ALLEN & OVERY LLP
1221 Avenue of the Americas
New York, NY 10020
Telephone: (212) 610-6300
Facsimile: (212) 610-6399
Ken Coleman
Stephen Doody
Andrew Dove

Attorneys for MFG Assurance Company Limited

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re	:	Chapter 11
MF GLOBAL HOLDINGS LTD., *et al.*,	:	Case No. 11-15059 (MG)
Debtors.	:	(Jointly Administered)

MEMORANDUM OF LAW OF MFG ASSURANCE COMPANY LIMITED IN SUPPORT OF PROPOSED STIPULATION AND ORDER BETWEEN THE CHAPTER 11 TRUSTEE AND MFG ASSURANCE COMPANY LIMITED REGARDING PAYMENT OF LOSS AND REIMBURSEMENT OF COVERED COSTS AND EXPENSES

MFG Assurance Company Limited ("**Assurance**"), by its undersigned counsel, respectfully submits this Memorandum in support of the *Notice of Presentment of Stipulation and Order Between the Chapter 11 Trustee and MFG Assurance Company Limited Regarding Payment of Loss and Reimbursement of Covered Costs and Expenses* dated February 3, 2012 [Docket No. 409] (the "**Stipulation**"), as requested by the Court during the February 9, 2012, omnibus hearing. This Memorandum replies in part to: (i) the *Objection of Certain Commodities Customers of MF Global Inc. to Stipulation and*

Order Between the Chapter 11 Trustee and MFG Assurance Company Limited Regarding Payment of Loss and Reimbursement of Covered Costs and Expenses dated February 7, 2012 [Docket No. 416]; (ii) the *Certain Interested Parties' Objection to Proposed Stipulation and Order Between the Chapter 11 Trustee and MFG Assurance Company Limited Regarding Payment of Loss and Reimbursement of Covered Costs and Expenses* dated February 7, 2012 [Docket No. 417]; (iii) the *Objection of Sapere Wealth Management, Granite Asset Management and Sapere CTA Fund, L.P. to Stipulation and Proposed Order Between the Chapter 11 Trustee and MFG Assurance Company Limited Regarding Payment of Loss and Reimbursement of Covered Costs and Expenses* dated February 7, 2012 [Docket No. 419]; and (iv) the *Comments in Support of Objection to Proposed Stipulation and Order Between the Chapter 11 Trustee and MFG Assurance Company Limited Regarding Payment of Loss and Reimbursement of Covered Costs and Expenses of Sapere Wealth Management LLC, Granite Asset Management and Sapere CTA Fund, L.P.* dated February 7, 2012 [Docket No. 422] (collectively, the "**Objections**" of the "**Objectors**"). For the reasons stated below and in the Trustee's Reply, the Court should overrule the Objections and approve the Stipulation.

BACKGROUND

1. Stated below are additional facts relevant to the Stipulation, supplementing those set forth in the Stipulation and the Trustee's Reply. These facts are supported by the Declaration of John Oliver Heyliger (the "**Heyliger Declaration**") filed in conjunction with this Memorandum.

A. MFG Assurance and the Policies

2. Assurance is a Class 1 insurance company domiciled in Bermuda and managed by its Board of Directors. It is required by its primary regulator, the Bermuda Monetary Authority (the "**BMA**"), to maintain a balance of appropriately skilled, experienced, and qualified individuals who can apply informed and independent judgment to Assurance's governance.[1] Following the commencement of these bankruptcy cases, the BMA increased its regulatory interest in Assurance, with specific regard for whether it is honoring its policy obligations. See Heyliger Decl. Ex. A. The BMA specifically imposed conditions, *inter alia*, that Assurance not vary any existing policy. Id.

3. Assurance issued certain professional liability insurance policies (the "**Policies**") governed by New York law to MF Global Holdings Limited ("**Global**") for the policy years May 31, 2009 to May 31, 2010 ("**Year One**"); May 31, 2010 to May 31, 2011 ("**Year Two**"); and May 31, 2011 to May 31, 2012 ("**Year Three**"). A list of the Policies and correct copies of the Policies themselves are annexed as Exhibit B to Heyliger Declaration.

4. The Policies consist of one primary policy and additional following excess policies for each policy year. Assurance fully reinsured the excess Policies. For the purpose of this application, the Policies are substantially similar.

5. The Policies are "claims made" policies, such that Assurance is obligated to pay losses in the policy year in which a claim was first made and reported.

[1] Section 5.0, BMA Insurance Department, Guidance Note #12, Corporate Governance (2005), http://www.bma.bm/uploaded/127-Corporate_Governance_Mar_05.pdf (last visited, March 3, 2012).

An exception applies for claims reported within a prescribed reporting period following termination of a Policy if it is not renewed or replaced, provided that such claim occurred during the policy period. Global, its subsidiaries, and individual insureds may submit claims for a loss under the Policies. Individual insureds include natural persons employed by Global or one of its subsidiaries, as well as certain other related persons. The insureds are estimated to comprise at least 2,800 persons or entities.

6. The Policies provide coverage for professional liability (also known as errors and omissions ("**E&O**")) and state that Assurance will "pay on behalf of the insured for all loss arising out of a wrongful act which gives rise to a claim first made against an insured by a third-party during the policy period (or discovery period, if applicable) and reported in writing to the insurer." Coverage under the Policies differs from Directors and Officers ("**D&O**") coverage in that the coverage is not typically designed in the first instance to reimburse a policyholder/entity for the costs of indemnifying other parties.

7. Assurance administrates claims on the Policies in the same manner that claims on liability policies are treated generally in the insurance market. Claims are addressed as they arise and receive equitable treatment. Assurance has no preference for which insureds benefit from the Policies and does not disrupt normal practices to favor any insured. In the normal course of events, assuming coverage applies, Assurance funds the defense, investigates, adjudicates (including agreeing settlements) and otherwise resolves claims as they arise.

8. As indicated by Exhibit C of the Heyliger Declaration, Assurance compiles and tracks known claims. While the size, complexity, and other characteristics

of individual claims cause their progression to resolution to vary, Assurance is aware of its obligation to treat claims in an equitable fashion in the event the limits of the Policies may not be sufficient to cover known claims.

9. Losses may occur quickly under a claim covered by the Policies. Defense costs typically arise upon notification of a claim, as counsel is immediately engaged to assist or advise in an investigation or litigation. Settlement opportunities may present early in a dispute, posing the chance to minimize litigation costs if proceeds are available to fund the settlement. Cases involving arbitration—which arises, for example, as a result of arbitration provisions in customer contracts or otherwise—can progress more quickly than litigation, resulting in accelerated demands for costs, settlement discussions, or judgments. In this sense, E&O claims can involve a faster pace of losses than D&O claims, in which protracted litigation is more typical.

B. Open Claims under the Policies

10. Annexed as Exhibit C to the Heyliger Declaration is a list of the current open claims on the Policies, identified by policy year and separated into pre- and post-bankruptcy claims. A number of the pre-bankruptcy suits named MF Global Inc. and therefore are understood to be subject to the automatic stay, minimizing the incurrence of losses covered by the Policies. But Assurance is aware that MF Global Inc. has been severed as a party in certain of those cases and the proceedings have recommenced. Exhibit C to the Heyliger Declaration confirms that relevant actions initiated after the bankruptcy cases exclusively name individual insureds; no debtors in the above-captioned cases (the "**Debtors**") have been sued. Among other lawsuits, Exhibit C lists the actions brought by the Objectors against certain individual insureds.

Because those cases do not name the Debtors, Assurance understands that the Objectors can prosecute their cases without constraint by the automatic stay.

11. Exhibit C to the Heyliger Declaration also indicates that covered individuals are subject to ongoing investigations by the Commodity Futures Trading Commission, the Securities and Exchange Commission, the Trustee appointed under the Securities Investor Protection Act in respect of MF Global Inc., the U.S. House of Representatives Committees on Financial Services and Agriculture, and the U.S. Senate Committee on Agriculture, Nutrition and Forestry. No entity insureds have been specifically named in any of these post-petition actions.

12. There are no claims against the Debtors or MF Global Inc. that require policy benefits at this time.

13. In light of these ongoing lawsuits and investigations, Assurance expects that certain individual insureds will suffer significant hardships if they are not afforded their policy benefits. They may be deprived of defense counsel and/or defense experts. They may be required to participate in investigations without the benefit of legal advice. They may be subject to default judgments. They may be deprived of efficient settlement opportunities. They may face personal financial loss for claims that they were not well-equipped to defend. Moreover, all of the foregoing could lead to "leakage," which describes claim adjudication inefficiencies that deplete policy limits to the detriment of all insureds.

C. The Stipulation and Objections

14. Assurance negotiated and agreed the Stipulation with the Trustee in order to facilitate continued operation of the Policies in a cost-effective manner. In

response, the Objectors sought additional information about the Policies and open claims and argued that the Policies should be disabled for the benefit of commodities customers of MF Global Inc.

15. Following the February 9, 2012, omnibus hearing, Assurance provided the Objectors with the Policies for all three policy years and a current list of open claims. Assurance also circulated, in accordance with direction from this Court and following agreement with the Trustee, a proposed Consent Order designed to permit payment of defense costs under the Policies for Year One and Year Two.[2]

16. In the event the Consent Order is entered, the Stipulation or similar relief would nevertheless be required to resolve questions about payments for losses other than defense costs under the Policies for Year One and Year Two and payments for all types of loss relating to Year Three.

ARGUMENT

17. This Court is being asked to approve the Stipulation in order to clarify the proper operation of the Policies with respect to the balance of the 2,800 insured individuals and entities who are not before this Court. Case law regarding D&O insurance suggests that the Policies—which cover the Debtors as well as non-debtors—are less susceptible to straightforward determinations regarding the scope of the bankruptcy estate than D&O policies that, on the one hand, only cover a debtor or, on the other, only cover directors and officers. See, e.g., In re World Health Alternatives, Inc., 369 B.R. 805, 810 (Bankr. D. Del. 2007) ("When [a D&O] insurance policy provides

[2] The Stipulation as filed with the Court addressed only Year Two and Year Three. Assurance determined that certain claims under the Policy for Year One required or may require payment for loss after the Stipulation was filed. A revised Stipulation will be filed in due course.

coverage only to the debtor, courts will generally rule that proceeds are property of the estate…. On the other hand, when a policy provides coverage only to directors and officers, courts will generally rule that the proceeds are not property of the estate."). As a result, Assurance is sensitive to the possibility that payments under the Policies may be viewed to violate the automatic stay applicable in the Debtors' cases pursuant to 11 U.S.C. 362. At the same time, however, Assurance is committed to fulfilling its immediate and ongoing obligations to the insured—particularly in light of its regulator's expressed interest in ensuring Assurance does so. See Heyliger Decl. Ex. A. As a result of this apparent conflict, Assurance is keenly interested in relief from this Court to ensure that the Policies' normal operation do not remain interrupted or impaired.

18. Assurance maintains that this Court should be highly reluctant to constrain the usual process for claim submission, determination, and payment at this time. The *Memorandum of Law of the Chapter 11 Trustee in Support of the Stipulation and Order between the Chapter 11 Trustee and MFG Assurance Company Limited Regarding Payment of Loss and Reimbursement of Covered Costs and Expenses* dated March 5, 2012 (the "**Trustee's Reply**") explains that the Debtors' interests in proceeds from the Policies, if any, are remote, inchoate, and otherwise insufficient to justify the Policies' impairment. Assurance agrees with that analysis but will not repeat what has been made clear by the Trustee regarding the Debtors' estates and the proper scope of the automatic stay. Its purpose in filing this Memorandum is to highlight the rights of contract and principles of insurance that would be undermined were restrictions imposed that could result in the denial—or even delay—of payments that were otherwise required under the Policies. Assurance believes that impeding operation of the Policies would be

highly prejudicial for the interests of the non-debtor insureds, particularly given the nature of this type of insurance. Limiting Assurance's ability to administer the Policies in accordance with its contractual and regulatory obligations would also threaten to create inefficiencies that would diminish the Policies' value for all insureds. Most importantly, Assurance believes that applicable requirements of the New York Insurance Law require that Policy proceeds be paid in the normal course so that claims are satisfied notwithstanding the bankruptcy cases.

A. Interference with the Policies Would Harm the Non-Debtor Insureds and the Policies

19. Disruption of the Policies would pose immediate hardships for the non-debtor insureds with open claims. To begin with, they have legitimate expectations to receive the benefit of their contractual rights notwithstanding these cases. Numerous courts considering the issue with respect to D&O insurance have recognized that such interests merit serious attention. See, e.g., In re Adelphia Communications Corp., 285 B.R. 580, 584 (Bankr. S.D.N.Y. 2002) ("The motions require a balancing of the needs and concerns of the insureds under D&O policies, who have their own contractual rights under such policies and an expectation that they can look to their D&O policies even when the companies for which they serve go into bankruptcy, and the needs and concerns of the debtors and creditors, for whom the policies (and in many cases their proceeds) are property of the estate, and who wish to preserve that property to facilitate their reorganization.") vacated and remanded on other grounds, 298 B.R. 49 (S.D.N.Y. 2003); In re Peters Co., Inc., 419 B.R. 369, 376 (Bankr. D. Minn. 2009) ("The case law recognizes that any individual insured has a contractually-distinct status that runs directly

between itself and the insurer. This makes the right to receive payment on a covered claim the property of that insured itself."); In re CyberMedica, Inc., 280 B.R. 12, 18 (Bankr. D. Mass. 2002) (allowing payment of defense costs because, in part, individual insureds "may suffer substantial and irreparable harm if prevented from exercising their rights to defense payments. [They] are in need *now* of their contractual right to payment of defense costs and may be harmed if disbursements are not presently made to fund their defense of the Trustee's complaint"). Furthermore, accusations of misconduct—even alleged misconduct directly related to the circumstances of insolvency—provide no basis for denying individual insureds the possibility of insurance protection. See, e.g., Adelphia, 285 B.R. 580 (individual insureds facing criminal prosecution); In re Allied Digital Technologies Corp., 306 B.R. 505 (Bankr. D. Del. 2004) (directors and officers named as defendants in a cause of action brought by the trustee allowed to obtain payment of their defense costs). To say otherwise would be to deny the very purpose of E&O and D&O insurance. Therefore, the Objectors' complaints that defense costs may be paid to individuals accused of wrongdoing are wholly inapposite and without legal justification.

20. The fact that the Debtors are also insureds under the Policies has only limited relevance. It is true that the Policies provide equal status to individual insureds and entity insureds, including the Debtors, and this characteristic of the insured does not effect claims administration. Assurance has no grounds for, or interest in, adjudicating claims by entity insureds differently from individual insureds. See supra ¶ 7. But courts considering D&O insurance have taken the view that a debtor's rights under such policies belie their primary purpose of insuring individuals. See Adelphia, 285 B.R.

at 598 ("[T]he Court believes that the observation made by the First Central Financial court, and endorsed in Youngstown Osteopathic and CyberMedica, that 'in essence and at its core, a D&O policy remains a safeguard of officer and director interests and not a vehicle for corporate protection,' is true—and that *bankruptcy courts should be wary of impairing the contractual rights of directors and officers even in cases where the policies provide entity coverage as well*." (emphasis added)).[3] The Policies cover errors and omissions, not D&O liability, but this fact should heighten the Court's sensitivity to the thousands of individual insureds. Directors and officers frequently enjoy separate rights of indemnification pursuant to their company's constitutional documents. As employees covered by E&O insurance typically do not, insurance protection may be even more meaningful to them.

21. The hardships individual insureds would face if the Policies were disabled are not merely theoretical. Depending on the claim, specific consequences would include the following: deprivation of defense counsel and/or defense experts; exposure to discovery or investigations without the benefit of legal advice; the imposition of default judgments; the loss of efficient settlement opportunities; inflated judgments or more burdensome professional or regulatory sanctions due to less effective defense; or out-of-pockets costs. See supra ¶ 13. Furthermore, these injuries can materialize quickly given the nature of losses covered by the Policies. Supra ¶ 9. As described in the Heyliger Declaration, E&O insurance differs from D&O insurance in that losses may

[3] References are to Ochs v. Lipson (In re First Central Financial Corp.), 238 B.R. 9, 16 (Bankr. E.D.N.Y. 1999), aff'd in unreported opinion, No. 99-CV-6730 (TCP) (E.D.N.Y. Mar. 2, 2000), In re Youngstown Osteopathic Hospital Ass'n, 271 B.R. 544, 550 (Bankr. N.D. Ohio 2002), and CyberMedica, 280 B.R. at 16-17.

well accumulate more quickly—a fact attributable in part to the role of arbitration in many E&O claims versus protracted litigation in D&O situations. Id. Such comparisons aside, it is important that the Policies operate without delays to avoid permanent effects that can arise from even a temporary absence of benefits, e.g., circumstances in which an insured must give testimony or be deposed without counsel. In other words, the practical effects of delayed payments will in some cases be indistinguishable from no coverage at all.

22. Finally, impaired operation of the Policies will have negative consequences, even in those cases where particular individual insureds avoid injury, due to an issue that does not appear to have received attention in past cases: the problem known in the industry as "leakage," whereby the cost of settling claims is needlessly increased. Supra ¶ 13. For instance, missed settlement opportunities can create additional litigation costs, and delays in defense efforts or investigations can cause critical proof to deteriorate. Individual insureds may not be exposed to out-of-pocket costs or other losses as a result of these inefficiencies, to the extent the Policies provide full coverage. But, in that event, policy limited will be depleted more quickly and the harm will be distributed among other insureds under the Policies.

23. Assurance respectfully asks this Court to consider these hardships, particularly with regard to the discussion of cause for lifting the automatic stay set forth in the Trustee's Reply.

B. New York State Insurance Law Requires that Current Claims Be Paid

24. Separately, Assurance maintains that provisions of state law should compel this Court to avoid any interference with the Policies that would disrupt policy

benefits for the insureds. In particular, § 3420(a)(1) of the New York Insurance Law—to which the Policies are subject—requires that any contract or policy for liability insurance provide that:

> the insolvency or bankruptcy of the person insured, or the insolvency of the insured's estate, shall not release the insurer from the payment of damages for injury sustained or loss occasioned during the life of and within the coverage of such policy or contract.

N.Y. Ins. Law § 3420(a)(1) (McKinney 2009). Although this language is absent from the Policies, the New York Insurance Law provides that such mandated provisions are deemed to appear in non-conforming contracts.[4] As a result, the Policies must be read to require Assurance to make payments for covered "loss" notwithstanding the Debtors' status under the Bankruptcy Code. Moreover, as discussed below, principles of reverse preemption pursuant to the McCarran-Ferguson Act, 11 U.S.C. §§ 1011-15, demand that the implied term be enforced in these cases.

25. It is not clear that bankruptcy courts have yet been asked to consider whether or not § 3420(a)(1) permits insurance proceeds to be sequestered, or their payment otherwise constrained, because of a debtor's putative interest in the funds.[5] But at least two decisions demonstrate that § 3420 does not permit the purposes of insurance to be disregarded in bankruptcy. See Baez v. Medical Liability Mutual Insurance Co., 136 B.R 65 (Dist. S.D.N.Y. 1992); In re F.O Baroff Co., 555 F.2d 38 (2d

[4] A policy issued in violation of the New York Insurance Law shall be valid and binding upon insurer "as if it conformed with such requirements or prohibitions." N.Y. Ins. Law § 3103(a) (McKinney 2009).

[5] The feature of § 3420 discussed most often is the right of direct action against an insurer provided to injured parties by § 3420(a)(2). See, e.g., Lebron v. St. Vincent Medical Center, 875 N.Y.S.2d 821 (N.Y. Sup. Ct. 2008) (holding that discharge via confirmed plan of reorganization does not eliminate right of direct action); Federal Insurance Co. v. Sheldon, 167 B.R. 15, 21 (S.D.N.Y. 1994) (acknowledging direct cause of action against insurer where judgment against insured remains unsatisfied for over 30 days); Brady v. United Airways Group, Inc., No. 01-CV-6224T, 2004 WL 1570264, *3 (W.D.N.Y. May 24, 2004) (finding, per majority rule, that prior judgment is a condition precedent to right of direct action).

Cir. 1977). In fact, the court in Baez declared that § 3420(a)(1) creates a "special exception" that can exclude an insurance policy and its proceeds from the bankruptcy estate. 136 B.R. at 68.[6] The Baez court explained that injured parties who, but for the insured's bankruptcy, would have had recourse to insurance proceeds can even obtain post-petition interest as a result of the "preferential position" created by the New York statute. Id. at 68. Similarly, the court in Baroff found that § 167(1) of the New York Insurance Law (now codified as § 3420(a)(1)) operated to transform a policy that indemnified a debtor for third-party liabilities into a policy that provided direct benefits to the third parties. 555 F.2d at 44. In that case, the debtor had already received payment from its insurer for the same losses borne by the third parties. As a result, the court's application of § 167(1) ensured that the injured parties received the proceeds of insurance rather than the estate's general creditors. Id. The court indicated, after extensive consideration of the policy and legislative history behind § 167(1), that this result fulfilled the intent of the New York State legislature "to mitigate the effects of an insured person's bankruptcy on those to whom the insured has liability within the scope of the policy…"[7] Id. at 42.

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[6] The court explained that "where the insured bankrupt has caused pre-petition injury covered by the policy," a bankruptcy filing causes the insured to be "divested of his interest in the proceeds of the policy to the extent that those proceeds are needed to compensate the injured party, which proceeds at that point vest in the injured party." Id.

[7] The court rejected the suggestion that the statute's sole purpose was the avoidance of insurer windfalls, noting that a boon for the insurer could also be described as a loss by the injured party:

> We conclude, however, that the New York Legislature did not intend the effect of section 167 to be so narrowly circumscribed by the goal of avoiding insurer's 'windfalls.'….[I]n the great majority of cases, to say that the insurance company has received a 'windfall' is as much to say that a third person wronged by the insured and otherwise entitled to proceeds of insurance has been deprived of benefits of the insurance on account of his malefactor's bankruptcy or insolvency.

Id. Section 3420(a)(1) of the New York Insurance Law was formerly codified as § 167(1).

26. In Baez and Baroff, parties with losses covered by the debtors' insurance were recognized to have preferred status relative to general creditors. The decisions illustrate that, even in a bankruptcy, insurance proceeds must be used to address losses that fall within the scope of a policy. Bankruptcy does not transform insurance from a means of addressing covered losses into a source of recovery for general creditors. Thus, any suggestion that proceeds from the Policies should be preserved for the direct benefit of the general creditors would be inappropriate. It is evident that Baroff featured the opposite outcome, as value was stripped out of the estate to address covered losses. See 555 F.2d at 44. The touchstone is that insurance proceeds must be used to make payments for losses in accordance with policy terms. Whether such payments increase the value of the estate is secondary. In fact, it was particularly clear in Baroff that the opposite occurred.

27. What the plain meaning of § 3420(a)(1) makes clear is that what is true for debtors and their claimants is also true for non-debtor co-insureds and their claimants. In either case, New York law requires that insurance continue to address covered losses in a bankruptcy. The statute does not distinguish between losses tied to a debtor and those tied to a non-debtor covered by the same policy, and an interpretation that resulted in worse treatment for claims by non-debtor co-insureds would be perverse and illogical. As a result, Assurance respectfully submits that it would be inappropriate for this Court to enter any order that resulted in the non-payment of losses that would otherwise be duly paid under the Policies—keeping in mind also that payments delayed will be, in some cases, no different than payments denied. The policy of the State of New York expressed in § 3420(a)(1) does not countenance such a result for parties with

legitimate rights and expectations under Policies, even in the face of speculative or hypothetical concerns about future claims and losses that may implicate the Debtors.

C. The Bankruptcy Code Is Reverse Preempted Under McCarran-Ferguson

28. The strict primacy of § 3420 in these cases is underscored by the McCarran-Ferguson Act, 11 U.S.C. §§ 1011-15, which creates an exemption to normal preemption rules for federal statutes not directly related to insurance. McCarran-Ferguson provides that "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." 15 U.S.C. § 1012(b). The result is that federal law will be reverse preempted by state insurance law if (i) the federal statute does not specifically relate to insurance; (ii) the state law was enacted to regulate the business of insurance; and (iii) the federal statute would invalidate, impair, or supersede the statute. In re Medical Care Management Co., 361 B.R. 863, 871 (Bankr. M.D. Tenn. 2003) (citing United States Deb't of Treasury v. Fabe, 508 U.S. 491, 113 S.Ct. 2201, 124 L.Ed.2d 449 (1993). All three requirements are met by the conflict between § 3420(a)(1) of the Bankruptcy Code and potential application of § 362 of the Bankruptcy Code.

29. First, it is well established that the Bankruptcy Code does not specifically relate to the business of insurance. See, e.g., id. ("it is clear that the Bankruptcy Code does not specifically relate to insurance"); In re Agway, Inc., 357 B.R. 195 (Bankr. N.D.N.Y. 2006) (parties disputing applicability of McCarran-Ferguson agreed the Bankruptcy Code does not specifically relate to insurance); Logan v. Credit Gen. Ins. Co. (In re PRS Ins. Group, Inc.), 294 B.R. 609, 612-12 (Bankr. D. Del. 2005)

(finding that the Bankruptcy Code does not specifically relate to the business of insurance). This conclusion is supported by the exclusion of domestic insurance companies from relief under the Bankruptcy Code. 11 U.S.C. § 109(b)(2).

30. Second, the plain meaning of New York Insurance Law § 3420(a)(1) and its established purpose leave no doubt that the statute was enacted to regulate the business of insurance.[8] The relevant considerations have been articulated by the Supreme Court in a number of ways, but statutes that reflect a focus on the insurer-insured relationship and the operation of insurance policies have consistently passed the test.[9] In contrast, statutes relating to the business of insurance companies (as opposed to the business of insurance) or the rights of an insurance company's non-insured creditors have not. In this case, it should be uncontroversial that § 3420(a)(1) is the type of state law that reverse preempts conflicting federal statutes. Its express terms—the requirement that insurance policies state that they shall operate notwithstanding an insured's bankruptcy—squarely implicate how and when claims are paid, which is the heart of insurance and the insurer-insured relationship. Furthermore, the policy and legislative history behind § 3460(a)(1) directly confirms that lawmakers were focused on

[8] The Second Circuit has held that a statutory scheme may be considered in its entirety for purposes of the McCarran-Ferguson analysis. Stephens v. American International Insurance Co., 66 F.3d 41, 45 (2d Cir. 1995). Other courts have required a statute to be parsed more specifically. See, e.g., Garcia v. Island Program Designer, Inc., 4 F.3d 57, 61-62 (1st Cir. 1993). The split is moot here, where § 3420 clearly targets the business of insurance and the broader statutory scheme need not be considered.

[9] In S.E.C. v. National Securities, Inc., 393 U.S. 453, 460 (1969), the Court explained that "The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.'" In another case, the Court described a three-pronged analysis: (i) the practice in question must have the effect of transferring or spreading policyholders' risk; (ii) the practice must be an integral part of the policy relationship between the insurer and insured; and (iii) the practice must be limited to entities within the insurance entities industry. Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982) (citing Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 212 (1979)). More recently, the Court declared that "[t]he broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance." Fabe, 508 U.S. at 505.

policyholders, insureds, and injured parties. See supra ¶ 30. As a result, reverse-preemption should apply to federal laws that "invalidate, impair, or supersede" § 3420(a)(1).

31. In this case, the automatic stay pursuant to § 362 of the Bankruptcy Code is the federal law that must yield to state law. 11 U.S.C. § 362. This Court has been asked to uphold or apply the stay to inhibit operation of the Policies. As has already been described, the scope for the Court to restrict Assurance's administration of the Policies without running afoul of what the New York Insurance Law requires—particularly given the possibility that the mere delay of benefits will amount to their denial—is highly limited. McCarran-Ferguson eliminates questions about whether the contractual provisions required by the New York Insurance Law may be preempted by the Bankruptcy Code, underscoring that interference with the Policies is inappropriate. Accordingly, this Court should decline to apply the automatic stay to the Policies, leaving Assurance to fulfill its obligations to the insured in accordance with the contracts and applicable nonbankruptcy law. Alternatively, to the extent this Court believes the stay already applies to proceeds of the Policies, it should be lifted.

D. Impairment of the Policies Could Harm Assurance

32. Any limitation on the Policies that results in a loss of benefits for the insureds with open claims and current losses may be harmful to Assurance itself. First, as noted, the BMA has directed that Assurance not vary existing contracts of insurance without its prior written approval. An Order of this Court limiting the operation of the Policies would run contrary to this instruction. Second, § 3420(a)(2) provides injured parties with a direct right of action against insurers in the case of an

unsatisfied judgment against the insured. N.Y. Ins. Law § 3420(a)(2), supra n. 6; see also § 3420(b) (defining who may bring such an action). As described above, numerous cases involving individual insureds are proceeding at this time, and judgments against the insured may occur in some cases. An Order that restricted Assurance's authority to pay judgments could result in a scenario in which the company is vulnerable to suit under § 3420(a)(2).

CONCLUSION

Assurance respectfully requests that the Court approve the Stipulation (as amended to cover Policies for Year One).

Dated: March 5, 2012
New York, New York

ALLEN & OVERY LLP

/s/

Ken Coleman
Stephen Doody
Andrew Dove

1221 Avenue of the Americas
New York, NY 10020
Telephone: (212) 610-6300
Facsimile: (212) 610-6399
ken.coleman@allenovery.com
stephen.doody@allenovery.com
andrew.dove@allenovery.com

Attorneys for MFG Assurance Company Limited