SITs. Ex. PW-7, at 9.

Mr. Walther stated that his opinions would remain the same if the GSIAs and SITs were not considered "insurance companies" under various state statutes. He believes the GSIAs and SITs assumed risk from their members and were recognized by various states as insurance-type entities. Additionally, his opinion would remain the same if the transactions were not subject to regulatory scrutiny. The GSIAs and SITs still entered into contracts of insurance or insurance obligations. Ex. PW-7, at 9-10.

Mr. Walther described his involvement with the *Bowles* case and the *SunHealth* case.[17] In both instances he was retained by the North Carolina Self-Insurance Guaranty Association to determine whether there had been informed consent and an assumption reinsurance transaction. Both cases involved an insurance company assuming the business written by a GSIA. In the Bowles case, Reliance Insurance Company ("Reliance") assumed the business of the Selective

[17]See, *Bowles v. BCJ Trucking Services*, I.C. No. 821763 (N.C. Indus. Comm'n, April 16, 2004); *See also supra* note 10.

Insurance Fund ("Selective"). Reliance was later declared to be insolvent. In that case, Mr. Walther opined that Reliance had stepped into the shoes of Selective and assumed the obligations of Selective back to its inception date. Consequently, Reliance was the insurance company of record on the claim in question. In the SunHealth case, Mr. Walther opined that ROA had stepped into the shoes of SunHealth with regard to SunHealth's policyholder obligations. In both instances the North Carolina Property and Casualty Insurance Guaranty Association was directed to pay the claims. Tr. at 275-78.

Mr. Walter disagrees with the Insurance Guaranty Associations' position that the Assumed Claims were known losses. He believes the transactions involved both outstanding losses and unreported losses. There were claims that may have been reported, but those claims had not been paid or settled. In addition, there may have been claims that had not been reported. In exchange for accepting those risks, ROA was entitled to the assets that pertained to those unknowns. Mr. Walther believes there was significant risk transfer by virtue of the assumption agreements. He determined that ROA could not collect additional premiums from the members to offset adverse loss development for the risks it had assumed. Tr. at 290-91.

Mr. Walther reviewed the transactions between ROA and Coastal. He opined that while there were certain known claims, there were also significant unknown claims at issue. The Coastal transaction was an assumption reinsurance transaction that transferred significant risk to ROA. ROA assumed all of the assets and liabilities of Coastal and assumed direct responsibility for the claims of the policyholders of A-HAT and HWCF. In his opinion, ROA stepped into the shoes of A-HAT and HWCF with respect to their obligations to their policyholders. Mr. Walther noted the respective policyholders approved the A-HAT and HWCF transactions. Accordingly, Mr. Walther believes the transactions constituted a novation, substituting ROA for A-HAT and HWCF. After the transactions with ROA, the policyholders of A-HAT and HWCF no longer had any responsibility for the claims of A-HAT or HWCF. Mr. Walther believes these transactions were not reinsurance, but the transfer of direct insurance. He believes that A-HAT and HWCF had a direct insurance obligation with their members, and the agreements with ROA did not change these insurance obligations. The obligations remained insurance obligations to policyholders arising from contracts of insurance after the transactions, just as they were before the transactions. Ex. PW-8, at 1-3.

On cross-examination, Mr. Walter stated the opinions he expressed apply equally to the C-HAT and K-HAT consolidations or mergers with ROA. He further stated that you do not need an authorized insurer to issue a contract of insurance. The fact that a policy may be assessable also would not change Mr. Walther's opinion that the contract is a policy of insurance. Tr. at 299-300.

Mr. Walther testified that he reviewed the transactions between ROA and the Coastal group, which included HWCF and A-HAT. He opined that while there were certain known claims, there were also significant unknown claims at issue. There was an assumption reinsurance transaction that included the transfer of significant risk from the Coastal group to ROA. ROA assumed all the assets and liabilities of the Coastal group, and assumed direct responsibility for the claims of the policyholders of HWCF and A-HAT. In his opinion, ROA stepped into the shoes of HWCF and A-HAT with respect to the obligations they had to their policyholders. Mr. Walther's understanding was that the policyholders of HWCF and A-HAT approved the transactions with ROA. He

believes the transactions with ROA constitute a novation whereby ROA was substituted for HWCF and A-HAT. After the transaction, HWCF's and A-HAT's members no longer had any responsibility for HWCF's or A-HAT's claims. Mr. Walther stated the transactions were not reinsurance transactions because there was no longer a party to reinsure; HWCF and A-HAT were going out of business as part of the transaction. In these cases, there was the transfer of a direct insurance obligation. Mr. Walther testified there was an insurance relationship between the members of HWCF and A-HAT and the entities themselves. The transactions with ROA did not change these relationships; the obligations remained insurance obligations to policyholders arising from contracts of insurance. Ex. PW-8, at 1-3.

Mr. Walther identified Exhibits DR-10, Tab A 1 and DR-10, Tab B 1 as the coverage agreements for HWCF and A-HAT. The agreements identify the subject matter being insured as well as the general terms and conditions of that insurance. The risks insured against were workers' compensation exposures in the case of HWCF and medical, professional, and general liability in the case of A-HAT. The agreements generally identify the commencement and period of risk undertaken by HWCF and A-HAT. The HWCF agreement provides for statutory workers' compensation coverage; the A-HAT agreement has limits on the medical, professional, and general liability coverage provided. Finally, Mr. Walther stated the agreements contain references to the premium and time at which it was to be paid. Tr. at 304-06.

Mr. Walther testified that he had spent most of his career in the reinsurance industry. He has never worked in a state insurance department, as an insurance regulator, or for a GSIA or SIT. He agreed that he was not an expert on workers' compensation coverage, insurance insolvencies, insurance guaranty fund issues, and group self-insurance associations. He further agreed that he was not qualified to give legal opinions since he was not trained as a lawyer. In those cases where he has testified as an expert, Mr. Walther has testified on reinsurance issues. Tr. at 309-10.

In this case, Mr. Walther was retained to review the 11 transactions at issue. He reviewed and analyzed the contracts and supporting documents relating to each of the transactions, and his opinions are based on that review. He did not rely on any journal articles or textbooks in formulating his opinion. Mr. Walther did some limited research into several elements of the Code of Virginia, specifically the sections dealing with the definition of insurance and reinsurance. He reviewed the National Association of Insurance Commissioners' Assumption Reinsurance Model Act, but he did not rely on the Act when he opined that the transactions were assumption reinsurance. Additionally, his opinion was not based on any statutory definition of assumption reinsurance. Mr. Walther has reviewed hundreds of reinsurance agreements during his career, but only five to ten of those agreements were assumption reinsurance. He agreed that assumption reinsurance transactions are not very common. Of the assumption reinsurance agreements that he has reviewed, two of those transactions involved a situation in which an insurer assumed the business of a GSIA. These two instances were the *Bowles* and the *SunHealth* cases. Mr. Walther confirmed that the *SunHealth* case is on appeal. Tr. at 311-17.

Mr. Walther testified that transferring a risk of loss with consideration for the acceptance of that risk is the essence of insurance. He agreed that there is a difference between a business risk and an insurance risk. Not all business risks are insurance risks, and risk retention is the opposite of risk transfer. He confirmed his position that the assumption agreements between ROA and the

GSIAs and SITs were contracts of insurance. Mr. Walther explained that the agreements represented an assumed reinsurance transaction where, for consideration, ROA assumed the insurance obligations the GSIAs and SITs had to their members. Tr. at 317-22.

Mr. Walther agreed that the certificates of membership issued by the GSIAs referenced that the certificates were subject to the terms and conditions of the indemnity agreement. He further agreed the indemnity agreement and power of attorney established the members' joint and several liability. Pursuant to the language in the agreement, one of the members could be liable for the entire group's losses. Mr. Walther believes one of the reasons the groups entered into the agreements with ROA was to eliminate the members' joint and several liability. If one of the members terminated its membership in the group, it would still be jointly and severally liable for claims arising during the period it was a member. Mr. Walther agreed that the members of the GSIAs and SITs were assessable. He further agreed that the GSIAs and SITs were not insurers under certain states' laws. He stated this fact had no impact on his opinion. Exs. DR-10, Tab F 2 and DR-10, Tab J 1; Tr. at 323-28.

Mr. Walther believes the members of the GSIAs and SITs did not retain their risk of loss. He believes the members purchased insurance by virtue of their certificates and the terms and conditions of the certificates were applicable to the members. The members paid premiums that were not commensurate with the ultimate liability faced by the members prior to the purchase. He believes there is a distinction between the insurance provided to the members and the nature of the entity providing the insurance. He agreed that the GSIAs and SITs were not like a traditional insurance company, but the members of the GSIAs and SITs pooled their risk like a traditional insurance company. Mr. Walther stated the indemnity agreements addressed how losses were distributed among the members, which was different than the evidence of coverage provided to the members. In a typical insurance arrangement, the policyholders do not enter into indemnity agreements binding themselves to joint and several liability. Mr. Walther agreed if a single employer self-insured, that would not be insurance. He is unsure whether any of the GSIA policies were retrospectively rated. With a typical retrospectively rated policy from an insurer, once the premium has been paid, the policyholder pays no additional premium for adverse losses. He stated this was the case with the members of the GSIAs and SITs. Typically, the premium for the next year is increased in accordance with the experience of the group. Tr. at 328-31, 335-36 and 339-40.

Mr. Walther believes the Virginia Bureau of Insurance was incorrect when it opined that HPG was not an insurer. He further believes the indemnity and the spreading of the risk principles are not lost with a GSIA. While there may be organizational differences between an insurer and a GSIA, Mr. Walther believes the insurance operations are similar in a number of respects. The Virginia Bureau of Insurance's opinion had no effect on Mr. Walther's opinions in this case. Tr. at 332-33 and 335-39.

Mr. Walther testified that in his opinion Exhibit DR-10, Tab J 3 has the characteristics of an assumption reinsurance agreement; the parties intended the agreement to create a novation of the insurance obligations from the GSIA to ROA, and the agreement sets forth the assumption of liabilities including insurance obligations. He agreed that the words "insurance obligations" do not appear in Section 1.3 (Assumption of Liability) of the agreement. Mr. Walther did not rely on any statutory definition of assumption reinsurance or the Assumption Reinsurance Model Act in

reaching his opinion. He stated that an assumption reinsurance agreement is an agreement between two parties, not necessarily two insurance companies, where there is a transfer of existing insurance obligations. Mr. Walther explained what he meant by insurance obligations, which may not in all cases be evidenced by a contract of insurance. He agreed that with respect to the novation element of an assumption reinsurance transaction; the notice and consent elements would have to be satisfied. He further agreed that the significance of a novation is that the obligations of the ceding company become direct obligations of the assuming insurer. In this case, the obligations are for accidents that occurred prior to the assumption transactions. Tr. at 340-48.

Mr. Walther testified that the indemnity agreements and power of attorney were terminated as of the date of the assumption transactions; ROA agreed to issue policies on a prospective basis; no obligations under the indemnity agreements or power of attorney were transferred to ROA; insurance obligations were transferred to ROA, but no specific insurance agreements were transferred to ROA. Tr. at 352-54.

Mr. Walther was unsure whether the policies issued by the GSIAs and SITs in Kentucky and North Carolina were cancelled and ROA issued stub policies for the remainder of the year. He believes the transactions were similar to all the other assumption transactions in which ROA stepped into the shoes of the GSIAs. Mr. Walther stated there are differences between an assumption reinsurance agreement and a loss portfolio transfer. He described a loss portfolio transfer as an arrangement in which a portfolio of business or losses is transferred from one insurer to another insurer. In this instance, the assuming insurer's obligations run to the ceding insurer and not to original the policyholders. Tr. at 348-52.

Mr. Walther agreed that after a novation, the policyholders' coverage remains the same, the effective date of the coverage remains the same, the nature of the insurance obligations or coverage remains the same, and whatever obligations existed prior to the effective date of the novation, also remain after the transaction. Mr. Walther further agreed that a novation could not create an insurance obligation where one had not previously existed. However, he is of the opinion that an insurance obligation existed between the GSIAs and SITs and their members. Mr. Walther is aware of the requirements for policyholder notice and consent in an assumption reinsurance transaction. His testimony did not address whether those notice and consent requirements were met in all 11 assumption transactions. Tr. at 355-59.

Mr. Walther testified that subject to each state's guaranty fund statutes, the Assumed Claims would be covered claims. He further testified that he was not an expert on guaranty fund issues, and he did not review the individual state guaranty fund statutes before offering his opinion. Mr. Walther believes ROA should be deemed to have directly issued the policies in question. By virtue of the assumption reinsurance agreement, he believes ROA is deemed to have issued the insurance policies to the members of the GSIAs and SITs, although ROA had not originally issued the policies. Mr. Walther confirmed that the GSIAs or SITs were not members of any insurance guaranty association. He also confirmed that neither the GSIAs nor the SITs were licensed as insurance companies, but they were authorized, in effect, to conduct the business of insurance under applicable state law. Mr. Walther stated his opinions were based on a review of the applicable documents and were not influenced by the fact ROA represented to various state regulators that the GSIAs and SITs were not insurance companies. Tr. at 359-65.

Mr. Walther explained the insurance concept of fortuity as an event that occurs without prior knowledge. He agreed that, in the case of the workers' compensation coverage, the event giving rise to the coverage had occurred prior to the assumption transactions. However, he did not agree that the liability for the claims was fixed at the time of the assumption transactions. Mr. Walther confirmed that, with the exception of Missouri, ROA did not issue any policies to the former GSIA and SIT members covering past losses. He based his opinion on the effect of the documents by which ROA assumed the business from the GSIAs and SITs. Tr. at 367-70.

On redirect, Mr. Walther agreed that an assumption re-insurer does not issue new policies, but merely assumes the policies that have been previously issued by the ceding company. In his review of the documents, he saw no instance in which a policy was terminated and a stub policy issued where the liability assumed by ROA was less than the liability incurred by the GSIAs or SITs. Mr. Walther confirmed that the opinions he stated in this case do not rely on whether the transactions comply with any assumption reinsurance regulations. Additionally, assuming HPG was not an insurer, would not have changed Mr. Walther's opinions regarding the underlying transaction between HPG and its members, and the reinsurance transaction between HPG and ROA. He confirmed that reciprocal insurers may issue assessable policies, but that does not change the nature of the insurance contracts that they issue. Tr. at 372-74.

On re-cross, Mr. Walther agreed that the issue in this case is not whether ROA has any liability, but the nature of the claim for which it has liability. He did not agree with the proposition that failure to comply with various assumption reinsurance statutes affected the nature of the policyholder liabilities assumed by ROA. Tr. at 376.

Mr. Walther was asked to read into the record portions of the Merger Agreement between C-HAT and ROA. In his opinion, C-HAT was relieved of any liability related to the assessable policies it issued when ROA assumed its business as part of the merger. Additionally, the policy change or termination language in the Merger Agreement had no effect on Mr. Walther's opinions. He was aware that no liabilities were excluded in the merger between C-HAT and ROA. As part of the merger, C-HAT and ROA entered into separate assumption of liability and indemnification agreements. Mr. Walther confirmed that the opinions he expressed also applied to the K-HAT merger. He agreed that the policies issued by K-HAT were claims-made policies which were not assessable. Additionally, he agreed that under the terms of the K-HAT agreement, ROA assumed "all of the terms, conditions and other provisions of K-HAT Policy No. 2053-97 issued to the named insured as if the company originally issued such K-HAT policy to the named insured," which covered claims made back to the inception of the K-HAT trust. Mr. Walther noted the same language was used with respect to the umbrella coverage assumed by ROA. He agreed that in addition to the Missouri program, ROA issued a policy of insurance that was retroactive to the inception date of the K-HAT trust. Tr. at 378-89.

The Kentucky Hospitals offered the testimony of four witnesses: Brian Brezosky, general counsel to the Kentucky Hospital Association and the senior vice president of the Kentucky Hospital Service Corporation ("KHSC"); George Meredith, chief executive officer of Twin Lakes Regional Medical Center; George Walz, chief executive officer of Breckinridge Memorial Hospital; and Mona Carter, national policy development executive with the NCCI.

Mr. Brian Brezosky testified that during his employment with KHSC, KHSC acted as the third-party administrator for C-HAT and K-HAT both pre- and post-merger. KHSC is a wholly-owned for-profit subsidiary of the Kentucky Hospital Association, which operates under the name Coverage Option Associates. He described KHSC as a third-party administrator for self-insured and other workers' compensation insureds or self-insured employers. After the merger with ROA, KHSC served as the third-party administrator for ROA's Kentucky book of business. In addition, KHSC is a full-lines insurance broker and provides various employee health benefit programs among the insurance products it offers. Ex. BB-10, at 1; Tr. at 391-92.

Mr. Brezosky testified that C-HAT was organized to provide workers' compensation insurance to hospital members of the Kentucky Hospital Association. C-HAT was formed as a self-insured group under Ky. Rev. Stat. § 342.350. At the time, C-HAT was considered to be an insurance carrier pursuant to Kentucky law. KHSC provided marketing, accounting, risk management, and claims management services to C-HAT. Mr. Brezosky identified Exhibit KH-3 as the C-HAT First Amended Trust Agreement which was dated April 24, 1996. He further identified Exhibit KH-48 as the workers' compensation certificate for C-HAT which provided the statutorily mandated workers' compensation coverage. Ex. BB-10, at 1-2; Tr. at 399-400.

Mr. Brezosky testified that C-HAT provided statutorily mandated workers' compensation coverage to the employees and volunteers of the hospitals. Each member hospital was provided a certificate of coverage. The risks insured against were workplace injuries to employees and volunteers at the hospital. Mr. Brezosky testified C-HAT's policies were issued on an annual basis, generally January 1 to December 31 of each year. If a hospital joined C-HAT mid-year, it would be issued a policy for the number of months until the January 1 renewal date. Mr. Brezosky confirmed that the member hospitals paid premiums for the risk insured for the coverage period provided. He stated that no member hospital had defaulted on its premium payments when C-HAT merged with ROA. He also confirmed that KHSC would review each of the foregoing criteria to determine whether coverage was in effect before paying a claim. After the merger, KHSC performed the same review for ROA. Tr. at 402-05.

Mr. Brezosky testified that K-HAT was organized to provide medical professional and general liability insurance as a self-insured group under Ky. Rev. Stat. § 304.48. K-HAT's members were also members of the Kentucky Hospital Association. Mr. Brezosky identified Exhibit KH-18 as the K-HAT Amended Trust Agreement which was dated December 28, 1994. He further identified Exhibit KH-21 as the insuring agreements for K-HAT. Ex. BB-10, at 2.

Mr. Brezosky stated that each member of K-HAT was insured. They were insured against the risk of medical professional liability of the hospital staff for medical malpractice, bodily injury occurring in the hospital, property damage, product liability, fire coverage, employee benefit liability, and limited pollution liability. K-HAT provided a specific amount of insurance specified in the policy, one million dollars per claim, three million dollars aggregate per year, and an umbrella above that at the request of the hospital. The coverage period ran from January 1 to December 31 of each year, and the members of K-HAT paid premiums for the coverage provided. At the time of the merger with ROA, no K-HAT member was in default in the payment of its premiums. KHSC reviewed each of the foregoing criteria before paying a claim. After the merger,

KHSC handled K-HAT claims as it had prior to the merger, with the exception that claims above a certain dollar threshold required ROA approval of any settlement. Tr. at 413-16.

Mr. Brezosky described the market conditions that led up to the merger of C-HAT and K-HAT with ROA. In the mid-1990's, the professional liability and workers' compensation insurance markets in Kentucky were becoming extremely soft. Due to extreme pricing differentials between traditional insurers and the GSIAs, both C-HAT and K-HAT were steadily losing insureds as the result of rate reductions in the professional liability commercial and workers' compensation markets. In contrast, Mr. Brezosky explained that C-HAT and K-HAT were formed in the late 1970's and early 1980's in response to extremely hard professional liability and workers' compensation markets. The cost and availability of commercial insurance during this period was extremely limited. In response, the Kentucky Hospital Association, along with several other hospital and medical associations across the country, formed trusts to provide insurance to its members which were having difficulty acquiring coverage in the commercial market. Ex. BB-10, at 2; Tr. at 398-99.

Mr. Brezosky testified that the C-HAT and K-HAT programs were extremely successful and financially sound up to the time of the merger with ROA. Both programs maintained stop-loss insurance and umbrella insurance, which KHSC procured on their behalf. Over the years, both programs returned several million dollars in dividends to their subscribing members. These dividends were declared by the boards of C-HAT and K-HAT during their annual rate reviews and were used to offset a member's premium for the following year. C-HAT and K-HAT employed the actuarial firm of Milliman & Robertson ("Milliman") to determine the rate needs for the following year, and the C-HAT and K-HAT boards always followed Milliman's rate recommendations. KHSC's underwriting staff would then take the total rate recommendations, which were made by book of business, and underwrite them to specific hospital risk based on the hospital's payroll and past loss factors for workers' compensation coverage, and bed exposures or equivalent bed exposures for professional liability coverage. In the mid-1990's, even with the dividend offsets, the C-HAT and K-HAT boards were unable to price their policies competitively. Both boards were faced with chasing an under-priced commercial market or losing members to that market over time. Both boards were aware that market conditions were cyclical, and they wanted to seek out a merger partner which would give them some control of their book of business when market conditions changed. Both boards instructed KHSC to make recommendations regarding a merger partner which would provide that capability. Ex. BB-10, at 2-3; Tr. at 400-01.

Mr. Brezosky testified that approximately one month before the merger with ROA, C-HAT held reserves in the amount of $19,123,000, surplus of $5,262,000, and $5,224,000 in written premium. K-HAT held reserves in the amount of $22,457,866, surplus of $11,377,000, and $7,922,000 in written premium. Mr. Brezosky stated that C-HAT and K-HAT's reserves, although reported on a GAAP basis, were redundant, meaning that there were more monies in reserves than actually needed to pay claims. Both boards believed their respective financial strengths placed them in a good position for any merger negotiations. When the Master Agreements with ROA were consummated, C-HAT transferred $2,134,000 in surplus and $19,123,000 in reserves, and K-HAT transferred $11,377,000 in surplus and $22,000,000 in reserves to ROA. Additionally, C-HAT and K-HAT transferred to ROA any stop-loss insurance recoveries that would have been due on claims arising in prior years. Ex. BB-10, at 3; Tr. at 406 and 453-54.

Mr. Brezosky explained the selection process used by both boards to select a merger partner. As the manager for C-HAT and K-HAT, KHSC sent requests for proposals to dozens of commercial insurance carriers located throughout the United States. Upon receipt of the responses, four or five insurance carriers were selected to make presentations to the boards. At the conclusion of this process, ROA was selected as the merger partner. Mr. Brezosky was directly involved in negotiations with ROA on the major aspects of the merger and master agreement. The boards obtained a fairness opinion from Duff & Phelps prior to approving the merger. Mr. Brezosky identified Exhibit KH-4 as C-HAT board's recommendation to approve the termination and liquidation of C-HAT upon the closing of the merger with ROA. He further identified Exhibit KH-14 as C-HAT board's letter advising its members that the merger had been completed and C-HAT was being dissolved. Both C-HAT and K-HAT were merged into ROA and the members of C-HAT and K-HAT were relieved of all liabilities which were assumed by ROA as policyholder claims. Ex. BB-10, at 3-4; Tr. at 399.

Mr. Brezosky testified approvals of the C-HAT and K-HAT mergers were obtained from the Kentucky Department of Insurance and the Kentucky Department of Workers' Claims, as well as the Federal Trade Commission. He identified the various documents associated with those approvals. Of particular note, are the opinion letter of C-HAT's counsel that the members of C-HAT would have no responsibility with respect to the Assumed Claims after the closing date, and the Kentucky Department of Workers' Claims order approving the merger which stated: "the Department of Insurance has confirmed that [Ky. Rev. Stat.] Chapter 304 Guaranty Fund will cover past and incurred claims of C-HAT as well as future claims of [ROA] as 'covered claims' under the insurance code." As part of the mergers, C-HAT and K-HAT's members were relieved of any further liability regarding the assumed claims. ROA assumed all coverage obligations, including known claims and expenses, and claims incurred but not reported. Ex. BB-10, at 3-6; Exs. KH-45, 20, 6, 7, 8, 9, 25, 26, 10, 11, 17, 16, 23, 24, 29, and 27; Tr. at 407-08, 412, and 420-21; Tr. at 447.

Mr. Brezosky testified that C-HAT's members voted to approve the merger with ROA at a special meeting and through proxies. He further testified that there were no negative responses or objections from any members or former members of C-HAT. After the merger was completed, a Notice of Policy Termination was issued to all C-HAT members regarding their C-HAT policy, and ROA issued new policies as of the merger date. ROA assumed all rights and interests of C-HAT under such policies or coverages provided by C-HAT as of the date of the closing as though the policies were issued by ROA. Mr. Brezosky agreed that at no time has ROA treated the Assumed Claims as anything other than claims of policyholders of ROA. Mr. Brezosky identified the Notice of Policy Termination and the new workers' compensation policy issued by ROA for one of C-HAT's members, St. Claire Medical Center. Ex. BB-10, at 6-7; Exs. KH-5, 12, and 30.

Mr. Brezosky testified that the members of K-HAT approved the merger with ROA through a member vote at a special meeting and through proxies. He further testified that no negative responses or objections were received from any members or former members of K-HAT. He agreed that at no time has ROA treated the Assumed Claims as anything other than claims of policyholders of ROA. Mr. Brezosky identified the ROA comprehensive hospital liability policy issued to Gateway Regional Medical Center. The stated policy period was November 1, 1997 to

January 1, 1998, but the policy was retroactive to June 29, 1984. Ex. BB-10, at 7; Exs. 19 and 22; Tr. at 427.

Mr. Brezosky described the risks transferred by C-HAT and K-HAT and assumed by ROA as substantial. The most significant risk was that the surplus and equity received might be insufficient to pay the ultimate losses that might occur. There was risk that the claim reserves that had been established would be inadequate to pay the claims, and that the reserves established for the incurred but not reported claims might be insufficient. Tr. at 417-19.

Mr. Brezosky testified the Executive Summary of the merger provided to the members of C-HAT and K-HAT advised that ROA was assuming all of their liabilities. Pursuant to Exhibits KH-1.4 and 2.4, ROA agreed to assume and become responsible for all assumed liabilities at the closing date. The agreements defined assumed liabilities as all obligations of C-HAT and K-HAT in connection with its business, the conveyance and delivery of the transferred assets, and any related transactions, except for the excluded liabilities. Mr. Brezosky confirmed that there were no liabilities excluded in the agreements. As part of the merger, ROA agreed to indemnify C-HAT and K-HAT. After the merger, C-HAT and K-HAT were liquidated and dissolved. KHSC then functioned as the administrative arm, handling claims processing and risk management for ROA. Mr. Brezosky dealt with every Kentucky hospital insured by C-HAT and K-HAT prior to the merger and thereafter until the liquidation order was entered. He stated that KHSC maintained the records of C-HAT and K-HAT; Mr. Brezosky had direct contact with ROA concerning the assumed liabilities and treatment of claims. Mr. Brezosky learned that the Assumed Claims were not going to be treated as policyholder claims after the Commission ordered ROA liquidated. Ex. BB-10, at 7-9; Exs. KH-28, 1.2 and 2.2; Tr. at 405, 412.

Mr. Brezosky identified the C-HAT policy documents and the K-HAT certificates of insurance for the record. Exs. KH-50 and 51; Tr. at 421-426.

On cross-examination, Mr. Brezosky testified that in addition to the certificate of coverage, all C-HAT members were subject to the trust agreement. Pursuant to that agreement, all members were assessable. Mr. Brezosky agreed that C-HAT was formed to allow members of the Kentucky Hospital Association to form an association or enter into an agreement to pool liabilities to qualify as a group workers' compensation self-insurer. He agreed that C-HAT was formed pursuant to the Kentucky workers' compensation statutes as an insurance carrier and not as an insurance company pursuant to its insurance code. Exs. KH-48 and KH-3; Tr. at 432-36.

Mr. Brezosky confirmed that the issues stated on C-HAT's proxy were the only two issues the members were asked to approve. Essentially, the members were voting to approve the transaction, provided the transaction took place according to its terms, which did occur. As part of the agreement, the existing in-force coverages were terminated and new policies were issued by ROA. Ex. KH-5; Tr. at 436-39.

Mr. Brezosky identified the coverage document for K-HAT members. K-HAT members were subject to the terms of an amended trust agreement, whereby the members were assessable. Additionally, the members were jointly and severally liable for liabilities incurred by the trust for the period of their membership. The trust agreement provides that a member is not relieved of such

joint and several liability except through payment of the liabilities by the trust or the member. Mr. Brezosky confirmed that K-HAT was formed to address commercial insurance rates that exceeded the loss experience of Kentucky hospitals. Ex. KH-21 and KH-18; Tr. at 439-441, and 442-43.

Mr. Brezosky testified that the issues stated on K-HAT's proxy were the only two issues the members were asked to approve. Essentially, the members were voting to approve the transaction, as long as the transaction took place according to its terms, and then to liquidate K-HAT. Ex. KH-19; Tr. at 443-45.

Mr. Brezosky confirmed that the members of C-HAT and K-HAT were not covered by the Kentucky Insurance Guaranty Association ("KIGA"). This fact was stated in the coverage agreement. The members of C-HAT and K-HAT did not pay guaranty fund assessments, which was one of the cost savings achieved. Ex. KH-21; Tr. at 441-42.

Mr. Brezosky testified that it was his understanding that the term "self-insured" or "self-insurance" used in the C-HAT trust agreement meant that a licensed insurance company was not issuing a workers' compensation policy. It did not mean that no risk was being pooled, shared, or transferred among members. Mr. Brezosky believes risk was being pooled and transferred among the members of C-HAT. After the merger with ROA, C-HAT and K-HAT's members were no longer assessable. Mr. Brezosky could think of not a single instance in which a member would have to pay ROA additional monies once ROA became responsible for the liabilities. Even if a member terminated its membership in the trust before the merger date, ROA assumed that member's liabilities and could seek no further monies from the former member to pay those liabilities. Mr. Brezosky's understanding is that ROA assumed all of the liabilities of the trust, those that arose prior to the transaction and those that might occur after the transaction. These liabilities became the sole and exclusive liabilities of ROA. Mr. Brezosky could think of no claim that might have arisen prior to the merger that would not have become a liability of ROA. Ex. KH-3; Tr. at 448-52.

Mr. Stephen Meredith testified that for the past 23 years he has served as the chief executive officer of Twin Lakes Regional Medical Center. He also served on C-HAT's board of directors from 1987 until 1997 when it merged with ROA. Mr. Meredith described C-HAT as a hospital workers' compensation group self-insurer organized pursuant to the Kentucky Workers' Compensation Code. C-HAT provided workers' compensation liability coverage to certain hospitals in Kentucky, including his hospital, as permitted under Kentucky law. He explained the principal purpose for the establishment of C-HAT was to provide for the orderly presentation, examination, investigation, defense or settlement of statutorily mandated workers' compensation claims made against the members. Mr. Meredith identified the trust agreement that established C-HAT in 1986. Ex. SM-11, at 1-2; Ex. KH-3; Tr. at 455-56.

Mr. Meredith stated that it is a matter of semantics whether the Kentucky hospitals were self-insured or fully insured for their workers' compensation coverage. By law, the hospitals were required to have workers' compensation insurance for employees; the Kentucky legislature has provided several mechanisms for obtaining that coverage, but the end result is the same. He identified the workers' compensation risk and how the member hospitals addressed that risk by assessing premiums to their members. The premiums were pooled to protect all of C-HAT's

members. In Mr. Meredith's opinion, C-HAT had all the attributes of an insurance company: risks were identified, assets were assigned to those risks, rates were actuarially set, reserves were established to pay claims, and both incurred but not reported and reported claims were evaluated. Mr. Meredith believes C-HAT acted as an insurer under Kentucky law by providing workers' compensation insurance coverage to its members. Tr. at 471-73.

Mr. Meredith testified that he was familiar with K-HAT, but was not directly involved in K-HAT's operations. His hospital had its medical professional liability coverage with K-HAT. He explained that C-HAT's board of directors held its meetings separately from K-HAT's board, although the boards held joint meetings on occasion. Mr. Meredith believes there was only one director that served on both boards. He described the functions performed by C-HAT's board, noting that the primary function was to ensure C-HAT's financial solvency. The board engaged actuaries to review C-HAT's past claims history and to project future claims. Based on this information, the board would establish the total premium for the program, and authorize KHSC to develop premium quotes for individual members. Ex. SM-11, at 2; Tr. at 457 and 465.

Mr. Meredith was involved with the merger transaction with ROA. He participated in the negotiations with ROA, reviewed the transaction documents, and was involved in all stages of the transaction. He explained the insurance climate leading up to the merger. In the mid-1990's, the market for workers' compensation insurance had become extremely competitive; workers' compensation insurers were deeply discounting their rates to attract new business. This resulted in a substantial price disparity between coverage in the commercial market and coverage from self-insured groups such as C-HAT. As a result, C-HAT's membership was declining as members switched their coverage to the commercial market. The C-HAT board was concerned that if the declining membership trend continued, the C-HAT program would be unable to maintain the critical number of member hospitals necessary to achieve the economies of scale essential to offer workers' compensation insurance coverage at prices competitive with the commercial market. This trend would have led to the demise of the C-HAT program. Because of the market conditions that led to the formation of C-HAT, the board explored ways to maintain control over the C-HAT program should an insurance availability crisis arise in the future. The board directed KHSC to explore the possibilities of a merger or buy-out of the C-HAT program. This culminated in solicitations from several potential insurance partners, including ROA. Mr. Meredith identified the Executive Summary of the Merger Proposal and the minutes of a joint C-HAT and K-HAT Board Meeting. Ex. SM-11, at 3-4; Exs. KH-28 and 43; Tr. at 463-64 and 466-67.

Mr. Meredith explained the reasons that C-HAT decided to merge with ROA. It appeared to the board that the structure and philosophy of ROA closely mirrored the existing C-HAT program, which included the continued involvement of member hospitals. Equally important to the board was the continued involvement of KHSC as the third-party administrator for ROA's C-HAT book of business. The board believed this offered a number of options if coverage was limited again in the commercial market, or something unforeseen happened to ROA. ROA represented to C-HAT's board that with the transfer of C-HAT's assets, ROA would assume all of C-HAT's liabilities; establish an equity account for each C-HAT member; relieve C-HAT's members of any further liability with respect to the liabilities assumed by ROA; and C-HAT's members would no longer be assessable for the liabilities assumed by ROA. Mr. Meredith stated that, as a hospital administrator and C-HAT board member, he would not have agreed to the merger had those

representations not been made. He noted that the merger involved the transfer by C-HAT of over $21 million in assets to ROA. The goal of the C-HAT board was to ensure that ROA assumed a comparable liability, and that C-HAT members would have no liability exposure after the merger. Ex. SM-11, at 4; Tr. at 467-70.

Mr. Meredith identified the Master Agreement that resulted in the merger of C-HAT and ROA. He explained that under Sections 2.1 and 2.3 of the agreement, ROA acquired all of C-HAT's assets and assumed all of C-HAT's liabilities. This included ROA's assumption of all reserves for claims of C-HAT members, including but not limited to incurred claims, incurred but not reported claims, as well as claims subject to re-opening. Mr. Meredith explained that it was the intent of all parties involved in the merger, that C-HAT would cease to exist and that all of its liabilities, past, present, and future would be assumed and paid by ROA as policyholder claims of ROA. He further explained that this intent was evidenced by the transfer of assets from C-HAT to ROA with the approval of the Kentucky Department of Insurance, the Kentucky Department of Workers' Compensation, and the Federal Trade Commission. Mr. Meredith further explained that it was explicitly stated at the members' specially called meeting on October 23, 1997, that approval of the merger would transfer substantially all of C-HAT's assets and liabilities to ROA. Considering the financial strength of C-HAT at the time of the merger, C-HAT's membership would not have transferred the assets of the program without an understanding that the liabilities of the program would also be assumed by ROA without any further liability of C-HAT and its members. Mr. Meredith stated that C-HAT had a financial surplus of $5,262,000 on $5,244,000 in written premium. Ex. SM-11, at 5-6.

Mr. Meredith confirmed that after the merger, C-HAT's members retained no liability. He cited Section 2.3 of the Master Agreement which provides that neither C-HAT nor its members would have any responsibility with respect to any of the liabilities for coverage written by C-HAT. Also in Section 2.3, it was understood that the ROA coverage replaced all coverage previously written by C-HAT, with no off-sets or retention by C-HAT's members. Mr. Meredith believes that Section 2.3 of the Master Agreement makes it clear that ROA was directly responsible for the Assumed Claims. ROA assumed the liability for all of C-HAT's existing and incurred but not reported claims. Mr. Meredith further relied on Section 2.5 of the Master Agreement for support. This section provides that "[ROA] shall assume and exercise all rights and interests of C-HAT under policies issued or coverages provided by C-HAT as of the Closing." Mr. Meredith believes this was a direct insurance relationship and not a reinsurance relationship because C-HAT was being dissolved as part of the transaction. He explained that after ROA assumed all of C-HAT's assets and liabilities, C-HAT no longer had any obligations to its members and it dissolved and ceased to exist. He identified the document that dissolved C-HAT. Ex. SM-11, at 6-7; Ex. KH-46.

Mr. Meredith identified the closing certificates signed by C-HAT and ROA, and the Indemnification Agreement. He further identified the Bill of Transfer and Assumption Agreement. Ex. SM-11, at 6-7; Exs. KH-1.2, 1.7, 1.8, 1.3, and 1.4.

Mr. Meredith described the process C-HAT followed to obtain the approval and consent of its members to merge with ROA. After the C-HAT board decided to recommend approval of the merger, it conducted a due diligence review by seeking and obtaining opinions and concurrence in its actions from the Kentucky Department of Insurance, the Kentucky Department of Workers'

Compensation, and the Federal Trade Commission. C-HAT retained outside counsel to assist with the regulatory filings. After the regulatory approvals were obtained, C-HAT called a special meeting of its membership to vote on the proposed merger. At the meeting, C-HAT's members voted on whether to transfer substantially all of C-HAT's assets and liabilities to ROA, and for C-HAT's members to become subscribers of ROA, with a corresponding subscriber's equity account in ROA. Mr. Meredith explained that those members who did not attend the special meeting voted by proxy. He identified the informational material and the proxy sent by the board to C-HAT's members. He also identified the returned proxy ballots and the agenda of the special meeting where the proxies were tallied. He testified that C-HAT's members voted unanimously to authorize the C-HAT board to execute the merger transaction with ROA. He further testified that all of C-HAT's members became subscribers of ROA. Ex. SM-11, at 8-9; Exs. KH-4, 5, and 44; Tr. at 467 and 471.

Mr. Meredith explained that after the C-HAT members approved the merger, Section 2.2 of the Master Agreement required ROA to establish equity accounts to recognize past equity surplus in C-HAT of each member or former member. Additionally, the Kentucky member hospitals were given proportionate representation on ROA's board of directors and board committees. Pursuant to Section 3.4, ROA was required to deliver an Indemnification Agreement and insurance coverage to C-HAT's members. Mr. Meredith further explained that following the merger, C-HAT's former members looked exclusively to ROA for the payment of all claims, past and present, and for the establishment of the necessary surpluses to pay future claims. In instances in which stop-loss limits were reached on specific claims formerly covered by C-HAT, the payments from the stop-loss insurer were transferred to ROA to assist ROA in meeting its financial responsibility for the assumed liabilities. KHSC continued in its role as third-party administrator for ROA's C-HAT book of business, but all claims were the liability of ROA and payment was expected from ROA by the Kentucky hospitals. Mr. Meredith identified ROA's Subscriber Agreement and Power of Attorney. Ex. SM-11, at 10-11; Ex. KH-31.

Mr. Meredith described the hardship placed on C-HAT's former member hospitals by the guaranty associations' refusal to cover the Assumed Claims. Since C-HAT's members transferred all of C-HAT's assets to ROA, the hospitals are now faced with drawing from their own financial surpluses, if they exist, to meet obligations to workers' compensation claimants, obligations which the hospitals were relieved of when C-HAT merged with ROA. Mr. Meredith stated the continuing nature of a workers' compensation injury may cripple a hospital's financial position for years to come if the hospital were required to pay the claim directly. Besides the financial hardship, Mr. Meredith also raised the ethical and moral dilemma faced by the hospitals in that there is a recognized obligation to compensate employees injured in the workplace. The Kentucky hospitals met that obligation through the transfer of C-HAT's assets to establish equity accounts in ROA and the payment of premium dollars to ROA. Mr. Meredith believes the current situation places Kentucky hospitals in double jeopardy, assuming a liability which legally should not be theirs and compromising the financial integrity of the hospitals. Ex. SM-11, at 11-12.

Mr. Meredith provided his personal knowledge of the impact of ROA's insolvency on his hospital. In deciding whether to vote for approval of the merger with ROA, Mr. Meredith relied heavily on the opinion of the Kentucky Workers' Compensation Commissioner that the Assumed Claims would be covered by the Kentucky Insurance Guaranty Association ("KIGA"). His hospital

has had one claim that has not been covered by KIGA. This has created both a legal and a moral dilemma for his hospital. The people in his small rural community do not understand the legal proceedings currently pending before the Commission. Mr. Meredith finds it difficult to tell a healthcare worker who has been injured on the job that the hospital has met its obligation for providing workers' compensation coverage, and the hospital will not be providing services directly to the injured worker. Many in the community question whether his hospital is meeting its moral and legal obligations to the injured worker. Mr. Meredith knows that other Kentucky hospitals are facing the same dilemma. Tr. 473-75.

On cross-examination, Mr. Meredith testified the workers' compensation coverage certificate issued by C-HAT had an estimated annual member contribution for the coverage and that contribution was subject to a final yearly audit. In addition to the coverage certificate, C-HAT members were also subject to the terms and conditions of the C-HAT trust agreement. Mr. Meredith confirmed that the annual contribution and special assessment section of the trust agreement did not mention the term "premiums." The trust agreement provided that if contributions were insufficient to pay all claims, the trustees were authorized to impose a special assessment, and all members were jointly and severally liable for the trust's claims. He confirmed that one of the stated purposes of the trust was to "formulate, develop, and administer a program of self-insurance for the members of the Kentucky Hospital Association." He also confirmed that another stated purpose of the trust was to assist Kentucky Hospitals to qualify as self-insurers. Ex. KH-3; Tr. at 491-95.

Mr. Meredith identified the two issues in the proxies sent to C-HAT's members for a vote.[18] He confirmed that the members were voting to approve the transaction, so long as it occurred pursuant to the terms of the Master Agreement. Ex. KH-5; Tr. at 496-98.

Mr. Meredith testified that prior to the merger with ROA, the Kentucky member hospitals made contributions to C-HAT and in return the members expected to get workers' compensation coverage for their employees. He believes those contributions were the equivalent of premiums that would be paid to a traditional insurance company. For accounting purposes, his hospital expensed the contributions as an insurance expense. Mr. Meredith believes the term "self-insurance" used in the trust documents describes how the premiums in the program were to be funded. He described the two options available to a hospital: either use a traditional insurer and pay the premium, or have a self-insured trust and pay the premium to the trust. He confirmed that the C-HAT trust pooled the assets of its members to meet the pooled liabilities of its members. Tr. at 499-501.

Mr. Meredith explained the method C-HAT used to assess its members the premiums for the workers' compensation coverage. In August or September preceding the anniversary date of the policy, C-HAT sent its members a form asking them to identify the structure of their payroll. The hospital would recognize the amount of its clerical, professional, and all other salaries. This

[18]C-HAT's Board of Trustees unanimously recommended a vote for the following proposals: (1) a proposal to approve and adopt the master agreement among C-HAT, ROA, and others pursuant to which C-HAT will transfer all of its assets and liabilities to ROA, and C-HAT's members will become subscribers of ROA, having equity accounts with ROA; and (2) if the master agreement is approved, a proposal to terminate and liquidate C-HAT in accordance with Article XVIII of C-HAT's first amended trust agreement, dated April 24, 1996, and applicable law, but only if the transactions described in the master agreement are completed. *See*, Ex. KH-5.

estimated payroll was used by C-HAT to calculate a member's premiums for the coming year. At the end of the year, an audit was performed to confirm whether the hospital's actual payroll matched its estimated payroll. ROA followed this same procedure after the merger. Tr. at 502-03.

Mr. Meredith confirmed that to the best of his knowledge, every C-HAT member hospital either returned a proxy, or voted in person at the special meeting to approve the merger with ROA. Tr. at 504.

Finally, Mr. Meredith confirmed that under Kentucky law, the payment made by a C-HAT member hospital for workers' compensation coverage is deemed to be a premium. Tr. at 504.

Mr. George Walz testified he is the chief executive officer of Breckinridge Memorial Hospital and he also served on K-HAT's board of directors from 1978 until K-HAT merged with ROA in 1997. He explained that K-HAT was a hospital liability self-insurance group organized pursuant to the Kentucky Insurance Code. K-HAT was formed in 1977 by four Kentucky hospitals after all the commercial medical malpractice insurers left the state. K-HAT provided professional liability coverage to its member hospitals, as permitted under Kentucky law. Mr. Walz explained that K-HAT's operations involved the transfer of risk. K-HAT was established to provide for the orderly presentation, examination, investigation, defense or settlement of professional liability claims made by third parties against K-HAT's members. K-HAT's members understood that the trust provided insurance to its members through the issuance of policies of insurance as an insurer. Mr. Walz identified the K-HAT Amended Trust Agreement and the K-HAT Professional and General Liability Coverage Policy. Ex. GW-12, at 1-2; Exs. KH-18 and 21; Tr. at 505-06.

Since he was a member of K-HAT's board at the time of the merger, Mr. Walz participated in the negotiations with ROA, reviewed the transaction documents, and was involved at all stages of the transaction. Mr. Walz described the market conditions that led up to the formation of K-HAT. In the mid-1990's, the medical malpractice market in Kentucky became extremely soft. During this period, K-HAT employed a strategy of abating premium increases with retroactive dividend offsets. Even so, K-HAT found it increasingly difficult to compete with commercial insurers and retain its members, who were actively price shopping their malpractice coverage. K-HAT was also being pressured by members who questioned its inability to insure hospital-affiliated physicians. Mr. Walz stated K-HAT was still a financially solid entity, but the board concluded that K-HAT should seek a merger partner or an affiliate relationship. K-HAT's board spent two years exploring various business combinations with several other entities. The board narrowed the field to Michigan Physicians Mutual, which had recently absorbed the Kentucky Medical Insurance Company, and ROA. Mr. Walz identified the Executive Summary of the K-HAT and ROA merger proposal and the minutes of the joint K-HAT and C-HAT board meeting in which the merger was approved. Ex. GW-12, at 3-4; Exs. KH-28 and 43; Tr. at 509-10.

Mr. Walz explained why K-HAT decided to merge with ROA. In addition to the organizational and cultural considerations that favored ROA, it became clear to K-HAT during the evaluation process that a merger with ROA would retain the independence and autonomy of the Kentucky book of business. Operational decisions, including setting the rates for the Kentucky book of business would be made by the Kentucky Committee subject only to a 2/3 majority veto by the ROA board of directors. Additionally, with the surplus contribution from K-HAT to ROA, the

Kentucky book of business received 20% representation on ROA's board. Additional factors supporting the merger included: lower reinsurance costs; increased investment income; and access to a physician insurance vehicle. Mr. Walz testified that representations made by ROA's management to the joint boards of K-HAT and C-HAT also influenced the decision to recommend approval of the merger. ROA's management represented that K-HAT members' assessability would be extinguished upon the merger with ROA. Without such a representation, Mr. Walz believes the K-HAT board would not have recommended approval of the merger. Mr. Walz identified the Master Agreement that effected the merger of K-HAT and ROA. Ex. GW-12, at 4-5; Ex. KH-2; Tr. at 510-11.

Mr. Walz explained that pursuant to Sections 2.1 and 2.3 of the Master Agreement, ROA acquired all of K-HAT's assets and assumed all of K-HAT's liabilities. In addition, ROA assumed all of the reserves for the pending claims of K-HAT's members. Mr. Walz further explained that pursuant to Section 2.3 of the Master Agreement, neither K-HAT nor its members had any responsibility with respect to any of the liabilities associated with the coverage written previously by K-HAT. It was understood that ROA took responsibility for all coverage written previously by K-HAT, with no offsets or retention by K-HAT's members. Section 2.5 of the Master Agreement provided that upon the closing date or on the renewal date of the policies or coverages of K-HAT's members, ROA would issue insurance policies or coverages to K-HAT's members on terms and conditions similar to the policies or coverages provided to the members as of the time of the closing. Section 2.5 also provided that "[ROA] shall assume and exercise all rights and interests of K-HAT under policies issued or coverages provided by K-HAT as of the Closing."[19] Mr. Walz explained that following the transfer of K-HAT's assets and reserves, ROA assumed liability for all of K-HAT's existing and incurred but not reported claims. He believes ROA assumed direct responsibility for the Assumed Claims. It was impossible to have any form of reinsurance because K-HAT was being dissolved as part of the transaction and there was no entity left to reinsure. After K-HAT no longer had any obligations to its members because of ROA's assumption of all its liabilities, K-HAT was dissolved and its charter was cancelled by the Kentucky Department of Insurance. Mr. Walz identified the Indemnity Agreement between K-HAT and ROA, the Bill of Transfer and Assumption Agreement, the closing certificates signed by K-HAT and ROA, and the Professional and General Liability Policy issued by ROA to K-HATs former members. Ex. GW-12, at 5-7; Exs. KH-2, 2.2, 2.3, 2.4, 2.7, 2.8, and 22; Tr. at 511.

Mr. Walz described the process K-HAT followed to obtain its members' approval and consent of the merger with ROA. K-HAT retained outside counsel to handle the regulatory filings with the Kentucky Department of Workers' Claims, the Kentucky Department of Insurance, and the Federal Trade Commission. K-HAT's outside counsel also sent a letter to all of K-HAT's members explaining the merger transaction with an enclosed proxy to vote for or against the merger. Mr. Walz testified that all 60 members of K-HAT voted in favor of the merger with ROA, and all current and former members became subscribers of ROA. Mr. Walz identified the K-HAT proxies and the agenda for the joint K-HAT and C-HAT meeting in which the proxies were tallied. Mr. Walz is aware of no K-HAT member objecting to the merger with ROA. Ex. GW-12, at 7-8; Exs. KH-19 and 44; Tr. at 511-12.

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[19] *See*, Ex. KH-2.

Mr. Walz testified that after the closing of the Master Agreement, ROA established and maintained an equity account for every subscriber previously insured through K-HAT. He further testified that Section 2.2 of the Master Agreement provided that the value of each member's equity account would be adjusted periodically to reflect the relationship of the Kentucky book of business to the combined surplus of ROA. Mr. Walz explained that after the merger, ROA paid all the former K-HAT members' claims; any stop-loss receivables due on K-HAT claims were transferred to ROA. Mr. Walz stated that after the merger, KHSC continued to do the administrative claims processing and risk management for the Kentucky book of business. The payment of all claims was the liability of ROA and the Kentucky subscribers expected payment from ROA. Mr. Walz is aware that there are substantial outstanding claims of at least one former K-HAT member, claims which everyone understood at the time of the merger would be policyholder claims of ROA. Ex. GW-12, at 9-10; Exs. KH-28 and 31.

On cross-examination, Mr. Walz confirmed that K-HAT was a group self-insurance trust made up of hospitals that pooled their liabilities. He agreed the self-insured members of the trust were subject to the amended trust agreement and the document providing the professional and general liability coverages. He agreed the members were both assessable and jointly and severally liable for the trust's liabilities. If a member terminated its membership, it remained jointly and severally liable for the claims incurred during its period of membership. He confirmed that K-HAT was formed to avoid the high cost of malpractice insurance and to have individual member equity accounts in the trust. He stated the general feeling at the time was that the cost of malpractice insurance in Kentucky was being unduly influenced by other areas of the country. The goal for the hospitals was to obtain insurance at cost. He supposed that one of the cost savings achieved by K-HAT members was not paying guaranty fund assessments. Finally, Mr. Walz confirmed the two proposals included in the proxies sent to members were the only ones the members voted on as part of the transaction with ROA. Exs. KH-18 and 21; Tr. at 513-18.

Mr. Walz confirmed that after the transaction, K-HAT's former members had equity accounts at ROA. He confirmed that claims of K-HAT members who had terminated their membership prior to the closing of the transaction were also assumed by ROA. Mr. Walz understood that terminated members no longer had any responsibility for their claims. He also understood that K-HAT's members were pooling and assuming each other's risks. He noted that K-HAT transferred approximately $30 million in assets to ROA, and in return ROA assumed all of K-HAT's claims and liabilities. Mr. Walz understood that after the merger, K-HAT had no liability for any pre-merger claims. Tr. at 519-21.

Mr. Walz provided his personal account of the hardship arising as a result of the treatment of the Assumed Claims. He knows of eight or nine outstanding claims pre-dating the merger that are not being covered. For the not-for-profit hospitals that participated in K-HAT, Mr. Walz believes those outstanding claims create a hardship for the hospitals. Tr. 522-23.

Ms. Mona Carter testified she is currently employed as national policy development executive NCCI. NCCI is a data and statistical organization which aggregates and analyzes workers' compensation data in 38 states to assist those states with their workers' compensation insurance market. Ms. Carter was formerly employed by the Kentucky Department of Insurance (the "Department"), serving as the director of the Property and Casualty Division from 1994 to

1999 and deputy commissioner of insurance from 1999 to 2002. Prior to her employment with the Department, Ms. Carter owned her own insurance agency and was also a registered representative for Metropolitan Life. She has significant experience in the insurance industry and is currently involved with several committees of the National Association of Insurance Commissioners ("NAIC"). Ex. MC-13, at 1-3; Tr. at 526 and 531-32.

Ms. Carter explained that until 1996, the Department had no responsibility over self-insureds. In 1996, the Kentucky legislature passed a workers' compensation reform law which provided that a GSIA, statutorily authorized to write workers' compensation insurance coverage in Kentucky, is an insurance carrier for purposes of the Kentucky Workers' Compensation Act. Ms. Carter further explained this change required the establishment of a guaranty fund, and also required the Department, along with the Department of Workers' Claims, to monitor GSIAs operating in the state. In particular, the two departments were concerned with the financial solvency of the GSIAs. Ms. Carter was directly involved in developing the memorandum of understanding between the Department and the Department of Workers' Claims in which the two departments pledged to cooperate to ensure the financial strength of GSIAs operating in the state. She described the working relationship between the two departments as encompassing a variety of issues. The Department reviewed everything leading up to the issuance of the policy, which included regulation of the GSIA, the rates, and the forms used to write the coverage. Ms. Carter stated that although a GSIA was not a licensed insurance company, it was still involved in writing contracts of insurance. The Department of Workers' Claims was responsible for everything that happened after the GSIA issued the workers' compensation policy. Ex. MC-13, at 4-5; Ex. KH-45; Tr. at 533-36 and 543.

Ms. Carter described the Department's regulatory role over liability insurance carriers. In Kentucky, the regulation of liability insurance is solely the responsibility of the Department, and in particular, its Property and Casualty Division. The Department would determine whether the insurer was licensed to conduct business in the state and approve the insurer's rates and forms prior to their use. She stated the Department's responsibility over GSIAs was no different. As part of the 1996 legislative amendments, the definition of "insurer" was amended so the Department could monitor the financial solvency of trusts, reciprocals, and GSIAs. She explained that during her tenure as director of the Department's Property and Casualty Division, the Department routinely received requests from the Department of Workers' Claims to review a GSIA's excess insurance policy. Additionally, when a group of self-insureds wanted to change their coverage to a licensed insurance company or when a GSIA was being acquired by a licensed insurance company, Ms. Carter was responsible for leading the team that reviewed the contracts and agreements between the entities. This team included representatives from the Department's Life and Health, Financial Standards, and Legal Divisions. Ex. MC-13, at 6-7.

Ms. Carter defined the term "loss portfolio transfer." She stated the term was used by both the Department and the Department of Workers' Claims to describe the transfer of the liability and assets of a GSIA to a conventional insurance carrier. She explained that upon the completion of a loss portfolio transfer, the assuming carrier is substituted for a ceding insurer as if the ceding insurer no longer exists, and a direct relationship is established between the assuming insurer and the policyholders of the ceding insurer. Ms. Carter did not know the legal definition of "loss portfolio transfer," but she explained the essence of the transaction is that the assuming insurer replaces the original ceding insurer, so that after the transaction, only the assuming insurer is responsible to the

policyholders as though it had issued the policies or certificates. She explained that a loss portfolio transfer would not result in any changes to the original coverage document. The assuming insurer becomes the entity which is deemed to have issued the original policies or certificates to the insureds, and the ceding insurer's insurance obligations or risks under the policies would be extinguished. Ms. Carter stated with respect to workers' compensation policies there would be no need for change in coverage, since workers' compensation benefits in Kentucky are fixed by statute. Ex. MC-13, at 7-8.

Ms. Carter described the review process employed by the Department when a loss portfolio transfer occurred between a GSIA and an insurance company. When notice was received from a GSIA that it wanted to convert to a fully insured program, the Department of Workers' Claims would conduct an actuarial study of the GSIA's reserves, incurred claims, incurred but not reported claims, and its finances in general. At that point, the Department of Workers' Claims would notify the Department, provide copies of the transaction agreements, and provide an overview of how the acquisition would be structured. Several divisions within the Department would review the transaction documents and the Department would provide its recommendation to the Department of Workers' Claims. In general, the Department was primarily concerned with ensuring that the GSIA was being acquired by an insurance company with sufficient financial resources to assume the GSIA's claims, so that policyholders who had an expectation of coverage would be covered. Ms. Carter's team would review the coverage issues, the legality of the transaction, and the financial condition of the GSIA and the acquiring insurance company. Ex. MC-13, at 8-9.

Ms. Carter explained that whenever a GSIA sought to transfer its insurance obligations to another company, the Department of Workers' Claims required the GSIA to send a proxy statement to its members stating that the members had to approve the transfer of assets and liabilities to the new company. Ms. Carter's understanding is that there is no statutory requirement in Kentucky mandating that an assuming insurer issue retroactive policies to effectuate coverage on the prior risks to be considered policies of the assuming insurer. Ex. MC-13, at 9-10.

Ms. Carter did not remember being specifically involved in the review of the loss portfolio transfer between C-HAT and K-HAT to ROA, but she did remember discussing the transactions with other employees of the Department. She explained that in the review process the Department of Workers' Claims would have reviewed C-HAT, and the Department would have reviewed ROA. The Department would have approved ROA's policy forms to be used on the assumed business. Those policy forms would have been approved to effectuate the loss portfolio transfer of the risk to ROA, and the release of risk for C-HAT and K-HAT and their respective members. Pursuant to Chapter 48 of the Kentucky Insurance Code, the Department was required to confirm that all obligations of the GSIA were satisfied in order for the GSIA to be liquidated. The Department of Workers' Claims was responsible for the final approval of the C-HAT transaction and the Department was responsible for the final approval of the K-HAT transaction. Ms. Carter explained that in the review process, both departments were primarily concerned with the insurance company "stepping into the shoes" of the GSIA and assuming all of the GSIA's liabilities and risks associated with its operations. Following the loss portfolio transfer, the assuming insurance company would become directly liable to the GSIA policyholders and the assuming insurance company was deemed to be the direct insurer under the original coverage. Ms. Carter explained that in developing the

memorandum of understanding between the two departments, the review protocol and the intent of the review process were established. Ex. MC-13, at 10-12; Tr. at 537-42.

Ms. Carter defined "direct insurance" as an insurance contract between an insured and an insurer; the relationship is direct and uninterrupted by the presence of another insurer. She stated that certificates of coverage issued by a GSIA are within the definition of the business of insurance. She noted that "insurance" by definition provides coverage and covers risks for the payment of consideration. Ms. Carter stated that issuing a certificate of coverage is insurance. She further stated that the author of the certificate is immaterial. She could decide to insure someone else. Finally, Ms. Carter stated that if one person agrees to provide insurance coverage to another person and the second person still remains liable, there is still an insurance arrangement between the two parties. Ex. MC-13, at 12.

Ms. Carter testified that it was her understanding during her tenure with the Department that guaranty fund coverage was available for claims assumed by a licensed insurance company from a GSIA. She stated that the obligations of KIGA are established by statute and not by contract. The view within the Department was that if an insurance company was licensed to do business in Kentucky, then its policyholders were protected by the guaranty fund if that insurer became insolvent. She noted that a GSIA's claims were not protected by KIGA, but once they were assumed by an insurance company licensed in Kentucky, those claims were protected by KIGA. In this circumstance, the protection afforded by KIGA extended to all covered incurred and incurred but not reported claims. As part of the review process, Ms. Carter would have communicated to the Department of Workers' Claims whether or not the Assumed Claims were afforded guaranty fund coverage. Ex. MC-13, at 12-13; Tr. at 542.

Ms. Carter testified it was the intent of the Department and the Kentucky Department of Workers' Claims that the Assumed Claims would be treated as and considered policyholder claims of ROA as if ROA had originally issued the policies or certificates, and that the GSIAs and their members would have no further liability. She testified that there was a transfer of risk from the GSIAs to ROA. She further stated that any other position would be contrary to the intent and basis of the approvals for the transactions. The two departments would not have approved the transactions, the release of the liabilities, the dissolution of the GSIAs, and the release of the security deposits unless the Assumed Claims were to be given such treatment. Ex. MC-13, at 13-14; Tr. at 542.

On cross-examination, Ms. Carter testified that she was not an expert on insolvency issues or insurance guaranty fund law, nor was she qualified to give legal opinions since she was not a lawyer. She was not directly involved in any reinsurance transactions during her employment with the Department, and she has not worked in the reinsurance industry. She is familiar with the term "assumption reinsurance," but was not familiar with the term "novation" prior to this proceeding. Tr. at 546-48.

Ms. Carter testified that prior to the 1996 workers' compensation reform law in Kentucky, the Department had limited involvement with GSIAs. Since 1994, at the request of the Department of Workers' Claims, the Department had been reviewing the GSIAs' excess policies on a regular basis to confirm that the policies were providing adequate coverage for GSIA members. Ms. Carter

confirmed that workers' compensation GSIAs are regulated under Chapter 342 of the Kentucky Code, the workers' compensation administration section of the Code; that GSIAs were not licensed by the Department; and that the 1996 reform laws required the establishment of the Kentucky Group-Self Insurance Guaranty Fund. Tr. at 549-551.

Ms. Carter testified that prior to the transactions in this case, the C-HAT and K-HAT claims were not covered by KIGA, and C-HAT and K-HAT were not subject to assessment by KIGA. As part of reviewing the transactions between C-HAT, K-HAT, and ROA, Ms. Carter stated that the goal was to ensure that the GSIAs' incurred claims were being assumed by a licensed insurer so that they would be covered by KIGA. Ms. Carter agreed that the Department had no regulatory authority over KIGA; it is an independent entity. Tr. at 552-53.

Although Ms. Carter does not recall being personally involved in the Department's review of the C-HAT and K-HAT transactions, she stated that she established the process by which loss portfolio transfer transactions would have been reviewed by the Department. She was aware of the ROA transactions, but does not recall the specifics of the transactions. She agreed that whatever insurance obligations existed prior to the transactions would remain unchanged after the transactions, and that the transactions could not transform an obligation into an insurance contract if the obligation was not already an insurance contract. Conversely, Ms. Carter testified that a claim that was not initially covered by KIGA could be transformed by the transactions into a covered claim under the guaranty fund. She agreed that for KIGA to cover a claim, the policy of insurance has to be issued by a member insurer that becomes insolvent. She further agreed that the GSIAs were not members of KIGA. However, Ms. Carter reiterated her position that the policies issued by the GSIAs were contracts of insurance under Kentucky law, even though the GSIAs were not members of KIGA and the policies were not covered by KIGA. She stated her position was unaffected by the fact the GSIAs did not pay assessments to KIGA. Ms. Carter believes a guaranty fund assessment has nothing to do with whether a claim is covered under the guaranty fund. Tr. at 553-58.

Ms. Carter explained why she believes ROA is "deemed" to have issued the original policies or certificates of insurance to the GSIAs' former members. She explained that through the transaction approval process, once ROA assumed the assets and liabilities of the GSIAs, ROA was deemed to have issued the original contracts of insurance. Ms. Carter cannot recollect any specific conversations with the administrator for KIGA, but she does remember general discussions involving the ROA transactions. She did not get anything in writing from KIGA expressing an opinion that the Assumed Claims would be covered by the guaranty fund, nor is she aware whether KIGA agrees with her that the Assumed Claims are covered claims. Ms. Carter makes no distinction between a loss portfolio transfer and an assumption reinsurance agreement. She believes the end result of both transactions is the same. Ms. Carter agreed that the transfer of risk is a required element of insurance, and that the members of the GSIAs were jointly and severally liable. Finally, she agreed that at the time of the transactions, the GSIAs' insurance policies were cancelled and new policies were issued by ROA. Tr. at 559-62.

Ms. Carter testified that the Department referred to the ROA transactions as "loss portfolio transactions" and not "assumption reinsurance," "merger," or "consolidation." Tr. at 562-63.

Ms. Carter testified the GSIA policies were contracts of insurance and transferred risk. The members of the GSIAs transferred and pooled risk among one another. The GSIAs were not members of KIGA prior to the transactions with ROA; however, once ROA assumed those contracts, ROA had the risk and KIGA was then responsible for those claims. Ms. Carter stated that some loss portfolio transfers the Department reviewed did not involve the assumption of the claims by a licensed insurance company. In those cases, the Department required that a bond be posted to assure that past losses would be paid. Ms. Carter stated that whenever one of KIGA's members assumed something, bought something, or merged with something, the member insurance company was responsible for it. KIGA was ultimately responsible when its member insurer became insolvent. Ms. Carter confirmed that the same procedure was used by the Department to review all of the requests for a loss portfolio transfer. The primary purpose of the review was to ensure that there was some provision to take care of the incurred claims so that the people who were entitled to receive workers' compensation benefits would receive those benefits. Ms. Carter understood that the GSIAs transferred all their liabilities to ROA, and ROA was obligated to pay those liabilities, not the GSIAs. Finally, Ms. Carter testified the fact the GSIA policies were cancelled makes no difference whether ROA was obligated to the GSIAs' members. ROA had assumed the liabilities and issued a new contract to the members. C-HAT and K-HAT were no longer in existence, leaving ROA solely responsible. Tr. at 564-67.

Coastal offered the testimony of three witnesses: Jackson Payne, a partner in the law firm Leitman, Siegal & Payne, P.C.; Joseph Ammons, general counsel for the Alabama Workers' Compensation Division of the Department of Industrial Relations; and Melvin Capell, president of Coastal Insurance Risk Retention Group, Inc.

Mr. Jackson Payne testified that his law firm represented the Coastal Insurance Group during the transaction with ROA.[20] Mr. Payne identified the Acquisition of Assets and Assumption of Liabilities Agreement for A-HAT.[21] He described the transaction between A-HAT and ROA. Pursuant to Sections 2.1 and 2.2 of the agreement, ROA acquired from A-HAT all of its assets and assumed all of its liabilities, including the assumption of all reserves for pending claims of A-HAT members. He explained that Section 2.2 of the agreement clearly states that neither A-HAT nor its members would have any responsibility with respect to any of the liabilities, including existing claims, after the effective date of the transaction. He further explained that Section 2.4 of the agreement states that on the effective date or on the renewal date of the policies or coverages of A-HAT's subscribers, ROA would issue insurance policies or coverages to A-HAT subscribers on terms and conditions similar to those provided by A-HAT as of the effective date. Mr. Payne quoted a portion of Section 2.4 of the agreement which states that "ROA shall assume and exercise all rights and interests of A-HAT under policies issued or coverages provided by A-HAT as of the Effective Date."[22] He testified this language was included in the agreement at the insistence of A-HAT. The sentence was added for the express purpose of confirming the parties' understanding that ROA insurance coverage was replacing the insurance coverage that had been written by

[20]The Coastal Insurance Group consisted of the Alabama Hospital Association Trust ("A-HAT"), the Healthcare Workers' Compensation Self-Insurance Fund ("HWCF"), Coastal Insurance Enterprises, Inc. ("CIE"), and Coastal Insurance Exchange (the "Exchange"). Ex. JP-14, at 1.
[21]By agreement of counsel, Coastal exhibits C-1 through 24 were admitted into the record.
[22]*See*, Ex. C-2.

A-HAT. Mr. Payne stated that ROA was assuming direct liability for A-HAT's claims. He believes it was impossible to have any form of reinsurance transaction between A-HAT and ROA because A-HAT was being dissolved as part of the transaction; there was no entity left to reinsure. He stated that Section 2.9 of the agreement required A-HAT to terminate its agreements with its members and, as soon thereafter as practicable, terminate its existence. Mr. Payne confirmed that A-HAT ceased to exist. Ex. JP-14, at 1-3; Exs. C-2 and 6; Tr. at 575-77.

Mr. Payne testified that A-HAT's board of directors sent a letter dated December 11, 2000, to all of its members explaining the proposed transaction with ROA, with an enclosed proxy ballot to vote either for or against the transaction. Included in the letter was a statement that ROA would issue hospital professional liability and general liability insurance policies, with coverages similar to A-HAT's current coverage. The board represented that the transaction with ROA would be "almost seamless," and that all insurance services would continue to be provided by the same individuals who had provided those services on behalf of A-HAT. Mr. Payne confirmed that A-HAT's members approved the transaction with ROA. Ex. JP-14, at 4-5; Exs. C-7 and 8.

Mr. Payne described the nature of the transaction between HWCF and ROA. He explained that pursuant to Sections 2.1 and 2.2 of the Acquisition of Assets and Assumption of Liabilities Agreement between HWCF and ROA, ROA acquired all of HWCF's assets and assumed all of its liabilities, including all reserves for pending claims of HWCF members. Section 2.2 of the agreement provided that neither HWCF nor its members would have any responsibility for the liabilities, including existing claims, after the effective date of the transaction. The agreement addressed existing policies of HWCF members. Section 2.4 of the agreement provided that on the effective date or on the renewal date of the policies or coverages of HWCF's subscribers, ROA would issue insurance policies or coverages to HWCF subscribers on terms and conditions similar to the policies provided by HWCF as of the effective date. Additionally, Section 2.4 provided that "ROA shall assume and exercise all rights and interests of HWCF under the coverages provided by HWCF as of the Effective Date." He stated this language was included in the agreement at HWCF's insistence. The sentence was added for the express purpose of confirming the parties' understanding that ROA insurance coverage was replacing the insurance coverage that had been written by HWCF. Mr. Payne stated that ROA was assuming direct liability for HWCF's claims. He believes it was impossible to have any form of reinsurance transaction between HWCF and ROA because HWCF was being dissolved as part of the transaction, there was no entity left to reinsure. He stated that Section 2.9 of the agreement required HWCF to terminate its agreements with its members and, as soon thereafter as practicable, to terminate its existence. Mr. Payne confirmed that HWCF ceased to exist. Ex. JP-14, at 5-6; Ex. C-10 and 14; Tr. at 575-77.

Mr. Payne testified that HWCF's board of directors sent a letter dated November 30, 2000, to all of its members explaining the proposed transaction with ROA, with an enclosed proxy ballot to vote either for or against the transaction. Included in the letter was a statement that ROA would issue workers' compensation insurance policies, with coverages similar to HWCF's current coverage. The board represented that the transaction with ROA would be "almost seamless," and that all insurance services would continue to be provided by the same individuals who provided those services on behalf of HWCF. Mr. Payne confirmed that HWCF's members approved the transaction with ROA. Ex. JP-14, at 7-8; Ex. C-15 and 22.

Mr. Payne stated the HWCF transaction required the regulatory approval of the Alabama Department of Industrial Relations. At the department's request, Mr. Payne provided copies of the transaction documents. The department requested that HWCF separate approval of the business combination from the opting-in or opting-out process of becoming a subscriber of ROA. HWCF was required to send a supplemental letter to its members asking whether they wanted to opt-in or opt-out of becoming a subscriber of ROA. Mr. Payne communicated the results of the opt-in opt-out vote to the department, and the department subsequently approved the transaction. Ex. JP-14, at 8-9; Exs. C-16, 18, 19, 20, 21, and 24.

On cross-examination, Mr. Payne testified that after the A-HAT and HWCF transactions closed, he did not review the ROA policies issued to the former members of A-HAT or HWCF. He is aware, as part of the negotiation process with ROA, that the policies issued to the former members of A-HAT and HWCF were required to be substantially similar to their existing policies. Mr. Payne was unsure whether ROA issued a policy to HWCF members to cover past claims, whether the members were required to pay a premium for this coverage, or whether a certain dollar amount of insurance was being provided. Although the transactions involved A-HAT, HWCF, and ROA, ROA issued its coverage directly to the former members of A-HAT and HWCF. Mr. Payne was unaware of any direct agreement between the members and ROA to issue insurance policies directly to the members. Tr. at 582-86.

Mr. Payne confirmed that the agreements between A-HAT, HWCF, and ROA do not use the word "premium" with respect to ROA assuming past claims. However, with respect to future claims, the former members of A-HAT and HWCF would pay premiums to ROA. Mr. Payne explained that in its simplest form, the agreement between HWCF and ROA involves a transfer of all HWCF's assets and an assumption of all the liabilities. Although the agreements do not express a dollar amount of insurance to cover past claims, the insurance to cover those liabilities is included in exchange for subscriber equity accounts in ROA. Mr. Payne stated that at the time of the transactions, it was clearly understood from counsel for ROA that the transactions were to be seamless, and that the coverages formerly provided by A-HAT and HWCF were to be carried forward with ROA. Tr. at 587-89, 592-93.

Mr. Payne confirmed that the term "liabilities" used in the agreements encompassed all the liabilities of A-HAT and HWCF, which would include monies owed for lawn maintenance or furniture purchases. He confirmed that the word "risk" is never mentioned in the definition of "liabilities" in the agreements. Additionally, he confirmed that the HWCF agreement does not address the risk that workers' compensation claims would be greater than either HWCF or ROA expected. Mr. Payne confirmed that there may be agreements in which one company acquires the liabilities of another company, but the agreement is not considered an insurance contract. However, he noted that in a typical sale and purchase of a business that is a taxable transaction, the assets are defined globally and the liabilities are typically left with the seller. If liabilities are included in the sale agreement, those liabilities will be expressly enumerated so it is clear what is being assumed in the transaction. Mr. Payne stated the A-HAT, HWCF and ROA transactions were structured as a C-reorganization, a tax-free exchange under Section 368 of the Internal Revenue Code. He explained that in such circumstances there is a transfer of all the assets, an assumption of all the liabilities, solely in exchange for common stock, or in the case of ROA, the establishment of subscriber equity accounts. Tr. at 590-92.

Mr. Payne testified that under the agreements with ROA, A-HAT and HWCF were dissolved within one year of the effective date of the transactions. He confirmed that HWCF was subsequently re-established under its old certificate of authority, which had been dormant with the Alabama Department of Industrial Relations, after ROA was declared insolvent. Mr. Payne believes the Alabama Hospital Association is a sponsoring association of the new HWCF. He knows that some of the trustees are the same, but is unsure whether all of the trustees were on the board of trustees before the merger. In addition, he knows that there are hospitals that were members of HWCF and are members of the new HWCF. Tr. at 594-99, 697-99, 736-37.

Mr. Payne identified the letter he sent to the Special Deputy Receiver for ROA on April 11, 2003, requesting that the A-HAT, HWCF, and ROA business combinations be "unwound" pursuant to the terms of the business combination agreements. Ex. VA-49; Tr. at 601.

Mr. Payne confirmed that the HWCF Participation Agreement contains a section addressing the members' joint and several liability. He further confirmed that the board of directors of HWCF unanimously approved the business combination with ROA. He also confirmed that the board resolution contained language that "[t]he potential liability of HWCF's members is eliminated because they would neither be subject to joint and several liability nor assessments from members' adverse losses." Exs. GA-14 and VA-50; Tr. at 604-07.

Mr. Payne described the process whereby HWCF obtained the approval of its members to enter into the business combination with ROA. The process involved three separate votes by the membership. Mr. Payne confirmed that after the first ballot, the subsequent ballots were required by the Alabama Department of Industrial Relations. These requirements involved a separate vote for the business combination and a vote for whether the member wanted to become a subscriber of ROA. The members were given 30 days in which to decide whether to become subscribers of ROA or obtain alternative coverage. Mr. Payne is unsure of the membership number of HWCF at the times of the various proxy ballots. He was not involved in sending the ballots to the members or tabulating the results. A representative of HWCF provided the results of the votes to Mr. Payne. He was unable to explain why certain members had voted against the business combination in earlier proxy ballots, and why they did not appear in the final ballot. Ex. C-16, 21, 22, and 23; Tr. at 699-713.

Mr. Payne was unsure whether there were any amendments to the trust agreement that governed the organization of HWCF. He read Article XI of the agreement which governs the term of the trust.[23] He was unaware of any other provision governing the termination of the trust; however, he noted that HWCF's members approved the business combination transaction, and the transfer of the assets and liabilities in exchange for subscriber equity accounts in ROA. Mr. Payne confirmed that if a member did not agree to become a subscriber of ROA, it was not entitled to any residual assets of the trust as contemplated in Article XI. Ex. C-9; Tr. at 714-19.

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[23]Article XI "Term of the Trust" states that

> "[t]he term of this instrument shall be 21 years and shall be renewable at the end of that term, but with the assent of two-thirds (2/3) of the Board of Trustees, this Fund may at any time be wound up and the assets distributed. Such distribution shall be made until all claims, and other lawful debts shall have been paid. Upon such winding up, the residual assets of this Fund shall be distributed by prorating the remaining monies among the then Members on the basis of each Member's total contribution to the Fund for the immediately preceding Fund year." *See,* Ex. C-9.

With respect to the termination provisions of the A-HAT trust agreement, Mr. Payne confirmed that the agreement provides for the creation of a liquidation fund for the members. The liabilities of the fund would be paid first and any balance of the fund would be sent to the members who were members during the previous fiscal year. Mr. Payne was unaware whether the A-HAT trust agreement had ever been amended. Ex. C-1; Tr. at 719-20.

Mr. Payne does not distinguish between the term "policies" used in Section 2.4 of the A-HAT agreement and the term "coverages" used in Section 2.4 of the HWCF agreement. He believes the nature of the transactions does not change. Mr. Payne understood that the members of A-HAT and HWCF pooled their risks and were jointly and severally liable prior to the transactions with ROA. After the transactions occurred, ROA assumed all of the A-HAT and HWCF claims, and the members of A-HAT and HWCF were no longer jointly or severally liable for those claims because the insurance obligations had been transferred to ROA. Tr. at 721-22.

Mr. Payne testified that when A-HAT and HWCF were in operation, the members made contributions, which the members believed were the equivalent of premiums. In addition, the members had equity accounts in A-HAT and HWCF. He identified the consideration provided by A-HAT and HWCF to ROA to accept their insurance obligations was all of the trusts' assets, which included the premiums paid by the members. Mr. Payne explained the economics of the transactions with ROA. A-HAT and HWCF transferred their claims and approximately $92 million in claim reserves to cover the payment of those claims. In addition, they transferred approximately $52 million in surplus to ROA. He described the surplus as the trusts' retained earnings. The trusts accumulated their surpluses through premium payments by their members. In addition to insurance coverage for their incurred but not reported claims and their continuing coverage claims, the members of A-HAT and HWCF received a proportionate interest in ROA in relation to the amount of surplus they provided to ROA's combined surplus. This was in addition to the other benefits offered to subscribers of ROA, namely, insurance with an entity that was not assessable or had no joint and several liability. Tr. at 722-724, 731-32.

Mr. Payne explained that HWCF did not issue polices to its members, but instead issued certificates of insurance. The certificate sets forth the term of the insurance, the beginning date, the ending date, and any special provisions or caps in coverage. He stated that A-HAT actually issued an insurance policy to its members. The coverage that had been provided by HWCF and A-HAT would be provided by ROA on a going-forward basis. For this reason, Mr. Payne believed the transactions with ROA would be seamless. HWCF and A-HAT had insurance coverage on their existing claims and those were the claims that ROA assumed and was insuring. To cover the claims, HWCF and A-HAT sent ROA $92 million in reserves and $50 million in surplus. Mr. Payne agreed that the members of the two groups fully expected to have the liability for existing claims transferred to ROA and removed from the members. He agreed the existing claims became the direct obligation of ROA. Tr. at 724-26, 730-31.

Although the agreements do not specifically mention the word "risk" or the word "premium," Mr. Payne confirmed that the liability to pay the assumed claims was among all the liabilities transferred to ROA. He also confirmed that no matter when the proxy ballots were sent, the members of HWCF and A-HAT approved the transactions with ROA. He agreed that if one member failed to approve the transaction, or opted-out of the transaction, ROA would not be

relieved of its obligations to the other members. Further, Mr. Payne confirmed that the liabilities of members who terminated their membership in HWCF or A-HAT prior to the effective date of the transactions were also assumed by ROA. Although those members did not receive a distribution of money when the trusts were dissolved, their claim liabilities were assumed by ROA. Tr. at 726-28.

Mr. Payne confirmed again that the Alabama Department of Industrial Relations approved the HWCF business combination with ROA. Ex. C-24; Tr. at 728-30.

Mr. Payne explained that ROA received cash consideration for assuming responsibility for the insurance contracts that had existed between HWCF and A-HAT and their members. The cash consideration amounted to $92 million in reserves for ROA to cover any potential claims. The members of HWCF and A-HAT were the covered insureds under the insurance contracts for which ROA assumed the liability. The HWCF and A-HAT insurance contracts defined the coverage and contained specific coverage limits for which ROA assumed the liability. The HWCF and A-HAT insurance policies provided coverage for a specific period of time, which typically began on January 1 and ended on December 31. The members of HWCF and A-HAT were obligated to pay annual premiums for the insurance coverage they received. Tr. at 732-34.

Mr. Payne explained the procedure in which the members of HWCF and A-HAT received subscriber equity accounts in ROA. After the effective date of the transactions with ROA, HWCF and A-HAT owned the equity in ROA represented by the surplus provided to ROA. Through liquidation of the two trusts, the members received equity accounts in proportion to the surplus they had individually contributed. Ex. C-14; Tr. 734-36.

Mr. Payne described the unwind provision in Section 2.12 of the business combination agreements. The provision was built into the agreements so the Coastal Group would maintain some autonomy over its book of business. It would determine who actually provided third-party administrative services and how the claims were handled. To effect this control, the Coastal Region Board of Directors was created to represent the Alabama hospitals that were insured with ROA. The agreements had a built-in provision that within three years after the effective date of the transactions, the Coastal Region Board of Directors had the right for any reason to terminate the agreement with ROA, and the parties would be placed back in the position they were in had the agreements not been entered. If this occurred after the first year, the Alabama entities that were dissolved as part of the transactions would have to be re-created. Mr. Payne stated that the Coastal Region Board of Directors attempted to initiate the unwind process with the Deputy Receiver, but has met with little success. Tr. at 740-43.

Mr. Joseph Ammons testified that for the past seven years he has been the general counsel for the Alabama Workers' Compensation Division of the Department of Industrial Relations. He stated in Alabama an employer with five or more employees is required to provide insurance coverage for workers' compensation benefits. He outlined the methods an employer may use to satisfy this requirement: obtain insurance through the voluntary market with a traditional insurer; become a member of a GSIA that provides workers' compensation coverage; or become an individual self-insured. The Workers' Compensation Division regulates GSIA workers' compensation funds pursuant to Ala. Code § 25-5-9. Ex. JA-17, at 7-11.

Mr. Ammons is familiar with the HWCF and ROA transaction. HWCF's administrator advised him that HWCF's board of trustees had determined the fund would be acquired or merged into ROA. Mr. Ammons reviewed all the documentation filed with the Department of Industrial Relations related to the transaction. The primary focus of his review was to ensure that the members of HWCF were protected. The Department ultimately approved the transaction. As part of the transaction, ROA assumed all of HWCF's assets and liabilities, and became the primary insurer for the HWCF's former members. Mr. Ammons stated that had ROA not assumed HWCF's existing claims, he would have disapproved the transaction. He explained that the Department wanted a list of all members to ensure that the members fully understood the transaction, and were afforded the opportunity to opt-in or -out of the transaction. As part of the approval process, ROA was requested to provide a copy of the insurance policy that was to cover HWCF's members. The Department wanted to ensure that when the transaction was consummated, HWCF's former members had workers' compensation coverage with ROA. Mr. Ammons explained that in Alabama the members of a GSIA workers' compensation fund are held jointly and severally liable for all of the liabilities of the fund. The Department understood that the transaction with ROA eliminated HWCF members' joint and several liability. Ex. JA-17, at 10-16.

Mr. Ammons confirmed that HWCF: had never failed to pay a claim; was solvent prior to the transaction with ROA; had accumulated surplus and reserves for pending claims; and after the transaction, had no assets. After the transaction with ROA, HWCF ceased to exist. Ex. JA-17, at 16-17.

Mr. Ammons testified that he reviewed the assumption agreement between HWCF and ROA. It was his understanding that under the agreement HWCF's former members would become insureds of ROA, and ROA would cover them in the same manner as any other insurance company. Mr. Ammons believes ROA's insurance relationship with HWCF's former members covered existing and incurred but not reported claims. Mr. Ammons stated he would have felt uncomfortable with the transaction if the members were not protected. He would not have approved the transaction had ROA not assumed the responsibility for existing and incurred but not reported claims. Ex. JA-17, at 19-21.

On cross-examination, Mr. Ammons clarified that the protection he sought for HWCF's members was that their claims would be paid by ROA. Ex. JA-17, at 21.

Mr. Ammons stated he was not involved in the A-HAT transaction. Ex. JA-17, at 23.

Mr. Ammons was unsure whether the assumption agreement specifically provided for the elimination of the members' joint and several liability. He was aware that one of the transaction documents addressed the elimination of the members' joint and several liability. Mr. Ammons agreed that if he were to review the transaction today, HWCF's former members still would have no responsibility for the claims that were assumed by ROA. Ex. JA-17, at 23-25.

Mr. Ammons confirmed that prior to the transaction with ROA, the Department did not consider HWCF to be an insurance company, nor were HWCF's members considered policyholders. Mr. Ammons testified that the members of HWCF entered into a participation agreement with HWCF. He stated that his Department never formed an opinion whether those

agreements were contracts of insurance. He was unaware whether the participation agreements were subject to regulation by the Alabama Insurance Department. He confirmed that workers' compensation GSIAs were not subject to regulation by the Alabama Insurance Department. Mr. Ammons explained that participation agreements were contracts that provided workers' compensation benefits to the members' employees according to the Alabama Workers' Compensation Act. It was his Department's primary duty to ensure that the employees received their statutory benefits. Mr. Ammons believes that in Alabama, only a licensed insurance company can write contracts of insurance. Other than the excess insurance policy maintained by HWCF, Mr. Ammons was unaware of any other insurance policies maintained by HWCF's members. Ex. JA-17, at 27-33.

Mr. Ammons testified that throughout the HWCF and ROA transaction documents, the parties used terms like "insurance services" and "insurance products." This led Mr. Ammons to believe that ROA was going to become a direct insurer of the members' existing claims. Mr. Ammons is not sure why HWCF and ROA used such terminology. He stated he would have to consult the agreements to determine whether the terminology applied to existing claims or claims going forward. In his discussions regarding the transaction, Mr. Ammons did not distinguish between existing claims and claims going forward. Mr. Ammons stated that he was led to believe in correspondence from HWCF's board of trustees that ROA was providing insurance coverage for existing claims to the members. However, the only document that he reviewed that was signed by both parties was the assumption agreement. Mr. Ammons was unsure if the assumption agreement addressed existing claims. He did remember that the agreement addressed books of business. Ex. JA-17, at 33-37.

Mr. Ammons recalls having one meeting in which preliminary discussions were held between HWCF and the Department. The Department did not require a hearing to approve the transaction. Mr. Ammons did not recall whether he required any changes to the assumption agreement as a condition of its approval, or discussed whether the members' existing claims would be covered by any guaranty fund in the event of ROA's insolvency. Mr. Ammons confirmed that Alabama has a guaranty fund for GSIAs. He does not believe that HWCF was a member of that fund. Mr. Ammons confirmed he had opined to the administrator of HWCF that group funds were not insurance companies; however, that opinion related to the possibility of the Alabama Department of Insurance requiring HWCF to pay premium taxes if it was considered an insurance company. Ex. JA-17, at 37-42, 52-54.

On redirect, Mr. Ammons testified there is no difference between workers' compensation benefits provided by a GSIA and a traditional insurance company. He confirmed that HWCF had posted additional securities with the Department. In the event of HWCF's insolvency, these securities would have been used to pay its liabilities. Ultimately, the members would have been responsible for any unpaid liabilities. Mr. Ammons opined that under the definitions found in § 38.2-100 of the Code of Virginia for "insurance contracts" or "policies of insurance," the agreement between HWCF and its members would be an insurance contract. He further testified that the Department required HWCF's members to vote to approve the transaction, and to opt-in or -out of the transaction. Mr. Ammons believes the vote to approve the transaction was unanimous, and that no member opted-out of obtaining its workers' compensation insurance coverage with

ROA. The board of trustees of HWCF provided Mr. Ammons the results of the two votes. Ex. JA-17, at 43-46, 49-51, and 54.

Mr. Ammons testified he was aware that the members of HWCF spread risk among themselves and that one member potentially could be liable for all of the other members' claims. He confirmed that on the date ROA assumed the pending claims, there was no way of knowing how long benefits would be owed on each of the claims or the total dollar amount of those claims. Mr. Ammons believes the assumption of HWCF's pending claims by ROA contained the assumption of risk. ROA assumed the risk for all liabilities, whatever those liabilities were determined to be. Ex. JA-17, at 46-48.

Mr. Melvin Capell testified that from 1995 to December 31, 2000, he was employed by Coastal Associates as senior vice president of underwriting and risk management. Coastal Associates was the third-party administrator that provided daily operations support for A-HAT and HWCF, since neither of those groups had any employees. After the A-HAT, HWCF, and ROA business combinations, all of Coastal Associates' employees were hired by TRG. Mr. Capell stated that the same employees were providing the same services to the same insureds after the transaction. The only exceptions were the accounting and information technology areas, which coordinated more closely with ROA. He stated there was no difference in how the claims were handled by Coastal Associates and how claims were handled by TRG; however, the claims were paid on ROA check stock. His employment with TRG terminated in June or July of 2003, after ROA and TRG were declared insolvent. He is currently employed as the president of Coastal Insurance Risk Retention Group, Inc. Ex. MC-18, at 1; Tr. at 756-57, 759, 774-77.

Mr. Capell identified the plan document for A-HAT and explained that A-HAT was a hospital liability self-insurance trust organized pursuant to Ala. Code § 22-21-240 that provided professional and general liability coverages to certain hospitals in Alabama.[24] He explained that pursuant to section 1.04 of the A-HAT plan documents, all monies paid to the trust for all member accounts, any earnings thereon, or any other sums coming to the trust from any source, became part of the "trust funds." As provided in section 1.07, the members became both grantors of the trust funds and beneficiaries of all rights, benefits, and privileges of the trust. While individual members had "accounts" established in their names as provided in section 7.01, all funds, contributions, income, and other assets were held and commingled into a single trust fund, out of which all sums required to be paid were paid. Ex. MC-18, at 1-2; Ex. C-1; Tr. at 764.

Mr. Capell believes the A-HAT fund involved the transfer of risk for consideration. He explained that as provided in section 11.01, the principal purpose for the establishment of the trust was to provide the orderly presentation, examination, investigation, defense, or settlement of certain identified claims made by third parties against the members. The members understood that the sums contributed by them and deposited into the trust fund were to be used only for the administration, defense, and payment of certain professional liability claims. Section 11.04 further provided that A-HAT would pay to each of the members, or for their account, all such sums which the member became legally obligated to pay as damages on account of covered claims incurred and

[24]The statute permits GSIAs in Alabama "... for the purpose of insuring against general public liability claims based upon acts or omissions of such hospitals or dentists, including without limitation, claims based upon malpractice." *See,* Tr. at 764.

presented during the fiscal years when the member was a member in good standing. If a member's account was insufficient to pay a certain loss, A-HAT would take the money from other member accounts to fund the difference. Section 7.04 describes this procedure and characterizes the transfer as a "loan." That section authorizes the trustees to make loans and advances from any member's account to any other member's account in any instance where the recipient member's account balance at that time was depleted by claims payments or otherwise, and the account had additional claims or expenses to be paid out of it. Section 7.04 further provides that in no event would a member, the trustee, or the administrator be liable for the payment of such debt. Since the member was not liable for the debt, Mr. Capell believes the risk of loss was transferred to A-HAT. He explained that even though A-HAT retroactively kept separate accounts for accounting purposes, all of the members mutually accepted the transfer of risk from each other for the consideration of the financial contribution of each member. A-HAT accepted the responsibility to indemnify the member for the claim and litigation costs. Ex. MC-18, at 2-4; Ex. C-1.

Mr. Capell believes the members of A-HAT were considered to be and were treated the same as policyholders. Although A-HAT was not a regulated insurance company under Alabama law, the plan documents were considered by the members to create an insurance contract, and the members considered themselves to be, and were treated as, policyholders. A-HAT provided insurance coverage for specific types of losses described in the trust documents. A-HAT provided coverage within defined limits, which is similar to most insurance policies. The members made annual financial contributions, which were similar to premium payments. A-HAT investigated claims that arose and either declined or proceeded to adjust or settle the claims. When necessary, A-HAT provided the member with a legal defense, pursuant to section 11.03 of the plan documents and paid defense costs. Section 11.07 of the plan documents required members to surrender control of the claims handling process to A-HAT; all members were required to permit A-HAT to defend any and all claims. In addition, A-HAT had the power and authority to settle without the consent of the member. According to Mr. Capell, A-HAT rarely exercised this power. The fund documents expressly provided that while members could have co-counsel, the co-counsel did not have authority to settle claims. A-HAT was even relieved of any obligation to pay settlements if it did not specifically approve the amount. Ex. MC-18, at 4; Ex. C-1.

Mr. Capell believes the agreements between the members and A-HAT were contracts or policies of insurance. As explained in the trust documents, membership in A-HAT imposed an obligation based on the written terms and conditions in the trust documents. Mr. Capell believes this was an enforceable agreement between the members and A-HAT, under which each member guaranteed the payment, on behalf of any member, of certain specified benefits, subject to the occurrence of certain specified events. Mr. Capell identified each of the elements necessary for finding A-HAT had an insurance contract with its members. Ex. MC-18, at 5; Tr. at 764-65, 769-771.

Mr. Capell identified the HWCF plan documents and explained that HWCF was a workers' compensation self-insurance trust organized pursuant to Ala. Code § 25-5-9 that provided workers' compensation coverage to certain hospitals and healthcare providers in Alabama. He explained that pursuant to section 1.03 of the plan documents, all the monies paid to HWCF as premiums, contributions, or monies from any other sources, and any earnings thereon, became part of the "Fund Account." As provided in section 1.06, the members became both grantors of the trust funds

and beneficiaries of all rights, benefits, and privileges under the fund. Although HWCF tracked the premium contributions of individual members as provided in section 6.05, all premiums, contributions, or other monies coming into the fund became part of the Fund Account, which was the sole account provided for in section 6.01 of the plan documents. Mr. Capell identified the "Fund Coverage Agreement." The document lists the coverages to be provided by HWCF and the premium to be paid for those coverages. The form was approved by the Alabama Department of Industrial Relations, and each time a new member joined HWCF, the trust had to provide a completed copy to the Department. Ex. MC-18, at 5-6; Exs. C-9 and DR-10.A.1; Tr. at 765-66.

Mr. Capell believes the HWCF fund involved the transfer of risk for consideration. As provided in section 6.05 of the plan documents, an individual member was not liable for losses generated by that member or any other member in an amount greater than the member's established premium attributable to claims loss. He explained that if a member's aggregate losses during any fund year exceeded that member's established claims loss portion, the excess, up to the established retention for the entire fund account, would be borne by HWCF's remaining members according to the proportion of that member's premium to the total premium of the Fund Account. This process is also explained in the recitals. Since individual members are not liable for the debt, Mr. Capell believes the risk in the event of claims is transferred to HWCF. Although HWCF retroactively tracked the member's claim history, all of the members accepted the transfer of risk for the consideration of the contribution of any given member. HWCF accepted the responsibility to indemnify each member for claim and litigation costs. Ex. MC-18, at 6.

Mr. Capell believes the members of HWCF were considered to be, and were treated as policyholders. He stated HWCF was subject to regulation under Alabama law. HWCF covered only specific types of losses as specified in the fund documents, and provided coverage within defined limits, which is similar to traditional insurance policies. The members made annual financial contributions, which were substantially identical to premiums. When claims arose, HWCF investigated them and either declined or attempted to adjust or settle the claims. HWCF provided members with a legal defense and paid defense costs. Section 9.02(f) of the fund document provided that HWCF's administrator would handle any claims filed against its members. Subparagraph (g) provided the administrator with the power to retain an attorney when disputing claims filed by members' employees. Ex. MC-18, at 7.

Mr. Capell believes the agreements between HWCF and its members were contracts. The fund documents imposed an obligation on members based on their written terms and conditions. Consequently, Mr. Capell believes this was an enforceable agreement between the members and HWCF, under which each member guaranteed the payment, on behalf of any member, of certain specified benefits, subject to the occurrence of specified events. Mr. Capell identified each of the elements necessary for finding that HWCF had an insurance contract with its members. Ex. MC-18, at 7; Tr. at 769-771.

Mr. Capell testified that representatives of ROA stated consistently that A-HAT's and HWCF's members would be treated exactly in the same after the transaction as before. As an example, he referenced a business plan ROA filed with the Department of Industrial Relations. Mr. Capell understood the business plan was implemented after the A-HAT and HWCF transactions were completed. Ex. MC-18, at 7-8.

Mr. Capell testified that when the A-HAT, HWCF, and ROA business combinations occurred, neither A-HAT nor HWCF had defaulted on the payment of any claim. Both entities had claim reserves and incurred but not reported claim reserves. Based on their December 31, 2000, audited financial statements, A-HAT had cash reserves of $70,490,084 and HWCF had reserves of $21,740,131, which were transferred to ROA. In addition, A-HAT and HWCF transferred approximately $52 million in surplus to ROA. Mr. Capell confirmed that at the time of the transactions ROA had an A.M. Best & Co. rating of A, and A-HAT and HWCF had a rating of B-plus.[25] Tr. at 758-59, 762-63.

Mr. Capell testified that Coastal Insurance Enterprises, Inc. ("CIE") was also part of the A-HAT, HWCF, and ROA business combination. CIE, a licensed stock insurance company in Alabama, was a wholly-owned subsidiary of A-HAT. CIE wrote medical malpractice insurance for physicians in Alabama. As part of the business combination, ROA assumed responsibility for claims that arose under policies written by CIE, which were in effect at the time of the transaction. Mr. Capell explained the CIE policies assumed by ROA were claims-made polices. Under a claims-made policy, the coverage is determined by the date on which the claim is reported to the insurance company. Typically, CIE wrote its policies to cover a twelve-month period. When ROA acquired CIE's business, CIE had pending claims. Some of the claims were on policies that were in effect at the time of the acquisition, and some were on polices that had expired, but were in effect when the claim was made. ROA assumed responsibility for both types of claims. Mr. Capell confirmed that the Alabama Guaranty Association was covering all of the CIE claims assumed by ROA, but was not covering the A-HAT and HWCF claims assumed by ROA. The Alabama Guaranty Association is covering CIE's claims because CIE was a licensed insurance company that had paid into the guaranty fund. Mr. Capell confirmed that the Alabama Guaranty Association at no time stated that its denial of the A-HAT and HWCF claims was because they were not contracts of insurance. Tr. at 766-69.

Mr. Capell clarified the process by which HWCF obtained approval from its members to enter into the business combination with ROA. He confirmed that HWCF mailed a total of three ballots. In an attempt to have the business combination completed by December 31, 2000, HWCF first sent out one ballot with two questions: whether to dissolve the fund, and whether the member wanted to opt-in or -out of coverage from ROA. Mr. Capell confirmed that the Alabama Department of Industrial Relations objected to having both questions on one ballot. Consequently, HWCF sent out a second ballot with only one question, whether to dissolve the fund and be acquired by ROA. After the members approved the ROA transaction, a third ballot was sent out asking each member whether it wanted to opt-in or -out of coverage from ROA. The results of the second and third ballots were reported to the Alabama Department of Industrial Relations, which subsequently approved the HWCF business combination with ROA. Tr. at 772-74.

On cross-examination, Mr. Capell testified that at the time of the transactions with ROA, HWCF had approximately 370 to 380 members and A-HAT had 57 members. Tr. at 778

[25]Mr. Capell testified that A.M. Best & Co. is in business to do financial reviews of insurance companies and to assign a financial rating so that individuals can know the financial strength of insurance companies as evaluated by an outside party. *See,* Tr. at 762.

Mr. Capell testified the Coastal Region Board determined that the relationship with ROA was not going well in early 2003. The Board was having difficulty obtaining financial information and other agreements from ROA. Consequently, the Board decided to exercise the unwind provision of the business combination agreements. At the time, the Board was unaware of ROA's financial difficulty. Tr. at 779-80.

Mr. Capell confirmed that in 2003, HWCF filed new articles of incorporation or bylaws, created a new plan document, and recapitalized. HWCF then filed with the Alabama Department of Industrial Relations a new application for a certificate of approval, and the same participation agreement it had formerly used to be approved by the Department. The Department re-activated HWCF's certificate of approval, which it had kept dormant after HWCF had been dissolved, and approved its participation agreement. HWCF currently has approximately 170 members, of which 95% were members of HWCF before it was acquired by ROA. Mr. Capell stated that A-HAT has evolved into Coastal Insurance Risk Retention Group, a recapitalized insurance company licensed in Alabama to write medical malpractice and general liability policies for hospitals in Alabama. He clarified that the creation of the new HWCF or Coastal Insurance Risk Retention Group did not affect the claims that ROA assumed. ROA assumed all of the assets and all of the liabilities of the old HWCF and A-HAT. Tr. at 780-84, 786-89.

Mr. Capell confirmed that the members of HWCF and the members of A-HAT separately pooled their risks; the liability of the members was removed as a result of the transactions with ROA; and ROA assumed the risk that the assets it acquired from HWCF and A-HAT would not be sufficient to pay the liabilities it assumed. In reviewing the transactions with ROA, Mr. Capell did not contemplate that ROA would become insolvent; however, as a licensed reciprocal insurer in the State of Alabama, ROA was eligible for guaranty fund coverage. Mr. Capell assumed that since ROA acquired the liabilities of HWCF and A-HAT, those liabilities would be afforded guaranty fund coverage. Tr. at 784-86.

The VPCIGA offered the testimony of three witnesses: John Domeika, senior vice president and general counsel of Premera Blue Cross; Paul Gulko, president of Guaranty Fund Management Services; and Etti G. Baranoff, associate professor of insurance and finance at Virginia Commonwealth University.

Mr. Domeika testified that since December 1, 1997, he has been employed as senior vice president and general counsel of Premera Blue Cross in Seattle, Washington. Prior to that, he was a partner with the law firm of Crews and Hancock in Richmond, Virginia. He left Crews and Hancock to take his current position. His private law practice focused on representing healthcare companies in transactional, regulatory, tax, and general corporate matters. The Crews and Hancock firm represented both TRG and ROA, and Mr. Domeika performed work for both entities. Ex. JD-15, at 1-2.

During Mr. Domeika's tenure at the firm, the firm represented TRG in establishing the following GSIAs: HPG, SunHealth, MHA Public, MHA Private, and THA. A subsidiary of TRG, Specialty Insurance Services, Inc., managed the GSIAs. Almost all the members of the GSIAs were insureds of ROA prior to becoming members of the GSIAs. Some members joined the GSIAs over time and some members terminated their coverages with the GSIAs. Mr. Domeika explained the

reasons that ROA's insureds decided to terminate their coverage with ROA and create GSIAs. The insurance market had "hardened" or become more expensive, and the hospitals were trying to reduce their insurance costs by forming and becoming members of a GSIA. He explained that the hospitals knew that membership in a GSIA was riskier than having insurance. GSIA members have joint and several liability for the GSIA's claims; the members could be assessed if the claims exceeded the reserves of the GSIA; and if the GSIA became insolvent, the insurance guaranty fund in their state would not pay the GSIA's claims. Mr. Domeika stated the hospitals were trading lower payments and costs for increased retained risk and exposure. The market later "softened" and the GSIAs decided to terminate their existence and again become insureds of ROA. Ex. JD-15, at 2-3.

Mr. Domeika represented HPG and served as HPG's assistant secretary. He performed insurance regulatory, workers' compensation, and general corporate work for HPG. He represented HPG in 1992, when the Virginia Bureau of Insurance ("Bureau") audited HPG, and he provided HPG's response to the Bureau's examination report. The Bureau examiners took the position that HPG lacked statutory authority to purchase reinsurance from ROA because HPG was not an insurer but instead a self-insurance mechanism, which could not purchase reinsurance under § 38.2-136 of the Code of Virginia.[26] The examiners stated that "[GSIAs] are not licensed insurers, [therefore, HPG] lacks the statutory authority to enter into a reinsurance agreement." The examiners recommended that HPG terminate its reinsurance agreement prior to the next renewal date and execute an acceptable excess insurance contract as allowed under § 65.2-802 E of the Code of Virginia and Insurance Regulation 16. Mr. Domeika learned of the examiners' position at the exit meeting upon completion of the audit. He discussed the examiners' position with the chief examiner and the Bureau staff person responsible for administering GSIAs. Mr. Domeika stated the Bureau refused to change its position that HPG was not an insurer, even after his firm sent two letters and a legal memorandum arguing that HPG was similar to an insurance carrier. The Bureau's position remained unchanged. As a result, HPG terminated its reinsurance agreement, purchased an excess insurance policy, and began the process whereby legislation was introduced and passed that allowed GSIAs to purchase reinsurance. Ex. JD-15, at 4-6; Ex. VA-40, 41, 121, 122, 123, and 124; Tr. at 640-44.

Mr. Domeika confirmed that his former firm represented ROA in transactions with K-HAT and C-HAT. He worked on all facets of the transactions, and Crews and Hancock lawyers made presentations to the boards of trustees of C-HAT and K-HAT regarding the details and the pros and cons of the transactions. During the preliminary stages of the transactions with C-HAT and K-HAT, the issue arose whether C-HAT and K-HAT were "insurers" or transact the business of insurance. Mr. Domeika explained that if C-HAT or K-HAT were considered to be insurers, then the transactions with ROA, a licensed insurer, would be between two insurers and would therefore be subject to approval by the Bureau under § 38.2-136 of the Code of Virginia. He further explained that C-HAT, K-HAT, and ROA believed such approval was not necessary. C-HAT and K-HAT were aware of the position taken by ROA before the Bureau that C-HAT and K-HAT were not insurers. Ex. JD-15, at 6-8; Tr. at 644-48.

[26]Section 38.2-136 of the Code of Virginia provides in part that: "any insurer licensed to transact the business of insurance in this Commonwealth may, by policy, treaty or other agreement, cede to or accept from any insurer reinsurance . . . ."

Mr. Domeika described a meeting held on May 20, 1997, attended by representatives of the Bureau, the Commissioner of Insurance, the chief financial officer of ROA, Mr. Domeika, and the senior partner of his firm, Mr. Bill Crews. During the meeting, the Commissioner of Insurance noted that C-HAT and K-HAT were Kentucky entities with facilities and employees in Virginia, and questioned whether the transactions fell within § 38.2-136 of the Code of Virginia. On behalf of ROA, C-HAT, and K-HAT, either Mr. Crews or Mr. Domeika advised the Bureau that the transactions did not fall within § 38.2-136; approval of the Bureau was not required because C-HAT and K-HAT were not insurers; and the transactions were not mergers between insurance companies. The Commissioner of Insurance requested a written legal opinion supporting the position. Ex. JD-15, at 7-8; Tr. at 648-49.

Mr. Domeika described the process of preparing a response to the Commissioner of Insurance. Although no signed copy has been located, Mr. Domeika is 99% sure he sent a letter on or about June 9, 1997, to the Commissioner of Insurance outlining the position of C-HAT, K-HAT, and ROA. Mr. Domeika recalls no response to the letter from the Commissioner of Insurance; however, this was not unusual if he agreed with the position. It is Mr. Domeika's understanding that the Commissioner of Insurance later took the position that the transaction between ROA and HPG needed Bureau approval because it was a distribution of surplus assets under 14 VAC 5-370-110 B, not a merger between insurers pursuant to § 38.2-136. Ex. JD-15, at 8-9; Ex. VA-13; Tr. at 649-62 and 664.

When he was working on the C-HAT and K-HAT transactions, Mr. Domeika referred to them as mergers or acquisitions. He is familiar with the term "assumption reinsurance." In his dealings with various state agencies, he does not recall anyone referring to the transactions as assumption reinsurance transactions because C-HAT and K-HAT were not insurers. Mr. Domeika stated that C-HAT and K-HAT were to terminate just before ROA insured their members, and the members' joint and several liability did not carry over into the ROA insurance coverage. Mr. Domeika is not aware of C-HAT, K-HAT, or ROA ever taking the position with any state insurance or other regulatory agency that the transactions were assumption reinsurance. Ex. JD-15, at 9-10; Tr. at 662-64.

On cross-examination, Mr. Domeika testified he had a role in establishing certain of the GSIAs. He confirmed that ROA provided workers' compensation insurance coverage to most of the members before they joined the GSIAs. He also confirmed that the GSIAs provided workers' compensation coverage to their member hospitals. Except for some statutory changes, Mr. Domeika confirmed that the workers' compensation coverage provided by ROA and the GSIAs was virtually identical. Mr. Domeika was not involved in the GSIA and ROA mergers, he had left Crews and Hancock by that time. He understood from later conversations with management at Specialty Insurance Services that there was no material difference in member coverage between ROA and a GSIA, although there were some organizational and structural differences between the two. Tr. at 666-71.

Mr. Domeika explained the division of duties between the lawyers representing C-HAT and K-HAT and the lawyers representing ROA in the mergers. The lawyers for C-HAT and K-HAT were responsible for dealing with the Kentucky regulators and the lawyers for ROA were

responsible for dealing with the Bureau to ensure that the transactions received the necessary regulatory approvals. Tr. at 672.

Mr. Domeika agreed that in 1992 he worked hard to convince the Bureau that HPG was an insurer so that it could obtain reinsurance. Later, in 1997 he worked hard to persuade the Bureau that HPG was not an insurer so that it would not have to file a Form A in connection with its merger with ROA. Mr. Domeika stated that the Bureau never took the position that the GSIAs were not pooling risk. He stated that the discussions with the Bureau centered on whether HPG was an insurer, not what was occurring between HPG and its members. Tr. at 673-76.

Mr. Domeika testified that he is not licensed to practice law in the Commonwealth of Kentucky and was not licensed in Kentucky at the time of the C-HAT and K-HAT transactions. Mr. Domeika stated that he referenced Ky. Rev. Stat. § 342.345, which deals with the issuance and revocation of a certificate of self-insurance by the Kentucky Workers' Compensation Commissioner, in his June 9, 1997, letter to the Virginia Commissioner of Insurance. He did not reference the definitions found in Ky. Rev. Stat. § 342.0011, subparagraph 6, which defines "carrier;" subparagraph 22, which defines "insurance carrier;" and subparagraph 26, which defines "insurance policy."[27] Mr. Domeika remembers no correspondence related to the C-HAT or K-HAT mergers that stated that C-HAT or K-HAT were not insurers under Kentucky law. Tr. at 681-84.

Mr. Domeika confirmed that as part of the regulatory approval process in Kentucky, both C-HAT and K-HAT were required to file a Form A, which is typically filed under a state's Insurance Holding Company Act whenever there is an acquisition or merger of an insurer. He is aware that the Kentucky Department of Insurance and the Kentucky Department of Workers' Compensation approved the C-HAT and K-HAT transactions with ROA. He identified the project list used to complete the acquisition of C-HAT and K-HAT. Ex. JD-16; Tr. at 683-87.

Mr. Domeika confirmed that he left Crews and Hancock before the transactions with A-HAT and HWCF were completed; however, he remembers that initial discussions were taking place. Mr. Domeika was not engaged to do any research or offer any opinions regarding the Alabama entities. Tr. at 689.

Mr. Domeika could not recall why he failed to cite to the Virginia Supreme Court's opinions in *Group Hospitalization Medical Service* or *American Surety*, which discuss the elements for a contract of insurance, in his June 9, 1997, letter to the Virginia Commissioner of Insurance.[28] He

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[27]Ky. Rev. Stat. § 342.0011 provides:

> (6) "Carrier" means any insurer, or legal representative thereof, authorized to insure the liability of employers under this chapter and includes a self-insurer.
> (22) "Insurance carrier" means every insurance carrier or insurance company authorized to do business in the Commonwealth writing workers' compensation insurance coverage and includes the Kentucky Employers Mutual Insurance Authority and every group of self-insurers operating under the provisions of this chapter.
> (26) "Insurance policy" for an insurance company or group self-insurer means the term of insurance coverage commencing from the date coverage is extended, whether a new policy or a renewal, through its expiration, not to exceed the anniversary date of the renewal for the following year. *See,* Ex. KH-33.

[28]*Group Hospitalization Medical Service, Inc. v. Smith*, 236 Va. 228, 372 S.E.2d 159 (1988); *American Surety Co. v. Com.*, 180 Va. 97, 21 S.E.2d 748 (1942).

could not recall whether the cases were brought to the attention of Bureau, or whether he was aware of the cases at the time. Mr. Domeika agreed that the same words may have different meaning depending on the section of the Code in which they are found. He further agreed that his opinion to the Virginia Commissioner of Insurance regarding the C-HAT and K-HAT transactions was limited to the applicability § 38.2-136 of the Code of Virginia, and no other section of the Code. Tr. at 689-93.

Mr. Paul Gulko testified that since 1981 he has been employed with Guaranty Fund Management Services ("GFMS"), an unincorporated not-for-profit association, and currently serves as its president. GFMS administers eight property and casualty insurance guaranty funds in Massachusetts, Rhode Island, Connecticut, New Hampshire, Maine, Vermont, Virginia, and the District of Columbia. Mr. Gulko holds executive positions in each of the guaranty funds he administers. In Virginia, he serves as the executive secretary and manager of VPCIGA. VPCIGA has no employees. Ex. PG-20, at 1; Tr. at 856-57, 871.

Mr. Gulko testified that as a result of the insolvency of ROA, VPCIGA has paid approximately $12,000,000 in "covered claims" and claims expenses as of June 2004. He estimates that VPCIGA will ultimately pay approximately $48,000,000 in "covered claims" and claims expenses. As a result of its claim payments, VPCIGA has become a creditor of the ROA estate. VPCIGA has filed an application for an early access distribution from the ROA estate, but it has not received a distribution. Ex. PG-20, at 2.

Mr. Gulko testified VPCIGA determined the HPG claims assumed by ROA were not "covered claims" under the Virginia Insurance Guaranty Association Act (the "Act"). GFMS claims examiners reviewed the HPG Assumed Claims. VPCIGA conferred with its legal counsel regarding Virginia law, the legal status of HPG, and the claims of its former members. VPCIGA denied the HPG Assumed Claims because of the absence of an insurance policy issued by an insolvent insurer or a member insurer. Mr. Gulko stated the VPCIGA was never able to locate an insurance policy issued by ROA. He received no complaints related to VPCIGA's denial of the HPG Assumed Claims. Mr. Gulko stated that VPCIGA cannot levy assessments against group self-insurance associations, and it did not levy assessments on HPG. Ex. PG-20, at 2-3.

Mr. Gulko stated the position of VPCIGA: the HPG Assumed Claims are not claims of policyholders arising out of contracts of insurance. VPCIGA determined that HPG was not a licensed insurer, did not transact the business of insurance, and was a group self-insurance association. VPCIGA believes the disposition of assets by HPG to ROA and the termination of HPG did not create a direct insurance obligation between HPG and its former members. Mr. Gulko stated there is no coverage under the Act for assessable coverages under a group self-insurance association such as HPG. He believes the assumption obligations are not insurance as to past losses; there was no fortuity involved. Ex. PG-20, at 3.

Mr. Gulko addressed the recent amendment to § 38.2-1603 of the Code of Virginia, which was proposed by the Virginia Bureau of Insurance.[29] VPCIGA was contacted concerning the proposed amendment and met with the Virginia Commissioner of Insurance. After assurances by the Bureau that the amendment would not apply retroactively, VPCIGA agreed not to oppose the amendment. Tr. at 858-59.

On cross-examination, Mr. Gulko testified that he made VPCIGA's decision on the Assumed Claims with the advice of legal counsel. Counsel asked him to look at Ex. DR-10, Tab K 2. Mr. Gulko admitted he had not reviewed the document prior to making his decision on the Assumed Claims. Mr. Gulko stated he based his decision on the fact that HPG was not a licensed insurance company, and the fact that no policy of insurance could be found. He further stated the testimony he heard throughout his time in the courtroom had not changed his position. After examining Ex. DR-10, Tab K 2, Mr. Gulko agreed that the document was issued by HPG to Children's Hospital; HPG was a Virginia group self-insurance association; HPG issued workers' compensation coverage to its members; the coverage provided by HPG was not insurance; HPG was later merged with or assumed by ROA; VPCIGA denied the HPG claims that arose pre-merger; VPCIGA has not denied pre-merger claims that were covered by a replacement insurance policy issued by ROA; and the coverage provide by ROA after the merger was insurance. Tr. at 860-64.

Mr. Gulko was asked again to look at Ex. DR-10, Tab K 2. He agreed Children's Hospital was the name on the participation agreement; the agreement provided workers' compensation coverage under Virginia law; the agreement was governed by the workers' compensation employers' liability policy of NCCI as approved for use in Virginia; the agreement provided a commencement and period of coverage; the agreement provided an amount of coverage; and the agreement provided details related to the premium. Tr. at 864-65.

Mr. Gulko testified that the opinions he expressed did not apply to the C-HAT or K-HAT transactions, since he had not reviewed any of the documentation related to those transactions. Tr. at 866-67.

Mr. Gulko stated the purpose of a guaranty association is to provide a limited safety net and to pay covered claims of an insolvent licensed insurance company. He confirmed that there is no cap on guaranty fund coverage for workers' compensation claims in the states he covers. He agreed that a workers' compensation claimant who was injured and received an award, and who filed a claim with a guaranty association, would be a third-party claimant. Mr. Gulko believes there is no net worth cap in Virginia for third-party claims or workers' compensation claims. Tr. at 867-69.

Mr. Gulko disagreed that one of the purposes of a guaranty association is to protect the interests of the association and the insurers that make up the association. He stated that licensed insurance companies make up the guaranty association; the association is governed by a board of directors; member insurance companies elected by the association and approved by the Virginia Bureau of Insurance serve on the board; and there are no citizen representatives serving on the

[29]The 2004 amendment by c. 285, in the paragraph defining "Covered claim," inserted the clause designation (i) and added clause (ii) in the first sentence; added the language beginning "any amount due any reinsurer" at the end of the third sentence; and added the fourth and last sentences; inserted "when the obligation with respect to the covered claim was assumed" in the paragraph defining "Insolvent insurer."

board of directors of VPCIGA. Mr. Gulko stated that whenever an insurer is declared insolvent, the board asks GFMS to protect the interests of the association by making claims with the receiver and by denying claims that the association is not responsible by statute for paying. Tr. at 869-71.

Mr. Gulko testified that the National Conference of Insurance Guaranty Funds ("NCIGF") is made up of the property and casualty guaranty funds throughout the country. Its purpose is to coordinate the activities of guaranty funds with receivers and to disseminate information to the insurance industry and to the public as needed. Mr. Gulko is the chairman of the NCIGF coordinating committee for ROA. The NCIGF coordinating committee does not make coverage decisions, that decision is left up to the individual state guaranty associations. Tr. at 872-75.

Mr. Gulko is unsure whether he reached his position on the Assumed Claims before or during the VPCIGA board meeting. He would not have taken the position unless the board, on the advice of counsel, approved the position. The VPCIGA board asked its counsel to protect the interests of the association, and the board took the position of denying the Assumed Claims. Tr. at 875-76.

Mr. Gulko confirmed that there is no reference to "licensed insurer" in the 2004 amendment to § 38.2-1603 of the Code of Virginia, and that had the amendment been in effect at the time of the various merger or assumption transactions, the Assumed Claims would be covered claims if there was a policy of insurance. Mr. Gulko stated that he did not personally look at the definition of "insurance policy" in Title 38.2 of the Code of Virginia before reaching his position; he relied on the advice of counsel.[30] Tr. at 876-79.

Counsel posed a hypothetical situation in which a movie company wants to film "The Great Train Robbery" on a railroad company's property. The railroad requires the movie company to sign an agreement agreeing to indemnify the railroad against any loss if one of the movie company's employees is injured while on the railroad's property. Mr. Gulko concurred that the agreement between the railroad and the movie company was an indemnity agreement and that under the definition found in § 38.2-100, the agreement would be a contract of insurance. He disagreed with the premise that the A-HAT members' agreement to indemnify each other against a loss was an indemnity agreement, because there is a sharing of risk rather than assumption of risk by a third party. Tr. at 880-83.

Mr. Gulko clarified that the $48,000,000 claims estimate he provided in his testimony includes loss adjustment expense and administrative costs. Tr. at 883-84.

Finally, Mr. Gulko offered his opinion that the A-HAT and HWCF Assumed Claims did not arise out of contracts of insurance. His opinion was based on the advice of counsel. Tr. at 884-85.

Ms. Etti Baranoff is an associate professor of insurance and finance at Virginia Commonwealth University in Richmond, Virginia. She has held this professorship since 1995. Ms. Baranoff teaches courses on insurance, risk management, pensions, employee benefits, and finance

[30]The last sentence in Section 38.2-100 of the Code of Virginia provides that: "[w]ithout otherwise limiting the meaning of or defining the following terms, "insurance contracts" or "insurance policies" shall include contracts of fidelity, indemnity, guaranty and suretyship."

to both graduate and undergraduate students. In 1993 she earned her doctorate in finance, insurance, and statistics from the University of Texas at Austin. In 1972, she earned a bachelor of arts in economics and statistics from the University of Tel Aviv in Israel. Ms. Baranoff holds a teaching certificate from the University of Tel Aviv and the Fellow of Life Management Institute ("FLMI") designation. Ms. Baranoff is widely published and is frequently asked to speak on insurance topics. Ex. EB-23, at 1-2; Tr. at 1201-02, 1204-13.

Before her career in teaching, Ms. Baranoff worked for the Texas Association of School Boards ("TASB") for a year after earning her doctorate. She did market research for TASB's workers' compensation, health, property and casualty, and unemployment risk pools that were created for school districts in Texas. From 1982 to 1984, Ms. Baranoff worked for the Texas Department of Insurance. She started in the rate development department doing actuarial work and several years later moved to the research and analysis department. She researched legislative issues relating to all lines of insurance including workers' compensation, property, and health insurance for the three members of the Texas insurance board. Ex. EB-23, at 2-3; Ex. VA-137; Tr. at 1203 and 1206.

Ms. Baranoff gave two reasons for her opinion that the Assumed Claims were not "claims of other policyholders arising out of insurance contracts." First, the members of the SITs and GSIAs were not "policyholders arising out of insurance contracts" before the mergers. Second, the members were not transformed into policyholders under insurance contracts by virtue of the mergers between the SITs and GSIAs and ROA. On the second point, Ms. Baranoff believes no "assumption reinsurance" transaction occurred, and the members did not become "direct insureds" of ROA with respect to known liabilities that existed prior to the mergers. The members of the SITs and GSIAs were not policyholders under insurance contracts before the mergers because they were members of a group self-insurance arrangement. She opined that group self-insurance is not insurance because it does not involve the transfer of risk from one person to a third party, which she believes is a necessary element of insurance. Ms. Baranoff noted that § 38.2-100 of the Code of Virginia defines "insurance" as involving the "business of transferring risk," which is consistent with the standard definition found in the insurance field. Ms. Baranoff explained that the mergers did not transform the members of the SITs and GSIAs into policyholders through an assumption reinsurance transaction. Assumption reinsurance also involves the transfer of risk. The "ceding insurer" transfers its risks to the "assuming insurer." Even assuming that the SITs and GSIAs were "ceding insurers," Ms. Baranoff believes no risk transfer occurred when the mergers took place. The workers' compensation claims that existed prior to the mergers were existing liabilities that were transferred to ROA. Ms. Baranoff opined that transferring liabilities does not equate to transferring risks, which she believes is an essential element of reinsurance. Ex. EB-23, at 4-5; Tr. at 1214-15.

According to Ms. Baranoff, "insurance" must have all of the following elements: risk transfer, risk sharing or pooling, and a resulting reduction in risk. For support, Ms. Baranoff relied on the definition of insurance found in § 38.2-100 of the Code of Virginia, which states "[i]nsurance means the business of transferring risk by contract. . . ." She believes her definition of insurance is consistent with this definition. The fact that the Code of Virginia defines insurance as risk transfer is important, since the issue in this case is whether the members of the SITs and GSIAs were "policyholders under insurance contracts." Second, all of the elements of insurance that she listed

are present in definitions of insurance found in standard insurance textbooks, including the textbook she authored. Ms. Baranoff has not seen a definition of "insurance" that did not contain the element of risk transfer. She believes the three elements noted above must be established before determining whether a contract meets the five-part test for an insurance contract. Ms. Baranoff conceded that one need not be an insurance company to enter into an insurance contract; however, there might be regulatory consequences for doing so. Ex. EB-23, at 5-6; Tr. at 1215-17, 1234-37.

Ms. Baranoff defined "risk" in the insurance and finance context as the deviation from expectation, which is the unknown about future outcomes. She stated this definition of risk is used in all insurance and financial management textbooks. She explained the statistical measure of risk in the insurance and finance industries is termed "variance" or "standard deviation." Ms. Baranoff gave an example using "standard deviation" as a measure of risk. She started with a sample of 1,000 similar homes and looked at fire losses during a three-year period. There were 10 fire losses in the first year, 13 fire losses in the second, and 7 in the third. For this sample, the expected losses in the future would be 10, or the average of the three years. In statistical terms, the risk is the variation around the average expected losses. The measure of the variation is called the "standard deviation." In this example, the standard deviation is 3. In any given year while 10 homes may have a fire loss, the number of homes having a loss may vary up or down by 3. Insurance companies measure the risk around expected losses. Ex. EB-23, at 6-7; Tr. at 1217-23.

Ms. Baranoff defined "transfer of risk" as the transfer of the potential variation in expected outcomes from the original holder of the risk to a third party. The transfer of risk is the transfer of the "unknown" element in predicting future losses to a third party. Ms. Baranoff believes transfer of risk occurs before losses are completely known. The unknown element (the standard deviation) is the part that is transferred to the third party, not the losses themselves. In her opinion, the transfer of losses is not equal to the transfer of risk. Ms. Baranoff gave an example to illustrate a transfer of risk. A homeowner has a risk that she will lose everything she owns if her house burns to the ground. She may or may not have such a loss in the future. The unknown is whether she will have a loss. When she purchases homeowner's insurance, she transfers this risk to a third party, the insurance company. In doing so, she has reduced her risk of loss from 100% to 0% (assuming no deductible and coverage for the full value of her home). The homeowner pays a premium in exchange for coverage for unknown outcomes. Ms. Baranoff created the award-winning Risk Ball Game to explain the concepts of risk and risk transfer, and she used this game at the hearing to demonstrate transfer of risk. Ex. EB-23, at 8-9; Tr. at 1223-33.

Ms. Baranoff explained that a contract must include an element of risk transfer to be an insurance contract and it must be: based on utmost faith; a contract of adhesion; a contract of indemnity; and a personal contract. Ms. Baranoff explained that the existence of these elements in a contract does not automatically make it an indemnity contract. She explained that indemnity restores a person who experiences a loss to his original condition and no more. She further explained that all insurance contracts are indemnity contracts because they pay a person for economic loss, but not all indemnity contracts are insurance contracts. Insurance involves risk transfer, risk pooling, and risk reduction. An example of an indemnity contract that is not insurance is a product warranty. The manufacturer promises to fix or replace the product if it is defective, make the purchaser whole, but this is not insurance because the risk is not pooled or reduced. Ms.

Baranoff described the manufacturer's promise as a guarantee of workmanship, which is not insurance. Ex. EB-23, at 9-10.

Ms. Baranoff explained that her definitions of risk, risk transfer, and insurance contracts are widely used in standard insurance textbooks, including her own. She has seen no authority that disagreed with her definitions of risk and risk transfer. EB-23, at 10-11.

Ms. Baranoff developed a graphic presentation illustrating why the members do not have an insurance contract with their SIT or GSIA. In year one, employers A, B, C, D, and E are members of a GSIA.[31] They are members of a pool in which the risk is shared by all members of the pool. As Ms. Baranoff described it, "they are simmering in their own juice...." She contrasted that scenario with an insurance company where the risk is transferred. In year two, employers D and E decide to leave the group and get insurance from an insurance company.[32] She described the difference between a GSIA and an insurance company as the difference between a man dressing like a woman and a real woman. While a GSIA may appear to be an insurance company, in reality it is not. In year five, employers A, B, and C decide to join ROA and are insured on a going-forward basis. In Ms. Baranoff's opinion, the assets and liabilities that the GSIA transferred to ROA represent a financial transaction, not an insurance transaction. She explained that if the amount of the liabilities assumed by ROA increased after the transaction, those liabilities are not related to any insurance transaction. Tr. at 1242-56.

Ms. Baranoff explained that "group self-insurance" is not insurance because it does not include an element of risk transfer. When a member joins a GSIA, it does not transfer its risk from itself to another party. The member retains its risks. The members of the GSIA pool their risks for predictive accuracy of the pool's future losses. The predictive accuracy of future losses is necessary to adequately fund the pool and to obtain stop-loss coverage. Ms. Baranoff believes risk *pooling* is not risk *transfer* to a third party. She believes employers who want to transfer risk, purchase insurance from an insurer. Additionally, she believes the joint and several liability of the members of the GSIA may make one member of the group liable for the losses of the entire group. Ms. Baranoff provided two examples. In the first example, a GSIA with ten members predicted that next year's losses would be $100 million for the entire group with a margin of error (standard deviation or risk) for the group of $10 million. The losses experienced by the GSIA reach $110 million, within the margin error. The members planned for such a situation and were able to adequately fund the GSIA. In the second example, the GSIA missed its prediction because of a catastrophic event and losses for the pool reach $200 million. The members of the pool must pay the additional losses. The risk was never transferred to a third party and the members are contractually obligated to pay the losses. If eight of the ten members declare bankruptcy, the other two members would be responsible for the entire $200 million in losses. Ms. Baranoff noted that the example would have had a different outcome if all ten members had purchased an insurance policy and transferred their risk to an insurance company. The insurance company would be obligated to pay for the catastrophic year. Ex. EB-23, at 11-13.

[31] *See*, Ex. EB-24.
[32] *See*, Ex. EB-25.

Ms. Baranoff explained that SITs and GSIAs fear catastrophic losses; therefore, the groups purchase "stop-loss" insurance. Stop-loss insurance has both individual and aggregate attachment points. For example, stop-loss insurance may cover $1 million for each claim and $10 million for aggregate annual claims. Ms. Baranoff explained that the self-insurance retention of the employers is not like a large deductible. The stop-loss insurer does not get involved with a claim until it reaches the stop-loss attachment point. The insurer will not step in and defend the GSIA in legal proceedings until the attachment point is reached. On the other hand, in insurance with a deductible, the insurer is involved with the claim from the outset. Ex. EB-23, at 13.

Ms. Baranoff described a situation in which the members of a GSIA with stop-loss insurance still could be liable under their joint and several liability. This would involve a catastrophic loss that causes the stop-loss insurer to become insolvent. In this instance, the last surviving employers would be responsible for paying all the remaining liabilities of the pool under their joint and several liability. If the employers had purchased insurance, making them policyholders under an insurance contract, and catastrophic losses bankrupted the insurer, the employers would not be responsible for paying their employees' workers' compensation claims because the employers had transferred their risk to a third party. In this instance, the guaranty fund would be responsible for paying the injured employees' claims. Ex. EB-23, at 13-14.

Ms. Baranoff provided an overview of the laws and documents that allowed her to reach her first opinion that the members of the SITs and GSIAs were not "policyholders arising out of insurance contracts" before the mergers. She specifically relied on § 65.2-802 A of the Code of Virginia, the Workers' Compensation Act, which provides that: "[t]wo or more employers having a common interest may be licensed by the State Corporation Commission as a group self-insurance association and permitted to enter into agreements to pool their liabilities under this title." Ms. Baranoff noted that the statute fails to mention risk transfer. In contrast, § 38.2-100 of the Code of Virginia defines "insurance" as "the business of transferring risk. . . ." Additionally, she relied on § 65.2-802 C of the Code of Virginia which provides that: "[m]embers of a group shall execute a written agreement under which each agrees to jointly and severally assume and discharge any liability under this title of employers party to such agreement. . . .; however, no such agreement nor membership in a group self-insurance association shall relieve an employer of the liabilities imposed by this title with respect to his employees." Ms. Baranoff reviewed the licenses or certificates of authority of the GSIAs, and determined the documents established that the entities were not insurers, insurance companies, or in the business of insurance under each state's insurance code. Instead, the GSIAs were licensed or authorized under each state's workers' compensation law. In some instances affidavits were supplied indicating that the SITs and GSIAs were not authorized to transact the business under the applicable state insurance codes. For example, a certification provided by the Clerk of the Commission stated that: "[n]o license to transact the business of insurance in the Commonwealth of Virginia has ever been issued pursuant to Section 38.2-1024 of the Code of Virginia to [HPG]."[33] Ms. Baranoff reviewed the agreement that the members executed to join HPG. This agreement provided that: "the Members of the Association have agreed to provide for joint and cooperative action to self-insure and to pool their separate liabilities arising pursuant to the terms of the Virginia Workers' Compensation Act. . . ."[34] Ms. Baranoff observed that the HPG agreement did not transfer risk, a necessary element of insurance.

[33] *See*, Ex. VA-135.
[34] *See*, Ex. VA-29, at 1.

She further observed the members transferred their joint and several liability to ROA in the assumption and merger agreements. Ms. Baranoff's observations regarding HPG were supported by a memorandum from the staff of the Virginia Bureau of Insurance.[35] Ex. EB-23, at 14-16; Tr. at 1237-41.

Ms. Baranoff explained the reasons an employer would become a member of a GSIA if risk is not transferred. She noted that during a hard insurance market, rates are high and certain insurance might be unavailable. Employers choose alternative mechanisms or markets for risk management solutions to reduce their insurance costs. A large employer might choose to self-insure since it can predict future losses with minimal variations. Smaller employers might not have enough exposures to predict accurately future losses. They join a group to have predictive accuracy of their risks and to qualify for stop-loss insurance. In both instances, Ms. Baranoff believes the employers are aware of the risks of self-insurance, and they forgo the benefits of risk transfer and the safety net of insurance to save money. When the insurance market softens, employers typically return to traditional insurance. Those employers with lower loss experience are offered lower premiums to move, and employers with higher loss experience do not have an incentive to move. The result is the GSIA is left with employers with poor loss experience, and the GSIA becomes a high-risk pool. Ex. EB-23, at 16-18.

In support of her second opinion that the members were not converted into policyholders under insurance contracts by virtue of mergers between the SITs, GSIAs, and ROA, Ms. Baranoff explained that assumption reinsurance is an arrangement in which a ceding insurer transfers all or a portion of its risk under contracts of insurance to an assuming reinsurer. Like insurance, reinsurance must have an element of risk transfer. Ms. Baranoff explained that the merger agreements between the SITs, GSIAs, and ROA did not constitute reinsurance because no risk transfer occurred with respect to the workers' compensation claims that existed on the merger dates. She noted that the obligations that were transferred were known liabilities, not unknown future events. Ex. EB-23, at 18.

Ms. Baranoff addressed two points in support of her opinion. First, she noted the merger agreements themselves do not evidence any unknown elements in the losses, a prerequisite of a transfer of risk. With the exception of the Missouri agreement, the merger agreements do not mention unknowns. For example, she noted that the agreement with MHA Private states that: "[ROA] agrees to assume and become responsible for all the liabilities of MHA Private (the 'liabilities') at the Closing Date. Neither MHA Private nor its members shall have any responsibility with respect to the liabilities after the closing date."[36] Ms. Baranoff found no mention of risks being transferred, and she believes the reference to "the liabilities" is a reference to pre-existing obligations, not future unknowns. She believes the liabilities of the GSIAs are static as of the closing date. Ms. Baranoff concluded that to be assumption reinsurance, an unknown element would be expressly contemplated (i.e., some risk) in the agreements. She believes the transactions

[35] *See*, Ex. VA-121. In a memorandum addressing whether HPG had authority to enter into a reinsurance agreement, the Virginia Bureau of Insurance staff opined that HPG could not enter such an agreement because it was not an insurer as defined by § 38.2-100 of the Code of Virginia. As part of its discussion, the Staff stated that: "HPG has [not] proven that it is an insurance company and therefore able to purchase reinsurance. If group self-insurance associations are insurance companies then all provisions of the insurance code should be applied to their regulation. There are fundamental differences between a group self-insurance association and an insurance company."

[36] *See*, Ex. VA-4, at 3.

constituted a transfer of an absolute sum of liabilities as of the closing date, but not a transfer of risk of an unknown amount. Second, the mergers were not treated by ROA in its financial statements as a risk transfer. An insurer reports its loss development for its various lines of insurance in Schedule P of its financial statements. ROA did not include the liabilities it assumed from the SITs and GSIAs in Schedule P of its annual financial statements for the years 1996 to 2000. ROA started to report data on the assumed liabilities after 2000. The number of outstanding claims did not change from 1996 to 2000. Instead, ROA included the liabilities in the Underwriting and Investment Exhibit, Part 3A – Unpaid Losses and Loss Adjustment Expenses of its annual statements. Ms. Baranoff also found that ROA had not reported the assumed liabilities in Schedule P, Part 3D or Part 5D. Ms. Baranoff concluded that ROA did not consider the liabilities of the SITs and GSIAs to be risks meriting inclusion in its loss development, or liabilities with some unknown element. She stated that no insurance company would wait years after a transaction to report claims for loss development because the company's reserves and liabilities would be incorrectly stated. If an insurance company's liabilities are incorrectly stated, Ms. Baranoff believes this might lead to its insolvency, which is what she believes happened to ROA. Since state insurance regulators did not take issue with ROA's financial reporting, Ms. Baranoff believes the various state insurance departments concurred that the transactions involved no risk transfer. She observed that § 38.2-1316.6 of the Code of Virginia requires that: "[f]or the purpose of determining the financial condition of any reinsurer, the reinsurer shall establish a reserve liability at least equal to the amount that it would be required to maintain in accordance with this title if it were the direct insurer of the assumed risks as specified in the reinsurance agreement." Ms. Baranoff concluded that ROA did not treat the losses of the merged SITs and GSIAs as a risk transfer under Virginia law. Ex. EB-23, at 18-21; Ex. VA-31, 34, and 36; Ex. DR-12, Tab B; Tr. at 1256-73.

Ms. Baranoff opined that A-HAT did not have insurance contracts with its members. For support, she relied on the A-HAT trust agreement. She believes the members were sharing risk, not transferring risk, and the members were jointly and severally liable. She noted that anyone who has a contract of insurance with an insurance company; can cancel their policy at any time. The members of A-HAT had to obtain approval before they terminated participation with the trust. Her opinion applied to HWCF as well. Exs. C-1, C-9, and GA-14; Tr. at 1274-79.

Ms. Baranoff opined that neither C-HAT nor K-HAT entered into any insurance contracts with their members. Both entities involved self-insurance. Exs. KH-3 and KH-21; Tr. at 1279-81.

Ms. Baranoff stated there were no Assumed Claims in this case, only assumed liabilities. She opined that none of the entities involved in this case had contracts of insurance with their members. The arrangements were all alternative risk mechanisms. Tr. at 1281-82.

On cross-examination, Ms. Baranoff stated that she received all the documents necessary for her to form her opinions in this case. Her prefiled testimony contains all of her opinions. Those opinions are: before the mergers the members of the SITs and GSIAs were not policyholders arising out of insurance contracts; and the members were not transformed into policyholders arising out of insurance contracts by virtue of the mergers between the SITs, GSIAs, and ROA. Related to the second opinion were two additional points: no assumption reinsurance transaction occurred; and the members did not become direct insureds of ROA with respect to known liabilities that existed prior to the mergers. She understands that this case will be decided under Virginia law. Ms.

Baranoff agreed that it's not necessary to be an insurance company to issue a contract of insurance. Hypothetically, any individual or business can issue an insurance contract. Tr. at 1290-1300.

Initially, Ms. Baranoff would not agree that the assumption and merger agreements eliminated the members' joint and several liability. However, she later agreed that ROA assumed all of the liabilities of the SITs and GSIAs, including the members' joint and several liabilities. Tr. at 1300-05.

Ms. Baranoff agreed that workers' compensation insurance is typically written on an occurrence policy. She agreed that there may be a substantial lag between the time the claim arises and is presented, and when the claim is finally paid. Tr. at 1305-06.

Ms. Baranoff has not worked on any insurance company liquidations. She is not an accountant; she has not prepared or audited an insurance company annual statement or participated in an insurance company financial examination. She is an insurance expert and she has some expertise in reinsurance. Tr. at 1306-08.

Ms. Baranoff further testified that the members of the SITs and GSIAs were not policyholders arising out of insurance contracts because they were members of a self-insurance agreement. The members did not transfer their risk to a third party, a party unrelated to the members of the group. As Ms. Baranoff described it, the members of the group "simmer in their own risk." Each member is jointly and severally liable for all the other members' losses. In her opinion, each member has its own risk and no risk is transferred between the members of the SITs and GSIAs. Ms. Baranoff agreed that once a member makes its initial contribution and the SIT or GSIA has sufficient funds, all of the members' claims would be paid. She further agreed that a SIT and GSIA typically have stop-loss insurance with an aggregate attachment point that is hopefully equal to the amount of members' annual contributions. Ms. Baranoff has seen no evidence that the SITs and GSIAs in this case did not fund at least up to the stop-loss attachment point. Tr. at 1308-15.

Ms. Baranoff did not have enough information to determine whether the SITs or GSIAs transferred surplus to ROA. She believes the SITs and GSIAs were well managed and that the members believed all they had to pay was their annual contribution. The members knew they did not have policies from an insurance company, but they managed their own money well. Tr. at 1315-17.

Ms. Baranoff referred to Exhibit EB-25 to illustrate the transfer of risk to a third party. A third party is someone who is not a member of the self-insurance pool. The members of the SITs and GSIAs pooled their risks. Ms. Baranoff agreed that if someone purchased an automobile insurance policy from State Farm, State Farm would be a third party. She further agreed that a third party may be an individual or a corporation that is not part of the pooling arrangement. Ms. Baranoff was given the hypothetical of two hospitals agreeing to insure each other for the same amount. She explained that the two hospitals were exchanging risks by transferring risk to each other. Tr. at 1317-26.

Another reason for Ms. Baranoff's finding that the members were not policyholders arising out of insurance contracts was the members' joint and several liability. It is her understanding of joint and several liability that if one member's claims exceed all of the money from contributions and the stop-loss coverage, another member may be ultimately responsible for paying those claims. In this instance, Ms. Baranoff believes there is no transfer of risk from the first member to the second member. She believes this is a pooling of risk which will allow the group to purchase stop-loss insurance. In her opinion, the risk is the deviation from expectations or the standard deviation. Tr. at 1326-31.

Ms. Baranoff refused to agree it was only a remote contingency that the 11 programs involved in this case would run out of contributions and stop-loss coverage. While she believes the SITs and GSIAs were well managed, she believes the softening insurance market encouraged employers to leave the groups, leaving all the higher risk employers in the self-insurance pools; however, Ms. Baranoff has seen no documents supporting her beliefs. Tr. at 1331-32.

Ms. Baranoff has occasionally reviewed insurance contracts and she can discern whether a contract is an insurance contract. She identified Exhibit EB-29, the NCCI policy form, as both a contract and a policy of workers' compensation insurance. In her opinion, Exhibit EB-29 could not have been used by the SITs and GSIAs with the word "policy" in it. Although the same form may have been used by the SITs and GSIAs, Ms. Baranoff believes it would be self-insurance masquerading as insurance. She referred to her analogy of a man dressing as a woman. In her opinion, the NCCI policy form would be a contract allowing the members to pool their risks if it was issued by one of the SITs or GSIAs. Ms. Baranoff agreed that the coverage provided by ROA to the employers before they became members of the SITs and GSIAs was insurance, and that by law the coverage was the same after the employers became members of the SITs and GSIAs. She further agreed that after the mergers with ROA, the members became ROA policyholders and their coverage was mandated by law. Tr. at 1332-39.

Ms. Baranoff refused to agree that the members of the SITs and GSIAs agreed to directly indemnify each other, but she did agree there was a contract of indemnity among the members through their pooling arrangement. In her opinion, every time there is pooling the result is indemnity among the members. Tr. at 1339-43.

Ms. Baranoff confirmed that she relied on the definition of "insurance" in § 38.2-100 of the Code of Virginia and her knowledge of the definition in forming her opinion that insurance requires the transfer of risk to a third party. She agreed that the definition in § 38.2-100 of the Code of Virginia provides that an agreement to indemnify another person is insurance; however, in her opinion, the requirements of the statute are cumulative. According to Ms. Baranoff, an insurance agreement in Virginia must: indemnify another person; pay or provide a specified or ascertainable amount of money; and provide a benefit or service upon the occurrence of a determinable risk contingency. In Ms. Baranoff's expert opinion, the second requirement refers to limits of liability in an insurance agreement. Tr. at 1343-50.

According to Ms. Baranoff, the last sentence of § 38.2-100 of the Code of Virginia does not make a contract of indemnity a contract of insurance. She believes an insurance contract must have the elements of fidelity, indemnity, guaranty, and suretyship. She described fidelity as good faith,

guaranty as a promise to pay, and suretyship as a contract of adhesion. Ms. Baranoff was given a hypothetical that Aetna Life and Casualty issues Virginia Commonwealth University a group health insurance policy. She responded that the group health insurance policy was a contract of insurance that contained the fidelity, guaranty and suretyship elements found in § 38.2-100 of the Code of Virginia. Tr. at 1350-56.

Ms. Baranoff was asked to comment on the five-part test for finding a contract of insurance under Virginia law. She prepared Exhibit EB-30 which listed each of the elements. Ms. Baranoff admitted that she had not read the *American Surety* or *Group Hospitalization* cases. She was told by her lawyers that the five elements she had listed came from the two cases. Ms. Baranoff applied the five-part test to the relationships between the members and the SITs and GSIAs and concluded that the members were not insureds. Ms. Baranoff was asked to assume that the arrangements provided coverage. She agreed that the members would be the subject matter of the coverage; the risk covered in nine of the programs would have been employee work-related injury, and in the other two programs liability of the member as result of negligence or omission; the period and commencement of the coverage is stated in the plan documents; the amount of coverage is specified in the plan documents; and the premiums or the contributions are stated in the plan documents. She agreed all five elements of *American Surety* or *Group Hospitalization* were present in each of the eleven relationships, however, as long as it was not characterized as insurance. Ms. Baranoff believes no insurance is present because no risk has been transferred to a third party. Tr. at 1357-66.

Ms. Baranoff reaffirmed her opinion that the mergers did not transform the members into policyholders arising out of insurance contracts, because there was no assumption reinsurance and the programs did not become direct insurance. Ms. Baranoff added a third reason to support her opinion: the mergers represented a financial transaction that transferred assets and liabilities. She referred to Exhibits EB-26 and EB-30 and applied the five-part test to the balance sheet transfer of assets and liabilities. She could not identify the subject matter insured, but did find that the liabilities or the risks may be variable. She found a starting date for the commencement period of the risk but no ending date. Since the liabilities are dynamic, there is no static amount of insurance. She believes the assets that were transferred should not be considered premiums. In summary, Ms. Baranoff believes elements two and four of Exhibit EB-30 are not satisfied because if there is assumed risk, the amount is dynamic and the amount of insurance cannot be determined. However, if you can determine the amount of insurance, then the risk is static and there is no risk transfer. Ms. Baranoff was given a hypothetical in which a person offers to pay State Farm $47,000 a year for automobile insurance for his teenage driver, and State Farm agrees to provide coverage up to $48,000 for any claims that the teenager may have. Ms. Baranoff agreed the amount of insurance was the $48,000 policy limit, and the policy covered the risk of accidents that may occur while the car is being driven. Tr. at 1366-76.

Ms. Baranoff agreed that a person could be a policyholder arising out of an insurance contract without an assumption reinsurance transaction. Further, she agreed that assumption reinsurance is irrelevant to this case. She agreed that a person may purchase an insurance policy to cover future losses and become a policyholder arising out of an insurance policy. Ms. Baranoff agreed that through the merger agreements, ROA became responsible for the past liabilities and future liabilities of each of the SITs and GSIAs. She opined the SITs and GSIAs were relieved of

their liabilities as long as ROA remained solvent, basing her opinion on her expertise in the insurance field. Ms. Baranoff was unable to cite any document which stated that the SITs and GSIAs remained responsible for their liabilities after the merger agreements. Tr. at 1377-82.

Ms. Baranoff confirmed that one of the reasons the transactions were not insurance was that ROA did not consider the liabilities to be risks that needed to be included in Schedule P of its annual statement. Accordingly, she believes ROA conducted no risk assessment on the liabilities it assumed. However, Ms. Baranoff was unable to state conclusively that ROA conducted no risk assessment on the assumed liabilities. She based her belief on the fact that Schedule P showed no loss development. She has seen no other documents that would support her belief. Ms. Baranoff clarified her earlier testimony on risk assessment by stating that prior to completion of the mergers, no one had evaluated the exposure created by the transactions. Ms. Baranoff agreed that Schedule P is part of an insurance company's annual statement that is filed in March of each year and reflects the insurer's financial condition as of December 31 of the preceding calendar year. She agreed that ROA may have conducted a risk assessment prior to the merger transactions in November 1997, and simply forgot to include this in its annual statement. Tr. at 1382-91.

Ms. Baranoff reaffirmed her position that based on her review of Schedule P, Part 5D of ROA's annual statements for 1996 to 2002, ROA did not incorporate any of the past claims of the SITs or GSIAs in its loss development triangles; the number of claims did not change to reflect inclusion of the open claims of the groups; and ROA did not treat the acquired liabilities of the SITs and GSIAs as claims that needed to be developed or claims that had some unknown risk to them. Ms. Baranoff stated that she had examined closely Schedule P of ROA's annual statements for the period. Tr. at 1391-94.

Ms. Baranoff was asked to look at Exhibit VA-31, ROA's 1996 annual statement. In particular, she was directed to page 79, Schedule P, Part 1D, Column 12, Number of Claims Reported – Direct and Assumed. She noted that line 7 reported 1135 claims for the 1992 policy year, line 9 reported 6 claims for the 1994 policy year, and line 10 reported 3 claims for the 1995 policy year. Ms. Baranoff agreed that ROA was basically out of the workers' compensation insurance business in 1994 and 1995. Ms. Baranoff was directed to Part 1D, Column 23, Total Net Losses and Expenses Unpaid. She noted that line 7 reported $1.5 million in losses for the 1992 policy year, line 9 reported $227,000 in losses for the 1994 policy year, and line 9 reported $264,000 in losses for the 1995 policy year. Tr. at 1394-98.

Ms. Baranoff reaffirmed her earlier testimony that ROA never updated its claim development in Schedule P, Part 5D to reflect the assumed liabilities. She chose to look at Part 5D because she could not work with the other sections of Schedule P. Tr. at 1399.

Ms. Baranoff also was directed to look at Exhibit VA-32, ROA's 1997 annual statement. In particular, she was directed to page 83, Schedule P, Part 1D, Column 13, Number of Claims Reported – Direct and Assumed. She noted that line 6 reported 1218 claims for the 1992 policy year, line 8 reported 196 claims for the 1994 policy year, line 9 reported 313 claims for the 1995 policy year, and line 10 reported 1,846 claims for the 1996 policy year. Ms. Baranoff was directed to Part 1D, Column 25, Total Net Losses and Expenses Unpaid. She noted that line 6 reported $5 million in losses for the 1992 policy year, line 8 reported $5.3 million in losses for the 1994 policy

year, and line 9 reported $9.3 million in losses for the 1995 policy year. Ms. Baranoff agreed that ROA's 1997 annual statement was the first one prepared after the mergers. She was asked whether the 1997 annual statement showed development that could have come only from the assumptions from the SITs and GSIAs. Initially, Ms. Baranoff did not respond to the question, but then she answered that Part 1D did not speak to her when she did her analysis. She later qualified her answer that Part 5D is the place where the liabilities should have been developed, and she questioned why ROA was inconsistently reporting the liabilities in its annual statements. Ms. Baranoff would concede only that the increase in losses was partially due to the assumption of the SITs and GSIAs. She was directed to page 136, Schedule P Interrogatories and asked to read into the record Interrogatory 8.[37] Afterwards, Ms. Baranoff conceded that ROA had embedded the results of the mergers in Part 1D of Schedule P. She questioned again why the annual statements inconsistently reported the merger of the SITs and GSIAs. Tr. at 1399-1411.

Ms. Baranoff confirmed that she had not read the North Carolina Industrial Commission's decisions in the *Bowles* and *Sun Health* cases. Tr. at 1411.

Ms. Baranoff confirmed that she was familiar with the C-HAT and K-HAT mergers. She reviewed the merger agreements; portions of the Kentucky revised statutes; the C-HAT and K-HAT prefiled exhibits, which included the two agreements that established the trusts; and some affidavits prepared by the Kentucky Insurance Department. Ms. Baranoff stated that her opinions in this case would not be affected by the fact that C-HAT and K-HAT performed an actuarial analysis and due diligence prior to and after the mergers with ROA. However, she could not dispute the fact that an actuarial analysis and due diligence were done prior to and after the mergers with ROA. Exs. KH-3 and KH-18; Tr. at 1412-21.

Under cross-examination, Ms. Baranoff reviewed her credentials as an expert witness. Ms. Baranoff confirmed that she is not a C.P.A., but she does have a Ph.D. in finance; she is not a member of any actuarial society; she has never issued an actuarial opinion on an insurance company's statutory statement; and her only experience with the review or analysis of loss reserves relates to the solvency studies and rate development she performed when she was employed by the Texas Insurance Department. Ms. Baranoff has no firsthand knowledge of how C-HAT or K-HAT conducted their operations prior to the merger with ROA, or how ROA treated the C-HAT and K-HAT liabilities after the merger. She assumed the two groups had actuaries that established the reserves for the losses and determined the members' contributions, and was not surprised to hear that Kentucky law required the two groups to have actuaries appointed. Tr. at 1421-23.

Ms. Baranoff confirmed that she relied on ROA's annual statements for her analysis. She did not request the workpapers associated with those annual statements. Tr. at 1424.

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[37]Interrogatory 8 states: "[t]he data reported on Schedule P is affected by the assumption of all assets and liabilities of six (6) companies during 1997. The reserves reported as of 12/31/97 have been reported for all entities for all report/accident years. The paid data reported for the calendar year 1997 has been reported for all entities for all report/accident years. Prior calendar activity has not been restated. Therefore, data in report/accident years for 1996 and prior include both pre-assumption and post-assumption data and is not consistent with premiums reported." *See*, Ex. VA-32, at 136.

Ms. Baranoff explained that insurance companies pool their risks to estimate future losses, and they quantify the risk of missing their loss estimate with the standard deviation. Ms. Baranoff testified that an insurance company's reserves do not measure the company's risks. Rather, the reserves measure the losses that an insurance company may have. For a self-insurance pool, Ms. Baranoff believes this type of reserve analysis has the appearance of being like that of an insurance company. She again compared it to a man dressing like a woman. Tr. at 1424-28.

Ms. Baranoff confirmed that whether an insurance guaranty fund or a group self-insurance guaranty fund exists is not determinative of whether an insurance contract exists. She explained that group self-insurers pool their losses to reduce their combined risk. She agreed risk retention groups pool risks, have the same attributes as GSIAs, and do not issue insurance to their members. Ms. Baranoff described a captive insurer as a separate subsidiary of a parent corporation that is used to provide insurance to the parent. A captive insurance company pools risk. Since it is a separate corporation, it provides insurance to its parent because the risk is transferred from the parent to a third party. Ms. Baranoff did not know the definition of an association captive. Tr. at 1428-33.

Ms. Baranoff explained that the distinguishing factor between insurance and self-insurance groups is the transfer of the risk, not the pooling of risk. When asked to explain how reciprocal insurance companies provide coverage, Ms. Baranoff testified that a reciprocal insurance company provides insurance to the subscribers; the subscribers do not insure one another. Ms. Baranoff was referred to § 38.2-1201 of the Code of Virginia and asked to read the definition of reciprocal insurance.[38] She agreed that subscribers were acting as both the insurer and insured. Ms. Baranoff confirmed that she reviewed the subscription agreement issued by ROA to the members of the SITs and GSIAs after the mergers. The fact that the subscribers were both the insurer and the insured makes no difference in her opinion. She believes reciprocal insurance involves the transfer of risk to a third party. Tr. at 1433-38.

Ms. Baranoff agreed the C-HAT and K-HAT merger documents provided that the members and the entities themselves were relieved of any further liability from that point on. Ms. Baranoff was not aware that the Kentucky Department of Workers' Claims required this provision in the merger agreements. She was also unaware the Kentucky Department of Workers' Claims had issued an order reciting that the Kentucky Department of Insurance had determined the claims would be covered by the Kentucky Insurance Guaranty Association. Tr. at 1438-39.

Ms. Baranoff did not recall reading § 38.2-1509 of the Code of Virginia prior to this proceeding. This case was her first opportunity to testify regarding the interpretation of a Virginia statute. Ms. Baranoff testified she did not know what trusts were or that a trust can be an independent entity. Therefore, her preparation for this case did not include a review of whether a trust is a separate legal entity from its grantors and beneficiaries. Ms. Baranoff reviewed the documents that formed A-HAT and HWCF. Initially, she refused to offer an opinion whether A-HAT or HWCF were trusts; however, Ms. Baranoff later stated that HWCF was a self-insurance fund that was also a trust. Ms. Baranoff was asked to assume that under Virginia law a trust was a separate legal entity from its grantors and beneficiaries. She confirmed that when she rendered her

[38]The statute defines "reciprocal insurance" as "insurance resulting from the mutual exchange of insurance contracts among persons in an unincorporated association under a common name through an attorney-in-fact having authority to obligate each person both as insured and insurer." *See*, § 38.2-1201 of the Code of Virginia.

opinion in this case she considered a trust as a self-insurer, but did not consider that a trust could be an independent entity. Tr. at 1444-53.

Ms. Baranoff confirmed that there was no transfer of risk between the members of A-HAT and the trust. She was directed to review Exhibit DR-10, Tab B 1 and asked to read a portion of the document into the record.[39] In her expert opinion, the agreement transfers no risk from a member to the trust. Tr. at 1454-56.

Ms. Baranoff was directed to review Exhibit GA-14, the Participation Agreement for Decatur Clinic X-ray and Lab, Inc., and asked to read a portion of the document into the record.[40] In her expert opinion, the agreement transferred no risk from the employer to the fund. Tr. at 1456-57.

Ms. Baranoff was given an excerpt from Ala. Code § 22-21-240 and asked to read a portion of the statute into the record.[41] She stated that she had no access to the statute nor did she research the statute prior to offering her expert opinion. She offered no opinion on whether the Alabama Legislature used the term "insurance" correctly in the statute. Tr. 1457-63.

Ms. Baranoff was also directed to review Exhibit 10, Tab A 1, the Fund Coverage Agreement for Adams & Bridger Pathology Laboratories, P.A., and asked to read a portion into the record.[42] Although the word "insuring" is used, Ms. Baranoff believes the relationship had no risk transfer and is therefore not insurance. She believes the use of the word "insurance" or "insured" in group self-insurance documents is an insurance artifice. Ms. Baranoff offered no opinion on

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[39]The A-HAT Medical Professional and General Liability Coverage Document states that: [t]he Trust will pay on behalf of members those sums which the member shall become legally obligated to pay as ***damages*** because of any ***claim*** or ***claims*** first made against the member and reported by the member to the Administrator of the Trust during the ***report year*** which occurred subsequent to the ***retroactive date*** and prior to the end of the ***report year*** because of:
Coverage A: Medical Professional Liability
Coverage B: General Liability
Coverage C: Personal Injury Liability
and the Trust shall have the right and duty to defend any ***suit*** against a member seeking such ***damages***, even if any allegations of the ***suit*** are groundless, false, or fraudulent and shall make such investigation and settlement of any ***claim*** or ***suit*** as it deems expedient.
While the Trust may have the duty to defend, under no circumstances will it be obligated to pay any amount of ***damages*** above the actual limits of coverage. (Emphasis in original).

[40]The Participation Agreement provides under paragraph 16, Claims Payment, that: "[t]he Fund will process, investigate and pay valid and appropriate workers (sic) compensation claims made by employer's covered employees during the term of this agreement subject to the terms of the Alabama Workers' Compensation Law and applicable rules and Regulations of the department of Industrial Relations." *See*, Ex. GA-14, at 2.

[41]The statute provides that "[t]here is hereby authorized the establishment, maintenance, administration, and operation of any trust established by agreement of any hospitals or other healthcare units, licensed as such by the State of Alabama (hereinafter referred to as "Hospitals") or by agreement of any dental practitioners licensed as such by the State of Alabama (hereinafter referred to as "Dentists") as grantors with such hospitals and dentists as beneficiaries for the purpose of insuring against general public liability claims based upon acts or omissions of such hospitals or dentists, including, without limitation, claims based upon malpractice." *See*, Ala. Code § 22-21-240.

[42]The Fund Coverage Agreement provides in part that: "[t]his is to further certify that the above captioned entity has been issued self-insurers compliance certificate number 8-00345 by the Alabama Department of Industrial Relations for the period shown in Item 3. which evidences that they are insuring their Alabama Workers' Compensation liability in the Healthcare Workers' Compensation Self-Insurance Fund."

whether the Alabama Department of Industrial Relations used the term "insuring" correctly. Tr. at 1463-65.

Ms. Baranoff was given a hypothetical situation in which an employer enters into a contract with a bank under which the bank agrees for a period of one year to pay the workers' compensation benefits required pursuant to Virginia law. The contract with the bank requires the employer to reimburse the bank for all the workers' compensation benefits paid by the bank and a bank service fee. In Ms. Baranoff's opinion, this arrangement is purely self-insurance; the bank is performing administrative services for the employer; and the employees are the third-party beneficiaries of the relationship between the bank and the employer. Tr. at 1465-67.

Ms. Baranoff was asked how many times the employers in all the SITs and GSIAs were held jointly and severally liable on a claim. Ms. Baranoff testified that although she requested certain information for this case, she did not ask this specific question and did not receive an answer. She has no reason to dispute that the answer is zero. Ms. Baranoff confirmed that the various funds or trusts paid the claims, not their employer members. She believes this was part of the pooling function of the funds or trusts. Tr. at 1467-69.

Ms. Baranoff was given another hypothetical involving a prepaid legal services plan in which the attorneys are jointly and severally liable for the provision of legal services. The legal services plan is an insurance contract with joint and several liability among the lawyers participating in the plan. Ms. Baranoff was unsure whether there has been a transfer of risk from one party to another. Since she has not studied prepaid legal plans, she was uncomfortable rendering an opinion. The hypothetical was changed to three hospitals that agree to provide prepaid medical services to employers and the hospitals are jointly and severally liable for the provision of the services. Given this hypothetical, Ms. Baranoff agreed that insurance and joint and several liability could exist in the same arrangement. Tr. at 1469-76.

As she had previously testified, Ms. Baranoff stated that whether there was a transfer of risk when ROA acquired the liabilities of the SITs and GSIAs depends on whether the liabilities were dynamic or static. She explained that the risk for the insurer was not that it would receive less in premiums than it would pay out in benefits; the risk for the insurer is its deviation from expectation. In her opinion, when ROA assumed the liabilities of the SITs and GSIAs, it believed the liabilities were a static amount, which in retrospect was not correct. Tr. at 1480-83.

Ms. Baranoff agreed that the deviation from expectation in a medical practice claim may be quite large, especially if the claim goes before a jury. She testified that if ROA was solvent, it would pay the claims of the SITs and GSIAs. She also stated that if the jury rendered a defense verdict, ROA would keep the reserves that had been established for the claim. Ms. Baranoff agreed that prior to the transactions with ROA, someone else would have paid the claim or kept the reserves established for the claim. Tr. at 1483-85.

Ms. Baranoff agreed that the members who were first insured by ROA and then joined the SITs and GSIAs were receiving insurance benefits during the period their coverage was with ROA. She was asked whether the fact that ROA's policies were assessable until 1982 changed her opinion, and it did not. Tr. at 1487.

Ms. Baranoff agreed that by joining the SITs and GSIAs, the members were better able to predict their loss experience because of the law of large numbers. By pooling their risks, the members were able to decrease their standard deviation. As a result, the members were able to make statistical predictions of their losses. She agreed all the members contributed funds to the SITs and GSIAs, and the losses of the members were paid from those funds. She further agreed the SITs and GSIAs promised to pay whatever losses the members incurred as long as the losses were within the scope of coverage and did not exceed the applicable limits. Ms. Baranoff was asked whether the program just described was insurance and she responded that it was not. She was given Exhibit EB-31, which is page 30 from Ms. Baranoff's textbook. Portions were read into the record.[43] Tr. at 1487-92.

The Guaranty Associations offered the testimony of two witnesses: David Broemel, an attorney in private practice and executive secretary of the Tennessee Insurance Guaranty Association; and James Newman, Jr., an independent insurance consultant.

Mr. David Broemel testified that after graduating from law school in 1972, he was a judicial law clerk for a year and then went to work for the Tennessee Insurance Department. After seven years with the Insurance Department, Mr. Broemel started his own law practice in 1981 and has been in the private practice of law since then. Since 1986, he has served as the executive secretary of the Tennessee Insurance Guaranty Association ("TIGA"). His duties include carrying out the day-to-day operations of TIGA; overseeing the claims handling; seeking reimbursement of payments of covered claims and administrative expenses by asserting creditor claims against the estates of insolvent insurers; and taking all steps necessary to carry out the Tennessee Insurance Guaranty Association Act. Mr. Broemel reports to the board of directors of TIGA. He is familiar with the statutory responsibilities of other state guaranty associations after having served on various NCIGF committees. Ex. DB-19, at 1-2; Tr. at 806, 808-09.

Mr. Broemel explained that guaranty associations are established by statute in all fifty states to provide a limited safety net for policyholders and claimants in the event of an insurance company insolvency. They are somewhat analogous to the Federal Deposit Insurance Corporation ("FDIC"). The protection offered by a guaranty association is limited as to types of insurance companies, types of insurance, amount of protection, and other limitations and exclusions, including in some states a net worth exclusion. The guaranty associations exist to avoid excessive delay and loss that results from the insolvency of a member insurer. The members of the guaranty association are insurance companies licensed to transact the business of insurance in the state. The guaranty associations are funded through assessments of their member insurance companies, through distributions from the insolvent insurer's estate, and through investment income. Member insurers may recoup their guaranty fund assessments through a premium tax offset or through an increase in rates. In those states that allow a premium tax offset, Mr. Broemel stated that the taxpayer or consumer ultimately pays for guaranty fund assessments. Ex. DB-19, at 3-4; Tr. at 809-11.

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[43]The first portion stated: "[i]nsurance" is a social device in which a group of individuals (called "insureds") transfer risk to another party (called an "insurer") in order to combine loss experience, which permits statistical prediction of losses and provides payment of losses from funds contributed (premiums) by all members who transferred risk." The second portion stated: "[t]he insurer assumes risk in that it promises to pay whatever loss may occur as long as it fits the description given in the policy and is not larger than the amount of insurance sold." *See*, Ex. EB-31.

Mr. Broemel explained that guaranty fund coverage is triggered upon a judicial finding of insolvency and order of liquidation of a member company. After such finding, the guaranty association is obligated to pay "covered claims" only, and to deny all other claims. Mr. Broemel further explained that guaranty associations may not deviate from "covered claim" criteria established by statute. A guaranty association may not consider financial hardship or the prevailing equities in deciding whether to pay a claim. Ex. DB-19, at 4.

Mr. Broemel described the three instances in which a guaranty association may recover monies from the estate of the insolvent insurer. First, the guaranty associations are entitled to reimbursement for paying "covered claims" on a priority equal to other policyholder claimants. Second, insurance solvency statutes may provide for early access distributions to the guaranty association based on the association's expected claim payments. Third, the guaranty associations may be able to recover their administrative and claims handling expenses on a priority equal to the liquidator or receiver. Ex. DB-19, at 5.

Mr. Broemel testified that as of August 31, 2004, TIGA has paid $920,162.32 in loss expense, $618,690.90 in loss adjustment expenses, $102,973.00 in unearned premium claims, and $381,839.21 in unallocated loss adjustment expenses. TIGA's estimated loss reserves on ROA claims as of August 31, 2004, totaled $7,342,397.00, and its estimated loss adjustment expenses totaled $1,716,560.00, which totals $9,058,957.00. TIGA believes that 10% of the total reserve amount, $905,895.00, is a reasonable estimate for unallocated loss adjustment expense, which represents TIGA's administrative expenses. Mr. Broemel testified that as a result of its payments, TIGA has become a creditor of the ROA estate. Although TIGA joined in an application for an early access distribution from the ROA estate, it has received no distribution from the ROA estate. Ex. DB-19, at 5-6; Tr. at 816, 821.

Mr. Broemel learned of ROA's financial difficulty in 2002 when A.M. Best downgraded ROA's rating. He was aware that ROA had assumed business from THA, which operated a workers' compensation GSIA. Although the documents refer to the transaction between THA and ROA as a merger, Mr. Broemel believes the transaction involved a partial transfer of assets from THA to ROA. ROA agreed to assume the liabilities that had been incurred prior to January 1, 1998, and then it issued new policies for coverage after January 1, 1998. He noted that there had been no Form A filing approving the merger of THA and ROA, as would have been required in the merger of two insurers. The only evidence he had found that the Tennessee Insurance Department had approved the transaction was a letter from the assistant commissioner that approved the transaction, required ROA to track the Assumed Claims through their entire claims history, and required ROA to post a $175,000 deposit with the state. Since GSIAs are not considered insurers under Tennessee law, Mr. Broemel outlined the reasons a GSIA is unlike a licensed insurance company: the members enter into indemnity agreements and are jointly and severally liable; the GSIA pays no guaranty fund assessments; the GSIA does not participate in any residual market mechanism such as the assigned risk plan; the GSIA does not have to file its rates and forms; and the GSIA does not have to maintain the same capital and surplus as a licensed insurance company. Ex. DB-19, at 7; Tr. at 812-15, 817-19.

Mr. Broemel explained the reasons he believes the Assumed Claims are not covered claims. First, the Assumed Claims do not meet the definition of a "covered claim" because they are not claims under a policy issued by a member insurer, which is an insurer licensed to transact the business of insurance in the state. THA was not a member insurer of TIGA. Second, guaranty associations cover only direct insurance. ROA's assumption of THA's workers' compensation coverage did not create a direct insurance obligation between ROA and the former members of THA. Third, there is no coverage under the Tennessee Guaranty Fund Act ("Act") for assessable policies, such as those issued by THA. Fourth, the assumption obligations are not insurance obligations as to losses that had already happened. There was no fortuity, therefore, no insurance obligation and no coverage under the Act. DB-19, at 7-8; Tr. at 817-19, 821-22.

Mr. Broemel explained the process he used to determine the THA Assumed Claims were not "covered claims." First, he determined that a GSIA set up by the Tennessee Hospital Association was assumed by ROA. Second, he received a letter from the Deputy Receiver's staff describing THA as a GSIA. Third, he looked at the file concerning the merger of THA and ROA maintained by the Tennessee Insurance Department. Fourth, he had TIGA's claim manager review the files of the 27 Assumed Claims and a spreadsheet with a listing of the claims. Policy numbers were used that were indicative of a GSIA and some of the loss dates were as old as 1992. Finally, Mr. Broemel was never presented with an insurance policy issued by a member insurer. He explained that TIGA has procedures in place for determining the origin of an insurance policy that is presented for payment as a covered claim. Ex. DB-19, at 8-9; Tr. at 819.

Mr. Broemel expressed TIGA's position that the THA Assumed Claims are not claims of policyholders arising out of insurance contracts. He stated the initial obligations were self-insured obligations of the employers of the group, not insurance. The members of THA were jointly and severally liable under their indemnity agreements and there was no actual transfer of risk. Workers' compensation GSIAs are not considered insurance companies or regulated as insurance companies under Tennessee law. Finally, the Assumed Claims were incurred prior to being assumed by ROA, and were therefore known losses that do not constitute "insurance" because there was no fortuity. He confirmed that TIGA has received no complaints related to its denial of the Assumed Claims. Ex. DB-19, at 9; Tr. at 820.

Mr. Broemel gave examples of other receiverships in which TIGA denied claims assumed by insolvent insurers licensed in Tennessee. He stated that the position taken by TIGA in this case is consistent with the position it has taken in the other cases. TIGA believes the position taken by the Deputy Receiver in this case constitutes an unlawful preference in violation of § 38.2-1509 B of the Code of Virginia. He believes neither the Commission nor the Deputy Receiver may create a hardship or equitable exception to the distribution statute. He further stated the Assumed Claims are not policyholder-level claims because they are not claims of "other policyholders arising out of insurance contracts." Rather, the Assumed Claims are general creditor claims. As a creditor of the ROA estate, TIGA believes it has a right to have the estate comply with Virginia law when it disburses estate assets. Ex. DB-19, at 10-11; Tr. at 821.

On cross-examination, Mr. Broemel confirmed that TIGA filed a $12 million claim with the ROA estate and that it is not paying the Assumed Claims. Tr. at 823-24.

Mr. Broemel was aware that the THA group was made up of hospitals. He is unsure whether the hospitals were insureds of ROA prior to the formation of THA, or insured in the commercial market or individual self-insureds. He agreed that if they had been insured by ROA, they would have been insured under an insurance policy. Mr. Broemel does not believe the workers' compensation coverage offered by THA was the same as the coverage formerly provided by ROA. He reviewed one THA certificate and found it was not the standard NCCI form that would have been used by ROA. The coverage provisions were controlled by an indemnity agreement. Tr. at 825-26.

Mr. Broemel was asked to identify a coverage certificate issued by THA to one of its members. Although the certificate states that the coverage will be governed by the workers' compensation and employers liability policy of NCCI, Mr. Broemel stated the certificate also provides that the NCCI policy applies only to the extent that the policy does not conflict with the member's indemnity agreement and power of attorney. He believes the member's joint and several liability, lack of transfer of risk, and Tennessee law bring the certificate in conflict with the NCCI policy form. Other than the differences he cited, the coverage offered by the certificate appeared to be the same as the NCCI form. Mr. Broemel agreed the certificate provided workers' compensation and employers liability coverage, contained a coverage period, provided coverage limits, and contained an estimated premium that might be subject to further assessment. He identified when the premiums were due on the certificate. Ex. DR-10, Tab J 2; Tr. at 828-31, 838-39.

Mr. Broemel is generally familiar with the THA and ROA transaction. He believes the transaction purports to transfer all of THA's coverage obligations to ROA. Mr. Broemel believes it is unclear whether THA's former members were still assessable after the transaction with ROA. He agreed that the merger or assumption document would control whether they were still assessable. Mr. Broemel is unaware of any provision in the policies issued by ROA that would allow ROA to assess the former members of THA for past or future claims. In addition, he is unaware of any further obligation on the part of THA to pay ROA any additional monies once the initial transfer of assets was completed. Tr. at 832-35.

Mr. Broemel explained some of limitations under Tennessee's guaranty fund: it applies only to direct insurance; eleven property and casualty lines of insurance are excluded; covered claims are capped at $100,000.00; there are net worth limitations and residency restrictions. He confirmed that workers' compensation insurance was not subject to the $100,000.00 cap. Under the net worth limitation, TIGA would pay the claim, but might seek reimbursement from the insured. Tr. at 835-38.

Mr. Broemel confirmed that his testimony is based primarily on Tennessee law. He had not reviewed the Kentucky insurance guaranty fund statutes or the statutes applicable to the two Kentucky transactions. Mr. Broemel was unaware that in Kentucky, workers' compensation coverage issued by a GSIA is deemed to be insurance. He was also unaware that Form A filings were made in the K-HAT, C-HAT, and ROA transactions with the Kentucky Department of Workers' Claims and the Kentucky Department of Insurance. Mr. Broemel confirmed that TIGA does not provide coverage for assessable policies. He agreed that some reciprocals and mutual insurance companies may issue assessable policies, but he believes ROA's policies were not

assessable. Mr. Broemel had heard that the Kentucky Department of Workers' Claims had issued an order stating that the Kentucky Insurance Guaranty Association would apply to the K-HAT, C-HAT, and ROA transactions. Tr. at 839-43.

Since he had not reviewed the documents related to the Alabama transactions, Mr. Broemel could not express an opinion whether the Assumed Claims in those transactions were "claims of other policyholders arising out of insurance contracts." Although the language used by Mr. Broemel in his testimony was similar to that found in § 38.2-1509 of the Code of Virginia, he was not offering an opinion on the meaning of the statutory language. He applied Tennessee law when he rejected the THA Assumed Claims. He did not apply Alabama or Kentucky law in his testimony. He confirmed that TIGA had denied assumed claims in the past when the claims were assumed from a licensed insurer. Mr. Broemel has not given any thought to whether assumption reinsurance would be covered by TIGA. Tr. at 844-48, 853-55.

On redirect, Mr. Broemel clarified that the premium shown in Ex. DR-10, Tab J 2 is not a traditional insurance premium. It is not a guaranteed premium or a retro premium because it is subject to further assessment. Tr. at 852-53.

Mr. James Newman testified his insurance career began several years after college when he was appointed the deputy commissioner of insurance of the Virginia Bureau of Insurance ("Bureau") in June 1976. In October 1978, he was appointed the commissioner of insurance, and held that position until October 1981. Since 1981, he has held positions with the American Insurance Association, Cigna Corporation, Insurance Company of North America, Florida Residential Property and Casualty Joint Underwriting Association ("FRPCJUA"), and Citizens Property Insurance Company. Mr. Newman has earned the Fellow, Life Management Institute designation and certificate of general insurance from the Insurance Institute of America. He has written on insurance topics and been involved in insurance industry research efforts. In particular, Mr. Newman was involved with an NAIC comprehensive review of state laws and regulations applicable to workers' compensation self-insurance associations throughout the United States. Ex. JN-21, at 1-4; Ex. GA-39; Tr. at 888-94, 897-98.

Mr. Newman is familiar with the Virginia insurer liquidation statute, the NAIC Assumption Reinsurance Model Act, and assumption agreements used to transfer risks and obligations from one insurer to another. Mr. Newman has personally been involved in an assumption agreement to transfer a book of business from a medical malpractice insurer to another insurance company. Additionally, as the executive director of the FRPCJUA, he was involved in a number of assumption agreements through which 1.2 million insurance policies were transferred from the FRPCJUA to 20 to 25 insurance companies. Mr. Newman is familiar with assumption reinsurance agreements and the differences between assumption agreements and assumption reinsurance agreements. Several of the assumption agreements with which he has been involved did not meet the statutory requirements of an assumption reinsurance agreement. He explained that an assumption reinsurance agreement is a transaction between two insurance companies under a state's assumption reinsurance act that includes a novation whereby the assuming insurer becomes legally obligated to the policyholders for policies that had been issued by the ceding insurer. Mr. Newman explained the NAIC promulgated the Assumption Reinsurance Model Act in 1993 to address concerns about transfers of books of business without policyholder informed consent. The Model

Act provides for the regulation of the transfer and novation of contracts of insurance through assumption reinsurance agreements. Mr. Newman checked with the NAIC and found that nine states have adopted legislation similar to the model act and an additional seven states have related legislation in place. He stated Section 38.2-136 of the Code of Virginia governs assumption reinsurance transactions and the statute requires that policyholders consent to the assumption transaction. Mr. Newman distinguished "direct insurance" from "reinsurance." He described direct insurance as the sale of insurance policies by an insurance company to individuals, businesses, and other entities. Ex. JN-21, at 4-7; Tr. at 894-97.

As part of his assignment, Mr. Newman reviewed the eleven assumption or merger agreements, certain correspondence, copies of statutes and regulations, and other relevant materials to evaluate the nature of the transactions involved in this case, with the ultimate goal of expressing an opinion on the status of the Assumed Claims. He relied on these materials and his 28 years of experience in the insurance industry in rendering his opinion. Ex. JN-21, at 7-9; Tr. at 899-902.

Mr. Newman opined that the claims of the SITs and GSIAs assumed by ROA in the assumption/merger agreements do not constitute claims of "other policyholders arising out of insurance contracts," under the Virginia insurer liquidation statute, § 38.2-1509 B 1 (ii) of the Code of Virginia. The members of the SITS and GSIAs were not policyholders under insurance contracts during their membership in the self-insurance groups, and their status did not change, nor was it transformed, when the obligations of the SITs and GSIAs were assumed by ROA. Ex. JN-21, at 9.

Mr. Newman expressed four reasons in support of his opinion. First, self-insurance is not "insurance" and the SITs and GSIAs were not "insurers" engaged in making contracts of insurance. Rather, they were self-insured workers' compensation groups and self-insured trusts that were not authorized to issue contracts of insurance. Accordingly, Mr. Newman believes the claims under the agreements are not claims of policyholders under contracts of insurance. Second, ROA's agreements to assume the liabilities of the SITs and GSIAs for existing losses, losses that had occurred prior to the effective dates of the agreements, do not constitute "insurance" because ROA assumed existing liabilities. Mr. Newman believes there was no fortuity and, therefore, the claims are not claims of policyholders arising under contracts of insurance. Third, ROA's agreements to assume the liabilities of the SITs and GSIAs were not assumption reinsurance transactions as defined in the NAIC Assumption Reinsurance Model Act, and they did not effect a novation because there was no transfer of obligations or risks of existing in-force contracts of insurance, and the obligations assumed were not contracts of insurance. As a result, Mr. Newman believes ROA's assumption of the liabilities of the SITs and GSIAs did not transform those liabilities into contracts of insurance and did not transform ROA into a direct insurer with respect to those past losses. He further believes the members of the SITs and GSIAs did not become policyholders of ROA with respect to those past losses. Consequently, the members of the SITs and GSIAs are at best general creditors, rather than policyholder-level claimants. Finally, the NAIC Assumption Reinsurance Model Act contains an exclusion that would apply to the ROA assumption agreements. Mr. Newman stated that Section 2B(2) of the model act makes it clear that no assumption reinsurance arises when a new insurance policy is issued by another insurer at the expiration of previous coverage. Ex. JN-21, at 9-10; Tr. at 913-14.

Mr. Newman opined that the SITs and GSIAs were not insurers or insurance companies. He based his opinion on certain state statutes which provide that SITs and GSIAs are not insurance companies and are not to be regulated as insurance companies. Mr. Newman noted that SITs and GSIAs are not members of state guaranty funds or residual market mechanisms, and in many states they do not pay premium taxes. The joint and several liability of SITs and GSIAs is related to their status as self-insurers rather than insurance companies. Mr. Newman noted that ROA itself took the position in several documents sent to state insurance regulators, that the agreements were not assumption reinsurance transactions, and that the SITs and GSIAs were not "insurance companies" and did not issue "policies" or "contracts of insurance."[44] In other documents he reviewed, state insurance regulators stated that the SITs and GSIAs were not "insurers."[45] Finally, Mr. Newman stated the SITs and GSIAs self-insurance obligations were created by indemnity agreements and powers of attorney executed under applicable state law. Ex. JN-21, at 10-12; Tr. at 903-04.

Mr. Newman opined that the SITs and GSIAs were not in the business of making contracts of insurance. He stated that contracts of insurance are issued by insurance companies. For support, he cited § 38.2-100 of the Code of Virginia which defines an "insurance company" as any company engaged in the business of making contracts of insurance. He noted that SITs and GSIAs are not licensed insurers because the principal document used by SITs and GSIAs is an indemnity agreement and power of attorney executed by their members, not a contract of insurance. This document establishes the joint and several liability of the members, and the power of the SIT and GSIA to assess their members in certain circumstances. He noted that a member who elects to terminate its membership remains jointly and severally liable for workers' compensation obligations which were incurred during the member's period of membership. For these reasons, Mr. Newman believes indemnity agreements are not insurance contracts because there is no actual risk transfer; the members of the SITs and GSIAs always retain their liability for workers' compensation claims. Ex. JN-21, at 12; Tr. at 905 and 908.

Mr. Newman stated that an insurance contract has two common distinguishing characteristics, an element of risk transfer and the occurrence of a contingent or fortuitous event. He cited a number of statutory examples in support and stated that the Virginia Supreme Court's five-part test for finding a contract of insurance would not change any of the opinions he offered in this case.[46] Mr. Newman reviewed Ex. DR-10 Tabs J 1, J 3, and J 2 and stated that in his opinion, they do not describe the subject matter to be insured, the risk insured against, the commencement and period of risk, the amount of coverage, or the premium to be paid. Therefore, in Mr. Newman's opinion, the documents are not contracts of insurance. Ex. DR-10, Tab J 2 does contain some of the

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[44] *See*, Exs. GA-23, 29, 30, and 34.

[45] *See*, Exs. GA-22, 31, and 33.

[46] *See*, Va. Code Ann. § 38.2-100 ("Insurance" means the business of *transferring risk by contract* wherein a person, for a *consideration*, undertakes (i) to *indemnify* another person, (ii) to pay or provide a specified or ascertainable amount of money, or (iii) to provide a benefit or service upon the *occurrence of a determinable risk contingency*). (emphasis added). *See also*, Ala. Code § 27-1-2 ("Insurance" is a "contract whereby one undertakes to indemnify another or pay or provide a specified amount or benefit upon *determinable contingencies*"); Ark. Stat. Ann. § 23-60-102 ("Insurance" is "any agreement, contract, or other transaction whereby one party, the "insurer," is obligated to confer benefit of pecuniary value upon another party, the "insured" or "beneficiary," dependent upon the *happening of a fortuitous event. . . .*"); and Ky. Rev. Stat. Ann. § 304.1-030 ("Insurance" is a "contract whereby one undertakes to pay or indemnify another as to loss from certain *specified contingencies or perils called ' risks,'* or to pay or grant a specified amount or determinable benefit or annuity in connection with *ascertainable risk contingencies . . . .*"). (emphasis added).

elements of a contract of insurance, such as a premium charge; however, Mr. Newman believes the elements do not hold up upon closer scrutiny. Although a GSIA follows some of the methodologies employed by an insurance company, it does so for administrative reasons, not to create an insurance contract. Ex. JN-21, at 12-13; Tr. at 903, 915-19, and 924-27.

Mr. Newman opined that the assumption of responsibility for the Assumed Claims by ROA involved a business risk, rather than an insurance risk, because the losses occurred prior to the effective date of the agreements. He stated that insurance policies provide coverage for the occurrence of a contingent or fortuitous event, not past occurrences or known losses. He stated that there may be some uncertainty in the total amount that ROA would pay out on the Assumed Claims; however, there was no uncertainty regarding the future occurrence of losses. Mr. Newman believes the uncertainty assumed by ROA was not associated with the concept of fortuity, risk transfer, or risk contingency. Even if ROA assumed incurred but not reported claims, Mr. Newman's opinions would not change. He believes an important distinction is the fact the losses have already occurred and reserves have been established for those claims. Ex. JN-21, at 13; Tr. 914-15, 919-20.

Mr. Newman opined that the assumption or merger agreements are neither insurance contracts nor assumption reinsurance agreements. He believes the agreements did not transfer risk or involve indemnity against a fortuity, essential features of insurance and reinsurance. He noted that in correspondence to state insurance regulators, ROA did not view the agreements as assumption reinsurance transactions.[47] Mr. Newman further opined the agreements did not create a direct insurance relationship between ROA and the former members of the SITs and GSIAs with respect to the Assumed Claims. He believes ROA's agreements to assume the liabilities of the SITs and GSIAs were not assumption reinsurance transactions and did not effect a novation because (1) there was no transfer of obligations or risks of existing or in-force contracts of insurance from a ceding insurer to an assuming insurer, and (2) the obligations assumed were not contracts of insurance. On the effective date of each of the transactions, the previous coverage provided by the SIT or GSIA had expired or was cancelled, and then ROA issued its own policies to the members the day after the closing date of the agreement. While the agreements transferred the liabilities of the SITs and GSIAs to ROA, Mr. Newman believes they did not transfer obligations or risks of existing in-force contracts of insurance. The original obligations of the SITs and GSIAs assumed by ROA were not "contracts of insurance." For these reasons, Mr. Newman believes ROA's assumption of the liabilities of the SITs and GSIAs did not transform those liabilities into contracts of insurance and did not transform ROA into a direct insurer with respect to those past losses. Ex. JN-21, at 14-15; Tr. at 909-10.

Mr. Newman opined the Assumed Claims are not "covered claims" under state guaranty fund laws. The Assumed Claims do not meet the definition of "covered claims" because they are not claims under a policy issued by a member insurer, which is an insurer licensed to transact the business of insurance in the state. The SITs and GSIAs were not licensed insurers and were not members of the guaranty association. Additionally, he noted that guaranty funds cover only direct insurance, and the assumption agreements were not direct insurance. The assumption agreements did not create a direct insurance obligation between ROA and the former members of the SITs and GSIAs. Mr. Newman stated the obligations assumed by ROA were not insurance obligations as to losses that had already happened; there was no fortuity. The guaranty fund acts only provide

[47] *See*, Exs. GA-23 and 25.

coverage for insurance obligations. Finally, Mr. Newman provided the public policy reasons for not treating the Assumed Claims as "covered claims." He believes providing retroactive guaranty fund protection to members of self-insured groups that were never licensed or regulated as insurance companies, and did not comply with state laws and regulations regarding insurance companies, would be against sound public policy. Ex. JN-21, at 16.

Mr. Newman explained the differences between a group self-insurance association and an insurance company. The members of an SIT or GSIA are jointly and severally liable for the experience of the group; they may be assessed to cover adverse losses; and the groups are not regulated as insurance companies. In contrast, insurance policyholders are not liable for the losses experienced by an insurance company, nor are they subject to assessment for adverse losses. Mr. Newman also explained the difference between risk transfer and risk pooling. Risk transfer involves the transfer of risk to a third party such as an insurance company. Risk pooling occurs in GSIAs. The administrator of the GSIA manages a pool of money for the benefit of all the members. Ex. JN-21, at 16-17; Tr. at 920-22.

Mr. Newman differentiated between the regulation of SITs and GSIAs, and insurance companies. Workers' compensation self-insured groups are typically regulated by the state's workers' compensation agency and not the insurance department; in most states GSIAs do not pay premium taxes; members of a GSIA might be required to be in the same industry, business, or trade association; membership in a GSIA requires prior approval of the workers' compensation agency; withdrawal from the GSIA requires prior approval of the workers' compensation agency; GSIAs might not have to report exposure and loss data to workers' compensation rating agencies; GSIAs might be required to have excess insurance; and public and private employers may have to be members of two different GSIAs because of joint and several liability of the members. Mr. Newman noted that in Virginia, GSIAs pay maintenance assessments to the Virginia Bureau of Insurance, but they do not pay premium taxes. Ex. JN-21, at 17-18; Tr. at 911-13.

Mr. Newman addressed two points raised by the Deputy Receiver and aligned parties. First, the workers' compensation coverages offered by the GSIAs before the transactions, and ROA after the transactions, were identical. Mr. Newman explained that an employer may satisfy its workers' compensation obligations in three ways: it may be an individual self-insured; it may join a GSIA; or it may purchase an insurance policy from an insurance company. The workers' compensation benefits provided to the employee are the same under all three options. Second, even if the various transactions failed to comply with the assumption reinsurance statutes and there was no novation, the Assumed Claims are still direct policyholder level claims. Mr. Newman explained that the obligations were not initially insurance obligations and no assumption agreement would convert them to insurance obligations. Tr. at 922-24.

On cross-examination, Mr. Newman testified that he was given all the information he needed to form the opinions he expressed in this case. He identified all the documents and authorities he relied on in forming the opinions expressed in his prefiled direct testimony. Tr. at 928-932.

Mr. Newman was then asked to assume a hypothetical situation in which one party agrees to provide the other party flood insurance for his home for an annual premium of $100; the other party accepts the offer, and the parties enter into the agreement. Mr. Newman was unsure whether that agreement would be considered an insurance contract. He believes the agreement may be an enforceable contract, but he was unsure whether it should be classified as an insurance contract. After further questioning and after qualifying his answer, Mr. Newman affirmed that the agreement was an insurance contract. Tr. at 933-36.

Mr. Newman believes an essential element of insurance is the transfer of risk to a third party, although he was unable to cite to any authority supporting his position, other than his own understanding of various insurance statutes and his general insurance experience. He believes the existence of joint and several liability provisions in some of the agreements means there is no risk transfer in those contracts and they are not insurance. However, Mr. Newman agreed that the possibility that a member may owe an additional payment beyond his initial contribution would not take the agreement out of the realm of insurance. He explained that joint and several liability is the foundation of the financial security of the group. It is an unlimited obligation on the members of a GSIA to pay claims. That additional potential obligation does not exist in property and casualty insurance contracts, except in very limited circumstances and in those circumstances the assessment obligations are limited. In those instances in which there are assessable insurance polices, the assessment provisions are provided under state insurance law. For this reason, Mr. Newman believes there is a difference between the contracts issued by a GSIA and an insurance contract issued by an insurance company. He was unaware whether any of the state laws governing the GSIAs in this case classified the coverage provided by the GSIA as insurance. In his opinion, under joint and several liability the members of a GSIA have pooled their liabilities, which means the arrangement is not insurance. Tr. at 936-43.

Mr. Newman agreed that he was not an expert witness in the areas of insurance accounting, actuarial science, or economics. He further agreed that the Virginia Supreme Court would be the final authority on what constitutes insurance under Virginia law. Mr. Newman accepted the five-prong test found in *American Surety* and *Group Hospital Medical Service, Inc.*, and agreed that those cases would govern the definition of insurance in Virginia. He agreed that the five-prong test found in the two cases did not mention transfer of risk; however, he believes an agreement must transfer risk before the five-prong test is even considered. Mr. Newman believes the five prongs are used to determine whether an actual contract exists. Tr. at 944-49.

In discussions of the elements of the five-prong test, Mr. Newman would not agree that the SITs and GSIAs were providing coverage to their members. He believes GSIAs are pooling mechanisms that pay benefits to injured employees on behalf of the members of the pool as required under state workers' compensation laws. However, he agreed that the pooling mechanism was for the benefit of the members of the pool. He agreed that the members of a GSIA pool their risks, particularly their liability to their employees for workplace injuries. He accepted that the agreements covered a specified period of time, provided benefits according to the state's workers' compensation statutes and as otherwise stated in the agreement, and specified a contribution amount to be paid by the member.[48] Although he believes otherwise, Mr. Newman was asked to assume that the $73,987 contribution made by the employer in Ex. DR-10, Tab J 2 was correctly referred to

[48]*See*, Ex. DR-10, Tab J 2.

as a premium. Given this assumption, Mr. Newman agreed that Ex. DR-10, Tab J 2 met the five-prong test of an insurance contract found in *American Surety* and *Group Hospital Medical Service, Inc.* Tr. at 949-56.

Mr. Newman was asked if he had reviewed the *Bowles* or the *Sun Health* cases from the North Carolina Industrial Commission. He had heard of the cases, but had not read them. Tr. at 957.

Mr. Newman has no experience in insurance liquidations, rehabilitations, or receiverships, nor does he have any experience administering a guaranty fund, administering guaranty fund claims, or advising a guaranty fund in determination of "covered claims." Tr. at 957-58.

Mr. Newman agreed that the coverage provided by ROA to the members of HPG and THA, before those two groups were formed, was direct insurance. He further agreed that after the groups were formed, the protection afforded was the same because the workers' compensation statutes govern the level of protection provided to injured employees.[49] He stated the protection is the same whether it is provided by an individual self-insured, an employer that is a member of a GSIA, or an employer that purchases an insurance policy from a licensed insurance company. In his opinion, the protection is insurance when it is provided by ROA, but not insurance when provided by HPG or THA. Mr. Newman was asked to differentiate between the two circumstances. He initially stated that state law provided that workers' compensation self-insurance groups were not insurance companies; however, he was unable to cite to any Virginia statutory authority for his position. When pressed on the issue to provide his opinion as an insurance expert, he stated the two relationships were different. In his opinion, the joint and several liability of a GSIA creates a fundamentally different relationship between the member of a GSIA and a policyholder of an insurance company. Mr. Newman felt that he did not need to cite to any authority, that his opinion was widely followed in the insurance field. Tr. at 960-68.

Mr. Newman agreed that ROA assumed all of the liabilities of the SITs and GSIAs up until the effective date of the assumption agreements. He was not sure whether the members' joint and several liability was assumed by ROA, but after additional questioning he admitted that the agreements did provide for the assumption of the members' joint and several liability, and the parties intended that the members' joint and several liability be assumed by ROA. Mr. Newman agreed that if the dollar amount of liabilities assumed by ROA exceeded the amount of assets it received from the SITs and GSIAs, ROA does not have the ability to seek additional payments from either the members or the SITs or GSIAs to pay those liabilities. He agreed that none of the parties to the assumption transactions knew the ultimate dollar amount of the liabilities assumed by ROA. Mr. Newman maintained his position that since the majority of claims had been reported, they were known claims and there was no insurance risk assumed by ROA. Mr. Newman believes the uncertainty associated with the ultimate dollar amount of the claim is not a measure of risk. For him, risk is the exposure of the insurance company for the occurrence of the loss. Tr. at 968-74.

[49]Since Mr. Newman would not agree that the SITs or GSIAs were providing coverage to their members, the term "protection" was used in some instances to describe the benefits afforded to the members.

Mr. Newman explained the difference between known losses and risk. For example, a person cannot purchase a homeowners insurance policy on his house while it is on fire. Although there is some question about the cost of the damages to the house, the insured event is the possibility of a fire and in this case the fire has already occurred. Mr. Newman disagreed with the proposition that when an insurer buys a block of in-force insurance policies it takes on the liability for claims that have already occurred. He was asked about loss portfolio transfers, in which insurance company A sells to insurance company B a complete block of business with current losses, incurred but not reported claims, and other current exposures included. Mr. Newman was unsure whether a loss portfolio transfer was an insurance transaction. He was also unsure how insurance companies reported loss portfolio transfers on their financial statements. Tr. at 975-78.

Mr. Newman agreed that the NAIC Assumption Reinsurance Model Act has not been adopted in Virginia, and that unless adopted by the legislature, it had no force of law. He stated that he had read § 38.2-136 B of the Code of Virginia, which is the statute governing assumption reinsurance in Virginia. He restated his opinion that the assumption agreements in this case do not comply with the Virginia assumption reinsurance statute. Mr. Newman identified two areas in which the assumption agreements fail to comply with the statute: the assumption transactions were not between two insurers licensed in Virginia; and the risks assumed were not direct insurance policy obligations. Mr. Newman later conceded that the statute does not require both insurers to be licensed in Virginia. The ceding insurer is not required to be licensed in Virginia. In his opinion, if two insurers that entered into an assumption reinsurance agreement failed to comply with § 38.2-136 B of the Code of Virginia, the assuming insurer would still be liable to policyholders under the assumed policies. Mr. Newman agreed that ROA was still liable for the Assumed Claims even if the eleven assumption transactions did not comply with the assumption reinsurance laws of the various states involved in this case. He agreed that one of the requirements for a covered claim under the guaranty fund statutes is that it must be a claim for which the insolvent insurer was liable. But for the assumption agreements, Mr. Newman believes the Assumed Claims were not direct obligations of ROA. Finally, he agreed that § 38.2-136 B of the Code of Virginia is not a condition precedent for a finding of an insurer direct obligation. Tr. at 979-91.

Mr. Newman testified the members of the SITs and GSIAs had a right to assert claims directly against ROA under the policies issued by ROA on and after the effective date of the assumption agreements. He further testified the assumption agreements created a contractual obligation on ROA's part to pay the Assumed Claims. He agreed that prior to the assumption agreements ROA had no obligation to pay any SIT or GSIA claim, and after the assumption agreements ROA had an absolute obligation to pay the Assumed Claims. He agreed that after the assumption agreements ROA's claim payments would have been made to the injured employees in the case of the workers' compensation coverage or to the hospitals in the case of the liability coverages, not the SITs or GSIAs. He agreed that ROA assumed all of the liabilities of the SITs and GSIAs, which according to Mr. Newman is an obligation to pay dollars for known claims. Mr. Newman is unsure whether the assumption agreements could provide for the elimination of the members' joint and several liability. Tr. at 991-1002.

Mr. Newman confirmed that the SITs and GSIAs were not members of the individual state guaranty funds, and he agrees with the guaranty associations' position that the Assumed Claims should not be afforded guaranty fund coverage. Mr. Cantilo asked Mr. Newman to assume that a

risk retention group rather than the SITs or GSIAs issued policies to members in the various states. Further, the risk retention group and ROA complied with every assumption reinsurance statute in every state, ROA assumed the policies, and then ROA was declared insolvent. Mr. Newman was unsure whether this situation was covered under the various guaranty fund statutes, or whether the statutes contain a risk retention group exemption. Mr. Newman was unable to recall whether he had ever seen a risk retention group exemption. Tr. at 1002-04.

Mr. Newman confirmed that he did not conduct an extensive study of the Kentucky statutes and regulations involved in this case, although he did remember reviewing the statute related to self-insured trusts. He reviewed the assumption agreement for the C-HAT transaction, which was critical in forming his opinion in this case. Mr. Newman was unsure whether he had seen any certificates of coverage, but they were not particularly critical in forming his opinion. He also was unsure whether he had seen the C-HAT or K-HAT indemnity agreements. Tr. at 1005-09.

Mr. Newman opined that although pooling of risk may be involved with insurance, standing alone it is not insurance. Mr. Newman believes that risk pooling does not involve a transfer of risk and does not make the SITs or GSIAs insurance companies. He believes the essential element for finding that the SITs and GSIAs were not insurance was the existence of joint and several liability. Mr. Newman was asked to explain the difference between the SITs and GSIAs and a reciprocal insurance company. He described a reciprocal insurance company as a type of pooling arrangement that includes risk transfer which has a limited assessability feature. He stated that most reciprocal and mutual insurers may begin operations with a limited assessability feature, but over time they seek to eliminate that feature for marketing reasons. Mr. Newman is unaware of any reciprocal or mutual insurer that is assessable. Tr. at 1009-12.

Mr. Newman believes ROA would have provided coverage through policies of insurance. ROA also would have had a subscription agreement and a power of attorney, but he believes these documents were not the operative insurance agreements. Mr. Newman did not review or study any of these documents and was unable to confirm whether the subscription agreement and power of attorney were the operative insurance documents. Although he saw documents issued by the SITs and GSIAs labeled certificates, he believes these certificates were not policies of insurance. Tr. at 1013-15.

Mr. Newman explained that captive insurers are not regulated as insurance companies, nor do they have the rights and obligations of an insurance company. They are permitted only under some state laws. Since he had not looked at captive laws in 20 years, Mr. Newman was unable to opine whether a captive provided insurance to its members. He explained that risk retention groups are licensed as insurance companies in one state and permitted to operate in other states under the federal risk retention act without being an admitted insurance company in that state. Risk retention groups insure their members or subscribers. Mr. Newman was unsure whether risk retention groups belong to a state's guaranty association, or whether they pay premium taxes. Tr. at 1016-17.

Mr. Newman reiterated his position that the transfer of known losses does not constitute a transfer of risk and is not an insurance transaction. He explained that if two insurance companies were negotiating the transfer of a block of policies, the effective date of the agreement would be in

the future. The agreement would not cover losses that had already occurred or might occur during the negotiation process. Tr. at 1017-21.

Mr. Newman clarified his comment about the homogeneity of a GSIA compared to an insurance company. The difference relates to the regulatory oversight a GSIA receives as opposed to that of an insurance company. The members of a GSIA are typically required to share a common interest or be engaged in the same trade or business, whereas insurance companies have no such homogeneity requirement. Mr. Newman acknowledged that there might be some instances in which a heterogeneous group is allowed to form a GSIA. He was unsure whether risk retention groups had a homogeneity requirement. Tr. at 1021-23.

Mr. Newman agreed that the Kentucky Department of Workers' Claims and the Kentucky Department of Insurance approved the C-HAT and ROA consolidation or merger, the release of C-HAT's security deposit, and the liquidation of C-HAT. He further agreed that the assumption agreements provided that the members of C-HAT and K-HAT were no longer liable for the coverage provided during their membership in the groups. Mr. Newman agreed that a possible outcome of this case would be that the workers' compensation claimants may be left with no one to pay their claims. Mr. Newman indicated he had seen no order from the Department of Workers' Claims approving the C-HAT transaction that mentioned the Kentucky Insurance Guaranty Association would cover any known or incurred losses, but that he had seen a letter from an official mentioning that was the case. Tr. at 1023-26.

Mr. Newman disagreed with Ms. Carter's opinion that the C-HAT and K-HAT programs and the agreements involved a transfer of risk. Tr. at 1026.

Mr. Newman was given a copy of Ex. KH-33, an excerpt from the Kentucky workers' compensation statute, and asked to read portions of the statute.[50] He had not seen or reviewed the statute before he prepared his testimony. Mr. Newman read the definitions of "Carrier," "Insurance carrier," and "Insurance policy" into the record.[51] Tr. at 1028-30.

Mr. Newman was asked if he had followed the insolvency and rehabilitation of AIK Comp, another GSIA domiciled in Kentucky. He indicated that he had seen some trade press on the subject, and noted that the order directing the rehabilitation recites that AIK Comp is an insurer. Ex. JN-21; Tr. at 1031-33.

Mr. Newman was asked to look at Ex. KH-51 entitled "Acord Certificate of Liability Insurance." He stated that Acord prepares standard forms for general use in the insurance industry,

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[50]Ky. Rev. Stat. § 342.0011.

[51]The statute defines:

> (6) "Carrier" means any insurer, or legal representative thereof, authorized to insure the liability of employees under this chapter and includes a self-insurer.
>
> (22) "Insurance carrier" means every insurance carrier or insurance company authorized to do business in the Commonwealth writing workers' compensation insurance coverage and includes the Kentucky Employers Mutual Insurance Authority and every group of self-insurers operating under the provisions of this chapter.
>
> (26) "Insurance policy" for an insurance company or group self-insurer means the term of insurance coverage commencing from the date coverage is extended, whether a new policy or a renewal, through its expiration, not to exceed the anniversary date of the renewal for the following year.

but was unsure whether the use of a standard form makes the coverage insurance. He agreed that the named insured was Rockcastle Hospital and the companies affording the coverage were C-HAT and K-HAT. He identified the coverage periods, coverage limits, the K-HAT Umbrella Agreement Declarations Page, and confirmed that it was for the coverage period prior to the ROA merger. Other than the documents he has seen, Mr. Newman has examined no other documents addressing the method of operation of C-HAT and K-HAT. Tr. at 1038-42.

Mr. Newman concurred that it was his testimony that the agreements under which the GSIAs operated were not insurance contracts because they did not involve a transfer of risk, an essential element for a contract of insurance. Additionally, he agreed it was his position that there was no assumption reinsurance when ROA assumed the liabilities of the GSIAs because the GSIAs were transferring known losses and the transaction was not between two insurers. Tr. at 1051-53.

Mr. Newman was asked to define "risk transfer." He prefers the definition of "insurance" found in § 38.2-100 of the Code of Virginia.[52] Mr. Newman was given the example of a film company agreeing in a contract to indemnify a railroad company for any injuries that might occur on railroad property during the filming of "The Great Train Robbery." Mr. Newman stated that the agreement was an indemnification which was part of a larger business contract, but it was not an insurance contract. He believes the situation described does not involve the transfer of risk. Mr. Newman further testified that in the insurance context the term "indemnity agreement" does not refer to the situation described. He is not certain that indemnification and hold harmless provisions in certain business arrangements should be characterized as indemnity agreements. Mr. Newman believes the term "indemnity agreement" has a different context in the Insurance Code than in a general business contract. Tr. 1054-64.

Mr. Newman was given a hypothetical situation of an insurance company with 100 insureds who each pay $100 in annual premiums for a total of $100,000 in collected premiums. There is also a GSIA with 100 members who each pay $100 in annual assessments for a total of $100,000 in assessments collected. The insurance company and the GSIA each have $80,000 in losses resulting in a $20,000 underwriting profit for the insurance company and a $20,000 surplus for the GSIA. Mr. Newman explained that there is no connection between the premium a particular insured pays and any losses that the insurance company may pay. Although each insured paid only $100 in premium, he believes all 100 insureds received essentially the same benefit. The losses were paid with the collected premiums from all the insureds. When asked to contrast the insurance company with the GSIA, Mr. Newman stated the GSIA involves the concept of pooling. Although both situations involve pooling, Mr. Newman believes one is insurance and the other is not. He believes that one situation involves the transfer of risk and the other does not. The GSIA has joint and several liability and the members are subject to additional assessments if loss experience is poor. An insurer may not pass underwriting losses to its insureds. Tr. at 1064-74.

Mr. Newman was given another hypothetical situation involving Coastal Insurance Enterprises ("CIE"), a traditional insurance company that wrote claims-made insurance policies in the State of Alabama. At the time ROA acquired CIE, CIE had in-force policies covering several

[52]"Insurance" means the business of transferring risk by contract wherein a person for a consideration, undertakes, (i) to indemnify another person, (ii) to pay or provide an ascertainable amount of money, or (iii) to provide a benefit or service upon the occurrence of a determinable risk contingency.

hundred insureds. In addition, CIE had liability for several hundred claims which arose under claims-made policies written by CIE, but which had expired prior to ROA's acquisition of CIE. In the assumption agreement, ROA agreed to assume responsibility for CIE's liability for its in-force polices and expired policies. Mr. Newman agreed that the claims that arose under the expired policies are claims of policyholders arising under insurance contracts. He further agreed that the assumption reinsurance statute, § 38.2-136 of the Code of Virginia, did not apply to the transaction because the risks assumed by ROA were not located in the Commonwealth of Virginia. Mr. Newman agreed that the Alabama Insurance Guaranty Association would not be acting improperly if it paid the CIE assumed claims. Mr. Newman was asked to differentiate between the CIE assumed claims and the GSIA Assumed Claims. His only response was that the GSIA claims did not arise out of contracts of insurance. Mr. Newman was unable to render an opinion as an insurance expert whether the CIE and ROA transaction was assumption reinsurance. He referred to noncompliance with the NAIC Assumption Reinsurance Model Act and the Virginia assumption reinsurance statute as a basis for finding that the transaction was not assumption reinsurance, but he freely admitted that the Model Act and the Virginia statute did not apply in this instance. He then opined that the transaction did not involve a policy novation, but could cite no authority for his position, except a common law theory that he could not articulate. Tr. at 1076-82; 1092-94; 1111-13.

Mr. Newman conceded that all of the assumption agreements involved the assumption of the liabilities of the GSIAs, which included the known losses. He believes ROA is responsible for the liabilities associated with the Assumed Claims. As Mr. Newman understands an assumption reinsurance agreement, the assuming insurer is responsible for the liabilities from a date certain going forward. In his opinion, assumption reinsurance contracts do not involve the transfer of liabilities associated with past losses. Mr. Newman is unsure how an assumption reinsurance transaction could occur in this case if the NAIC Assumption Reinsurance Model Act or the Virginia assumption reinsurance statute did not apply. He believes assumption reinsurance must arise under some statutory authority, but he could cite to no authority for his position. Tr. at 1083-87.

Mr. Newman was asked to examine Exhibit C-2, the A-HAT assumption agreement, which he reviewed when he prepared his testimony. Mr. Newman agreed that the assumption agreement provided that the policies written by the GSIAs either expired or terminated on the effective date of the agreement. He further agreed that from the effective date forward, ROA was liable for the insurance policies it had written. Mr. Newman was asked to read Section 2.4 of the A-HAT assumption agreement.[53] In his opinion, the language does not constitute assumption reinsurance; however, Mr. Newman was unable to provide language that would have constituted assumption reinsurance. He identified substantially similar language in Exhibit C-10, the HWCF assumption agreement, and again opined that it did not constitute assumption reinsurance.[54] Tr. at 1087-91.

Mr. Newman was given another hypothetical situation involving facts similar to those found in the *Group Hospitalization* case. In his opinion, the hypothetical situation did not involve a transfer of risk to a third party and was not a contract of insurance. Mr. Newman stated the

[53]Section 2.4 provides in part that: "[ROA] shall assume and exercise all rights and interests of [A-HAT] under policies issued or coverages provided by [A-HAT] as of the Effective Date." *See*, Ex. C-2, at 7.
[54]Section 2.4 provides in part that: "[ROA] shall assume and exercise all rights and interests of HWCF under the coverages provided by HWCF as of the Effective Date." *See*, Ex. C-10, at 8.

hypothetical situation did not involve the payment of a premium; however, it included the subject matter, defined the risk, and the term of coverage. Tr. at 1094-97.

Mr. Newman was asked to examine Exhibit DR-10, Tab A 1 and explain his understanding of the document. He described it as a certification that a medical lab submitted an application to the Alabama Department of Industrial Relations for membership in HWCF, which was approved by the issuance of a Self-Insurance Compliance Certificate that covered a specific period of time. Mr. Newman identified the risk covered by the document as the employer's legal obligations under Alabama's workers' compensation statute. Mr. Newman agreed the document identified the parties, the period of coverage, and the amount paid for the coverage. In his opinion, the agreement did not include a transfer of risk because there is no transfer of risk associated with self-insurance funds. Mr. Newman believes that to have transfer of risk, the ultimate responsibility must fall on the fund itself and not on the members of the fund through their joint and several liability. Tr. at 1097-1102.

Mr. Newman then was asked to examine Exhibit DR-10, Tab B 1 and explain his understanding of the document. He stated it established the framework under which claims would be reported and paid by A-HAT. Mr. Newman indicated that the document has the outward appearance of an insurance policy; however, since there is no transfer of risk, it cannot be an insurance policy. Mr. Newman agreed that the document identified the parties to the transaction, provides for the payment of certain liabilities, and contains contributions to be made by the members. Mr. Newman was somewhat equivocal on whether this document was a policy of insurance. He believes the A-HAT situation is a close call. He agreed it was a contract; however, he has not reached a final conclusion on whether it is or is not an insurance contract. Tr. at 1103-09.

Mr. Newman confirmed that he reviewed the laws of several states, none of which referred to coverage written by a GSIA as insurance. Mr. Newman was asked to read a portion of Ala. Code § 22-21-240 into the record.[55] He agreed the statute uses the word "insuring;" however, he was unsure whether "insuring" and "insurance" had different meanings. Tr. at 1110-11.

Mr. Newman confirmed his opinion that to have a novation in an assumption reinsurance transaction there must be an underlying policy of insurance and both parties to the agreement must be insurance companies. Mr. Newman's opinion was based on his own insurance experience involving insurance policy novations and not on any Virginia or Alabama law. Tr. at 1114-18.

Mr. Newman was questioned from the bench whether it was his position that only licensed insurance companies may issue contracts of insurance in Virginia. Initially, Mr. Newman had no position, but then said there needed to be a distinction between someone who enters into a contract of insurance and someone who engages in the business of insurance. Based on his answer, Mr.

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[55]"There is hereby authorized the establishment, maintenance, administration, and operation of any trust established by agreement of any hospitals or other healthcare units, licensed as such by the State of Alabama (hereinafter referred to as "Hospitals") or by agreement of any dental practitioners licensed as such by the State of Alabama (hereinafter referred to as "Dentists") as grantors with such hospitals and dentists as beneficiaries for the purpose of insuring against general public liability claims based upon acts or omissions of such hospitals or dentists, including, without limitation, claims based upon malpractice." *See*, Ala. Code § 22-21-240.

Newman was asked whether a GSIA could enter into a contract of insurance and he responded it could not. Tr. at 1118-19.

Mr. Newman was also questioned on a hypothetical involving Mike's Rock Solid Insurance Company ("Mike's") licensed by the Virginia Bureau of Insurance to write contracts of insurance in Virginia. Mr. Newman agreed that Mike's was issuing contracts of insurance to the citizens of Virginia. The hypothetical was slightly altered. The Virginia General Assembly no longer required Mike's to be licensed as an insurance company to transact the business of insurance in Virginia. Mr. Newman agreed that the change in licensing status would not affect the substantive nature of the insurance contracts that Mike's issued to citizens of Virginia. He further agreed that the change by the General Assembly created different types of insurers in Virginia. He agreed that some would be licensed, but he would not agree that others could belong to a class of insurers not licensed. Mr. Newman confirmed that Lloyd's of London was not licensed in Virginia, yet it was still able to enter into contracts of insurance in Virginia. Tr. 1119-22.

On redirect, Mr. Newman was asked to assume a different fact in a hypothetical earlier discussed. Rather than $80,000 in losses, he was asked to assume that the GSIA suffered $200,000 in losses. Mr. Newman indicated that in this instance, the joint and several liability provision would be implemented and assessments would be levied against the members to make up the shortfall. The same situation would not occur with a licensed insurance company. If the claims exceeded the assets of the insurer, the insurer would be declared insolvent and the guaranty association would be responsible for paying covered claims. The policyholders would not be responsible for paying any claims. Tr. at 1122-24.

Mr. Newman stated that there may be regulatory consequences for someone issuing contracts of insurance without complying with Virginia's laws. In his opinion, the GSIAs are not issuing contracts of insurance without a license, an opinion shared by the Virginia Bureau of Insurance. Mr. Newman believes that if GSIAs were considered insurance companies they would be subject to the full spectrum of Virginia's insurance laws. Tr. at 1124-25.

The fact that neither *American Surety* nor *Group Hospitalization* mentions transfer of risk does not alter Mr. Newman's opinions in this case. Mr. Newman relied on the Code of Virginia which states that insurance involves the transfer of risk on risk contingencies and is a necessary condition for a contract of insurance. In his opinion, a contract may meet the five-part test of *American Surety* and *Group Hospitalization* and still not be a contract of insurance. For example, on the recent purchase of a lawn mower, Mr. Newman was given the opportunity to purchase an extended service contract. Although the service contract meets the five-part test, it is not insurance. Tr. at 1125-27.

Mr. Newman's opinions were also unaffected by the fact that the employees received the same workers' compensation benefits both before and after joining the GSIAs. He believes the point is irrelevant for determining whether there is a contract of insurance, or whether one of the entities is an insurance company. Additionally, the fact that the statutory definition of "carrier" includes an insurance company and a self-insurer does not mean that self-insurance is insurance or that a self-insurer is an insurance company. Mr. Newman believes that AIK Comp was deemed to be an insurer for the purpose of bringing the entity under Kentucky's liquidation statutes. He noted

that $49 million is being assessed against the members of AIK Comp under their joint and several liability. Mr. Newman's opinions remain unchanged after having examined Exhibit KH-51. Tr. at 1127-30.

On recross-examination, Mr. Newman stated that pursuant to the assumption agreements, ROA is liable for the Assumed Claims. The fact that they are not assumption reinsurance does not change the fact that ROA is liable for the Assumed Claims. Mr. Newman agreed there is nothing in § 38.2-1509 of the Code of Virginia that requires the Assumed Claims to arise from an assumption reinsurance transaction. He agreed there may be a myriad of claims arising under contracts that still may be covered under § 38.2-1509. Upon being asked whether the Assumed Claims became direct obligations of ROA, Mr. Newman indicated he was not capable of giving the Court an answer because he was unsure of the legal significance of the term "direct obligation." Mr. Newman changed one of his positions. He had formerly stated that the lack of an assumption reinsurance prevented the Assumed Claims from being direct obligations of ROA. He now stated the lack of an assumption reinsurance transaction was no longer relevant to the opinions he expressed in this case. Tr. at 1131-41.

Mr. Newman was asked whether there were different elements for an indemnity contract that is insurance and an indemnity contract that is part of a common business contract. He described an insurance indemnity contract as one designed to make someone whole after a loss. He did not know the elements of an indemnity contract that is part of a common business contract. Tr. at 1142-44.

Mr. Newman was asked to clarify whether he had stated that past loss experience was not taken into account in ratemaking. He responded that insurance ratemaking sets rates on a prospective basis; the rates are not designed to make up for past losses. He did concede, however, that past loss experience is an important element in ratemaking. He explained that past claims experience and trends predicted from past experience form the basis for ratemaking. Mr. Newman was asked to assume a hypothetical situation in which insurer X suffers underwriting losses which are expected to be the same in future years. Would the insurer charge its insureds more for their coverage? Mr. Newman agreed there would most likely be some kind of rate increase associated with those losses. Tr. at 1145-47.

Mr. Newman was questioned again about his opinion of the A-HAT program. If Mr. Newman learned the A-HAT program had no joint and several liability, would he concede the program transferred risk? Mr. Newman admitted that as the Guaranty Associations' expert witness he was not able to provide an opinion on whether the A-HAT program transferred risk. He agreed that in all eleven programs the members are no longer liable for the Assumed Claims under their joint and several liability. Tr. at 1148-40.

Mr. Newman noted his earlier agreement that anyone can issue a contract of insurance. He further agreed that if the party issuing the contract is in violation of the insurance statutes, there is nonetheless an enforceable insurance contract. He agreed that § 38.2-319 of the Code of Virginia makes those types of insurance contracts enforceable. He agreed the mere fact that the SITs and GSIAs were not licensed insurers does not preclude them from issuing contracts of insurance. Tr. at 1150-52.

Mr. Newman confirmed that he did not investigate whether the SITs and GSIAs in this case had stop-loss insurance. In the earlier hypothetical situation of a GSIA having $200,000 in losses, Mr. Newman was asked whether the members would have to pay anything under their joint and several liability if there was stop-loss insurance covering the full amount of the losses. Mr. Newman agreed that in instances in which the losses that exceed the members' contributions are covered by a stop-loss policy, there would not be a deficit and there would be no need to invoke the members' joint and several liability. Tr. at 1152-53.

Mr. Newman was asked whether lawn mower warranties of the type he had described are expressly exempted from the definition of insurance in § 38.2-100 of the Code of Virginia. He believes they are, but they still meet the five-part test for finding an insurance contract. Notwithstanding the exemption, Mr. Newman believes the extended service contract would not be a contract of insurance because there is no transfer of risk. Mr. Newman did not know whether there was an assumption of risk if the warrantor assumed the fortuitous risk that an unpredictable event, the failure or loss of the appliance, will occur, giving rise to a liability. He later qualified his answer and provided his definition of transfer of risk as a situation in which one party by contract and for consideration agrees to pay a loss or provide some service if a risk contingency occurs on the date of the agreement and thereafter. In this situation, the party that has agreed to assume the risk has no recourse against the other party for the payment of any claim. Mr. Newman agreed that he purchased the extended warranty on his mower to transfer the risk that the future cost of repairs would exceed the amount he was paying for the contract. Tr. at 1153-56; 1176-78.

Mr. Newman was asked also to define "loss contingency." He described it as an uncertain event, a fortuitous event, or one not in the control of the party attempting to transfer the risk. Mr. Newman confirmed that incurred and reported claims made under a claims-made policy that was no longer in force would not be a loss contingency because the claims had already happened. Based on his response, Mr. Newman was asked whether the Alabama Insurance Guaranty Association was improperly paying the claims of CIE since they do not constitute a transfer of risk or a loss contingency. Mr. Newman has not reviewed the circumstances under which the CIE claims are before the Alabama Insurance Guaranty Association, but he believes there is no improper conduct. Tr. at 1156-58.

Even if it is found that there were contracts of insurance in all eleven assumption transactions, Mr. Newman believes the Assumed Claims still would not be covered by the guaranty associations. He noted that there were other provisions of the guaranty fund statutes that must be followed, but Mr. Newman neglected to specify these provisions. Mr. Newman believes the Deputy Receiver would even be precluded from paying the Assumed Claims as insurance claims; however, he failed to articulate the reasoning for his position. Tr. at 1157-59.

Mr. Newman was asked to provide the elements of a novation under Virginia law. He was unable to do so, except to respond that an assumption reinsurance transaction involves the transfer of liability from one insurer to another insurer. Tr. at 1160-62.

Mr. Newman was asked to look at Exhibits KH-1 and 2 and provide his understanding of the intent of the language found in Section 2.3 of the merger agreements.[56] He responded that the intent was that ROA would be responsible for paying the claims and meeting the liabilities. He agreed that neither K-HAT nor C-HAT had any further responsibility for the Assumed Claims. Mr. Newman was unsure whether the agreement constituted a novation under Virginia law. Tr. at 1163-65.

Mr. Newman was asked to look at Exhibit KH-21, the K-HAT Professional and General Liability Coverage agreement, and distinguish any elements of that agreement that were different from Exhibit DR-10, Tab B 1, which was the A-HAT Medical and Professional and General Liability Coverage agreement. Mr. Newman confirmed that Exhibit KH-21 only provides for joint and several liability with respect to the indemnification provision for board members, the administrator, and other parties identified under the agreement. He was unsuccessful in finding a general joint and several liability provision in the agreement. He agreed that the members of C-HAT and K-HAT were relieved of any liability as a result of the merger with ROA. Tr. at 1166-73.

Mr. Newman believes the Assumed Claims should be treated as general unsecured creditor claims of ROA and not as policyholder claims. Tr. at 1183-74.

Mr. Newman confirmed that in the hypothetical situation in which the members of a GSIA were assessed to cover an underwriting loss, the members would be assessed equally regardless of which members had incurred the losses. Tr. at 1174-76.

Mr. Newman was again posed the question: If the contracts issued by the SITs and GSIAs are found to be contracts of insurance, then would the Assumed Claims be covered by § 38.2-1509 B 1 of the Code of Virginia? After avoiding the question, Mr. Newman finally responded that he interpreted the reference to insurance contracts in § 38.2-1509 B 1 to mean contracts of the insolvent insurance company. In his opinion, ROA assumed existing liabilities, the assumption agreements are not contracts of insurance, and there are no other contracts of insurance issued by ROA that would fall under § 38.2-1509 B 1. Tr. at 1184-90.

Mr. Newman was referred to § 38.2-1213 of the Code of Virginia and asked again whether ROA had issued assessable policies from the date of its formation until 1982 when it was granted authority to issue non-assessable policies. His recollection was that ROA had issued non-assessable policies. Tr. at 1190-92.

[56]Section 2.3 provides that: "On and subject to the terms and conditions of this Agreement, [ROA] agrees to assume and become responsible for all of the Assumed Liabilities at the Closing Date. Neither K-HAT nor its members shall have any responsibility with respect to the Assumed Liabilities after the Closing Date." *See*, Ex. KH-2, at 6.

Discussion

The issue presented is whether certain claims assumed by ROA from nine workers' compensation and two liability SITs and GSIAs (the "Assumed Claims") are claims of "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1(ii) of the Code of Virginia. If the Assumed Claims are claims of "other policyholders arising out of insurance contracts," they would receive the same priority in the liquidation of ROA assets as the claims arising from insurance polices issued by ROA and the claims of the various guaranty associations for "covered claims." If the Assumed Claims are not claims of "other policyholders arising out of insurance contracts," they would be "other creditor" claims pursuant to § 38.2-1509 B 1(v) of the Code of Virginia and would be paid after all of the ROA policyholder claims and the guaranty association claims for "covered claims" are paid.

Despite the voluminous record in the case, the facts surrounding the formation of the SITs and GSIAs, their business operations, and the subsequent assumption or merger of their business operations into ROA are not in dispute.[57] The dispute centers on the legal significance of: their business operations, whether those operations involved providing insurance or self-insurance to their employer-members; and the various assumption and merger agreements, whether ROA assumed the insurance obligations or the financial obligations of the SITs and GSIAs. These issues are questions of law to be determined by the Commission.[58] Questions of law "are reserved for determination by a court and cannot be the subject of expert testimony." *Heyward & Lee Constr. Co. v. Sands, Anderson*, 249 Va. 54, 57, 453 S.E.2d 270, 272 (1995).[59]

Choice of Law

The first question to be decided is which state's law governs this case, Virginia or the states in which the various SITs and GSIAs were domiciled. Typically, the law of the domiciliary state in which the insurance company's insolvency matter is pending controls, because such proceedings are fundamentally *in rem*.[60] "An action brought in Virginia must be litigated under the procedural rules of Virginia, including Virginia's choice of law principles." 4A M.J. *Conflict of Laws, Domicile and Residence* § 3 (1990).[61]

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[57]There were a number of objections raised to the admission of evidence in this proceeding. Although this is a judicial matter rather than a legislative, this matter involved solely questions of law; therefore, a liberal standard was applied to the admission of evidence into the record.

[58]Section 8.01-401.3 B of the Code of Virginia provides that: "[n]o expert or lay witness while testifying in a civil proceeding shall be prohibited from expressing an otherwise admissible opinion or conclusion as to any matter of fact solely because that fact is the ultimate issue or critical to the resolution of the case. However, in no event shall such witness be permitted to express any opinion which constitutes a conclusion of law."

[59]*See also, Ortiz v. Barrett*, 222 Va. 118, 130-32, 278 S.E.2d 833, 839-40 (1981).

[60]*See, Penn Gen. Cas. Co. v. Pennsylvania*, 294 U.S. 189, 195 (1935), *Eden Fin. Group v. Fidelity Bankers Life Ins. Co.*, 778 F. Supp. 278, 281 (E.D. Va. 1991).

[61]*See, Zukowski v. Dunton*, 650 F.2d 30, 34 n.3 (4th Cir. 1981).

The laws of another state are permitted to have effect in Virginia as the result of comity or some courtesy extended by a tribunal.

> Comity is not a matter of obligation. It is a matter of favor or courtesy, based on justice and good will. It is permitted 'from mutual interest and convenience, from a sense of the inconvenience which would otherwise result, and from moral necessity to do justice in order that justice may be done in return.' Comity is not given effect when to do so would prejudice a State's own rights or the rights of its citizens.

Eastern Indem. Co. v. Hirschler, Fleischer, Weinberg, Cox & Allen, 235 Va. 9, 14, 366 S.E.2d 53, 55 (1988), *quoting McFarland v. McFarland*, 179 Va. 418, 430, 19 S.E.2d 77, 83 (1942), *quoting in turn* 11 Am. Jur. *Conflict of Laws* § 5 (1937). Thus, "[c]omity does not require the application of another state's substantive law if it is contrary to the public policy of the forum state." *Willard v. Aetna Casualty & Sur.*, 213 Va. 481, 483, 193 S.E.2d 776, 778 (1973).

Chapter 15 of Title 38.2 of the Code of Virginia sets forth a comprehensive statutory scheme for the rehabilitation and liquidation of insurance companies domiciled in Virginia. The chapter describes the rights, powers, and duties of receivers. In addition, the chapter establishes a statutory scheme for the priority and payment of claims made against the receivership estate. The Commission has affirmed that:

> [t]he General Assembly's clear purpose in enacting these statutes was to consolidate litigation involving the insolvent insurer in Virginia and to avoid possible conflicting damage awards, which would have the effect of wasting the assets of the insolvent insurer. The General Assembly has set forth the public policy in Virginia that similar classes of policyholders and creditors are to be treated equally. Application of another state's law would clearly defeat the intent of the General Assembly by affording residents of other states remedies that may not be available to residents of Virginia and may create an unlawful preference among creditors of the same class.

Petition of Thomas and Mary Porcella, Case No. INS010268, Report of Hearing Examiner Michael D. Thomas at 3 (January 29, 2002) (Adopted by the State Corporation Commission in its Final Order dated April 2, 2002).

The treatment of policyholders and creditors under Virginia's receivership statutes was addressed by the United States District Court for the Eastern District of Virginia. The court reviewed Virginia's insurance company receivership statutes and found "the salutary purposes of state insurance receiverships, of treating all policyholders fairly and ratably, would be circumvented if [a claimant] is allowed to have its claim . . . adjudicated in a manner inconsistent with other claimants' and policyholders' claims." *Eden Financial Group v. Fidelity Bankers Life Ins.*, 778 F. Supp. 278, 283 (E.D. Va. 1991) (Federal Arbitration Act does not preempt state insurance company rehabilitation statutes and regulations). Other courts have held "the weight of authority is that the assets of insolvent insurance companies should be treated as a unit, and disposed of for the benefit of all creditors ratably without regard to the location of the assets or the residence of creditors."

Jump v. Goldenhersh, 474 F. Supp. 1306, 1313 (E.D. Mo. 1979), *affirmed* 619 F.2d 11 (8th Cir. 1980), *quoting McDonald v. Pacific States Life Ins. Co.*, 344 Mo. 1, 124 S.W.2d 1157, 1159 (1939).

The court in *Jump* found that insurance receivership cases do not follow the same conflict of law rules that apply to contract and tort cases.

> Most states have found it wise to [apply the substantive law of the state of incorporation and domicile of the insurer, even if most of the events of the case happen elsewhere] because insurance companies have traditionally been state-regulated, rather than being subject to the Federal Bankruptcy Act (11 U.S.C. § 22), and the state laws form a delicately balanced network designed to protect all creditors of an insurance company equally, regardless of the state of their residence.

(*Id.* at 1313), *accord Allendale Mut. Ins. Co. v. Melahn*, 773 F. Supp. 1283, 1286 (W.D. Mo. 1991) (Missouri substantive law controls issue of setoff between insolvent insurer and reinsurer because insurer incorporated and domiciled in Missouri, although reinsurance contract provided for application of New York law); *Frontier Insurance Services Inc. v. David A. Gates, Commissioner of Insurance*, 109 Nev. 231, 236, 849 P.2d 328, 331 (1993) (Applying substantive law of the domiciliary state advances the Uniform Insurers Liquidation Act of centralizing proceedings in one state's court to protect all creditors equally).

The Commission has affirmed that "[a]pplying a myriad of inconsistent and contradictory state laws to evaluate . . . claims against [an insolvent insurance company] would create chaos, promote inconsistent decisions depending on the [claimant's] state of domicile, and produce Commission decisions which would likely violate the disbursement scheme for claims established by § 38.2-1509 of the Code of Virginia." *Petition of McKellar Development of La Jolla*, Case No. INS960026, Report of Senior Hearing Examiner Glenn P. Richardson at 4 (April 11, 1997) (Adopted by the State Corporation Commission in its Final Order dated August 13, 1997).

I find that Virginia substantive law should control in this case to avoid exposing the ROA receivership estate to a myriad of possibly conflicting state laws, to provide for the equitable payment of claims and distribution of the assets of the ROA estate among creditors of the same class no matter where the creditors may reside, and to provide for the orderly administration and wind down of the ROA estate.

The SITs and GSIAs: Insurance or Self-Insurance

The second question to be decided is whether the SITs and GSIAs provided insurance or self-insurance to their employer-members. The Deputy Receiver, Kentucky Hospitals, Coastal, and VWCC argue: (i) the coverages provided by the SITs and GSIAs to their members are contracts of insurance under Virginia law; and (ii) there was transfer, pooling, and spreading of risk among the members of the SITs and GSIAs. The VPCIGA and the Guaranty Associations argue: (i) a self-insurance entity is not an insurer, does not issue contracts of insurance, and does not transact the business of insurance under Virginia law; and (ii) the contracts between the former members and

the SITs and GSIAs are not contracts of insurance under Virginia law because there was no transfer of risk and the members were jointly and severally liable.

a. The VPCIGA's and the Guaranty Associations' Objections

The first issues that must be addressed are the arguments advanced by the VPCIGA and the Guaranty Associations that: (1) a licensed insurance company is a necessary party to an insurance contract in Virginia; (2) chaos will result if the SITs and GSIAs are deemed to be insurers; (3) the Bureau of Insurance's interpretation that Healthcare Providers Group ("HPG") was not an insurance company should be afforded some precedential weight; and (4) ROA and the SITs and GSIAs should be judicially estopped from arguing that the SITs and GSIAs were "insurers" or that they wrote "contracts of insurance." Theses arguments are wholly without merit.

The first and longest continuously operating insurance company in Virginia was founded in 1794. The Mutual Assurance Society Against Fire on Buildings of the State of Virginia (the "Society") was founded on December 22, 1794, by an act of incorporation by the Virginia General Assembly.[62] As stated in its charter, the founding principal of the Society was "[t]hat the citizens of this state may insure their buildings against losses and damages occasioned accidentally by fire and that the insured pay the losses and expenses, each his share, according to the sum insured." Mutual Assurance Society Charter, 1794.

From 1794 until approximately 1906, insurers operated in Virginia free from state insurance regulation.[63] The existence of a contract of insurance was determined by application of common law contract principles. A contract of insurance is "[a]n agreement by which one party for a consideration (. . .usually paid in money, either in one sum, or at different times during the continuance of the risk), promises to make a certain payment of money upon the destruction or injury of something in which the other party has an interest." *Cosmopolitan Life Ins. Co. v. Koegel*, 104 Va. 619, 624, 52 S.E. 166, 168 (1905). (emphasis added). The party offering to insure the risk is generally referred to as the "insurer" and the other party to the agreement is referred to as the "insured."[64] The common law definition of "insurance" has been codified in § 38.2-100 of the Code of Virginia. "Insurance" is defined as "the business of transferring risk by contract wherein a person, for a consideration, undertakes (i) to indemnify another person, (ii) to pay or provide an ascertainable amount of money, or (iii) to provide a benefit or service upon the occurrence of a determinable risk contingency." (emphasis added). The statute further provides that "[w]ithout otherwise limiting the meaning of or defining the following terms, 'insurance contracts' or 'insurance policies' shall include contracts of fidelity, indemnity, guaranty and suretyship." The common law term "party" was replaced with "person." The Code of Virginia defines "person" as "any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal, or

[62] *See*, www.mutual-assurance.com/about. On May 17, 1982, the name of the Society was changed to the "Mutual Assurance Society of Virginia."
[63] *See*, 1906 Va. Acts ch. 112.
[64] "Insurer" is a "company offering protection through the sale of an insurance policy to an insured." "Insured" is defined as the "party covered by an insurance policy." *Dictionary of Insurance Terms* 233-34 (3d ed. 1995).

interinsurance exchange, trustee or society."[65] An "insurance company" is defined as "any company engaged in the business of making contracts of insurance."[66]

Although the term self-insurance has become widely used in the lexicon of insurance and business, including the Code of Virginia, most commentators and the Supreme Court of Virginia recognize that self-insurance is impossible by definition.[67] Generally, the term self-insurance is now used to distinguish between risk management programs that utilize insurance techniques to manage risk from those that do not. Self-insurance programs are distinguished on the basis of the formality of the program, whether approval is required from a state regulatory agency to self-insure; whether third parties are involved, such as the employees of an employer in an employer group program; and whether the formal trappings of insurance are required, such as actuarial funding, loss reserving, certificates of coverage, and the payment of premiums.[68]

The VPCIGA and the Guaranty Associations argue that a licensed insurance company is a necessary party to an insurance contract. This argument is flawed because it fails to consider that the Virginia General Assembly, not the State Corporation Commission or its Bureau of Insurance, defines the transaction of "the business of insurance" in Virginia. The General Assembly may require certain persons who transact the business of insurance to comply with all, some, or none of Virginia's insurance laws; and it may deem "insurance" to be "self insurance" or "self-insurance" to be "insurance" under Virginia law.

The extent of permissible state insurance regulation is provided for in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, adopted by Congress on March 9, 1945.[69] The Act provides that:

> (a) State regulation. The business of insurance and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
> (b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.[70]

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[65] § 38.2-100 of the Code of Virginia.
[66] *Id.*
[67] *See, Yellow Cab Co. v. Adinolfi*, 204 Va. 815, 818, 134 S.E.2d 308, 310 (1964), superseded by statute on other grounds as stated in *William v. Newport News*, 240 Va. 425, 397 S.E.2d 813 (1990) ("[T]he term "self-insurer" is not strictly accurate as a definitive term. Insurance is a matter of contract . . . [therefore,] [n]o entity actually insures itself. A necessary element of insurance is the existence of a contract between insurer and the insured, and an entity cannot contract with itself.").
[68] *See generally*, E. Vaughan and T. Vaughan, *Fundamentals of Risk and Insurance* 49-50 (7th ed. 1996).
[69] In *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 553, 64 S.Ct. 1162, 88 L.Ed. 1440 (1944) the United States Supreme Court held that the "business of insurance" fell within Congress' power to regulate interstate commerce. That holding conflicted with the previous understanding of the relationship between the business of insurance and the Commerce Clause. Before 1944, the Court had implied that the states could regulate the insurance industry without federal intervention. *See, Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 414-16, 66 S.Ct. 1142, 90 L.Ed. 1342 (1946) (discussing the history of insurance regulation and the Commerce Clause). The McCarran-Ferguson Act was Congress' response to the decision in *South-Eastern Underwriters*.
[70] 15 U.S.C. § 1012.

The phrase "business of insurance" in 15 U.S.C. § 1012(a) refers to the relationship between the insurer and the policyholder, and includes the fixing of rates, selling and advertising of policies, and licensing of companies and their agents. *SEC v. National Sec., Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969).

The Virginia General Assembly has responded to the cyclical nature of the voluntary insurance market, hard and soft markets, by permitting "residual market mechanisms," "alternative insurance mechanisms," or "alternative risk-pooling mechanisms" to operate in Virginia without complying with all of the state's insurance laws. Examples of "residual market mechanisms" are: the Virginia Auto Insurance Plan, which is established pursuant to the provisions of § 46.2-464 of the Code of Virginia; the Virginia Property Insurance Association, which is established pursuant to Chapter 27 of Title 38.3 of the Code of Virginia; and the Virginia Workers' Compensation Insurance Plan, which is established pursuant to the provisions of § 65.2-820 of the Code of Virginia.[71] These entities issue contracts of insurance in Virginia; however, they are not licensed insurance companies. These entities are generally referred to as governmental insurers or insurers of last resort. Examples of "alternative insurance mechanisms" are: surplus lines insurance, which is permitted pursuant to Chapter 48 of Title 38.2 of the Code of Virginia; and risk retention groups, which are permitted pursuant to Chapter 51 of Title 38.2 of the Code of Virginia. Surplus lines insurance companies offer insurance coverages not available through an insurance company licensed in Virginia.[72] Lloyd's of London is a surplus lines insurer. It is not licensed to transact the business of insurance in Virginia; however, it is approved to transact such business.[73] Risk retention groups are creatures of federal law, the federal Liability Risk Retention Act of 1986.[74] A risk retention group is a corporation or limited liability company, that assumes and spreads all or a portion of the liability exposure of its group members. It is chartered and licensed in a single state as a liability insurance company.[75] Once licensed in a state, a risk retention group can operate in every other state without obtaining a license as an insurance company or complying with all of the state's laws regulating insurance. Risk retention groups are an exception to the exclusive grant of power to the states under the McCarran-Ferguson Act. Examples of "alternative risk-pooling mechanisms" are: the underground and aboveground storage tank pools, established pursuant to §§ 62.1-44.34:12 and 62.1-44.34:16 of the Code of Virginia; local government group self-insurance pools, established pursuant to §§ 15.2-2700 through 15.2-2709 of the Code of Virginia; and workers' compensation group self-insurance associations, established pursuant to §§ 65.2-800 through 65.2-824 of the Code of Virginia. The General Assembly and the United States Congress have permitted "residual market mechanisms," "alternative insurance mechanisms," or "alternative risk-pooling mechanisms" to operate in Virginia to ensure that insurance coverage remains available and affordable to individuals and businesses in the Commonwealth, when such coverage is either unavailable or unaffordable in the voluntary insurance market.

Focusing on the last two alternative risk-pooling mechanisms, the question arises: How can an entity that is labeled a "group self-insurance pool" or a "group self-insurance association" issue contracts of insurance without being a licensed insurance company or complying with Title 38.2 of

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[71] *See*, § 38.2-2000.1 of the Code of Virginia.
[72] *See*, § 38.2-4806 of the Code of Virginia.
[73] *See*, § 38.2-4811 of the Code of Virginia.
[74] *See*, 15 U.S.C. §§ 3901 through 3906.
[75] *See*, § 38.2-5101 of the Code of Virginia.

the Code of Virginia? The answer is straightforward: the Virginia General Assembly said they could.

The Virginia General Assembly expressed its purpose in permitting the operation of local government group self-insurance pools in § 15.2-2700 of the Code of Virginia. The statute states that:

> [t]he General Assembly hereby finds and determines that insurance protection is essential to the proper functioning of political subdivisions; that the resources of political subdivisions are burdened by the high cost of and frequent inability to secure such protection through standard carriers; that proper risk management requires the spreading of risk so as to minimize fluctuation in insurance needs; and that, therefore, all contributions of financial and administrative resources made by a political subdivision pursuant to an intergovernmental contract as authorized by this chapter are made for a public and governmental purpose, and that such contributions benefit each contributing political subdivision. (emphasis added).

The General Assembly then permitted the formation of local government group self-insurance pools in § 15.2-2703 of the Code of Virginia. The statute provides that:

> A. Any political subdivision of this Commonwealth may, by contract with one or more political subdivisions of this Commonwealth or of another state, form a group self-insurance pool to provide for joint or cooperative action relative to their financial and administrative resources for the purpose of providing to the participating political subdivisions risk management and liability insurance coverage for pool members and employees of pool members, for acts or omissions arising out of the scope of their employment, including any or all of the following:
>
> 1. Casualty insurance, including general and professional and public officials liability coverages;
> 2. Property insurance, including marine insurance and inland marine and transportation insurance coverage;
> 3. Group life, accident and health coverages including hospital, medical, surgical and dental benefits to the employees of member political subdivisions and their dependents;
> 4. Automobile insurance, including motor vehicle liability insurance coverage and collision and security for motor vehicles owned and operated, as required by Title 46.2, and protection against other liability and loss associated with the ownership and use of motor vehicles;
> 5. Surety and fidelity insurance coverage; and
> 6. Umbrella and excess insurance coverages.
>
> B. A group self-insurance pool may obtain excess insurance or reinsurance of risks, and may cede and sell the risks for coverages set forth in this section. (emphasis added).

As noted above, a local government group self-insurance pool may offer as many insurance coverages as a licensed insurance company in Virginia. It may engage in the business of both property and casualty insurance and life and health insurance. Additionally, a local government self-insurance pool may cede or sell any of its books of business to an insurance company. If the coverage provided by a local government self-insurance pool is "self-insurance," then how could the pool sell or cede a book of "self-insurance" to an insurance company? The chaos contemplated by the VPCIGA and the Guaranty Associations, if group self-insurance pools are considered to be insurers, then they must comply with all of Virginia's insurance laws, is avoided by the General Assembly's determination that local government group self-insurance pools are not insurance companies or engaged in the business of insurance. Essentially, the General Assembly has established a separate regulatory scheme for group self-insurance pools. The General Assembly provided in § 15.2-2709 of the Code of Virginia that:

> [a]ny group self-insurance pool organized pursuant to this chapter is not an insurance company or insurer under the laws of the Commonwealth. The development, administration, and provision of group self-insurance programs and coverages authorized by this chapter by the governing authority created to administer the pool does not constitute doing an insurance business.
>
> However, a group self-insurance pool shall be subject to the provisions of Chapter 5, Unfair Trade Practices and 6, Insurance Information and Privacy Protection Act of Title 38.2.

This statute avoids all the perceived problems associated with the regulatory burdens and costs of compliance with Virginia's insurance laws: licensing, premium taxes, guaranty fund coverage, and participation in residual market mechanisms. Essentially, the General Assembly has stated that it is permissible for a local government group self-insurance pool to issue contracts of insurance in Virginia covering the risks of political subdivisions. Yet this activity is not "transacting the business of insurance," that would subject any other entity engaged in such activity to regulation as an insurance company. The reason the General Assembly created this exception is clear, it wanted to provide political subdivisions access to insurance when the voluntary market was unable to provide such coverage.

Although not as clear-cut as the local government group self-insurance pools, the General Assembly has likewise provided that workers' compensation group self-insurance associations insure their members' risks for providing workers' compensation benefits, but are not otherwise regulated as insurance companies. The General Assembly has provided in the Workers' Compensation Act, § 65.2-800 of the Code of Virginia, that:

> [e]very employer subject to the compensation provisions of this title shall insure the payment of compensation to his employees in the manner hereinafter provided. While such insurance remains in force he or those conducting his business shall only be liable to an employee for personal injury or death by accident to the extent and in the manner herein specified. (emphasis added).

In ordinary usage "insure" means "[t]o cover with insurance."[76] Expressed differently, the statute requires every employer subject to the compensation provisions of this title to cover with insurance, the payment of compensation to his employees. "Where the legislature has used words of a plain and definite import the courts cannot put upon them a construction which amounts to holding the legislature did not mean what it has actually expressed." *City of Winchester v. American Woodmark Corp.*, 250 Va. 451, 457, 464 S.E.2d 148, 152 (1995); *Tazewell County School Board v. Brown*, 267 Va. 150, 162, 464 S.E.2d 148, 152 (2004). "[A] statute should be read and considered as a whole, and the language of a statute should be examined in its entirety to determine the intent of the General Assembly from the words contained in the statute." *Dep't of Med. Assistance v. Beverly Healthcare*, 268 Va. 278, 285, 601 S.E.2d 604, 607-8 (2004); *Colchester Towne Condominium Council of Co-Owners v. Wachovia Bank*, 266 Va. 46, 51, 581 S.E.2d 201, 203 (2003). The various parts of the statute should be harmonized so that, if practicable, each is given a sensible and intelligent effect. *Id.* "A statute is not to be construed by singling out a particular phrase; every part is presumed to have some effect and is not to be disregarded unless absolutely necessary." *Commonwealth v. Zamani*, 256 Va. 391, 395, 507 S.E.2d 608, 609 (1998).

The one court that has interpreted § 65.2-800 of the Code of Virginia (formerly, § 65-99 of the Code of Virginia) first noted that Newport News Shipbuilding and Dry Dock Company was a self-insurer under Virginia's Workers' Compensation Act and then stated that:

> [i]t is, of course, mandatory upon every employer subject to the compensation provisions of the Act to insure the payment of compensation to his employees and, while such insurance remains in force, the employer is only liable to an injured employee to the extent specified.

McCann v. Newport News Shipbuilding & Dry Dock Co., 177 F. Supp. 909, 911-12 (E.D. Va. 1959) (emphasis added).

In § 65.2-801 of the Code of Virginia, the General Assembly provided four ways for an employer to "insure" his liabilities under the Act:

> 1. Insuring and keeping insured his liability in an insurer authorized to transact the business of workers' compensation insurance in this Commonwealth;
> 2. Receiving a certificate pursuant to § 65.2-808 from the Workers' Compensation Commission authorizing such employer to be an individual self-insurer;
> 3. Being a member in good standing of a group self-insurance association licensed by the State Corporation Commission; or
> 4. Entering into an agreement with a professional employer organization for professional employer services which includes voluntary market workers' compensation insurance for coemployees. . . .

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[76] *See, American Heritage College Dictionary* 706 (3d. 1997). In contrast, the word "ensure" means "[t]o make sure or certain." *See, id.* at 458.

There are no published Supreme Court of Virginia or Court of Appeals of Virginia opinions that address both §§ 65.2-800 and 65.2-801 of the Code of Virginia. On the one hand, § 65.2-800 mandates that every employer subject to the Virginia Workers' Compensation Act "insure" their workers' compensation liability. On the other hand, § 65.2-801 A allows every employer subject to the Act to secure his liability in one of four ways, one of which references "self-insurer" and another "self-insurance." The Virginia Workers' Compensation Commission has opined that:

> the obligations of 65.2-800 (A) can only be accomplished by one of three ways [now four ways] authorized under 65.2-801 (A): by purchasing a workers' compensation insurance policy issued through a private insurer, being certified by the Commission as an individual self-insurer or by becoming a member of a group self-insurance association licensed by the State Corporation Commission. Although these statutes are not without ambiguity, we find, consistent with our long-standing interpretation, that the statutes require an employer to have in effect a policy on which it is the named insured. (The Virginia Workers' Compensation Commission was addressing the requirements for workers' compensation insurance in an employee leasing arrangement.)

Gulbranson v. C.F.W. Contracting, 77 O.W.C. 234 (1998).

The only logical way to reconcile §§ 65.2-800 and 65.2-801 of the Code of Virginia is to read the two statutes consistently and conclude that the General Assembly intended that a certificated employer self-insurer and a group self-insurance association licensed by the State Corporation Commission are deemed to be insurers for purposes of providing workers' compensation insurance coverage in Virginia. In the case of a certificated employer self-insurer, the employee transfers his risk of loss for workplace injuries to his employer. The employee is the subject matter insured. The risk insured against is the employee's workplace injuries. The commencement and period of the risk would be the employee's commencement of work for the employer. The amount of the insurance would be the workers' compensation benefits provided by law. The premium and time at which it is to be paid would be supplied by the employee's hours of work for the employer.[77] In return for the workers' compensation insurance coverage provided by his certificated employer self-insurer, the employee gives up his right to sue his employer for personal injuries received on the job. The employee's remedies for such injuries lie exclusively with Virginia's workers' compensation system. In the case of a group self-insurance association, the employer-members are both the insurer and the insureds. The employer would be the named insured under a certificate of insurance issued by the group self-insurance association. If the employer fails to comply with § 65.2-801 of the Code of Virginia, the employer is then considered to be an uninsured employer, subject to the penalties provided for in Title 65.2, and liable to his employees for injuries received in the workplace.

This conclusion is appropriate given that § 65.2-807 of the Code of Virginia prohibits an employer from deducting from the wages of any of his employees "any part of the cost of insurance as provided for in § 65.2-801 to insure liability, or to require or permit any of his employees to contribute in any manner toward such cost of insurance." If workers' compensation coverage provided by § 65.2-801 A 2 and A 3 were not deemed to be insurance, employers who qualify under

[77] *See, Group Hospitalization Medical Service, Inc. v. Smith*, 236 Va. 228, 230-31, 372 S.E.2d 159, 160 (1988).

the Act pursuant to those two sections could make deductions from their employees' wages for providing such coverage. Additionally, §§ 65.2-811 and 65.2-813 lend further support to this conclusion. Section 65.2-811 provides that any agreement to secure liability under the Workers' Compensation Act is construed to be a direct promise by the insurer to the person entitled to compensation, enforceable in his own name. In the case of a certificated employer self-insurer, this statute establishes a contractual relationship between the employer and the employee for the provision of workers' compensation insurance benefits, which the employee may enforce in his own name. Section 65.2-813 provides that "[e]very policy for the insurance of compensation herein provided or against liability therefor shall be deemed to be made subject to the provisions of this title." The statute further vests the Workers' Compensation Commission with authority to approve any agreement providing insurance under the Act. The intent of the General Assembly is manifestly clear: workers' compensation coverage provided pursuant to § 65.2-801 A 2 and A 3 is insurance that is not otherwise regulated under Title 38.2 of the Code of Virginia.

The wholesale exemption of a class of insurers from Virginia's insurance regulatory laws is not foreign to the Virginia General Assembly. As recently as 1995, the General Assembly exempted from Virginia's insurance regulatory laws, fraternal benefit associations that were organized prior to 1880 whose principal purpose involved providing insurance to members of the Armed Forces or Sea Services of the United States.[78]

Like the Virginia General Assembly, the legislatures of the other states in which the SITs and GSIAs were domiciled have adopted laws allowing group self-insurers.[79] For example, after the healthcare liability crisis in the early 1970's, the Alabama legislature approved an act allowing hospitals to pool funds for the limited purpose of self-insuring hospitals' professional and general liability exposures. A-HAT was formed to provide a stable source of hospital professional liability insurance for its member hospitals. A-HAT quickly became the major market for hospital liability insurance and insured the majority of the market in Alabama. Over the years, A-HAT added

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[78] *See*, 1995 Va. Acts ch. 321.

[79] *See*, Ala. Code § 25-5-9 (2004) (two or more employers may enter into agreements to pool their liabilities for purposes of qualifying as a self-insurer under the Alabama Workers' Compensation Act); Ala. Code § 22-21-240 (2004) (licensed hospitals, healthcare units, and dentists permitted to a form a trust for the purpose of insuring against general public liability claims based upon acts or omissions of such hospitals or dentists, including without limitation, claims based upon malpractice); Ark. Stat. Ann. § 11-9-404(a)(3)(A) (2004) (two or more employers engaged in the same type of business activity may enter into agreements to pool their liabilities for purposes of qualifying as self-insurers under the Arkansas Workers' Compensation Act); Ky. Rev. Stat. Ann. 342.350(4) (2004) (eleven or more employers or two or more city, county, municipal, or urban-county employers or their agencies may enter into agreements to pool their liabilities for the purpose of qualifying as self-insurers under the Kentucky Workers' Compensation Act); Ky. Rev. Stat. Ann. § 304.48-010 through 304.48-260 (2004) (a group or association of health facilities and health services institutions may form a liability self-insurance group for the purpose of providing adequate coverage for professional or public liability risks for bodily injury or property damage); Miss. Code Ann. § 71-3-75 (2004) (two or more employers engaged in a common business or pursuit, or having other reasons to associate, may enter into agreements to pool their liabilities for the purpose of qualifying as group self-insurers under the Mississippi Workers' Compensation Act); Mo. Rev. Stat. § 287.280 (2004) (a group of employers may enter into an agreement to pool their liabilities for purposes of qualifying as a self-insurer of their liability under the Missouri Workers' Compensation Act); N.C. Gen. Stat. § 58-47-65 (2004) (two or more employers who are members of and are sponsored by a single bona fide trade or professional association may be licensed by the North Carolina Insurance Commissioner to pool their workers' compensation liabilities under the North Carolina Workers' Compensation Act); and Tenn. Code Ann. § 50-6-405(c) (2004) (ten or more employers of the same trade or group may enter into agreements to pool their liabilities for the purpose of qualifying as a self-insurer under the Tennessee Workers' Compensation Act).

additional liability coverages to its insurance program. With the success of A-HAT, HWCF was formed to provide workers' compensation insurance coverage for its members. HWCF was one of the predominant workers' compensation insurers in the State of Alabama for the healthcare industry.[80]

Despite her colorful analogies of self-insureds simmering in their own juices and GSIAs cross-dressing to appear like insurance companies, a review of Professor Baranoff's textbook *Risk Management and Insurance* reveals her belief that coverage provided by group self-insurance associations is "non-regulated or semi-regulated insurance."[81] In discussing insurance institutions, markets, and regulation, she notes that "some insurance structures such as governmental risk pools or Lloyd's of London do have specialized organization structure."[82] She further notes that "public risk pools" and "self-insurance/captives" are types of insurers that are non-regulated or semi-regulated insurance. In her textbook, she described the Texas Association of School Boards ("TASB") as a "governmental risk pool" that provided workers' compensation, property, liability, and health insurance to member school districts.[83] Ms. Baranoff's stated position in her textbook differs from her testimony at the hearing; however, it is consistent with the discussion above. State legislatures may permit certain entities to operate as *de facto* insurance companies without having to comply with the state's laws governing insurance regulation. In common parlance, they are "non-regulated or semi-regulated insurance."

The VPCIGA and the Guaranty Associations argue that prior to this case, the Bureau of Insurance has never treated group self-insurance pools as licensed insurance companies. They rely on *Tazewell County School Board v. Brown*, 267 Va. 150, 163-64, 591 S.E.2d 671, 678 (2004) (citations omitted).[84] In that case, the Virginia Supreme Court stated that an:

> 'elementary rule of statutory interpretation is that the construction accorded a statute by public officials charged with its administration and enforcement is entitled to be given weight by the court.' We presume that the General Assembly is cognizant of [an agency's construction of a term] and, since that construction has continued for a long period without any change by the General Assembly, we further presume that it has acquiesced in the particular construction of the term. (citations omitted).

The VPCIGA and the Guaranty Associations rely on two statements appearing in Exhibit VA-121. In the Examination Report of HPG, the Chief Examiner stated that "[a]n 'Insurance company' is defined as any company engaged in the business of making contracts of insurance." He then recited the language found in § 65.2-802 A of the Code of Virginia that two or more

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[80]*See*, Ex. C-15.
[81]E. Baranoff, *Risk Management and Insurance* 95 (2004).
[82]*Id.* at 94.
[83]*Id.* at 113.
[84]*See also*, *Commonwealth v. Carter*, 198 Va. 141, 146-47, 92 S.E.2d 369, 371 (1956) ("the practical construction given to a statute by public officials charged with its enforcement is entitled to great weight and in doubtful cases will be regarded as decisive").

employers may form a group self-insurance association to pool their liabilities. The Examiner then concluded:

> [s]ince group self-insurance associations are not licensed as insurers, it is the Examiners (sic) position that [HPG] lacks the statutory authority to enter into a reinsurance agreement. (emphasis added).

Taken in the context in which it was written, the Examiner's statement stands for the proposition that a reinsurance transaction is a transaction between two licensed insurance companies. At the time, HPG was not a licensed insurance company and it was, therefore, ineligible under § 38.2-136 of the Code of Virginia to enter into a reinsurance transaction with an insurance company. This statutory oversight was corrected when the General Assembly amended § 65.2-802 E of the Code of Virginia to provide that "any group self-insurance association entering into a reinsurance transaction pursuant to the provisions of this section shall be deemed an insurer for purposes of such transaction and shall be subject to Article 3.1 (§ 38.2-1316.1 *et seq.*) of Chapter 13 of Title 38.2."[85]

The second statement appears in an internal memorandum prepared by a staff member of the Bureau of Insurance to the Chief Examiner. The memorandum responds to arguments of counsel to HPG supporting its position that HPG is an insurer. The salient portions of the memorandum state:

> HPG has [not] proven that it is an insurance company and therefore able to purchase reinsurance. If group self-insurance associations are insurance companies then all provisions of the insurance code should be applied to their regulation. There are fundamental differences between a group self-insurance association and an insurance company. Group self-insurance associations are not insurers and therefore should not be allowed to enter into reinsurance agreements. (emphasis added).

Again, the memorandum is based upon the fact that HPG was not an insurance company. That fact was absolutely correct. HPG was not a licensed insurance company; it was a licensed group self-insurance association. Granted, there are fundamental differences between an insurance company and a group self-insurance association. However, those differences are provided for by statutes adopted by the General Assembly. The staff person incorrectly opined that if group self-insurance associations are insurance companies then all of the provisions of the insurance code should be applied to their regulation. That statement would have been true except for the fact that the General Assembly has provided an alternative regulatory scheme for group self-insurance associations.

The Commission is not bound by the erroneous legal conclusions of a staff member in the Bureau of Insurance. The Commission is vested with the authority to regulate insurance companies and group self-insurance associations under the provisions of Article IX of the Constitution of Virginia and Titles 38.2 and 65.2 of the Code of Virginia. Employees appointed or employed by the Commission pursuant to § 12.1-18 "merely assist the Commission in the discharge of its duties." *Roanoke Gas v. Attorney General*, 219 Va. 1072, 1079, 254 S.E.2d 102, 106 (1979). The positions espoused by a member of the Commission's staff are "recommendations" that may be accepted or rejected by the Commission. *Id.*

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[85] *See*, 1994 Va. Acts ch. 408.

The Guaranty Associations argue that ROA and the SITs and GSIAs should be judicially estopped from taking the position that the SITs and GSIA were "insurers" or that they wrote "contracts of insurance." For support, the Guaranty Associations rely on *Burch v. Grace Street Building Corp.*, 168 Va. 329, 340, 191 S.E. 672, 677 (1937). In *Burch*, the Supreme Court of Virginia stated it is the general rule in Virginia that a party is forbidden to assume successive positions in the course of a suit, or a series of suits, relating to the same facts or a series of facts, which are inconsistent with each other or mutually contradictory. A litigant is estopped from taking a position that is inconsistent with one previously assumed, either in the course of litigation for the same cause of action or in his dealings outside of court.

In the *Burch* case, the plaintiff filed two lawsuits in the same court alleging the same personal injury. The cases were assigned to two different judges, and both cases were heard. In the first case, the plaintiff took a nonsuit after the defendant moved to strike at the completion of the plaintiff's evidence. In the second case, the trial court allowed the case to go to the jury, and a verdict was returned for the plaintiff. The defendant moved to set aside the verdict as contrary to the law and without evidence to support it. The motion to set aside the verdict was sustained and final judgment was entered for the defendant. On appeal, the Supreme Court of Virginia found that the testimony given by the plaintiff in his first trial was inconsistent and directly contradictory to the testimony he gave in his second trial. Applying the doctrine of judicial estoppel, the Court found that the plaintiff was bound by his admissions in his first trial. The Court stated that "the consistency of proceeding and the consistency of testimony are highly essential to the proper administration of justice." *Id.* at 343.

Since there have been no prior judicial proceedings in which the status of the SITs and GSIAs has been litigated, and no change in the position of ROA and the SITs and GSIAs during the course of this proceeding, I find no basis for estopping ROA and the SITs and GSIAs from arguing in this case that they were self-insured trusts or group self-insurance associations that issued contracts of insurance covering their members' liability or workers' compensation risks.

b. Transfer of Risk, Joint and Several Liability, and the *American Surety* Test

A second series of issues must be addressed: (1) whether there was transfer of risk in any of the SIT and GSIA programs; (2) whether joint and several liability prevents self-insurance from being insurance; and (3) whether any of the SIT and GSIA programs meet the five-prong test for an insurance contract under Virginia law.

Both the definition of insurance in § 38.2-100 of the Code of Virginia and applicable precedent require that an insurance transaction include a transfer of a risk of loss. The Supreme Court of Virginia has held that if the risk of loss remains with the same person, then there is no insurance transaction. *Lawyers Title Insurance Corp. v. Norwest*, 254 Va. 388, 393, 493 S.E.2d 114, 116 (1997). There is no transfer of risk if "throughout the entire transaction, there is a *retention* of the risk by [the same person], and not a *shift* of the risk." *Id.* (emphasis in original).

The expert witnesses' testimony and the legal authorities cited by the parties differ on whether there is a transfer of a risk of loss in a SIT or GSIA program. The textbook *Fundamentals of Risk and Insurance* provides an excellent description of risk-sharing pools and whether risk transfer occurs in such situations.[86] Risk-sharing pools are:

> mechanisms that are closely related to and sometimes confused with association or group captives, but they actually constitute a separate [risk management] technique. A group of entities may elect to pool their exposures, sharing the losses that occur, without creating a formal corporate insurance structure.[87] In this case, a separate corporate insurer is not created, but the risks are nevertheless 'insured' by the pooling mechanism.
>
> Viewed from one perspective, pooling may be considered a form of transfer, in the sense that the risks of the pooling members are transferred from the individuals to the group. Viewed from a different perspective, pooling is a form of retention, in which the entity's risks are retained along with those of other pooling members. This dual nature of pooling stems from the sometimes-forgotten fact that in a pooling arrangement, members are both insureds and insurers. (footnote in original).[88]

The parties rely on two cases with diametrically opposite results that arose from the insolvency of Mission Insurance Company ("Mission"). Mission wrote excess or stop-loss insurance for self-insured groups. In the first case, the Supreme Court of Iowa found that a group self-insurance association was not an "insurer" under Iowa law and the excess insurance policy it purchased from Mission was therefore direct insurance and not reinsurance. The Iowa Insurance Guaranty Association ("IIGA") was required to pay the group self-insurance association's claim. *Iowa Contractors Workers' Comp. Group v. Iowa Ins. Guaranty Ass'n*, 437 N.W.2d 909 (Iowa 1989). In the second case, the Supreme Court of South Carolina found that a workers' compensation self-insurance fund was an "insurer" under South Carolina law and the excess insurance policy it purchased from Mission was reinsurance, not direct insurance. The Court upheld the South Carolina Insurance Guaranty Association's ("SCIGA") denial of the workers' compensation self-insurance fund's claim. *South Carolina Property & Cas. Ins. Guaranty Ass'n v. Carolinas Roofing & Sheet Metal Contractors Self-Insurance Fund*, 315 S.C. 555, 446 S.E.2d 422 (1994).

In *Iowa Contractors*, the Court noted that any amount due an insurer or an underwriting association is excluded from the definition of "covered claim" under the Iowa guaranty fund statutes. IIGA relied on this statute to deny the group self-insurance association's claim. The Court reviewed the definition of "insurer" in the guaranty fund statutes and determined that under the

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[86] *See*, E. Vaughan and T. Vaughan, *Fundamentals of Risk and Insurance* 53 (7th ed. 1996).

[87] "The laws in virtually all states currently permit public bodies such as municipalities and counties to form self-insurance or risk-sharing pools. The pools are generally deemed not to be insurance companies and are not subject to the provisions of the state's insurance laws, except as specifically provided by the statutes under which they are organized." *Id.*

[88] Virginia law recognizes reciprocal insurance which is defined as: "insurance resulting from the mutual exchange of insurance contracts among persons in an unincorporated association under a common name through an attorney-in-fact having authority to obligate each person both as insured and insurer." *See*, § 38.2-1201 of the Code of Virginia.

narrow definition of "insurer" in the statute, the association was not an "insurer" because it was not licensed as an insurance company pursuant to either of the statutes. The court reasoned the narrow definition in the statute was a "manifestation of legislative intent to provide guaranty fund protection not only to single self-insurers but also to self-insured groups like the [association]."[89]

Instead of stopping at this point, the Court also addressed whether the transaction between the group self-insurance association and its members was insurance because the IIGA had argued that, notwithstanding the members' joint and several liability, the transaction met all of the requirements of an insurance contract under Iowa law. In response, the Court stated:

> [a]pplying the above principles to the arrangement between the [association] and its members, we think such an arrangement hardly resembles insurance as it is commonly understood. The joint and several liability provision underlying the separate indemnity agreement between the [association] and its members materially distinguishes the arrangement from traditional forms of insurance. No traditional insurance policy that we are aware of requires all of the company's insureds to contribute their own funds, without limitation, to satisfy the company's claims in the event of its insolvency.

Iowa Contractors at 916.

The Court concluded that the arrangement between the employers and the association did not make a self-insured group an insurer for purposes of the Iowa guaranty fund statute. It reasoned that "[r]isk spreading, the primary function served by the arrangement between the [association] and its members, may be accomplished without insurance, just as risk transference may be." *Id.* at 917. The Court affirmed the lower court's finding that the IIGA was liable to pay the association's "covered claim."

In contrast, the South Carolina insurance guaranty fund statutes exclude claims made by "insurers," not claims by "insurance companies." The question before the Court was whether a group self-insurance fund was an "insurer." The Court found the arrangement between the fund and its members, and between the fund and Mission, met the definition of insurance under South Carolina law.[90] The Court noted that in the context of single automobile self-insurers it had previously determined they were not technically insurers, but the service they provided was insurance. This case was the Court's first opportunity to address whether a group self-insurer was an "insurer." The Court found that a "single employer self-insured merely retains its own risk that an event will occur which will render it liable." *South Carolina Property & Cas. Ins. Guaranty Ass'n* at 425. The Court further found that "the members of a group self-insurer such as [the fund] transfer a portion of their risk to the group, and in turn assume a risk that belongs to the other members of the group." *Id.* In the lower court, the trial judge found SCIGA's experts' opinions more credible and found there was a "substantial transfer of risk" between the employer-members of the fund and the fund itself. The Court affirmed this finding since it was supported by the evidence. The Court noted that South Carolina's statutory definition of insurance does not even

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[89]*See, id.* at 915.

[90]The South Carolina Code defined "insurance" as "a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies. . . ." S.C. Code Ann. § 38-1-20(19) (Supp. 1993).

mention transfer of risk; it merely requires a contractual agreement to pay or indemnify another. The Court held that "since the [fund] engages in a 'kind of insurance,' it is an insurer" under South Carolina law and its claim is not covered by the Guaranty Fund Act, since the policy between the fund and Mission was a reinsurance policy between two insurers. *Id.*

A couple of simple examples demonstrate there is significant transfer of risk among the employer-members of a SIT or GSIA. Assume that a SIT or GSIA has 100 members. In year one, only one of the members has a claim. In this example, all 100 members, including the member that had the claim, would have to pay a portion of the claim. In effect, the one member that had the claim transferred 99% of its risk of loss to the other members of the group. In year two, 99 of the members have catastrophic claims, declare bankruptcy, seek to dissolve their corporate identity, and withdraw from participation in the SIT or GSIA. The one member left in the SIT or GSIA had no claims. In this instance, the one surviving member of the SIT or GSIA would be responsible for 100% of the claims. The result is that 99 former members of the SIT or GSIA transferred their risk of loss to the one surviving member. Unlike a single employer self-insured who retains 100% of its risk of loss, the motivation for an employer to join a GSIA is the ability to transfer its risk of loss to the other employer-members of the group. The result is that the employer-members act as both the insurer and the insured in spreading the risk among themselves. The evidence in the record, particularly the testimony of Messrs. Hyland, Brezosky, Meredith, Walz, and Capell, established that there was significant risk transfer occurring among the employer-members and the SITs and GSIAs. The reasoning in *South Carolina Property & Cas. Ins. Guaranty Ass'n* should be followed in this case. This position is consistent with the generally accepted understanding of risk transfer in self-insurance pools.

The VPCIGA and Guaranty Association rely upon the *Iowa Contractors* case for the proposition that joint and several liability prevents self-insurance from being insurance. The Supreme Court of Iowa placed great emphasis on the point that "no traditional insurance policy that we are aware of requires all of the company's insureds to contribute their own funds, without limitation, to satisfy the company's claims in the event of its insolvency." The Court relied on this logic in reaching its decision that the group self-insurance association was not an "insurer." *Iowa Contractors* at 916.

The Court's statement evidences a clear misunderstanding of the practical application of joint and several liability. Joint and several liability should be thought of as a penalty that might be employed if all other attempts at getting a member to pay its assessments fail. The concept is pretty simple to understand: either pay your fair share, or else you can pay the whole thing. Joint and several liability is a particularly effective tool to use against a recalcitrant former member who refuses to pay its *pro rata* assessment for claims incurred during the period of its membership in the SIT or GSIA. Pay your fair share or we, the SIT or GSIA, will institute an action to enforce the joint and several liability clause in your indemnity agreement and power of attorney and you can pay all of the outstanding claims incurred during the period of your membership. Joint and several liability does not change the fact that the members of the SIT or GSIA are transferring a risk of loss among themselves, or that the SIT or GSIA provides insurance for its members. Not one example of the application of joint and several liability was provided at the hearing by any party. An argument could be made that joint and several liability evidences that the members of the SIT and GSIA do indeed transfer their risk of loss. If one member of the SIT or GSIA could be liable for the

claims of the other 99 members, have not the other 99 members transferred their risk of loss? If the members are solvent, pay their assessments as required in their indemnity agreements, and the excess or stop-loss insurer or reinsurer meets its contractual obligations, the joint and several liability of the members of an SIT or GSIA is a legal fiction.

The Supreme Court of Iowa was unaware of any insurance product that had an unlimited assessment feature. Unlike Iowa, Virginia has recognized since 1794 that insureds may be assessed, without limitation, to pay the claims of their insurer. In mutual assessment insurance each member agrees to pay his *pro rata* share of all losses or damages sustained, expenses of operation of the insurer, and maintenance of an adequate surplus to policyholders, unless the insurer has limited the members' assessment liability.[91] Additionally, Virginia recognizes that subscribers of a reciprocal insurer covered under an assessable policy have a contingent assessment liability for actual losses and expenses incurred while their policies were in force. The contingent assessment is fixed at the annual premium of the member multiplied by a factor of not less than one or more than ten. The contingent assessment liability is not joint, but it is individual and several.[92] The mere fact that an insurance policy may be assessable does not make it any less a contract of insurance under Virginia law.

Based on the evidence in the record and for the reasons set forth herein, I find: (1) the employer-members of SITs and GSIAs pooled their risk of loss for the purpose of transferring an individual employer-member's risk of loss to the group; (2) the SITs and GSIAs were a type of reciprocal insurer in which the employer-members were both the insurer and the insured; and (3) Virginia law recognizes that entities such as the SITs and GSIAs transact the business of insurance, but are exempt from regulation as insurance companies under Title 38.2 of the Code of Virginia, except as specifically provided in statutes adopted by the General Assembly.

The next issue is whether any of the SIT or GSIA coverage documents meet the five-prong test for an insurance contract under Virginia law. In *Group Hospitalization Medical Service, Inc. v. Smith*, 236 Va. 228, 230-31, 272 S.E.2d 159, 160 (1988), the Supreme Court of Virginia set forth the essential elements for an insurance contract under Virginia law. Those elements are:

(1) the subject matter to be insured;
(2) the risk insured against;
(3) the commencement and period of the risk undertaken by the insurer;
(4) the amount of insurance; and
(5) the premium and time at which it is to be paid.

American Surety Co. v. Commonwealth, 180 Va. 97, 105, 21 S.E.2d 748, 752 (1942).

In *Group Hospitalization*, the Court was faced with deciding whether Fairfax County's self-funded employee healthcare plan was an insurance agreement covered by the anti-subrogation statute, former § 38.1-342.2 of the Code of Virginia.[93]

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[91] *See*, §§ 38.2-2518 – 38.2-2520 of the Code of Virginia.
[92] *See*, § 38.2-1212 of the Code of Virginia.
[93] Re-codified as § 38.2-3405 of the Code of Virginia.

As part of its compensation package, Fairfax County (the "County"), a self-insurer, provided a healthcare plan to its employees through a contract with Group Hospitalization Medical Service, Inc. ("GHMSI") in which GHMSI acted as the third-party administrator for the plan. The plan had limitations, exclusions, and many other provisions typical of health insurance policies. The County reimbursed GHMSI for funds that GHMSI paid to healthcare providers for medical services rendered to the County's employees. In addition, the County paid GHMSI a service fee for acting as its third-party administrator. The contract between the County and GHMSI had a subrogation provision that required beneficiaries of the plan to reimburse GHMSI any monies that GHMSI paid for covered health care services which the beneficiaries recovered from third parties responsible for the beneficiaries' injuries. A minor child of a County employee was injured in an automobile accident. She recovered an amount greater than the cost of the medical treatment for her injuries from the negligent third party and GHMSI sought reimbursement under the subrogation provision in its contract with the County. *Id.* at 229-30.

The Court applied the five-prong test to the contract between the County and GHMSI and found that: (1) the County's employees and their minor dependents were the subject matters insured; (2) their need for medical and hospital attention was the risk insured against; (3) the period of the risk was the period stated in the plan; (4) the amount of insurance was as stated in the plan; and (5) the premium and time for payment were supplied by each employee's performance of work for the County. The Court further found that the County, as a self-insurer, "assumed the risk of loss by obligating itself to the payment of those health claims covered by the terms of the contract." *Id.* at 231. The Court ultimately found that the County's health benefit plan was an insurance agreement covered by the anti-subrogation statute.

The five-prong test will be applied to the coverage documents in the record for each of the SITs or GSIAs.

The "HWCF Fund Coverage Agreement" is located in Exhibit DR-10, Tab A 1. The hospital named in the agreement was the subject matter insured; the risk insured against was the hospital's Alabama workers' compensation liability; the period of the risk was stated in the agreement; the amount of insurance was provided under the Alabama workers' compensation law; and the premium and time at which it was to be paid were stated in the agreement. I find the arrangement in which HWCF provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law.

The A-HAT "Medical Professional and General Liability Coverage" agreement is located in Exhibit DR-10, Tab B 1. The subject matters insured were certain enumerated employees and the member hospital; the risks insured against were the medical professional liability, general liability, and personal injury liability exposures of the employees and the hospital; period of risk was provided in Section VII of the agreement and the agreement's definition of "Report Year" and "Fiscal Period"; the amount of insurance is provided in Section II of the agreement and the limit of liability stated on each member's certificate of coverage; and the member's premium and time at which it was to be paid were set forth in Section VIII A of the agreement and A-HAT's Retrospective Rating Plan, which was incorporated by reference and made a part of the

agreement.[94] I find the arrangement in which A-HAT provided its employer-members medical professional liability, general liability, and personal injury liability coverage was an insurance contract under Virginia law.

The C-HAT "Workers' Compensation and Employers Liability Coverage Agreement" is Exhibit KH-50 and the "C-HAT Workers' Compensation Coverage Certificate" issued to a hospital pursuant to the coverage agreement is Exhibit DR-10, Tab D 1. The subject matter insured was the hospital named in the coverage certificate; the risk insured against was the hospital's Kentucky workers' compensation liability; the period of the risk and the amount of insurance were stated in the coverage certificate; and the member's premium was stated in the coverage certificate and was payable when due. I find the arrangement in which C-HAT provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law.

The K-HAT "Professional and General Liability Coverage" agreement is Exhibit DR-10, Tab E 1 and the "Certificate of Liability Insurance" and "Declarations Page" issued pursuant to the agreement is Exhibit KH-51. The subject matter insured was the hospital named in the Declarations Page; the risks insured against were the hospital's professional and general liability; the period of the risk, the amount of insurance, and the premium for the insurance coverage were stated in the Declarations Page; and the premium was due in accordance with a payment schedule adopted by K-HAT's trustees. I find the arrangement in which K-HAT provided its employer-members hospital professional and general liability coverage was an insurance contract under Virginia law.

The "MHA Public Certificate of Membership" is Exhibit DR-10, Tab F 2. The subject matter to be insured was the hospital named in the certificate; the risk insured against was the hospital's workers' compensation liability under the Mississippi workers' compensation law; the period of the risk, the amount of insurance, and the annual premium to be paid are stated in the certificate. I find the arrangement in which MHA Public provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law.

The "MHA Private Certificate of Membership" is Exhibit DR-10, Tab G 2. The subject matter to be insured was the hospital named in the certificate; the risk insured against was the hospital's workers' compensation liability under the Mississippi workers' compensation law; the period of the risk, the amount of insurance, and the annual premium to be paid are stated in the certificate. I find the arrangement in which MHA Private provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law.

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[94]Although the A-HAT agreement characterizes the member's payment as a "contribution," the purpose of the "contribution" was to keep the insuring agreement in place. The long-standing precedent in Virginia is that a court will look at the substance of a transaction rather than its form. *The Texas Company, Inc. v. Frederick Northup*, 154 Va. 428, 444, 153 S.E. 659, 664 (1930) ("equity considers substance rather than shadow; reality rather than form"); *Virginia Machinery & Well Co. Inc. v. Hungerford Coal Co. Inc.*, 182 Va. 550, 556, 29 S.E.2d 359, 362 (1944) ("[e]quity looks at the substance of a transaction and not its mere form"). In ordinary usage "premium" is defined as "the periodic payment required to keep an insurance policy in effect." *Black's Law Dictionary* 1199 (7th ed. 1999). No matter what label the SITs and GSIAs placed on the monetary payments made to secure the insurance coverage with the SIT or GSIA, those payments were "premium" payments.

The "SunHealth Certificate of Membership" is Exhibit DR-10, Tab I 2. The subject matter to be insured was the hospital named in the certificate; the risk insured against was the hospital's workers' compensation liability under the North Carolina workers' compensation law; the period of the risk, the amount of insurance, and the annual premium to be paid are stated in the certificate. I find the arrangement in which SunHealth provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law.

The "THA Certificate of Membership" is Exhibit DR-10, Tab J 2. The subject matter to be insured was the hospital named in the certificate; the risk insured against was the hospital's workers' compensation liability under the Tennessee workers' compensation law; the period of the risk, the amount of insurance, and the annual premium to be paid are stated in the certificate. I find the arrangement in which THA provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law.

The "HPG Certificate of Membership" is Exhibit DR-10, Tab K 2. The subject matter to be insured was the hospital named in the certificate; the risk insured against was the hospital's workers' compensation liability under the Virginia workers' compensation law; the period of the risk, the amount of insurance, and the annual premium to be paid are stated in the certificate. I find the arrangement in which HPG provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law.

Mr. Hyland testified that he was unable to locate copies of the membership certificates for AWCT and MHA/MSC; however, he stated that their forms were similar to the other nine referenced above.[95] The VPCIGA and the Guaranty Associations put on no evidence to rebut Mr. Hyland's testimony.

The concept of burden of proof involves two distinct legal requirements at a hearing. These requirements are generally referred to as the "burden of producing evidence" and the "burden of persuasion." The burden of producing evidence requires a party to produce sufficient evidence to avoid a directed verdict. The burden of persuasion requires a party to convince the trier of fact that a particular result should be reached in favor of that party. During a hearing, the burden of producing evidence may shift from one party to the other, but the burden of persuasion never shifts. In this case, the party with the burden of persuasion must prove its case by a preponderance of the evidence. In other words, the Deputy Receiver must prove that it is more likely than not, that the AWCT and MHA/MSC membership certificates contained the essential elements for a contract of insurance under Virginia law.[96]

The Deputy Receiver met his initial burden of putting on evidence that the AWCT and MHA/MSC membership certificates contained the essential elements of a contract of insurance. If the two missing membership certificates were indeed similar to the other nine, as Mr. Hyland testified, then they would have had all of the elements for finding a contract of insurance. At this point, the burden shifted to the VPCIGA and the Guaranty Associations to produce evidence that Mr. Hyland's testimony was untrue and the two missing agreements were not similar to the other nine. The VPCIGA and the Guaranty Associations failed to meet their burden of producing rebuttal

[95] *See*, Ex. MH-4, at 6-7.

[96] *See generally*, C. Friend, *The Law of Evidence in Virginia* §§ 9-1 through 9-9 (1993).

evidence. Given Mr. Hyland's un-rebutted testimony, I find it is more likely than not, that the AWCT and MHA/MSC membership certificates contained the essential elements for a contract of insurance under Virginia law, and were therefore contracts of insurance under Virginia law.

The Fortuity and Known Loss Doctrines

The VPCIGA and the Guaranty Associations argue the assumption transactions between the SITs, GSIAs, and ROA were not insurance transactions because ROA was acquiring known losses. They argue the losses had already occurred; therefore, the element of fortuity was lacking in each of the transactions. An example was given at the hearing: insurance cannot be purchased on a house while the house is burning down. The witnesses for the VPCIGA and the Guaranty Associations used the terms "fortuity" and "known losses" interchangeably when describing this type of loss; however, these are two separate doctrines.

The known loss doctrine is an affirmative defense to a suit on an insurance policy. The insurer bears the burden of proving the insured's actual knowledge of the loss. The insurer also bears the burden of proving the lack of fortuity as a defense apart from the known loss doctrine.[97] The question arises whether strangers to the contracts between the SITs, GSIAs, and ROA, the VPCIGA and the Guaranty Associations, have standing to raise defenses that lie solely with ROA. The overwhelming evidence in this case is that the parties to the assumption agreements, including ROA, the insurer, believed that it was assuming the insurance obligations of the SITs and GSIAs, not assuming known losses. Since the parties have not addressed this issue, an examination of the fortuity and known loss doctrines is necessary.

The courts distinguish between first party insurance and third party insurance when applying the known loss doctrine.[98] The differences in the two types of coverage result in a different analysis by the courts. In first party insurance, if a person knows his house is burning down, he cannot obtain insurance for the damage because the absence of risk precludes coverage. Third party insurance, which includes the workers' compensation and liability coverages provided by the SITs and GSIAs, affords coverage for sums the insured becomes legally obligated to pay. In third party insurance, insurance cannot be obtained for a known liability.[99]

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[97]*See, Couch on Insurance* 3d § 254.122 (2001). *See also, U.S. Liability Ins. Co. v. Selman*, 70 F.3d 684, 691 (1st Cir. 1995). The known loss doctrine has several variants, which are referred to as the "known risk" or "loss-in-progress" doctrines. The courts appear to use the terms interchangeably. *See e.g., City of Johnstown v. Bankers Standard Ins. Co.*, 877 F.2d 1146, 1152 (2d Cir. 1989) (discussing doctrine of "known risk"); *Inland Waters Pollution Control, Inc. v. National Union Fire Insurance Co.*, 997 F.2d 172, 179 (6th Cir. 1993) (describing "loss in progress" as a variant of the "known loss" doctrine). In this case, the term "known loss" will be used as it was the term most often used by the parties.

[98]First party insurance is "coverage for the insured's personal and real property and the insured's own person." Third party insurance is "liability insurance purchased by the insured (first party) from an insurance company (second party) for the protection against possible suits brought by another (third party)." *Dictionary of Insurance Terms* 176, 483 (3d ed. 1995).

[99]*See, Montrose Chemical Corp. v. Admiral Ins. Co.*, 10 Cal. 4th 645, 913 P.2d 878, 905 (Cal. 1995).

The state courts are divided on how narrowly or broadly the known loss doctrine should be applied in the context of third party insurance. Some have construed the doctrine narrowly. In *Montrose Chemical Corp.*, the Supreme Court of California held that the known loss doctrine "will not defeat coverage for a claimed loss where it had yet to be established, at the time the insurer entered into the contract of insurance with the policyholder, that the insured had a legal obligation to pay damages to a third party in connection with a loss."[100] The court held that a potentially responsible party letter sent by the Environmental Protection Agency to a chemical company did not establish any legal obligation to pay damages or cleanup costs in connection with contamination at a site owned by the company. The known loss rule was not implicated and the insured was not precluded from seeking the liability coverage it had obtained for the site. Other courts have construed the doctrine broadly. In *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 154 Ill. 2d 90, 104, 607 N.E.2d 1204, 1210 (1992), the Supreme Court of Illinois held that "[i]f the insured knows or has reason to know, when it purchases a [commercial general liability] policy, that there is a substantial probability that it will suffer or has already suffered a loss, the risk ceases to be contingent and becomes a probable or known loss." The court held that the question is not whether the insured knew it was discharging pollutants into a river, which it was permitted to do by a state issued pollution discharge permit; but rather, whether the insured knew or had reason to know that a probable loss or liability would occur due to polychlorinated biphenyls (PCBs) contamination.

The Federal Courts of Appeal also have addressed the known loss doctrine and its application in the states of Massachusetts, New Jersey, and South Carolina. In *U.S. Liability Ins. Co. v. Selman*, 70 F.3d 684, 691 (1st Cir. 1995), the court held that "the common law version of the known loss doctrine only applies when the insured actually knows on or before the effective date of the policy either that a loss has occurred or that one is substantially certain to occur." The court further held that the applicability of the doctrine depends on the insured's actual knowledge of the impending loss, *i.e*, that the insured "knew he was virtually certain to experience a loss. . . ." *Id.* at 693. The court held that the fact the owner of an apartment building knew his building contained lead paint and that a child who lived in his building was suffering from lead paint poisoning, were insufficient to prove that the owner insured against a known loss. In *Pittston Co. Ultramar American Limited v. Allianz Ins. Co.*, 124 F.3d 508, 518 (3d Cir. 1997), the court held that "the known loss doctrine will bar coverage only when the legal liability of the insured is a certainty." Although the new owner of an oil storage and transfer terminal might have had limited information about contamination at the site when it purchased the site in 1983, the owner did not receive notice of a legal liability until 1989. The court held the owner had a legitimate insurable risk from the time it acquired the property to 1989. In *Stonehenge Engineering Corp. v. Employers Ins. of Wausau*, 201 F.3d 296, 302 (4th Cir. 2000), the court held that the known loss doctrine applies if the insured "(1) actually knew that it was legally liable for the property damage claimed [by the third party at the time one of its insurance policies] took effect or (2) knew that such liability was substantially certain to occur." Although the developer of a condominium complex was put on notice by the homeowners' association that the association intended to hold it liable for certain construction defects and the association filed a subsequent lawsuit against the developer for damages, the court held the known loss doctrine did not apply. The court reasoned that the developer raised viable defenses to the lawsuit so that an adverse judgment was not certain to occur, and the developer had not been found legally liable for the property damage claimed by the association.

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[100]*See, id.* 906.

The Supreme Court of Virginia has not addressed the known loss doctrine. No matter which version the Court may adopt, the Assumed Claims were not known losses. The experts testifying at the hearing failed to appreciate the difference between first party insurance and third party insurance when giving their examples of known losses. In the context of third party liability, the insurable risk is the uncertainty of liability.[101] The Assumed Claims represent workers' compensation liability claims, and medical malpractice and other liability claims. The claims can be separated into three types: (1) incurred, reported, and adjudicated; (2) incurred, reported, but not adjudicated; and (3) incurred but not reported.[102] The mere fact that an employee might have had an injury in the workplace or that a medical malpractice claim was reported, does not by itself establish liability on the part of the employer or the hospital, or establish that liability is virtually certain. Even in the case of a workers' compensation claim that might have been adjudicated, the ultimate liability on the claim is not certain. As the Virginia Uninsured Employer's Fund noted in its Post-Hearing Brief, although a claim may have been adjudicated, there remains significant additional liability that may be imposed on an employer under Virginia's workers' compensation laws. For example, Virginia Code § 65.2-512 provides, in part, that if death results from an accident within nine years from the date of the accident the employer shall pay 66 2/3% of the employee's average weekly wage to the employee's dependents for a period of 500 weeks from the date of the injury.[103] The resulting death requires the filing of a new claim for benefits. In all three types of claims noted above, there is an insurable interest; therefore, the known loss doctrine is inapplicable. Even if the Assumed Claims are considered known losses, the known loss doctrine would not apply because the parties intended the known losses to be covered by ROA.[104] The overwhelming evidence is that the parties intended ROA to provide insurance coverage for the Assumed Claims. ROA reported the assumption of the Assumed Claims from the SITs and GSIAs as insurance business in its annual statements to regulators.

The fortuity doctrine rests on the premise that insurance provides coverage for risks that may or may not occur.[105] As noted above, even in the case of a workers' compensation claim that has been adjudicated, there is sufficient risk of additional liability that the assumption of the claim represents an insurance transaction. Accordingly, I find the fortuity and known loss doctrines inapplicable in this case.

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[101] *See, Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp.*, 73 F.3d 1178, 1215 (2d Cir. 1995).

[102] The term "adjudicated" is used in the sense that liability on the claim has been determined either by a state workers' compensation commission in the case of the workers' compensation Assumed Claims, or by a court of competent jurisdiction in the case of the Liability Assumed Claims. Even though claims may have been adjudicated, the liability on the claim remains uncertain if the right to appeal has not been exhausted.

[103] Additional examples include: change in condition related to the original injury, an award of permanent partial disability, and a new and separate injury related to the original injury.

[104] *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 154 Ill. 2d 90, 104, 607 N.E.2d 1204, 1210 (1992) ("insurer has no duty to defend or indemnify the insured with respect to the known loss *ab initio*, unless the parties intended the known loss to be covered").

[105] *See, Bartholomew v. Appalachian Ins. Co.*, 655 F.2d 27, 29 (1st Cir. 1981) (insurer insures against a risk, not a certainty).

The Assumption and Merger Agreements

The Deputy Receiver, Kentucky Hospitals, Coastal, and VWCC argue the Acquisition of Assets and Assumption of Liabilities and Merger Agreements (the "Agreements") are contracts of assumption reinsurance in which a novation occurred, and ROA became directly liable for the insurance coverages formerly provided by the SITs and GSIAs. Conversely, the VPCIGA and the Guaranty Associations argue the Agreements are not insurance contracts or assumption reinsurance agreements, and no novation occurred. Although the Agreements bear different titles, the substance of the transactions was the same in each instance – to transfer all the assets and liabilities of the SITs and GSIAs to ROA.[106]

Reinsurance comes in two basic types, indemnity reinsurance and assumption reinsurance. In indemnity reinsurance, the ceding insurer remains directly liable to its policyholders, continues to collect premiums from its policyholders, and pays their claims. The indemnity reinsurer assumes no direct liability to the ceding company's policyholders. The reinsurer merely has agreed to indemnify, or reimburse, the ceding insurer for a specified percentage of the claims and expenses attributable to the risks that have been reinsured. In return for the coverage provided by the reinsurer, the ceding insurer pays the reinsurer a percentage of the premiums attributable to the risks it has assumed. In assumption reinsurance, the assumption reinsurer steps into the shoes of the ceding insurer with respect to the reinsured policy, assuming all of the ceding insurer's liabilities and the responsibility to maintain required reserves against future claims. Thereafter, the assumption reinsurer receives all premiums directly from the policyholders and becomes directly liable to the policyholders it has reinsured.[107]

Indemnity reinsurance is insurance for insurance companies. From the perspective of the reinsurer, the reinsurer is offering the ceding company an indemnity or co-insurance arrangement. In substance, with indemnity reinsurance the reinsurer sells an insurance policy to the ceding insurer.[108] For this reason, an indemnity reinsurance agreement must meet the requisites of a contract of insurance.

The law relating to assumption reinsurance agreements is not as well developed. Assumption reinsurance is also referred to as "substituted insurance," "portfolio reinsurance," or "bulk reinsurance."[109] Since the parties referred to the transactions among the SITs, GSIAs, and ROA as alleged assumption reinsurance transactions, that naming convention will be used herein. Assumption reinsurance is described as "the purchase of already issued insurance policies and the elimination of any participation or interest of the selling or ceding company."[110] Assumption reinsurance is used in situations in which an insurer has been found to be insolvent or desires to withdraw from a line of insurance. The ceding company transfers all of its risks to the reinsurer. The reinsurer either makes itself liable on the old policies that were issued or issues its own

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[106]In the SunHealth transaction, the agreement is entitled "Acquisition of Assets and Assumption of Liabilities and Reinsurance Agreement." The SunHealth transaction was the same substantively as the others. *See*, Ex. DR-10, Tab I 3.

[107]*See, Colonial American Life Ins. Co. v. Commissioner*, 491 U.S. 244, 247, 109 S. Ct. 2408, 2411, 105 L.Ed. 2d 199, 207 (1989).

[108]*See, Merit Life Ins. Co. v. Commissioner*, 853 F.2d 1435, 1441 (7th Cir. 1988).

[109]*See*, 14 Eric Mills Holmes, *Holmes' Appleman on Insurance 2d* §109.1 (2000).

[110]*Merit Life Ins. Co.* at 1441.

contracts of insurance. The Supreme Court of New Mexico is the only court to address the form of an assumption reinsurance agreement. The court found the agreement is "basically a contract of conveyance and assumption, resulting in substituted personal insurance and is not a reinsurance treaty in the classical sense." *Sierra Life Ins. Co. v. First National Life Ins. Co.*, 85 N.M. 409, 412, 512 P.2d 1245, 1248 (1973). The court noted that:

> [t]here is substantial evidence, which finds support in the texts, that under [an assumption reinsurance agreement,] the ceding (insuring) company transfers and assigns to the receiving (reinsuring) company the entire risk of the policy contracts being transferred, together with the statutory reserves of those policies. All policy records and files are also delivered to the reinsuring company which is thereafter totally responsible for all aspects of the policy contracts pertaining to the policies ceded. The reinsuring company shall thereafter be entitled to receive all premium income and profits flowing from the policies reinsured, and shall be the insurer of policyholders, indemnifying the original insurer from all future responsibility or liability concerning the policies.[111]

The Supreme Court of New Mexico affirmed the trial court's finding that concurrent corporate resolutions by the boards of both insurers to "cede back, by treaty of bulk reinsurance" created a contract of assumption and conveyance.[112]

The analysis employed by the Federal District Court of Kansas, in deciding whether an insurer was released from its liability under an annuity contract by reason of an assumption reinsurance agreement, is particularly instructive in this case. The court noted that:

> [u]nder the common law of contracts, an obligor may generally delegate performance of his contractual duty to another. However, neither the fact that the obligor delegates performance of a contract, nor the fact that a person contracts with the obligor to assume the duty, will discharge any duty or liability of the original obligor, unless the obligee agrees otherwise.
>
> An obligor is discharged by substitution of a new obligor only if the contract so provides or if the obligee makes a binding manifestation of assent to the substitution, forming a novation. Otherwise, the obligee retains his original right against the obligor, even if the obligor intends to substitute another obligor in its place and the new obligor purports to assume the duty. The obligee may have rights against the other obligor, however, as an intended beneficiary of the promise to assume the duty.
>
> '[A simple novation involving a substitution of obligors] results when a third person promises an obligor to assume, immediately and in substitution for the obligor's duty, a duty to the obligee to render the performance that was due from the obligor or some other performance, and the obligee agrees with the obligor or with the third person to that substitution. The third person then comes under

[111] *Id.*
[112] *Id.*

> a new duty to the obligee, who is an intended beneficiary of his promise to assume, and this is consideration for the obligee's agreement to discharge the original obligor. . . . However, a mere promise by a third party to assume the obligor's duty, not offered in substitution for that duty, does not result in a novation, and the new duty that the third party may owe to the obligee as an intended beneficiary is in addition to and not in substitution for the obligor's original duty. For a novation to take place, the obligee must assent to the discharge of the obligor's duty in consideration for the promise of the third party to undertake that duty.'

Security Benefit Life Ins. Co. v. F.D.I.C., 804 F.Supp. 217, 225 (D.Kan. 1992), (quoting in part, Restatement (Second) of Contracts §§ 280, 302, and 318 (1) and (3) (1979)).

The law of Virginia relating to novations is in accord with the discussion above.[113]

The HWCF transaction is typical of the transactions that occurred among the SITs, GSIAs, and ROA. On November 21, 2000, the president of ROA sent a letter of intent to the chairman of the Alabama Hospital Association Trust concerning the business combination between HWCF and ROA. The letter represented that "the business combination will take the legal form of an assumption of all the assets and the liabilities of HWCF by [ROA]. As soon after the business combination as is practicable (but in no event more than one year after the business combination), HWCF will take all actions necessary to dissolve and otherwise cease its legal existence."[114] On November 30, 2000, HWCF's board of trustees entered its unanimous consent to the proposed business combination with ROA. The board noted the best interests of HWCF and its members would be served by transferring its assets and liabilities to ROA. In particular, the board noted that "[t]he potential liability of HWCF's members is eliminated because they would neither be subject to joint nor several liability nor assessments for members' adverse losses."[115] The board directed HWCF's administrator to obtain all the necessary approvals to effect the business combination with ROA, which included a two-step approval process mandated by the Alabama Department of Industrial Relations. The employer-members of HWCF first had to approve the business combination with ROA. After the results of that vote, the employer-members were given the opportunity to opt-in or -out of obtaining coverage from ROA.

The notice sent to the employer-members of HWCF describing the business combination with ROA provided, in part, that:

> After careful consideration, the board has unanimously determined the "Business Combination" with [ROA] will have a very favorable impact on HWCF and the future of your workers' compensation coverage, and thus has approved the Business Combination.
>
> . . . .
>
> The Business Combination as approved by the Board of Trustees will be accomplished by means of the complete assumption of HWCF's assets and

[113] *See, Honeywell, Inc. v. Elliott*, 213 Va. 86, 89-90, 189 S.E.2d 331, 334 (1972) (citations omitted).
[114] Ex. C-15.
[115] *Id.*

> liabilities by [ROA]. [ROA] will assume all of HWCF's liabilities, however characterized, including reported claims and incurred but not reported claims. The claims will therefore be backed by [ROA's] substantial assets. On January 1, 2001, [ROA] will issue workers' compensation insurance policies, with coverage similar to your current coverage, to all of HWCF's members that do not opt out of such coverage and the HWCF members will become subscribers of [ROA]. After the transfer of all of its assets and liabilities, HWCF will cease operations and its existence as a workers' compensation self-insurance trust. . . .
>
> From a practical standpoint, the Business Combination will be almost seamless. All insurance services will continue to be provided by the same individuals who have provided services to you on behalf of HWCF. This is the case because the insurance services will be provided by The Reciprocal Group ("TRG") the attorney-in-fact for [ROA], and TRG has agreed to employ the employees of Coastal Associates, Inc. (HWCF's current services provider) to handle this task.
>
> Your HWCF membership interest will be converted into equity in [ROA]. Pursuant to the Business Combination, the HWCF members will become [ROA] subscribers, and their equity in HWCF will be transferred into subscribers' equity accounts, which will be established for each new [ROA] subscriber. [ROA] will assume all accrued retrospective rating plan account balances, dividends and surplus distributions, which will be converted into equity allocations to your [ROA] subscribers' equity account.[116]

The employer-members of HWCF approved the business combination with ROA by more than a two-thirds vote, although some did vote against the business combination with ROA. No HWCF member elected to opt-out and obtain its workers' compensation coverage from an insurance company other than ROA.[117] By opting-in, the employer-member authorized HWCF to transfer its equity interest, retrospective rating plan balance, and its workers' compensation coverage to ROA.[118]

The facts of this case are undisputed. When the hard market for workers' compensation insurance occurred in the early 1970's, TRG and ROA were instrumental in establishing some of the GSIAs to transfer ROA's workers' compensation books of business to the GSIAs. An affiliate of TRG and ROA, Specialty Insurance Services, provided the third-party administrative services, accounting, actuarial, and claims administration services, and ROA provided stop-loss insurance or reinsurance to the GSIAs. The other SITs and GSIAs were established at about the same time because their member hospitals were also having difficulty obtaining workers' compensation and hospital liability insurance. The SITs and GSIAs were in business to provide a lower cost insurance alternative for their employer-members. The SITs and GSIAs were specifically permitted by state law in their respective states to provide workers' compensation and hospital liability insurance. When the market for workers' compensation and hospital liability insurance softened in the mid

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[116] *Id.*
[117] *Id.*
[118] Ex. C-23.

1990's, ROA saw an opportunity to become a dominant regional insurer of hospitals in the Southeast. To effect its business plan, ROA needed to bring its sheep back into the fold and convince others to join its flock.

ROA began its acquisition of the SITs and GSIAs in November 1997, and completed its last acquisition in April 2001, approximately two years before it was found to be insolvent. The common thread throughout all of the transactions was that ROA acquired everything, all of the assets and all of the liabilities of the SITs and GSIAs.[119] The intention of the parties is abundantly clear from the Agreements. ROA assumed the obligations of the SITs, GSIAs, and their employer-members on the policies of insurance that had been issued by the SITs and GSIAs. The members of the SITs and GSIAs agreed to the substitution of ROA as their insurer when they opted-in to have their insurance coverage transferred to ROA. In effect, what occurred was an assumption by ROA of the in-force policies of the SITs and GSIAs, the termination of those polices, and the issuance of new policies on ROA's own paper. The Agreements effected an assumption reinsurance transaction. The required novation occurred when the employer-members agreed to transfer their existing and future workers' compensation or hospital liability coverage from the SITs or GSIAs to ROA. For the employer-members to be relieved of their joint and several liability, which was the intent of the parties to the Agreements, there needed to be a complete substitution of ROA for the SITs, GSIAs, and their employer-members on their then existing insurance obligations. This is precisely what occurred. Although it might be argued that ROA acquired the liability for the lawn service and janitor in the Agreements, through the all-encompassing language of the Agreements, it also acquired the liability of the SITs, GSIAs, and their member-employers for the insurance contracts that had been issued during the life of the SITs and GSIAs. ROA reflected its acquisition of the various insurance books of business from the SITs and GSIAs in its financial statements at the time it acquired the business. ROA acquired the insurance obligations of the SITs, GSIAs, and

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[119]For example, the Agreement between HWCF and ROA defined the "assets" and "liabilities" as follows:

> 'Assets' shall mean any and all property, of any kind or nature whatsoever and wherever situated, and any thing of value, owned, possessed or claimed by HWCF or in which HWCF has an interest (present, future or contingent), and all rights, titles and interests related thereto, whether or not specifically referred to herein or in any instrument of conveyance delivered pursuant hereto, including, without limitation, the following:
> (a) all real property;
> (b) all personal property (whether tangible or intangible), including, but not limited to: (i) cash, cash equivalents, stocks, bonds, and other investments; (ii) licenses, franchises or other similar rights; and (iii) trademarks, patents, copyrights, trade names (whether used now or in the past), service marks and similar rights;
> (c) all property of a mixed nature consisting of both real and personal property and fixtures;
> (d) all accounts receivable, premiums receivable, contract rights, tax refunds due, and any other receivables;
> (e) all of HWCF's rights and interests in, to and under Contracts, policies of insurance and reinsurance agreements to which HWCF is a party, subject or in regards to which HWCF holds some interest; and
> (f) the Books and Records.
> . . . .
> 'Liabilities' shall mean all the obligations, debts and liabilities of HWCF in connection with [the operation of HWCF as a workers' compensation group self-insurance trust, and all acts incident thereto, including, without limitation, the provision by HWCF of workers' compensation insurance coverages to Alabama hospitals as permitted under Alabama law]. Ex. DR-10, Tab A 3 (emphasis added).

their employer-members and it did so in a manner that the obligations it acquired are no different than if ROA had directly insured them. ROA stepped into the shoes of the SITs, GSIAs, and their employer-members.

I find the Agreements effected an assumption reinsurance transaction in which ROA assumed the then existing insurance obligations of the SITs, GSIAs, and their employer-members on the policies of insurance that had been written by the SITs and GSIAs. I further find a novation occurred in which ROA was substituted as the insurer of those obligations in place of the SITs, GSIAs, and their employer-members. Accordingly, I further find the Assumed Claims are "claims of other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 (ii) of the Code of Virginia.

"Covered Claims"

The issue whether the Assumed Claims are also "covered claims" pursuant to § 38.2-1603 of the Code of Virginia was not assigned to the Hearing Examiner by the Commission; however, the Deputy Receiver, the Guaranty Associations, and the VPCIGA chose to address the issue through their witnesses and in their Post-Hearing Briefs.[120] If the Assumed Claims are also "covered claims," then the VPCIGA would be responsible for paying the claims of the Virginia policyholders.[121] If the Assumed Claims are not "covered claims," then ROA would be responsible for paying the claims, subject to the limitations in § 38.2-1509 B of the Code of Virginia. The second scenario raises the question whether ROA can pay the workers' compensation Assumed Claims at 100% and the Liability Assumed Claims at the same percentage as the Guaranty Associations and the VPCIGA without creating an unlawful preference, and without having to address at this time whether the Assumed Claims are "covered claims."

Since the parties chose to muddy the waters on this issue, some clarifying comments are in order. The Guaranty Associations appear to be operating under the misconception that the right to guaranty fund coverage is determined when an insurance policy is purchased. They raised arguments such as: the SITs and GSIAs were not licensed insurance companies, the SITs and GSIAs did not pay any guaranty fund assessments, and there was no insurance policy evidencing coverage by ROA. These "red herring" arguments are completely irrelevant to whether an insured in this case is entitled to guaranty fund coverage. In fact, the legislatures of the various states did not require the SITs and GSIAs to be licensed insurance companies or to pay guaranty fund assessments. There was no expectation of guaranty fund coverage during the period the employer-members were insured with the SITs and GSIAs. In fact, most states require SITs and GSIAs to note on their policies that there is no guaranty fund coverage available.[122] However, the wrinkle in this case is that ROA acquired the last of the SIT or GSIA Assumed Claims in April of 2001, almost two years before it was declared insolvent. ROA was a member of the VPCIGA and it was current on the payment of its guaranty fund assessments at the time it was declared insolvent.

[120] *See*, Testimony of Mr. Gross at Ex. AG-1, at 6-7, and testimony of Mr. Newman at Ex. JN-21, at 16.
[121] A Commission decision on the "covered claim" issue would not affect policyholders in other states.
[122] *See e.g.*, 14 VAC 5-360-110 C.

In the insurance industry, insurers enter into assumption reinsurance agreements to divest or acquire books of business. The ceding insurer may wish to focus its efforts on its core business and divest itself of certain types of insurance or withdraw from a particular geographic market. The assuming insurer may be seeking to grow its business by acquiring books of business, as evidenced by ROA's business plan. Although more prevalent in life and health insurance, it is not completely unheard of for other books of insurance business to be the subject of assumption reinsurance agreements. An example highlights the tenuous position adopted by the Guaranty Associations. Surplus lines insurers and risk retention groups are not licensed insurance companies in Virginia, they are not members of the VPCIGA, they do not pay assessments to the VPCIGA, but they do issue contracts of insurance in Virginia. Instead of the SITs and GSIAs in this case, assume that a surplus lines insurer or a risk retention group entered into an assumption reinsurance agreement with ROA in April 2001. ROA assumed the Virginia book of business written by the surplus lines insurer or the risk retention group, and was subsequently declared insolvent in 2003. Whether there is guaranty fund coverage in this example and in the case of the SITs and GSIAs must be determined at the time the insurer was declared insolvent, not when the policy was purchased. At the time ROA was declared insolvent, were the elements of § 38.2-1603 of the Code of Virginia satisfied? In the example and in this case, the answer turns on the definition of "issued" as the term is used in § 38.2-1603 of the Code of Virginia.

Prior to the 2004 amendments to § 38.2-1603 of the Code of Virginia, a "covered claim" was defined as "an unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of a policy covered by this chapter and issued by an insurer who has been declared to be an insolvent insurer." (emphasis added). The Supreme Court of Virginia has defined "issued," when referring to the issuance of an insurance policy, as "when the policy is made and delivered, and is in full effect and operation."[123] No court has addressed when an insurance policy is "issued" in the context of an assumption reinsurance transaction, whether it is the original issue date or the date the assumption reinsurance agreement is effected. It could be argued that it should be the original issue date since the reinsurer stepped into the shoes of the ceding insurer, or it could be argued that it should be the date the assumption reinsurance agreement is effected since that is the point in time the reinsurer is being substituted for the ceding insurer.

Presumably, the issue of "covered claim" was raised in this proceeding in anticipation of a potential preference objection by the Guaranty Associations and VPCIGA to the Deputy Receiver's paying 100% of the workers' compensation Assumed Claims, while paying some lesser percentage to the Guaranty Associations and the VPCIGA for the other workers' compensation claims that they paid. Given the findings herein, the Assumed Claims and "claims of the associations for 'covered claims'" have the same priority in the distribution of the assets of ROA and those assets have to be "apportioned without preference."[124] The question arises whether the General Assembly intended that similarly situated workers' compensation insurance policyholders should be treated differently when their insurer is declared insolvent. This question goes to the heart of the distribution priority of the statute at issue in this proceeding, § 38.2-1509 of the Code of Virginia. I find the Deputy Receiver may pay the workers' compensation Assumed Claims at 100% without creating an

[123] *Homestead Fire Ins. Co. v. Ison*, 110 Va. 18, 23, 65 S.E. 463, 465 (1909).
[124] § 38.2-1509 B 1 (ii) of the Code of Virginia.

unlawful preference. Therefore, the issue of whether the Assumed Claims are "covered claims" may be saved for another day.

In the guaranty fund statutes, the General Assembly provided that the VPCIGA is obligated to pay "[t]he full amount of a covered claim for benefits under a workers' compensation insurance coverage."[125] Of all the various classes of property and casualty insurance covered by the Virginia property and casualty insurance guaranty fund, workers' compensation insurance is the only one that is not subject to any coverage limits. The General Assembly clearly expressed its intent that citizens of this Commonwealth who are injured in the workplace are to have their claims paid in full. In Virginia,

> [t]he general rule is that statutes may be considered as *in para materia* when they relate to the same person or thing, the same class of persons or things or to the same subject or to closely connected subjects or objects. Statutes which have the same general or common purpose or are parts of the same general plan are also ordinarily considered as *in para materia*.

Prillaman v. Commonwealth, 199 Va. 401, 405, 100 S.E.2d 4, 7 (1957).

However, the mere fact that statutes relate to the same subject or object or are part of the same general legislative scheme does not mean they cannot conflict with one another. The Supreme Court of Virginia has stated that the reason for considering statutes *in para materia* is that it permits "any apparent inconsistencies [to] be ironed out whenever that is possible." *Commonwealth v. Sanderson*, 170 Va. 33, 38, 195 S.E. 516, 518 (1938). The Court has further stated that the requirement to consider statutes *in para materia* is one rule of statutory construction among many:

> [i]n the construction of statutes, the courts have but one object, to which all rules of construction are subservient, and that is to ascertain the will of the legislature, the true intent and meaning of the statute, which are to be gathered by giving to all the words used their plain meaning, and construing all statutes *in para materia* in such a manner as to reconcile, if possible, any discordant feature which may exist, and make the body of the law harmonious and just in their operation.

Tyson v. Scott, 116 Va. 243, 253, 81 S.E. 57, 61 (1914).

Applying these guiding principles to the instant case, it is abundantly clear that Chapters 15 and 16 of Title 38.2 of the Code of Virginia relate to the same subject or object – the insolvency of insurance companies and its impact on the policyholders of that insurance company. In fact, the statute specifically at issue in this proceeding, § 38.2 -1509 of the Code of Virginia, makes specific reference to obligations incurred in Chapter 16 of Title 38.2 and how those obligations are to be treated by the receiver of the insolvent insurer. I find the General Assembly never intended that one group of workers' compensation policyholders of an insolvent insurer should receive 100% payment of their claims; while an identical group of workers' compensation policyholders from the same insolvent insurer might receive less than 100% payment of their claims. The intent of the

[125] § 38.2-1606 of the Code of Virginia.

General Assembly is manifestly clear. In an insurance company insolvency proceeding, individuals who are injured in the workplace through no fault of their own and are covered by an insurance policy are to have their claims paid at 100%, no matter who pays the claim. Accordingly, I find the Deputy Receiver may pay the workers' compensation Assumed Claims at 100% without creating an unlawful preference pursuant to § 38.2-1509 B 1 (ii). The Liability Assumed Claims would be subject to whatever distribution percentage the Deputy Receiver established. There is no evidence that these classes of insurance are afforded preferential treatment under Virginia law. If the Deputy Receiver believes that he has paid claims for which the Guaranty Associations or the VPCIGA should be responsible, the Deputy Receiver is entitled to offset any monies owed to the Guaranty Associations and the VPCIGA by such amount. The "covered claim" issue could then be litigated without affecting the payment of any insured's claim.

Findings and Recommendations

Based on the evidence received in this case, and for the reasons set forth above, I find that:

(1) Virginia substantive law should control in this case to avoid exposing the ROA receivership estate to a myriad of possible conflicting state laws, to provide for the equitable payment of claims and distribution of the assets of the ROA estate among creditors of the same class no matter where the creditors may reside, and to provide for the orderly administration and wind down of the ROA estate;

(2) Virginia law recognizes that entities such as the SITs and GSIAs transact the business of insurance, but are exempt from regulation as insurance companies under Title 38.2 of the Code of Virginia, except as specifically provided for in statutes adopted by the General Assembly;

(3) The Commission is not bound by the erroneous legal conclusions of a member of the staff in the Bureau of Insurance;

(4) There is no basis for judicially estopping ROA and the SITs and GSIAs from arguing that they were self-insured trusts or group self-insurance associations that issued contracts of insurance providing coverage for their employer-members' liability or workers' compensation risks;

(5) The employer-members of SITs and GSIAs pooled their risk of loss for the purpose of transferring an individual employer-member's risk of loss to the group;

(6) The SITs and GSIAs were a type of reciprocal insurer in which the employer-members were both the insurer and the insured;

(7) The arrangement in which HWCF provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

(8) The arrangement in which A-HAT provided its employer-members medical professional liability, general liability, and personal injury liability coverage was an insurance contract under Virginia law;

(9) The arrangement in which C-HAT provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

(10) The arrangement in which K-HAT provided its employer-members hospital professional and general liability coverage was an insurance contract under Virginia law;

(11) The arrangement in which MHA Public provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

(12) The arrangement in which MHA Private provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

(13) The arrangement in which THA provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

(14) The arrangement in which HPG provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;

(15) The arrangements in which AWCT and MHA/MSC provided their employer-members workers' compensation liability coverage were insurance contracts under Virginia law;

(16) The fortuity and known loss doctrines are inapplicable in this case;

(17) The Acquisition of Assets and Assumption of Liabilities and Merger Agreements effected an assumption reinsurance transaction in which ROA assumed the then existing insurance obligations of the SITs, GSIAs, and their employer-members on the policies of insurance that had been written by the SITs and GSIAs;

(18) A novation occurred in which ROA was substituted as the insurer of the former insurance obligations of the SITs, GSIAs, and their employer members;

(19) The Assumed Claims are "claims of other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 (ii); and

(20) The Deputy Receiver may pay the workers' compensation Assumed Claims at 100% without creating an unlawful preference.

I therefore ***RECOMMEND*** the Commission enter an order that:

(1) ***ADOPTS*** the findings contained in this Report;

(2) ***DIRECTS*** the Deputy Receiver to pay the workers' compensation Assumed Claims at 100%;

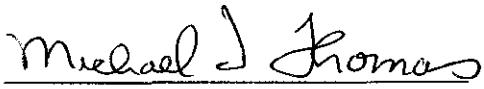
(3) ***DIRECTS*** the Deputy Receiver to pay the Liability Assumed Claims at the same percentage as the claims of the Guaranty Associations and the VPCIGA; and

(4) ***PASSES*** the papers herein to the file for ended causes.

Comments

The parties are advised that pursuant to Rule 5 VAC 5-20-120 C of the Commission's Rules of Practice and Procedure, any comments to this Report must be filed with the Clerk of the Commission in writing, in an original and fifteen copies, within twenty-one (21) days from the date hereof. The mailing address to which any such filing must be sent is Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Any party filing such comments shall attach a certificate to the foot of such document that copies have been mailed or delivered to all other counsel of record and to any party not represented by counsel.

Respectfully submitted,



Michael D. Thomas
Hearing Examiner

A copy hereof shall be sent by the Clerk of the Commission to all persons on the official Service List in this matter. The Service List is available from the Clerk of the State Corporation Commission, c/o Document Control Center, 1300 East Main Street, First Floor, Tyler Building, Richmond, VA 23219.