NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 08/18/2023

Virtual Meeting

RECEIVERS' HANDBOOK (E) SUBGROUP
Friday, August 18, 2023
9:00 – 10:00 a.m. ET / 10:00 – 11:00 a.m. CT / 11:00 a.m. – 12:00 p.m. MT/ 12:00 – 1:00 p.m. PT

ROLL CALL

Kevin Baldwin, Chair	Illinois	Leatrice Geckler	New Mexico
Miriam Victorian, Vice Chair	Florida	Donna Wilson/Jamin Dawes	Oklahoma
Joe Holloway	California	Laura Lyon Slaymaker/ Crystal McDonald	Pennsylvania
Jared Kosky	Connecticut	Brian Riewe	Texas
Tom Mitchell	Michigan		

NAIC Support Staff: Sherry Flippo

AGENDA

1. Consider adopting Chapter 7 of the *Receivers' Handbook for Insurance Company Insolvencies—Kevin Baldwin (IL)* — Attachment A

2. Consider re-exposing Chapter 6 due to HMO changes and exposing Chapter 8 of the *Receivers' Handbook for Insurance Company Insolvencies—Kevin Baldwin (IL)* — Attachment B

3. Announce one drafting group for Chapters 9, 10, and 11. For informational purposes included redlined version of Chapter 9 in the materials to show repositioning of HMO material. Also, the appendix and the checklists will be revised by this drafting group. *—Kevin Baldwin* — Attachment C

4. Discuss Any Other Matters Brought Before the Subgroup
—Kevin Baldwin (IL)

CHAPTER 7—REINSURANCE

I. INTRODUCTION

Reinsurance is often referred to as "insurance for insurance companies," but it is separate and distinct from the insurance relationship existing between a policyholder and its insurer. The direct (primary, umbrella, or excess) insurer (reinsured or ceding company) cedes to a reinsurer (assuming company) a portion of its risk under policies issued to its policyholder (the original insured) pursuant to a reinsurance agreement. Reinsurance is an agreement of indemnity, whereby the assuming insurer in consideration of premium paid agrees to indemnify the ceding company against all or part of the loss that the ceding company may sustain under the policy or policies it has issued. Generally, absent a cut-through (discussed below at _), the reinsurer has no privity with or obligation to the original insured.

Just as reinsurance is important to the operations of an insurer, it is equally important to a receiver. Reinsurance receivables often represent a significant portion of an insurer's assets. Understanding reinsurance is critical to the efficient collection of this important asset. Generally, ceded reinsurance agreements should be continued. In the context of a life/health company insolvency, IRMA §612 provides for ceded reinsurance to be continued or terminated pursuant to the terms of each contract if the ceding insurer is in conservation or rehabilitation proceedings, but further provides that such contracts *shall be continued in liquidation* unless they were terminated in accordance with their terms prior to liquidation or were terminated pursuant to the liquidation order. In addition, both IRMA §612 and §8(N) of the NAIC's Life GA Model Act, as adopted in state laws, provide the life and health insurance guaranty associations the right to elect to continue and assume the rights and obligations of the ceding insurer with respect to reinsurance contracts that relate to guaranty association covered obligations, subject to the requirements set forth therein. To the extent those guaranty association covered obligations are subsequently transferred to an assuming insurer, the reinsurance continued on those contracts may also be transferred to the assuming insurer.

Reinsurance is a sophisticated international industry involving various types of unique contractual relationships. Reinsurance is utilized by insurers to achieve a variety of purposes and effects. It can increase an insurer's capacity to accept larger risks, provide financial support for an insurer, add stability to an insurer's results, protect against accumulations of losses, and provide the expertise of reinsurers who specialize in a particular area of insurance. Reinsurers may in turn be reinsured by other reinsurers referred to as "retrocessionnaires," who may also be reinsured, and so on. In this fashion, a broad spreading of risk is achieved.

It is important to note the terms used in reinsurance do not necessarily have the same meaning when used in the insurance context. A classic example is date of loss. In insurance it often means the date of the damage, while in reinsurance it can be the date the contract was accepted, terminates or any other meaning agreed by the parties. Some common definitions are:

Acceptance	Agreement by which a reinsurer consents to underwrite risk from a ceding company under specified circumstances.
Bordereau	A list compiled by a ceding insurer that provides the loss and premium histories of risks ceded or proposed to be ceded to a reinsurer.
Cede	To transfer part or all of a risk to a reinsurer.
Cedent	Company that is transferring the risk to a reinsurer. Generally the term is used when referring to the direct insurance company that is ceding business to the reinsurer.
Ceding Commission	The amount the reinsurer pays (or ceding company retains) when the cedent buys reinsurance. Generally, the amount of the commission is attributable to the cedent's acquisition costs.

Cession	The portion of the risk that has been ceded to the reinsurer.
Commutation	The manner in which the cedent and the reinsurer will agree to a termination of past and future liabilities under a reinsurance contract.
Cover Note	A document issued by the reinsurance intermediary or the broker, indicating the reinsurance coverage that has been bound.
Cut-through Clause or Endorsement	A guarantee by the reinsurer to a party that is otherwise not in privity with the reinsurance contract (often the insured) that payment will be made by the reinsurer under certain specified conditions, e.g., insolvency of the cedent.
Excess of Loss Reinsurance	Reinsurance that attaches once a loss has exceeded a specific amount.
Facultative Reinsurance	Reinsurance in which the reinsurer retains the "faculty" to underwrite each risk individually.
Inuring Reinsurance	When for the benefit of the reinsurer, it will refer to other reinsurance contracts that will reduce the amount otherwise recoverable under a particular reinsurance cover. When for the benefit of the cedent, it refers to other reinsurance contracts that will not reduce the amount recoverable under a particular reinsurance cover. Sometimes referred to as "common account."
Quota Share Reinsurance	Generally, a reinsurance agreement by a reinsurer to reimburse a cedent in the same percentage in which the reinsurer receives premium from the cedent.
Reinsurer	A person or entity that assumes risk from the cedent.
Retention	The amount of risk retained by the ceding company.
Retrocedent	A reinsurer that transfers risk it has assumed to another reinsurer; e.g., cedent cedes to a reinsurer that in turn retrocedes to a retrocessionnaire.
Retrocession	A transaction whereby a reinsurer transfers risk that it has assumed from the cedent to another reinsurer.
Retrocessionnaire	A reinsurer that assumed risk from the retrocedent.
Surplus Share Reinsurance	A type of reinsurance treaty, similar to quota share reinsurance, which spells out specific amounts to be retained by the cedent.
Treaty [New row] Unauthorized	A type of reinsurance contract that differs from a facultative contract because it does not retain the faculty of underwriting the individual risk. A reinsurer that is unlicensed to conduct the business of insurance. The reinsurer is said to be "unauthorized" and not to provide security to the cedent which the cedent may reflect in its statutory financial statements either as an asset or a reduction in liabilities.

Additional definitions may be found in the NAIC's *Credit for Reinsurance Model Law* (#785), *Credit for Reinsurance Model Regulation* (#786), *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787) *Special Purpose Reinsurance Vehicle Model Act* (#789), *Life and Health Reinsurance Agreement Model Regulation* (#797), and *Assumption Reinsurance Model Act* (#803). Glossaries can be found at various Web sites.

Guaranty Association Coverage

When an insolvent insurer is a reinsurer, guaranty associations do not provide coverage for reinsured policies unless there has been an assumption and novation and the insolvent insurer has become directly obligated to the original policyholders. See NAIC Life GA Model Act § 3(B)(2)(b) and NAIC P&C GF Model Act § 5(D) (which has been adopted in a minority of states and sometimes with modification to supporting definitions).

II. REINSURANCE BASICS

There are several reinsurance arrangements that one might expect to find in an insurer's reinsurance program. Whether undertaken in property and casualty, or life, accident and health insurance lines, there are numerous provisions that are required to be included in reinsurance agreements pursuant to state law (e.g., an insolvency clause – see _ below). In addition, all of the terms and conditions of a reinsurance relationship are required to be written as part of the principal agreement; "side" agreements and letters are not permitted.A. Property and Casualty Reinsurance Arrangements

A reinsurance program can be extremely complex and may consist of multiple interacting arrangements, all responsive to the same loss. Furthermore, an insurer's net retention, after applyingtreaty reinsurance and facultative reinsurance, may be further protected by catastrophe or stop loss reinsurance. Also, overlap between different treaties may cover aspects of the same loss.

Two particular types of reinsurance arrangements bear specific mention – fronting and cut-through arrangements. Both fronting and cut-through arrangements affect the parties to the transaction, but do not change the ultimate economics involved.

Fronting is an arrangement by which an authorized insurer issues policies to cover risks underwritten by unauthorized or inexperienced insurers (or for the benefit of insureds who cannot transact the business of insurance) and then transfers its own liability to such unauthorized insurer by means of reinsurance. Fronting involves two actions: (1) a substantial cession of business; and (2) a delegation of claims and underwriting authority from a licensed to an unlicensed insurer. The fronting insurer remains financially liable to the policyholder for the entire insured amount even though, in reality, the fronting insurer may only bear a small financial liability, if any. While fronting can serve useful purposes, abuses can occur if the fronting company fails to exercise control with respect to underwriting, claims, or the risk to which it exposes its assets. A certain amount of disclosure, however, is required on Schedule F of the Annual Statement. Ceding companies are required to disclose whether they have contracts ceding 75 percent of direct written premiums in Schedule F.

A cut-through is either a clause in or an endorsement to an insurance policy or reinsurance contract which provides that, in the event of the insolvency of the insurance company, the amount of any loss that would have been recovered from the reinsurer by the insurance company (or its statutory receiver) will, instead, be paid by the reinsurer directly to the policyholder, claimant or other payee, as specified by the clause or endorsement. Cut-throughs may provide a competitive advantage among commercial insurers. Some clients require insurers to obtain a cut-through or face the possibility of losing business to another insurance company. Reinsurers usually provide cut-throughs only when requested by the insured and reinsured. If a reinsurer issues a cut-through, it has a contractual obligation to pay the beneficiary of the cut-through rather than the receiver. The cut-through does not change the amount of the reinsurance recoverable, only to whom

it is paid. Cut-throughs are common in captive arrangements, particularly where the insured owns, rents, or otherwise participates in the captive.

In general, reinsurance agreements are written as proportional or non-proportional and on either a treaty or facultative basis. Proportional reinsurance is reinsurance that involves the cession by the cedent of a specified share of risk, so that premiums and losses are shared proportionately between the ceding insurer and the reinsurer. Non-proportional reinsurance is a form of reinsurance that, subject to a specified limit, indemnifies the ceding company against the amount of loss in excess of a specified retention. It includes various types of reinsurance, such as catastrophe reinsurance, per risk reinsurance, per occurrence reinsurance and aggregate excess of loss reinsurance. Treaty reinsurance (or obligatory reinsurance) refers to an arrangement under which a reinsurer automatically reinsures all the risks of a specific portfolio of the reinsured, without an option to decline specific risks within the portfolio. Facultative reinsurance, on the other hand, refers to the type of risk where the reinsurer has retained the "faculty" to underwrite the individual risk. A facultative contract is generally referred to as a facultative certificate.

1. Treaty Reinsurance

Under a treaty, the reinsurer is obligated to accept the cession of a class or certain classes of business written by the ceding insurer in accordance with the definitions, exclusions, terms and conditions of the reinsurance agreement. There are common treaty clauses, but each treaty must be read in its entirety to determine how subject premiums and losses are to be treated and how the treaty is affected by other treaties, i.e., inuring treaties. (See definitions in I. Introduction, above.)

A treaty can cover different types of risks. Some treaties cover one line of business, such as fire, casualty, marine, aviation, directors and officers, or boiler and machinery. Others cover an entire program or all business written by a managing general agent, program administrator or specific underwriting department. There are two principal categories of treaty reinsurance: (i) pro rata or proportional reinsurance, and (ii) non-proportional or excess of loss reinsurance.

Treaties tend to be long documents with many clauses and provisions. There are no "standard" contracts, and no two are alike.

2. Facultative Reinsurance

Facultative reinsurance is reinsurance of individual risks by offer and acceptance wherein the reinsurer either retains the "faculty" or ability to accept or reject each risk offered by the ceding company, or limits its acceptance to certain risks or lines of business of the cedent.

There are two principal categories of facultative reinsurance: facultative obligatory and semi-automatic facultative.

- Facultative obligatory reinsurance: These contracts are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

- Semi-automatic facultative reinsurance: Semi-automatic facultative reinsurance requires the reinsurer to accept certain defined risks of the reinsured, subject to the right of the reinsurer to reject liability for any of such risks within a stated period after submission. Like facultative obligatory reinsurance, semi-automatic facultative reinsurance is also a hybrid of both treaty and facultative reinsurance.

Unlike treaties, many facultative contracts take the form of "certificates" comprising a Declarations page and a page of "standardized" General Terms and Conditions in order to ensure concurrency of terms within the reinsurance market.

3. Pro Rata and Excess of Loss Reinsurance

Pro rata and excess of loss reinsurance are forms of either treaty or facultative reinsurance.

a. Property/Casualty Pro Rata Reinsurance

Pro rata reinsurance, also known as proportional reinsurance, consists of quota share reinsurance and surplus reinsurance. Quota share reinsurance is a cession of a specified portion of the risk up to a certain limit of liability, such as 50 percent of the risk per occurrence up to $1 million.

Surplus treaties are pro rata reinsurance that are usually designated by such names as first surplus, second surplus, special surplus, etc., reflecting layers of surplus reinsurance over specified retentions. Several reinsurers may each have a percentage of liability on a surplus treaty in each of these layers. Each reinsurer's liability may be referred to as their "participation." It is called surplus reinsurance because it is reinsuring over a net retention by the cedent or over other layers of reinsurance. A reinsurer's respective participation is designated in a document known as an Interests and Liabilities Statement or agreement (I&L) and is designated as being on either a joint (each insurer is liable for the entire amount reinsured) or several (each reinsurer is liable only for a specified amount or percentage) basis.

b. Excess of Loss Reinsurance

Excess of loss reinsurance applies to losses that exceed an agreed dollar amount or percentage of premium. The reinsurance may apply to a single risk, to a number of losses arising out of one event, or to an aggregation of losses. Excess of loss reinsurance written on a per risk basis is most common, sometimes supplemented by aggregate loss limits applied on an annual basis. Because excess of loss reinsurance does not participate in the entire loss, premium and losses are not shared on a proportional basis with the cedent.

There are many types of excess of loss reinsurance, such as working excess, layered excess, per-risk reinsurance, aggregate excess of loss, and catastrophe or clash cover. The following are examples of excess of loss reinsurance:

- Working excess: This form of excess of loss reinsurance focuses on loss frequency, as opposed to loss severity, and is usually written with relatively low indemnity in excess of low retention, e.g., $400,000 indemnity in excess of $100,000 retention. (In reinsurance parlance, this is expressed as $400,000 xs. $100,000.)

- Layered cover: First excess is usually written over a retention where frequency diminishes and severity of loss is more of a factor. To protect against increased severity, second, third, fourth and higher excess layers may have also been purchased. A single loss may potentially expose any number of these excess covers.

- Per risk: Reinsurance in which the reinsurance limit and the reinsured's loss retention apply "per risk" rather than per accident, per event, or in the aggregate. With per risk reinsurance, the cedent's insurance policy limits are greater than the reinsurance retention. For example, an insurance company might insure commercial property risks with policy limits up to $10 million and then buy per risk reinsurance of $5 million in excess of $5 million. In this case, a loss of $6 million on that policy will result in the recovery of $1 million from the reinsurer.

- Catastrophe reinsurance: This cover requires more than one loss resulting from a catastrophe or series of events. For example, if only one insured building was damaged due to an earthquake, catastrophe reinsurance would not cover the claim. If multiple losses

resulted, the catastrophe reinsurance might respond, but only after application of other available reinsurance. It is generally very high level, such as xs. $100 million. It is a form of excess of loss reinsurance that, subject to a specific limit, indemnifies the ceding company in excess of a specified retention with respect to an accumulation of losses resulting from an occurrence or series of occurrences arising from one or more disasters. It generally covers multiple books of business. Catastrophe contracts can also be written on an aggregate basis, under which protection is afforded for losses over a certain amount for each loss in excess of a second amount in the aggregate for all losses in all catastrophes occurring during a period of time, usually one year. There will be two limits that the receiver will have to track: the catastrophe limits and the individual loss limits.

- Clash cover: Clash cover is a form of casualty excess of loss reinsurance under which a cedent may combine and cede the losses of multiple direct insureds, subject to a single reinsurance retention, when the losses arise from the same event or occurrence.

- Aggregate or stop loss reinsurance: This coverage applies when total losses on a group of risks accumulate to a specified retention, which may be defined as a specific amount or a percentage of premium. Generally, once the retention is reached and the aggregate or stop loss reinsurance kicks in, the reinsurance covers all risks above the designated retention.

B. Life Reinsurance Arrangements

1. Types of Reinsurance

There are three distinct types of life reinsurance: yearly renewable term, coinsurance and modified coinsurance.

- Yearly renewable term (YRT): Under yearly renewable term reinsurance, the reinsurer indemnifies only the mortality risk. The mortality risk, but not the permanent plan reserves, is transferred to the reinsurer for a premium that varies each year with the amount at risk and ages of the insureds. While YRT reinsurance allows a ceding company to transfer mortality risk, it leaves the company responsible for establishing reserves. The reinsurer becomes liable for the reinsured portion of the net amount at risk but has no cash surrender value liability. While the precise formula for determining the reinsured portion of the net amount at risk varies from treaty to treaty, in general it equals the death benefit less cash surrender value on the portion reinsured. Thus, as the cash surrender value grows from year to year, the amount of reinsurance decreases.

- Coinsurance: Coinsurance is a broader form of reinsurance, under which the reinsurer indemnifies a proportionate share of all risks under the policy. In return, the reinsurer receives a proportionate share of the cedent's gross premium, less an expense allowance or ceding commission, and is responsible for establishing reserves. Under a coinsurance funds withheld treaty, the cedent retains all or some of the reinsurance premiums as security for the reinsurer's obligations. With a reinsurer that is not authorized for credit for reinsurance purposes ("unauthorized reinsurer"), additional security is often provided by trust accounts and letters of credit for any difference between the liability of the reinsurer and the funds withheld by the cedent.

- Modified coinsurance: Modified coinsurance differs from coinsurance in that the reserves on the reinsured portion of the policy are not held by the reinsurer; instead, the reserves are held by, and are the responsibility of, the cedent. The reinsurer receives its proportionate share of the cedent's gross premium, less expense allowances. Periodically, a reserve adjustment payment is made, which is equal to the reserves at the end of the reporting period less the sum of (i) the reserves at the beginning of the period and (ii) the earnings on the reserves at the

beginning of the period. The interest element in this calculation is stated in the treaty. If the result of this calculation is positive, the payment is made to the ceding insurer, and if it is negative, the payment is made to the reinsurer. Generally, as long as new business flowing into the account exceeds lapses, the reserve adjustment will be positive.

Each of these forms of life reinsurance are documented in agreements having clauses and provisions unique to the business reinsured. Some contracts empower reinsurers to compel cedents to raise premium rates on the underlying business, which present many unique issues for receivers. Obtaining advice of competent legal counsel in such situations is important.

2. Types of Acceptance

- Automatic reinsurance: This is the most common form of life reinsurance. Automatic reinsurance enables the cedent to issue policies in excess of its retention promptly and economically. The maximum amount of reinsurance that may be ceded automatically on a particular life policy is usually a multiple of the ceding insurer's retention. In the past, the most common multiple was four, but in recent years, there has been a tendency toward higher multiples, such as six, eight or ten. Automatic treaty limits may also be expressed as a dollar amount. Reinsurers seek a reasonable relationship between a cedent's exposure and the exposure it can cede automatically to a reinsurer. It is assumed that the proper balance will provide more assurance that the ceding insurer will act prudently in underwriting a risk if it is retaining a meaningful or "material" portion of that risk.

- Facultative reinsurance: Virtually all automatic treaties also provide facultative facilities for risks that cannot be ceded automatically and for situations where the ceding insurer seeks the underwriting assistance of the reinsurer. A "facility" is an agreement setting out, among other things, the rules under which a reinsurer will reinsure risks ceded by the other party. Unlike automatic reinsurance where the underwriting assessment is made by the cedent, under facultative reinsurance, the reinsurer determines whether it will accept the risk and, if so, at what underwriting classification.

- Facultative obligatory reinsurance: These treaties are hybrids of automatic and facultative reinsurance. Under facultative obligatory reinsurance, the ceding insurer has no obligation to cede a particular risk to the reinsurer, but if it does, the reinsurer has an obligation, within specified limits, to accept the risk. Facultative obligatory treaties are commonly used between reinsurers as a means of securing retrocessions on very large risks or, to a lesser degree, for retrocessions a reinsurer might cede to one of its clients.

- Second excess reinsurance: These are automatic reinsurance treaties that are excess of an initial layer of automatic reinsurance provided by another reinsurer. For instance, a cedent might have first excess automatic cover of four times its $150,000 retention from one reinsurer plus a second excess automatic facility of two times retention from another reinsurer, permitting the cedent to issue up to $1,050,000 of insurance ($150,000 + 4 x $150,000 + 2 x $150,000) on its own underwriting authority. Second excess facilities are sometimes provided on a "criss-cross" basis by two reinsurers sharing an automatic account. One reinsurer might provide first excess cover on lives of persons whose surnames begin with any letter from A to K and second excess cover for surnames starting with L to Z. The other reinsurer would then provide first excess for L to Z and second for A to K. It is a convenient way of providing higher automatic cover when appropriate, without either reinsurer having too large a risk on any one life.

C. Financial Reinsurance

A reinsurance contract that fully participates in the insurance risk of the underlying policies and literally follows the fortunes of the ceding company, such as a simple quota share reinsurance treaty, is referred to

as traditional reinsurance. A reinsurance transaction that does not transfer sufficient insurance risk, sometimes referred to as financial reinsurance or finite reinsurance, should be accounted for separately and not commingled with traditional reinsurance transactions. (See SSAP No. 62R, Property and Casualty Reinsurance and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, for further discussion on deposit accounting for reinsurance that does not transfer sufficient risk.) Thus, reinsurance transactions that do not transfer sufficient insurance risk are still a viable tool to achieve economic goals, but must be accounted for and reported separately from traditional insurance or reinsurance transactions. See Chapter 9—Legal Considerations.

Although the authoritative language on transfer of risk is in the Statement of Statutory Accounting Principles—SSAP No. 61R for Life, Deposit-type, Accident and Health and SSAP 62R for P&C—of the NAIC's *Accounting Practices and Procedure Manual*, some jurisdictions have enacted legislation, promulgated insurance regulations, or issued insurance bulletins that address transfer of risk issues. The receiver should consult applicable or governing state laws and regulations on this subject.

D. Loss Portfolio Transfer

Loss portfolio transfers are arrangements under which an existing block of loss reserves from events that have already occurred is transferred to a reinsurer acting as retrocessionnaire, and so without privity to the insured. The loss reserves may include known case reserves, reserves for incurred but not reported (IBNR) losses, and loss adjustment expense reserves. Since the losses on casualty business are not payable until future years, the consideration for the loss portfolio transaction is calculated based on present value concepts, i.e., the time value of money. Thus, the ceding company is transferring ultimate loss reserves at a discounted value, and the transaction will create immediate income and surplus relief to such company. The essential elements in this transaction are the payout stream of the loss reserves and the time value of money. The financial responsibility of the reinsurer may be capped.

E. Pooling Arrangements

Pooling arrangements are utilized among two or more insurers or reinsurers to underwrite a particular risk or type of business. An allocation of a share of premium, loss and expense is made to each member of the pool based on the pooling agreement. Pooling can be used among either affiliated or unaffiliated companies. Pooling is common within insurance holding company systems or groups of affiliated insurers, and must be reported as such.[1]

III. INTERMEDIARIES AND THEIR ROLES

A. Reinsurance Intermediaries and Brokers

If the ceding insurer chooses direct placement, it will handle all negotiations directly with the reinsurer. However, a ceding insurer may have received the assistance of a reinsurance intermediary (also known as a broker) to place reinsurance coverage. The terms "reinsurance intermediary" and "broker" are sometimes used interchangeably. In a number of jurisdictions, the reinsurance intermediary/broker is legally considered to be the agent of the cedent; this can be reversed by the reinsurance contract.

The reinsurance intermediary facilitates the relationship by acting as the liaison between the ceding insurer and the reinsurer. The reinsurance intermediary may be responsible for documenting the activity between the parties and passing through accounts and payments between the ceding insurer and reinsurer. Should the reinsurance intermediary agree that it is to have any of these obligations, the reinsurance contract should contain a reinsurance intermediary clause. The following is a sample:

> Intermediary is hereby recognized as the intermediary negotiating this Agreement for all business hereunder. All communications (including but not limited to notices, statements, premiums, return

[1] NAIC SSAP No. 63; *see also* Statutory Issue Paper No. 97 (Finalized March 16, 1998)

premiums, commissions, taxes, losses, loss adjustment expense, salvages and loss settlements) relating thereto shall be transmitted to Insurer or Reinsurer through Intermediary. Payments by Insurer to Intermediary shall be deemed to constitute payment to Reinsurer. Payments by Reinsurer to Intermediary shall be deemed to constitute payment to Insurer only to the extent that such payments are actually received by Insurer.[2]

For the cedent, the reinsurance intermediary finds reinsurers willing to accept the risk and helps to negotiate reinsurance agreement terms and produce documentation. For the reinsurer, the reinsurance intermediary brings proposals from cedents and administers the transaction details. The reinsurance intermediary receives a fee (called brokerage or commission), which may be deducted from the premium amounts paid to the reinsurer.

Typically, the reinsurance intermediary will place a cedent's business with one or more reinsurers. When accounts are rendered by the cedent, the reinsurance intermediary will prepare an account for each reinsurer and distribute payments to them or seek reimbursement of amounts due the cedent, as appropriate.

The insolvent cedent, possibly subject to certain limitations, may elect to change the reinsurance intermediary at any time during the treaty and need only notify, in writing, the reinsurance intermediary of its decision and its intended handling of its reinsurance in the future. The receiver should be aware; however, that such change may result in the insolvent cedent incurring an obligation to pay an additional commission. Whether such commission is subject to set-off is an issue to consider with competent legal counsel.

The ceding insurer provides the reinsurance intermediary with a broker of record letter pursuant to which the reinsurance intermediary is granted the authority to solicit reinsurers to subscribe to a program. The reinsurance intermediary then presents a package of information to potential reinsurers, compiled in coordination with the insurer, which documents the program to be written and the insurer it represents. Traditionally the reinsurance contract was rarely signed by all parties prior to the inception date of the coverage. Instead, the reinsurers signed placement slips indicating their percentage participation and containing a summary of the reinsurance coverage—limits, retention, exclusions, standard clauses to be used in the contract, etc. The ceding insurer signed a similar document but referred to it as a cover note. When the reinsurance contract was ultimately circulated for execution, each reinsurer would execute a separate signature page or I&L , binding them to the formal contract. More recently, pursuant to US and international regulations, documentation of the transaction must be executed within nine months. many brokers and direct reinsurers have been moving toward contract at placement or contract certainty, the idea being that the full contract wording is agreed upon prior to the inception date of the coverage. In such a case, there would be no need for a placement slip; rather, the reinsurer would sign the I&L page to the contract.

The reinsurance intermediary then gathers all executed slips and I&Ls and provides them to the ceding insurer, indicating that the placement has been completed and summarizing its terms and conditions. Thereafter, the reinsurance intermediary often has the responsibility to draft a reinsurance treaty based on the agreed terms.

The ceding insurer reports premiums to the reinsurance intermediary, who then prepares the necessary accounts to the reinsurer or correspondent broker, together with appropriate remittances less the reinsurance intermediary fee, which may be netted against such premiums.

The ceding insurer reports losses through the reinsurance intermediary to the reinsurer. The reinsurer pays losses through the reinsurance intermediary to the ceding insurer. In some instances, a reinsurer will make its check payable to the cedent and forward it to the reinsurance intermediary, who will simply mark his records as paid and forward the check to the cedent. In other instances, the check will be drawn in favor of

[2] Note that the last sentence of the intermediary clause reverses the general accepted rule that payment to a disclosed agent is payment to the principal.

the reinsurance intermediary, who will then be obligated to pay the cedent. Funds so paid are held in a fiduciary capacity. Most current reinsurance intermediary clauses deem payment as having been made only upon actual receipt by the cedent. For an example, see the NAIC *Reinsurance Intermediary Model Act* (#790) and New York Regulation 98.

State law following the NAIC Model requires reinsurance intermediaries to be licensed and to have written agreements with their cedents.

B. Role Upon Insolvency

The reinsurance intermediary should be immediately notified of the receivership of either the cedent or reinsurer. The reinsurance intermediary should be provided with a copy of any legal documents (insurance department letter or court orders). It is then the responsibility of the reinsurance intermediary to notify and advise all reinsurers or cedents of the status of the insolvent insurer. It may also be necessary to obtain underwriting and premium records of the reinsurance intermediary, since they are generally more complete than those of the company in receivership.

The responsibility of the reinsurance intermediary does not terminate when the insurer is placed in receivership. The reinsurance intermediary must continue to act in the best interest of the insolvent insurer, including rendering accounts and assisting in the collection of funds from reinsurers. In turn, the estate should continue to provide the reinsurance intermediary with timely claims and accounting reports that need to be rendered to reinsurers. Nonetheless, given the change in the relationship due to the receivership, the receiver may have to contemplate making a new arrangement if he/she has difficulty receiving service from the reinsurance intermediary. If not, there may be an issue whether the intermediary is entitled to assert set-off in respect of pre-receivership financial obligations that include commission(s). In that event, the receiver will want to seek advice from competent legal counsel.

IV. REINSURANCE ACCOUNTING AND COLLECTION PROCEDURES

The purpose of this section is to describe the accounting and collection responsibilities of the receiver for assumed and ceded reinsurance.

A. Introduction

For accounting purposes, reinsurance treaties are classified as either prospective or retroactive. A prospective treaty is one that covers future insurable events arising on or after the effective date of the contract. A retroactive reinsurance treaty (e.g., loss portfolio, as described above in _) is a treaty that covers past insurable events. A reinsurance treaty, whether prospective or retroactive, must transfer insurance risk. Unless insurance risk is transferred, the treaty must be accounted for as a deposit and not as reinsurance. Deposit accounting postpones recognition of revenues and income until the end of the treaty. Under the "nine-month rule," unless the full treaty wording is signed by the parties within nine months of its effective date, the accounting treatment for the reinsurance treaty must be converted from prospective to retroactive. For statutory accounting, a retroactive treaty must be excluded from the underwriting results of an insurance company and cannot be commingled with a prospective treaty.

SSAP No. 62R requires that, for a transaction to be classified as reinsurance, and to be included in the underwriting accounts of the company, the reinsurance treaty must be prospective, and the transaction must contain both underwriting and timing risk.

1. Underwriting risk is the ultimate amount of net cash flows from premiums, commissions, claims, and claims settlement expenses.
2. Timing risk is the timing of the receipt and payment of such cash flows.

SSAP No. 62R further requires that indemnification of the ceding company against loss or liability relating to insurance risk in reinsurance requires both of the following:

1. The reinsurer assumes significant insurance risk under the reinsured portions of the underlying insurance contracts.
2. It is reasonably possible that the reinsurer may realize a significant loss from the transaction.

For complex or non-traditional reinsurance contracts, present value cash flow analysis of a transaction is often prudent to determine whether significant risk has been transferred or a loss may be realized. If a transaction does not meet these requirements, then the transaction must be reported in the financial statements as non-reinsurance or as a deposit. The authoritative statutory guidance for deposit accounting is contained in SSAP No. 61R.

The receiver's primary objective should be to examine the reinsurance agreements with a view to what is best for the estate. It is possible that reinsurance agreements may be amended, terminated, rescinded, commuted or continued to meet this objective.

B. Unearned Premium Reserves

There may be unearned premium reserves related to a reinsurance treaty for some time after the termination date of the treaty, as the underlying policies have not yet reached their expiration and premiums have not been fully earned. This situation may be altered by the termination method utilized. Typically, the parties may elect to terminate a treaty on either a "cut -off" or "run-off" basis. In run-off, a reinsurer will remain liable for losses for policies in force at termination, even if the occurrences take place after the termination date. Since cut-off terminates the reinsurer's liability as of a certain date, usually with a return to the cedent of any unearned premium reserves held by the reinsurer, the period for which the reinsurer may be liable for losses may be substantially reduced as compared to a run-off provision.

C. Contractual Adjustments

Reinsurance treaties may be subject to future premium or commission adjustments based upon experience. Common adjustments are retrospective premium rating, deposit premium adjustment and reinstatement premium adjustments. The most common commission adjustments are for contingent (profit) and sliding scale commissions.

A retrospective rated premium adjustment is a calculation of the final reinsurance premium for the treaty based upon the loss experience developed during the term of the treaty. An estimated reinsurance premium, sometimes referred to as a deposit premium, is paid by the cedent until the retrospective premium is determined. The final reinsurance premium is the deposit premium plus or minus the adjustment, often subject to a minimum and maximum dollar limit.

Ceding commission adjustments represent a sharing of profits between the reinsurer and cedent and are usually associated with pro rata reinsurance. A contingent commission, or profit commission, is a sharing of a predetermined amount of the profits, if any, realized by the reinsurer from the reinsurance treaty. A formula is specified in the treaty describing how premium, losses, IBNR, expenses and commissions are calculated for determining profitability. At specified dates, this calculation is made and settlement of accounts is undertaken. No additional premium results from a contingent commission agreement. These arrangements in life reinsurance may be referred to as experience refunds.

A sliding scale commission arrangement is one in which the final ceding commission is determined by calculating the loss ratio and relating this to a predetermined range of commission rates. As the loss ratio increases, the amount of commission decreases, or vice versa, usually subject to stated limitations.

D. Ceded Reinsurance Recoverables

The initial step in establishing control over ceded reinsurance receivables is to gather and update all ceded reinsurance treaties and facultative certificates in order to create working abstracts of these arrangements. Once individual arrangements have been analyzed, a matrix of reinsurance coverages in place, by book of business, should be established so that the relationship of various ceded treaties is known. See Exhibits 7-1 and 7-2.

The most current account rendered for each treaty should be reviewed, and any open balances due to or payable from the estate should be reconciled. If the reinsurance was purchased through a reinsurance intermediary, there are likely to be multiple reinsurers. Each reinsurer and its percentage of participation should be identified and accounts verified.

Each treaty should be reviewed to determine:

- Lines of business covered
- Limits of coverage
- Dates of coverage
- Workflow and procedures needed to generate premium, losses, etc.
- Outstanding balances
- The appropriateness and method of cancellation of the coverage
- The method of termination (run-off or cut-off)
- The location and security of records underlying the placement of the treaty

Once all participants have been identified in the treaty review phase, an analysis of each reinsurer should be made to determine its financial strength. Procedures should be established to periodically monitor the solvency of reinsurers. If the financial stability of a reinsurer becomes a concern, possible commutation of the reinsurer's liability should be considered.

Treaties may contain security provisions requiring or permitting the insurer to obtain collateral for the reinsurers' obligations. If a treaty provides for letters of credit to secure the obligations of the reinsurers, the obligations of reinsurers should be reviewed and letters of credit either obtained or updated to reflect appropriate liability.

The initial step in the ceded reinsurance accounting process is to develop procedures that allow the assembly of data to produce reporting in conformity with requirements under the treaty.

Allowed claims in liquidation proceedings constitute the basis for submitting claims to reinsurers. Generally, rehabilitation follows the rules of the contract. Thus, it is important to maintain record-keeping systems that fully support the calculation of total claims reinsured.

1. Premium Processing

   In most property/casualty liquidations, the court order cancels coverage on the insurer's direct in force insurance business within 30 days of the date of the receivership. The cancellation of the underlying business terminates the need for ceded reinsurance for losses occurring after the termination date, but does not terminate the reinsurance under the treaty when the receivership is a liquidation based upon a finding of insolvency. In this event, the first consideration in premium accounting is to calculate any

unearned premium reserves that the reinsurers may be holding at the termination date and request that they be returned to the estate. There may, however, be additional premiums or adjustments to be forwarded to the estate for direct business issued and in-force prior to receivership.

Appropriate calculation of this premium should take into consideration the earned portion due reinsurers. Proportional ceded reinsurance involves a calculation of the gross earned premium that is subject to the agreement and a credit to the reinsurer's account for the appropriate proportion. The gross earned premium is subject to ceding commissions due to the estate and, in most events, may be subject to an offset for paid losses.

2. Reinstatement Premiums

Premium adjustments may become due from the insurer to one or more reinsurers as subject premium is received or loss experience develops on business that was reinsured.

Certain types of excess of loss reinsurance agreements, primarily aggregate excess of loss agreements, may provide for an additional premium to be paid to the reinsurers if the total liability limit under the agreement is exhausted by loss payments. This additional premium is known as a reinstatement premium because its payment reinstates the limit of liability of the reinsurance agreement. Reinstatement may be optional, in which case the liquidator may wish to consider whether it should be paid, or if ultimate liabilities will be reduced due to the termination of the underlying policies.

Losses from direct business may be known sooner by the receiver, and reinstatement calculations, as defined by the treaty, may be prepared more rapidly. Losses from assumed reinsurance, however, usually develop over a period of years. For this reason, appropriate controls in accounting and claims are needed to identify any aggregate losses that may be subject to recovery from reinsurers.

The relative priority of such obligations should be considered in a liquidation, and the potential for preferential transfers should be considered in a rehabilitation. Notwithstanding this, it is important for the receiver to maintain current billing practices.

3. Losses Recoverable

Losses to be recovered from reinsurers may arise from both direct and assumed reinsurance operations. It is desirable for the receiver to coordinate reporting with guaranty funds to ensure complete, accurate and detailed information. Controls over this information are required to meet the data requirements of the reinsurance agreements.

In establishing its reinsurance processing procedures, the insurer should have provided for the capture of loss balances due or owing under each treaty or facultative certificate and for each participating reinsurer. If this information does not exist, it is important for the receiver to analyze each treaty by participation to identify each reinsurer. As a result of closer monitoring, a better control over slow-paying or non-paying reinsurers should be achieved.

In addition to paid losses for which the insurer seeks indemnification, outstanding reserves for losses and expenses (and possibly IBNR calculations) are to be reported to reinsurers. Controls should exist to identify certified and unauthorized reinsurers and to monitor the collateral they should provide, as well as the potential recovery against such collateral.

E. Assumed Reinsurance

Accounts for assumed business usually represent liabilities of the estate, as most premiums, except for premium adjustments, are typically received prior to receivership. Because assumed reinsurance is not covered by guaranty funds, and assumed reinsurance generally falls within the general creditor class of the estate's distribution priorities, its accounting is often not of primary importance in liquidations unless

collateral is involved. The existence of collateral account heightens the importance for ongoing accounting and reporting in the underlying business. Whether collateral is supporting an assumed reinsurance transaction might not be clear on the insurer's financial statement, but that collateral could go back to the ceding company if the reinsurance agreement terminates. That transfer of assets could have an adverse effect on the assuming insurer. Typically, ceding companies have low priority claims in liquidation and GAs don't cover assumed (but not novated) reinsurance, therefore unwinding assumed reinsurance agreements could have an effect on the assuming insurer's financials. The insurer, however, may have purchased reinsurance protection on this business and is required to properly record and report these transactions to its reinsurers or retrocessionnaires in order to realize recoveries from them, which may be significant. Also, it is common for insurers both to assume and cede reinsurance to the same insurers/reinsurers, so that mutual accounts may need to be completed to collect balances.

The general accounting approach to assumed reinsurance is the same as that for ceded reinsurance. The receiver should obtain and safeguard all original documentation, abstract arrangements for working purposes, establish balances as of the receivership date, review each treaty and facultative certificate, develop experience histories by treaty, and assign maintenance responsibilities.

Controls similar to those used for ceded insurance should exist over assumed reinsurance reporting. If business has been solicited directly from cedents, those cedents should be informed of any reporting requirements. If, however, a reinsurance intermediary is involved, then the receiver should communicate the requirements to the intermediary, who has the continuing obligation to report to the ceding insurers.

Intermediaries often remit a net payment for the balance due, which may cause problems in the identification and allocation of payments to various cedents' balances. This becomes more of a problem in liquidations, due to possible statutory limitations on setoff. The receiver should consult with competent legal counsel and determine whether to notify intermediaries not to use net accounting or multiple treaty or reinsurer setoffs. Unless rigorous control is maintained by the receiver, the cash allocation process may become difficult.

The action plan for assumed reinsurance is:

1. Documentation
    - Obtain all treaties and update all documentation
    - Establish how treaties were assumed (direct/broker)
    - Abstract treaties into usable format
    - Update any electronic data processing systems used for assumed reinsurance
    - Prepare a matrix of the reinsurance program
2. Accounts
    - Establish latest account position by treaty and cedent
    - Verify balances with broker or cedent, if direct assumption
    - Review experience on each treaty
    - Develop plan to deal with problem accounts
    - Request any missing accounts

- Establish diary for any adjustments due on accounts
- Review documentation to ensure proper reporting of catastrophic losses and aggregate accumulations
- Establish diary control for collection of balances
    - separate responsibility for pro rata reinsurance and excess of loss reinsurance
    - set up procedures for evaluating and recording excess of loss claims

F. Reinsurance Accounting Systems

Reinsurance accounting systems can vary however most systems are web-based. In a few cases, there may be a limited accounting systems.. The type of system used may depend upon the extent and the diversification of the cedent's reinsurance program.

1. Minimum Accounting System Requirements

The reinsurance accounting system must provide information to record the subject business for reinsurance in a manner readily identifiable for each reinsurance contract. The subject reinsurance premium is computed by application of the treaty rate to the subject premium and is adjusted for premiums paid on other reinsurance treaties that inure to the benefit of the treaty.

Losses that emanate from the subject business should be identified. Once the covered losses are identified, reinsurance recoverable under each treaty is computed. If the cedent reports to a reinsurance intermediary, who in turn reports to individual reinsurers, then one summary report should be prepared and mailed to the reinsurance intermediary. If the cedent insurer reports directly to the reinsurers, then individual reports should be prepared. The ceding insurer often retains a percentage of the risk for its account. This can be accounted for on a net basis or as if the ceding insurer is also a reinsurer.

2. Inventory of Reinsurance Accounting Records

The inventory of reinsurance accounting records should be coordinated with the inventory of records for the primary accounting function. The reinsurance accounting records should include:

- Chart and summary of the reinsurance program
- Correspondence files with intermediaries
- Correspondence files with reinsurers
- Formal reinsurance contract wording
- Reinsurance slips (if a formal treaty has not been finalized)
- Signed I&L forms from each reinsurer
- Letters of credit or other forms of security from reinsurers
- Reinsurance accounting folders

The insurer may have a reinsurance accounting procedure manual available that describes the reinsurance accounting cycle and how the data necessary for the reinsurance accounting is obtained and processed to comply with the reinsurance treaties.

The chart and summary of the reinsurance program should describe the various reinsurance treaties, the business covered, and the relationship between the treaties. An individual chart and summary may be available for each reinsurance accounting year. The chart and summary change from year to year as the reinsurance program changes to meet the insurer's needs, objectives and business reinsured.

Correspondence files with intermediaries may include confirmations of reinsurers' participation, accounting reports sent to the intermediaries, or letters requesting payments or cash advances, disputing amounts recoverable, requesting collateral, etc. The reinsurance intermediary is required under the NAIC *Reinsurance Intermediary Model Act* (#790) to retain documents for 10 years. The receiver should instruct the reinsurance intermediary to retain all documents until notified that the documents are no longer needed by the receiver. If the relationship with the reinsurance intermediary is to be terminated, arrangements should be made for the intermediary to deliver all documents in its possession, or copies of the documents, to the receiver.

3. Review of Reinsurance Intermediary Records

The receiver may benefit by reviewing the systems and procedures currently being used by the reinsurance intermediary and evaluating its performance. Where applicable, various reports generated by the insurer should be compared to the reinsurance intermediary's records. When reviewing the records of the reinsurer or of the reinsurance intermediary, consider the following:

- What is the status of the treaty documentation?
- Do the balances developed by underwriting year and by reinsurer conform to the balances generated from the insurer's system?
- Has there been a delay between submission of a request for payment and receipt of the payment? This information may become part of the reinsurer evaluation process. If a reinsurer is habitually late in making payments, the receiver should determine what actions are required. The receiver may wish to have the reinsurance intermediary copy the receiver on all billing transmittals.
- While not customary, the receiver should consider a periodic review of the reinsurance intermediary (every quarter to six months). The purpose of the audit is to verify that the receiver has received complete documentation concerning its reinsurance contracts (e.g., wordings and I&Ls), the reinsurance intermediary has collected all money due from the reinsurer, and all payments received by the reinsurance intermediary have been paid to the appropriate parties.

G. Reinsurance Audits

By custom as well as by contract, reinsurers may have access to the cedents' books and records that pertain to the business reinsured. This section will briefly explain the various types of audits, the purpose of each and the information that one can expect to obtain.

Virtually every reinsurance treaty has an access-to-records clause or an inspection clause, such as, "The reinsurers or their authorized representative shall at all times have access to the books and records of the company, which pertain in any way to the business transacted under this agreement." Most facultative certificates have a similar provision. The same often holds true for agreements with pool managers, managing general agents and reinsurance managers.

Audits typically cover accounting, claims and underwriting. Many reinsurance counterparties conduct separate audits, although it may be more effective to examine all three areas simultaneously. This is especially true in those instances where the audit is being conducted as a result of a dispute or in anticipation of arbitration or litigation. (Note that a "dispute" has statutory accounting consequences, so the prudent receiver will beware declaring a dispute too soon.) The receiver needs to coordinate with the reinsurer and

any affected guaranty funds as to how the audit should be conducted and who should be involved in the audit. The prudent receiver also will negotiate a memorandum of understanding or non-disclosure agreement that summarizes the intent, scope and logistics (onsite vs. remote access, hours and location(s)) for any audit, which may include, e.g., provisions governing confidentiality, admissibility in a dispute resolution foruam, etc.

Except in unusual circumstances, the auditors may be limited to review of records directly related to the business their clients assumed. They are generally allowed to review original records together with the cedent's and receiver's summaries of experience, to the extent those are prepared in the normal course of business. However, auditors should be denied material prepared in anticipation of litigation or preparation for trial, and in particular they should be denied access to communications to and from counsel retained in connection with reinsurance collections. These materials should be kept in files separate from the underlying claims and underwriting files. Auditors generally do, however, receive access, under appropriate safeguards to preserve confidentiality, to communications to and from claims counsel.

An important consideration is who needs to be present during an audit, from both the audting and audited sides.

1. Accounting Audit

The primary scope of this review focuses on verification of the periodic reporting (monthly, quarterly accountings) of the cedent. Although the bulk of the audit will be conducted at the cedent's offices, a significant amount of work, such as the following, may be conducted prior to that time.

- Review terms and conditions of reinsurance contracts, such as:
  - coverage (type of reinsurance contract, limits, underwriting restrictions, classes of risk and territory)
  - reinsurance period (including cancellation and termination provisions)
  - reporting and settlement
  - definitions
  - procurement of common account protection
- Review cedent's recent financial information, including:
  - financial statements
  - independent auditor's reports
  - financial reports filed with the Securities and Exchange Commission or similar authorities
  - financial statements filed with insurance regulatory authorities
  - other insurance department regulatory reports

A schedule of accounts and settlements between the assuming company and the cedent, according to the reinsurer's documentation, should be prepared to verify the balance outstanding on the account. This analysis should then be compared to a similar schedule from the cedent's records. The results can be used as a source of further investigation, if necessary.

Copies of the cedent's procedural manuals for accounting, claims, reinsurance, and audit should be obtained, reviewed and stored.

Documentation on hand should include the most recent experience reports on the program. Investigation should be made into significant deviations from normal business custom and practice. If desired, a comparison to similar programs with other cedents may also be made.

Comparison of such data to actual historical information, especially in the areas of premium volume and loss experience, may be performed to help determine the scope of the audit required.

Prior to inception of the audit, which maybe in person or remote, a list of information and documentation required for the audit should be submitted to the cedent to facilitate its availability. The documentation that may be requested would include digital/electronic, read-only access to document sharing systems, and/or printed copies of:

- Premium and claim registers for originating business (primary or assumed)
- Individual policy and claim files to support registers for originating business
- Premium and claim registers for ceded business
- Individual policy and claim files to support ceded registers
- Accounts and bordereau from the cedent
- Cash receipt and disbursement records (including checks, cash journals, ledgers) applicable to settlement of premiums and losses for originating and ceded business
- All contracts relating to managing general agents, brokers, intermediaries and common account protection for originating and ceded business
- All documentation and support relating to letters of credit, trust accounts and funds withheld

Although generally not specified in the inspection clause, the auditors should have reasonable access to personnel involved in the preparation of any of the cedent's documentation pertinent to the audit procedures.

Having completed review of the pre-audit documentation and assuming the availability of all required information at the cedent's office, the audit may:

- Trace information on originating premium and claim registers through the reports to assuming reinsurers.
- Determine relationship of premium and claim registers for originating business (primary or assumed) to ceded premium and claim registers.
- Verify accuracy of reinsurance accounts and the existing control procedures for preparation of accounts to assuming reinsurers based on review of originating and ceded premium and claim registers.
- Analyze cash records in conjunction with accounts to assuming reinsurers to determine balance due from or to cedents;
- Verify timeliness of reporting and settlement of accounts.

- Sample policy files (reinsurance contract files for assumed business) and claim files from premium and claim registers to verify that:
    - policies are in agreement with treaty terms relative to class of risk, period, limits and other provisions.
    - premium allocations for policies are proper, as are all commissions and other deductions.
    - claims are adequately documented and fall within the policy conditions.

Irregularities encountered in any of the above may be referred to the appropriate staff member of the cedent for resolution of the problem.

This is a simplified outline designed to establish a pattern for the audit. These general steps may not apply to the same degree in all instances. Individual audit programs should be geared to address the needs of the situation, contingent on the nature and volume of the business, as well as the auditor's evaluation of control systems in place.

2. Claim Audit

The ceding insurer should have adequate control procedures in place to allow the assuming insurer to make a determination on the accuracy and validity of the claim information it receives, as well as to assess the competence of the cedent's claims personnel.

- Claims procedure. Preliminary examinations of claim procedures, as outlined in the cedent's current and any prior claims manual(s), should be performed prior to the on-site review. Prior to the examination, a list of documentation required, including the following, should be requested:
    - Claim staffing, including description of positions
    - List of outside vendors, including adjusters, defense/claim attorneys and others
    - Claim control log
    - Claim registers, including aged listing of outstanding claims and salvage and subrogation registers
    - Claim files and related policy/assumed contract files
    - Cash records applicable to claim and expense payments

Assess the Claim Staff. An analysis of the claim control log, claim register and aged listing of outstanding claims, along with the claim handling and diary system procedures outlined in the cedent's claim manual, should be indicative of the adequacy of staffing levels. Discussion with the appropriate claim personnel and review of the claim manual should indicate procedures used to assign claims to outside adjusters and the follow-up procedures used to keep the status on claims current.

A random sampling of claims from the loss registers should be made to determine files to be examined for the remaining portions of the audit. If specific areas or claims are suspect, these files can be requested and examined in addition to the random sample.

- Claims review generally will include the following:

- Determination of adequacy of file documentation, including notice of loss, adjusters' reports, attorneys' reports,[3] litigation releases and proofs of loss (including reinsurance notices)

- Verification of coverage of originating policy and reinsurance agreements as to term, risk, limits and other provisions

- Reconciliation of payments (loss and expense) to claim filed documentation

- Determination of third-party recoveries (salvage, subrogation, third-party deductibles and other reinsurance)

Claims accounting may require special attention. The auditor will want to verify the correctness of claim allocation by sampling allocation by claim registers and the cedent's retention. In some instances, a review of the claim registers for originating and ceded business may disclose problems in claim allocation.

3. Underwriting Audit

An underwriting audit conducted by the receiver of an insolvent company may differ from that performed by a reinsurer contemplating a continuing relationship with an insolvent cedent. Some vital areas that may be considered during such audit include verification that:

- Premium volume is within guidelines outlined in the reinsurance agreement, if any.

- Controls are in place to determine effective and complete reporting of premiums.

A sample of policy files may be selected (or the policy files that correspond to those used in the accounting or claims audit should be reviewed) to determine whether:

- Risks written conform to the specifications of the reinsurance agreement relating to class of business, types of coverage, exclusions and other warranties.

- Risks written conform to underwriting guidelines.

- Underwriter's approval has been properly executed in accordance with the reinsurance agreement and any related underlying agreement (e.g., managing general agents, brokers).

- Policy endorsements alter reinsurance obligations.

- Premiums have been properly developed to include reporting forms, business subject to audit and retrospectively rated business.

Auditing counterparties typically prepare summaries of their findings. The receiver will want to request and receive a copy of any such report.

4. Handling Audits of Receiver's Records

Because of the receiver's activity in collection of reinsurance balances claimed due, the receiver frequently receives requests for audit of his or her own records and those of the insolvent company. Allowing an audit is an important step in the ultimate collection of the insurer's reinsurance recoverables, but care should be taken that the audit process neither creates new defenses for reinsurers,

[3] Whether the reinsurer is entitled to these reports is the subject of frequent litigation, and the receiver should seek legal counsel before providing or not providing these reports.

disrupts the receiver's own efforts to manage claims and assets, nor violates any applicable statutory confidentiality provisions.

a. Preconditions to audit

After taking possession of the insurer, the receiver is entitled to adequate time to gain control and understanding of the insurer's affairs and records before being subject to audit by reinsurers. Reinsurers may make preemptory demands for audit well before the receiver can respond. The receiver should assure the reinsurer that it will have an opportunity to audit as soon as the receiver has had sufficient time to become familiar with the records he or she has inherited.

The receiver should consider developing a standard audit procedure to be followed. Once the receiver in consultation with triggered guaranty funds is prepared to schedule an audit by the reinsurer(s), several dates should be requested from the auditor, so that the receiver and guaranty funds have the opportunity to ensure availability of requested claim files, crucial staff and space, and possibly counsel. The receiver needs a firm commitment from the auditors as to the time required for completion of the audit, especially where the claims requested include claims that are open and ongoing with guaranty funds.

To facilitate the audit and ensure document control, the receiver should request a list from the auditor of all files to be reviewed. The receiver should contact affected guaranty funds and arrange for file shipment. The receiver should send a letter to the auditor outlining the procedures to be used for the audit and identifying the liaison between the auditor and the company. The receiver should also have the auditor and the reinsurer sign a confidentiality agreement before the audit to protect the interests of the estate and the insured.

b. Preparations for audit

The auditor may be asked to designate in advance the records to be reviewed, so that they can be located and retrieved. Someone on the receiver's staff or counsel is usually designated to become familiar, if they are not already, with the history, terms, accounts and major issues arising from the business being audited, and to serve as principal liaison between the auditors and the receiver. Arrangements should be made to provide the auditors with a designated space, ideally a separate room, to which records can be brought as requested. Control over records produced for the auditors is essential. Arrangements should be made to have copies (and/or screen shots of electronic or digitally stored material) made, at the reinsurer's expense, of any records or documents they designate, and the receiver should keep track of what is copied. Pricing and availability of copying services should be discussed with the auditing company.

c. Conduct of the audit and follow up

Members of the receiver's staff not personally involved in the audit should be advised that an audit is being conducted, and reminded that requests for information from auditors should be in writing and referred to the designated liaison to ensure correctness and consistency of the information provided.

The receiver should request, and often will receive, a copy of the auditor's findings at the conclusion of the audit.

H. Managing Assumed Reinsurance

Even though assumed reinsurance claims have a lower payment priority in liquidation, maintaining and processing assumed reinsurance claim activity may be vital for setoff purposes, to develop satisfactory support for any retroceded reinsurance that the insolvent insurer may have purchased, and to ensure that existing funded security is not improperly drawn down. Preparation of a schedule of reporting due dates for each assumed reinsurance treaty is helpful.

Pro rata reinsurance loss activity will be reported in a summary of all losses on individual policies reinsured. This summary report, or bordereau, should be accompanied by individual policy identification and loss data.

Initially, a reconciliation of the proofs of loss submitted by or on behalf of cedents may be undertaken with the physical inventory of pending or unprocessed assumed reinsurance claims. The receiver's staff should establish procedures so claims submitted by cedents conform with the terms of the reinsurance treaty, including dates of loss, coverage impacted such as lines or classes of business, and types of risks reinsured. Questions or problems may be referred to the reinsurance intermediary or cedent as appropriate.

Next, all assumed claims should be reviewed to ensure that they are being reported to the reinsurer in a manner consistent with the requirements of the reinsurance agreement, including issues of coverage, claim support, and timing of reporting. Each reported loss should also be reviewed to ensure there is an appropriate reserve. The receiver's staff should develop additional case reserves if required and, if appropriate, notify reinsurers and retrocessionnaires. The retrocedent should consider doing the following:

- Review (all) incoming loss advices.
- Match loss advices with treaty or facultative certificates.
- Confirm coverage.
- Create a file and enter data, calculating the appropriate share of paid and outstanding.
- Maintain a diary system, either manual or(preferably) electronic.
- Identify all applicable retrocessional treaties and transmit timely notice based on respective terms and conditions.
- Request updates, pertinent information, and documentation through the intermediaries as needed.
- Establish format for closing and eventual purging and storage, pursuant to applicable law and any litigation holds(s).
- Confirm that catastrophic losses are identified and reported (these should be accumulated with potential retrocessional recoveries in mind).
- Review each loss in detail and post any additional case reserves deemed necessary.
- Inquire as to any inuring reinsurance or common account.
- Monitor cedents' pursuit of subrogation, salvage, and other recoveries.
- A separate file is usually required for each facultative certificate or excess of loss treaty, and a separate claim file for each loss under a certificate or treaty may be desirable.
    - For pro rata reinsurance treaties, a single file encompassing one underwriting period should suffice, provided the bordereaux are informative enough for the technical staff to verify coverage.
- If annual aggregate coverage is involved, a system-produced report is helpful for tracking aggregate exhaustion.
- Develop forms for all the above.

I. Managing Ceded Reinsurance Collections

1. Direct Claims and Guaranty Funds

A primary consideration for the receiver is to prepare for the collection of ceded reinsurance for claims that will eventually be allowed by the liquidation court. To that end, the receiver should:

- If necessary, in addition to Uniform Data Standards (UDS), develop a reporting system to be used by the guaranty funds that conforms to the requirements of the insurer's reinsurance agreement(s).
- Reconcile the insurer's records to periodic reports from the guaranty funds.
- Promptly and adequately document the handling of direct claims that are not covered by guaranty funds so as to be able to notify and bill reinsurers
- Ensure there is adequate control over any claims settled at an amount in excess of the guaranty funds' statutory limits.
- Ensure that the guaranty associations are handling claims properly. This is generally done by audits of the associations.

2. Reports

Accounts rendered should be on forms mutually agreed upon by the cedent and reinsurer, and payments from the reinsurers should be made within the payment terms required by the treaty, without diminution because of the insolvency of the cedent.

The different forms of reinsurance contracts may have different reporting requirements. Because the reinsurer is not required to pay a loss unless the information to support the cedent's payment has been received, it is prudent that the receiver deliver this information as soon as possible. Developing this information often requires coordination with guaranty funds.

3. Insolvency Clause

A reinsurer is obligated to reimburse its ceding insurer for a covered loss after the cedent pays or becomes liable or responsible for underlying loss. This arrangement functions well in ongoing business; however, historically it raised practical problems when the ceding insurer became insolvent. Given the indemnity nature of a reinsurance contract, the receiver often could not demand the reinsurer pay its portion of covered claims until the receiver had paid the underlying claims. Typically, the receiver of a ceding insurer was not able to pay such claims prior to receiving the reinsurance payments and, therefore, had difficulty recovering reinsurance receivables.

In 1939, the New York legislature passed a law requiring that all reinsurance contracts contain an "insolvency clause" if the cedent desired to receive credit for reinsurance. Following the 1939 law in New York, many states enacted a similar requirement, and all states now require some type of insolvency clause, which comes into effect if the ceding insurer is found by a court to be insolvent in an order of liquidation. The insolvency clause obligates the reinsurer to pay recoveries it owes under the reinsurance contract on the basis of the ceding company's allowed claims, not on the basis of whether the insolvent cedent has actually paid the money it owes its policyholders.

Most courts recognize that the main purpose of the insolvency clause is to ensure that a receiver has the requisite access to reinsurance funds.

There may be unusual instances where the reinsurance contract does not contain an insolvency clause, but the contract provides that its interpretation or enforcement is subject to applicable state law (typically the ceding insurer's state of domicile). Many state insurance laws provide that a reinsurance contract must contain required terms before the ceding insurer may claim reinsurance credit for the reinsurance, and one of the required terms provides that the contract must contain insolvency clause language. Thus, a receiver should also determine if the applicable state law requires that reinsurance be paid without diminution because of the ceding insurer's insolvency, as this state law may allow for recovery in situations where an insolvency clause is not otherwise available for the recovery of reinsured claims.

4. Notice to Reinsurers

The insolvency clause usually provides that the reinsurer shall be given notice of the pendency of each claim against the company on the policies insured within a reasonable period of time after such claim is filed in the insolvency proceeding. The clause also provides that the reinsurer has the right to investigate each such claim and to interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defenses which it may deem available to the company or its liquidator.

V. TERMINATION OF REINSURANCE RELATIONSHIP

There are five principal methods for terminating a reinsurance relationship: commutation, cancellation, novation, rescission, and by operation of law. Before a receiver uses any of these methods, careful consideration should be given to whether the financial consequences will benefit the insolvent insurer and, consequently, the creditors. By assessing the potential benefits, a receiver will be able to prioritize efforts. If a receiver is considering terminating a reinsurance relationship in a life/health insurer liquidation, the receiver will need to coordinate with the affected guaranty associations. As noted above, both IRMA §612 and §8(N) of the NAIC's Life GA Model Act, as adopted in state laws, provide the life and health insurance guaranty associations the right to elect to continue and assume the rights and obligations of the ceding insurer with respect to reinsurance contracts that relate to guaranty association covered obligations, subject to the requirements set forth therein.

A. Commutation

A commutation is simply a mutual release from a contract in exchange for consideration. The mechanics of a loss commutation are that the reinsurer, by a cash payment to the cedent, discounted to present value, removes the outstanding reserves and IBNR from its books. The result on the cedent's books is that its surplus decreases by the amount of the difference between the cash received and the undiscounted reinsurance recoverable; the reinsurer's surplus is benefited in the same amount.

Commutation may be viewed as a special type of cancellation or as a means of ending the relationship after cancellation has occurred. Note that the New York Insurance Law requires commutation clauses to be included in life reinsurance agreements.

1. Commutation During Rehabilitation

It may be advantageous for the receiver to commute assumed business of an insurer or reinsurer in rehabilitations. Under certain circumstances, commutation could permit the receiver to expedite billing and collection from its reinsurers and retrocessionnaires. The alternative is to allow claims to remain open for an extended period, increasing the administrative burden and expense for both the receiver and the cedents. Note that the insolvency clause may apply, especially in property/casualty

Likewise, the receiver in rehabilitation may find a benefit in offering to commute outstanding losses with its reinsurers. There may be factors, such as knowledge of the weakened financial condition of a reinsurer, a desire to quantify IBNR relating to long-tail casualty business, or the ability to obtain immediate cash, which need to be considered when commuting with reinsurers and retrocessionnaires.

Early commutation may benefit the estate by bringing in cash and avoiding controversy and delay in collection. The receiver is unlikely to be as concerned as an insurer outside of receivership would be, with the loss of surplus inherent in discounting loss reserves to present value.

2. Commutation During Liquidation

Commutation of assumed business by an insolvent reinsurer is the equivalent of determining creditors' claims but may raise questions of priorities or preferences to creditors in rehabilitation as well as liquidation, because commutation terms may require immediate payment to a creditor class which otherwise may not share in distributed assets until a later date, if at all. Commutation of an insolvent insurer's ceded business should involve consideration of the factors discussed above for the commutation of ceded business by an insolvent insurer in rehabilitation. The receiver should consider the advisability or necessity of obtaining receivership court approval of commutation agreements.

The NAIC *Insurer Receivership Model Act* (#550) (IRMA) contains provisions regarding commutation of a reinsurer's liabilities. Sections 614 and 615 of IRMA allow a receiver to commence mandatory arbitration of commutation proposals after a certain amount of claims development or in the case of a reinsurer in financial difficulty (as defined by the state's RBC provisions). Section 614 requires receivership court approval for commutations having a gross consideration in excess of $250,000.

The provisions of IRMA outline the procedures, rights and duties of both receivers and reinsurers in the arbitration process and allow the formation of a reinsurance recoverable trust for the satisfaction of any arbitration award. State law should be consulted to ensure compliance with the specific applicable details.

3. Technical Aspects

a. Data

A successful commutation requires complete, accurate and current data. Therefore, the receiver of a ceding insurer should update loss and premium figures in collaboration with respective state guaranty associations and reinsurance intermediaries before attempting a commutation.

The receiver of a reinsurer is largely dependent on information provided by the ceding insurers and reinsurance intermediaries. As a result, the receiver should consider conducting an on-site review or audit of the cedent's records relative to the program or treaty in question. The purpose of the examination is to ascertain that the reinsurer's accounts accurately reflect the business that was or should have been ceded.

b. Evaluate Future Loss Development

Future loss development is necessary to estimate the cost of the commutation. Actuarial staff should provide the calculation. Three basic steps are involved:

- Project reported outstanding and IBNR losses to ultimate incurred commensurate with the risk reinsured (e.g., auto v. general liability and/or asbestos).
- Project the timing of payment of losses to ultimate incurred.
- Calculate the net present value of ultimate incurred losses based on anticipated payment dates. If the parties can agree on a net present value, that becomes the commutation figure.

B. Cancellation of Reinsurance Treaties

1. Term Treaties

The majority of facultative reinsurance agreements and some reinsurance treaties have a fixed termination date, often an anniversary of the date of inception. Nothing need be done to end coverage as of that date; it simply expires. These contracts often may be canceled as of an earlier date with 60 or 90 days' written notice to the other party, or as specified within the terms of the reinsurance agreement. Cancellation, however, does not usually end the reinsurance relationship, which continues until all claims are submitted and paid, particularly in respect of business written on an occurrence basis.

Non-life business in force at the date of receivership, including assumed reinsurance, is usually terminated within 31 days of the receivership order. Some categories of reinsurance agreements are difficult to terminate midterm (such as aggregate excess of loss and stop loss reinsurance agreements), due to loss accumulation period requirements under the contractual provisions. Under a rehabilitation proceeding, however, the receiver would have the option of continuing in-force reinsurance business during an appropriate run-off period instead of effecting a cut-off or early cancellation date.

2. Continuous Treaties

Most obligatory treaties and some facultative agreements have no fixed termination date and continue until terminated by one of the parties. Often, these agreements may be terminated by written notice 90 or 120 days prior to an anniversary of the inception date, or as defined by the reinsurance agreement.

3. Notice of Cancellation

While the form of the notice of cancellation is usually stated in the reinsurance agreement, there are certain aspects to the cancellation process that are not as obvious. The prudent receiver will consult competent legal counsel on the legality and/or effectiveness of a receivership triggered termination. Reinsurance treaties, both term and continuous, are reviewed annually in what is known as a renewal process. Either party may issue a provisional notice of cancellation while renewal negotiations continue. The provisional notice can be withdrawn once a new agreement is reached. Another means of accomplishing the same purpose is for the parties to agree to a reduced period for notice of cancellation.

4. Cut-off vs. Run-off Cancellation

Facultative reinsurance is generally coterminous with the underlying policy. Treaty reinsurance generally applies to policies incepting during its term, and therefore continues to apply as long as the underlying policies have losses reported the underlying policies are often canceled by a liquidation order, but claims will continue to be reported). This is referred to as "run-off." The receiver may also elect to cancel treaties on a "cut-off" basis, pursuant to which the reinsurer returns any unearned premiums and has no responsibility for losses that occur after the treaty terminates.

C. Novation

1. Definition

In novation, a new insurer is substituted for the existing insurer, and the insured must look to the substituted insurer for performance and must pay premiums to the substituted insurer. In a reinsurance context, the principles remain the same, although it should be a three-party agreement between the cedent, the reinsurer and the original policyholder.

Insurance terminology tends to call a novation "assumption and reinsurance." This term is more descriptive of implementation techniques but is inaccurate even in this limited role. The novation

usually takes the form of a reinsurance treaty but one with an unusual feature. Not only does the reinsurer assume 100 percent of the risk, the reinsurer also is substituted for the original insurer. It is the latter feature that distinguishes a novation from a reinsurance transaction.

2. Use of Novation

The principal purpose of a novation is to move an existing book of business from one insurer to another. Novation may be more efficient than having the original carrier not renew the business while the new insurer is soliciting the same insureds. Regulatory limitations on nonrenewal of certain lines of business and consumer protection may be primary reasons for novation.

3. Practical Difficulties

Traditionally, a novation requires the consent of all parties to the contract, the insured, the original insurer and the reinsurer. Some states exempt assumption/novation transactions in the context of a rehabilitation or liquidation from the policyholder consent requirement. It may be difficult to obtain the actual consent of thousands of policyholders who may not understand the process and who may not be sufficiently interested. There is considerable debate as to the level of notification and consent necessary for a novation. Some insurance departments have required mass mailings to insureds explaining the transaction and offering the opportunity to object or decline novation. However, in a receivership, a transfer of business can often be arranged under the receivership authority statute and/or the order of the receivership court.

4. Bulk Transfer Distinguished

In general, a bulk transfer is the reinsurance of all or substantially all of a book of business. Often, a bulk transfer requires notice to the cedent's state of domicile. A bulk transfer may or may not involve a novation, and a novation may or may not involve all or substantially all of an insurer's book of business. The difference is whether the prior reinsurer continues to retain any liability or ongoing obligation.

D. Rescission

1. Definition

It is important to distinguish "rescission" from "cancellation." Cancellation means to terminate the unperformed portion of a treaty. Rescission restores the parties to their original position prior to entering into the treaty. Rescission is a remedy available only under limited circumstances.

2. Technical Aspects

Typically, general contract principles apply to reinsurance contracts. Under general contract principles, rescission may be obtained by mutual consent of the parties, by a party that has been injured by acts of the other, or through litigation or arbitration proceedings Generally, reinsurance agreement rescissions occur because a party contends it has been defrauded or damaged. Most disputes arise because the reinsurer believes the cedent has made material misrepresentations respecting the nature, quality or volume of the business ceded. In these cases, a complete accounting or a reconstruction of accounts for the contract period may be required.

E. By Operation of Law

In some states with enabling legislation, insurance business may be transferred by operation of law. Since 2000, reinsurance counterparties in the EU have been able to transfer direct and assumed insurance

portfolios with continued coverage for re/insureds and a full release for the transferor without completion of either a novation process or concomitant opt-in/out rights for re/insureds. In the US insurance market, a small number of states offer one or both of the following two alternatives: insurance business division and insurance business transfer. Coordination regarding policyholder rights in other jurisdictions and other state laws is an important aspect that is receiving ongoing study in US Insurance regulators. See meeting materials, exposure drafts, and other documents of the NAIC Restructuring Mechanisms Subgroup[4] for updates in this area.

Business *division* (e.g., in Arizona, Connecticut, Delaware, Georgia, Illinois, Iowa, Michigan, Pennsylvania[5]) offers companies the ability to divide business operations into two or more entities upon the approval of the regulator; business *transfer* is effected via novation following judicial approval (e.g., in Rhode Island, Vermont and Oklahoma[6]); both mechanisms have regulatory and judicial components.

Oklahoma approved the first transfer in an intra-group transaction and Illinois approved the first US division, also in an intra-group transaction. Each of these is highly specialized, and review of the requirements to effect in, and/or the impact upon, a receivership should be undertaken with the advice of competent legal counsel.

VI. SETOFF

A. Overview

Setoff is a device that permits two contracting parties to net reciprocal debt obligations and pay only the remaining balance. It is an important element of any receivership. Setoff is an area of considerable controversy, and it is important to develop an effective approach for handling the various issues that will arise because of its application. It is important to begin this approach early in the receivership with a careful analysis of the applicable provisions of the governing receivership state law. Note that there are/may be unique issues arising from the organizational structure of counterparties; e.g., policyholder-owned reinsurers, fronting insurers, captives (including "pure," hybrid, and series captives), and special purpose vehicles. For example, "triangular" set-offs are not permitted. Thus, where A owes B, C owes A, and B and C are affiliates, A may not lawfully set off what it owes B against what C owes A.[7]

B. Recoupment and Counterclaims

The concepts of setoff, recoupment and counterclaim are often confused. Although each provides a means by which a debtor may attempt to limit the net amount of a creditor's recovery, it is important that the receiver have a basic understanding of the distinguishing features of each procedure, as well as the central concept of "mutuality" (and potential differences imposed by varying priorities of asset distribution) which are discussed in Chapter 9—Legal Considerations.

C. Procedural Steps in Administering Setoffs

The receiver should review the governing receivership state's current statute relating to setoff, and determine the past practices and procedures that have been utilized within the jurisdiction. It would also be prudent to review any court rulings and decisions relating to setoff to determine their applicability to various

[4] https://content.naic.org/cmte_e_res_mech_sg.htm
[5] *See, e.g.,* 215 ILL. COMP. STAT. 5-35B.
[6] *See, e.g.,* OKLA. STAT. tit. 36, § 1681-8
[7] *In re Orexigen Therapeutics, Inc.*, 990 F.3d 748 (3d Cir. 2021).

issues that may arise. The reinsurance agreement may also have provisions relating to setoff, although they may not override applicable statutes.

Once the receiver has elected a course of action for handling setoff issues, written policy and guidelines should be prepared, and coordinated with and reviewed by counsel. The receiver may file the setoff policy and its guidelines with the receivership court and communicate as soon as practicable to cedents, reinsurers, intermediaries and other interested parties.

It may also be necessary for the receiver to audit or review reinsurance account statements, including payments received and processed earlier by the receiver's internal staff, to ensure that there is a consistent application of the mandated setoff procedures. If it is determined that improper setoffs are being applied, communications to appropriate parties should be initiated, and if the matter cannot thereafter be mutually resolved, the receiver should consider mediation, partial or total rejection of a proof of claim, or appropriate legal action, including arbitration and litigation.

Some receivers require details about claimed set-offs to be included in proofs of claim.,

D. Setoff Against Insolvent Insurers and Reinsurers

To determine if the receiver has a right of setoff against an insolvent insurer or reinsurer, the insurance law of the state of domicile of the insolvent insurer or reinsurer may be applicable and therefore will need to be reviewed. It will be necessary to determine whether the receiver will be able to assert setoff under the other insolvent's domiciliary state laws. See Chapter 9—Legal Considerations.

VII. ARBITRATION CONTROVERSIES

An insolvent insurer will likely be involved in dispute resolution. There will be looming questions, however, of how the resolutions will occur, how the disputes will be resolved, how long they will take and how much they will cost. These are questions a receiver will face on a regular basis.[8]

The insolvent insurer has various options in settling disputes: negotiation, mediation, arbitration and litigation. As a general rule, negotiation is the fastest and least expensive option, and litigation is the most costly and time consuming.

Many reinsurance agreements contain clauses that require parties to a reinsurance agreement to resolve their disputes through arbitration. When one of the parties is in receivership, the issue of whether reinsurers may compel arbitration or are required to resolve their disputes in the receivership court is governed by local law.

A majority of reinsurance agreements provide for arbitration as the sole means of resolving conflict. Most courts, including the U.S. Supreme Court, favor enforcing agreements to arbitrate, but a small number of jurisdictions have held otherwise.Historically, arbitration awards were forthcoming much sooner than a similar decision from a court of law. The result was usually less expensive than litigation and had other advantages, such as being a confidential process, having expert triers of fact, offering broad ranges of relief, and other procedural and substantive benefits. However, there is no right of appeal *per se,* and successful challenges to arbitral awards are difficult to moiunt.

Arbitration rights within reinsurance agreements are enforceable under Section 105E of the NAIC *Insurer Receivership Model Act* (#550). If there is a balance payable to the receiver after offsets are considered by the arbitrator, that balance must be paid in cash. If, alternatively, the balance is in favor of the reinsurer, that balance becomes a claim against the insolvent insurer to be paid pursuant to the priority scheme, pro rata, when the insolvent insurer's assets are distributed.

[8] This is a very cursory discussion—please refer to the Legal Chapter for a detailed analysis of this subject.

VIII. LETTERS OF CREDIT

A. Nature of the Letter of Credit in Reinsurance Transactions

In general terms, the letter of credit (LOC) is an undertaking by a bank as issuer to honor a draft drawn upon it by a beneficiary (the cedent) in accordance with the terms of the LOC. The LOC is issued by the bank at the request of a the reinsurer, in furtherance of a separate agreement between the reinsurer and the ceding insurer. Reinsurers may also be beneficiaries of LOCs provided by cedents to collateralize future premium payment obligations and ensure financial statement credit.

The bank is obligated to pay on the LOC when the beneficiary presents a sight draft that complies on its face with the terms of the LOC. In many jurisdictions, compliance with the LOC terms must be exact to trigger the bank's payment obligation. In some jurisdictions, substantial compliance is sufficient to trigger the bank's payment obligation. The bank should not look at whether the underlying reinsurance agreement was properly performed before it pays on the complying sight draft. Any contractual disputes between the account party and the beneficiary involving the reinsurance agreement remain separate from the issuing bank's obligation to pay under the LOC.

In the insurance industry, LOCs are frequently used to enable the reinsurer to secure their obligations to the cedent under reinsurance agreements so that the cedent may take credit for the reinsurance on its financial statement, either as an asset or as a deduction from liability. This is permitted under the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786).

In the event of a failure of the reinsurer to fulfill its obligations under the reinsurance agreement, the cedent may draw down the LOC. The issuing bank must honor such a demand, unless the demand documents are forged or are otherwise tainted by fraud, or there was fraud in the underlying transaction. These exceptions must be distinguished from mere commercial disputes between the parties, which, as noted above, do not impact the bank's obligation to pay on a complying sight draft.

B. Basic Features of the Letter of Credit

The Credit for Reinsurance Model Law and Regulation are an accreditation standard, and as such the provisions for LOCs in each state's laws must be substantially similar. LOCs supporting reinsurance with certified or unauthorized must be "clean" (that is non-"documentary" under which certain evidence may be required), meaning the LOC must be payable on a sight draft without any supporting documents, and the LOC must be irrevocable, meaning it cannot be terminated prior to expiration by the account party without the beneficiary's consent.

Acceptable LOCs are required to contain an evergreen clause, which requires the bank to give specified advance notice (usually 30 days) of non-renewal to the beneficiary/cedent. Failure of the bank to serve notice of non-renewal prevents expiration, resulting in an automatic renewal of the LOC. On the other hand, non-renewal of the LOC while balances remain due to the cedent is grounds for the cedent to draw down the LOC.

In addition to these basic features, the bank issuing the LOC must meet certain standards in accordance with Model #785, Section 4. Other states require that the LOC be issued or confirmed by either a domestic bank, a foreign bank licensed in the United States, which is either on the NAIC Securities Valuation Office (SVO) list.

C. What Should a Receiver Know About LOCs?

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the LOCs and list them in accordance with the treaties collateralized and expiration dates. Any evergreen clauses should be noted on treaties under notice of cancellation.

Counsel should be consulted to confirm that the receiver has the power to draw down the LOCs, or if the receiver does not, this power should be immediately obtained from the supervisory court.

It is recommended that a receiver notify each issuing bank that the cedent is in receivership. The receiver should take whatever steps are necessary to ensure that only the receiver is empowered to draw down the LOCs and that the receiver will receive notices of non-renewal. The receiver should seek to have the LOC amended to change the name of the beneficiary to the estate.

Each reinsurer should be advised by the receiver that it must maintain the outstanding LOCs in accordance with the terms of the specific reinsurance agreement.

Once the above steps have been taken, the receiver should verify the liabilities secured by the LOCs. If an LOC is about to expire and leave outstanding obligations unsecured, the receiver should notify the reinsurer to renew the expiring LOC. If the reinsurer does not agree to renew, counsel should be consulted on the appropriateness of drawing down the LOC to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify all of the LOCs issued on behalf of the reinsurer and list them in accordance with the contract collateralized and expiration date. If any notices of termination have been issued pursuant to evergreen clauses, these should also be listed. Finally, if any collateral has been posted with an issuing bank to secure the LOC, the receiver should properly identify such collateral.

It is also recommended that a receiver notify each issuing bank that the reinsurer is in receivership, and identify the receiver to confirm that only the receiver is authorized to give the bank instructions with respect to the LOCs, which would normally be given by the account party.

The receiver should also communicate with all cedents in whose favor banks issued LOCs on behalf of reinsurers so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the LOCs will be maintained in accordance with the reinsurance agreement. The receiver should also take whatever steps are necessary to ensure that the LOCs will not be improperly drawn down.

Once the receiver properly identifies all of the outstanding LOCs and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the LOCs in order to protect the reinsurer's position by preserving its collateral. The receiver should ascertain the liabilities secured by the LOCs and guard against wrongful draws by cedents against the outstanding LOCs. A danger also exists that the collateral posted will be wrongfully used by the bank to gain a preference on other, unsecured debts allegedly owed to the bank by the reinsurer. The receiver can also protect the reinsurer's position by depositing any interest earned on collateral into the reinsurer's estate, assuming this power is consistent with the account agreement.

There also may be unique set-off issues.

IX. TRUST FUNDS

A. Nature of the Trust Fund in Reinsurance Transactions

A reinsurance trust fund is an arrangement between the reinsurer (the grantor) and the cedent (the beneficiary), under which assets are deposited with a trustee, pending the performance of certain contractual obligations between the parties. In some instances the cedent may be the grantor and the reinsurer may be the beneficiary. If the beneficiary makes a demand upon the trustee stating that the contractual obligations are unfulfilled, the trustee is obligated to pay in accordance with the terms of the trust. The Credit for Reinsurance Model Regulation (#786) contains minimum standards for how a trust should be established and operated.

In reinsurance, trust funds serve as an alternative to LOCs. Certified and unauthorized reinsurers establish and fund them to secure their obligations to the cedent. Trust funds serve as security for the risk undertaken by the cedent and ceded to the reinsurer, allowing the cedent to take reinsurance credit for the ceded risk. Only certain specified assets are generally permitted to be used to fund the trust, including: cash, certain readily marketable securities such as United States government obligations and nationally traded stocks, and clean, irrevocable letters of credit.

B. Basic Features of the Trust Fund

The administration of the trust fund is governed by the trust instrument that provides for the term, or duration, of the trust fund. It may also include a provision concerning control of the trust assets. The grantor is often given the power to substitute qualified assets, so long as the value of the corpus remains at the agreed level. The trust instrument may also include a provision concerning the ability to control investment of trust assets.

During the term of the trust fund, the principal will yield interest, and the trust instrument may contain a provision allocating the interest either to the grantor or the trust corpus. The trust instrument may also specify under what circumstances a demand can be made on the trustee, allowing the grantee to obtain trust funds. In the event that the grantor wishes to terminate the trust, the trust instrument will include a provision requiring the grantor to give advance notice to the trustee that the trust will be terminated. Finally, in the event that a trustee should resign or die, a provision may be included that allows for the substitution of trustees.

C. What Should a Receiver Do About Trust Funds

1. Cedent in Receivership

When a cedent is in receivership, the receiver should first identify all of the trust funds established in the cedent's favor and list them in accordance with the treaty collateralized and expiration dates. If any notices of termination have been issued on the identified trust funds pursuant to their termination provisions, these should also be listed.

The receiver should also ensure that he or she is empowered to remove assets from the trust funds if such removal is necessary to fulfill the reinsurer's obligations under the reinsurance agreements. Counsel should be consulted to confirm that the receiver has the power to remove assets and under what conditions assets can be removed, or if the receiver does not, such power should be immediately obtained from the supervisory court.

It is also recommended that a receiver notify each trustee that the cedent is in receivership, clearly identify the receiver, and take whatever steps are necessary in each case to ensure that only the receiver is empowered to remove assets from the trust funds that might otherwise be removed by the cedent.

The receiver should also communicate with each reinsurer on whose behalf a trustee holds a trust fund with the cedent as grantee so that each is aware that the cedent is in receivership. The receiver should assure each reinsurer that no improper removal of assets will occur. It should also be emphasized to the reinsurer that it must maintain the trust funds in accordance with the terms of the specific reinsurance agreement.

Once the receiver properly identifies all of the established trust funds and takes the necessary steps to solidify the receiver's powers with regard to them, the receiver must then manage the trust funds in order to protect the cedent's position by preserving its security. The receiver should ascertain the liabilities secured by the trust funds. If a trust fund is about to expire, and may leave outstanding obligations unsecured, the receiver should call upon the reinsurer to continue the expiring trust fund. If the reinsurer refuses to maintain the fund, counsel should be consulted on the appropriateness of removing assets from the trust fund to protect the cedent's position.

2. Reinsurer in Receivership

When a reinsurer is in receivership, the receiver must first identify the trust funds established on behalf of the reinsurer as grantor and list them in accordance with the agreements collateralized and expiration dates. If any notices of termination have been issued pursuant to the termination provisions of certain trust instruments, these should also be listed.

It is also recommended that a receiver notify each trustee that the reinsurer is in receivership, clearly identify the receiver, and confirm that only the receiver is authorized to give the bank instructions with respect to the trust funds, which would ordinarily be given by the reinsurer.

The receiver should also communicate with all cedents in whose favor a trustee holds a trust fund with the reinsurer as grantor so that each is aware that the reinsurer is in receivership. The receiver may assure each cedent that the trust funds will be maintained in accordance with the reinsurance agreement, although the receiver will probably be unable to comply with the demands for increases in trust funds or LOC balances due to the probability of creating an illegal preference. Occasionally, trust accounts and LOCs are in excess of amounts necessary to secure liabilities, and in cooperation with cedents, the receiver may be able to retrieve those excess amounts. The receiver should also take whatever steps are necessary to ensure that trust fund assets will not be improperly removed.

Once the receiver properly identifies all of the outstanding trust funds and takes the necessary steps to solidify his powers with regard to them, the receiver must then manage the trust funds in order to protect the reinsurer's position by preserving its assets. The receiver should ascertain the liabilities secured by the trust funds and guard against wrongful removal of assets by cedents. The danger that the assets will be wrongfully used to gain a preference on other, unsecured debts, should be addressed. The receiver can also protect the reinsurer's position by depositing any interest earned on the assets into the reinsurer's estate, assuming this power is consistent with the terms of the trust.

X. FUNDS WITHHELD

"Funds withheld" refers to an arrangement wherebythe fact that the cedent does not pay the premiums to the reinsurer; instead, the cedent "withholds" the premiums. Generally, this provision is only used with unauthorized reinsurers. The purpose of these provisions is to allow the cedent to reduce the provisions for unauthorized reinsurance in its statutory statement. The reinsurer's asset, in lieu of cash, is "Funds held by or deposited with reinsured companies." So in other words, the receiver will already have the funds under his exclusive control.

XI. INSOLVENT NON-UNITED STATES LICENSED REINSURERS

The estate may have ceded reinsurance with a non-United States licensed reinsurer[9] that is subject to a rehabilitation or liquidation proceeding in its domiciliary jurisdiction. In addition, that non-United States licensed reinsurer may also be subject to an ancillary proceeding under Chapter 15 of the United States Bankruptcy Code.

A. The Non-U.S. Proceeding

As in the United States, the non-U.S. proceeding may be either a rehabilitation, liquidation or equivalent (e.g., in the UK, there are voluntary arrangements, schemes of arrangement, and winding ups, among other mechanisms). In either event, particularly if ceded reinsurance is involved, the receiver should communicate with the non-U.S. receiver to ensure that the estate receives notice of the proceedings and is identified as a creditor. It will then be necessary to keep current with the proceedings to protect the interests of the estate. The procedures described in this chapter for dealing with ceded reinsurance will generally be applicable to these non-U.S. proceedings.

B. Chapter 15 Proceedings

Insurance receiverships are specifically excluded from the ambit of the U.S. Bankruptcy Code; however, the Code does have an influence on insurance issues in at least one important case: if an insurer purchased reinsurance from a non-U.S. reinsurance company, and that reinsurer has become insolvent.

Chapter 15 permits a representative of a non-U.S. proceeding to petition the United States bankruptcy court for relief and permits the court to: (a) enjoin proceedings against the non-U.S. licensed reinsurer, enforcement of judgments or the commencement or continuation of any action against the debtor; (b) order the delivery of the debtor's property to the representative; and (c) order other appropriate relief. Chapter 15 proceedings are limited in scope, do not commence a full bankruptcy proceeding, and confer broad discretion to the courts. Generally, following the adoption of a plan of rehabilitation or liquidation in the non-U.S. proceeding, the debtor requests the bankruptcy court to give full force and effect to that plan and make it binding and enforceable against all creditors in the United States.

Receivers should consider various approaches when faced with a Chapter 15 proceeding. A receiver should file a notice of appearance and request for service of notice to ensure that it receives copies of the filings made in the proceeding, including periodic status reports. Consideration should be given to participation on the creditors' committee if the amount due to the estate is material, and the expense and time to the estate justify participation. Evaluation of proposed schemes of arrangement may also need to be made to protect the interests of the estate. The estate should also continue to report claims as it did prior to the proceeding and should review and recognize any of its obligations under the existing agreements.

Chapter 15 of the Bankruptcy Code now states that a court may not grant relief under the chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable state insurance law or regulation for the benefit of claim holders in the United States. The purpose of the language is to make certain a bankruptcy court has no power over U.S.-based reinsurance collateral posted for the benefit of U.S. claimants.

[9] Also known as alien reinsurers.

CHAPTER 6 – GUARANTY FUNDS / ASSOCIATIONS

NOTE: ALL PAGE NUMBERS WILL BE UPDATED IN THE FINAL

I. INTRODUCTION

This chapter provides an overview of the operation of state Property and Casualty Insurance Guaranty Funds and the Life and Health Insurance Guaranty Associations and their relationship to a receivership. All 50 states, Puerto Rico, the United States Virgin Islands (property/casualty only) and the District of Columbia have a guaranty mechanism[1] in place for the payment of covered claims arising from the insolvency of insurers licensed in their state. In the case of life/health insurance, the guaranty mechanism also provides for the continuation of eligible contracts that would otherwise terminate because of the insolvency. Before the creation of guaranty association systems, policyholders might have waited years for payment of their policy claims and then receive only a small percentage of what was due under the policy or contract. Guaranty associations, subject to statutory limitations, alleviate these problems. Section II of this chapter will discuss in greater detail the operation of property/casualty guaranty funds. Section III is devoted entirely to life/health guaranty associations.

Insurance guaranty mechanisms obtain the funds necessary to pay claims from remaining estate assets, in some cases from statutory deposits collected by states, and by assessing member insurers. Assessments are limited by state law to a certain percentage of the members' written premium. In the case of property casualty guaranty funds, the members may be permitted by statute to recoup the assessments through premium increases, premium tax offsets or policy surcharges. As for the life/health guaranty associations, recoupment of assessments through premium increases or policy surcharges is typically not feasible because many life/health contracts are issued on a level premium basis.[2] The burden of the assessments on solvent insurers is mitigated in the majority of states, by statutes that allow insurers to offset a portion of the insurer's assessments, over a period of years, against the insurer's premium tax liability. Section 13 of the NAIC's Life and Health Insurance Guaranty Association Model Act (the "Life Model Act"), some version of which has been adopted in most states, permits offsets against premium, franchise or income taxes over a five year period for amounts paid by life/health insurers to meet their assessment obligations. In addition, Section 9G of the Life Model Act allows life/health insurers to consider the amount reasonably necessary to meet their assessment obligations in the determination of the premiums they charge.

Guaranty associations (both life and health and property and casualty) in most states are overseen by a board of directors, largely composed of representatives of member insurers. Some guaranty association boards also include public members. A minority of guaranty associations also have representatives of state departments of insurance or legislative representatives sitting on the guaranty association's board. The guaranty associations typically employ a Manager, Administrator or Executive Director to oversee daily operations.

Before a claim against an insolvent insurer can be considered a "covered claim" and eligible for guaranty association coverage, the guaranty association must be "triggered" with respect to the particular insolvency. Guaranty associations generally are triggered by the issuance of a court order of liquidation with a finding of insolvency. Some guaranty associations may be triggered under other circumstances. In the event of a multi-state insolvency, it is important that the receiver communicate and coordinate with NOLHGA or NCIGF, as appropriate, before preparing an order of rehabilitation or liquidation. This will ensure that guaranty associations are triggered as intended, and are not triggered prematurely or inadvertently. NOLHGA and NCIGF have the ability to help with coordination and communication with affected guaranty associations.

The guaranty associations and the receiver both have statutory duties to protect policyholders of the insolvent insurer. The duties of the guaranty associations to protect policyholders are limited to covered policies or claims, as set forth in state guaranty association statutes. The guaranty associations can be very helpful, if not critical, to the receivership process. In a life/health insolvency, for example, the guaranty associations may, in some cases, be

[1] The term "guaranty fund" typically refers to a property and casualty insurance guaranty fund. The term "guaranty association" typically refers to a life and health insurance guaranty association. However, in various places throughout this handbook, the terms "guaranty fund" and "guaranty association" are used synonymously, particularly when referring to both types of guaranty mechanisms. Efforts have been made in this chapter to specify property and casualty or life and health when referring specifically to one or the other type of guaranty mechanism or insurer insolvency proceeding.

[2] A few states do permit policy surcharges to recoup assessments for health insurance insolvencies.

able to arrange for and facilitate transfer of covered obligations to a solvent insurer upon entry of an order for liquidation with a finding of insolvency, provided there has been sufficient pre-liquidation planning and coordination.[3] Maintaining open communication and cooperation between the guaranty associations and the receiver (subject to appropriate confidentiality agreements) during pre-receivership planning and throughout the course of the proceedings will enable both the guaranty associations and the receiver to function more efficiently for the benefit of those whose interests they are obligated to serve.

II. PROPERTY AND CASUALTY GUARANTY FUNDS

A. Introduction

Most property/casualty guaranty fund enabling acts are based on the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act (Model Act). Although the Model Act is useful for a better understanding of how guaranty funds operate, the law in each state should be consulted, as most states have modified provisions of the Model Act.

The property and casualty guaranty funds have formed an organization known as the National Conference of Insurance Guaranty Funds (NCIGF). Its address is:

National Conference of Insurance Guaranty Funds
300 North Meridian Street
Suite 1020
Indianapolis, IN 46204
Phone: (317) 464-8199
Facsimile: (317) 464-8180
Web site: http://www.ncigf.org

NCIGF can be a useful source of information to receivers when a new property/casualty insolvency occurs. It can help disseminate information to triggered guaranty funds, schedule initial meetings between the receiver and guaranty funds, and establish a coordinating committee to work with the receiver to resolve issues that may arise during the receivership. This organization can also provide names and addresses of guaranty fund contacts and assistance in establishing data reporting to and from the guaranty funds. The Secure Uniform Data Standards (SUDS) is managed by the NCIGF and has become the standard mechanism to transfer data in a secure manner. (See supra for more information on UDS and SUDS.)

The NCIGF Web site (See at http://www.ncigf.org) has tables that summarize the key provisions contained in each state's property/casualty guaranty fund enabling act, including lines of insurance covered, whether coverage is provided for unearned premium, whether the guaranty fund has net worth limitations or a claims bar date and the per claim limit and deductible that applies to each claim. The tables are intended to provide a general summary of the guaranty fund laws. The applicable state statute should be reviewed to determine coverage for a specific claim.

B. Triggering Fund Liability See Chapter 1(II) (G) (4)

1. General Statutory Activation Requirements

Previously, the Model Act defined insolvent insurer as "(a) an insurer authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and (b) determined to be insolvent by a court of competent jurisdiction." Due to a variety of triggering related issues that could not be readily resolved by such a general, simplistic definition, amendments to the Model Act expanded the definition of "insolvent insurer" to read as follows:

[3] In some instances, it is possible to arrange for the transfer to close as of the effective date of the liquidation order.

> "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

This amended language makes it clear that guaranty fund resources are only to be used in situations where any doubt pertaining to the insurer's insolvent status has been fully considered and resolved by a judicial proceeding. It must be noted, however, that there are a number of variations found within enacted guaranty fund statutes around the country. While many jurisdictions have either adopted or moved toward the current Model Act triggering test, there are numerous others that fall at various points along the spectrum between the current version and the original 1969 version. It is imperative that the statutes be carefully reviewed in each jurisdiction where activation is anticipated.

2. Regulatory Status of Company

In addition to being declared insolvent, an insurer must have been "licensed," either at the time the policy was issued or when the loss occurred, to be eligible for guaranty fund coverage.[4]

New Jersey has a separate statutory mechanism for the payment of covered claims arising in connection with coverages issued by eligible surplus lines insurers. This mechanism exists in addition to the guaranty fund for insolvent licensed property and casualty insurers. Even in New Jersey, however, there is no statutory protection for ineligible surplus lines insurers.

The initial triggering inquiry must not be limited to whether the insurer in question was licensed at the time of the finding of insolvency.[5] Many, probably most, guaranty fund acts contain language that is sufficiently broad to include claims against an insurer whose license has been surrendered or revoked prior to the declaration of insolvency, so long as the insurer was licensed at the time the policy was issued or when the insured event occurred. When this situation arises, the receiver should contact the relevant guaranty fund as it will be most familiar with its enabling statute and local court decisions interpreting the statute.

3. Court of Competent Jurisdiction

The requirement of a finding of insolvency can only be satisfied by a judicial declaration. The rationale for this requirement is that activation triggers numerous consequences, many of which are irreversible once put in motion. Judicial review is perceived to be an effective safeguard against arbitrariness and ambiguity.

The current version of the Model Act gives exclusive competent status to the court that is within the insurer's state of domicile. Although it is theoretically possible for a court in another jurisdiction to be viewed as competent for the purpose of triggering guaranty fund obligations, the Model Act's current version does not confer jurisdiction on these courts.

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[4] In this context, "Licensed" means holding a Certificate of Authority, which authorizes an insurer to do business in a state. Such insurers are also referred to as "admitted insurers." Insurers doing business on a surplus lines or other non-admitted basis are not authorized.

[5] At the time of publication of this Handbook, the NAIC is considering "restructuring mechanisms" permitted under the laws of some states (i.e., insurance business transfers and corporate divisions). Whether claims of an assuming or resulting insurer in one of these transactions would be considered "covered claims" eligible for guaranty fund coverage in the event of its liquidation is a question of state law. NCIGF is working with the NAIC to address this issue and provide clarity going forward.

4. Liquidation Order

Were a court of competent jurisdiction to issue a declaration of insolvency that is later modified or reversed on appeal, after guaranty funds have been triggered and claim payments have been initiated, problems can arise. To remedy such consequent dilemmas, both the Model Act and many state legislatures have modified the triggering test, requiring that the judicial declaration of insolvency be final. In other words, activation of guaranty funds in such jurisdictions can be deferred, and perhaps avoided, depending upon the pursuit or exhaustion of stays or appellate remedies.

Nonetheless, although the Model Act drafters clearly contemplated that activation of the guaranty funds would occur only where liquidation had been ordered, the wording of the initial triggering clause left open the possibility that companies placed in rehabilitation could trigger guaranty fund benefits. The more current view, which has also been incorporated in the Model Act, is to require not only a final determination of insolvency, but rather an actual order of liquidation with a finding of insolvency. This limiting language precludes the use of guaranty fund resources as bail-out funds to be used in an attempt to rehabilitate—rather than liquidate—the company. There are a few guaranty funds, however, which still trigger with a finding of insolvency without an order of liquidation. Because of the complexity and variation from state to state of the trigger, it is important to seek legal assistance and to work with the NCIGF when drafting the orders of liquidation or rehabilitation to ensure the appropriate activation of the guaranty funds. (See the Laws and Laws Summaries under Resources on the NCIGF Web site at http://www.ncigf.org).

C. Scope of Coverage

Guaranty funds that have been properly triggered by a liquidation order are obligated to pay "covered claims," that is, claims that are defined as covered under the applicable guaranty fund act(s). Generally speaking, unpaid loss and unearned premium claims under specified property/casualty lines of business written by an insolvent insurer are covered claims, but only to the extent of the lesser of either (1) the applicable policy limits; or (2) the statutory guaranty fund limits on covered claim payments. Residency is usually determined at the time of the insured event. In addition, in order for claims to be covered, the various acts typically require that: the claim be incurred either prior to the entry of the liquidation order or within 30 days of the entry of the order, or before the policy expires or the insured replaces the policy if either of the latter occurs within 30 days of the entry of the liquidation order. Claims of an affiliate of the insolvent insurer typically are not covered, even if such claims otherwise meet the definition of covered claims.

Property/casualty lines of business usually not covered by a guaranty fund include: mortgage guaranty; financial guaranty; fidelity and surety; credit insurance; insurance of warranties or service contracts; title insurance; ocean marine insurance; and any insurance provided by or guaranteed by government. Only direct insurance (not reinsurance) is covered. The receiver should consult with the affected guaranty fund(s) to determine which lines are covered and which lines are excluded.

Usually the guaranty fund of the state of the insured's residence has primary responsibility for a claim, and the guaranty fund of the state of the claimant's residence has secondary responsibility. One exception to this rule involves workers' compensation claims. The guaranty fund of the state of residence of the claimant has primary responsibility for these claims. With respect to claims involving property with a permanent location, the guaranty fund of the state where the property is located has primary responsibility. Guaranty funds are usually entitled to take credit for amounts paid by other guaranty funds on the same claim.

Some guaranty fund statutes provide for a per claim deductible. A majority of guaranty fund statutes provide that coverage is limited to $300,000 per covered claim, except for workers' compensation claims, which are covered to the extent of benefits provided by state law.

Most guaranty fund statutes require a claimant to first exhaust all other sources of recovery, including other insurance. The guaranty fund's obligation is reduced by any amounts recovered from other sources.

The majority of the property casualty guaranty funds' enabling acts contain "net worth" limitations. These net worth limitations either exclude high net worth insureds (and in a few cases, third party claimants) from coverage in the first instance or permit the guaranty fund to recover from the high net worth insured amounts paid on their behalf.

Most of the guaranty funds' enabling acts also require the claim to be timely filed either with the liquidator or the guaranty fund. Bar date restrictions vary from state to state and specific state law should be reviewed on this matter. See Section D (3) for more information regarding bar dates.

D. Notice and Proof of Claims

1. Notice

a. Notice to Claimants

Most state receivership statutes give the receiver the primary responsibility for issuing notice to all persons known or reasonably expected to have claims against the insolvent insurer. The guaranty funds have a secondary responsibility in this regard under the Model Act. Because of the extensive interrelationship between the receiver and the guaranty funds regarding claims resolution, the receiver should coordinate the drafting of the receivership claims notice with the guaranty funds so that accurate information concerning the following is included:

- Brief general explanation of the guaranty fund system: the policyholder protection it offers, its anticipated role in the receivership and any delay that will be necessary while the receiver assembles and forwards the files to the guaranty funds.

- Receivership bar date and its legal significance: the fact that many guaranty funds will have no obligation regarding claims filed after the receivership bar date, recommendation to check with the appropriate guaranty fund immediately in order to ascertain whether the guaranty fund has a separate bar date in addition to the receivership bar date.

- Receivership proof of claim form: information, if available, about whether a separate guaranty fund proof of claim form may be required by certain participating guaranty funds; information concerning the address to which proof of claim forms must be sent.

- Clarification that questions regarding the claims determination process should be directed to the appropriate guaranty fund; include here any comments deemed necessary regarding the determination process for claims which are in excess of the statutory maximum coverage of the guaranty funds.

Insolvencies involving long-tail business present notice challenges to liquidators. Company records may not exist to provide addresses for occurrence based policyholders that were in force from 5 to 25 years ago. Public policy considerations confront the receiver.

A supplemental notice may also be used in situations where additional relevant information becomes available after the first notice has been sent.

b. Notice to the Guaranty Funds

The receiver must notify the guaranty funds that may become obligated as a result of the receivership as soon as possible. Even if such notice is not a statutory requirement, the receiver should notify all interested guaranty funds as a matter of courtesy. That notice should include a copy of the claimants' notice issued by the receiver, along with copies of the receivership order and any domiciliary injunction which has been entered. The regulator, receiver, and guaranty funds

should coordinate and share information well before the liquidation order is rendered. See Section E for more information in this regard.

2. Proof of Claim

a. Claims Determination Framework

Nowhere is the interrelationship between the receiver and the guaranty funds more prominent than in the area of claims determination. This relationship is defined by Section 11(3) of the Model Act that provides that the receiver shall be bound by settlements of covered claims by the guaranty funds. However, Section 703 A of the Insurer Receivership Model Act (IRMA) and many state receivership statutes contain provisions that prohibit the receiver from accepting any claim for an amount in excess of or contrary to the terms of the policy.

There has been uncertainty between guaranty funds and receivers as to who determines whether a claim is covered under the policy terms. The receiver and the guaranty funds should discuss questionable coverage issues as they arise in order to prevent subsequent problems.

b. Forms of Proof

The information to be contained in the proof of claim form is usually established under the receivership statutes in the insolvent insurer's state of domicile. However, some guaranty funds require that each claimant submits a separate proof of claim form, the contents of which will be dictated by the law and practice of the guaranty fund's state. This is because statutes creating the guaranty funds contain a series of specific eligibility requirements and limitations on allowability, each of which may require additional information in order to establish the fund's obligation. For this reason, the receiver should coordinate with the guaranty fund prior to any notification to potential claimants regarding the proof of claim form.

c. Protective Filings via Proof of Claim Forms

Many guaranty funds are not permitted to recognize general proofs of claim (intended as a protective filing for claims that are unknown to the insured at the time of filing) as sufficient notice. These guaranty funds require that specific claim information about known claims must be provided in the proof, including the date and other particulars relating to the insured event.

3. Late-Filed Claims

a. Rationale

Most receivership statutes contain a provision that requires claims to be filed by the claims filing date established by the liquidation court. See IRMA § 701. If a claim is filed after that date, it is usually not allowed or is subordinated to a lower distribution priority. In addition, many guaranty funds are not permitted to pay claims filed after the earlier of the claims filing date or a bar date established pursuant to the guaranty fund's enabling act.

The receiver may have the ability to allow policyholders to file "omnibus" or "policyholder protection" claims to meet the bar date requirements, but guaranty fund statutes may not allow coverage of such claims.

b. Extensions

Once a receivership's bar date has been established, guaranty funds generally take the position that the receiver should not extend the bar date, as such an extension may result in guaranty fund coverage issues.

c. Excused Lateness

Some receivership statutes provide a procedure for allowance of late-filed claims which authorizes the receiver to allow such claims under certain circumstances. See IRMA § 701. The receiver should consider claimant requests on a case-by-case basis, through the specific mechanism established in the receivership statutes. The receiver should also consider giving notice to those guaranty funds that may be affected prior to allowing a late-filed claim in order to provide those guaranty funds the opportunity to address how allowance of the claim would impact them.

E. Claim Files Information

1. Information Needed by Property and Casualty Guaranty Funds

The key to the successful handling of filed claims is cooperation between the receiver and the guaranty funds throughout the claim process. Receivers should keep in mind that the guaranty funds require reasonable access to those insurer's records which are necessary for them to carry out their statutory obligations.

Recent experience has shown that pre-liquidation coordination and information exchange are essential for the smooth transition of claims servicing responsibilities to the guaranty funds without disrupting ongoing benefit payments. Regulators, receivers and guaranty funds should coordinate and communicate, even if liquidation of the company is not a certainty. A "two-track" approach is recommended. While efforts continue to revitalize the company, the receiver and the guaranty funds should also be taking steps to ensure a smooth transition to liquidation if liquidation becomes necessary.

The receiver's cooperation in providing information and making files available to the guaranty funds is essential to minimize claim interruption. More specifically, the receiver should locate and forward to the involved guaranty funds the following information (See § 405 of IRMA):

- A general description of the business written or assumed by the insurer;
- Information concerning licensure of the insurer;
- Claim counts and policy counts by state and line of business;
- Claim and policy reserves;
- Unpaid claims and amounts;
- Sample policies and endorsements;
- Listing of locations of claim files;
- Listing of third party administrators, description of contractual arrangements and copies of pertinent executed contracts;
- Listing of claims in litigation or dispute and assigned defense counsel; and
- Such other information as may be needed by the guaranty funds.

Please note, loss adjustment expenses incurred prior to the liquidation order are not covered by guaranty funds, and therefore, should not be sent to the guaranty funds for payment.

2. Claim Files

To facilitate the protection of policyholders and claimants; regulators, receivers and guaranty funds should coordinate transition of claim files well before the company is liquidated. The receiver should forward claim files as soon as possible to the appropriate guaranty funds. Some guaranty funds may require access to or copies of the filed proof of claims forms. Receivers and guaranty funds should consider entering into agreements as to ownership, return of files, auditing rights, inventory controls and reporting.

Most company claim records are held in electronic format. It is essential to address data conversion to Uniform Data Standards (UDS) well before the guaranty funds are triggered. (See chapter 2 of this handbook.) If there are non-electronic claims records, UDS records will need to be prepared.

Priority should be given to identifying and forwarding all active workers' compensation files and all active files where major litigation or settlement is imminent.

Determination of which guaranty fund should be the recipient of a particular file will depend on a series of factors. Generally, the receiver should deliver the file to the guaranty fund of the insured's place of residence. However, if it is a first-party claim for damage to property with a permanent location, the receiver should deliver the file to the guaranty fund where the property is located. In most instances, if it is a worker's compensation claim, the receiver should deliver the file to the guaranty fund of the state with jurisdiction over the claim.

Claim files sometimes are delivered to the wrong guaranty fund. In this situation, the preferable course of action is for the guaranty fund that received the file to secure from the appropriate guaranty fund their concurrence. After that, either fund will ask the receiver to resend the UDS record to the appropriate guaranty fund or will notify the receiver if the receiver does not make the actual UDS records transfer. The receive will let the parties know if it prefers the original fund to close the file or to report the transfer with UDS "C" record with transaction code "080". See the UDS Manual[1] for additional information. NCIGF can assist in cases where a high volume of files needs to be transferred.

In multi-state insolvencies receivers and guaranty funds should work together on protocols for transmitting files to the appropriate guaranty fund.

F. Unearned Premium Claims

Although most guaranty funds cover unearned premium claims, some do not (see the NCIGF Web site at http://www.ncigf.org at the Guaranty Fund Laws tab for unearned premium coverage by state). For those states where unearned premium is covered, the receiver should prepare and disseminate the necessary calculations as soon as possible. This will allow guaranty funds to make timely refunds to enable the insureds to make arrangements for replacement coverage.

To make payments possible, guaranty funds will need the following information for each potential claimant: policy identification, insured name and address, policy periods and expiration dates, cancellation date, current payment status, and the amount of the unearned premium. If possible, this information should be provided by the receiver by Uniform Data Standards (UDS) B Record. (The initial B Record may not have the calculation but will advise of the "potential" claimants. A subsequent B Record would provide the calculation/audit.) In addition, the receiver should forward to the guaranty funds a general explanation clearly showing how the unearned premium was calculated. The calculations should be on a pro rata basis rather than short-rated. The information should be as accurate as possible, given the state of the insurer's records, and should be accompanied by the receiver's initial evaluation of the information's reliability.

The receiver should be prepared to provide a sampling of the insurer's records and the receiver's calculations to demonstrate the reliability of the unearned premium figures to guaranty funds. Where agents

have advanced unearned premium to the insureds in exchange for valid legal assignments, the receiver and guaranty fund should coordinate their positions on acceptability.

It should be kept in mind that where the insured's return premium claim is based on a premium audit or retrospective rating plan, it may not be covered by some guaranty funds. Additionally, net worth limitations embodied in a number of guaranty fund acts may preclude payment of unearned premium claims to certain high net worth insureds.

Premium financing arrangements often create special problems for the affected guaranty funds in processing return premium claims. If the receiver has information concerning premium financing arrangements, the receiver should provide that information to the guaranty funds to facilitate payment of returned premium to the appropriate person or entity.

G. Claim Reporting

How guaranty funds report claims and expense payments, outstanding reserves and administrative expenses to a receiver is an item of concern in every insolvency. This reporting is not only important for the guaranty funds as a creditor, but it also assists the receiver in gathering what is usually the major asset in most receiverships—reinsurance recoverables.

The NAIC in December 1993, adopted the UDS to be used for the reporting of policy and claim information between guaranty funds and receivers. UDS was the result of a joint effort of a number of receivers and guaranty funds to facilitate (1) reporting between receivers and guaranty funds, and (2) reporting to reinsurers by the receiver. The use of UDS file formats to transmit information at the policy or claim level will provide both receivers and guaranty funds with needed information in a uniform, easily usable format. Currently, most guaranty funds and receiverships are able to send and receive information in the UDS format. (The NAIC endorsed the use of UDS by receivers and guaranty funds effective March 31, 1995. Most insolvencies instituted prior to that date did not use UDS, nor did they later convert to UDS.) It is very important to note that an Operations Manual exists, and should be reviewed and used by receivers and guaranty funds for understanding UDS. Version 2 of the UDS was adopted by the NAIC for implementation on Jan. 1, 2005. Version 2 includes many improvements and revisions based upon the collective experience of receivers and guaranty funds with the original version over several years and insurer insolvencies. In 2006, the NAIC adopted the Standardized Financial Report (D Record) for addition to the Uniform Data Standards. A copy of the updated UDS Manual and file formats are at the National Conference of Insurance Guaranty Funds (NCIGF) Web site at https://www.ncigf.org/resources/uds/.

It is important to remember that the earlier the receiver determines what information is needed, and communicates those needs to the guaranty funds, the better and more efficient the reporting process will be. UDS, through the implementation of several lettered record formats, has simplified the aforementioned receivers' requirements. The formats were designed by the UDSTSD (UDS Technical Support Group), a group comprised of members of the receiver and guaranty fund communities and approved by the NAIC.

As stated above, almost all claims data for the insolvent insurer will be in electronic format. Security concerns are paramount. The NCIGF addresses the security concerns with a system called the UDS Data Mapper. Using the Mapper, the receivers can map raw data to, or fully created UDS files to UDS record fields in a database. The Mapper will then create new UDS files to be placed in the guaranty funds' SUDS directories. This process has the dual benefit of ensuring UDS compliance and scrubbing the data of any unknown malicious code. This service is available at no charge to the receiver.

Recent estates with significant reinsurance recoveries have found it useful to also develop claims protocols setting out additional information that is needed for reinsurance recovery purposes and dealing with other matters such as new and reopened claims and closed files. Needed information often extends beyond that which can currently be provided by UDS data feeds. Some guaranty funds have agreed to give receivers

limited, read-only access to their claims database. Assistance from the UDSTSG can also be found by submitting a help request to help@udstsg.org.

H. Claims Exceeding Guaranty Fund Limits and Aggregate Claims

1. Claims Exceeding Guaranty Fund Limits or Claims Excluded from Guaranty Fund Coverage

Under the Model Act and state enabling acts, guaranty funds have per claim limits, or "caps," that can limit the guaranty fund's obligation to an amount less than the insolvent insurer's policy limits. For example, the amount paid in satisfaction of a covered claim (either non-workers' compensation or unearned premium) under the NAIC Model Act may not exceed $500,000 per claimant, even if the actual policy limits are greater. The caps vary among the states and the receiver must review applicable state guaranty fund acts. Here, the interrelationship between the guaranty fund and the receiver becomes critical (i.e., both act to pay or determine claims made against the insolvent insurer arising under the same policy and are eventually allowed against the insolvent insurer's estate).

The guaranty fund has a claim against the insolvent insurer's assets for the amounts paid as indemnity and the expenses and costs of handling the claims it pays. Furthermore, anyone with a claim over the guaranty fund's cap, subject to a guaranty fund deductible or subject to a statutory net worth exclusion has a claim against the estate for that portion of the claim not covered by the guaranty fund. From this perspective, the role of the guaranty fund and the receiver are not easily distinguishable. The guaranty fund is concerned with determining and paying its covered claims obligations under its statute while the receiver is determining how much of the claim should be allowed as a claim in the receivership. As a result, whenever a covered claim is filed in excess of the cap, it gives rise to a situation where extra effort and cooperation between the guaranty fund and the receiver will be necessary.

It should be noted here that, in some states, the guaranty fund will not settle a claim without a complete release, which may require participation by the receiver prior to any settlement. In some cases, however, the guaranty fund may pay the claim up to its statutory limit, leaving the excess to be paid by the insured, who will then retain a claim against the estate for the excess amount. Where the insured is unwilling or unable to pay the excess, the claimant may have a direct claim against the estate for the unpaid amount. In either instance, there is a portion of the claim above the cap that is left unsatisfied by the guaranty fund's payment. After approval by the receiver, the "over-cap" claim, as other allowed claims, will be paid as part of a distribution, pursuant to the applicable priority statute.

There may be other situations where the guaranty fund and the receiver will both have an interest in handling a claim. For example, where a claim includes allegations of bad faith or seeks punitive damages, the claim would not be covered by the guaranty fund but may be a claim in the estate.

The successful handling of over-cap claims is dependent upon early communication between the guaranty fund and the receiver. To prevent, or at least minimize, potential conflicts between the guaranty fund and the receiver regarding the payment of over-cap claims, full disclosure, communication and cooperation between the guaranty fund, the insured and the receiver's claims department must begin as soon as it is determined that an over-cap claim may exist. Prior agreement with the receiver should be obtained, where possible, on the amount of the over-cap claim. The guaranty fund has no authority to settle the claim in excess of its limit, and without the consent of the receiver, the claimant or insured (if paid by the insured) is taking a risk that all or a portion of the over-cap claim may be denied by the receiver. In fact, arranging to have the over-cap claims allowed as a claim in the estate may provide the needed leverage to settle the claim.

Receivers and guaranty funds have found it useful to develop specific procedures for dealing with claims where the cap will be exceeded and including such procedures in the claim protocols described above.

2. Aggregate Claims

Certain types of policies are often written on an aggregate basis. Aggregate policies may be in terms of a policy aggregate, a coverage aggregate, or both. In a policy aggregate, all claims are accumulated until the maximum limit of liability is reached. A coverage aggregate is one where claims against a specific coverage, such as products liability, are accumulated until the maximum coverage limit is reached. When an insurer is solvent, it monitors the erosion of all of its outstanding policies—in other words, the insurer keeps track of how much of a policy's aggregate limit is left as various claims under it are satisfied.

When an insurer is declared insolvent, and one or more guaranty funds begin to satisfy claims against such aggregate policies, problems can arise. The most obvious problem occurs when a guaranty fund paying claims under a policy is not aware that the policy has an aggregate limit. The receiver should take special care to advise the guaranty funds which policies are subject to an aggregate limit. The receiver should not assume the guaranty funds will discover this information on their own.

It is equally important that the receiver and the affected guaranty funds work together to monitor the erosion of aggregate limits. The receiver should advise the affected guaranty funds of claims that have been paid under the policy by the insurer before insolvency and track payments made by the guaranty funds after insolvency. Similarly, guaranty funds should not pay a claim under an aggregate policy prior to coordinating with the receiver. When the aggregate limits are close to being exhausted, the receiver should alert the guaranty funds and require that they obtain prior approval on any payment against such policy. See IRMA § 706 D.

The following example should help illustrate the problem. Assume that there is a products liability policy with an aggregate limit of $2,000,000. Assume further that there are 10 claimants filing claims under the policy with 10 separate guaranty funds. If each guaranty fund has a cap of $300,000, but is unaware of the other claims, then potentially, payments totaling $3 million could be made, thereby exceeding the aggregate limit. In this situation, regardless of the original extent of an individual guaranty fund's knowledge of a policy's aggregate nature, it cannot independently keep track of the policy's erosion. In situations like this, it is critical that the receiver monitor each guaranty fund's activity closely and keep all affected guaranty funds apprised of the situation as it develops.

When adequate safeguards are not in place, payments may be made in excess of a policy's aggregate limit and conflicts will arise between the receiver and the guaranty fund. Although the guaranty fund may have made the payment in good faith and within its statutory guidelines, the receiver may feel compelled to deny reimbursing the guaranty fund for that portion of the claim in excess of the aggregate limit. These problems are sometimes not discovered until long after the guaranty fund has settled all of its claims. To avoid such problems, the guaranty funds should not pay a claim covered by an aggregate policy without first consulting the receiver. State liquidation acts vary on the handling of estate distributions for amounts paid in excess of aggregate caps. These laws should be carefully reviewed in dealing with these matters. Section 706 D of IRMA addresses policies with aggregate limits and provides that the liquidator may apportion the policy limits ratably among timely filed allowed claims or notify the insured, third party claimants and affected guaranty funds of the erosion of the aggregate limit.

In summary, upon taking control of the estate, it is recommended that the receiver institute the following procedures:

- Determine which policies have aggregate limits;
- Determine policy erosion and continue to monitor aggregate accumulations resulting from payments made by guaranty funds;

- Advise guaranty funds of these policies and keep them apprised of any pre- and post-insolvency erosion;

- Require guaranty funds to determine how much of the aggregate limit remains available before making any settlements under these policies;

- As soon as it appears that the aggregate limit is about to be reached, notify the guaranty funds immediately that all future settlements should be cleared with the receiver;

- Require guaranty funds to immediately report to the receiver any paid or settled claims that affect aggregate limits; and

- Initiate a system that can earmark pending settlements. One of the benefits of the UDS is that it facilitates the tracking of policies subject to aggregate limits (See the Publications tab of the NCIGF Web site at http://www.ncigf.org).

I. Early Access

Most state receivership statutes contain a provision that requires the receiver to submit to the court a proposal to disburse general assets to guaranty funds. Such proposals are commonly referred to as "early access plans," and apply equally to life and health and to property and casualty insolvencies. The statutes typically contain provisions specific to both.

The purpose of an early access plan is to distribute funds from the estate to the guaranty funds as soon as possible and in the maximum amount possible in order to reduce the assessment burdens on member companies. Early access distributions are essential to the guaranty funds' continued ability to fulfill their statutory duties. See IRMA § 803.

1. Timing

   The standard early access provision requires that the receiver submit an early access plan within 120 days of entry of the liquidation order. IRMA requires that the receiver apply to the receivership court for approval to make early access distributions, or report that the receiver has determined that there are not sufficient distributable assets to make any distribution to the guaranty funds at that time, within 120 days of entry of the liquidation order, and at least annually thereafter. See IRMA §803 B. In practice, in order for the receiver to make the calculations necessary to demonstrate to the court that there are insufficient assets at that time to make any distribution, receivers should formulate an early access plan and file the form of the plan within the 120-day period for approval by the court. This procedure will fulfill the receiver's statutory obligation for filing a plan and will ensure that a plan is in place to make distributions when assets become available.

2. Reserves

   Most early access provisions in state receivership statutes require an early access plan to include, at a minimum, reserve amounts for the expenses of administration and the payment of the higher priority claims. See also IRMA §803 A(2). The reserve for expenses should take into account all administrative expenses anticipated to be incurred during the duration of the receivership proceeding. (See specific state statutes to determine if guaranty fund administrative expenses are Class I or Class II; see also IRMA §801 A & B.) The reserve for receivership expenses and for other claims that are at a higher priority than the guaranty funds' claim payments need not, however, be reserved 100% out of current liquid assets of the estate, as long as there are sufficient non-liquid assets that will be liquidated during the course of the receivership proceedings to cover those claims. The receiver should reserve a portion of the liquid assets to cover receivership expenses that will become due in the near term and prior to the liquidation of other non-liquid assets.

It may be difficult for the receiver of some estates to accurately determine the amount of policyholder claims not covered by the guaranty funds. An absolute determination of the amount is not necessary for purposes of the plan, however, as an estimate for calculation purposes is all that is needed. This estimate will be updated from time to time, and any overpayment to guaranty funds must be returned to the receiver. This "claw back" requirement is mandated by Section 803 F of IRMA and should be included in any written agreement between the receiver and the guaranty funds.

3. Liquid or Distributable Assets

Most early access agreements provide for payments from distributable assets, which generally means cash and cash equivalents, less reserves for Classes I and II. In developing early access plans, it is anticipated that the receiver will liquidate non-liquid assets as soon as economically prudent.

The receiver, however, is not required to increase liquid assets for purposes of the plan by making forced or quick sales of non-liquid assets that result in obtaining less than market value. In other words, receivers are not expected to hold "fire sales" in order to generate liquid assets for distribution as early access. It is in the interest of all creditors, including the guaranty funds, for the receiver to attempt to obtain full value for the estate's assets. On the other hand, where an asset can be sold at a fair market price, the receiver should consider liquidating the asset in order to generate early access funds and thereby reduce the assessment burden on solvent insurers and their policyholders. The public policy behind maximizing the value of estate assets and reducing assessment burdens on guaranty funds through early access distributions sometimes conflict and special understanding and cooperation between the receiver and the guaranty funds is necessary to resolve this conflict amicably.

Liquid assets do not include real estate, the book value of a subsidiary, assets pledged as security, special or general deposits held by other states that are unavailable to the receiver, or any assets over which the receiver does not have complete control.

4. Early Access Agreements

Any payment to be made under the provisions of an early access plan typically is conditioned upon the guaranty fund executing and returning an early access agreement to the receiver., IRMA obviates the need for an agreement by incorporating the key provisions of a typical agreement in the statute; however, currently, only a small minority of states have adopted this IRMA provision. In the context of a property and casualty insolvency, such agreements include provisions requiring the guaranty funds to:

- Submit to the exclusive jurisdiction of the receivership court, but only for the purpose of the early access plan;

- Return to the receiver any previously disbursed assets, plus interest if applicable, that are required to pay claims that are of an equal or higher priority; no bond shall be required of any guaranty fund. See §803 F of IRMA; and

- Periodically report to the receiver: all amounts paid by the guaranty fund on claims to date; the amount of expenses entitled to priority that have been paid by the guaranty fund; the reserves established by the guaranty fund on open claims; the amounts collected by the guaranty fund as salvage or subrogation recoveries; the amounts collected by the guaranty fund from any state deposit; and other information needed by the receiver. See §803 B of IRMA; UDS is the platform commonly utilized by the property and casualty guaranty funds for the transfer of this data. See Chapter 2 for a broader discussion of UDS.

Calculations and distributions by the receiver should be done at least annually; however, in instances where the guaranty funds are reporting on a quarterly or more frequent basis and sufficient assets are

available to make distributions, the receiver may consider making distributions on a more frequent basis.

5. Expenses

Early access plans typically contemplate that the guaranty funds should receive prompt reimbursement of their administrative expenses. The calculation of liquid assets available for distribution as early access should be made after payment of all incurred receivership and guaranty fund administrative expenses.

Certain categories of guaranty fund expenses may or may not be included in the administrative expense priority class. Therefore, it is necessary to consult the applicable statute to determine appropriate treatment.

In a case where there is disagreement between the receiver and guaranty funds concerning the priority of particular guaranty fund expenses, it may make sense to make administrative expense distributions under a reservation of rights, clearly specifying that the priority of certain expenses was a matter of dispute and that such payment does not preclude the receiver from later challenging the priority of particular expenses. Dealing with the issue in this manner ensures that the guaranty funds receive maximum distributions early in the proceeding—when the need for cash can often be critical. Resolution of expense classification issues, which may involve protracted discussions or even litigation, can be conducted while the funds have the necessary cash to pay claims.

6. Basis of Distribution

Most early access statutes provide that distributions to guaranty funds will be based on claims paid and to be paid by the guaranty funds. Some states, however, have based distributions solely on paid claims. In states that follow the reserve language, early access should be based on both paid claims and reserves. This permits a more equitable distribution of assets among the guaranty funds instead of benefiting guaranty funds that make claim payments at an early stage of the receivership proceeding (e.g., a state that has mostly workers' compensation claims). See §803 A(2)(c) of IRMA.

7. Special Deposits

Early access plans typically take into account state deposits by excluding such assets from the calculation of liquid assets available. Similarly, the plans typically take into account payment to guaranty funds from general or special state deposits by essentially treating such payments as prior early access distributions, thereby reducing the early access distribution to those guaranty funds receiving state deposits. If after receiving early access distributions, a guaranty fund receives payment from a special state deposit, then the guaranty fund may be required to return all or part of the early access distribution. Most early access plans do not allow the receiver to take credit for a special or statutory deposit that has not been paid to or is unavailable to the guaranty fund. See § 803 G of IRMA.

8. Salvage/Subrogation

Historically, the majority of receivers have taken the position that salvage or subrogation recoveries collected by a guaranty fund, based on payments made by the guaranty fund, are the property of the guaranty fund. The recoveries are applied to reduce the net guaranty fund payment total that is the ultimate claim of the guaranty fund against the insolvent estate. These receivers accept reimbursement on a pro rata basis in instances where a guaranty fund has made a recovery that includes consideration of both pre-liquidation payment by the insurer and subsequent payment by the guaranty fund. Early access agreements will not be affected when receivers take this position.

A minority point of view is that salvage or subrogation recoveries by a guaranty fund become general assets of the liquidation estate, regardless of whether the payment on which the recovery is based was

made by the insurer or the guaranty fund. Specific language to address concerns may be needed in early access agreements when a receiver adopts this view.

J. Large Deductible Policies

In 2016, the NAIC adopted a white paper titled *Workers' Compensation Large Deductible* Study. The paper revisits and reconsiders issues raised in an earlier 2006 *Workers' Compensation Large Deductible Study.* The 2016 study provides valuable information about how large deductible policies work and special issues that can arise with their use.

As used in workers' compensation coverages, large deductible policies allow employers to retain a certain amount of claims risk, thereby reducing the cost of their workers' compensation coverage. Typically, these policies are administered by the insurer or a third-party administrator paying claims within the deductible and obtaining reimbursement from the insured employer. In the receivership context, where guaranty funds pay claims within the deductible, there is an issue as to the handling of the insured employer's reimbursement of payments within the deductible. That is, should the reimbursement be paid to the guaranty fund outside the receivership distribution scheme, or should the reimbursement be treated as an asset of the receivership estate subject to the claims of all creditors? Several states have provisions in place in their respective receivership statutes which provided that large deductible reimbursements should be paid directly to the guaranty fund outside the receivership distribution scheme.

Where the insolvent insurer wrote large deductible policies, the receiver should be mindful of this issue and should consult with the affected guaranty funds as soon as possible. The receiver should also review those states' guaranty fund statutes where the claims will be processed to determine whether claims within large deductibles are "covered claims" as defined in the appropriate guaranty fund act. Typically, claims under workers compensation policies will be covered. However, claims under policies for other lines of business may not be covered. The availability of guaranty fund coverage is to some extent dependent upon the specific language of the policy involved.

IRMA provides for a different treatment of large deductible collections. Under IRMA § 712, payments of such monies to the guaranty funds are treated as early access.

Under the *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) deductible recoveries are paid to the guaranty fund to the extent of their claim payments and are not considered early access distributions. Subsection B of this Guideline states, "Unless otherwise agreed by the responsible guaranty fund, all large deductible claims that are also "covered claims" as defined by the applicable guaranty fund law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty fund for handling." Refer to the Guideline subsection B for further discussion of deductible claims paid.

K. Coordination among Regulators, Receivers and Guaranty Funds

In 2005, the NAIC adopted a white paper titled Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System. The white paper addresses the various issues relating to communication and coordination among regulators, receivers and guaranty funds, and how the parties might better work together to protect consumers.[6]

[6] A copy of this White Paper may be obtained from the NAIC at: http://www.naic.org/store_home.htm
Phone: 816.783.8300; Fax: 816.460.7593; E-mail: prodserv@naic.org

III. LIFE AND HEALTH GUARANTY ASSOCIATIONS

A. Introduction

In 1970, the NAIC adopted the Life and Health Insurance Guaranty Association Model Act (the Life Model Act). Since 1970, the Life Model Act has undergone several major revisions. The most recent revisions to the Life Model Act were made in 2017 (the "2017 Amendments").[7] All 50 states, the District of Columbia and Puerto Rico have enacted guaranty association laws based on some version of the Life Model Act. (For summaries of the provisions in each state's guaranty association laws see the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) Website at https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

The Life and Health Insurance Guaranty Associations were created to protect certain policy, contract and certificate holders (and their beneficiaries, assignees and payees) from loss due to the insolvency or impairment of a member insurer. Life/health insurance guaranty associations pay benefits and continue coverage, subject to statutory limitations, either directly or through a third-party administrator. With early communication, information sharing and coordination between guaranty associations and receivers, the guaranty associations can work with receivers to help develop and put in place the infrastructure and solutions that may be able to provide for a seamless transition into liquidation, thereby avoiding unnecessary delays and disruptions, and maximizing protections for policyholders. Early coordination between the receiver and the guaranty associations will also help minimize confusion, avoid duplication of effort and lead to greater administrative efficiency and lower costs for both the receiver and the guaranty associations.

NOLHGA is a vital resource for receivers in multistate life/health insolvencies. NOLHGA, whose members are the life/health guaranty associations of all the states and the District of Columbia, collects and distributes information for its members and receivers. It performs analyses of various alternatives by which guaranty associations can fulfill their statutory obligation to protect policyholders and serves as the guaranty associations' national coordinating mechanism for resolving issues. Through its Members Participation Council, NOLHGA works with its affected member guaranty associations and the receiver to develop and implement plans for the disposition of covered claims and contractual obligations through, for example, assumption reinsurance or claims administration.

Ideally, the receiver and NOLHGA, on behalf of the guaranty associations, should commence planning and coordination efforts at the earliest practicable opportunity. As discussed in the NAIC's 2004 white paper on Communication and Coordination Among Regulators, Receivers and Guaranty Associations, cited in Chapter 1 of this Handbook and earlier in this Chapter, coordination and communication with guaranty associations should begin "no later than when a company is placed into rehabilitation, and in many cases, involvement even earlier will enhance consumers' protection and decrease costs of the insolvency to all stakeholders" subject to entering into a confidentiality agreement as appropriate. NOLHGA can be reached at:

National Organization of Life and Health
Insurance Guaranty Associations
13873 Park Center Rd., Suite 505
Herndon, VA 20171
Phone: (703) 481-5206
Web Site: https://www.nolhga.com

[7] All references in this chapter to the "Life Model Act" are to the 2017 version, unless otherwise specified. As of this writing, a majority of states had adopted or substantially adopted the 2017 Amendments, and further legislation is expected in additional states. It is always important, however, to check individual state statutes for variations from the Life Model Act in actual cases.

B. Triggering Guaranty Associations

1. "Insolvent" Insurers

Under the Life Model Act, guaranty associations are triggered when a member insurer is determined to be an "insolvent insurer," as defined therein, i.e., it has been placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency. A member insurer is defined in the Life Model Act as "an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn…." Certain types of insurers are excluded from the Life Model Act definition, such as fraternal and mutual assessment companies.

The 2017 Amendments added health maintenance organizations ("HMOs") as member insurers and extended guaranty association coverage to HMO products.[8] At the time of this Handbook update, the 2017 Amendments had been largely adopted in 40 states, resulting in coverage for HMOs in the vast majority of states, and legislation to adopt the 2017 Amendments was pending or expected to be introduced in additional states. State guaranty association laws should be consulted to determine whether HMOs are member insurers for purposes of guaranty association coverage in a given state.[9]

2. "Impaired" Insurers

Under the Life Model Act, a guaranty association may act in its discretion if a member insurer is "impaired," subject to certain conditions and limitations. An insurer is an "impaired insurer" as defined in the Life Model Act, if it has not been declared insolvent but is under a court order of rehabilitation or conservation. In such situations, the Life Model Act provides that the guaranty association may, in its discretion and subject to any conditions imposed by the guaranty association that do not impair the contractual obligations of the impaired insurer, and that are approved by the Commissioner, take certain actions to provide protections to policyholders of the impaired insurer. However, the primary purpose of the guaranty associations is to protect policyholders, not to bail out impaired or insolvent insurers so that they can continue as going concerns. Guaranty associations, therefore, have traditionally been extremely reluctant to trigger before entry of a final order of liquidation with a finding of insolvency, particularly in the case of a multi-state receivership.

3. Uniform Triggering

Because the life and health insurance guaranty associations continue coverage under policies and have responsibility for administration of the business upon triggering, the uniform triggering of guaranty associations across affected states is very important. However, there can be subtle variations among some state guaranty association laws which could potentially impact uniform triggering. Coordination with guaranty association representatives and NOLHGA (in multistate insolvencies), as early as possible and, subject to appropriately executed confidentiality agreements, before a petition for receivership is filed will help to reduce the risk of complications in regard to guaranty association

[8] Historically, a few states had stand-alone guaranty funds for HMOs that were separate from the life and health guaranty associations. The nature and scope of such stand-alone guaranty funds for HMOs varied from state to state. With the wide adoption of the 2017 Amendments, fewer stand-alone guaranty funds for HMOs remain.

[9] The NAIC state adoption map shows status of states' adoption of these amendments. Refer to individual state laws for specific language adopted in each state. https://content.naic.org/sites/default/files/smi_state_adoption_maps_models.pdf.

triggering. For individual state provisions, see the NOLHGA Web site (https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo).

C. Scope of Coverage

1. Covered Policies and Limits of Coverage

Guaranty associations were created to provide a limited, but substantial safety net to protect policyholders from loss as a result of the impairment or insolvency of a member insurer. Under the Life Model Act, the following coverages are provided:[10]

- Life insurance: $300,000 in death benefits, but not more than $100,000 in net cash surrender and withdrawal values, per life. In the case of corporate-owned or bank-owned life insurance, however, overall benefit coverage is capped at $5,000,000 per owner.

- Health insurance: i) $500,000 in benefits for health benefit plans, which are defined to include "any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract", subject to certain enumerated exclusions. The term "health benefit plan" which was introduced in the 2017 Amendments, replaces the prior reference to basic hospital, medical and surgical insurance and major medical insurance, and includes coverage under HMO subscriber agreements; ii) $300,000 in benefits for disability income insurance and long-term care insurance; and iii) $100,000 for other health policies not defined as disability income insurance, long-term care insurance or health benefit plans. All limits are applied per life.

- Individual (allocated) annuities: $250,000 in present value of annuity benefits, including net cash surrender and withdrawal values, per life.

- Structured settlement annuities: $250,000 in present value of annuity benefits, per payee or beneficiary. See Chapter 3 for a discussion of structured settlements.

- Unallocated annuities: Coverage for unallocated annuity contracts[11] is typically limited. As of this writing, 28 states provide coverage for limited types of unallocated annuity contracts. The remaining 22 states, plus the District of Columbia and Puerto Rico, do not provide coverage for unallocated annuity contracts. For those states that do provide coverage for unallocated annuity contracts, coverage is typically limited to unallocated annuity contracts issued to or in connection with specific employee benefit plans or government lotteries. Life Model Act §3(A)(3). Coverage limits are stated as (i) $5,000,000 per contract owner/plan sponsor for unallocated annuity contracts issued in connection with either governmental lotteries or private employer employee benefit plans that are not protected by the Pension Benefit Guaranty Corporation, and (ii) $250,000 per plan participant for unallocated annuity contracts issued to governmental retirement plans. Life Mode Act §3(C)(2)(b) and (e). Unallocated annuity contracts are not covered in every state, and the Appendix to the Life

[10] While there are a few exceptions, these coverage limits have been fairly uniformly adopted in most states. For individual state limits, see the NOLHGA website (https://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo) or consult the applicable state guaranty association.

[11] For purposes of guaranty association coverage, an unallocated annuity contract is "an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate." Life Model Act §5(Y).

Model Act includes alternate Section 3 text adopted by several states that do not provide coverage for unallocated annuities.

- Aggregate limits across policy types: Aggregate benefits covered with respect to any one life for life insurance, individual annuities, and health insurance (other than health benefit plans) are capped at $300,000. Aggregate coverage for health benefit plans and other policy types is limited to $500,000 with respect to any one life.

2. Exclusions

Products excluded from coverage, in whole or in part, are described in Life Model Act Section 3(B)(2). Under the Life Model Act, coverage is expressly excluded for policies or portions of policies under which the risk is borne by the policyholder or that are not guaranteed by the insurer, as well as certain interest crediting rates that exceed the limits described therein. Self-funded employer-provided welfare benefit plans are also among the products excluded, as are unallocated annuity contracts issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation. Reinsurance is also specifically excluded unless assumption certificates have been issued. For a more complete listing of products or portions thereof generally excluded from guaranty association coverage, refer to Section 3(B)(2) of the Life Model Act. For specifics concerning coverage exclusions in any particular state, consult with the guaranty association in that state.

In addition to the product exclusions referenced above, the Life Model Act excludes coverage for policies or products issued by entities that are not regulated under the standards applicable to legal reserve carriers, and are therefore excluded from the definition of Member Insurer under the model, such as insurance exchanges, assessment companies, fraternals, and hospital or medical service corporations. Hospital or medical service corporations that are members of the Blue Cross/Blue Shield Association may be required by their franchise to participate in their state's guaranty association if permitted by statute, or to establish some other form of insolvency protection for their participants. Whether these entities are included as member insurers for purposes of guaranty association protection may vary by state and must be considered based on the circumstances in each case.

3. Residency Requirements

Residency is determined on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer, whichever occurs first. Typically, this results in the state of residence being determined on the date an order of liquidation with a finding of insolvency is issued. If there is a gap between the start of the receivership and the date an order of liquidation is issued, policy and contract holders may relocate, which could affect the situs of coverage.

The Life Model Act generally provides for coverage of policyholders and certificate holders under group policies who are residents of the state, as well as their beneficiaries, regardless of where the beneficiaries reside. It also provides coverage for contract owners of unallocated annuities if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in the state. Nonresident policyholders and contract holders may be covered under certain limited circumstances. If the insolvent insurer's domiciliary state follows the Life Model Act, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty association law and the policyholders in that state are not eligible for coverage there because the insurer was not licensed in that state at the time specified in that state's guaranty association law. An example of such a situation might be a resident of State A, who owns a policy of the XYZ Life Insurance Company, domiciled in State B, and placed in liquidation in state B. If the State A resident policyholder is not eligible for coverage by the State A guaranty association because the company was not licensed in State A (and therefore was not a member insurer of the State A guaranty association), coverage may be provided by the State B life and health insurance guaranty association.

D. Guaranty Association Claims Administration

In the case of a multi-state insolvency, life/health guaranty associations work through NOLHGA's Members' Participation Council (MPC) to develop and implement a plan for providing guaranty association coverage, whether through transfer of the covered policies to a solvent insurer, making arrangements for providing ongoing policy and claims administration, or some combination thereof.

For multi-state insolvencies, NOLHGA appoints a guaranty association task force that includes representatives from the domestic guaranty association and other state guaranty associations affected by the insolvency. The size of the task force depends in large part on the number of affected state guaranty associations and the size of the insolvency.

1. Information Needs of the Guaranty Associations

For guaranty associations to evaluate and discharge their functions with the least possible duplication and delay, they must have detailed information about the insurer and its business. While information needs may vary from case to case, NOLHGA typically requests this information from the receiver on behalf of its members and, if necessary, will offer to assist the receiver in obtaining and assembling the information. Types of information routinely requested include:

- All administrative and judicial petitions and orders with attachments or exhibits;
- The insurer's most recent annual statement;
- The insurer's most recent financial statement, audited or unaudited, and department or independent financial audits or reviews, including identification of assets that are hypothecated or not publicly traded and unbooked contingent liabilities;
- A list of states that have terminated or suspended the insurer's license;
- A breakdown, by state, of the insurers' estimated liabilities/reserves by line of business;
- A list of third-party administrators and administrative offices, identifying the policies, claims and group policyholders they served, and copies of all provider/vendor agreements;
- Actuarial evaluations of the insurer's business;
- Copies of policy and contract forms;
- Copies of reinsurance contracts, assuming or ceding;
- Drafts of the receiver's notices to policyholders, including any cancellation notices;
- A breakdown of assets, by category, at the most recent market value available and other valuations of assets that would be helpful in cash flow analysis;
- The names and addresses of policyholders and certificate holders with in-force coverage during the preceding year, broken down by state, indicating the type of coverage each had, the date to which premiums have been paid, cancellation or non-renewal dates for business that was

canceled or non-renewed according to policy terms, copies of cancellation notices, and the date to which claims have been paid; .[12]

- Policy values (face amounts, cash surrender values, policy loans, interest crediting rates, rate crediting history, etc.);
- Premium files (and status indicators, such as Reduced Paid Up, Extended Term, or Waiver of Premium status);
- Claims data/claims history (including plan of care and related information for LTC lines);
- Rate files/history;
- Provider contracts and information about provider networks (for health and HMO lines); and
- Information concerning the receiver's marketing contacts and expressions of interest received about the insurer's business.

2. Notice to Claimants

Shortly after a receiver is appointed, the receiver should collaborate with NOLHGA to provide notices to policyholders. Several notices may be necessary over the course of the receivership. Because of the special nature of life and health insurance guaranty association obligations, the receiver and the guaranty associations should collaborate closely on the contents of all notices to policyholders that involve guaranty association obligations, and may, in some instances, send joint communications to policyholders. Normally, the notices should:

- Provide notice of proceedings against the company;
- Explain the existence of the guaranty associations and their role in the receivership
- Provide basic information concerning guaranty association continuation of coverage, including general reference to the statutory limitations;
- Where applicable, advise regarding the possibility that a portion of the policies or contracts may be assumed or reinsured by another insurer;
- Provide instructions on filing claims under their insurance policies and remitting future premiums (during rehabilitation);
- Indicate how the guaranty associations intend to treat cancelable policies;
- Provide information about conversion policies in the event of policy terminations;
- Provide notice of liens or moratoriums;
- Identify any applicable claims bar date;

[12] Specific policy data needs will depend on the facts and circumstances of each case as well as the types of business involved. Initial, critical data needs will typically include all relevant summary policy and reserve information. If the policy master/eligibility records can be provided, that file may contain sufficient information for preliminary coverage determinations and to consider the potential feasibility of an assumption transfer. Additional information will be needed to coordinate coverage and begin planning for implementation of any administration, transfer or other disposition strategies.

- Describe the receiver's handling of claims in excess of guaranty association statutory maximums; and

- Describe the receiver's handling of claims that are ineligible for guaranty association coverage.

When a company goes into liquidation, the guaranty associations will typically send their own notice to policyholders, sometimes as part of a joint mailing with the receiver. The guaranty association notices will provide information about guaranty association coverage and limits, contact information for the state guaranty association providing coverage for insureds in each state, instructions for continuing to pay premiums and submitting claims, customer service contact numbers, and other relevant details depending on the unique facts and circumstances of the case.

3. Notice to Guaranty Associations

In many states, the receiver is required to provide notice of the receivership to all guaranty associations that may be triggered as a result of the receivership. Even if the notice is not a statutory requirement, the receiver should provide NOLHGA (in the case multi-state receiverships) and all affected guaranty associations as much advance notice of receivership as is reasonably possible under the circumstances subject to appropriate confidentiality agreements in order to facilitate the coordination that will be necessary for a successful receivership and achieve the best outcomes for policyholders. NOLHGA and the affected guaranty associations should also be provided with an advance copy of all notices being issued by the receiver to policyholders, as well as copies of the receivership order and any domiciliary injunctions that may have been entered.

4. Proof of Claim

A proof of claim form is less frequently required in life/health receiverships, due in part to the fact that in many instances the guaranty associations will be continuing coverage. Generally, policyholders are not required to file formal proofs of claim for policy benefits. However, policyholders may assert claims for extra-contractual liability against the insurer, such as claims for bad faith. The receiver should consider requiring a proof of claim where extra-contractual liability is involved. Neither the guaranty associations nor assuming reinsurers accept liability for extra-contractual claims.

Receivers and guaranty associations must have data on the policy deductibles and benefit caps under health insurance policies. If the business is transferred to a new carrier, incurred claims will have to be allocated between pre- and post-assumption date periods. In addition, special provisions in the assumption agreement may require additional information in the proof of claim form.

5. Claim Files

The information needs of the guaranty associations generally are addressed earlier in this section of the Handbook. To ensure secure data transfer, receivers or insurance department personnel typically establish a secure website portal or FTP site to provide NOLHGA and its member associations with secure access to the data needed. Otherwise, NOLHGA (or a designated Third-Party Administrator or consultant) can establish a secure file portal where designated users can upload records. Files and records should be made available at the earliest practical opportunity to allow for the planning and coordination needed for a smooth transition and to avoid any disruption to benefits and claim payments.

6. Premiums

The continued and timely payment of premiums is necessary in order for a policyholder to receive continued coverage from a life/health guaranty association. Under the Life Model Act, "premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association." Receivers should work with NOLHGA and the guaranty associations to ensure smooth transition of premium collection. For premiums collected before the

liquidation order but providing coverage for periods after the liquidation order, the Receiver should coordinate with the guaranty association to facilitate appropriate allocation of those funds.

E. Early Access

The guaranty associations' administrative costs, like the receiver's, typically have the highest priority in distribution of funds from the insolvent insurer's estate. In addition, guaranty associations have a statutory claim and right of subrogation, allowing them to recover from the estate to the extent they pay covered benefits. Guaranty association claims for the payment of covered benefits are accorded the same priority as policyholder claims (Class 3 under §801 of IRMA), and are taken into account in the calculation of association benefits as part of a rehabilitation or liquidation plan. The guaranty associations' claims in the aggregate often make the guaranty associations the largest claimants against the estate.[13] In recognition of this fact, most state laws provide for the guaranty associations' "early access" to payments from the estate. See §803 of IRMA. Early access is typically accomplished by specific agreement, which should include a provision that the guaranty associations will return excess funds.

F. Claim Reporting

Guaranty associations should make timely reports to receivers of their costs for policy transfers, policy administration (including TPA costs), claim payments and administrative expenses. In multi-state insolvencies, NOLHGA will typically collect the necessary data from the affected guaranty associations and report to the receiver on their behalf in the form of an Omnibus Proof of Claim, which may be updated from time to time.

G. Guaranty Association Obligations During the Formulation of a Rehabilitation or Liquidation Plan

The successful creation and implementation of a plan to protect policyholders requires good communication and cooperation between receivers and guaranty associations. To the extent consideration may be given to restructuring of covered policies or contracts, the receiver should coordinate with the guaranty associations early in the development of the plan to consider whether the proposed restructuring is consistent with the guaranty association statutory obligations with respect to those policies or contracts. Any restructuring needs to be carefully considered in light of all applicable statutory requirements.

H. Reinsurance

The guaranty associations may find it advantageous to keep in-force ceded reinsurance treaties that the insolvent insurer had in place on covered blocks of business. Accordingly, the receiver should not cancel ceded reinsurance contracts with reinsurers or stop paying premium to reinsurers without consulting NOLHGA or the affected state guaranty associations. The existence of a ceded reinsurance treaty covering a block of business may make the business more attractive to prospective purchasers. In the case of health insurance, reinsurance recoveries may lessen the impact of catastrophic claims upon the affected guaranty associations. See Section 8 N of the Life Model Act and Section 612 of IRMA, both of which provide that the guaranty association(s) may elect to succeed to the rights and obligations of the insolvent insurer under ceded indemnity reinsurance agreements.

J. Special Issues

Under the Life Model Act, guaranty associations have the power and discretion to "guarantee, assume or reinsure . . . the policies or contracts of the insolvent [or impaired] insurer." Relying on this authority, guaranty associations have, on more than one occasion, acted collectively to establish an insurance company for purposes of collectively managing assets and assuming or administering guaranty association

[13] In some cases, the guaranty associations may also present claims against the estate for the insolvent insurer's unpaid guaranty association assessments. These claims have general creditor status ranking below other guaranty association claims and all policyholder claims.

covered obligations. Whether similar arrangements may be appropriate in future insolvencies depends entirely on the circumstances.

J. Guaranty Association Procedures for Collective Action

Many individual state guaranty associations may be triggered in connection with a multistate insolvency. Simply communicating with each guaranty association individually would be a difficult task for a receiver's staff. The receiver should work closely with NOLHGA, through the MPC's appointed task force, to communicate and coordinate with the affected guaranty associations. Recognizing the need for concerted action when multiple guaranty associations must cover the insurance obligations of an insolvent company, the guaranty associations have developed and institutionalized procedures that, through NOLHGA, enable them collectively to administer continuing policy obligations, pay covered claims and, ultimately, discharge the covered obligations. These procedures provide a valuable mechanism for resolving major issues and entering into binding contracts

[1] USD Manual link to be included when published.

CHAPTER 8 – SPECIAL RECEIVERSHIPS PAGE NUMBERS WILL BE UPDATED IN THE FINAL

I. INTRODUCTION

In each of the other chapters in this Handbook, the authors make two assumptions: first, that the entity placed into receivership is an "insurance company" and is subject to state statutory receivership procedures; and second, that the receivership is administered in the "insurer's" state of domicile. This chapter addresses receiverships where neither assumption can be made.

Many entities engage in the business of insurance without obtaining the requisite license, and are organized as business corporations rather than insurers—or might not even be properly organized as corporations at all. For example, unlicensed entities transacting health insurance business often claim exemption from state licensure requirements under the Employee Retirement Income Security Act (ERISA).[1] Such unlicensed organizations present special problems to insurance commissioners, insurance consumers and, where state law allows the liquidation of such entities, to receivers. The problems stem from a number of factors, some of which include:

(1) The fact that such unauthorized activity is ongoing, and not isolated;

(2) The potential for criminal activity occurring within the business of insurance. This issue arises by virtue of the fact that the insurance codes of many jurisdictions provide that the unauthorized transaction of insurance within the jurisdiction constitutes a crime;[2]

(3) The adverse economic impact of such activity upon authorized insurers and other insurance licensees;

(4) The potential for large volumes of unpaid claims due to the dishonesty of plan sponsors, promoters, and others, and from inherent actuarial unsoundness of the plans;

(5) The absence of guaranty funds or other mechanisms to cover unpaid claims;

(6) The adverse economic impact upon health care providers and plan participants resulting from unpaid claims;

(7) The potential adverse impact on the future insurability of plan participants under statutes mandating guaranteed-issue health coverage;

(8) The lack of comprehensive federal oversight, including licensure and regulation similar to that found in state insurance codes; and

(9) The inability of federal authorities to act rapidly to investigate and terminate illicit operations, and to quickly discipline the perpetrators. This factor is related, in part, to the relatively limited nature and extent of the Department of Labor's jurisdiction over real and claimed ERISA plans.

When considering a potential receivership involving one of these unlicensed entities, it must first be determined whether the entity is risk-bearing, and therefore susceptible to treatment as an insurance company. Section 103 (D) of the Insurer Receivership Model Act ("IRMA") states that the Act covers "all other persons organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state." Most states have provisions similar to this based on prior versions of the NAIC Model.

This chapter begins with a general discussion of the issues involved in making these determinations. If the entity is to be placed into receivership, most of the other provisions of this Handbook are applicable or may be adapted to the circumstances presented. In some instances, however, the nature of the entity may warrant the adoption of different procedures, and this chapter discusses some of those procedures. Finally, many insurers are licensed to do business, and have assets located, in many states. (See Chapter 9—Legal Considerations, section on Liquidation,

[1] 29 U.S.C. Section 1001, *et seq*.

[2] See, for example, Section 626.902, *Florida Statutes*

Jurisdiction and Ancillary Receiverships.) In such cases, "ancillary" receiverships may be established to administer the assets located in states that are not the insurer's domicile. Ancillary receiverships present their own problems and considerations. Finally, insurers organized under the laws of, or having assets located in, other countries create additional issues for a receiver to deal with. This chapter concludes with a discussion of these multi-national (or "cross-border") receiverships.

II. GENERAL CONSIDERATIONS

The receiver of an entity discussed in this chapter frequently must make a number of determinations at the outset: Is the entity entitled to bankruptcy protection? Where should the receivership be initiated? Are there any assets to distribute? What other remedies are available such as injunctive relief, criminal prosecution, etc. Should other regulatory agencies be contacted or involved in the receivership process? This chapter begins with a discussion of these issues, and then continues with a discussion of particular types of entities that may be involved in special receiverships.

Many states do not have explicit statutory language authorizing receiverships of some of the entities discussed in this chapter. In such instances, counsel may have to analogize statutory provisions and similar receivership proceedings in other jurisdictions for guidance and persuasive authority. Proponents of the receivership often must convince the court in their pleadings and proof that the entity is the functional equivalent of an insurer (or some other kind of risk-bearing entity that is clearly within the ambit of the state's insurance code) and, therefore, is subject to the state receivership statutes. Some states have explicit statutory language that allows the insurance regulator to be appointed as receiver of any "insurer," which is defined broadly to include persons purporting to be, or organized or holding themselves out as organized for the purpose of becoming, insurers. This type of language has been invoked to enable the appointment of receivers of entities that are not domiciled in any state (e.g., an alien excess or surplus lines insurer) and might not be licensed or authorized anywhere they transact the business of insurance. For purposes of the discussion in this chapter, we will employ the licensed/unlicensed (authorized/unauthorized, admitted/non-admitted) distinction, and will use the term "insurer" to describe the person or entity in receivership, notwithstanding the fact that there may be an issue whether the person or entity in fact was organized or authorized as an insurer.

A. Federal Bankruptcy vs. State Receivership

Whether an entity may be placed into bankruptcy or a state receivership depends upon whether the entity is determined to be an insurance company or its equivalent. The reason for this rule lies in Article I, Section 8 of the United States Constitution, which provides that Congress shall have exclusive authority to establish uniform laws on the subject of bankruptcies. The United States Bankruptcy Code, 11 U.S.C. § 101 *et seq*. (the Code), is national legislation applicable in all 50 states, the District of Columbia and the U.S. territories. It provides a comprehensive scheme for the resolution of individual and corporate insolvencies. The Code offers debtors four types of relief, but the three that are most likely to apply to the business of insurance are reorganization under Chapter 11, liquidation under Chapter 7, and injunctions and other relief in aid of a foreign proceeding under law relating to insolvency or adjustment of debt pursuant to Chapter 15.

Congress generally has precluded domestic and foreign insurance companies doing business in the United States from seeking relief under Chapters 7, 9, 11, 12 and 13 of the Code.[3] See 11 U.S.C. § 109(b)(2) and (3). However, foreign insurance companies doing business in the United States may seek relief under Chapter 15 of the Code, which is described in more detail in Chapter 9—Legal Considerations.

Determining whether an entity may be eligible to be a debtor under the Code, or whether an entity may be placed into a state insurance receivership, depends, in part, upon whether the entity is, or functions as, a "domestic" or "foreign" insurer. Most regulators distinguish between insurers on the basis of: (i) legal form of ownership (e.g., proprietary, cooperative, pools and associations, governmental and other); (ii) their place

[3] Chapters 9, 12 and 13 govern adjustment of debts by composition, extension or discharge for municipalities, certain farmers and fishermen, and certain individuals.

of incorporation (i.e., domestic, foreign and alien—see section V.(C) on Alien Insurers in this chapter); (iii) their licensing status (i.e., licensed/admitted vs. unlicensed/nonadmitted); and (iv) the type of their product and service distribution systems (i.e., independent agency, exclusive agency, direct writer and mail order). See generally, Bernard L. Webb, et al., *Principles of Reinsurance Volume I* (1990).

The courts have not developed clear rules for ascertaining whether an entity is eligible for federal bankruptcy relief as opposed to state receivership proceedings. However, the courts have devised several tests for determining whether an entity is excluded from bankruptcy eligibility because it is an insurance company. See 2 *Collier on Bankruptcy*, § 109.03[3][b] (15th ed. rev.). The first test is the state classification test, which is the test favored by most courts. Under this test, the court looks at how the entity is classified under the law of the state in which it is organized. If the entity is classified as an insurance company under state law, the inquiry typically ends there. If the state law does not clearly classify the entity as an insurance company, the court will attempt to determine whether the entity is the substantive equivalent of an insurance company. In doing so, the court will look at the manner in which the entity is actually operated as well as the degree to which the entity is regulated by state law. The higher the degree of regulation, the more likely the courts are to find that Congress intended to exclude the entity from eligibility for relief under the Code. This approach is based, in part, on the recognition that Congress has codified its policy of leaving the regulation of the "business of insurance" to the states in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. See In re *Estate of Medcare HMO*, 998 F.2d 436 (7th Cir. 1993).

The second test is the independent classification test. Under this second test, courts limit their review to the language of the Code itself and, using traditional techniques of statutory construction, attempt to determine whether the entity is an insurance company that is excluded from being a debtor under the Code. See In re *Cash Currency Exchange, Inc*., 762 F.2d 542, 551-552 (7th Cir. 1985).

A third, less-utilized approach looks to congressional intent and public policy factors to determine whether state law provides an adequate scheme for reorganizing or liquidating the entity. If adequate relief is not available, the court may find that the entity is eligible for bankruptcy relief. See In re *Florida Brethren Homes, Inc*., 88 B.R. 445 (Bankr. S.D.Fla. 1988).

Some entities have sought the protection of a federal bankruptcy court either before or during the course of a state receivership. Under federal bankruptcy laws, the policyholders of the debtor would receive no priority and would be treated the same as other unsecured creditors. Unlike most state insurance insolvency laws, under the Bankruptcy Code many federal and state tax claims are given priority over unsecured creditors, including policyholders. This fact often provides impetus for the initiation by unsecured creditors of an involuntary bankruptcy action against an unlicensed insurer. Some state regulators have successfully challenged the federal bankruptcy proceedings of unlicensed insurers and obtained dismissals on the ground that the states have full jurisdiction over the liquidation of licensed and unlicensed insurance entities, and that the Bankruptcy Code specifically exempts insurance companies. However, a jurisdictional battle may ensue and could delay the receivers' efforts to gain control over the records, accounts and operations of the unlicensed insurer, leaving little or nothing to liquidate by the time the order is granted.

Even if the receiver is unsuccessful in challenging the federal bankruptcy proceeding, the receiver should consider continuing an earlier initiated receivership for the limited purposes of preserving its rights on appeal or enforcing its regulatory powers. Although the filing of a bankruptcy petition typically results in an automatic stay of most other legal action against the entity, there are exceptions to this rule. For example, the commencement of a bankruptcy action does not operate as a stay "of the commencement or continuation of an action or proceeding by a governmental unit to enforce such governmental unit's police or regulatory power; [or] … of the enforcement of a judgment, other than a monetary judgment, obtained in an action or proceeding of a governmental unit to enforce such governmental unit's police or regulatory power" (11 U.S.C. § 362(b)(4), (5)). Thus the receivership may coexist with the bankruptcy estate so long as the receivership falls within these exceptions. The receiver should consult with legal counsel regarding how bankruptcy courts have addressed the circumstances of such situations.

B. Jurisdiction and Venue

Once the decision has been made to place an unlicensed entity into receivership, an appropriate jurisdiction (i.e., state, district or territory) must be chosen. Numerous questions arise: Should the domiciliary receivership be initiated in the state (i) in which most of the insurance policies were issued; (ii) in which most of the insurer's assets are located; (iii) where the company is physically located; or (iv) where the books and records are kept? The jurisdictional choice depends upon the relative weight of the facts discovered, as well as the strength of the statutory and regulatory framework in each of the potential jurisdictions. The potential receiver should determine whether a state's insurance regulatory authority has already taken some type of action against the entity, such as by issuance of an emergency cease and desist order, or some other type of administrative proceeding. If so, there will likely exist factual information gathered in preparation for that action, or during the course of discovery, that will assist in this determination. Another source that should be consulted is the consumer assistance bureau of the state insurance regulatory authority. Of course, a particular insurance regulator will likely not be able to put a company into receivership in any other state, but would be able to coordinate with other state regulators on these issues. Many times the issue is not which state, but whether the particular regulator's state is an appropriate jurisdiction to bring receivership proceedings.

C. No-Asset Estates

It is important to determine as early as possible if there are sufficient assets to operate a receivership. Most states' insurance statutes require that the costs and expenses of receiverships be paid out of the assets of the estates, including seized bank accounts. Generally, the receiver of an unlicensed insurer has to rely on the funds held in bank accounts to fund the receivership. Unlicensed insurers frequently have little or no money with which a receivership may be administered. In that case, some states' permanent receivership departments may absorb the regulatory costs of liquidating such entities through a variety of funding options. Consistent with many state statutes, IRMA Section 116 provides for alternative funding in cases where the insurer does not have sufficient assets to pay expenses, either from funds advanced from an appropriation from the state's insurance department, or from a specific fund created for such a purpose. IRMA Section 804 (Alternative 1) provides a mechanism for using residual assets to fund low- or no-asset estates. In either event, the funds advanced are repayable from available monies of the insurer. In some instances, some special deputies or other consultants (e.g., those who have been contracted by the commissioner as receiver in past or current receivership proceedings) have accepted such no-asset receiverships on a *pro bono* or a contingency basis.

In the event that there are insufficient assets, the regulator may elect to forego receivership proceedings. If a receivership is not financially feasible, then the state may seek an injunction to put the unlicensed entity out of business. Frequently, commissioners or receivers discover that the unlicensed entities have moved money from their accounts to other corporate or personal accounts, and the only thing left for a commissioner or receiver to do is aid in any criminal prosecution.

In situations where the risk-bearing entity appears not to have sufficient assets in the jurisdiction, it may be useful to look to some of the ancillary actors. The investigation should include, for example, agents who sold the entity's plan and real or *de facto* third-party administrators who may be holding, processing or transmitting funds for the entity. Frequently, the unauthorized entity will use many such administrators located in various parts of the country. Just as frequently, the entity may use a succession of them. Once again, coordination with the state insurance regulators can be useful, as their investigation may have already determined the identity of some or all of those people and organizations.

D. Injunctive Relief, Criminal Prosecutions and Posting Security

In addition to the injunctive relief to protect assets, most states' insurance laws provide for permanent injunctions against the further transaction of insurance business. These laws often allow for actions to be initiated by state law enforcement agencies, including the attorney general and local prosecuting attorneys.

The agencies also may become involved in prosecuting unlicensed insurers in criminal actions. Some states' statutes require that an unlicensed insurer post security for liquidation costs before the insurer may file any pleadings in judicial proceedings. This is an effective tool for a receiver to use to prevent frivolous actions which otherwise might exhaust an estate's limited assets.

E. State-Federal Cooperation

Some receivers have successfully coordinated their receivership activities with the activities of federal agencies. A few states have convinced certain agencies, including the Federal Bureau of Investigation (FBI), the Internal Revenue Service (IRS), the U.S. Postal Inspector, the U.S. Department of Labor and the U.S. Department of Justice, to initiate federal investigations into the activities of unlicensed insurers and suspected looters of insurance company assets. These investigations have resulted in the issuance of federal grand jury subpoenas to protect the integrity of books, records and documents originally seized by the receivers and to freeze assets which a receiver may not be able to seize in a cost-efficient or expeditious manner. Joint state/federal investigations are extremely important in obtaining criminal sanctions, forfeitures and restitution orders for those who operate as unlicensed insurers or who have looted insurance companies. It should be noted, however, that once federal or state law enforcement officials begin investigating potential crimes involving individuals related to the insurance company, they may exert control over a significant portion of the receivership's records.

Establishing a working relationship between the receiver and law enforcement officials early on is essential because the objectives of receivers and law enforcement officials are very different. The focus of law enforcement will be on the crime and conviction of the criminal, while the focus of the receiver will be on the recovery of assets for the benefit of the creditors. Good communication can overcome these divergent goals.

The receiver considering whether to approach or cooperate with law enforcement officials frequently must confront a number of issues. One issue is the effect that a criminal investigation/conviction may have upon the receiver's ability to recover, and the timing of recoveries, against the officers and directors of the insolvent insurer (specifically any directors and officers' liability insurance) and under reinsurance agreements. Criminal activity and fraud are frequently excluded from coverage by the applicable directors and officers' insurance policy that the receiver is attempting to reach, and this exclusion may be invoked to support a reinsurer's action for rescission of the reinsurance agreement.

Another issue is control of the insurer's books and records. Prosecutors frequently acquire such books and records by means of a grand jury subpoena or a search warrant. It may be difficult for the receiver to review or copy books and records obtained by such means. Similarly, a criminal investigation or proceeding may involve several enforcement agencies (Postal Inspector, FBI, IRS and Department of Labor) and several jurisdictions. To the extent that the records are deemed essential to the receivership proceeding, the receiver should immediately attempt to negotiate an agreement to obtain access to and use of the records before relinquishing control over documents or other materials that the applicable authorities are seeking from the receiver. Unless there are strict controls on access to and removal of documents, the documents may be lost or difficult to retrieve. In such cases, the receiver may wish to negotiate and create and implement a file retrieval system. While it may be cost prohibitive in some instances, a receiver should also consider copying all applicable documents and establishing the appropriate chain of custody. Even if the receiver is successful in negotiating continuing access to documents, a receiver may have to address the access issue again if different federal agencies or different U.S. attorney offices become involved. Thus, maintaining a copy of the documents may be the best solution.

Overcoming these obstacles may be worthwhile because there are certain advantages to working with law enforcement officials. For example, one of the impediments to the collection of money judgments against culpable persons in multiple states is the fact that the receiver often must enforce its judgment in a foreign jurisdiction. This burden may be overcome by requesting the U.S. attorney, in conjunction with a criminal prosecution, to move for injunctive relief in a civil proceeding to "freeze" all known bank accounts and

other assets of the principals and entities controlled by the principals who are the subject of the prosecution. Additionally, the receiver should consider that the federal authority, if convinced to do so, has the ability to freeze assets in multiple jurisdictions in a very expeditious manner. It could sometimes take a receiver weeks or months to freeze the same assets because they are outside of the receiver's jurisdiction, and the receiver may not have immediate access to the appropriate professionals needed to freeze assets in numerous jurisdictions. Thus, although the receiver may experience delay in ultimately recovering an asset because the federal government is involved, they may be able to secure assets for the benefit of the estate that may have been dissipated by the time the receiver was able to freeze them. In such cases the receiver should attempt to reach a written agreement with the prosecutor(s) that any money recovered as a result of the criminal prosecution, either through forfeiture, cooperation with the criminal or other means, will be transferred to the receiver, with all due credit given to the prosecutor. The receiver should be aware, however, that it may be necessary to go beyond the local U.S. attorney to secure the appropriate agreements for assets seized by the federal authorities. Agreements with a local U.S. attorney to deliver forfeited assets to the receiver may not be enforceable. In some instances, agreements to return forfeited assets must be approved by the appropriate division of the Department of Justice in Washington, D.C.

Even when a U.S. attorney who pursues assets at the behest of a receiver cannot forfeit those assets because the defendant claims that the assets recovered did not derive from the criminal enterprise, it is still of benefit to the receivership. This is true because the assets, once seized, are identified for the receiver and thus facilitate the receiver's assertion of a claim, lien or other legal hold on them, notwithstanding the alleged rights of other claimants. Thus, the receiver may be able to prevent a dissipation of the asset without having an opportunity to make a claim to it, which may not have been possible but for the seizure by the U.S. attorney.

Additionally, given the proliferation of unauthorized health insurers posing as ERISA-exempt plans, an extremely useful resource within the U.S. Department of Labor is the Employee Benefits Security Administration, previously known as the Pension & Welfare Benefits Administration (EBSA). Charged with the general oversight and enforcement of both the benefit and welfare plan provisions of ERISA, the EBSA has regional and local offices across the country.[4] The EBSA also has processes by which advisory opinions concerning multiple employer welfare arrangements (MEWAs)[5] may be requested. Utilizing that process can be of enormous assistance in overcoming jurisdictional objections to the commencement and continuation of a receivership.

D.

III. HOSPITAL AND MEDICAL SERVICE CORPORATIONS

A. Organization and Regulation

Hospital service corporations (such as traditional Blue Cross plans) and medical service corporations (such as traditional Blue Shield plans) do not fit neatly into any category of insurer (proprietary, cooperative, etc.). In some service areas, Blue Cross and Blue Shield are combined into a single plan, and other types of health plans, notably Delta Dental plans, might also be established under state nonprofit health plan laws. Also, many Blue Cross/Blue Shield plans are now organized as stock or mutual insurers and are fully subject to state insurance codes and are not within the scope of this section. This section addresses nonprofit non-

[4] Employee Benefits Security Administration, previously known as the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210; www.dol.gov/ebsa/.

[5] Office of Regulations and Interpretations, Employee Benefits Security Administration, U.S. Department of Labor, Room N-5669, 200 Constitution Avenue, NW, Washington, D.C. 20210

stock corporations, often with charitable status, organized for the purpose of contracting with the public and with duly licensed hospitals, physicians, dentists and other health care providers for the provision of health care services to subscribers under the terms of their contracts with the corporation. Since the early 1940s, hospital service corporations have been joined together through reciprocal agreements to provide benefits for members who find themselves hospitalized away from home, to allow free transfer of membership between plans, and to facilitate enrolling national accounts.

B. Blue Cross/Blue Shield Plans

Each Blue Cross/Blue Shield Plan is independent of other Plans. There is no single Plan that operates on a nationwide basis. They have individual corporate names and have designated geographic areas in which they may conduct their operations. Some are statewide, while other Plans include only certain counties within the state or even a metropolitan area. Each Plan has its plan president and board of directors, frequently consisting of community representatives, hospital administrators, physicians and consumer groups. Under some state laws, a Plan is exempt from the payment of taxes and from the operation of the general insurance laws of the state; however, tax exemption may depend on whether the Plan is considered a nonprofit entity. Regulation is limited to those matters the legislature has deemed necessary for the adequate protection of members who subscribe for the services offered by such corporation. Thus, the great majority of Plans are subject to regulation by the insurance departments of various states to the extent that the state insurance department must approve the rates charged to the subscribers, the benefits, payments to hospitals and other contractual details.

The Blue Cross/Blue Shield Association acts as a national coordinating agency for all of the Plans. Headquartered in Chicago, the Association acts as spokesperson or agent for Plans in matters of national or regional concern. All Plans pay dues to the Association, which promulgates national policies, establishes performance standards and contracts for nationwide programs such as Medicare and the Federal Employees Benefit Program. Through the Association, several Plans have established an inner plan service benefit bank to act as a clearinghouse for administering subscriber benefits.

C. Receivership

The receivership of a hospital or medical service corporation is substantially similar to that of a standard health insurer, with the exception of the highly local nature of the insolvency. In the case of a Blue Cross/Blue Shield Plan, the receiver should be aware that the Blue Cross/Blue Shield Association controls the use of the Blue Cross/Blue Shield name and trademark. In addition to the usual claims-handling issues and lack of guaranty fund involvement[6], the most important considerations in the receivership of a hospital or medical service corporation can be insuring continued coverage and controlling the billing practices of the health service providers.

V. UNLICENSED INSURERS

Unlicensed insurers may be separated into two general but distinct categories. The first category consists of insurers or individual risk bearers who, while unlicensed in a state, have complied with that state's surplus lines or excess lines laws and are permitted to insure risks in that state, subject to the provisions of those laws. Such eligible surplus lines insurers may be incorporated or organized either under the laws of another U.S. jurisdiction ("foreign" insurers) or a non-U.S. jurisdiction ("alien" insurers).

The second category includes those entities (domestic, foreign or alien) engaged in the business of insurance or transacting insurance in a state where they are neither licensed nor deemed eligible as excess or surplus lines

[6] Model 520 excludes hospital and medical service organization, whether profit or non-profit, as member insurers of guaranty funds.

insurers. This category includes individuals, entities or corporations that may or may not be organized as "insurers" and that may or may not be operating legally. Such entities have included:

- Managing general agents;
- Third-party administrators;
- Marketing groups;
- Servicing organizations;
- Intermediaries;
- Telemarketing firms;
- Trusts;
- Benefit funds.

Note that some states impose personal liability against agents and other persons who place business with unlicensed insurers.

A. Eligible Surplus Lines Insurers

The terms "authorized" or "admitted" when used in conjunction with an insurer, mean an insurer that is licensed to transact business in the home state of the person, entity or risk to be insured. The terms "unauthorized" or "non-admitted" mean that the insurer is not licensed in the home state of the person, entity or risk to be insured. (For simplicity, "authorized" and "admitted" will both be referred to in this section as "admitted," and "unauthorized" and "non-admitted" will be referred to as "non-admitted.")

"Surplus lines insurance" is a mechanism that allows consumers to buy property-liability insurance from a non-admitted insurer when consumers are not able to obtain the coverage from authorized insurers. Under the surplus lines framework, certain non-admitted insurers are permitted to lawfully offer insurance in the state where the person or risk is located. The surplus lines regulatory framework differs from state to state, so the receiver must become conversant with the rules of the state where the insurer wrote on a surplus lines basis. There are, however, some basic principles that are common to all such frameworks:

(1) The purpose is to provide access to insurance that is not readily available from admitted insurers;

(2) They use specially trained and licensed agents, brokers and surplus lines associations to assist those consumers;

(3) They establish systems of levying and collecting taxes on the transactions;

(4) They authorize the state to establish who may insure risks on a surplus lines basis and the types of insurance they may offer.

All surplus lines insurers must be licensed in their home jurisdiction, whether that is within the United States or elsewhere. An "eligible surplus lines insurer" is generally one which, although non-admitted in the state of the insured or the risk, has been determined by that state's regulator to be eligible to write certain categories of insurance in that state.

Surplus lines insurers generally are permitted to write three broad categories of risk that are not readily available in the marketplace: distressed risk, unique risk and high-capacity risk.

Distressed risk consists of exposures that are characterized by unfavorable underwriting characteristics, such as having sustained frequent losses in recent years.

Unique risk consists of unusual types of exposures, including those that do not neatly fit within existing policy forms. Another factor that may make a risk unique is insufficient, or no, loss experience. The latter factor makes it very difficult, and perhaps costly, to price an insurance policy.

High-capacity risk does not relate only to possible or probable claims frequency, but more generally to those sorts of risks that require very high limits, which may be beyond the capacity of the authorized market.[7]

Special rules may govern alien surplus lines insurers. As a condition of eligibility to transact business in a state as a surplus lines insurer, alien insurers are required to execute a trust indenture pursuant to which monies are deposited and maintained with a U.S. trustee bank. The NAIC has a Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers, in which Article 4 of the form governs insolvency proceedings. Most alien insurers have executed the NAIC indenture or similar agreements. A copy of current trust indentures can be obtained from the NAIC website at:

https://content.naic.org/sites/default/files/inline-files/IID%20Trust%20Nov%2011%202022%20FINAL.pdf

Eligible surplus lines insurers are subject to the receivership laws of the U.S. jurisdiction in which they are domiciled. The insolvency of an alien insurer is usually triggered by the determination of its domicile regulating agency that it is insolvent. Liquidation proceedings may be commenced if the trust fund falls below a statutory minimum and is not replenished. In general, the insurance regulator in the U.S. jurisdiction in which the trust fund is maintained administers the insolvency proceedings. (Under IRMA, an alien insurer is considered to be domiciled in its "state of entry," and that domicile would undertake its liquidation in the U.S. (See IRMA, Section 104 (H) and 201 (A).)

The domiciliary regulator and the claimants of the company are the only entities to whom the trustee may transfer assets. The duties of the trustee and domiciliary regulator in prioritizing and paying claims are set forth in the indenture. The domiciliary regulator generally will seek a conservation order from a court that will enable the regulator to compel the trustee to pay over the corpus of the trust to the regulator. The domiciliary regulator then will administer the trust corpus for the benefit of those who otherwise would have been beneficiaries of the trust. Any assets remaining in the trust fund after all claims are paid should be transferred to the insurer or to its successor in interest. In some cases where an alien insurer has been placed in receivership in its domicile abroad, the U.S. domiciliary regulator, for reasons of economy, will enter into an agreement with the foreign receiver, whereby the domiciliary regulator will transfer the assets under that regulator's control to the foreign receiver upon being assured that the U.S. trust beneficiaries will receive no less from the foreign receiver than they would have received from the domiciliary regulator. Should the domiciliary regulator decide not to transfer the assets to the foreign receiver, the domiciliary regulator will pay all claims in accordance with the priorities set forth in the trust indenture and any governing statute. Any assets remaining after all claims are paid then would be transferred to the foreign receiver.

As of this writing, with the exception of New Jersey, no U.S. jurisdiction has enacted laws providing guaranty fund coverage to policyholders or claimants of eligible surplus lines insurers.

B. MEWAs

A common problem encountered by receivers involves life, accident and health insurance operations ostensibly operating under ERISA as a multiple employer welfare arrangement (MEWA).[8] The purveyors

[7] Ibid, pg. 6.

[8] ERISA Section 3(40)(A); 29 USCA Section 1002 (40)(A).

of unauthorized health insurance plans operating as MEWAs routinely invoke ERISA to assert that state insurance codes are inapplicable to their operations, and therefore, that state insurance receiverships cannot be maintained. The receiver's involvement will often arise in the context of plans that claim the exemption, but which, in reality, are MEWAs or other regulated risk-bearing entities subject to state regulation. It is thus vital for the receiver to have a good working understanding of MEWAs and related entities, and how they fit within the context of dual state and federal regulation. Following the adoption of ERISA in 1974 (which had the effect of limiting a state's authority to regulate self-insured employer plans), there was a rapid expansion in the number of self-insured employee benefit plans covering the employees of more than one employer. These plans were then referred to as Multiple Employer Trusts (METs), and claimed exemption from state insurance laws under the preemption provisions of ERISA. State insurance officials viewed these uninsured METs as purely for-profit entities, which were intentionally drafted to fall within the regulatory vacuum created by ERISA. Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, state regulation of the arrangement would have been precluded by ERISA's preemption provisions. However, as a result of the 1983 MEWA amendments to ERISA, states are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan.

State Regulation of MEWAs. The NAIC has adopted the Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation, for the purpose of preventing the operation of illegal health insurers, including illegal MEWAs. In addition, approximately 20 states currently have special licensing laws for self-insured MEWAs that specifically address the solvency concerns of MEWAs. However, these state solvency standards are often weaker than those for traditional insurers. Some state licensing requirements for MEWAs might include:

(1) Surplus and reserve requirements for MEWAs, which are generally much lower than for traditional insurers;

(2) The mandatory purchase of Stop-Loss insurance by MEWAs, in order to protect against unexpectedly large claims or a high frequency of claims;

(3) The requirement that MEWAs file annual financial statements audited by a certified public accountant;

(4) The disclosure by MEWAs to their members that they do not participate in a guaranty association; and

(5) Rate filing requirements.

Even if a MEWA is subject to state licensure, they are exempt from state taxes on premiums and from assessments for state guaranty fund coverage. In addition, some state receivership laws either exclude MEWAs or are vague about the department's authority to assume control over a MEWA in liquidation. Without the ability to invoke a receivership, licensed MEWAs may be subject to bankruptcy statutes, which, unlike state receiverships, do not give priority to outstanding health insurance claims. Receivers must initially determine whether state rehabilitation and liquidation laws apply to MEWAs, whether they are specifically licensed or unlicensed. Even if state insolvency laws are not an option, there are informal procedures that state insurance departments can take to assist consumers in such cases. These include:

- Ongoing oversight of the MEWA's financial condition;
- Facilitating discussions with licensed insurance entities to provide coverage for the employees and their dependents; and
- Other strategies to assist employers in finding new coverage and reduce the amount of unpaid medical bills.

Federal Regulation of MEWAs. If an unlicensed entity is attempting to operate as a MEWA under ERISA, in addition to available state remedies, the commissioner should also contact the U.S. Department of Labor (DOL), which has expressed an interest in working with the states to regulate MEWAs. Federal assistance is desirable because a MEWA operating as an unlicensed insurer may also be noncompliant with federal regulations, and federal authorities may have remedies available that provide sources of recovery for the estate.

ERISA does not require MEWAs to be federally licensed, nor does it contain any federal solvency or other consumer protections, similar to those generally found in state insurance law. However, the DOL still may be concerned with the same issues as the state insurance departments. Forms filed with the DOL or the IRS may provide the insurance departments with needed information as to the scope of the operations of the various entities. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established an annual Form M-1 filing requirement for MEWAs. The DOL already may be conducting a review and may be able to provide additional staffing to process some of the necessary paperwork.

Illegal MEWA Schemes. State insurance receiverships of MEWAs, where statutes allow, are becoming more frequent, requiring broadened receiver knowledge and sophistication. Because such schemes can be by their nature unlawful, they are often attended by both manipulation and secreting of assets, thereby making forensic accounting resources increasingly important. The schemes often differ in nomenclature and sophistication, but enough commonality usually exists to permit some generalizations and rules to guide the analysis. For example:

(1) The plans will claim total exemption from state insurance regulation under ERISA.

(2) The only plan structure that is arguably exempt from direct state insurance regulation, including jurisdiction for a receivership, is one that is single-employer based and fully self-insured. That is, the plan can apply only to the employees and their dependents of a single employer, and covered claims must be payable solely from the funds of the employer.

(3) The plans are usually MEWAs, which in a minority of states continue to be referred to as METs. Most state insurance codes define the terms in the following way: *[A]n employee welfare benefit plan or other arrangement that is established or maintained to provide one or more of various insurance benefits (including health insurance) to the employees of two or more employers*.[9] By this definition, a MEWA cannot be a single-employer plan so as to exempt it from state insurance regulation.

(4) Although they may employ terminology such as "single-employer trust" to convey the aura of a single-employer-based plan, the reality is that there is usually an upstream migration and/or commingling of money, consisting of employer and employee contributions, into the control of an entity that is not authorized in any jurisdiction as an insurer or as a MEWA, and which bears the financial risk of loss of covered claims.

(5) No individual employer, either by employer contribution or by the aggregate of employee contributions, is paying enough to fully self-insure the actuarially expected losses of the group during the period for which the contribution is made. Therefore, if claims are to be paid at all, they will be paid from a pool of funds comprised from the contributions of multiple employers or their employees. Invariably, that "pool" will not be authorized as an insurer or as a MEWA.

(6) ERISA also defines and recognizes MEWAs, and has some application to certain kinds of them.[10]

(7) The interplay of (3) and (6) in this section results in concurrent state and federal regulatory authority over most employee benefit plans that are MEWAs.

[9] See, for example, Sections 624.436-624.446, Florida Statutes.

[10] 29 USCA 1002 (40)(A)

(8) Special rules of preemption apply to MEWAs that meet the ERISA definition of a MEWA and that are also employee benefit plans:

i. If the plan is fully insured, the MEWA remains subject to state insurance laws that provide standards for the maintenance of specific levels of reserves and contributions so as to ensure the plan's ability to pay benefits when due, and to laws that enforce those standards.

ii. If the plan is not fully insured, the MEWA is subject to all state insurance laws that are not inconsistent with Title I of ERISA, unless it has been exempted from them by other regulations of the U.S. Department of Labor. If the MEWA has been so exempted, it is subject to state insurance regulation in the same manner and to the same extent as a fully insured MEWA.

iii. If the MEWA is not an employee benefit plan (that is, nothing more than a health insurance plan, sold to anyone, but using ERISA terminology), there is no preemption at all, and the plan is subject to complete regulation by the state insurance regulatory authority.

Perhaps the key to addressing issues related to so-called ERISA plans is that unless the plan is both single-employer-based and fully self-insured, it is subject to state insurance regulation either as an insurer or as a MEWA, and therefore is subject to state receivership proceedings. In brief, if the plan purports to provide, or does provide, benefits to two or more unrelated employers and their employees, it is subject to state insurance regulation, including state receivership proceedings. Likewise, if there is pooling of funds (contributions or otherwise) at any level, such that any entity other than a single employer is bearing the risk of loss as to covered claims, the plan is subject to state insurance regulation as an insurer or as a MEWA.

Entities Related to MEWAs. Union Plans are the one significant category of multi-employer plans that are not treated as MEWAs by ERISA and therefore are not subject to state regulation. Collectively bargained multi-employer plans are often confused with METs (multiple employer trusts), which are generally subject to state regulation as MEWAs. As a result, many illegal plans try to pass themselves off as bona fide collectively bargained plans. However, these plans must be recognized by the U.S. Department of Labor under strict standards that have been codified in regulations and, in most—if not all—states, the Department has not recognized any of the plans that have used this defense. The term MET is often used interchangeably with MEWA, along with the term VEBA. However, Voluntary Employee Beneficiary Assocations ("VEBAs") are a creature of the Internal Revenue Code and are not an insurance or ERISA concept. Instead, a VEBA is merely a vehicle by which certain employee benefits, including health care benefits, can be funded. It is a tax-exempt (not regulatory-exempt) vehicle that allows an employer to deduct payments made to the VEBA to fund the payment of employee benefits. VEBAs, however, can be maintained for the employees of more than one employer in certain situations.

Plans maintained by employee leasing firms and Professional Employer Organizations ("PEOs") are generally found to be MEWAs, because the employees are usually determined by the DOL to be the employees of the participating employers, and not the PEO. Finally, to the extent that an insurer, a third-party administrator or some other licensee of a state department of insurance is involved in or with the plan, the plan remains subject to "indirect" regulation because of the regulator's power over its direct licensee.

C. Alien Insurers

The receivership of unlicensed alien insurers presents special problems not encountered in other receiverships. An alien insurer is an insurer that is incorporated or organized in a jurisdiction that is not a state. See IRMA Section 104 (B) (definition of "alien insurer"). Preliminarily, IRMA provides that an alien insurer is considered to be domiciled in its "state of entry," and therefore that state's regulator would be responsible for insolvency proceedings regarding the insurer. See IRMA Section104 (H) (definition of "domiciliary state"). So while not necessarily admitted, an "unlicensed alien insurer" (meaning one that is not licensed in a particular state and is not eligible to write in that state as a surplus lines carrier) may still be considered "domiciled" in the state in which it initially began transacting business—at least for the purpose of a state's insurance insolvency act.

Often, alien insurers are not subject to adequate financial scrutiny or regulation in their alien jurisdiction, and their certificate of authority may not permit them to transact insurance in that jurisdiction. These facts, coupled with the stringent secrecy laws which prevent access to an alien insurer's corporate and financial information, make offshore locations an ideal haven for alien insurers with thin capitalization or other financial weakness.

When an unlicensed alien insurer is liquidated by its alien regulator for reasons of insolvency, the states in which it was transacting insurance may seek to establish an ancillary receivership. If the alien regulator refuses or fails to place the insurer into receivership, and the insurer is either transacting insurance in violation of a state's insurance laws or a state regulator has sufficient information to determine that the insurer is insolvent or not paying claims, then the state's regulator may petition its receivership court to appoint the regulator as receiver to protect the insureds in that state. Generally, the first state regulator to obtain a receivership order will take the lead in receivership matters over other state regulators that obtain later receivership orders. If a domiciliary receiver has already been appointed over an alien insurer (in the state of the alien insurer's entry), however, IRMA Section 1001(B) provides that another state's regulator may initiate an action against a foreign insurer only with the consent of the domiciliary receiver.

The receiver often encounters difficulty attempting to locate and marshal the unlicensed alien insurer's assets. This affects the receiver's ability to assess the potential to pay claims and administrative expenses. Usually, alien insurers maintain few or no assets in the states where they do business. Prior to placing an unlicensed alien insurer into receivership, the regulator may wish to investigate the insurer's assets, including real property, equipment and bank accounts. It is often difficult to identify and locate assets belonging to such insurers. Therefore, the receiver should immediately identify and locate all banks and financial institutions doing business with the unlicensed alien insurer and should serve the banks and financial institutions with certified copies of the receivership order as soon as possible to freeze the assets. Once the assets are frozen, it is unlikely that the insurer will be successful in attempting to dispose of or send the assets outside of the receiver's jurisdiction. Receivers often are unable to locate and marshal assets sufficient to administer the receivership, let alone to distribute assets to policyholders to pay claims.

Even if an alien insurer has executed the NAIC Standard Form Trust Agreement and purports to be an eligible surplus lines insurer, it may not have legitimate assets in trust for the payment of claims. The existence of a trust agreement may lead to a false sense of security for the receiver who really is dealing with an unlicensed insurer. Often, the bank that entered into the agreement did so without understanding the responsibilities it agreed to undertake on behalf of the insureds and upon which the regulators and insureds may have relied. Some unlicensed alien insurers open the requisite accounts in this country but only deposit worthless notes and stocks.

An unlicensed alien insurer's solvency or ability to pay claims may not be the only concern of regulators. Transacting insurance in a state without the proper certificate of authority or approval is often a criminal offense.

D. Unions

1. Organization and Regulation

ERISA preempts most state insurance laws as they relate to bona fide union-sponsored plans. Although such a plan may in fact afford health benefits to the employees and their dependents of multiple, unrelated employers, and hence be a MEWA, it is saved from state insurance regulation under ERISA language pertaining to "multi-employer plans."[11] A union sponsored plan will come within the exclusive jurisdiction of ERISA, however, only if the Secretary of the Department of Labor (Secretary) expressly finds that the plan was established and is maintained pursuant to a bona fide collective bargaining agreement. In the absence of such an express written finding, the plan is subject to state insurance regulation as a MEWA. The Secretary has never made such a finding on any of the union-

[11] ERISA Section 3(40)(A)(i)

sponsored plans in existence. Nonetheless, state insurance regulators have not routinely exercised authority over these union arrangements, at least if they are paying benefits exclusively to union members.

In recent years, however, bona fide unions have attempted to expand their membership by marketing health benefits to non-union members through "associate membership" programs. Unscrupulous entrepreneurs have also organized sham unions and marketed health benefits under the rubric of the sham union in an attempt to escape state regulation. Both instances have attracted greater scrutiny on the part of state regulators because participants/members have often been left with unpaid claims.

The Department of Labor (DOL) has responded by revisiting ERISA's preemption of state regulation in the context of union-sponsored plans. The DOL has issued proposed regulations which define the term "collective bargaining agreement" and limit participation of associate members in union-sponsored plans. The policy thrust of regulation by the DOL is that all arrangements marketing health benefits to the public are presumed subject to state regulation until the party proves that it is a bona fide union-sponsored plan and not a MEWA.

Similarly, many state insurance regulators have actively pursued these schemes. One of the best examples of state-federal partnership occurred in precisely this area. In a closely coordinated effort, the Florida Department of Insurance administratively terminated a Florida-based sham union health plan, and the following day, the Department of Labor obtained a temporary restraining order against the union, the plan, and all operatives, and the appointment of an Independent Fiduciary.

2. Receivership

The presiding U.S. District Court appoints an Independent Fiduciary to perform duties similar to those in an insurance receivership, including management of the entity, marshaling of assets and adjudication of claims. Periodic status reports are required by the court, including information on the actions of the Independent Fiduciary, the current financial position of the entity(ies), and the financial results for the period.

As there are no surplus requirements, there usually are limited assets available to discharge the obligations of the union and related welfare fund. Guaranty fund coverage is not afforded. ERISA requires specific notification of any amount denied on a claim, the reason for the denial, and the right of appeal by the member. The Department of Labor has historically required strict compliance with ERISA on this claim process. There is no specific language in ERISA that addresses liquidating distributions. Therefore, the required notification and right to appeal applies to liquidations as well as any ongoing claim processing. Liquidating distributions are typically on a pro rata basis for all obligations of the union and related welfare fund. The Independent Fiduciary generally prepares a plan of liquidation with the presiding court which sets forth the proof of claim process and proposed pro rata distribution.

E. Other Unlicensed Entities

The problem encountered by regulators and receivers are further compounded when the entity involved was not organized as an insurer, but is conducting business that is regulated as insurance. For ease of discussion, however, the term "insurer" again is used in this section to identify the entity.

Generally, a regulator faced with such an unlicensed entity must consider the following when deciding how to proceed: (i) will state regulatory action be effective in preventing further violations of state insurance laws; (ii) will receivership action through the courts be necessary to prevent further violations of state insurance laws; and (iii) should the activities of the unlicensed insurer be referred to state or federal law enforcement agencies for further investigation? The advantages of enforcing the receivership law and its provision for *ex parte* conservations may include: (i) the availability of a rapid procedure for injunctive

relief and the seizure of records or assets without advance notice; and (ii) available assets may be used to pay policyholders and other creditors in an orderly manner.

Many practical problems arise once an illegal insurer is placed into receivership. Once the insurer has been placed in receivership and the proper financial analysis and accounting groundwork has been laid, the receiver may be able to pursue the personal assets of the principals. There also may be hidden assets or potential causes of action that are not readily apparent at the time a decision must be made with regard to appointing a receiver. The criteria for appointment in that case may be that the entity has enough known assets to fund a search for unknown assets or to prosecute a cause of action against owners, operators or related companies which might have received fraudulent transfers. Often, the search for a list of policyholders or potential claimants will continue after the appointment of a receiver. As discussed in earlier chapters of this handbook, receivers typically do not find a complete policyholder list or indications of potential claims at the entity's office upon takeover.

In cases where an alien insurer has been placed into receivership, it may be appropriate to bring other persons and entities into the receivership net. In some instances, the alien insurer contracted with individuals and entities to facilitate the transaction of insurance statewide. These individuals and entities may include premium finance companies, third-party administrators, managing general agents and management companies. In other instances, the alien insurer may have set up affiliates and other entities which share common control and ownership. These alter egos of the alien insurer often commingle their assets with those of the alien insurer in an attempt to hide assets from U.S. regulators. If the receiver believes that these other entities may have assets belonging to the alien insurer and can demonstrate that the entities appear to be alter egos of the insurer, then these other entities also may be placed into receivership (most likely conservation, to enable the receiver to investigate their books and records). Often, premium dollars are funneled through or remain in the accounts of the insurer's affiliates and alter ego entities; making it necessary to seize their assets as well. Once in receivership, immediate attention should be given to tracking the insurance premiums from the point of sale through these various other entities.

IV. AGENTS

A. Managing General and Other Agents

1. Organization and Regulation

Managing general agents and other types of insurance producers may be subject to receivership laws because they have begun actually underwriting the business of insurance. In other words, they have begun to actually assume risks instead of merely acting as the agent or producer of business for the insurer. Under some states' laws, agents that have intentionally, or even inadvertently in some cases, begun assuming risks by not forwarding premiums to the actual underwriting insurer may fall within the definition of an "insurer." Accordingly, a commissioner may seek receivership of an agent under the same process as an insurer. The grounds for an agent receivership may be insolvency or some other violation of the insurance laws. The receivership statutes of the state in which the agent does business may apply to the agent in receivership.

2. Receivership

Generally, a commissioner will seek receivership of an agent to enjoin the agent's illegal activity (i.e., unauthorized issuance of policies) and to seize control of the agent's books, records and assets. The agent may have engaged in the unauthorized writing of insurance policies independently or on behalf of an insurer which had terminated his appointment. If the agent had apparent authority and premiums were collected, that insurer may be bound by the policies written by the agent even though the agent was not authorized to write such policies. The agent may also have written policies on illegitimate paper (i.e., a fictional insurer or unauthorized insurer) and collected premiums. The primary goals of an agent receivership are to prevent the continued operation of the agent's unauthorized business, to apply

recovered assets to any claims under policies of insurance that are not the responsibility of any legitimate insurer, and, more generally, to protect the public.

If the books and records of the insurer are so commingled with those of the agent that to separate them would result in a hazardous situation to the policyholders, the court may order the agent into receivership simultaneously with the insurer. This may be done by substantively consolidating the estates of the agent and the insurer, or it may be done by merely administratively consolidating the handling of the two separate estates in one proceeding. In either case, this empowers the receiver to seize the records and assets of the agent. There are significant legal issues related to this situation, and these should be considered carefully.

The action of the court in placing an agent in receivership generally results in permanent revocation of the agent's license and a permanent injunction against the individual from engaging in the business of insurance. The receiver should cooperate with other state insurance departments, if requested, to establish accurate and supportable findings as a basis for revoking an agent's license for unauthorized insurance activity.

B. Title Agents

A title agent is a person or a corporation that is authorized to act as an agent of a licensed title insurer to solicit insurance, collect premiums, issue and countersign title insurance policies. In some states, the title agent owns or controls an abstract plant. (An abstract plant is a facility that maintains real property records, typically by address as opposed to by grantor/grantee records.) In some states, a title agent is also an escrow agent and in some states, a title and escrow agent is called an "underwritten title company." Title agents may be subject to laws and regulations specifically governing their operations.

Title agents typically accept, hold and disburse funds deposited by buyers and sellers (or persons acting on their behalf) in connection with real property transactions. The funds may be held in trust or in an escrow account.

Under most state laws, a title agent is deemed to be in the business of insurance and is subject to receivership statutes. The purpose of receivership of a title agent is to protect the books and records, trust or escrow accounts, and other assets of the agent for the benefit of the creditors and perhaps especially, the escrow or trust depositors. Under state law, trust or escrow funds are under the control of the receiver, but they are not property of the receivership estate and thus they are not distributed pursuant to the priority statutes that apply to insurer insolvencies. Title agent insolvencies can create an immediate and heavy workload for a receiver because of the need to promptly handle escrowed funds and because of the time sensitivity of the transactions to which the funds pertain.

The grounds for receivership of a title agent typically include insolvency (based upon an examination of the escrow accounts), misappropriation of funds and/or unauthorized activity (e.g., the issuance of policies without appointment).

C. Reinsurance Intermediaries

Reinsurance intermediaries are brokers or agents in reinsurance transactions. In addition to the agency issues discussed above, the insolvency of a reinsurance intermediary raises the issue of who should bear the ultimate cost for the reinsurance intermediary's failure. The determination of this issue turns on a question of the law of agency, which most states have answered by statute, and by the terms of relevant reinsurance agreements in which the reinsurance intermediary is named. Those statutes have placed the risk of the insolvency of the intermediary upon the reinsurer. This is memorialized in the "intermediary clause," now required in every reinsurance contract (with respect to which the reinsured seeks statutory accounting credit).

Equally important is the issue of the proper forum for the liquidation of a reinsurance intermediary. This area of the law is largely undeveloped. The several courts which have addressed this issue suggest that the bankruptcy courts of the U.S. are the proper forum. However, the question becomes unclear when the reinsurance intermediary is a closely held or wholly owned subsidiary of an insurer which itself is in receivership.

D. Third-Party Administrators

1. Organization and Regulation

A third-party administrator (TPA) is any person or entity which receives or collects fees, charges or premiums for—or adjusts or settles claims on behalf of—an insurer. TPAs commonly provide such services to self-insured organizations. Over time, TPAs' services have expanded from claims adjudication and handling to that of full risk management services including cost control, auditing, litigation management and regulatory compliance. Some TPAs have also broadened their focus from health care and workers' compensation to property and casualty and professional liability.

Most states require that TPAs be licensed by the insurance commissioners and be subject to regulation by the states' insurance departments. Although some TPAs may also be subject to ERISA laws and supervision by the U.S. Department of Labor, this federal oversight is often ineffective. State insurance statutes usually require that TPAs apply for licensure, submit to examination by state commissioners, and hold all premiums in a fiduciary capacity separate and apart from their general operating funds.

2. Receivership

Commissioners may initiate receivership action against TPAs as a result of their unlawful insurance activities. TPAs are often found in the fray surrounding unlawful insurance activity. Sometimes the line between being an administrator operating on behalf of an insurer blurs when the TPA is performing the functions of an insurer without proper authorization or licensure. In these instances, the commissioner may choose to seize the TPA under the state's receivership laws in order to either stop the unlawful insurance business or to shut the TPA down completely.

Receivers are likely to encounter TPAs operating in conjunction with MEWAs, which may attempt to resist state regulation and/or receivership by asserting that they are only subject to federal ERISA statutes. The receiver may wish to contact the U.S. Department of Labor to determine if, in fact, the TPA or MEWA is in compliance with the federal ERISA laws. If the entity has failed to comply with ERISA statutes, then the states may have jurisdiction over the TPA and/or MEWA to initiate receivership action in the appropriate state court.

VI. ALTERNATIVE RISK FINANCING MECHANISMS

A. Captive Insurance Companies

1. Organization and Regulation

An ordinary captive insurance company is a risk-financing method, or a form of self-insurance, involving the establishment of a subsidiary entity or of an association organized to procure insurance. Captive insurance companies are formed to serve the insurance needs of a given entity or organization. The insureds normally have a direct involvement and influence over the company's major operations, including underwriting, claims, management policy and investments, although in practice the company usually is managed by a captive manager or attorney-in-fact. Leaving aside special purpose financial

captives[12] used in the issuance of insurance-linked securities, the common types of captive insurance companies are:

a) Pure Captive: An insurance company that insures only the property or risks of its parent and affiliated companies.

b) Association Captive: A captive insurance company established by members of an association to underwrite their own collective risks. An association captive usually only insures members of the sponsoring association.

c) Industrial Insured Captive: A captive insurance company that insures the property or risks of the industrial insureds that compose the industrial insured group, and their affiliated companies. An industrial insured is defined by statute, but commonly is one that has a full-time employee acting as an insurance manager or buyer and whose aggregate annual premiums for insurance on all risks total at least $25,000 and who has at least 25 full-time employees.

d) Rent-a-Captive: a rent-a-captive is an insurance company that, by contract with the participants, provides them the benefits of a captive insurance company without the capitalization requirements, administrative costs and legal ramifications associated with establishing and operating an insurance subsidiary. The contract may provide for return underwriting profits and investment income to a participant.

e) Sponsored Captive: A captive insurance company in which the minimum capital and surplus required by applicable law is provided by one or more sponsors, insures the property or risks of one or more participants, and segregates the assets and liabilities attributable to each insurance arrangement in one or more protected cells (sometimes called segregated accounts or segregated cells).

A variety of U.S. jurisdictions, as well as some off-shore jurisdictions (such as Bermuda), allow a captive to form in a protected cell structure. In such a structure, a captive insurance company containing separate units or cells is formed with a general surplus and general assets. However, each cell has its own assets and liabilities and the cells are bankruptcy-remote from one another and from the general account—i.e., the assets of one cell cannot be used to satisfy the liabilities of another cell or of the host company.[13] The captive insurance company must generally report an insolvent cell to the state insurance department, usually within 10 days. Actual state laws are neither uniform nor clear as to whether an individual cell can be treated as a free-standing entity for the purpose of insolvency proceedings; however, the definition of persons subject to receivership should be sufficiently broad in most states as to encompass an insolvent cell. The receiver, however, will be obligated to respect the separate nature of the cells.[14] Consequently, it is possible that a policyholder creditor of a given protected cell could receive a 100% distribution while the creditors of other cells or the general creditors of the captive do not. It is clear that the captive insurance company itself is subject to conventional insolvency proceedings.

2. Receivership

Domestic captives are subject to most states' receivership laws. Arguably, off-shore captives also are subject to state receivership statutes when such companies transact insurance business within the state without being properly licensed or authorized under the applicable insurance laws. However, there presently is no guaranty fund protection for insureds of captive insurance companies.

[12] E.g., S.C. Code § 38-90-410, *et seq.*

[13] *Accord* NAIC Protected Cell Company Model Act § 6.

[14] *Accord* NAIC Protected Cell Company Model Act § 7.

It is possible that captive insurers that are formed under the laws of a tax haven jurisdiction may be subject to the insolvency proceedings in that jurisdiction. As of this writing, the law regarding whether such proceedings can be recognized in the United States if the insurer lacks operations in the tax haven jurisdiction is open to question.

B. Risk Retention Groups

1. Organization and Regulation

A risk retention group is a company which insures similar companies with similar risks and operates nationally without having to be licensed in each state. Generally, every member or company must be insured by the risk retention group, and every insured must be a member of the group. A risk retention group is sometimes formed as a captive insurer in the domiciliary state. The federal Liability Risk Retention Act of 1986 also allowed for purchasing groups that purchase products liability, or completed operations, liability insurance.

Risk retention groups originally were intended to provide insurance to common groups of professionals (e.g., attorneys, bankers, accountants) nationwide without having to comply with each state's licensing requirements. Risk retention groups now cover a gamut of risks, including taxis, limousines and commercial autos, and other commercial liability types of risk.

Risk-retention groups organized or licensed in one state must register to transact business in other states. The risk retention groups are required to comply with the laws of the domiciliary state and certain laws of other states in which they transact business, including their insolvency laws, to the extent permitted by 15 U.S.C. § 3902(a)(1). The requirements for licensing (obtaining a certificate of authority) a risk retention group are less onerous than those for other domestic insurers. For a full discussion on risk retention groups, the NAIC Risk Retention and Purchasing Group Handbook is available from the NAIC Publications Department at www.naic.org.

2. Receivership

A domestic risk retention group is subject to that state's receivership statutes. If there is a challenge to the state's jurisdiction over a foreign entity, a state receiver may be required to initiate regulatory or receivership action against a foreign risk retention group in federal court. Particular attention should be paid to access to records of the risk retention group and issues that may arise with the captive manager. Finally, insureds of risk retention groups are not protected by guaranty funds and are prohibited by federal law from participating in a guaranty association.

C. Group Workers' Compensation Pools

1. Organization and Regulation

A Group Workers' Compensation Pool (GWCP) or group self-insurer is a risk-bearing entity which is permitted to bear workers' compensation risks without being organized as an insurance company. These entities are allowed in a few states. The GWCP must be sponsored by a trade association in most states and must insure a homogeneous group of workers' compensation insureds. A pool administrator or an attorney-in-fact sets up the GWCP as a trust and administers the entity. Typically, the GWCP provides group self-insurance or coverage through an indemnity agreement supported by joint and several liability of the members. GWCPs must prepare and file financial reports with their domiciliary state insurance commissioner or other regulatory agency and be audited annually by a certified public accountant.

2. Receivership

The receivership of a GWCP often is handled like that of any licensed insurer or unlicensed company. One state currently requires its Industrial Commission to administer a prefunded guaranty fund to protect GWCP insureds, thus evidencing the fact that (at least in that state) the GWCP is subject to the state's receivership laws. Some GWCPs are covered by guaranty funds, but the assessment, capacity and guaranty cover of the funds vary. A guaranty fund may be given the authority by statute to require the assessment by one financially impaired workers' compensation pool of that pool's participating employers. Alternatively, the guaranty fund would have to assess all of the pools in the fund to cover claims of an insolvent pool. This arrangement gives the fund incentive to require member pools to assess their own participants to avoid an insolvency.

D. Service Warranty/Extended Warranties

1. Organization and Regulation

A Service Warranty/Extended Warranty Entity is a risk-bearing entity which provides/ administers service warranties and/or extended warranties. The products can be supported by traditional insurance (Contractual Liability Insurance Policy, or CLIP) or the entity is required in those states providing for regulation to maintain reserves and otherwise file quarterly and annual reports with the department of insurance.

2. Receivership

A Service Warranty/Extended Warranty Entity in a few states, such as Florida, is subject to receivership statutes. Otherwise, bankruptcy or other receivership action may be required. Finally, service warranty/extended warranty products are typically not protected by guaranty funds but may be covered by surety bonds or the coverage provided by CLIPs.

VIII. MULTISTATE RECEIVERSHIPS

While this handbook generally assumes that receiverships are conducted in the insurer's state of domicile, in many to most cases insurers placed into rehabilitation or liquidation will have assets located, and creditors residing, in multiple jurisdictions. Note that the term "cross-border receiverships" generally will reference receiverships with issues in several countries, which will be addressed in the next section.

How the administration of a particular troubled insurance or reinsurance company will be affected by these multistate issues depends upon several factors. These include a) the insurer receivership law where the company is domiciled; b) the insurer receivership law in the states in which the company wrote business, held assets or incurred claims; and c) whether these states required the insurer to post special deposits. Several insurer receivership law models have been created to coordinate issues arising in multistate receiverships.

The earliest of these models is the Uniform Insurer's Liquidation Act (UILA), which was adopted by the NAIC as its insurer receivership model law in the 1930s. Created as a result of many insurers failing during the Great Depression, the UILA was designed for the specific purpose of solving certain problems inherent in multistate receiverships. Chief among these problems was that states would seize any assets found within their borders and apply those assets to the claims of residents of that state only. At that time, very few states had statutory insurer receivership laws, and the matters proceeded as equity receiverships in state courts whose jurisdiction was limited by that state's borders. This resulted in widely disproportionate levels of payment of claims and extravagant administrative expenses. The insurance receivership laws in most if not all states can trace their roots to the UILA..[15] In many states, later insurer receivership models were adopted, but the UILA was not repealed. In many other states

[15] Note that the UILA was withdrawn from recommendation for enactment by the National Conference of Commissioners on Uniform State Laws in 1981 due to it being obsolete.

these provisions were adopted because they were incorporated in the Interstate Relations sections of the NAIC's Insurers Rehabilitation and Liquidation Model Act (the Model Act). The Model Act was first adopted by the NAIC in 1968 and was amended several times prior to being replaced by IRMA in 2005. Most states have enacted receivership laws based upon the Model Act. These acts define the relative rights and responsibilities of state insurance commissioners in their capacities as both domiciliary and ancillary receivers of insolvent insurers.

A. Uniform Insurer's Liquidation Act

Under the UILA, the receivership or insolvency proceeding is referred to as a "delinquency proceeding," and defined as "any proceeding commenced against an insurer for the purpose of liquidating, rehabilitating or conserving" a delinquent insurer. The UILA designates the various states that may be involved in any given delinquency proceeding as follows:

Domiciliary State—The state in which the insurance company is incorporated or organized. If the insurer is incorporated or organized in a foreign country, then the domiciliary state is deemed to be the state in which the insurance company has, at the beginning of the delinquency proceedings, "the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States." The domiciliary state is deemed to be the primary location for the delinquency proceedings.

Ancillary State—Any state other than a domiciliary state. Ancillary states are those states where ancillary proceedings (i.e., receivership proceedings parallel to those of the domiciliary state) may be instituted. Generally, an ancillary may be instituted in any state where assets of the insurer are located.

Reciprocal State—Any state that has enacted provisions which are similar in substance and effect to the provisions of the UILA, which: a) state that only the regulator can be appointed as the receiver of an insurer; b) provide for the treatment of voidable preferential and fraudulent transfers; c) provide for the treatment of ancillary proceedings by the domiciliary state; and d) provide for the treatment of claimants residing in other-than-domiciliary states. [16]

The UILA defines certain types of assets and claims involved in delinquency proceedings. "General assets" are defined as "all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons." Assets located or situated in a state other than the domiciliary state are not exempt from classification as general assets by virtue of their location. Assets held in trust or on deposit in an ancillary state for the benefit of all of the insolvent insurer's policyholders are deemed to be general assets. Similarly, reinsurance proceeds typically are deemed to be general assets.

"Special deposit claims" are defined as any claims that have been secured by a deposit made pursuant to a statute for the security or benefit of a limited class of persons. Most states' statutes are designed to protect state residents against foreign insurance companies, and some states require that an insurance or reinsurance company post funds with the state in the form of a "special" or "statutory deposit" before being allowed to do business in that state. The special or statutory deposits can take the form of bonds, trust accounts, escrow accounts, letters of credit, cash or any other form of security approved or required by the state. The states usually require funds sufficient to cover all potential outstanding policyholder (and in some states, general creditor) claims against the insurance company by the residents of that state. In some states, the amount and form of the deposit depend upon the type of insurer involved and the type of insurance risk underwritten.

[16] If each state enacted the uniform law, the National Conference of Commissioners on Uniform State Laws reasoned, past embarrassments could be remedied by the following: (1) provision that the insurance commissioner or an equivalent official shall serve as receiver; (2) authority for domiciliary receivers to proceed in non-domiciliary states so as to prevent dissipation of assets therein; (3) vesting of title to assets in the domiciliary receiver; (4) provision for non-domiciliary creditors to have the option to proceed with claims before local ancillary receivers; (5) uniform application of the laws of the domiciliary state to the allowance of preferences among claims; and (6) prevention of preferences for diligent non-domiciliary creditors with advance information. Prefatory Note, Uniform Insurers Liquidation Act, 13 U.L.A. 322 (1986) (superseded).

The UILA has created a framework for simultaneous receivership proceedings in different states with respect to a single insurer. It outlines procedures for delinquency proceedings for both domiciliary and non-domiciliary insurance companies, as well as the duties and responsibilities of the domiciliary and ancillary receivers. The UILA also sets forth provisions governing the filing and proving of claims, priority of creditors' claims, special deposits, and the attachment and garnishment of assets. Overall, these provisions centralize the delinquency proceedings by vesting power in a single domiciliary receiver.

1. Domiciliary and Ancillary Receivers

Once delinquency proceedings are initiated in the state where an insolvent or delinquent company is domiciled, the UILA provides that the court shall designate that state's commissioner of insurance as the domiciliary receiver. Most states have specific requirements for the appointment of a receiver.

Some courts have held that an ancillary receiver cannot be appointed until after a domiciliary receiver has been appointed unless certain steps are taken. Generally, the commissioner of insurance may petition the court for appointment of an ancillary receiver (i) if there are "sufficient" assets of the company located in the ancillary state to justify the appointment of an ancillary receiver, or (ii) if 10 or more state residents petition the commissioner requesting an ancillary receiver. When appropriate, the court appoints the insurance commissioner of the state as ancillary receiver.

Upon appointment of a domiciliary receiver, the court "directs the receiver to take possession of the insurer's assets and administer them." Most states have statutes outlining the specific powers and duties of the receiver as supervisor, conservator, rehabilitator, or liquidator of the delinquent company. In addition, the UILA vests the domiciliary receiver (and successors) with title to all property, contracts and rights of action of the delinquent company, wherever situated, as of the date of entry of an order giving the receiver possession of the company. Upon taking possession of the assets, the domiciliary receiver must proceed to liquidate, rehabilitate, reorganize or conserve the company. Typically, the domiciliary receiver has sole responsibility to operate the delinquent company, to make policy decisions concerning the conduct of the delinquency proceedings, and to create a plan for administration of the company.

If an ancillary receiver is appointed in a reciprocal state, the UILA provides that the ancillary receiver has the same rights and powers regarding assets located in the ancillary state as the domiciliary state would grant to its own ancillary receivers. In addition, the ancillary receiver is deemed to have the sole right to recover assets of the company located in the ancillary state.

The ancillary receiver appointed under the UILA "as soon as is practicable" liquidates from assets in the receiver's possession those special deposit claims and secured claims which are proven and allowed in the ancillary proceedings. Any and all remaining assets of the company then are to be promptly transferred to the domiciliary receiver.

2. Claims, Special Deposits and Priorities

Once receivers are appointed in the domiciliary and ancillary states, the focus of the UILA shifts to the processing and payment of claims. In particular, the UILA provides for the filing of claims generally, the payment of claims out of specially deposited assets, and the relative priority of claimants in the payment process.

a. Filing Claims

Claimants residing in reciprocal states may bring claims against the delinquent company in either the domiciliary proceeding or in an ancillary proceeding in their own states. If ancillary proceedings have not been commenced, a claim against a company in delinquency proceedings must be presented in the domiciliary proceedings. If the claims are controverted, and the ancillary forum is chosen for resolution of those claims, proper notice of the disputed claims must be given to the domiciliary receiver. If such

notice is given, the final judgment as to the controverted claim will be conclusive as to amount and perhaps priority in both the ancillary and domiciliary proceedings.

b. Special Deposits

Under the UILA, claimants of a state are given priority against special deposit funds held for their benefit, according to that state's statutes. If the special deposit claims have not been fully paid after all special deposit funds have been fully exhausted, the special deposit claimants may share in the general assets of the company. However, in order to assure equal treatment of all of the delinquent company's creditors, the special deposit claimants who have received a distribution from special deposit funds cannot share in general assets until "general creditors, and claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit."

c. Priority of Preferred Claims

Pursuant to UILA, the preference or priority scheme of the domiciliary state determines which claims will be deemed preferred, regardless of where claims are brought. The priority provisions of the UILA, however, do not replace other principles generally applicable to the payment of claims.

3. Problems Under the UILA

Certain problems have arisen over the years in applying the UILA to multistate delinquency proceedings. Some of these problems have arisen from disputes over the scope of injunctions or stay orders issued by receivers, proper timing of claims, and enforcement of judgments against the delinquent company. Other problems have arisen where a nonreciprocal state—a state which has not enacted the UILA—is involved in the delinquency proceedings. The UILA does not address this problem, and courts have struggled to fashion equitable resolutions for the states involved. Most often, courts have held that UILA states have no duty to apply the principles of the UILA with regard to nonreciprocal states.

The UILA has several other "gaps" that have caused difficulties over the years. The UILA does not address the right of a commissioner in an ancillary state to initiate delinquency proceedings in the ancillary state in the event that delinquency proceedings are not initiated in the domiciliary state. Also, the UILA contains no provision governing a domiciliary receiver's remedies in the event that an ancillary receiver refuses to cooperate with the domiciliary receiver in the collection and distribution of assets.

Some of these problems have been addressed in the Model Act.

B. The Insurers Rehabilitation and Liquidation Model Act

The Model Act contains provisions governing all aspects of insurance company receivership regulation in the United States with regard to conservation, rehabilitation and liquidation, including provisions governing multistate proceedings. With respect to multi-jurisdiction receivership, the goals of the Model Act are to provide improved methods for the rehabilitation of insurers; to make the liquidation process more efficient and economical; to facilitate interstate cooperation in the rehabilitation and liquidation of insurers; and to protect the interests of policyholders, claimants and creditors.

1. Structure of the Model Act

Ten sections (54-63) of the Model Act adopt much of the UILA, as well as its policy objective: centralization of delinquency proceedings in the domiciliary jurisdiction. Unlike the UILA, however, the Model Act no longer refers to the insolvency proceedings as a "delinquency proceeding." Rather, the Model Act distinguishes between conservation and "formal proceedings," i.e., rehabilitation and

liquidation. States are considered reciprocal under the Model Act if each has enacted the substance and effect of Sections 5 (Injunctions and Orders), 17 (Rehabilitation Orders), 20 (Liquidation Orders) and six of the "Interstate Relations" sections (i.e., 54-56 and 58-60).

2. Domiciliary and Ancillary Receivers

The grounds for appointment of a domiciliary receiver under the Model Act parallel those in the UILA, i.e., the same grounds for rehabilitation or liquidation set forth in Section 15 of the Model Act. The two acts differ, however, as to the grounds for appointment of ancillary receivers. The UILA enables the state commissioner to petition for appointment as an ancillary receiver if there are sufficient assets in the state to warrant such action, or if 10 or more residents with claims against the company petition for the appointment of an ancillary receiver. Under the Model Act, proceedings may be initiated if: (i) there are sufficient assets in the state to justify the appointment of an ancillary receiver; (ii) "the protection of creditors or policyholders in [the ancillary] state so requires"; or (iii) the domiciliary receiver requests such a filing. The ancillary receiver of an insurer domiciled in a reciprocal state may render only such assistance as the domiciliary receiver requests, and has the same powers and duties as the domiciliary receiver when so requested. The ancillary receiver is entitled to payment of his or her costs or expenses, and may enter into agreements with the domiciliary receiver regarding the payment or advancement of such expenses.

3. Receivers of Foreign and Alien Insurers

The Model Act distinguishes between foreign (those from any other U.S. state, district or territory) and alien (those from another country) insurers. If grounds exist for the commencement of delinquency proceedings against a foreign or alien insurer (i.e., those set forth in Section 15, as well as official sequestration of the insurer's property in its domicile, or revocation of the insurer's certificate of authority while residents of the state have outstanding policies or claims) and no domiciliary receiver has been appointed, the Model Act enables the state commissioner to petition the designated court for appointment as conservator of the insurer's property found in the conservator's state. Under a state court order, the commissioner, as receiver, may conserve (but not liquidate) the assets of an alien insurer that has not established a domicile in the U.S. (but not those of a foreign insurer) found in the state.

4. Receiver's Control Over Assets

Like the UILA, the appointment of a receiver vests the receiver with title to all of the insurer's assets, by operation of law. Under both the Model Act and the UILA, a receivership is established in which the domiciliary receiver is directed to administer the insurer's assets under the general supervision of the receivership court. However, the Model Act requires that the receiver provide periodic accountings to the supervising court.

With respect to assets, the Model Act distinguishes between a domiciliary liquidator appointed in a reciprocal state and one appointed in a non-reciprocal state. A domiciliary liquidator appointed in a reciprocal state is vested with title to, and has the immediate right to recover, all assets in all reciprocal states—except for special deposits and the security on secured claims—upon the filing of the petition for liquidation. However, when a domiciliary liquidator is appointed in a non-reciprocal state, the commissioner of the non-reciprocal ancillary state is vested with title to all of the assets situated in that state and may petition for a conservation order or for an ancillary receivership, or transfer such assets to the domiciliary liquidator after obtaining court approval.

5. Claims

The Model Act and the UILA treat the filing of claims differently. Under the Model Act, creditors of an insurer under liquidation in a reciprocal state must file their claims in the domiciliary proceeding, subject to its deadlines. However, while the UILA is silent as to the rights of residents in non-reciprocal states to file claims with an ancillary receiver, the Model Act specifically allows such claimants to file

their claims with either the domiciliary liquidator or the ancillary receiver, if the domiciliary state's law permits. Similarly, under the Model Act, nonresident creditors of an insurer in liquidation in its domiciliary state must file their claims with the domiciliary receiver, subject to the domiciliary state's deadlines. In some states, the in-state residents, including policyholders and general creditors, have a lien on the deposits. The receiver should review the applicable state statutes under which the deposits were created.

The Model Act also now differs from the UILA in its treatment of controverted claims. Under the Model Act, controverted claims must be proved and decided in the domiciliary state unless the claimant notifies the domiciliary liquidator in writing that it elects to proceed in the claimant's respective reciprocal state's ancillary receivership. The ancillary court's determination of such a controverted claim is conclusive as to validity and amount, but priority of distribution shall be determined in the domiciliary proceeding. The claimant also may controvert its claim in the domiciliary proceeding.

Secured claimants may surrender their security and file their claims as general creditors, or they can resort to the security and make a claim for any deficiency on the same basis as unsecured creditors in the same class.

The Model Act now differs significantly from the UILA in the handling of special or statutory deposit claims. Upon the entry of a final order of liquidation or an order approving a rehabilitation plan of an insurer domiciled in the state or a reciprocal state, all deposits must be delivered to the domiciliary liquidator to be held as a general asset for the benefit of all creditors and distributed in accordance with the domiciliary state's law.

6. Priority of Distribution

Under the Model Act, general assets are distributed in accordance with the domiciliary state's priority of distribution scheme. The Model Act was drafted so that the determination of priority by an ancillary liquidator and court is not binding upon the domiciliary liquidator. The Model Act encourages interstate cooperation by penalizing claimants residing in states if their ancillary receiver fails to transfer any assets to the domiciliary receiver. The claims filed in the ancillary proceeding other than special deposits or secured claims are subordinated to the next-to-last class of claims under the priority of distribution schedule.[17] The UILA contains no similar penalty provisions.

C. Insurers Receivership Model Act

IRMA was adopted by the NAIC in December 2005 to replace the earlier Model Act. There are several areas of change between IRMA and the Model Act, but probably the subject of the greatest change was interstate relations. Article X deals with this subject in only two sections as compared to 11 in the 1998 version of the Model Act. Under IRMA, the authority and responsibility for administering the estate of an insolvent insurer is placed on the domiciliary receiver. If a domiciliary receiver has been appointed, an ancillary receivership may be initiated only with the consent of the domiciliary receiver (IRMA Section 1001B).

Prior to the appointment of a domiciliary receiver, any commissioner in any state may petition to be appointed as conservator of the assets of a foreign insurer that are located in that commissioner's state: 1) on the same grounds as would justify the appointment of a receiver in that state; 2) if any of its assets have been seized by official action in another state; 3) if its certificate of authority in the commissioner's state has been revoked and there are residents with unpaid claims or in-force policies; or 4) if it is necessary to enforce a stay under the state's guaranty association laws (IRMA Section 1001A).

An ancillary conservator may use assets of the insurer to pay the costs of administering the estate (IRMA Section 1001E). Once a domiciliary receiver is appointed, the conservator shall turn over all property of the

[17] Model Act § 58

estate to the receiver (IRMA Section 1001D). An ancillary liquidation order can only be issued for the purpose of liquidating assets to pay the administrative costs of the ancillary receivership or to activate the guaranty association in the ancillary state (IRMA Section 1001F).

With the exception of special or statutory deposits established with the state's guaranty association as the sole beneficiary, IRMA provides that the assets of an insurer belong to the domiciliary receiver. The domiciliary receiver is entitled to take possession of those assets (IRMA Section 1002A). Upon the entry of a liquidation order with a finding of insolvency, those special deposits are to be distributed to the guaranty associations as early access (IRMA Section 1002A). All other deposits are to be returned to the domiciliary receiver, who is obligated to administer them in accordance with the law under which they were created (IRMA Section 1002B). Special deposit claims are to be adjudicated and paid by the domiciliary receiver. If the special deposit is insufficient to pay all special deposit claims in full, special deposit claimants may share with other claimants in their priority class, but only after all others of the same class have been paid a percentage of their claims equal to the percentage that the special deposit claimants have received. (IRMA Section 1002C).

IRMA makes all states reciprocal states to the enacting state and directs that all receivership orders and related orders in another state are to be given full faith and credit by the courts of the enacting state (IRMA Section 1002A). This provision is to ensure that stay orders issued in relation to a receivership are honored by the courts in other states.

Reciprocity can be an issue in IRMA. While IRMA provides that a state adopting it would consider all other states reciprocal to that state, the other states may require allowance of their ancillary proceedings (which IRMA would not allow) for these other states to consider the IRMA-adopting state to be reciprocal to them. This may be remedied by a state adopting IRMA if it adds a provision for transitioning on reciprocity. Some suggested wording for this follows: "Notwithstanding any other provision of this Act, only to the extent necessary while other states are in the process of adopting Acts similar to this Act, the receivership court may allow for the treatment of ancillary proceedings reciprocal to the laws of any state providing for ancillary proceedings."

NAIC Guideline for Definition of Reciprocal State in Receivership Laws (#1985)

In 2021, the NAIC adopted the Guideline for Definition of Reciprocal State in Receivership Laws (#1985) to provide a statutory definition that may be used by state with a reciprocity requirement to effectuate the purposes of the following provisions, which in may states may only apply if the domiciliary state is a reciprocal state.

- The domiciliary receiver is vested with the title to the insurer's assets in the state.
- Attachments, garnishments or levies against the insurer or its assets are prohibited.
- Actions against the insurer and its insureds are stayed for a specified period of time.

The definition provided in Guideline #1985 states that: "Reciprocal state" means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state's insurance commissioner or comparable insurance regulatory official.

Under this definition, any state meeting the applicable Part A standards of the NAIC Financial Regulation Standards and Accreditation Program for state receivership laws will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws and should prevent unnecessary litigation regarding the recognition of a state as a reciprocal state.

Note that Guideline #1985 was adopted to address concerns with reciprocity under IRMA, as noted above, and is available for states to adopt if not already addressed through state statues or other means.

IX. INTERNATIONAL RECEIVERSHIPS

Due to the continued globalization of the insurance industry, insurance companies often may have assets, creditors and debtors located around the world. Therefore, the receiver of a domestic insurance company may be forced to address numerous legal, strategic, practical and political issues related to cross-border insolvencies.

When the insolvent domestic insurer has assets located in a foreign country, the receiver should consult with his or her professional advisors to determine how to administer those assets. Issues to consider include: (1) whether the domestic insurer can repatriate the assets without incurring unacceptable legal risk or significant expense; (2) whether the insurer (or the domestic receiver as legal representative of the insurer), the insurer's creditors, or a foreign regulator can initiate separate insolvency proceedings to ensure the orderly administration of the assets located in the foreign country; and (3) whether the domestic receiver can be granted relief from a foreign court in aid of the domestic receivership proceeding in the form of injunctions, stays, or other relief to prevent creditors from attaching the assets or commencing litigation against the insolvent insurer in the foreign jurisdiction. Additionally, where the insolvent domestic insurer's assets have been commingled with affiliates incorporated in foreign countries, the receiver should consult with his or her professional advisors to ascertain whether it would be possible and prudent to attempt to substantively consolidate the assets and liabilities of foreign entities into the domestic receivership estate, or other available mechanisms for achieving the same result.

When the estate has a claim against an entity that is the subject of foreign insolvency proceedings (such as a reinsurer, retrocessionaire or policyholder with retrospectively related premium or high deductible obligations), the receiver will be confronted with a different set of considerations with respect to the pursuit of its claim. The location of the entity's assets and the nature of the insolvency proceedings will be of significant importance. If all of the entity's assets are located in the foreign country, the receiver will need to consider the degree to which the receiver is willing to commit financial and personnel resources to participating in the foreign insolvency proceeding and the risks associated with submitting to the jurisdiction of the foreign court. Levels of participation can range from merely presenting claims in accordance with the foreign court's procedures to contesting the basis for the insolvency proceedings, and the specifics of the relief sought by the entity in the foreign court. If the entity has assets in the United States, the receiver may consider additional options, such as attaching the assets and contesting any relief sought by the entity in the United States in aid of the foreign proceedings.

Insolvency proceedings in foreign countries come in a variety of flavors. This is intended to be neither a comprehensive list nor comprehensive descriptions of the various proceedings. The Common Law jurisdictions in the English tradition (for example, Bermuda and the United Kingdom) recognize reorganization of both solvent and insolvent companies. Typically, "solvent schemes of arrangement" allow a solvent company to reorganize its liabilities under general corporate law, often in conjunction with an exit from business and often with limited or no court supervision. There are also schemes involving insolvent companies, using the scheme of arrangement mechanism in conjunction with an insolvency proceeding, often involving an insolvency practitioner acting as the provisional liquidator reporting to a court on a periodic basis. Some common law countries also allow court-supervised reorganizations or "orders of administration" similar to a United States proceeding under Chapter 11 of the Bankruptcy Code. European Union jurisdictions recognize a semi-uniform insolvency regime in which a main proceeding coordinates with ancillary proceedings in other member states. The United Kingdom also recognizes a corporate transaction in which a group of insurance policies may be transferred to another company through Part VII of the Financial Services and Markets Act 2000, which provides "for the transfer to the transferee of the whole or any part of the undertaking concerned and of any property or liabilities of the authorized person concerned." As of this writing, the balance of the European Union countries are expected to institute similar procedures.

There are essentially two ways that the orders of a foreign receiver could be enforced in the United States. A foreign receiver may seek recognition under Chapter 15 of the Bankruptcy Code, 11 U.S.C. §§ 1501-1532, or through the doctrine of comity.

Chapter 15 of the Bankruptcy Code is designed to enable "foreign representatives" acting in "foreign proceedings" to enforce orders from those proceedings in the United States. In effect, Chapter 15 opens the traditional bankruptcy tools to a foreign receiver. Chapter 15 replaces the Code's prior mechanism of granting cooperation with a foreign representative under the former Bankruptcy Code § 304.

Chapter 15 was designed to enact the United Nations model insolvency law in the United States. The House Report on the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 describes how the 2005 legislation "introduces Chapter 15 to the Bankruptcy Code, which is the Model Law on Cross-Border Insolvency ('Model Law') promulgated by the United Nations Commission on International Trade Law ("UNCITRAL")." H.R. Rep. No. 109-31, at 105 (2005). The Model Law commentary states: "The purpose of this Law is to provide effective mechanisms for dealing with cases of cross-border insolvency" (Preamble UNCITRAL Model Law). While courts will frequently analogize to case law under the old § 304 when examining Chapter 15 situations, it should be recognized that Chapter 15, by adopting the UNCITRAL Model Law, has adopted an entirely new regime, not simply modified the old one.

Chapter 15 relief is specifically open to foreign insurance companies. A case under Chapter 15 begins with the filing of a petition for recognition of the foreign proceeding. A court may grant a stay of execution on the debtor's assets upon filing of the petition, and prior to the grant of recognition. Chapter 15 provides direct access to U.S. courts for the foreign representative to sue or be sued and mandates that once a foreign representative is granted recognition, the representative will be granted comity and the cooperation of the U.S. courts. If recognition is not granted, the U.S. court may issue orders preventing the foreign representative from acting in the United States. There is an exception to recognition providing that the decision to seek or not seek recognition will not "affect any right the foreign representative may have to sue in a court in the United States to collect or recover a claim which is the property of the debtor" such as collect accounts receivable within the United States.

Once recognition is granted, a foreign representative may commence either an involuntary or voluntary case under the Code, opening the door to the entire array of bankruptcy powers. Once recognized, the foreign representative may seek a stay of actions against the debtor's assets, and the court may entrust distribution of the debtor's U.S. assets to the foreign representative. Chapter 15 specifically grants the foreign representative the power to avoid transactions as fraudulent transfers or preferences and use the Code's turnover mechanisms for recovery. Chapter 15 gives foreign creditors the same rights as U.S. creditors. Once a foreign proceeding is recognized as a foreign main proceeding, "sections 361 and 362 apply with respect to the debtor and the property of the debtor that is within the territorial jurisdiction of the United States…" 11 U.S.C. § 1520 (a)(1).

Significantly, Bankruptcy Code § 1501(d) provides that "[t]he court may not grant relief under this chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable State insurance law or regulation for the benefit of claim holders in the United States." Under a plain reading of this provision, claimholders should not be enjoined by the bankruptcy court from seeking recoveries out of statutory deposits. As of the date of this writing, there are no bankruptcy court opinions that have considered the question of whether Bankruptcy Code § 1501(d) precludes the court from enjoining a domestic ceding company from seeking recoveries out of a deposit, escrow, trust fund or any other security provided by an unauthorized alien reinsurer to satisfy credit for reinsurance statutes.

One of the unsettled questions at the early stage of the implementation of Chapter 15 is determining what constitutes a "foreign proceeding." A "foreign proceeding" under the Bankruptcy Code is a proceeding "under a law relating to insolvency or adjustment of debt in which proceeding the [debtor's assets and affairs] are subject to control or supervision by a foreign court for the purpose of reorganization or liquidation." 11 U.S.C. § 101(23). While the pre-Chapter 15 definition of "foreign proceeding" and the revised definition may appear similar, it is clear that Congress intended to fully scrap the prior definition in favor of the UNCITRAL Model Law. In fact, the current definition of "foreign proceeding" in the Bankruptcy Code makes clear that it applies only to proceedings "under a law relating

to insolvency or adjustment of debt." Therefore, a receiver should consider whether there is a basis for challenging a Chapter 15 petition on the grounds that the foreign restructuring is merely a corporate reorganization rather than a true insolvency proceeding under a law relating to the adjustment of debt.

Additionally, Chapter 15 contains a specific public policy exception: "Nothing in this chapter prevents the court from refusing to take an action governed by this chapter if the action would be manifestly contrary to the public policy of the United States." 11 U.S.C. § 1506. However, this exception is to be narrowly construed. A receiver should consider whether to oppose the Chapter 15 petition on the basis that the relief being sought by the entity in the foreign proceeding is contrary to public policy, such as applicable state insurance regulations.

It is also possible that a U.S. court may grant assistance to a foreign representative under the doctrine of comity when a case lies outside of those contemplated by Chapter 15. Comity is the recognition that one nation allows within its territory the legislative, executive or judicial acts of another nation, having due regard both to international duty and convenience, and to the rights of its own citizens, or of other persons who are under the protection of its laws. Comity is a flexible doctrine, but the courts are inclined to enforce foreign judgments unless they are contrary to public policy. Comity will not be granted when a foreign proceeding tramples on rights granted by the U.S. Constitution. However, other violations of U.S. law must pass a high threshold to prevent a grant of comity.

In summary, due to the complex nature of cross-border insolvency issues, there may be additional legal, strategic, practical and political issues that a receiver may need to address in order to ensure the orderly administration of the estate and the maximization of recoveries for creditors. Once the estate is confronted with issues related to insolvency proceedings in foreign countries, the receiver should consult with his or her professionals to identify potential problems and solutions.

Internationally Active Insurance Groups and Communication with International Regulators

U.S. based insurance holding company systems that operate internationally are designated Internationally Active Insurance Groups (IAIGs) if they meet certain criteria, generally based on size and writings, but may include other criteria[18].

For each IAIG, a group-wide supervisor is designated (which may not be a U.S. state regulator). Additionally, for each IAIG, supervisory colleges and crisis management groups are formed to meet periodically to discuss and exchange relevant information about the group. One key benefit to supervisory colleges is establishing routine communication channels with appropriate company personnel and regulators in other jurisdictions.

The NAIC through the state regulators has defined a supervisory college as a regulatory tool that is incorporated into the existing risk-focused surveillance approach when a holding company system contains internationally active legal entities with material levels of activity and is designed to work in conjunction with a regulatory agency's analytical, examination and legal efforts. The supervisory college creates a more unified approach to addressing global financial supervision issues. Supervisory colleges may also be formed for groups with international activity that do not fully meet the definition of an IAIG, at the discretion of the relevant jurisdictions' insurance regulators (often referred to as "regional colleges").

Additionally, the group-wide supervisor will establish a crisis management group (CMG) for the IAIG with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG.

In the event a U.S. insurance entity within an IAIG becomes financially troubled and/or insolvent, the U.S. domestic state insurance regulator and group-wide supervisor (if not the same) should utilize the communication channels established by the supervisory college and crisis management group when beginning a receivership process.

[18] A discussion of IAIG criteria and other analysis and regulatory considerations for group-wide supervision is included in the NAIC *Financial Analysis Handbook*.

The group-wide supervisor, in consultation with the CMG, determines whether to require that the IAIG develop a formal recovery plan[19] to establish in advance the options to restore the financial position and viability of the IAIG in a crisis. If a recovery plan is in place, it can be used by the CMG and the IAIG to take actions for recovery if the IAIG comes under severe stress. Regardless of whether a formal recovery plan is required, the ORSA Summary Report should discuss at a high level the severe stresses that may identify recovery options available and provide information for the state insurance department in the event of severe stress.

Resolution plans[20] are put in place at IAIGs where the group-wide supervisor and/or resolution authority, in consultation with the CMG, deems necessary. If a resolution plan is in place, it should contain information from relevant legal entities and other jurisdictions to aid in the receivership process. There may be in pace coordination agreements that outline roles and responsibilities of members of the CMG and the process for coordination and cooperation, including information sharing, among members of the CMG.

Refer to the NAIC *Financial Analysis Handbook* for more details on group-wide supervision, supervisory colleges, and CMGs.

[19] Refer to ICP CF 16.15 and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)

[20] Refer to ICP CF 12.2 and 12.3 and the Application Paper on Resolution Powers and Planning for more background information and possible best practice guidance, including the approach to determining if resolution plans are needed and key elements of a plan (e.g., resolution strategies, financial stability impacts, governance, communication, and impact on guaranty fund systems). (https://www.iaisweb.org/home)

CHAPTER 9 – LEGAL CONSIDERATIONS PAGE NUMBERS WILL BE UPDATED IN THE FINAL

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I. INTRODUCTION

A. Goal

This chapter's goal is to introduce, in as neutral a manner as possible, the legal issues that a receiver may encounter in administering the receivership of an insurer. The following caveats and limitations apply to the chapter:

- The insurance industry in the U.S. is regulated on a state, rather than a federal, level. Each state has its own insurance laws that may significantly differ from those of any other state. While these materials include information that is generally true throughout the U.S., it is essential that receivers and other practitioners examine the laws of each state involved. Federal law should also be consulted concerning certain issues.

- These materials are not an adequate substitute for advice of legal counsel. They are designed to assist the reader in effectively communicating with legal counsel and in understanding the relevant legal issues. They do not and cannot make the utilization of legal counsel unnecessary. Competent legal counsel must be retained to act on behalf of the receiver and participate in the administration of the insurer's affairs.

- The law relating to insolvent insurers is evolving. While these materials are intended to be current as of date of publication and will be periodically updated, it is suggested that counsel be consulted on all legal issues.

B. Diversity of Law

Historically, insurers and reinsurers have been excluded from the provisions of federal bankruptcy law.[1] They are governed instead by state receivership laws, even though the insurer's parent company and other non-insurance affiliates may be within the jurisdiction of the federal bankruptcy courts. When entities affiliated with an insurer in receivership are in federal bankruptcy proceedings, coordination of the proceedings may be advantageous, even essential, to bringing about an effective resolution of each proceeding.[2]

Insurers generally do not limit their business to the geographical confines of a single jurisdiction, so, when an insurer is declared insolvent, the laws of more than one state may be implicated. Consequently, during the takeover and administration of an insolvent insurer, it is of the utmost importance to consult the laws of each jurisdiction in which the insurer conducted business.

Most states have enacted insurer delinquency proceeding statutes modeled after either the Uniform Insurers Liquidation Act (Uniform Act), the *Insurers Rehabilitation and Liquidation Model Act* (Liquidation Model Act) or the *Insurer Receivership Model Act* (#555), also known as IRMA,—collectively, the Model Acts.[3] Because of the widespread influence of the Uniform Act and the Liquidation Model Act, they both serve as logical bases for any general analysis of legal issues involved in the takeover and administration of an

[1] See 11 U.S.C. § 109(b)(2). What constitutes an "insurance company" excluded from bankruptcy is a matter of federal law and may depend on whether the insurance department desires to assert jurisdiction over the entity. Compare *In re Estate of Medicare HMO,* 998 F.2d 436 (7th Cir. 1993) (HMO excluded from bankruptcy) with In re *Grouphealth Partnership, Inc.,* 137 B.R. 593 (Bankr. E.D.Pa. 1992) (HMO not so excluded).

[2] See e.g., *In re Baldwin-United Corp. Litigation,* 765 F.2d 343 (2d Cir. 1985) (insolvent insurers' settlement with state insurance administrators supervising their rehabilitation was conditioned on federal court confirmation of a plan of reorganization for the parent company under federal bankruptcy laws*);* see also In re *Kearns*, 161 B.R. 701 (D. Kan. 1993) (discussing split of authority regarding jurisdiction over effect of automatic stay on nonbankruptcy proceedings).

[3] See Uniform Insurers Liquidation Act, 13 U.L.A. 328 (1986 and Supp. 1991) [hereinafter Uniform Act]; NAIC Insurers Rehabilitation and Liquidation Model Act (1991) [hereinafter Liquidation Model Act]; and NAIC Insurer Receivership Model Act (2006) [hereinafter IRMA].

insolvent insurer. For this reason, both acts, along with case law, were used in preparing this chapter. IRMA is the most recent NAIC model act, so references to relevant provisions of IRMA are also included, where appropriate. Be aware, however, that the law of a particular state may deviate from the model acts, so counsel should be consulted.

C. Administration of Receivership

The model acts provide that the regulator of the state in which the insurer is domiciled, if a domestic insurer, will administer the insurer in receivership. Likewise, if the insurer is an alien insurer, i.e., an insurance company formed according to the legal requirements of a foreign country that gained admission to the U.S. market through a "port-of-entry," the regulator of the state through which the insurer gained admission will administer the U.S. deposit and/or trust assets of the insolvent insurer in receivership. The model acts dictate that a state's insurance regulator, as receiver, will administer all insurer receiverships under the supervision of the state courts, usually those courts located either in the county (or parish) of the domiciliary state's capital or the insurer's principal office.

This chapter is designed to serve as a supplement to each of the other chapters in the handbook. With the exception of Chapter 8—Special Receiverships, this chapter includes a topic heading that corresponds to each of the other chapter titles in the handbook. Thus, the first topic heading in the legal chapter entitled "Takeover and Administration" provides a discussion of the legal issues which may arise as a result of those activities discussed in Chapter 1—Takeover and Administration. Although most of the legal issues discussed in this chapter apply to Chapter 8—Special Receiverships, there are certain legal issues unique to such receiverships that are discussed solely in Chapter 8.

II. TAKEOVER AND ADMINISTRATION

Editor's Note—This subchapter deviates from the practice in the rest of the chapter of referring to all official proceedings as "receiverships" and all regulators assigned to administer the estate as "receivers." Instead, this subchapter, where appropriate, refers to "conservations," "rehabilitations" and "liquidations." This was done in an effort to avoid confusion where the different types of receivership require different treatment. Similarly, the term "regulator" is used to describe the state regulatory authority acting prior to the appointment of a "receiver," again to avoid confusion.

The takeover and administration of an insolvent insurer is a complicated process involving the rights and liabilities of the insolvent insurer and of its policyholders and claimants against policyholders, agents and intermediaries, cedents and reinsurers, creditors, former management, and local, state and federal governments, as well as coordination with state guaranty associations. While the practical aspects of the takeover and administration of an insurer are addressed in Chapter 1, this section will pay particular attention to those legal details and issues which may arise in the process. This section's goals are threefold. First, it identifies particular legal issues. Second, it illustrates the problems which may arise from those issues. And finally, it provides guidelines on how those issues may be resolved under statutory and case law.

A. Pre-Takeover/Informal Actions

The regulator may intervene in an insurer's business operations if the insurer is in financial difficulty. Some states provide grounds for informal supervisory action if an insurer is in a certain condition. If the regulator determines that an insurer is operating in a manner that poses a hazard to the insurer's policyholders, creditors or the public, the regulator may serve a corrective or supervisory order upon the insurer to provide short-term relief.[4] Oftentimes, the regulator may issue this order without formal court proceedings, but such orders are subject to administrative review. The orders are generally confidential.

[4] See Liquidation Model Act, *supra,* at Section 5, IRMA at Sections 201, 206, and 215 ILCS 5/186.1-186.2.

B. Seizure Orders

Most states have a statutory process for a judicial action that can be taken against an insurer prior to a formal delinquency proceeding.[5] This process is referred to as a "seizure" proceeding in the Liquidation Model Act and IRMA, and this term is generally used in most states. However, the use of this term is not necessarily universal, and some states may have a different term for a substantively similar process. A seizure order enables the regulator to determine the insurer's condition and the course of action that should be taken to rectify its condition. The order is also intended to protect the assets of an insurer while the regulator determines if it is necessary to seek an order of rehabilitation or liquidation. The regulator is authorized to file a petition for a seizure order with respect to a domestic insurer, an unauthorized insurer or a foreign insurer under § 201 A of IRMA.

The regulator may obtain such an order by filing a petition with a court of competent jurisdiction. A seizure order can usually be issued by the court on an *ex parte* basis. Ex parte orders are allowed in order to prevent the diversion of funds or destruction of records. It should be noted, however, that an ex parte seizure order is subject to subsequent court review to protect the insurer's right to due process.

The Liquidation Model Act, IRMA and a number of state statutes based on these models provide for the confidentiality of both the pleadings and the proceedings related to a seizure proceeding. The sequestered nature of the proceeding may continue until the regulator or the insurer subsequently requests that the matter be made public. This confidentiality may permit the receiver to resolve the insurer's problems without public disclosure and resulting damage to the insurer's ongoing business.

1. Grounds for Order

Generally, a petition for a seizure order must allege that there are grounds justifying a formal delinquency proceeding and that the interests of policyholders, creditors or the public are endangered by a delay in entering such an order. Specific requirements for obtaining a seizure order vary from state to state. See IRMA, § 201 A.

2. Contents of Order

Generally, the order appoints the regulator to take possession and control of all or part of the property, books, accounts, documents and other records of the insurer. Further, the order generally gives control of the insurer's physical premises to the regulator. The order will usually be accompanied by an injunction enjoining the insurer, its officers, directors, managers, agents and employees from disposing of property or transacting the business of the insurer except upon the permission of the receiver or further court order. (See Chapter 8—Special Receiverships, section on Liquidation of an HMO, Injunctions.)

3. Duration of Order

Depending on the applicable statute and the practice in a jurisdiction, the seizure order will either state the period that the order will remain in effect or state that it will remain in effect until such time that the regulator determines the condition of the insurer. IRMA § 201 D provides that:

a. the receivership court shall specify the duration of the seizure order, which shall be the time the court deems necessary for the regulator to ascertain the condition of the insurer;

b. the regulator may request an extension or modification of the order if necessary to protect policyholders, creditors, the insurer or the public; and

[5] Section 104 J of IRMA defines a "formal delinquency proceeding" as a conservation, rehabilitation or liquidation proceeding.

c. the court shall vacate the order if the regulator fails to institute a rehabilitation or liquidation proceeding after having had a reasonable opportunity to do so.

4. Review of Order

If the insurer wishes to contest a seizure order, it may petition the court for a hearing and review of the order. The Liquidation Model Act and § 201 F of IRMA provide that the court shall hold such a hearing not more than 15 days after the request.

5. Powers and Duties of the Regulator Under Order

The seizure order typically directs the regulator to take possession and control of the property, accounts and records of an insurer and its premises. The order will also usually enjoin the insurer and its officers, managers, employees and agents from disposing of the insurer's property and transacting its business, except with the regulator's consent. See § 201 B of IRMA.

C. Conservation

The term "conservation" is used in insurance regulation in a number of different contexts, depending on the circumstances and the jurisdiction. Statutes may use the term to apply to an administrative proceeding; a proceeding similar to a seizure action (see [I.B], above); a proceeding involving foreign insurers (see [I.C.2] below); or a rehabilitation proceeding (see [I.D], below). Finally, the term is used under Article III of IRMA to refer to a type of formal delinquency proceeding.

1. Conservation under Article III of IRMA

IRMA provides for conservation as an additional remedy available to a regulator to determine if an insurer's condition can be rectified and if not, to determine the appropriate action that should be taken. Unlike a seizure proceeding, conservation under IRMA is a formal delinquency proceeding, a term that also includes a rehabilitation or liquidation proceeding. However, unlike a rehabilitation or liquidation proceeding, a conservation proceeding is strictly limited in duration, and ultimately concludes with the insurer being released from delinquency proceedings or being placed into rehabilitation or liquidation. While conservation is not a prerequisite to a rehabilitation or liquidation proceeding, it can be instituted to ascertain whether rehabilitation or liquidation should be sought.

a. Conservation Orders

A conservation order under IRMA appoints the regulator as conservator, and directs the conservator to take possession of the insurer's assets and administer them under the court's supervision. A conservation order must require accountings to the court by the conservator at intervals specified by the order, no less frequently than semi-annually. See § 301 of IRMA.

b. Powers and Duties of Conservator

In some respects, the conservator's powers under IRMA are similar to those of the rehabilitator. The conservator is authorized to take necessary or appropriate action to reform and revitalize the insurer, including canceling polices (except life or health insurance or annuity contracts) or transferring policies to a solvent assuming insurer. The conservator also has: all the powers of the directors, officers and managers of the insurer; the authority to manage, hire and discharge employees; and the power to deal with the property and business of the insurer, pursue legal remedies on behalf of the insurer, and assert defenses available to the insurer. See § 302 of IRMA.

c. Termination of Conservation

The conservator must conduct an analysis of the insurer to determine if it is possible to correct the problems that precipitated the need for conservation. The conservator must then file a motion requesting that the insurer be either released from conservation, or placed in rehabilitation or liquidation. The motion must be filed within 180 days of the conservation order, unless the court grants a 180-day extension. See IRMA § 302. The conservator is required to coordinate with guaranty associations to ensure an orderly transition in the event of liquidation. See IRMA § 303.

2. Conservation of Property of Foreign or Alien Insurers

Most states' receivership statutes provide that a regulator may apply to the court for a conservation order of the property of an alien or foreign insurer not domiciled in the regulator's state. The grounds and terms of such an order generally include those necessary to obtain a similar order against a domiciliary insurer, but there may be some differences. Usually if the alien or foreign insurer has property sequestered in an official action in its domiciliary state or foreign country, or if its certificate of authority in the state has been revoked or was never issued, the regulator may seek an order of seizure. A conservation order against a non-domiciliary insurer is generally not confidential.

IRMA § 1001 provides for ancillary conservation of a foreign insurer that is separate and distinct from the process contained in Article III of IRMA.

D. Rehabilitation

A regulator may petition a court of competent jurisdiction for an order of rehabilitation that may be used in an effort to remedy an insurer's problems.

1. Grounds

The grounds upon which a regulator may petition the court for an order of rehabilitation vary from state to state. A regulator must allege and prove a specific statutory ground for rehabilitation. Per § 207 of IRMA, the grounds upon which a regulator may petition the court are the same whether the requested order is for conservation, rehabilitation or liquidation.

An order of rehabilitation is usually obtained through a formal proceeding that entails certain due process requirements, such as: the filing of a petition by the regulator, usually brought in the name of the people of the state; service of process upon the insurer; an opportunity for the insurer to be heard prior to the issuance of the rehabilitation order; and a formal order from which an appeal may be taken.

2. Burden of Proof

Generally, courts hold that if a regulator presents uncontroverted evidence that an insurer is in need of rehabilitation, entry of the order is justified. IRMA § 208 provides that if the regulator establishes any of the grounds for a receivership, the receivership court shall grant the petition and issue the order of conservation, rehabilitation or liquidation requested.

3. Contents of a Rehabilitation Order

An order of rehabilitation generally appoints the regulator as rehabilitator; vests the rehabilitator with possession or title to all of the insurer's assets, books, records, accounts, property and premises[6]; and directs the rehabilitator to take possession of the insurer's assets and to administer those assets under general court supervision, and to conduct the insurer's business (IRMA, §401(A)). The order should be recorded with the county clerk or recorder of deeds for the county in which the insurer resides and where any real property is located, so that creditors and the public are put on notice of the rehabilitation.

[6] See Liquidation Model Act, at Section 12; Uniform Act, Section 2(2); IRMA, §401.

Additionally, the order should be served on all financial institutions where the insurer maintains accounts or has other assets.

The rehabilitation order may require that the rehabilitator file reports and accountings with the court. The receivership act may provide for a filing of a rehabilitation plan for the court's review and approval. The rehabilitator is charged with implementing the restrictions, limitations and requirements set forth in the order of rehabilitation.

The ~~Model A~~receivership act~~s~~ typically provides that the rehabilitator has the power to take any legal action that is deemed necessary or appropriate to reorganize and revitalize the insurer. In accordance with the applicable receivership act, the order will typically suspend the insurer's directors, officers and managers powers, except as the rehabilitator delegates. The rehabilitator retains all powers not expressly delegated (IRMA, §402).

The order may prohibit the insurer from writing new business or may severely limit the amount and type of new business written. Similarly, the order might impose significant restrictions or prohibit the renewal of business when the renewal is at the option of the insurer. In some cases (particularly with guaranteed renewable or non-cancellable business), the order may require that certain policies be renewed. The order may also: (1)require the insurer to modify or even cancel certain managing general agent ("MGA"), third-party administrator ("TPA") and general agency agreements;. (2) suspend claims payments; (3)halt the transfer of cash or loan values on life insurance contracts; (4) provide that reinsurance agreements may not be canceled and that the insurer may not obtain any new reinsurance without the approval of the receiver; and (5) address other issues particular to the insurer.

The rehabilitator will be empowered under the order to seize the insurer's physical and liquid assets immediately and perform an inventory of these assets. In addition, the order will likely suspend the payment of any dividends to shareholders, affiliates and subsidiaries. The rehabilitator may restrict new investments and may, in fact, liquidate certain investments. If previously discussed by the regulator and agreed to by the insurer's parent or shareholders, the order may require infusion of capital into the insurer. In those states that leave directors and officers in power during rehabilitation, the order may provide for a change or suspension of their authority.

4. Rehabilitation Plan

The receivership act may allow, or require, the rehabilitator to file a plan of rehabilitation ("plan") by a specified date. At other times, the timing of that filing is left to the discretion of the rehabilitator. Under IRMA the filing of a plan is mandatory; § 403 A. requires that a plan be filed within one year after entry of the rehabilitation order or such further time as the court may allow. In contrast, some receivership acts require that a plan be filed only if the rehabilitator proposes to reorganize, convert, reinsure or merge the insurer.

The plan should not treat creditors less favorably than they would be treated in liquidation.[7] It should be noted that the Model Acts do not require that the plan provide for the emergence of the insurer from rehabilitation as a going concern. Thus, a plan for a run-off may be permissible. After formulating the plan, the rehabilitator must submit it to the supervising court for approval. The court will either approve, disapprove or modify the plan. State law typically requires that the court give notice and hold hearings upon any proposed plan. The court's review of the rehabilitator's proposed plan is generally a limited

[7] See generally Liquidation Model Act, *supra* note 3, at Section 12; Uniform Act, Section 2(2); IRMA §403 C. provides that the holder of a particular claim may agree to less than favorable treatment than would occur in liquidation; see also *Gersenson v. Pennsylvania Life and Health Ins. Guar. Assoc.*, 729 A.2d 1191 (Pa. Super. App. 1999) (court, not rehabilitator, empowered to compromise value of policies).

one, subjecting the rehabilitator's proposal to an abuse of discretion standard.[8] (See Chapter 8—Special Receiverships, section on Alternatives to Immediate Liquidation of a Financially Troubled HMO, for further discussion.)

IRMA §403C lists four requirements for every plan:

1. The plan must assure that each class of claimants will receive "no less favorable treatment" than those claimants would receive if the insurer is liquidated unless the claimant agrees to accept different treatment or if the claim is for a *de minimis* amount,

2. Provide adequate means for the plan's implementation,

3. The plan must provide sufficient financial data to allow the claimants and the receivership court to evaluate the potential for success of the plan, and

4. The plan must provide for the disposition of the books and records of the estate.

Note that restoring the insurer to solvency or to the marketplace are not requirements for the plan. Subsection D of §403 provide suggestions for other items which the rehabilitator may wish to consider, including:

1. Payment of claims. Depending on the sufficiency and liquidity of the estates' assets, the rehabilitator may wish to propose payment of administrative expenses and policy benefit claims on a current basis, while deferring payments to subordinate classes.

2. Transfer of the insolvent insurer's book of business, wholly or in part, to a solvent carrier.

3. Imposition of regulatory market conduct standards on third party administrators or assuming carriers.

4. Engaging a third-party administrator or guaranty association to handle claims for the rehabilitator.

5. Periodic audits of third-party administrators.

6. Establishing a termination date for the estate's non-policy liabilities.

Rehabilitation plans for life insurers may impose liens on policies if the rights of shareholder are waived. They may impose a one-year moratorium on cash surrenders or policy loans. The term of the moratorium can be extended by the receivership court.

Other considerations when drafting a rehabilitation plan include the following:

1. Whether to retain the insurer's former management or install new individuals in management positions.

2. A business plan.

[8] *Foster v. Mutual Fire, Marine & Inland Ins. Co.,* 531 Pa. 598, 614 A.2d 1086 (1992)*, cert. denied*, *Allstate Ins. Co. v. Maleski,* 506 U.S. 1080, 122 L.Ed.2d 356, 113 S.Ct. 1047; and cert. denied, *Rhine Reinsurance Co., Ltd., v. Mutual Fire, Marine & Inland Ins. Co.*, 506 U.S. 1080, 122 L.Ed.2d 356, 113 S.Ct. 1051; and cert. denied*, Republic Ins. Group v. Maleski,* 506 U.S. 1087, 122 L.Ed.2d 371, 113 S.Ct. 1066 (1993); and *Kuekelhan v. Fed. Old Line U.S. Co.,* 74 Wash.2d 304, 444 P.2d 667 (1968*).* But see In re *Executive Life,* 38 Cal. Rptr.2d 453, 32 Cal. App. 4th 344 (Cal. App. 2d Dist. 1995), as modified on denial of rehearing (Mar. 15, 1995), and review denied (May 11, 1995).

3. A work-out plan for the insurer's creditors.

4. A marketing plan for the insurer.

5. Hardship provisions.

6. An underwriting plan in the event the insurer is permitted to write new business.

7. Continuation of periodic reporting to the court, and ancillary states in which the insurer is licensed, including updated cash flows and projections to enable the court to determine whether the plan should be modified or terminated, and whether the insurer can ultimately meet its obligations. Under §117 of IRMA, quarterly financial reporting to the court is required unless such reporting is excused for good cause shown. Tax reporting should continue uninterrupted and statutory financial reporting should continue ~~uninterrupted~~ uninterrupted~~and statutory financial reporting should continue if possible~~. Coordination of the plan with other jurisdictions in which the insurer was licensed. The rehabilitator may wish to solicit acceptance of the plan in other jurisdictions in which the insurer was licensed. Coordination by and among states may facilitate the release of statutory deposits to the domiciliary state for use in satisfying the claims of policyholders and other creditors.

8. Replenishment of capital and surplus of the insurer to acceptable levels for all jurisdictions where the insurer is licensed. This will expedite the restoration of licenses previously suspended or revoked

9. Collection of assets which are speculative or illiquid. An objective of the plan should be to reduce as many assets as practicable to cash or cash equivalents. If there are assets which are speculative or illiquid and on which the rehabilitator will realize negative spreads in market values, the rehabilitator should weigh the advantages of holding them for future disposition in the hope of regaining value versus immediate disposition to prevent further deterioration of value. Conversely, assets on which the Rehabilitator will enjoy positive spreads in market values should be liquidated timely.

10. Quantification of liabilities and payment of claims. The Plan should provide for the actuarial justification of liabilities, both on a gross and net basis; reinsurers may pose a credit risk to the insurer, which, in turn, may further erode capital and surplus, or preclude the insurer from meeting obligations as they come due.

    The Plan may include claim moratoria, pending the collection of previously identified asset recoveries, particularly off-balance sheet. At a minimum, the Rehabilitator will want to address the moratorium for the payment of classes below policyholders (Class 3), either temporary or indefinite. The Rehabilitator as a part of the Plan and depending on the sufficiency of assets may wish to petition the Court to continue pay superior creditor (classes 1 through 3), while deferring payments to subordinate creditors (classes 4 through 9), pending the success of the Plan. Typically, subordinate creditors will be subject to a formal claims process including the filing of proofs of claims and a bar date established by the Court, whereas superior creditors will receive payment of claims from estate assets in the normal course. The Rehabilitator may wish to consider as part of the plan the appointment of court assistants to assist in the timely adjudication of claims and resolution of disputes with regard to class 3 claims.

11. Reinsurance programs. The plan should address the importance of the continuing timely reporting and collection of reinsurance proceeds, resolution of pending disputes and development of commutation plans to abate credit risk and facilitate the release of any excess funds held.

12. Sale or recapitalization of the insurer. If the plan calls for the ultimate transfer of the insurer back to original or successor management, if allowed under state law, the rehabilitator must be aware of all Form A requirements in the domiciliary state. The Form A process will require the formulation of a business plan inclusive of pro forma financial statements. The rehabilitator should work closely with the Department of Insurance to ascertain the viability of the business plan as well as the integrity and qualifications of management and proposed recapitalization and proposed assets to accomplish same. In a recapitalization where a Form A may not be required, the rehabilitator will need to consider these issues carefully as a part of the court approval process.

The culmination of the rehabilitation process will be court approval of the plan. IRMA provides that when a plan is filed with the court any party in interest may file objections to the plan; after any hearings the court feels necessary, it may approve or disapprove the plan or modify it and approve it as modified.

The filing should include applicable documents detailing the specifics of the proposed transaction, outlining the history of the plan and its objectives. The plan should also deal with such issues as recapitalization, litigation, final accounting, claims of creditors, tax ~~risk~~ planning, actuarial analyses, fees and expenses, and the rehabilitator's discharge. OK JG 7/20/21

The rehabilitator will want to provide notice to policyholders and creditors of the hearing on the plan and the specifics of the proposed transaction to enable objections and responsive pleadings to be timely filed.

Similarly, the receiver should be prepared to liquidate the insurer if rehabilitation is not feasible or practical. The receiver should organize the assets, books and records of the insurer to ensure an orderly transition to liquidation. Thus, the receiver should incorporate procedures that address the following:

1. Payment of administrative expenses, including staff salaries,

2. Notice to creditors and other interested parties,

3. Coordination of data transfer from the insurer's data processing system to the receiver's system,

4. Coordination for the distribution of claims and policy files and data with the guaranty associations, and with the National Conference of Insurance Guaranty Funds ("NCIGF") and NOLHGA, as necessary, and

5. Evaluation of staffing needs.

5. Insufficient Assets

Sometimes the rehabilitator discovers that the insurer does not have sufficient liquid assets to defray costs incurred during the receivership. In this instance, the rehabilitator may seek an advance for costs that will be incurred during the rehabilitation from the state regulator. Most statutes require that any money so advanced to the rehabilitator be repaid out of the assets of the insurer. § 804 of IRMA, under certain circumstances, allows unclaimed funds of receivership estates to be found by the court to be abandoned and disbursed under several methods, one of which is to fund a general receivership expense account.

6. Agency Force

In a rehabilitation proceeding or when the rehabilitator otherwise contemplates selling or reinsuring the in-force business of the delinquent insurer, it is important to create an atmosphere favorable to the preservation of the business. Public confidence in the insurer may be shaken. The relationship with

policyholders should be preserved to the extent possible. Communication with policyholders and agents of the insurer is necessary to maintain the desired book of business. Agents can influence the degree of confidence policyholders have in the receiver and the efforts to rehabilitate the insurer. Policyholders view life insurance, in particular, as a long-term investment. Their natural tendency, when notified that their insurer has been placed in receivership, is to withdraw their cash value and purchase insurance from another company at the earliest opportunity.

One way to preserve a book of business and retain the cash values and the premium income in the company is through the agency force. Most life insurance companies have a large and loyal force of agents. These agents may be employees or independent contractors; in either case, they provide a major link to the policyholders. In order to provide for the continued inflow of premium dollars that will facilitate a successful rehabilitation, the rehabilitator may consider continuing the contracts of the agency force and paying their renewal commissions as an incentive for them to continue to work with their policyholders during the rehabilitation and to recommend that the policyholders keep their policies in force.

Neither the Liquidation Model nor IRMA address the treatment of preexisting agent commission arrangements, but in many proceedings rehabilitators have maintained relationships with agents and continued to pay renewal commissions.[9]

The cases that have considered whether renewal commissions are owed to the agent in receiverships are split, and many have turned on the particulars of the agency agreements involved.[10]

7. Terminating the Rehabilitation

The time may come when the rehabilitator determines that rehabilitation of the insurer is not possible or that further attempts to rehabilitate the insurer would substantially increase the risk of loss to creditors, policyholders, cedents or the public. The rehabilitator may then petition the court for an order of liquidation. ~~§ 404 A of~~ IRMA §404A requires that there be coordination with guaranty associations and their national organizations to plan for transition to liquidation.

Some states may provide that if policy payment obligations have been suspended for a specified period of time after a rehabilitator's appointment and the rehabilitator has not yet filed an application for approval of the rehabilitation plan, the rehabilitator must petition the court for an order of liquidation on the grounds of insolvency. IRMA allows for a six-month period, after which the rehabilitator must apply for a liquidation order or apply for a longer suspension period~~,~~ (IRMA §~~-~~404~~-~~B).

Alternatively, whenever the rehabilitator determines that the causes and conditions that made the rehabilitation proceedings necessary have been removed, the rehabilitator should petition the court for an order terminating the rehabilitation. Under the NAIC Model Acts, officers and directors may also make such an application. Although this order will usually permit the insurer's owners and directors to resume possession and control of the insurer and the conduct of its business, it may require, or the plan of rehabilitation may have imposed, a change of ownership and/or control. Under IRMA §~~-~~902~~,~~ ~~of IRMA,~~ a termination order will also require that funds expended by guaranty associations be repaid, or that there be a guaranty association approved plan to repay, prior to resumption of control of the insurer and its assets by shareholders or management.

[9] The proceedings involving Executive Life of California and Mutual Benefit Life are recent examples.

[10] Compare e.g., *Cockrell v. Grimes,* 1987 Ok. Civ. App. 28, 740 P.2d 746 (Okl. App. Div. 3 1987); *Wear v. Farmers & Merchants Bank of Las Cruces,* 605 P.2d 27, on rehearing, 606 P.2d 1278 (Alaska 1980); with e.g., *D.R. Mertens, Inc. v. Florida,* 478 So.2d 1132 (Fla. App. 1st Dist., 1985), review denied, 488 So. 2d 829 (1986), and appeal dismissed, 479 U.S. 802, 93 L.Ed. 2d, 107 S.Ct. 43 (1986); *Layton v. Illinois Life Ins. Co.,* 81 F.2d 600 (7th Cir.) cert. denied, *Bachman v. Davis,* 298 U.S. 681, 80 L.Ed. 1401, 56 S.Ct. 949 (1936); *Myers v. Protective Life Ins. Co.,* 342 So.2d 772 (Ala. 1977).

E. Liquidation

Liquidation is typically necessary in situations where the insurer's deficiencies cannot be remedied. While liquidation may be sought after a rehabilitation proceeding has been initiated, the regulator is not required to attempt to rehabilitate the insurer as a prerequisite to seeking an order of liquidation.[11] In liquidation, the liquidator identifies creditors, marshals and distributes assets in accordance with statutory priorities, and dissolves the insurer.

1. Grounds

State statutes set forth the grounds for liquidation, any one of which is appropriate for the issuance of a liquidation order. The regulator may seek liquidation on the grounds that the insurer is insolvent, is in such a condition that further transaction of business would be hazardous, or on any ground applicable for an order of rehabilitation. If the insurer is in rehabilitation, the regulator may petition the court for an order of liquidation when it believes further attempts to rehabilitate the insurer would substantially increase the risk of loss to the insurer's policyholders, creditors or the public, or if liquidation is in the best interests of the parties.

2. Order of Liquidation

Once the court determines that an insurer should be placed in liquidation, it enters an order of liquidation, which affirms the statutory appointment of the regulator as the liquidator of the insurer and vests him or her with title to all of the insurer's assets, books, records, accounts, property and premises. The order enables the liquidator to control all aspects of the insurer's operations under the general supervision of the court. Where necessary to protect the interests of the estate and its claimants and creditors, affiliates and subsidiaries may be made subject to a receivership order issued by the liquidation court if it can be shown that the insurer, its affiliates and subsidiaries operated as a single business enterprise.[12] Orders of liquidation may be appealed by management and/or shareholders of the insolvent insurer. However, several state appellate courts have refused to reverse an order of liquidation without a clear showing that the regulator abused his or her discretion. The reviewing court's primary focus is whether the regulator properly and reasonably acted to protect the policyholders and the public.

Most state statutes provide that upon issuance of the order, all of the rights and liabilities of the insurer, its creditors and policyholders are fixed as of the date of entry of the order of liquidation, IRMA § 501. State statutes describe the effect of the order of liquidation upon contracts of the insolvent insurer, IRMA § 114, § 209 B and § 504 A(8).

3. Effect on Policies

a. Life & Health Policies

Care should be taken in life and health insurer insolvencies that the filing of a liquidation order does not inadvertently result in the cancellation of policies or contracts that are subject to ongoing guaranty association coverage. Before filing a motion for a liquidation order, the liquidator should consult with guaranty associations to ensure that covered contracts are not canceled, and that the liquidation order serves as an effective trigger for guaranty association obligations. IRMA, § 502 makes specific provisions and distinctions as to cancellations of property/casualty (property and casualty) coverages and continuations of life and health coverages.

[11] See In re *Conservation of Alpine Ins. Co.,* 741 N.E.2d 663 (Ill. App. 1st Dist. 2000) (decision whether to rehabilitate or liquidate not mandated by statute, but left to regulator's discretion based on circumstances); *Remco Ins. Co. v. State Ins. Dept.*, 519 A.2d 633 (Del. 1986) (regulator need not first pursue summary remedies).

[12] See e.g., *Brown v. Automotive Cas. Ins. Co.,* 644 So.2d 723 (La. App. 1st Cir. 1994), writ denied, 648 So. 2d 932 (La. 1995); see also *Green v. Champion Ins. Co.*, 577 So. 2d 249 (La. App. 1st Cir.), cert. denied, 580 So. 2d 668 (La. 1991).

b. Property & Casualty Policies

The cancellation of property and casualty policy obligations raises several legal issues. In general, the courts strictly enforce the statutes providing for the cancellation of insurance policies upon liquidation. Courts are reluctant to rule contrary to the statutes, even when a policyholder does not receive actual notice of the policy cancellation. Several cases have considered the question of whether the policyholder's claim would be accepted when it was filed after the bar date established in the order. These cases involve instances both where the claimant did and did not have notice of the bar date. Courts have held that the order of liquidation effectively cancels outstanding policies and fixes the date for ascertaining debts and claims against the insolvent insurer.

4. Powers and Duties of the Receiver, IRMA, § 504

The liquidator is authorized to:

- Marshal assets;
- Sue a defendant in the insurer's name;
- Sell the insurer's assets;
- Appoint one or more special deputies;
- Employ attorneys, accountants and consultants as necessary;
- Borrow on the security of the insurer's assets;
- Enter into contracts as necessary; and
- Obtain title to all of the insurer's assets.

The liquidator's powers have been challenged in numerous cases. Most jurisdictions hold that the liquidator steps into the shoes of the insolvent insurer and possesses the same rights as the insurer. Several cases have focused on the liquidator's specific duties. These cases have allowed liquidators to compound or sell any uncollectible or doubtful claims owed to the insolvent insurer, to disaffirm the fraudulent sale of mortgages, to act as statutory liquidators of the insolvent insurer's property, to sell the property of the insurer, to conduct business using the assets of the insurer, and to control bonds and mortgages held as collateral security.

5. Litigation

Often when an insurer is placed into receivership, the insurer is involved in litigation. Most state statutes provide for a stay of pending actions in which the insurer is a defendant. In any event, a receivership order should incorporate a provision to stay or enjoin litigation. Some state statutes or receivership orders provide for a temporary stay of litigation involving the insurer's policyholders. A stay or injunction may be enforceable in other states under statutory provisions or case law. If litigation is pending outside the domiciliary state, it may be necessary for the liquidator to petition the court in those jurisdictions for a stay in order to protect the estate and the insurer's policyholders

Most state statutes provide that an order of receivership vests the right to all causes of action of the insurer in the liquidator. The liquidator is thereby empowered to maintain specific causes of action on behalf of the estate. The liquidator may also be entitled to bring general causes of action belonging to policyholders, claimants and creditors of the estate.[13]

6. Notice

[13] See In re *Rehabilitation of Centaur Insurance Co.,* 238 Ill. App. 3d 292, 606 N.E.2d 291 (Ill. App. 1 Dist. 1992), *aff'd*, 158 Ill. 2d 166, 632 N.E.2d 1015 (Ill. 1994) (holding that receiver may not assert reinsured's claim against parent of insolvent insurer or claims based on fraud and misrepresentation made to creditors).

Most state statutes set the minimum requirements for notice to creditors and all persons known or reasonably expected to have claims against the insurer. The liquidator should notify the regulator of each jurisdiction in which the insurer does business, the applicable guaranty funds, all agents of the insurer and all policyholders, claimants against policyholders, cedents and reinsurers, creditors, and former employees at their last known address. The liquidator should also give notice by publication in a newspaper of general circulation in the county in which the insurer has its principal place of business. Potential claimants are required to file their claims on or before the date specified in the notice, IRMA § 208 and § 505.

Some liquidators maintain general service lists and notify anyone whose name is on the list of action to be taken in court. Others require persons who want notice to file an appearance in the receivership proceeding and then indicate whether they want notice of all actions or only those directly affecting their interest. IRMA provides that a person shall be placed on the service list to receive notice of matters filed by the liquidator upon that person's written request to the liquidator, § 107 A.

In some circumstances, a liquidator may wish to dispute the "right" of certain persons or entities to participate generally, or receive notice of all actions before the court, in a receivership. For example, a liquidator considering suing the directors and officers of the company may not wish to notify them or a parent company of all actions the liquidator proposes to take. In such circumstances, it may be incumbent upon the party seeking notice to establish their right to receive it.

The liquidator should also follow applicable federal and state statutes and regulations governing notice to relevant federal and state agencies. (See Chapter 5—Claims, section on Notice.)

Notice becomes an issue when the claimant does not receive notice of the liquidation. The cases addressing this issue turn on the specific facts. Courts have allowed late claims where the liquidator should have known of the claimant's existence and provided notice. The liquidator should provide notice to all persons known or reasonably expected to have claims against the insurer. IRMA provides that the liquidator has no duty to locate any persons or entities if no address is found in the insurer's records or if mailings sent to the address shown in the insurer's records are returned. Notice by publication or actual notice is deemed sufficient, § 505 D.

If a policyholder must file a "request for continuation of coverage" for a life or annuity policy to make a claim with the policyholder's state guaranty association, the liquidator's notice must clearly state that such action must be taken or forfeiture of the insurance may occur. (See Chapter 8—Special Receiverships, section on Liquidation of an HMO.)

7. The Right to Participate

    a. Necessary Parties

    A necessary party is one whose participation in a lawsuit is required by any of the following reasons: 1) to protect an interest the party has in the subject matter of the controversy that would be materially affected by the party's absence; 2) to reach a decision that will protect the interests of those before the court; and 3) to enable the court to make a complete determination of the controversy. The liquidator should consider the interests of *all* creditors and other persons interested in the insolvency estate. In most circumstances, this includes shareholders.

    b. Intervening Parties

    There are two types of intervention: mandatory and permissive.

    As a general rule, intervention is permitted as of right: 1) when a statute confers an unconditional right to intervene; 2) when representation of the applicant's interest is or may be inadequate and the applicant will or may be bound by an order or judgment in the action; or 3) the applicant is so

situated as to be adversely affected by a distribution or other disposition of property in the custody or subject to the control or disposition of the court.

Permissive intervention generally is permitted when: 1) a statute confers a conditional right to intervene; or 2) an applicant's claim or defense and the main action have a question of law or fact in common. In addition, the court must determine whether the intervention will unduly delay or prejudice the adjudication of the right of the original parties.

In either case, the applicant is required to present a petition for intervention, along with the initial pleading or motion he or she proposes to file. IRMA has three alternatives for dealing with right to intervene in § 105 I. Under all three alternatives, intervention is not allowed for the purpose of seeking or obtaining payment of any judgment, lien or other claim of any kind. Alternative 1 permits guaranty associations to intervene for a limited purpose upon application to and approval by the receivership court. Alternative 2 permits guaranty association intervention as a matter of right upon application to and approval by the receivership court. Alternative 3 is silent as to guaranty associations.

8. Deadline for Filing Claims

Unless established by statute, the court establishes a deadline or bar date for the filing of claims against an insolvent insurer or its assets. Creditors who do not file a claim by the bar date may be barred from participating in the distribution of the insurer's assets, or may be subordinated to a lower distribution priority. Many receivership acts provide that late claims may be treated as if they were timely filed under certain circumstances, and that claims not eligible for such treatment may be subordinated. See IRMA, § 701B and § 801. The liquidator may be permitted to request the court to set a date after which no further claims may be filed. See IRMA, § 701B. Many receivership acts also contain provisions permitting claimants to file unknown, unliquidated or contingent claims. See IRMA, § 704 and § 705.

9. Jurisdiction and Ancillary Receiverships

Many insurers are licensed to do business in several states. States other than the insurer's state of domicile in which the insurer is licensed to do business may have authority to establish an ancillary receivership. However, with the advent of reciprocal receivership statutes and enhanced cooperation among the states, ancillary proceedings have become less common. Generally, it is more efficient for the domiciliary regulator to manage the insolvency for the benefit of all affected regulators.

~~Liquidation of an insurer is conducted by the receiver in the insurer's state of domicile. Many insurers, however, are licensed to do business in several states. The states in which the insurer is licensed to do business can establish ancillary receiverships, which may be funded by the insurer's assets located in that state.~~

All states have adopted at least a portion of the Uniform Act or analogous Liquidation Model Act provisions. The Uniform Act was created in an effort to solve some of the interstate problems arising out of the receivership of an insurer conducting business in more than one state. The Uniform Act recognizes the central role of the domiciliary liquidator and the role of the ancillary receiver. Under the Uniform Act, a regulator in a non-domiciliary state may petition a court of competent jurisdiction to appoint an ancillary receiver of an insolvent insurer. The regulator will be appointed as the ancillary receiver if there are sufficient assets located in the state to justify the appointment or if the goal of protecting the policyholders or creditors located in the state mandates the establishment of the ancillary receivership. The ancillary receiver aids the domiciliary receiver in recovering assets of the insurer located in the state, liquidates special deposit claims and secured claims, pays necessary expenses, and remits the balance of the insurer's assets to the domiciliary receiver. In reciprocal states, the domiciliary receiver may perform the same functions without the necessity of establishing an ancillary receivership.

The owners of special deposit claims against an insolvent insurer (Deposit Claimants) receive priority against the deposits. However, if the special deposit is not sufficient to fully discharge the special deposit claims, Deposit Claimants may share in the general assets of the estate only after estate creditors who are in the same priority or class have been paid a percentage of their claims equal to the percentage paid to Deposit Claimants from the special deposit.

Some statutes permit a claimant who resides in a reciprocal state to file a claim in either the domiciliary or ancillary proceeding. When that is a possibility, the domiciliary and ancillary receivers should attempt to coordinate bar dates and claims procedures, if possible. The claimant is not allowed to present a claim in a non-domiciliary state unless ancillary proceedings have commenced. Most jurisdictions have held that, in the absence of an ancillary receivership, a claimant must seek recovery in the insolvent insurer's domiciliary state.

The priority of payment becomes an issue in liquidation proceedings involving one or more reciprocal states. In this situation, all of the claims of residents of reciprocal states are given equal priority of payment from the general assets regardless of where the assets are located. Owners of secured claims may also be affected when one or more reciprocal states are involved in the receivership. The owner of the secured claim is entitled to surrender the security and file a claim as an unsecured creditor. Alternatively, the secured creditor generally can liquidate the security to satisfy the claim and have any deficiency in the claim treated as a claim against the insurer's general assets on the same basis as claims of unsecured creditors.

Under §1001 of IRMA, authority for an ancillary receivership has been curtailed. IRMA allows the appointment of an ancillary conservator under limited circumstances. A domiciliary receiver is automatically vested with title to property in any state adopting IRMA, and the test of whether a state is reciprocal has been eliminated. IRMA also clarifies the procedures for handling deposits.

~~Ancillary receiverships are permitted under IRMA, but if there is a pending domestic receivership, an ancillary can only be established with the domicile's consent, § 1001.~~

10. Asset Marshaling: Identification and Recovery

One of the liquidator's duties is to marshal and seize all of the insurer's assets. Section 24 of the Liquidation Model Act requires the liquidator to prepare a list of the insurer's assets and liquidate the assets. There is no similar requirement to prepare a list of assets in IRMA. It is also the liquidator's duty to seek to recover assets which are the property of the insurer, but are in the possession of other parties. Illustrations include voidable preferences and fraudulent transfers.

11. Standard of Review

The scope of review to be exercised by the receivership court over the liquidator has been determined by the highest courts of several states. Without exception, those courts have held that the recommendations of a liquidator, in light of the liquidator's legislatively recognized expertise and statutorily delegated responsibility, should be accorded great deference by the receivership court, and rejected only when the liquidator has manifestly abused discretion. For example, in a series of leading receivership cases, the California courts have applied the abuse of discretion standard, according great deference to the liquidator's recommendations.[14] In order to establish an abuse of discretion, the person or entity challenging a liquidator's proposed action must demonstrate that the action is: 1) arbitrary, i.e., unsupported by rational basis; 2) contrary to specific statute; 3) a breach of fiduciary duty; or 4) improperly discriminatory. The Supreme Court of Pennsylvania explained that, given the expertise of that state's insurance commissioner and the legislative recognition thereof in mandating her

[14] See e.g., Quackenbush *v. Mission Ins. Co*., 54 Cal.Rptr. 2d 112 (Cal.Ct.App. 1996); *accord Executive Life Ins. Co*., 38 Cal.Rptr. 2d 453 (Cal.Ct.App. 1995).

appointment as liquidator, "[I]t is axiomatic … that judicial discretion is not to be substituted for administrative discretion."[15]

Under §107 of IRMA, where the liquidator's application for proposed action is opposed, the objecting party bears the burden of showing why the receivership court should not authorize the proposed action. This requirement in effect creates a rebuttable presumption that the liquidator's proposed action is proper under IRMA and in the best interest of the estate and creditors and codifies case law discussed above.

12. Insufficient Assets

Sometimes the liquidator discovers that the insurer does not have sufficient liquid assets to defray costs incurred during the receivership. In this instance, the liquidator may seek an advance for costs that will be incurred during the liquidation from the state regulator. Most statutes require any money so advanced to be repaid out of the first available assets of the insurer. § 804 of IRMA allows some unclaimed funds of receivership estates to be used to create a general receivership expense account which can provide the funds needed to administer low- or no-asset estates.

F. Substantive Consolidation

1. Substantive Consolidation in Receivership Proceedings of "Non-Insurer" with "Insurer"

Under the doctrine of substantive consolidation, all of the entities conducting a single insurance enterprise may be made subject to the jurisdiction of the receivership court, and their assets and liabilities may be pooled. The foregoing is effectuated without regard to the technical separateness of such entities or the fact that some of them are not nominally "insurers" subject to the relevant insolvency statutes. Substantive consolidation is a doctrine with a long history in federal bankruptcy cases. Under the bankruptcy doctrine of substantive consolidation, a non-bankruptcy debtor's assets and liabilities may be included in a debtor's bankruptcy case if two requirements are met: (a) sufficient indicia that the entities appeared as, and were treated as, a single business enterprise; and (b) consolidation of the entities will result in equitable treatment of all creditors of the consolidated group. Without specifically alluding to the doctrine of substantive consolidation by name, at least one jurisdiction has applied the doctrine in an insurance insolvency case.[16]

Application of the doctrine of substantive consolidation may benefit the receiver and further the purposes of the insolvency laws in certain insurance insolvency cases. For example, when a single insurance enterprise has been conducted through a corporate group, if the technical separateness of the entities is recognized, not all of the group may qualify as an "insurer" within the meaning of the insurance insolvency laws (i.e., only the nominal "insurance company" may qualify as an "insurer" within the meaning of the statute). If the receiver is directed to operate only the "insurer" in insolvency proceedings, the receiver may face grave difficulties. It may be very difficult or even impossible for the receiver to identify with any certainty which funds and other assets belong to the "insurance company" (as distinguished from other "non-insurer" members of the affiliated group). Moreover, the nominal "insurance company" may have no employees or insufficient property needed for its operation because all or a significant portion of its business has been operated by a non-insurer affiliate. If available, the remedy of substantive consolidation will bring the entire insurance enterprise into the insurance insolvency proceedings. That will give the receiver the tools needed to liquidate and/or operate the enterprise, and will free the receiver from the burden of trying to identify and obtain possession of assets on an entity-by-entity basis. In addition, substantive consolidation may confer

[15] *Foster v. Mutual Fire, Marine & Inland Ins. Co*., 614 A.2d 1086, 1092 (Pa.1992).

[16] See e.g., *Green v. Champion Ins. Co.,* 577 So.2d 249 (La. App. 1st Cir.), *cert. denied,* 580 So.2d 668 (La. 1991). For a more comprehensive discussion of the doctrine, see L.M. Weil and H.S. Horwich, *Substantive Consolidation in Insurance Company Insolvency Proceedings,* The Insurance Receiver, Vol. 5. No. 4 (1997).

certain other advantages upon the receiver, such as making the non-insurer affiliate's transfers vulnerable to preference attack by the receiver.

Assuming the availability of the remedy of substantive consolidation, serious consideration should be given to the decision to invoke it. One risk for the receiver is that the imprudent use of substantive consolidation could completely or substantially eliminate any return for creditors and/or policyholders. That would result if substantial claims against the "non-insurer" constitute senior priority claims under applicable law against the consolidated assets. For example, if there is a substantial federal tax claim against the target non-insurer entity, that claim would be allowed as a claim in the consolidated case with priority senior to certain classes of claims. Accordingly, there might be nothing left from the consolidated estate for those classes of claims even if a distribution might have been made to them out of the unconsolidated estate of the nominal "insurance company."

The consequences of substantive consolidation may militate against invocation of the doctrine in some cases. However, in a "single business enterprise" situation (and certain other situations as well), the receiver may still have a need to place the "non-insurer's" assets and business affairs under some form of control, either for operational or collection purposes. In that situation, the receiver might consider instituting involuntary bankruptcy proceedings against the target non-insurer.

2. Substantive Consolidation of Separate Proceedings of Two or More Insurers

Substantive consolidation also may be used to consolidate the pending proceedings of two or more insurers. Substantive consolidation of pending cases is well-established in bankruptcy practice, but is not without limitations in its application.[17] Accordingly, substantive consolidation of pending cases ought to be applicable to insurance insolvency cases as well, in proper circumstances. Similar to consolidation of an insurer with a non-insurer, when insurers are substantively consolidated, the assets and liabilities of the consolidated entities are "pooled" and administered on a pooled basis. As a result, inter-entity obligations are eliminated. Accordingly, a receiver may consider a substantive consolidation of insurers that are parties to complex dealings in order to effectuate the pooling of their assets and liabilities without the complexities of their dealings among themselves.

As discussed above, courts generally limit consolidation of companies in proceedings with companies not in proceedings to situations where the test for "piercing the corporate veil" is met. Although such a showing would also support consolidation of pending insurer insolvency proceedings, there is authority to support the proposition that a lesser showing may be sufficient to substantively consolidate companies when both are in proceedings.[18] Courts generally agree that consolidation of pending proceedings is appropriate if the assets of the relevant entities are so commingled that the costs of segregation threaten creditor recovery in either case.[19] Outside those circumstances, courts differ as to the appropriate standard for consolidation. The majority of courts look to certain characteristics of the entities in receivership.[20] Those courts generally require the proponent of consolidation to prove that the entities operated as a single entity, and that consolidation is necessary to achieve some benefit or to avoid some harm. Other courts focus instead upon creditor behavior rather than on debtor

[17] See e.g., *Chemical Bank New York Trust Co. v. Kheel*, 369 F. 2d 845 (2d Cir. 1966) (substantive consolidation should be used sparingly).

[18] See In re Alpha *&* *Omega Realty, Inc*., 36 B.R. 416 (Bankr. D. Idaho 1984); see also In re *United Stairs Corp.*, 176 B.R. 359 (Bankr. D.N.J. 1995); In re *Murray Industries, Inc.,* 119 B.R. 820, 829 (Bankr. M.D. Fla. 1990) (substantive consolidation if benefits estate without betraying debtor and creditor expectations).

[19] See e.g., In re *Gulfco Investment Corp*., 593 F.2d 921, 929-30 (10th Cir. 1979); *Chemical Bank New York Trust Co. v. Kheel*, 369 F.2d at 847.

[20] See e.g., In re *Affiliated Foods, Inc.*, 249 B.R. 770 (Bankr. W.D. Mo. 2000); *Eastgroup Properties v. Southern Motel Assoc. Ltd*., 935 F.2d 245, 249 (11th Cir. 1991); *Drabkin v. Midland-Ross Corp. (*In re *Auto-train Corp.)*, 810 F.2d 270 (D.C. Cir. 1987).

characteristics and require the proponent of substantive consolidation to prove that creditors generally dealt with the entities as if they were one enterprise.[21]

There appear to be three limitations upon the doctrine of substantive consolidation that apply to insurance insolvency proceedings. First, substantive consolidation is limited by the jurisdiction of the receivership court. With certain exceptions not here relevant, the receivership court's jurisdiction is typically limited to insurers domiciled in its state. Accordingly, it can be argued that the court lacks jurisdiction to order substantive consolidation of an insurance company domiciled in another state with a domestic insurance company even if grounds for substantive consolidation otherwise exist.[22]

A second limitation on the doctrine of substantive consolidation protects a creditor that can prove that it relied upon the separate credit of a single entity.[23] Such a creditor is entitled to a recovery based on the assets and liabilities of the entity on which the creditor relied. The third limitation on substantive consolidation is that it will not be used as a device to achieve or preserve an inequity. For example, courts have denied a parent company's attempt to substantively consolidate its subsidiary into the parent's proceedings if the effect would be to eliminate the subsidiary's claims against the parent for fraudulent transfer, breach of fiduciary duty and the like.[24] For that reason, if the insurer has claims against its affiliates for such misconduct, it is unlikely that substantive consolidation of that insurer into the cases of one or more of its affiliates will be imposed over the objection of that insurer's receiver.

3. Placing related entities into bankruptcy

The receiver may also have the ability to place some or all of the other entities into bankruptcy or may have to deal with other affiliates already subject to federal bankruptcy proceedings. In such instances, coordination between the multiple proceedings is essential to bring about an effective resolution. The receiver must file any appropriate bankruptcy claims in a timely manner and communicate with the trustees of the bankrupt parent and/or affiliates to protect the rights of the insolvent insurer.

G. Important Legal Procedural Issues

In handling the insurer's legal affairs, the receiver should become fully familiar with two legal issues that are of vital interest to the affairs of the insolvent's estate: the primacy of the jurisdiction of the liquidation court and statutes of limitations.

1. Jurisdiction of Liquidation Court and Related Issues

Jurisdiction means the power of a court to resolve a particular dispute or issue in such a way as to bind concerned parties. The ultimate jurisdiction or power to control the liquidation of the insolvent insurer resides in the liquidation court.[25] The liquidation court is the state court of the state where the insurer is domiciled that initially ordered the insolvent insurer into liquidation. (See Chapter 8—Special Receiverships for a discussion of jurisdictional issues specific to HMO receiverships.) A claimant against the estate who files a proof of claim in the liquidation proceeding is generally held to have submitted to the jurisdiction of the liquidation court, at least with respect to matters pertaining to the claim.

[21] See e.g., In re *Augie/Restivo Baking Co., Ltd*., 860 F.2d 515, 518 (2d Circ. 1988).

[22] See *F.D.I.C. v. Colonial Realty Co*., 966 F.2d 57, 58-59 (2d Cir. 1992) (jurisdictional provisions of Bankruptcy Code limit a bankruptcy court's power to substantively consolidate).

[23] See *Chemical Bank New York Trust Co. v. Kheel*, 369 F.2d 845; In re *Snider Bros., Inc*., 18 B.R. 230 (Bankr. D. Mass. 1982).

[24] See *Flora Mir Candy Corp. V. Dickson*, 432 F.2d 1060 (2d Cir. 1970); *Anaconda Building Materials v. Newland*, 336 F.2d 625 (9th Cir. 1964).

[25] *Dykhouse v.* Corporate *Risk Management Corp.,* 961 F.2d 1576 (Table), 1992 WL 97952 (Text) (6th Cir. 1992) (federal court abstention concerning *Cadillac Ins. Co.*).

In some states, the liquidation court is vested by statute, as interpreted by courts, with the exclusive jurisdiction to determine all claims both for and against the insurer and involving the assets or affairs of the insurer in any way. This means that creditors cannot assert simultaneous or subsequent claims against the estate, arising from an insurer insolvency, in a court other than the liquidation court. A single, integrated administration ensures equitable treatment for creditors and avoids preferences.

However, according to the common law of other states and the decisions of the U.S. Supreme Court, the jurisdiction of a liquidation court in an insurance insolvency is exclusive only regarding in rem matters involving the insolvency, i.e., the liquidation court alone may decide matters involving the control and distribution of estate assets. Otherwise, the liquidation court's jurisdiction is concurrent with all other courts, state and federal, over in personam matters involving the insolvency, i.e., any court may decide matters involving the legal rights of the insolvent toward debtors of the estate, and the liquidation court must honor the judgment of another court on these rights.[26]

For example, in states that recognize the existence of concurrent jurisdiction, a receiver might file a motion with the liquidation court for a show cause order alleging breach of contract by a reinsurer, and in response, the reinsurer will likely remove the dispute to a federal court. Assuming the federal court renders a judgment in favor of the reinsurer, finding that the insolvent owes the reinsurer money, the reinsurer may file the judgment along with a proof of claim in the estate of the insolvent, and the state liquidation court must accept the judgment as conclusive regarding legal liability. The liquidation court will then decide what priority of distribution the claim receives, and how much of the judgment the estate is able to pay.

Under normal circumstances, the liquidation court has exclusive jurisdiction to fully address the claims of all, and accordingly, has the power to bind such creditors to the court's adjudication of those claims.

a. Relation to Federal Court Jurisdiction

Federal courts have jurisdiction to handle cases involving an issue of federal law and cases in which the parties to a suit are citizens of different states, i.e., there is "diversity of citizenship." However, where federal courts are asked to exercise jurisdiction in a case concerning an insolvent insurer for which a state liquidation court has already exercised jurisdiction over the controversy, federal courts will follow the doctrine of abstention under some circumstances. This means the federal court will "abstain" from exercising jurisdiction, even though it would have the power to do so. If, however, a suit is brought before a federal court based upon claims which are exclusively federal, the abstention doctrine most likely will not apply. The abstention doctrine also will not apply to justify dismissal of a federal action when the relief sought is solely legal in nature, such as for money damages, rather than equitable or discretionary.[27] Even in a suit for money damages, however, a federal court may stay the action to allow the receivership court to decide an important issue of state law.[28] A federal court may also abstain where the relief sought is primarily equitable

[26] *Morris v. Jones*, 329 U.S. 545, 549, 91 L.Ed. 488, 67 S.Ct. 451, rehearing denied, 330 U.S. 854, 91 L.Ed. 1296, 67 S.Ct. 858 (1947); *Webster v. Superior Court*, 46 Cal.3d 338, 250 Cal. Rptr. 268, 758 P.2d 596 (Calif. 1988); *Woodside v. Seaboard Mut. Cas. Co.,* 415 Pa. 72, 202 A.2d 42 (Pa. 1964); *Seaway Port Authority of Duluty v. Midland Ins. Co.,* 430 N.W.2d 242 (Minn. App. 1988) *(*citing *Fuhrman v. United America Insurors,* 269 N.W.2d 842 (Minn. 1978)); *Campbell v. Wood,* 811 S.W.2d 753 (Tex. App. Hous. 1st Distr. 1991) (*citing Wheeler v. Williams,* 312 S.W.2d 221 (Tex. 1958)); *Moody v. State,* 487 So.2d 852 (Ala. 1986); *Capo v. Century Life Ins. Co.,* 610 P.2d 1202 (N.M. 1980)); In re *National Heritage Life Ins. Co.,* 656 A.2d 252 (Del. Ch. 1994); *Christian Broadcasting Network, Inc. v. Starr,* 401 So.2d 1152 (Fla. Dist. Ct. App. 1981).

[27] *Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 135 L.Ed.2d 1, 116 S.Ct. 1712 (1996), proceedings on remand, 121 F.3d 1372 (1997); see also *Feige v.* Sechrest, 90 F.3d 846 (3d Cir. 1996) (concerning Corporate Life receivership); but see *Munich American Reinsurance Co. v. Crawford*, 141 F.3d 585 (5th Cir.), cert. denied, *American Re-Insurance Co. v. Crawford*, 525 U.S. 1016, 142 L.Ed. 2d 448, 119 S.Ct. 539 (1998) (while Burford abstention not warranted, Federal Arbitration Act reverse preempted by McCarran-Ferguson Act, indicating that argument not raised in *Quackenbush, supra*.

[28] Id.

or discretionary in nature, but monetary damages or other legal relief is a less essential component of the case.[29]

b. Primacy of the Liquidation Court, Withstanding Collateral Attack, and Arbitration

The success of a liquidation effort may be heavily influenced by the degree to which the primacy of the liquidation court is recognized. Unless courts in other states defer to the liquidation proceedings in the insurer's state of domicile, there is no way a receiver can marshal assets, adjudicate claims and wind up the affairs of an insolvent multi-state insurer in an equitable, consistent, expeditious, orderly and cost-effective manner. This is why receivers often find it important to vigorously exercise their statutory and court-granted powers to bring before the liquidation court all disputes and proceedings that come within the scope of the liquidation court's jurisdiction.

Not all claimants, reinsurers and others with an interest in the insolvent insurer's affairs will agree with the receiver's preference for having decisions made exclusively by the liquidation court. For some, it is a matter of convenience: They prefer to have their disputes heard by a court close to where they are located, rather than traveling to a distant liquidation court. If their suit is already pending in another court, they object to having those judicial proceedings stayed so that the matter can be transferred to the liquidation court. They may also have a preference for federal court over a state court. A reinsurer, for example, may prefer to exercise its contractual right to arbitrate its claim. Finally, some claimants may believe that the liquidation court favors maximizing the assets of the insolvent insurer and may therefore not provide a truly objective forum for all claims, particularly those which, if successful, would diminish the assets and reduce the size of the estate.

There has been a plethora of litigation on the liquidation court's jurisdiction and the ability of litigants to send liquidation-related disputes to other state or federal courts or to arbitration. Several doctrines run through the case law, and the outcome of these disputes often depends upon the nature of the dispute, the relief sought and the exact parameters of local law.

The starting point is whether the state where the dispute is pending is a "reciprocal state" under the Uniform Act, analogous provisions of which are now a part of the Liquidation Model Act. If a claimant files an action in a state court in a reciprocal state, the local court should either dismiss the action or transfer it to the liquidation court.[30] The court should not permit the action to proceed outside an ancillary receivership proceeding.[31]

The next question is whether the local court will honor, on full faith and credit or other grounds, the liquidation court's injunction against outside litigation. Such an injunction is typically entered at the outset of the liquidation proceeding as a part of the order of liquidation. Most local courts have honored such judicial pronouncements from the liquidation court, particularly where the outside litigation seeks to attach or determine rights with respect to the insurer's property.

Arbitration presents different issues. The Federal Arbitration Act,[32] which establishes a federal policy favoring the arbitration of disputes, requires a court to stay an action pending arbitration when the governing contract has an arbitration clause. If a claimant, such as a reinsurer, tries to force the liquidator to arbitrate, based upon an arbitration clause in the claimant's or reinsurer's contract with the insurer, then federal courts have split on whether arbitration is permitted to

[29] See *Prentiss v. Allstate Ins. Co.*, 87 F.Supp. 2d 514 (W.D.N.C. 1999).
[30] See e.g., Checker *Motor Corp. v. Executive Life Ins. Co.,* No. 122, 615 A.2d 530 (Table), 1992 WL 29806 (Text) (Del. 1992) (dismissing claim against insurer in receivership in California, under Delaware statute which is based on Uniform Act).

[31] See e.g., *State ex rel. Juste v. ALIC Corp.,* 595 So.2d 797 (La. App. 2d Cir. 1992) (claim must be brought in either receivership proceeding or in ancillary receivership proceeding).

[32] 9 U.S.C. §§ 1-16, 201-208 (West 2001).

proceed outside the liquidation court. Some courts have enforced the arbitration clause, saying that federal law favorable to arbitration cannot be ignored.[33] Other courts, particularly in New York, have said that state insurance liquidation statutes control because of the federal McCarran-Ferguson Act[34] and that a claimant cannot compel arbitration over the liquidator's objection.[35] In some instances, the dispute may be held to be outside the scope of the arbitration clause and, therefore, within the liquidation court's jurisdiction.[36] In the end, the liquidator will need to evaluate the importance to the liquidation effort, from a substantive or a timing standpoint, as well as the decisional climate towards arbitration in the jurisdiction, of keeping the dispute in front of the liquidation court.

c. Class Actions/Policyholder Committees

It can be argued that a class action for all creditors and policyholders of an insolvent insurer is inappropriate in a receivership because the receiver represents the interests and claims of all policyholders and general creditors in an insolvent insurer's liquidation. Where the receiver refuses to bring such an action, the court may then direct certain designated representatives to proceed with the action, although this issue remains unresolved.

The receiver's expertise, coupled with the exclusive supervision of a single court, helps to produce an economical, efficient and orderly liquidation and distribution of the insolvent insurer's assets.

Given the role of the receiver, some courts have ruled that the creation of a policyholders committee would result in the inefficient administration of the estate, increased litigation, depletion of the estate's assets and would have an adverse impact upon the interests of all other creditors.[37] Other

[33] Costle *v. Fremont Indemnity Co.,* 839 F.Supp. 265 (D. Vt. 1993); *Fabe v. Columbus Ins. Co.,* 587 N.E.2d 966 (Ohio Ct. App. 10th Dist. 1990); *Benjamin v. Pipoly,* 155 Ohio App 3d 171 (2003); *Selcke v. New England Ins. Co.,* 995 F.2d 688 (7th Cir.), mot. to vacate denied, 2 F.3d 790 (7th Cir. 1993); *Garamendi v. Caldwell,* No. CV-91-5912-RSWL, 1992 WL 203827 (U.S.D.C., C.D. Cal., May 4, 1992); *Foster v. Philadelphia Mfrs.,*140 Pa. Cmwlth. 186, 592 A.2d 131, 133 (Pa. Commw. Ct. 1991); *Schacht v. Beacon Ins.Co.,*742 F.2d 386 (7th Cir. 1984); *Bennett v.Liberty National Fire Insurance Co.,*968 F.2d 969 (9th Cir. 1992); *Ainsworth v. Allstate Ins. Co.,* 634 F.Supp. 52 (W.D.Mo. 1985); *Bernstein v. Centaur Ins. Co.,* 606 F.Supp. 98, 104 (S.D.N.Y. 1984); *Phillips v. Lincoln Nat'l Health & Cas. Ins. Co.,* 774 F.Supp. 1297 (D. Colo. 1991); *Schacht v. Hartford Fire Ins. Co.,* 1991 U.S. Dist. Lexis 12145, 1991 WL 171377 (N.D. Ill.), reconsideration denied, 1991 WL 247664 (N.D. Ill. 1991); *Curiale v. Amberco Brokers, Ltd.*, 766 F.Supp. 171, 174 (S.D.N.Y. 1991); see *Quackenbush v. Allstate Ins. Co., supra* and *Munich American, supra*.

[34] See *McCarran-Ferguson Act*, 15 U.S.C.A. §§ 1011-1012 (West 2000).

[35] *Agency, Inc. v. Holz,* 173 N.Y.S.2d 602, 4 N.Y.2d 245, 149 N.E.2d 885 (1958); In re *Union Indemnity Insurance Co.,*137 Misc.2d 575, 521 N.Y.S.2d 617 (Sup. Ct. N.Y. County 1987); *Albany Insurance Co. v. Wright (*In re *Delta America Re-Insurance Co.),* Civil A. No. 85-CI-0591 (Ky. Cir. Ct. Fed 4, 1994) *(*relying on *Knickerbocker); Ideal Mut. Ins. Co. v. Phoenix Greek Gen. Ins. Co.,* No. 83 Civ. 4687, 1987 WL 28636 (S.D.N.Y. Dec. 11, 1987); *Corcoran v. Ardra Ins. Co.* 657 F.Supp. 1223 (S.D.N.Y. 1987), app. dismissed, 842 F.2d 31 (2d Cir. 1988), on remand, 156 A.D.2d 70, 553 N.Y.S.2d 695 (N.Y. Supr. App. Div. 1st Dept. 1990, stay denied, 76 N.Y.2d 890, 561 N.Y.S.2d 551, 562 N.E.2d 695 (N.Y. 1990), app. dismissed, 76 N.Y.2d 1006, 564 N.Y.S.2d 716, 565 N.E.2d 1267 (N.Y. 1990), aff'd, 77 N.Y.2d 225, 566 N.Y.S.2d 575, 567 N.E.2d 575 (1990), cert. denied, 500 U.S. 953, 114 L.Ed.2d 712, 111 S.Ct. 2260 (1991) (concerning Bermudian reinsurer and Convention on Recognition and Enforcement of Foreign Arbitral Awards); *Corcoran v. AIG Multi-Line Syndicate, Inc.* 167 A.D.2d 332, 562 N.Y.S.2d 933 (N.Y. App. Div. 1st Dept. 1990*); Michigan Nat'l Bank—Oakland v. American Centennial Ins. Co. (*In re *Union Indemn. Ins. Co. of N.Y.),* 137 Mis. 2d 575, 521 N.Y.S.2d 617 (Sup. Ct. 1987), aff'd on other grounds, 200 A.D.2d 99, 611 N.Y.S.2d 506 (N.Y. App. Div. 1st Dept. 1994); *Corcoran v. Doug Ruedlinger, Inc,* Index No. 5349/87, slip op. (Sup. Ct. N.Y. County Aug. 21, 1987); *Washburn v. Corcoran,* 643 F.Supp. 554, 556 (S.D.N.Y. 1986); *Gerling-Konzern Globale Rueckversicherungs-AG v.* Selcke, No. 93 C 4439, 1993 WL 443404 (N.D. Ill. Oct. 29, 1993), *Stephens v. American International Insurance Co.,* 66 F.3d 41 (2d Cir. 1995). It should be noted that all of the above decisions were rendered prior to the U.S. Supreme Court's decision in *Quackenbush v. Allstate Ins. Co., supra*.

[36] See e.g, *Washburn v. Societe Commerciale de Reassurance*, 831 F.2d 149 (7th Cir. 1987).

[37] See In Re *Liquidation of Integrity Insurance Company,* 231 N.J. Super. 152, 159, 555 A.2d 50 (N.J. Super. Ch. Div. 1988) (court declined to appoint policyholders committee); see also *Minor v. Stephens*, 898 S.W.2d 71 (Ky. 1995) (court declined to appoint official committee for shareholders).

receivership courts, however, have allowed policyholders committees to be appointed so as to provide an additional means of protecting the interests of policyholders.[38]

The Liquidation Model Act was amended to provide that the receiver may, with the approval of the court, appoint an advisory committee of creditors.

IRMA has no provision specifically addressing policyholder/creditor committees.

d. Court Approval of Receiver's Actions

A receiver, in consultation with counsel, needs to consider the extent to which particular actions taken by the receiver should be submitted to the receivership court for prior approval. The receiver should first determine whether there are particular transactions, which must be approved under the state statutes governing the receivership proceedings. While the statutes often provide that a liquidator's recommendations concerning claims against the estate are addressed to the liquidation court for acceptance, denial or modification, the statutes do not always directly address prior court approval of other receivership matters. The receiver should become familiar with the practice in the receivership court.

Receivers and receivership courts across the country take different approaches to seeking court approval. If the state law does not provide sufficient guidance, a receiver should follow or adopt consistent guidelines within the receiver's own jurisdiction concerning prior court approval of asset sales, settlements of litigation, releases of all future claims, compensation agreements with estate consultants or professional advisers, payment of administrative expenses, reinsurance commutations and other matters. However, as not all estates are alike, exact uniformity may not be possible. The guidelines applicable to a receivership with a small amount of assets may not function appropriately for an estate with a sizable asset portfolio.

The receiver also needs to consider to whom and to what extent notice of an application to the court will be given. For instance, if a receiver fails to give notice of an application to a person or entity the receiver knows will be affected by that application, the court approval may have limited usefulness. The receiver should determine whether notice of a particular application should be given by mail or by publication in a newspaper or other media, including the Internet. Particularly in estates with a large number of creditors, it may be financially impractical to give notice of all court filings to all creditors and other interested parties. The receiver should consult with counsel regarding the law and practice governing such notice and an opportunity to be heard.

IRMA provides some guidance on what actions require court approval in § 504 and to whom notice should be given in § 107. Nonetheless, the receiver should still consult with counsel as described above.

2. Statute of Limitations

Statutes of limitations prohibit persons from asserting rights against another party when the right asserted has become "stale." The key date, for purposes of statutes of limitations, is the date on which a cause of action "accrues," i.e., the date when a party comes into possession of a legally enforceable right that would be recognized by a court. For example, a cause of action for breach of contract may be said to accrue on the date on which the breach occurred. In some cases, the actual date of accrual will be difficult to ascertain, such as where there has been an ongoing relationship between the parties over

[38] Policyholder committees have been given standing by courts supervising the insolvencies of Mutual Fire, Marine & Inland Insurance Company (Pa. Court) and Constellation Reinsurance Company (N.Y. Court). See e.g., *Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 132 Pa. Cmwlth., 196 572 A.2d 798 (Pa. Cmwlth. 1990), (balance of subsequent citation history omitted as not pertinent here, but cited elsewhere herein).

a course of years. In such circumstances, it may be possible to delay the date on which the statute will begin to run.

A statute of limitations sets forth a period within which a person holding a cause of action must assert that cause of action in legal proceedings. If the person fails to assert a cause of action within the period specified in the relevant statute of limitations, that person can be forever barred from asserting the cause of action. Consequently, the cause of action (and the potential resultant recovery) is lost.

The period within which a cause of action may be asserted under statutes of limitations can vary significantly, depending upon the nature of the cause of action. For example, the statute of limitations for breach of contract may be significantly different from the statute of limitations for tort actions, and special limitations periods may apply to causes of actions against certain professionals. Consultation with counsel is essential to ascertain the specific statute of limitations requirements applicable to each potential cause of action.

a. Tolling in General

A related concept of which the receiver should be aware is the concept of "tolling" the statute of limitations. In some circumstances, the statutory time period will not begin to run, or may be modified, even though the cause of action has accrued. This most frequently occurs in cases where a party may not be aware that he or she has a cause of action. Thus, in some cases, the statutory period will not begin to run until the cause of action has accrued and the injured party either knew or should have known of the existence of the cause of action. This type of tolling is most frequently found in situations where the injury is not obvious (e.g., latent illness); where the person with the right of action is, through no fault of his own, not in a position to pursue the cause of action (usually because of age or infirmity but, in some states, an insolvent insurer taken over by regulatory authorities also may qualify); or because the person with the cause of action was prevented from discovering it through fraud committed by the potential defendant. These tolling provisions are sometimes accompanied by an outside limit. For example, a statute may provide that the action may be brought within three years of the date on which the party knew or should have known of the cause of action, but in no event may the cause of action be asserted more than 10 years after the date on which the cause of action has accrued. Again, counsel should be consulted to ascertain the potential impact of tolling provisions.

b. Circumstances Unique to Receivers

Many state statutes provide for the tolling of statutes of limitations for the benefit of receivers. For receivers in states which adopt or in which the delinquency proceedings statute patterns the Liquidation Model Act, the receiver may find direct authority for extending periods of limitation in a particular case. For example, under the Liquidation Model Act, if a limitation period is unexpired as of entry of the liquidation/rehabilitation order, entry of such order tolls, for the benefit of the receiver, the running of such period for two years. IRMA § 109 A. extends the applicable limitation period to the later of the end of the limitation period or four years after entry of the most recent receivership order.

In addition, some courts have held that certain causes of action (such as those against former directors and officers, voidable preferences and RICO actions) are unique to the receiver and, as a result, the statute of limitations does not begin to run until the receivership is commenced.[39] Those

[39] Early case law may also be instructive on whether statutes of limitations begin to run against a court appointed receiver upon the receiver's appointment. See *Hall v. Ballard,* 90 F.2d 939, 946 (4th Cir. 1937) (statute of limitations does not begin to run against receiver until the receiver's appointment); *Irvine v. Bankard,* 181 F. 206, 211 (D. Md. 1910), aff'd, 184 F. 986 (4th Cir. 1911) (in Maryland, statute of limitations does not begin to run against an insolvent estate until there is someone in existence qualified to sue). See also *Pioneer Annuity Life Ins. Co. v. Rich,* 179 Ariz. 462, 465, 880 P.2d 682, 685 (Ct. App. 1994) at n.5 (statute of limitations does not begin to run until a judicial determination of insolvency and appointment of a receiver).

cases generally are supported by the following doctrines: 1) the "discovery rule" as adopted by the individual states; 2) the doctrine of adverse domination; 3) analogy to other federal and state code provisions and guidelines which extend limitations; and 4) the premise that the receiver acts as arm of the sovereign.

Under the "discovery rule," periods of limitation in certain cases do not start to run until the date the wrongful act was or (by the exercise of reasonable care and diligence) should have been discovered. The doctrine of adverse domination follows the widely held rule that the limitations statute is tolled when a corporate plaintiff continues under the domination of wrongdoers. Generally, that means that causes of action against former directors and officers of an institution do not accrue while the culpable group of defendants retains control of the corporation. The doctrine of adverse domination has also been applied to persons other than corporate officers and directors.[40] Adverse domination is a reliable mechanism for fraud claims. However, some courts have refused to apply the doctrine to negligence claims.[41]

Moreover, an analogy to extending limitations upon the appointment of a receiver also may be found in certain federal statutes. For example, both the U.S. Bankruptcy Code and the Financial Institutions Reform, Recovery and Enforcement Act extend limitations upon the appointment of a receiver, or the equivalent of a receiver.[42] Furthermore, the common law rule of nullum tempus occurrit regi (time does not run against the King), which exempts the state from the statute of limitations, may also apply to the receiver of an insolvent insurance company. A receiver's functions in resolving claims may be found to constitute a government action. Therefore, the receiver, as an instrumentality of the state, may be entitled to assert the status of the sovereign in opposing a statute of limitations defense.[43]

c. Potential Impact upon the Estate

As previously noted, one of the primary duties of the receiver is to marshal the assets of the insurer. This will sometimes require the receiver to assert causes of action on behalf of the insurer against third parties. (See the section in this chapter on Important Legal Procedural Issues.) In administering the affairs of the insurer, therefore, it is essential that the receiver be aware of the

[40] See e.g., *Bornstein v. Poulas,* 793 F.2d 444, 447-49 (1st Cir. 1986) (doctrine extended to attorney); *Mosesian v. Peat, Marwick, Mitchell & Co.,* 727 F.2d 873, 879 (9th Cir.), cert. denied, 469 U.S. 932 (1984) (auditors); *IIT v. Cornfeld,* 619 F.2d 909, 930 (2d Cir. 1980) (accountants, stockbrokers and underwriters); *FSLIC v. Williams,* 599 F.Supp. 1184 (D.M.D. 1984) (lower level employee).

[41] For a discussion of the various theories of wrongdoer control and levels of culpability required to toll the statute of limitations, see *RTC v. Franz*, 909 F.Supp. 1128 (N.D. Ill. 1995), interlocutory appeal permitted, 1996 WL 166940 (N.D. Ill. 1996); see, e.g., *FDIC v. Dawson,* 4 F.3d 1303 (5th Cir. 1993), cert. denied, 512 U.S. 1205, 129 L.Ed. 2d 809, 114 S.Ct. 2673 (1994) (Texas law); *FDIC v. Henderson*, 61 F.3d 421, 427 n.3 (5th Cir. 1995) (Texas law); *FDIC v. Cocke*, 7 F.3d 396 (4th Cir. 1993), cert. denied, 513 U.S. 807, 130 L.Ed 2d 12, 115 S.Ct. 53 (1994) (Virginia law); *FDIC v. Grant,* 8 F.Supp. 2d 1275 (N.D. Okla. 1998), certified question answered by, *RTC v. Grant*, 1995 OK 68, 901 P.2d 807 (Okla. 1995) (Oklahoma law); *RTC v. Blasdell,* 930 F.Supp. 417 (D. Ariz. 1994) (Arizona law); but see *FDIC v. Jackson*, 133 F.3d 694 (9th Cir. 1998) (adverse domination doctrine may apply to negligence claims under Arizona law); *RTC v. Farmer,* 865 F.Supp. 1143 (E.D. Pa. 1994) (Pennsylvania law). But see *RTC v. Hecht, 833 F.Supp. 529 (D.Md. 1993),* certified questions answered by, *Hecht v. RTC, 333 Md. 324,* 635 A.2d 394 (Md. 1994); *RTC v. Rahn,* 116 F.3d 1142 (6th Cir. 1997); *Clark v. Milam,* 872 F.Supp. 307 (S.D.W.Va. 1994), affirmed, 139 F.3d 888 (4th Cir. 1998), No. 2:92-0935 (S.D. W. Va. June 28, 1994); *RTC v. Fleischer*, 890 F.Supp. 972, 976 n.2 (D.Kan. 1995) (Kansas law); *RTC v. Fiala*, 870 F.Supp. 962, 974 (E.D. Mo. 1994) (Missouri law).

[42] See 11 U.S.C. § 108; 12 U.S.C. §§ 1821(d)14(A), (B), (C).

[43] See *Diamond Benefits Life Ins. Co. v. Resolute Holdings (In re Diamond Benefits Life Insurance Co.)*, 184 Ariz. 94, 907 P.2d 63 (1995) (statutes of limitations do not run against receiver of insolvent entity because receiver acts on behalf of state); *Anne Arundel County v. McCormick,* 323 Md. 688, 594 A.2d 1138 (1991) (statutes of limitations do not run against the state or any of its instrumentalities, provided they are acting in a governmental, rather than a corporate or proprietary capacity); *Mitchell v. Taylor,* 3 Cal.2d 217, 43 P.2d 803 (1935) (California insurance commissioner not a mere private trustee in his capacity as receiver, but instead was a state officer performing duties conferred by statute, and acting on behalf of the entire state); but see *Williams v. Infra Commerc Anstalt*, 131 F.Supp. 2d 451 (S.D.N.Y. 2001) (doctrine inapplicable where state official acting to protect private interests rather than public interests).

statute of limitations so that necessary steps are taken to prevent the loss of potential rights or causes of action.

To some degree, the statute of limitations is also relevant in ascertaining the insurer's liability in that potential claims against the insurer which have been allowed to become stale under the relevant statute may be time barred.

3. Discovery

The general concept of discovery deals with the ability of outside parties to gain access to the insurer's books, records or other internal documents. This issue has vital significance to the receiver to the extent that it is necessary or desirable that the receiver keep certain information confidential. Discovery issues generally arise in one of two contexts: discovery pursuant to litigation and arbitration and requests pursuant to the freedom of information law. Discovery in the federal courts is governed by the Federal Rules of Civil Procedure. The rules of most state courts are largely patterned after the federal rules. The receiver also may have broad subpoena powers under state insolvency law even in advance of litigation.[44] The commissioner's administrative subpoena powers also may be available.[45]

a. Scope

The scope of discovery generally is broad. Whether information is discoverable will depend upon: 1) whether it is "relevant to the subject matter" involved in the action; and 2) whether it is subject to a legally cognizable privilege. "Relevance" usually is defined broadly as including any information reasonably calculated to lead to the discovery of admissible evidence.[46]

i. Relevance

Whether information is "relevant" will depend upon the issues raised in any particular litigation. For example, if the receiver is suing for payment of reinsurance recoverables, information regarding the payment of claims in the reinsured book of business would obviously be relevant. In other cases, the question of relevance will be less clear. For example, in a suit against an insolvent insurer's former officers and directors, information regarding the payment of claims during the receivership may or may not be relevant depending on the theory of damages adopted by the receiver's attorneys. If the damage theory focuses on the financial condition of the insurer at the time it was taken over by the receiver, subsequent events arguably would not be relevant. Obviously, these are judgments that should be made by the receiver in consultation with the receiver's attorney in any action.

ii. Privilege

Even if the data is relevant, it is not discoverable if it is within the scope of a privilege. The privileges that might commonly be considered are the attorney-client privilege; the attorney work-product privilege; and executive privilege. The scope of these privileges may be defined by state law where the litigation involves state law claims. These privileges also exist, however, as a matter of federal common law and federal rules. It is important to restrict access to data so as to avoid being found to have waived a privilege. It is also important to exercise care with both written and oral communications to prevent a waiver to the degree possible.

- Attorney-Client Privilege

[44] See e.g., Liquidation Model Act, *supra*, note 3, at Section 24.A.(6) and IRMA §504 A. (1).

[45] See e.g., *Angoff v. M&M Management Corp.,* 897 S.W. 2d 649 (Mo.Ct. App. 1995).

[46] Fed. R. Civ. P. 26(b)(1).

The attorney-client privilege is intended to promote open and honest communication between attorney and client. Preventing forced disclosure of such communications is justified on the ground that full disclosure is necessary to enable the attorney to use sound and informed advice and encourages voluntary compliance with the laws. To be within the scope of the privilege, a communication must be made between privileged persons in confidence for the purpose of seeking, obtaining or providing legal assistance for the client.

The attorney-client privilege may exist both with respect to pre-receivership and post-receivership information. Care should be taken by the receiver to separate (or be able to identify) what information was gathered by the receiver and what information existed before the takeover.

Communications between the former officers of the insurer and their attorneys, copies of which are maintained in the insurer's records, will be subject to the privilege. The receiver inherits the insurer's right to assert the privilege or to waive the privilege. Care must be taken, however, to determine what rights, if any, the individual former directors have in the preservation of the privilege. Communications between the receiver and the receiver's attorneys likewise would be within the scope of the privilege.

The fact that information is communicated to an attorney to obtain legal advice does not make the information itself privileged. It is the communication, not the information, which is privileged. Therefore, the mere fact that information used by the insurer in its business is communicated to an attorney does not protect that information from discovery. To determine the exact scope of the attorney-client privilege, and any exceptions that may apply, the receiver should consult legal counsel.

- Work-Product Doctrine

A second, more limited privilege which may preclude discovery is the work-product doctrine. This doctrine provides a qualified privilege to materials gathered by counsel and prepared by counsel in the course of preparing for possible litigation. The purpose of the rule is to protect an attorney's ability to properly develop and prepare the case without fear that the attorney's work product could be discovered by the other side and used against his or her client.

The work-product doctrine has been codified in the Federal Rules of Civil Procedure[47] and state rules patterned after the federal rules. It protects from discovery documents and tangible things otherwise discoverable which are prepared in anticipation of litigation or for trial and by or for another party or by or for that other party's representative. This immunity from discovery is only qualified and can be overcome if the party seeking discovery shows substantial need for the materials and an inability to obtain the substantial equivalent of the information without undue hardship. Thus, information specifically gathered and prepared by the receiver at the direction of counsel to assist counsel in conducting liquidation proceedings or other litigation may be protected from discovery by the work-product doctrine. Application of this doctrine depends on the particular circumstances and should be assessed by counsel retained by the receiver.

- Executive Privilege/Deliberative Process

Another privilege that may provide limited protection from discovery is a claim of executive privilege. Typically, the receiver as receiver would not have grounds for asserting this privilege. However, because the receiver is also a regulator for the

[47] See Fed. R. Civ. P. 26(b) (3).

domiciliary state, litigants often seek discovery of information within the possession of the insurance department. They may assert, for example, that part of the losses were the result of pre-takeover negligence by the commissioner as regulator. Whether regulatory negligence is in fact a partial defense is highly disputed. For discovery purposes, great care should be taken in maintaining the distinction between the commissioner as receiver and the commissioner as regulator, particularly as to the insolvent insurer.

Nonetheless, to the extent that data from the insurance department in its role as regulator is discoverable, a claim of executive privilege might be argued. Such a privilege would be based upon arguments as to the need to maintain confidentiality to enable the regulator to fulfill his regulatory obligations and protect the public interest.

A qualified privilege, sometimes called the deliberative process privilege, has also been recognized to protect memoranda containing advice, opinions and recommendations given in the course of deliberations regarding governmental, legal and policy decisions.[48]

- Consultants

Consultants providing day to day assistance to the receiver may be protected by privilege but such consultants should be advised that only the receiver may waive the privilege.

b. Freedom of Information Act

Another route that adverse parties may take to obtain information from the insurance department is to file a request under a state Freedom of Information Act (FOIA). A state FOIA generally permits any person to inspect or copy specified public records maintained by state agencies, including the insurance department. The FOIA has a number of specific exceptions to the requirement that the department allow such inspection or copying. Exceptions typically include matters related to litigation, internal memoranda and records or information compiled for law enforcement purposes. Insurance Codes, particularly laws on examination of insurers, may contain exception to state FOIA's. Receivers who are not a part of the Insurance Department may be exempt from FOIA, and records held by department personnel as receiver need to be looked at carefully as to whether they are covered by FOIA. The receiver should alert insurance department personnel to consult with the receiver before responding to a FOIA request to the department seeking any of the insolvent insurer's records held by the department.

c. Costs

The expense of compliance with discovery should be considered. Although the courts typically require the respondent to bear the cost of producing the information in usable form where the expense of recovery results from the respondent's choice of means for storing the information, courts have also required parties seeking discovery to share in the cost of retrieving data. If the party seeking discovery does not agree to share in such expense, a protective order should be sought. Applicable federal law and state statutes may require the party issuing the subpoena to bear the expense of document production. Some case law even supports the delay of producing documents until the cost of the production is advanced. Finally, counsel should review all documents prior to production to verify that the documents themselves are not protected by confidentiality.

[48] See *United States of America v. American Telephone and Telegraph Co.,* 86 F.R.D. 603 (D.D.C. 1979).

H. Health Insurance and Health Maintenance Organizations (HMOs)

1. Hold-Harmless Clause

There are two distinct types of hold-harmless clauses. The first, which is discussed in detail in this section, is the hold-harmless clause that is contained in the contract between a health plan and a provider. The second, which is discussed in more detail below, is a court-ordered hold-harmless clause that will only be triggered by judicial intervention into an insolvency. Generally, state law will require the HMO to protect the enrollee from liability for medical costs and expenses beyond the applicable co-payments, deductibles or fees for services not covered under the member plan or policy. The HMO, in turn, will include a hold-harmless clause in its provider contracts, prohibiting providers from seeking to recover any amounts from the enrollee that are ultimately the responsibility of the HMO, or amounts that are above and beyond the agreed reimbursement for a given service. These clauses are designed to protect patients not only against overbilling by providers, but also to protect them from the risk that the HMO will go insolvent and fail to pay its providers.

Receivers should seek to have an injunction to enforce hold-harmless clauses against contracted providers (and even non-contracted providers in some instances) included within the petition to rehabilitate or liquidate an HMO. In cases where the receiver has evidence that members have been inappropriately billed, efforts should be made to intercede on behalf of the member and require the return of monies collected by the contracted provider. The receiver should note that claims by a member that represent amounts the member has been inappropriately balance billed by a contracted provider may not be valid claims against the HMO. The amounts that were never the obligation of the HMO should therefore be referred to the offending providers. Many states require hold-harmless clauses in all provider contracts and will deem contracts that do not specifically contain them to do so by operation of law. The significance of the hold-harmless clause comes to light when priority-of-distribution provisions are examined.

2. Federal Regulations

a. Medicare and Medicaid

The advent of Medicare and Medicaid HMO plans has added new elements to the overall receivership picture. Medicare and Medicaid HMOs offer eligible enrollees services similar to those of a conventional HMO rather than the benefits set out by statute or regulation in the fee-for-service programs. HMOs usually offer enrollees extra benefits that they would not have received under conventional systems, or waiver of co-payments or deductibles that they would have been required to pay. Federal government oversight of the operation, financing, and market conduct of these programs is an important part of their business environment. In addition to the additional regulatory constraints under which these HMO programs operate, the unique characteristics of their enrollee population create both opportunities and challenges for a receiver.

The Centers for Medicare & Medicaid Services (CMS), previously known as the Federal Health Care Financing Administration,[49] guidelines require that non-participating providers with Medicare agreements must accept as full payment the amount that Medicare would have paid. For example, it is possible that a physician (with a participating Medicare agreement) may violate his or her Medicare agreement by accepting payment in excess of the Medicare allowed amount. In addition, at least ninety-five percent of "clean claims" (those properly documented claims having no defects or improprieties) must be paid within thirty days under CMS's prompt payment requirements. Late payments incur interest and civil monetary penalties. Receivers must consider the federal statutes, regulations and

[49] The Centers for Medicare & Medicaid Services' Web site is www.cms.gov/medlearn.

guidelines in adjudicating claims involving Medicare made by non-participating providers (including physicians, inpatient hospitals and skilled nursing facilities).

One challenge that arises at the outset of a receivership involving Medicare or Medicaid recipients is moving the subscribers to a solvent plan. In some cases, the federal government can roll all subscribers either to traditional Medicare or to other plans, but the timing of this must be coordinated to avoid a period of time where subscribers are trapped in an insolvent company. CMS will work with state insurance departments to try to avoid any disruption of coverage for recipients and to coordinate a relatively smooth transition, but this must be done while the petition for appointment of receiver is pending so that cancellation of coverage can be coordinated.

Another issue that arises with Medicaid receiverships is that typically some funds are held in trust for Medicaid services only, and the use of these funds must be coordinated with appropriate state and federal agencies.

b. ERISA

Federal regulation also plays a role in most health care programs offered to employee groups. The Employee Retirement Income Security Act (ERISA) is a complex statute that federalizes the law of employee benefits. As a receiver, it is important to understand the relationship between federal and state laws as they apply to ERISA employee benefit plans, since the receiver must operate in compliance with both state and federal laws.

When the HMO is responsible for the payment of employee benefits, it is likely to be acting as a fiduciary. ERISA requires that a plan fiduciary must discharge his/her duties solely in the interests of the plan's beneficiaries. It is important to consult an ERISA specialist to determine if the insolvent insurer, MCO or HMO is also a fiduciary and to understand the nature and scope of the fiduciary obligations.

3. Health Insurance Portability and Accountability Act (HIPAA)

The receiver also needs to be aware of the rights granted to HMO subscribers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A wide-ranging, complicated and often confusing law, HIPAA can affect how a receiver structures a plan. For example, HIPAA's guaranteed renewability requirements limit the ability of a receiver to terminate, or perhaps even to change, coverage under a health plan. HIPAA's guarantee issue requirements also permit covered groups and individuals to move more freely to other plans, thereby reducing the receiver's ability to assure a stable block of business for sale to other insurers. (These rights apply, generally speaking, to broad-based health plans, but not to plans that provide limited benefits such as dental-only plans.)

a. Guaranteed Renewability of Coverage by HMO in Receivership

HIPAA requires guaranteed renewal of all group products. Nonrenewal of group coverage is allowed for nonpayment, fraud or misrepresentation, carrier market exit, failure to meet minimum contribution or participation requirements, and a few other specified reasons. In those states that have adopted HIPAA provisions as part of state law, rather than implement an "alternative mechanism," HIPAA also requires guaranteed renewal, or continuation in force, of all individual products.[50] As with group coverage, nonrenewal is allowed for specified reasons, including carrier market exit.

b. Guaranteed Issue of Coverage by Other Plans

[50] Arizona, Colorado, Delaware, Hawaii, Maryland, North Carolina, Rhode Island, Tennessee and West Virginia are enforcing the federal fallback provisions. In California and Missouri, CMS is enforcing the federal fallback provisions (as of September 2000).

HIPAA requires all carriers serving the small employer market (2 to 50 employees) to accept every small employer that applies for coverage and to accept every eligible individual who applies when they first become eligible (although it should be noted that particularly in the individual market, underwriting requirements, or even the ability of carriers to underwrite at all will vary depending upon whether the state has filed an alternative mechanism or not). Small employers covered by an HMO in receivership will thus be able to move their business to another carrier serving that market without risking loss of coverage or gaps in coverage. The same is generally true for individual subscribers. A carrier offering coverage in the individual market may not decline to offer coverage to, or deny enrollment of, an eligible individual, and may not impose preexisting condition exclusions with respect to the coverage. Exceptions are permitted for insufficient network or financial capacity. HIPAA does not require guarantee issue in the large group market (more than 50 employees), although large group insurers and employer-sponsored plans may not establish rules of eligibility for enrollment based on a health status-related factor. Also, large group plans may not require an individual to pay a premium greater than that charged to a similarly situated individual based on a health status-related factor.

c. Documentation Requirements

Plans and carriers are required to provide documentation of coverage to individuals whose coverage is terminated, to include dates of coverage (including COBRA) and waiting periods, if any. The HMO in receivership will be required to issue these certificates of creditable coverage to individuals leaving the plan.

4. The Patient Protection and Affordable Care Act (PPACA)

Enacted on March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) or simply the Affordable Care Act (ACA) expanded HIPAA's guaranteed issue and guaranteed renewability market reforms for the individual and small group markets, and, in some cases, these reforms also extend to the large group market. Beginning with plan year Jan. 1, 2014, the ACA requires carriers to accept every employer and every individual that applies for coverage without imposing any preexisting condition exclusions except a carrier may restrict enrollment based upon open or special enrollment periods. Carriers must also renew coverage or continue coverage in force at the option of the plan sponsor or the individual. As with HIPAA, a receiver must be aware of the rights granted to HMO subscribers under the ACA as outlined above for HIPAA.

I~~H~~. The Application of Setoffs in Insurance Receiverships

1. Introduction

Setoffs in insurance receiverships are a controversial subject. Any appreciation of the subject must proceed from an understanding of its practical, legal and political implications. The issue is of particular importance to receivers because setoffs can deprive an estate of funds that otherwise would be used to pay administrative costs and claims of the company's insureds. Setoffs are equally important to creditors (who are also debtors) of the estate eager to minimize losses sustained as a result of the receivership. Given these conflicting interests, receivers must appreciate the fact that applying setoffs in an insurance receivership is an issue not easily resolved.

2. Discussion

To determine when a setoff may be taken in an insurance receivership, the receiver needs to be familiar with the statutory parameters imposed on setoffs in the receiver's jurisdiction.

a. Definition

The right to assert setoff in insurance receiverships in the United States arises by statute, contract and common law. In its simplest form, setoff is the right between two parties to net their respective debts when each party owes the other a mutual obligation. For example, if A owes B $100 and B owed A $75, setoff allows A, under certain conditions, to net the liabilities and pay B only the balance, $25. The general rule is that only mutual debts and credits may be set off. It should be noted that statutory obligations, and applicable case law, in the insurance receivership context, may be argued to vary the general rules and impose additional requirements and limitations.

b. Mutuality

Most of the controversy about setoffs arises out of the term "mutual." In general terms, there are two requirements of mutuality that must be satisfied before a setoff will be allowed: mutuality of capacity and mutuality of time.

i. Mutuality of Capacity

Simply stated, the mutuality of capacity requirement means that in order for debts to be set off, the parties between whom the setoff is to be made must stand in the same relationship or capacity to each other. If the debt to be set-off arose between the parties when they were acting in different capacities, the debt will not be considered mutual and no setoff will be allowed. The "capacity" referred to is legal capacity, e.g., principal, agent, trustee, beneficiary. Thus, contracting principals who are debtors and creditors of each other by virtue of entry into a contract have the same legal capacity. See Liquidation Model Act Section 30A.

Mutuality of capacity frequently arises as an issue in determining setoffs between agents or brokers and the company over premium obligations, setoffs between affiliated companies, setoffs when a mutual company is involved and, increasingly, setoffs of salvage and subrogation recoveries.

- Agents and Brokers and Premium Obligations. Traditionally, setoffs between agents or brokers and the company have been denied on mutuality of capacity grounds. The reason is that the agent's role usually is viewed not as that of a party to a contract, but rather as a fiduciary. Thus, the statutes of most states (with few, limited exceptions) provide, and most courts have held, that an agent may not set off its obligation to remit earned or unearned premiums to a company against claims for future commissions or other damages. This prohibition against agent setoffs of premiums generally does not apply to insureds, because there is no mutuality of capacity problem. See Liquidation Model Act Section 33A(1) and IRMA § 613.

- Affiliates. As a general rule, setoffs are permitted only between the parties to a particular contract. Thus, a debtor cannot set off an amount it owes the company against an amount the company owed the debtor's affiliate or subsidiary company. Similarly, an insolvent insurer may not assert a setoff owing to one of its affiliates or subsidiaries. See Liquidation Model Act Section 30B(3),(4) and IRMA § 609B(3),(4). Whether setoffs may be allowed in the case of debtors who have merged depends upon the circumstances of the merger. The general rule is that debts may not be purchased by, or transferred to, another debtor for setoff purposes. See Liquidation Model Act Section 30B(2) and IRMA § 609B(2).

- Assessment and Capital Obligations. In most instances, mutual company policyholders who are liable for assessment for company losses may not set off their losses and unearned premiums against their assessment obligations. Likewise, stockholders may

not set off their capital contributions. See Liquidation Model Act Section 30B(5) and IRMA § 609B(5).

- Receivers have unsuccessfully disputed reinsurance setoff where the debts and credits between the insolvent insurer and reinsurer arose from different contracts between the parties. The dispute centers on the mutuality of the debts and credits in issue, and is sometimes referred to as a dispute over multiple contract setoff.[51] For example, Insurer One might not only assume or reinsure risks from Insurer Two under one contract, but Insurer Two may also assume some other risks from Insurer One under a second, separate contract. This situation makes each insurer either a cedent or reinsurer, depending upon which contract is at issue. According to the statutes and common law of most states, if one of the insurers in the example becomes insolvent and the state puts it in receivership, the other insurer may assert a right to set off its debts or credits under one of the agreements with the debts or credits of the insolvent under the other agreement.[52]

- Salvage and Subrogation Recoveries. Salvage and subrogation recoveries in the hands of an insured (or reinsured) of the company generally may not be set off because the recoveries may be held in a fiduciary capacity.

ii. Mutuality of Time

In order for debts to be set off in an insurance receivership, the debts must be mutual as to time as well as capacity. This requirement often has been stated in terms of a restriction that hinges upon the "date of fixing of claimants' rights." One of the first steps in any insurance receivership is the establishment of an exact date upon which all rights, obligations and liabilities of the company can be fixed. (See Chapter 5—Claims, section on Establishing a Claims Procedure, The Fixing Date.) The date of fixing of claimants' rights is usually the date the order of rehabilitation or liquidation is entered. The general rule is (assuming all other requirements are met) that post-liquidation debts can only be set off against other post-liquidation debts. In other words, a pre-liquidation debt cannot be set off against a post-liquidation debt. Put another way, the debts and credits to be set off mush be owned contemporaneously.

- Pre- vs. Post-Liquidation Debts. Defining when a debt "arises" for purposes of fixing it as a pre- or post-liquidation debt has been a subject of great controversy. Receivers, therefore, must consult their statutes and the court cases construing their own or other states' similar statutes in order to determine whether a debt should be characterized as having arisen pre- or post-liquidation. At least one court has held that where all the debts in question arose under provisions in the reinsurance contracts that were executed and performed prior to the time of the insolvency, the debts were pre-liquidation obligations.[53]

[51] A different but related concept is called "recoupment." Recoupment allows a defendant to reduce the amount of a plaintiff's claims by asserting the defense that, while she may owe plaintiff money, plaintiff also owes the defendant money from the same transaction or contract, and the court should reduce the plaintiff's judgment against defendant, if any, by the amount plaintiff owes defendant. *Laventhol & Horwath v. Lawrence J. Rich Co.,* 62 Ohio Misc. 2d 718, 610 N.E. 2d 1214, 1216 (Ohio Mun. Cleveland 1991) *(quoting In re Holford,* 896 F.2d 176, 178 (5th Cir. 1990)). In contrast, setoff usually involves a claim of the defendant against the plaintiff, which arises out of a transaction, which is *different* from that on which the plaintiff's is based. *Id.*

[52] *Prudential Reinsurance Co. v. Superior Court*, 3 Cal. 4th 1118, 842 P.2d 48, 14 Cal. Rptr. 749 (Calif. Super. 1992). *Stamp v. Ins. Co. of N. America*, 908 F.2d 1375 (7th Cir. 1990); see also In re *Liquidation of American Mut. Liability Ins. Co.*, 434 Mass. 272, 747 N.E.2d 1215 (Mass. 2001); *Commr. of Ins. v. Munich American Reinsurance Co.*, 429 Mass. 140, 706 N.E.2d 694 (Mass. 1999).

[53] *Stamp v. Ins. Co. of N. America, supra*.

- Contingent, Unliquidated and Immature Claims. Satisfaction of the mutuality of time requirement often depends upon the relative stage of development of the claims and debts to be set off. The general rule is that only claims that are entitled to share in the estate as of the commencement of proceedings may be set off; contingent claims may not be set off if those claims are not entitled to share in the estate. For a discussion of the differences between contingent, unliquidated and immature claims, see Chapter 5—Claims, section on Establishing a Claims Procedure, The Fixing Date.

- After-Acquired Setoffs. Closely related to the rule against setoffs among affiliates is the general rule against after-acquired setoffs. The rule is that a party may not acquire after receivership a debt or claim by assignment or otherwise for use as a setoff in the receivership. See Liquidation Model Act Section 30.B.(2) and IRMA § 609B(2). Many states' statutes prohibit such setoffs.

c. Reinsurance Setoff

Some receivers are challenging the notion that insurers and reinsurers may set off their payables against receivables they may have against a company for losses under reinsurance treaties assumed by the company. The issue has been litigated in a number of state and federal courts, and likely will continue to be debated in state legislatures for years to come. The Liquidation Model Act was amended in 1990 to limit such setoffs. (See Insurers Rehabilitation and Liquidation Model Act Section 34B(6), 34D, 34E and 34F). Receivers should review their state's statutes to determine whether this change has been adopted.[54] In addition, some receivers have challenged the public policy assumptions underlying the historical development of setoffs in the common law and state statutes. It is imperative that receivers keep abreast of changes in the law of their jurisdictions.

d. Setoffs Outside Receivership Proceedings or Between Receivers

While the receivership court generally has exclusive jurisdiction over the liquidation and distribution of the assets of the estate, if there is a dispute regarding an estate's claim against a third party, those issues are sometimes addressed outside of the receivership court.[55] In such cases, the person or entity with whom the receiver is litigating may allege claims against the receiver in the same proceedings. The receiver may or may not be successful in requiring that person or entity to pursue those claims in the receivership proceedings and in denying that person a right of setoff in the litigation. Case law is still developing in this area and counsel should be consulted regarding this issue.

A related issue involves claims between two or more receiverships. Virtually all receivership orders have injunctions which preclude a person or entity from bringing claims against a receiver outside of the receivership proceedings. Some receivers have been successful in arguing that even though they are pursing claims in a second receivership proceeding, the injunction provision in their receivership order bars setoffs by another receiver in that receiver's own case. In those instances, the first receiver would pursue that receiver's full claim in the second receivership proceeding and the second receiver would, in turn, pursue that receiver's full claim in the first receivership proceeding. If receivers have mutual claims, the receivers should each consult counsel concerning the appropriate manner to deal with this issue.

[54] At least two courts have found that in the absence of a statute, there is no common law right to set off. See *Bluewater Ins. Ltd. v. Balzano,* 823 P.2d 1365 (Colo. 1992): *Allendale Mutual Ins. Co. v. Melahn,* 773 F.Supp. 1283 (W.D. Mo. 1991); but see *Transit Cas. Co. v. Selective Ins. Co. of the Southeast*, 137 F.3d 540 (8th Cir.), rehearing and suggestion for rehearing en banc denied (1998).

[55] The receivership court may determine that it does not have personal jurisdiction over a non-resident person or entity from whom the receiver is attempting to collect assets. See *In the Matter of Rehabilitation of National Heritage Life Insurance Company*, 656 A.2d 252 (Del. Ch. 1994).

e. Other Considerations

Determining how setoffs should be applied in a particular receivership is not dependent solely upon rote application of the foregoing rules. Receivers should be aware that some creditors have raised constitutional challenges to the application of statutory setoff rules. The application of setoff in a rehabilitation as opposed to a liquidation also should be considered where appropriate. Finally, there is an open issue of the extent to which setoffs may be taken regarding claims against the company by the federal government.

JI. Recoupment

The equitable doctrine of recoupment has been recognized in insurance and other types of insolvency cases.[56] Unlike setoff, recoupment typically is not provided for by statute. Recoupment generally is defined as the equitable adjustment of amounts owing between two parties arising out of the same transaction. Recoupment is usually limited to matters arising out of or related to a contractual relationship. Like setoff, recoupment does not yield a money judgment in favor of the party asserting it; it is defensive in nature. However, setoff differs from recoupment in that setoff applies to cross-obligations between parties arising out of different transactions.

When the doctrine is recognized, recoupment generally is not deemed to be subject to the setoff requirement of mutuality. Moreover, an otherwise valid assertion (and perhaps even the effectuation) of recoupment may not be subject to the receivership injunction against suits and setoffs, even if the assertion and/or effectuation of setoff would be barred by the injunction. The receiver should consult with counsel when considering the assertion of recoupment or when confronted with another person's assertion of the doctrine.

KJ. Retrospective Application of Statutes

A receiver may desire to apply a statute to events that occurred prior to the enactment of that statute. Whether a court will permit the receiver to do so may depend upon whether the court deems such application of the statute to be "retrospective" and, if so, whether surrounding circumstances are deemed to justify such application.

Application of "remedial" or "procedural" statutes to pre-enactment events generally is not deemed to be retrospective. A remedial or procedural statute is deemed merely to enhance an existing remedy or to change a mere rule of procedure. Generally, unless there is contrary legislative intent, remedial or procedural statutes are applied to all cases pending at the time of enactment, or become pending thereafter. That is without regard to whether the statute is to be applied in respect of pre-enactment events.[57] A statute also will be applied to pre-enactment events if it is deemed to be merely declarative of the law in effect at the time of the relevant events.[58] Generally, such application is deemed not to be retrospective.

By definition, a "substantive" statute adversely affects vested rights if retrospectively applied. Generally, courts will enforce a substantive statute retrospectively only if: 1) there is adequate expression of the legislature's intent that the statute be applied retrospectively;[59] and 2) such application is not inconsistent

[56] See, e.g., *Kaiser v. Monitrend Investment Management, Inc.*, 672 A.2d 359 (Pa. Commw. Ct. 1996) (recognizing the doctrine). But see *Albany Ins. Co. v. Stephens*, 926 S.W.2d 460 (Ky. App. 1995) (review denied) (deeming the doctrine to be superseded by statute precluding setoff against premiums).

[57] See *Angoff v. Holland-America Ins. Co. Trust*, 937 S.W. 2d 213 (Mo. App. Ct.), rehearing and/or transfer denied (1996) (claims estimation statute deemed to be procedural and applied to pre-enactment events).

[58] See *Bradley v. State Farm Mutual Automobile Ins. Co*., 212 Cal. App. 3d 404, 260 Cal. Rptr. 470 (Cal. App. Ct.), review denied (1989) (statute held merely declarative of prior law and applied to pre-enactment events).

[59] See *State ex rel Crawford v. Guardian Life Insurance Co. of America*, 1997 OK 10, 954 P. 2d 1235 (Okla. 1998) (contrary legislative intent; setoff restrictions not applied retrospectively).

with applicable constitutional limitations. Applicable constitutional limitations may include the Fourteenth Amendment and the Contracts Clause of the U.S. Constitution, and certain state constitutional provisions.[60]

Application of the foregoing general rules to any given situation tends to be unpredictable. That is because courts are not always consistent as to what they deem to be "remedial," "procedural" or "substantive," how they interpret legislative intent and how they construe constitutional limitations.

L~~K~~. Closing of a Receivership Estate

Prior to calculating the final distributions in a receivership estate, the receiver should consider:

- The length of time the receiver should maintain insurer and receivership records;
- Statutory requirements that affect the preservation and destruction of records;
- The cost of storage or retention of preserved documents; and
- The disposal of residual funds once the final expenses have been satisfied.

In most states, a receiver applies to the court for an order approving a final distribution of assets, closing the estate and discharging the receiver. The order may set aside funds, to be held in trust by the regulator, for post-estate closing administrative costs, such as those set forth above.

§ 902 of IRMA requires that a closing order be applied for, "when all property justifying the expense of collection and distribution have been collected and distributed."

M~~L~~. Destruction of Records

The receiver should identify the various types of documents in the estate's possession and determine the appropriate length of time that the documents should be preserved. In many cases it may be appropriate to review the documents in different categories, i.e., records that are the official records of the regulator, the insurer's records pre-receivership and those records of the receiver.

Counsel should determine whether the destruction of documents is governed by the state law, specifically concerning the destruction of public or governmental documents or by general state law concerning business documents. In certain situations, state law may require that certain types of records be maintained for a specific period of time and ethical standards, i.e., for attorneys, may require specific retention periods. Certain documents may need to be permanently preserved, perhaps through the state archival process.

Once the specific needs of the receiver, creditors and state law have been reviewed, the receiver should recommend to the court specific retention periods.

§ 904 of IRMA allows the receiver to recommend to the court records for destruction whenever it "appears to the receiver that the records … are no longer useful." It also allows for the retention of records post closing and the reserving of funds as administrative expenses needed to maintain the retained records, and for those records to be maintained by the insurance department.

N~~M~~. Escheat

After the receiver has established a procedure for the retention and destruction of documents, sufficient funds should be preserved to satisfy the costs of that long-term process.

[60] But see, e.g., *Jenkins v. Jenkins*, 219 Ark. 219, 242 S.W. 2d 124 (Ark. 1951) (state constitutional prohibition against retrospective laws does not inhibit certain laws made in furtherance of the police power of the state).

Counsel for the receiver should review state law with respect to the disposal of residual assets once the retention period has been satisfied or payment has been made to an entity in advance to carry out the receiver's procedure.

Many state laws provide for the escheat of funds to the state treasury. Procedures governing the escheat process and those responsible for implementing it may need to be established.

§ 804 of IRMA has two alternative approaches for dealing with unclaimed funds. Alternative 2 is to follow the general escheat process in state law. Alternative 1 sets up a procedure requiring the funds to be held for two years after termination of the receivership after which the court can order the funds be deposited in a general receivership expense account, be escheated to the state, or be used to reopen the receivership and distributed to known claimant.

III. CLAIMS

The focus of this section will be upon legal issues arising out of claims handling by a liquidator of an insolvent insurer rather than by a rehabilitator. A rehabilitator trying to decide whether a rehabilitation plan can be proposed that will avoid liquidation must consider the interests of the various groups of people with a stake in the insurer, including policyholders with current and future claims. Unless required by a rehabilitation plan, the rehabilitation process generally proceeds without a claims filing procedure, such as that used in liquidation, so that as much as possible, the result for the insurer and its policyholders is business as usual.

In the case of a life insurer, a moratorium may be placed on any claims for cash surrenders, dividends or policyholder loans, and the availability of those values may be restructured. This restructuring of the policyholder's accessibility to cash surrender and annuity values can create a larger surrender penalty for a reasonable period while confidence is restored in the life insurance company as it emerges from rehabilitation. If, in fact, some policyholders choose to withdraw cash from the insurer at that time, the substantial penalty for early withdrawal retains a larger portion of the nonforfeiture reserves while the liability of the company diminishes so that the resulting financial position is stronger even though the asset base is reduced. If the surrender penalty, however, is so punitive or so lengthy as to discourage policyholders from any hope of restoration of their account value, policyholders are likely to withdraw the available cash at the earliest possible time and look for other sources to recover their loss. Such a run will place substantial demands on the insurer's liquid assets and may endanger the future of the insurer.

Claim administration is at the heart of the receivership process. The receiver should establish claim procedures to ensure that the receivership will proceed, expeditiously and impartially, within the confines of applicable state statutes. The procedures should be clear and fair so that creditors and reinsurers can be secure that they are being dealt with equitably and that their respective interests are being properly addressed and protected by the receiver.

The issues discussed below represent pitfalls in the claims administration process where receivers have or may encounter legal controversy. There are few reported decisions on receivership claims administration questions. The guidelines in the claims chapter of this handbook are guidelines on how to conduct the claims administration process (see Section 8.B.7.g for a discussion of claims adjudication issues specific to HMOs).

A. State Liquidation Statutes and Federal Priority

The administration of claims is principally conducted according to relevant provisions of the applicable state liquidation law and judicial determinations. Federal laws affecting the federal government as claimant, however, may preempt state liquidation law (see Section 9.C.8.). The decisions since 1988 applying the federal superpriority statute[61] to insurance liquidation proceedings are discussed in detail below.

[61] 31 U.S.C. § 3713.

B. Notice Issues

Notice issues are discussed in section on Section II.F.2.

C. Primacy of the Liquidation Court, Withstanding Collateral Attack and Arbitration

Effective claims handling may be heavily influenced by jurisdictional issues discussed in detail in Section II.G. of this chapter.

D. Cancellation of Policy/Bond Coverage

Issues pertaining to cancellation of policy/bond coverage are discussed in detail in this chapter.

E. Claim Elements

1. In General

Once the order of liquidation is entered and the receiver starts the claims administration process, questions pertaining to claim valuation invariably arise. The receiver's role is to make sure that the claim process is fair to everyone and that no creditor is allowed more than the contractual, statutory or court-imposed rules permit. General principles of claims administration are discussed in detail in Chapter 5—Claims.

2. Punitive/Extra-Contractual Damages

In some jurisdictions, the insurability of punitive damages is prohibited as a matter of public policy. In these jurisdictions, punitive damages claims should not be recoverable against the estate. In most states, extra-contractual damage claims, such as bad faith, are subordinated and treated as general creditor claims.

Any claim that includes alleged punitive damages should be reviewed carefully under the applicable state law to answer the following questions:

- Are punitive damages insurable under applicable law?
- Is the punitive damage claim the result of alleged bad acts by the insured, by the agent or by the insolvent insurer?
- As to acts by the insured, is any part of the punitive damage claim within policy coverage?
- As to those punitive damage claims alleged to be a result of acts by the insured that are within policy coverage, what are the standards that would be applied by a court in awarding punitive damages and what would be the probable recoverable amount of damages?

Answers to these questions should enable a receiver to evaluate each punitive damage claim because the resolution of a punitive damage claim is fact intensive. Before a receiver recommends the approval of a punitive damage claim to the receivership court, the receiver should be certain that applicable law permits recovery.

§ 802 C(5) excludes punitive damages from the policyholder level (Class 3) unless the policy expressly covers punitive damages and subordinates punitive damages to Class 8.

3. Surety/Fidelity Bonds

The claim element questions in the surety/fidelity bond field usually revolve around the allowability of attorneys' fees, interest and liquidated damages. The case law seems to hold that, unlike punitive damages, if the underlying bond provided for such elements, they may be allowed by the receiver. With respect to coverage, at a minimum, there must have been a default by the bond principal before the cancellation date or, so far as fidelity bonds are concerned, the act or occurrence that caused damage covered by the bond must have taken place before the cancellation date. In addition, issues may arise concerning the return of unearned premiums (since surety premium is normally deemed to be fully earned at inception), whether bonds are cancelable, and what priority class a bond claimant is entitled to assert. IRMA § 801 C places in Class 3 (policyholder class) claims of "…obligees (and, subject to the discretion of the receiver, completion bonds) under surety bonds and surety undertakings (not to include bail bonds, mortgage or financial guaranty or other forms of insurance offering protection against investment risk, or warranties), claims by principals under surety bonds and surety undertakings for wrongful dissipation of collateral by the insurer or its agents …"

4. Contingent Claims

   a. Proofs of Claim—Unstated in Amount

   A proof of claim may be unstated in amount. As previously discussed, pursuant to the laws of many states, the failure to state a specific amount due may not necessarily result in its classification as a contingent claim. Approaches vary among receivers. Some state laws may require that the initial proof of claim be specific and cannot be materially amended after the bar date passes. Other receivers may permit proof of claim amendments until the claim is evaluated in the estate and a distribution is made.

   One technique for dealing with long-tail claims is estimation of contingent claims if it is determined either that: 1) "liquidation of the claim would unduly delay the administration of the liquidation proceeding"; or 2) "the administrative expense of processing and adjudicating the claim or group of claims of a similar type would be unduly excessive when compared with the property that is estimated to be available for distribution with respect to the claim," valuation of the claim may be made by estimate. See IRMA §705 C (2).

   Generally speaking, there are three alternative methods in a liquidation for valuing claims and making them absolute:

      i. the traditional run-off method in which the receivership is continued until all or substantially all the claims become absolute, i.e., mature to the point where liability and value are clearly proven;

      ii. the cut-off approach in which an estate's liability for any claims that remain contingent or unliquidated are terminated by a specific date or event, e.g., bar date;

      iii. an estimation method in which the receiver estimates and, if appropriate, allows (approves for distribution) contingent and unliquidated claims at a net present value.

   During a liquidation proceeding, in order to properly value and allow claims, the receiver needs clear-cut evidence that the policyholder has, in fact, sustained a loss: 1) within the coverage of an effective policy; and 2) in a specific or determinable amount. The nature of long-tail claims in a receivership makes it difficult or sometimes impossible to establish such proof because of limitations that may prevent potential claims from developing and maturing into enforceable claims.

   For example, § 39 of the Liquidation Model Act and § 701 A of IRMA require claims to be filed "on or before the last day for filing specified," i.e., by a bar date which, depending on the jurisdiction, can be as liberal as a date chosen by the receiver at his discretion or a specific date in

the statute. IRMA § 701 further specifies that the last day for filing shall not be later than 18 months after entry of the order of liquidation unless extended for good cause. An early bar date could prevent late-maturing or long-tail claims from meeting a receivership's proof requirements and exclude them from any distribution of assets. In any estate where long-tail exposure is significant, this not only causes inequity by eliminating long-tail policyholders' reasonable expectations of recovery but, by precluding the development of such long-tail claims, it also significantly reduces the amount of reinsurance that can be collected by the receiver and used to benefit creditors.

The run-off method, on the other hand, presents a more accurate claims valuation technique, i.e., substantially all claims ultimately become absolute through a natural process, but in a more costly manner. As time passes, there is delay in distribution of assets; increased attrition of knowledgeable and competent staff; and the benefit of any investment income is outweighed by mounting administrative costs resulting in depletion of an estate's assets.

An alternative is to use methodologies and techniques consistent with standards of actuarial practice to estimate the ultimate value of case reserves and to allocate remaining incurred but not reported (IBNR) to individual claims.

One problem inherent in such an estimation method is that, because of the uncertainty in the development of the law regarding environmental, asbestos and product liability claims, an estimate that is accurate at present could be rendered meaningless by a significant change in the law. As a result, it is possible for disparities to exist in individual claims estimates which would not occur in the natural development and maturity of such claims over time. Since it is impossible to project with total accuracy, some claimants will invariably be left out, some will receive too high an estimate, and some will receive too low an estimate.

A second problem facing estimation plans is the likelihood that they will be challenged by reinsurers.[62]

Missouri and Illinois have claims estimation statutes and there are numerous similarities and differences. The Missouri statute allows for both insureds and third parties to file contingent claims. It does not require that the claim be liquidated prior to distribution of estate assets. It does appear to allow for IBNR claims, i.e., claims based on losses that have occurred but which have not been reported to the insurance company, though there are provisions for present-value discounting of the claims.

Illinois' statute authorizes insureds, third parties and cedents to file contingent claims but treats all three somewhat differently. Insureds' contingent claims may be allowed: 1) if they are liquidated by actual payment on or before a bar date set by the court; or 2) by estimation if there is reasonable evidence that a claim exists, except that insureds' claims for IBNR are not allowable. Insureds' contingent claims that are liquidated by the bar date are entitled to the same level of priority as insureds' claims that were fully matured when filed. However, insureds' claims that are allowed by estimation are subject to the next lower priority for distribution. The Illinois statute permits third party claimants to file contingent claims and have their claims determined by estimation. It also expressly addresses cedents' claims and provides that cedents' contingent claims, including claims for IBNR, may be allowed by estimation. Under the Illinois statute, cedents participate at a lower priority than policyholders or third party claimants.

[62] See *Quackenbush v. Mission Insurance Co.*, 46 Cal. App. 4th 458, 54 Cal. Rptr.2d 112 (Rd. Dist. 1996); *In the Matter of Liquidation of Integrity Insurance Company,* 193 N.J. 86, 935 A. 2d 1184 (2007), *Angoff v. Holland-America Ins. Co. Trust,* 937 S.W.2d 213 (Mo. Ct. App. 1996).

b. Policyholder Protection Claims

Often creditors submit a proof of claim in the estate though they are unaware of any specific claim having occurred. These types of claims have been referred to as policyholder protection claims. Some courts have held that a creditor must know of the existence of a specific claim and submit a proof of that claim prior to the bar date. State law differs as to whether such claims will be recognized at all, and if so, under what circumstances.

§ 704 A of IRMA allows the filing of policyholder protection claims.

5. Policy Defenses

The receiver may assert any defenses that the insurer could have asserted to a claim. Moreover, if there are grounds to rescind the policy or bond, for example, where there were material misrepresentations on the policy/bond application by the proposed insured, the receiver should be able to assert those grounds on behalf of the insurer.

6. Unearned Premiums

Where possible, receivers do not require proofs of claim to be filed to assert unearned premium claims, or may deem a filing to be made if the books and records of the insurer are sufficient to calculate any unearned premium due. In those cases, the receiver automatically calculates the unearned premium amounts from the insurer's records so that guaranty associations will have the necessary information to make payment directly to the policyholder (See Chapter 6, Section II.D.1.a.)

7. Deemed Filed Claims

As with unearned premium claims, receivers often can obtain authorization from the liquidation court to handle certain routine types of claims without the submission of proofs of claim and the attendant additional paper work. For example, the policyholder or bondholder may have submitted to the company, before its demise, a significant amount of information on the insurer's standard claim forms. If the receiver determines that those insurer forms contain substantially similar information to that on the approved liquidation proof of claim forms, then the receiver may ask the liquidation court to consider the previously filed claims to be deemed filed as liquidation proofs of claim, i.e., to consider the insurer's standard forms to be, in effect, the liquidation proofs of claim. Such a procedure has two administrative benefits. First, it reduces the amount of duplicative claim information to be handled by the receiver. That is particularly true regarding health claims where the volume of physician, hospital and other provider documentation can be sizable, but it is also true with regard to property/casualty losses, including workers' compensation, where substantial documentation typically already exists. The deemed filed procedure can improve the receiver's efficiency considerably. Second, the deemed filed procedure is an aid to policyholders/bondholders that may be confused by the necessity of submitting a liquidation proof of claim in situations where considerable claim information has already been sent to the insurer. By streamlining the process and merely sending the policyholder/bondholder a summary of the claims deemed filed, the receiver cuts down on the possibility that some policyholder/ bondholder will fail to act timely because of confusion over the need to resubmit information that was sent to the insurer before the insolvency proceedings began.

F. Claims of Ceding and Assuming Companies and Setoffs

Claims of ceding and assuming insurers and right of setoff are discussed in Section IX of this chapter.

G. Assets that are not General Assets, Special Deposits and Letters of Credit

The preceding subsections have dealt with legal issues in connection with claims by people that may be entitled to a share of the insolvent insurer's general assets. "General assets" are defined in § 104 K of IRMA as follows:

> K. (1) "General assets" includes all property of the estate that is not:
>
> (a) Subject to a properly perfected secured claim;
>
> (b) Subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons; or
>
> (c) Required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons.
>
> (2) "General assets" includes all property of the estate or its proceeds in excess of the amount necessary to discharge claims described in Paragraph (1) of this subsection.

Discussed below are a few of the legal issues surrounding claims against assets that are restricted in one way or another, such as a "special deposit claim."[63] That term is defined in the Insurers Rehabilitation and Liquidation Model Act as follows:

> "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

If a regulator or a guaranty association in a non-domiciliary state where the insolvent insurer has assets, takes action to assert local statutory rights in the assets for the benefit of local policyholders, either in the receivership court or elsewhere, then it is likely that the receiver will be obligated to permit the local officials to conduct an ancillary receivership in that state with the insurer's local assets. If, however, the regulator or guaranty association does not act, and the rehabilitation/liquidation court makes a final determination as to the special deposit, the regulator or guaranty association will be bound by the court's determination.[63]

1. Special Deposits

Any plan of rehabilitation submitted to the supervising court should include a separate section dealing with special deposits. All state regulators and guaranty associations should be given notice and an opportunity to be heard on that provision and all others in the proposed plan. That will give as much protection as possible under the law from later attempts by state insurance regulators to exercise control over local assets.

In a liquidation, if a regulator in a non-domiciliary state takes action with respect to a special deposit and attempts to initiate an ancillary proceeding, it will be up to the receiver to review the terms and the

[63] *Underwriters National Assurance Company (UNAC),* 102 S. Ct. at 1357, involved a post-rehabilitation attempt by the state guaranty association in North Carolina to attach a special deposit in North Carolina made by UNAC prior to rehabilitation, even though the state guaranty association had participated actively in the UNAC proceeding in Indiana and had not raised any question about the deposit prior to the approval in 1976 of the plan of rehabilitation by the Indiana rehabilitation court. Justice Marshall writing for the court held that a judgment from one state court must be accorded full faith and credit in other states, even as to questions of jurisdiction, when those questions have been "fully and fairly" litigated and finally decided in the first court. See *Underwriters National,* 102 S. Ct. at 1366. The North Carolina guaranty association's claims were fully and fairly considered by the rehabilitation court, so North Carolina had to give *res judicata* effect to the Indiana decisions. See *id.* at 1367-68. The only place where the North Carolina guaranty association could have advanced its argument that the North Carolina statutory deposit scheme should be followed was in the rehabilitation court, not in a collateral attack in North Carolina. See *id.* at 1371.

law under which the deposit was placed and to make sure that the foreign jurisdiction is not obligated to return the deposit.

IRMA §104 CC, defines "special deposit" as "…a deposit established pursuant to statutes for the security or benefit of a limited class or classes of persons." § 104 DD defines "special deposit claim" as "any claim secured by a special deposit, but does not include any claim secured by the general assets of the insurer." IRMA § 1002 specifies how deposits are to be administered in various scenarios by specifying what action the IRMA adopting state must take as to special deposits in its state. An IRMA state is required to return all deposits to the domiciliary state upon appointment of the receiver, except deposits where its guaranty association is the only beneficiary. See IRMA § 1002 B.

2. Collateral

The receiver needs to consider all other assets purportedly held by the insolvent insurer in some trust, collateral or other non-general capacity to verify that these assets are, in fact, not general assets of the estate and to ascertain what continuing obligations the receiver may have (i.e., who has rights to the funds and how and to whom the funds should be distributed). The entry of an order of liquidation does not abrogate these special situations and the receiver should take steps to assure that these assets and obligations are separately addressed and the rights of claimants protected.

3. Letters of Credit

There has been some controversy surrounding the rights and obligations of receivers regarding letters of credit (LOCs). LOCs are typically used to support reinsurance and large deductible obligations. Letters of credit issued in connection with reinsurance transactions are discussed in detail in Chapter 7, Section VIII and in connection with large deductible transactions in Chapter 4, Section A.

4. Separate Accounts

Another special form of assets are separate accounts, which are those accounts set up by an insurer to fund specific blocks of insurance or other benefits, such as pension plans and other viable products. Separate accounts are generally created and administered in accordance with specific statutory or regulatory guidelines. Such statutes usually provide that funds properly maintained in the separate accounts of an insurer will not be chargeable with the liabilities arising out of any other business the insurer may conduct, which has been held to include the insurer's receivership.[64] (Refer to the following section III.H. and Exhibit 9-2.)

H. General Guidance for Receivers in a Future Receivership of a Troubled Insurer that Issued SEC Registered Products

1. Authority

a. Federal Statutes and Rules

Securities Act of 1933 (1933 Act)

Certain annuity and life insurance contracts issued by insurers are subject to the Securities Act of 1933 and must be registered with the U.S. Securities and Exchange Commission (SEC), unless the contract qualifies for an exception. Consequently, an insurer issuing certain types of contracts must comply with the requirements of the 1933 Act as well as with applicable state insurance law before issuing an SEC registered contract.

Investment Company Act of 1940 ("1940 Act")

[64] See, e.g., *Rohm & Haas Co. v. Continental Assurance Company,* 58 Ill. App. 3d 378, 374 N.E.2d 727 (1978)

Section 2(a)(37) of the 1940 Act defines a separate account as "an account established and maintained by an insurance company pursuant to the laws of any State or territory of the United States, or of Canada or any province thereof, under which income, gains and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company."

Section 2(a)(17) of the 1940 Act defines an insurance company to include "any receiver or similar official or any liquidating agent for such a company, in his capacity as such."

Under longstanding federal court precedent and SEC regulations, an insurer's separate account that supports a variable contract (which provides that separate account investment experience is reflected directly in contract values [Variable Products]) is treated as having a separate legal existence from the insurance company for purposes of the 1940 Act[65], and is subject to the registration and other requirements of the 1940 Act, unless an exception applies.

Securities Exchange Act of 1934 ("1934 Act")

Sections 13 and 15(d) of the 1934 Act require insurance company issuers of certain securities registered under the 1933 Act to file regular, publicly available reports with the SEC. These reports include Form 10-K, Form 10-Q and Form 8-K. Insurers that issue annuity and life insurance contracts registered under the 1933 Act that are not supported by a separate account registered under the 1940 Act are required to file such reports, unless the insurer qualifies for an exemption. For registered Variable Products, there is an alternative and much simpler reporting requirement (a separate account annual report on Form N-SAR).

Code of Federal Regulations

Rule 12h-7 under the 1934 Act generally exempts an insurance company issuer from the duty under Section 15(d) to file reports required by Section 13(a) if: 1) the securities do not constitute an equity interest of the issuer; 2) the insurer files an annual statement of its financial condition with the insurance commissioner of the insurer's domiciliary state; 3) the securities are not listed on any exchange; 4) the insurer takes steps reasonably designed to ensure that a trading market does not develop in the securities; and 5) the prospectus contains a statement stating that the insurer is relying on Rule 12h-7.

Rule 0-1 (e) (2) under the 1940 Act provides that, as a condition to the availability of certain exemptions, a separate account "shall be legally segregated, the assets of the separate account shall, at the time during the year that adjustments in the reserves are made, have a value at least equal to the reserves and other contract liabilities with respect to such account, and at all other times, shall have a value approximately equal to or in excess of such reserves and liabilities; and that portion of such assets having a value equal to, or approximately equal to, such reserves and contract liabilities shall not be chargeable with liabilities arising out of any other business which the insurance company may conduct."

For variable contracts funded by separate accounts that are registered under the 1940 Act, Rule 22c-1 under the 1940 Act requires insurers to calculate accumulation unit values daily and to price any premiums, withdrawals, or transfers of contract value at the accumulation unit value for such contracts that is next computed after the insurer receives the purchase, withdrawal, or transfer request in good order.

[65] This creation of federal common law under the Federal Securities Laws applies even though state law governing the creation of a separate account provides that it is not a legal entity. The result has reportedly resulted in a characterization of the "'ectoplasmic theory' of investment companies . . . ." Jeffrey S. Puretz, *Background Information: A Primer on Insurance Products as Securities*, PLI "Securities Products of Insurance Companies and Evolving Regulatory Reform," 39, note 21 (2012).

Rule 38a-1 under the 1940 Act requires insurers that sponsor a separate account registered under the 1940 Act: (i) to maintain current written compliance policies and procedures that are reasonably designed to prevent, detect and promptly correct violations of the federal securities laws (broadly defined), and (ii) to designate one individual as a chief compliance officer (CCO) responsible for administering the separate account's compliance policies and procedures. An annual review must be conducted of the adequacy of the written policies and procedures and the effectiveness of their implementation, and an annual written report prepared that addresses the operation of the policies and procedures, any material changes made or recommended and each material compliance matter that has occurred since the date of the last report.

b. State Statutes and Rules

NAIC Variable Contract Model Law (#260)

Model #260 permits a life insurer to establish separate accounts for life insurance or annuities, and allocate amounts to it, provided that:

- Income, gains and losses from assets allocated to a separate account are credited to or charged against the account, without regard to other income, gains or losses of the insurer.

- Amounts allocated to a separate account are owned by the insurer, and the insurer is not a trustee with respect to such amounts. If and to the extent provided under the applicable contracts, the portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business of the company (generally referred to as "asset insulation").

- Transfers of assets between a separate account and other accounts are subject to restrictions. The Commissioner may approve other transfers if they are not found to be inequitable.

- Except as otherwise provided, pertinent insurance law applies to such separate accounts.

NAIC Separate Accounts Funding Guaranteed Minimum Benefits under Group Contracts Model Regulation (#200)

- Applies to group life insurance contracts and group annuity contracts, as described in the rule, which use a separate account.

- Prescribes rules for establishing and maintaining separate accounts that fund guaranteed minimum benefits under group contracts, and the reserve requirements for accounts.

NAIC Variable Annuity Model Regulation (#250)

- Defines a variable annuity as a policy that provides benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer.

- Sets forth reserve and nonforfeiture requirements for variable annuity contracts and provides that the insurer must maintain separate account assets with a value at least equal to the reserves and other contract liabilities with respect to the account, except as may otherwise be approved by the commissioner.

- To the extent provided under the contracts, that portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

NAIC Variable Life Insurance Model Regulation (#270)

- Defines a variable life insurance policy as an individual policy that provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer.

- Sets forth reserve and nonforfeiture requirements for variable life insurance policies, and provides that the insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for the policies.

- Provides that for incidental insurance benefits, reserve liabilities for all fixed incidental insurance benefits shall be maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to the benefit.

- Every variable life insurance policy shall state that the assets of the separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account.

- The policy shall reflect the investment experience of one or more separate accounts, and the insurer shall demonstrate that the reflection of investment experience in the variable life insurance policy is actuarially sound. The method of computation of cash values and other nonforfeiture benefits shall be in accordance with actuarial procedures that recognize the variable nature of the policy.

NAIC Modified Guaranteed Annuity Regulation (#255)

- A modified guaranteed annuity is defined as a deferred annuity, the values of which are guaranteed if held for specified periods, and the underlying assets of which are held in a separate account. The contract must contain nonforfeiture values that are based upon a market-value adjustment formula if held for periods shorter than the full specified periods of the guarantee.

- At a minimum, the separate account liability will equal the surrender value based upon the market value adjustment formula in the contract. If contract liability is greater than the market value of the assets in the separate account, a transfer of assets must be made into the separate account so that the market value of the assets at least equals that of the liabilities. Any additional reserves needed to cover future guaranteed benefits will be set up by the valuation actuary.

- Provides that the contract shall contain a provision that, to the extent set out in the contract, the portion of the assets of any separate account equal to the reserves and other contract liabilities of the account shall not be chargeable with liabilities arising out of any other business of the company.

Insurers Rehabilitation and Liquidation Model Act (1999) (IRLMA), § 3 (K):

"General assets" includes all property, real, personal or otherwise which is not:

(1) Specifically subject to a perfected security interest as defined in the Uniform Commercial Code or its equivalent in this state.

(2) Specifically mortgaged or otherwise subject to a lien and recorded in accordance with applicable real property law.

(3) Specifically subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons.

(4) Required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons.

As to an encumbered property, "general assets" includes all property or its proceeds in excess of the amount necessary to discharge, in accordance with the Act, the sum or sums secured thereby. Assets held on deposit pursuant to a state statute for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

Separate Account Exclusion in Distribution Scheme

Several states have a provision in their receivership act's scheme for the distribution of assets that specifies the treatment of assets held in an insulated separate account once an order of receivership has been issued. Such state laws generally provide that, to the extent provided under the applicable contracts, the portion of the assets of any such separate account equal to the reserves and other contract liabilities regarding that account are not chargeable with any liabilities arising out of any other business of the insurance company. See, e.g., Ariz. Stat. § 20-651(D); Cal. Ins. Code § 10506(a); Conn. Gen. Stat. § 38a-433(a); N.J. Stat. § 17B:28-9(c); N.Y. Ins. Law § 4240(a)(12); Tex. Ins. Code § 1152.059.

c. Case Law

SEC v. Variable Annuity Life Ins. Co. of America, 359 U.S. 65 (1959)

Variable annuity contracts are securities that must be registered with the SEC under the 1933 Act. Such contracts are not annuity contracts within the meaning of the exemption provided in Section 3(a)(8) of that Act for annuity and life insurance contracts, or the McCarran-Ferguson Act.

SEC v. United Benefit, 387 U.S. 202 (1967)

A deferred variable annuity that promised to return net premiums at the end of a 10-year term is a security. The Court found that, despite the guaranteed return at the end of the term, the contract owner held too much investment risk, especially when the product's marketing appealed to purchasers with its prospect of "growth" through sound investment management rather than on "the usual insurance basis of stability and security."

Prudential Ins. Co. v. SEC, 326 F.2d 383 (3d Cir. 1964), cert. denied, 377 U.S. 953 (1964)

A separate investment account was established by Prudential for the sole benefit of variable annuity contract holders. The account was the "issuer" of securities for the purposes of the 1940 Act, and was separable from Prudential, so that the exclusion in the 1940 Act for insurance companies did not apply.

Rohm & Haas Co. v. Continental Assurance Co., 374 N.E.2d 727 (Ill. App. 1978)

A declaratory judgment determined that assets held by an insurer in insulated separate accounts equal to the reserves and other contract liabilities regarding such accounts were not subject to the claims of general creditors in the event of liquidation. The Court held that a provision in the Illinois Insurance Code stating that the insulated separate accounts may not be charged with unrelated liabilities was mandatory, and "forbids the invasion of separate accounts by a liquidator for the benefit of general creditors." The opinion did not discuss the receivership act; the case preceded the enactment of an exclusion for separate accounts in the distribution scheme.

d. Rehabilitation Orders

The following are examples of rehabilitation orders that provided exemptions for separate account assets:

- First Capital Life: In the rehabilitation of First Capital Life Insurance Company, the court froze policyholder withdrawals but exempted "whole or partial surrenders of variable separate account holdings of variable annuity contracts." See Limited Stop Order and Notice of Hearing (May 10, 1991) at Item II.A on Page 2. See also Order Appointing Conservator, Establishing of Procedures and Related Orders (May 14, 1991) at Item 7 on p. 6 ("Further, whole or partial surrenders of variable separate account holdings of variable annuity contracts shall continue to be paid").

- Monarch Life: In the rehabilitation of Monarch Life Insurance Company, the court imposed a temporary moratorium on any loan or cash surrender rights under fixed life or annuity contracts, but not under variable separate account products. See Verified Complaint and Request for Appointment of Temporary Receiver (May 30, 1991) at Item 24 on p. 10.

- Mutual Benefit Life: In the rehabilitation of Mutual Benefit Life Insurance Company, a court order provided that restraints on policy loans and surrenders do not prohibit the payment from separate accounts in connection with variable annuities. See Consent Order to Show Cause With Temporary Restraints (July 16, 1991) at Item 15 on p. 10. See also Order Continuing Rehabilitator's Appointment, Continuing Restraints and Granting Other Relief (August 7, 1991) at Item 2(c) on p. 3 (extending the exemption to cover separate accounts in connection with variable life, as well as variable annuity, products).

- Confederation Life: In the rehabilitation of Confederation Life Insurance and Annuity Company, the court imposed restraints on surrenders, exchanges, transfers and withdrawals, but provided that the restraints shall not prohibit the payment of funds from separate accounts in connection with variable annuity contracts, and surrenders, exchanges, transfers and withdrawals shall be permitted without restriction and without delay. See Order of Rehabilitation (Sept. 12, 1994) at Items 9-10 on p. 7-8.

2. Considerations

a. Variable Products Backed by Separate Accounts Registered Under the 1940 Act:

In the event of a liquidation of an insurance company, a separate account registered under the 1940 Act would be insulated as provided in the 1940 Act and the rules promulgated under the Act.

- The definition of "insurance company" in the 1940 Act includes a receiver, or a similar official or liquidating agent for such a company.

- A separate account is treated as an investment company separate from the insurance company for purposes of the 1940 Act.

- In SEC v. Variable Annuity Life Insurance Co. of America, the 1940 Act was not reverse pre-empted by the McCarran-Ferguson Act.

b. Products (Variable or Fixed) Backed by Separate Accounts NOT Registered under the 1940 Act:

If a separate account has been used by an insurer to back certain kinds of benefits guaranteed by the insurer under certain annuity contracts or life policies, the 1940 Act may not always apply to that separate account. However,

i. A separate account not governed by the 1940 Act may nevertheless be treated as legally insulated under a state's receivership act:

- If the state variable contract law (and the policy/contract, if necessary) so provide.
- If a state insurance law requires that a separate account be held for the benefit of specified persons, it is not a general asset under an act based on IRMA or IRLMA.
- If the separate account is established as a "valid and existing" express trust for the security or benefit of specified persons as described in the receivership act, it is excluded from the general assets of the receivership under an act based on IRMA or IRLMA.
- If the receivership act's distribution scheme contains a provision that governs the treatment of a separate account, and the account is established as specified by such provision, then claims under the separate account agreement are payable from the account as provided by the provision.

ii. If accounts are established in accordance with any of the requirements described in (a), they should be reflected as restricted assets on the receivership's financial statement. (It should be noted that state statutes or rules may vary from the NAIC models. Not all states have a specific exemption for separate accounts in the distribution scheme, and differences also exist in variable contract laws. At least one state has prohibited the use of insulated separate accounts for non-variable products that do not reflect investment results of the separate account, but have guaranteed rates or returns. See Minnesota Department of Commerce Bulletin 97-6, October 22, 1997.)

iii. If an account is not exempted from the definition of a general asset or excluded from the distribution scheme, the receivership act will typically provide that it is subject to distribution to creditors.

iv. An annuity contract or life policy that imposes certain significant investment risks on the owners, such as a "market value adjustment," or an "index-linked variable annuity," might be required to be registered under the 1933 Act regardless of whether it is funded by a separate account registered under the 1940 Act ("Other SEC Registered Products"):

- Other SEC Registered Products such as registered modified guaranteed annuities and index-linked variable annuities may be funded by a separate account established in accordance with one of the requirements described in B.2.(a), above.
- Whether or not funded by a separate account, the receiver could face compliance issues under the 1933 Act with respect to such Other SEC Registered Products.
- Section 989J of the Dodd-Frank Act contains a provision that limits the ability of the SEC to classify indexed annuities and other insurance products as securities. This provision known as the Harkin Amendment.

v. Transfers between a separate account and other accounts may create issues in a receivership. Under the NAIC Model Variable Contract Law, such transfers are subject to restrictions, and the Commissioner may approve transfers that are not "inequitable." Because the Model Law states that pertinent provisions of insurance law apply to separate accounts, except as otherwise provided, the provisions of a receivership act regarding voidable transfers and preferences may be applicable to such transfers.

3. Guidelines

The following identifies the issues, documents and material a receiver should focus on immediately if faced with a troubled insurance company (TIC) that issued Variable Products or SEC Registered Products. In addition, a receiver should collaborate with guaranty associations (through the National Organization of Life and Health Insurance Guaranty Associations [NOLHGA] in multi-state insolvency) and ensure that they are involved as soon as practical regarding registered products that may be eligible for guaranty association coverage, especially with respect to compliance, operational, and other issues arising from the possible continuation of coverage of such products.

a. Determine the Type(s) of Separate Accounts that Support the Products TIC Issued and Obtain Registration Statements for the SEC Registered Products

- Variable Products Backed by Separate Accounts Registered Under the 1940 Act. There are two types of 1940 Act Separate Accounts that TIC would have been required to register with the SEC. The applicable federal securities laws compliance issues that the receiver/insurance regulator of TIC will face differ somewhat depending on the type of Separate Account:

  - Unit Investment Trust Separate Account (UIT). Most variable products offered today utilize Separate Accounts that fall into this category. It is characterized by a "passive" Separate Account[66] into which premiums are deposited and allocated to "subaccounts," each of which invests in a specified underlying mutual fund, which itself must be registered under the 1940 Act. The underlying mutual fund may or may not be managed by an affiliate of TIC.

  - Managed Separate Account. A Separate Account that invests directly in a portfolios of securities or other investments and, therefore, actively manages the investments at the Separate Account level, and has a board of directors responsible for managing the Separate Account. See Section C (5)(D), below.

- Variable Products Backed by Separate Accounts NOT Registered Under the 1940 Act (Exempt SAs).

  - Separate Accounts supporting Variable Products issued in connection with certain qualified retirement plans as specified in Section 3(a)(2) of the 1933 Act and Section 3(c)(11) of the 1940 Act. Such Separate Accounts are not registered under the 1940 Act and the Variable Products are not registered under the 1933 Act.

  - Separate Accounts supporting private placement (i.e., not registered) Variable Products under Section 4 of the 1933 Act and either Section 3(c)(1) or Section 3(c)(7) of the 1940 Act. Very limited in number and qualification of policyholders. Such Separate Accounts are not registered under the 1940 Act.

  - Even though these insurance products are exempted from SEC registration, they are still deemed to be securities, and are subject to the anti-fraud provisions of the federal securities laws. The offering documents (e.g., private placement memorandums, including financial statements) and marketing materials for these products must not contain any material omissions or misstatements. Once a TIC goes into receivership, the offering documents and marketing materials for such products should be amended to reflect such a material event and to explain the consequences for the contract owner.

- Other SEC Registered Products Backed by Separate Accounts NOT Registered under the 1940 Act. In certain situations, products other than Variable Products may be registered

[66] Under Section 4 (2) (b) of the 1940 Act, a UIT may not have a board of directors.

under the 1933 Act and may be backed by a separate account that is not registered under the 1940 Act. (See Section B. 2 above.)

- Obtain and Review Available 1933 Act and 1940 Act Reports and Registration Statements. Both UITs and Managed Separate Accounts must file annual reports under the 1940 Act with the SEC on Form N-SAR. Managed Separate Accounts must file additional semi-annual reports with the SEC and send semi-annual reports to shareholders. The issuers of all SEC registered products must file updated registration statements with the SEC each year that contain current audited financial statements for the insurance company (and for the separate account, if the separate account is registered under the 1940 Act)[67], except in limited circumstances[68]. For products registered under the 1933 Act that are not backed by 1940 Act registered separate accounts, there could be filings that must be made with the SEC under Section 15(d) of the 1934 Act (Forms 10-Ks, 10-Qs and 8-Ks). The regulator/receiver should obtain a complete set of all SEC filings, including:

  - All recent SEC registration statements containing audited financial statements.
  - All periodic reports.
  - TIC's "plan of operations" or similar documentation for the operation of the Separate Account(s) (filed with certain state insurance departments).
  - All agreements with reinsurers, distributors, third party credit support providers, guarantors, investment advisors to the underlying mutual funds, custodians and other service providers involved in TIC's maintenance of the Separate Account(s).

- Rule 38a-1 Written Compliance Policies and Procedures and Annual Reports of the Chief Compliance Officer

  Rule 38a-1 under the 1940 Act provides that all separate accounts registered under the 1940 Act must have written compliance policies and procedures that are reasonably designed to prevent violations of the federal securities laws. In addition, Rule 38a-1 requires that the insurer appoint a Chief Compliance Officer ("CCO") for each separate account registered under the 1940 Act, and that an annual review and annual report must be prepared each year documenting the effectiveness of the company's compliance policies and procedures. The receiver should obtain a complete set of the registered separate account's Rule 38a-1 written compliance policies and procedures and the written annual reports previously prepared, and consider how compliance with Rule 38a-1 will be accomplished during the period of the receivership.

b. Determine the Type(s) of Products TIC Issued and TIC's Net Financial Exposure

- Locate and review all Prospectuses TIC filed with the SEC, and all Product Forms TIC Issued. Unless the TIC utilized only Exempt SAs, Variable and Other SEC Registered Products would require the TIC to file a Prospectus and updated audited financial statements with the SEC under the 1933 Act for each Variable and Other SEC Registered

[67] If contract benefits are guaranteed by a third party or supported by a credit support agreement as defined by the federal securities laws, then the audited financial statements of the guarantor or credit support provider must be included in, or incorporated by reference into, the registration statement.

[68] The staff of the SEC has taken a no action position with respect to issuers that do not distribute an updated prospectus to contract owners when the product is no longer being sold in certain limited circumstances. See Great-West Life Insurance and Annuity Company (avail. Oct. 23, 1990). However, even in such cases, current audited financial statements for the insurance company and the registered separate account must be prepared, and in some cases, mailed to contract owners each year.

Product and keep the Prospectus and financial statements current for as long as the TIC was issuing such Products.

- Section 10(a)(3) of the 1933 Act requires that SEC Registered Product issuers (and underlying funds) making a continuous offering of their securities maintain a current or "evergreen" prospectus. The receiver should obtain and review ALL Prospectuses and ALL Variable Product and SEC Registered Product forms issued by the TIC (which Product Forms should have been filed and approved for issuance by the TIC's insurance regulators).

- The SEC believes that issuers of variable annuities that contemplate a series of purchase payments are under a duty to maintain a current prospectus as long as payments may be accepted from contract owners. The SEC views each premium payment under a Variable Product as the purchase of a new security. Absent the TIC suspending the ability of policyholders to make additional premium payments on Variable Products and SEC Registered Products, the TIC should continue to update its Registration Statements and Prospectuses, unless no-action relief from SEC staff has been obtained.[69]

- Determine all Guaranteed Benefits issued by the TIC. Guaranteed Benefits (on both Variable and fixed products) will include expense charge guarantees and mortality guarantees, but likely will also include some combination of "optional" guaranteed benefits:

  - Guaranteed Living Benefits (GLBs), which may take various forms, including one or more of the following:

    - Guaranteed Minimum Withdrawal Benefits (GMWBs), including Guaranteed Lifetime Withdrawal Benefits (GLWBs).

    - Guaranteed Minimum Accumulation Benefits (GMABs).

    - Guaranteed Minimum Income Benefits (GMIBs).

  - Guaranteed Death Benefits (GDBs).

- Determine standards governing the Guaranteed Benefits. Guaranteed Benefits may be based upon, or determined from, one or more of the following:

  - Guaranteed return of premium.

  - Guaranteed annual interest rate return (roll-up).

  - Highest anniversary (or other periodic value (step-up).

  - Other.

- Determine the TIC's financial risk not supported by a Separate Account. Review all actuarial memoranda and analysis to determine:

  - Amount of premium allocated to fixed investment options provided by TIC under variable and fixed products, which may be:

[69] But see footnote 65.

- Fixed products or investment options funded by a separate account.
- Funds held by the TIC in its general account subject to the TIC's commitment to provide minimum guaranteed interest returns.

- Amount of the TIC's Exposure on Guaranteed Benefits not fully funded by separate account.
- The TIC's exposure to increased risk by policyholder behavior (e.g., partial withdrawals and surrenders under dollar-for-dollar guarantees or proportional guarantees, or movement of money within separate account or between separate account and fixed account options).
- Surrender Charges remaining on Variable Products.

- Determine the TIC's financial hedging transactions to support its Guaranteed Benefits and other obligations under its Variable and SEC Registered Products.

c. Evaluate Options

- Are the TIC's hedging programs adequate?
  - Are the terms of the hedging programs adequate to protect the TIC from further financial loss if economy deteriorates?
  - Are the TIC's hedging program partners willing and financially able to satisfy their obligations under the hedging program agreements?
  - Is there any ability or opportunity to transfer, or to obtain hedging partner consent to transfer, the hedging program to a solvent assuming insurer that might be willing to assumptively reinsure the Variable Products and other SEC Registered Products and take over the Separate Accounts?
- What administrative systems are in place to match daily the value of the Separate Account to each Variable Product?
  - Are the systems adequate and working properly?
  - Who owns the systems? Does TIC own the systems, or does it license the systems or contract with a third party vendor to provide the systems?
- What regulatory or receiver actions might require disclosure to owners of Variable and other SEC Registered Products and/or the SEC under 1933 Act or 1940 Act?
  - Unless supported by Exempt SAs, Variable Products (or the unitized interest in the Separate Account) constitute "redeemable securities" under the 1940 Act. Section 22(e) of the 1940 Act provides that the issuer of a redeemable security registered under the 1940 Act may not suspend the right of redemption and must pay redemption proceeds within seven days. There is no clear legal guidance about whether a court with jurisdiction of TIC (i.e., the insurance company issuer of Variable Products) could order any temporary or partial restrictions (e.g., a temporary moratorium, or a temporary limitation on partial withdrawals or surrenders). A receiver should contact the SEC staff prior to seeking any order from the receivership court restricting withdrawals funded from a 1940 Act registered separate account. This includes partial withdrawals, full surrenders, death benefits, 1035 exchanges and similar transactions.

- Suspending acceptance of premiums under Variable and other SEC Registered Products raises disclosure issues under the federal securities laws, that is whether the insurer had adequately disclosed previously to those considering purchasing the contract that it had reserved the right to take that action in the future.

- Cash Out Offer with Waiver of Remaining Surrender Charges?

  - In cases where the economic value to TIC of remaining surrender charges plus ongoing fees on Variable Products are less than the economic burden of TIC's guarantees, offering incentives to owners of Variable Products to surrender by offering a "free" full surrender window should be considered.

  - Such offers should not create any preferences since Separate Account assets can be used only to support obligations under Variable Products. So, other policyholders should not be harmed, unless there could be an exposure to an anti-selection problem created by incentive.

  - Should explore possible 1035 exchange options with other insurers to minimize possible adverse tax impact on owners.

  - Any cash out offers involving Variable Products or SEC Registered Products likely would create disclosure obligations under the 1933 Act, and depending on the facts and circumstances for Variable Products, the possible need for no-action or exemptive relief under the 1940 Act.

- What Guaranty Association coverage for the Variable Products might be available?

  - Guaranty associations exclude from coverage any investment risk or other risks born by the Variable Product owners and/or not guaranteed by an insurer. Nonetheless, as either life insurance or annuities, Variable Products may be eligible for coverage by guaranty associations subject to this nearly uniform exclusion. The regulator or receiver should work with the NOLHGA, which will coordinate with its member guaranty associations to evaluate coverage and the possible methods by which the guaranty associations may discharge their statutory obligations Early communications with the guaranty associations through the NOLHGA to help evaluate the possible guaranty association coverage and approaches for delivering that coverage, including with respect to compliance, operational, and other issues arising from the possible continuation of coverage of such products, would be an important piece of the approach.

- Are TIC's Separate Accounts UITs or Managed Separate Accounts or Exempt SAs? If the TIC structured its separate accounts as Managed Separate Accounts (i.e., actively managed and investing directly in securities), then it will be governed by a separate board of directors (sometimes called a board of managers) subject to specified duties and obligations under the 1940 Act.

  - What, if any, authority does the TIC have over the Separate Account Directors or their election or appointment?

  - What limitations exist on the actions of those in control of the Separate Account?

d. Coordination with Other Interested Federal Regulators

Other regulators may be involved with issues concerning the insulation of separate accounts assets, such as federal banking regulators concerning variable contract bank owned life insurance (BOLI)

funded through the life insurer's separate accounts. Receivers should identify other interested federal regulators and establish lines of communication with them.

e. General Guidance for Receivers in a Future Receivership of a Trouble Insurer that Issued SEC Registered Products

Through discussions with SEC representatives about the national state-based system of insurance financial regulation and its insurance receivership process, the life guaranty system, and issues an insurance receiver might encounter in a rehabilitation or liquidation of a troubled insurer that issued SEC registered products (the insurer), general guidance for receivers was developed. The following guidance covers the SEC's role and identifies areas where receivers should be in communications with the SEC staff, and the receiver's own experienced legal counsel, about registered products and how the receiver might handle the products in the receivership.

i. SEC Staff Contacts

As part of the guidance, organizational points of contact at the SEC were established. Receivers will need to know how to reach the appropriate staff contacts at the SEC when involved in a receivership with insurance products registered as securities. The SEC's website contains contact numbers for SEC offices in Washington and for SEC's regional offices: *www.sec.gov*.

The Division of Investment Management regulates investment companies, variable insurance products, and federally registered investment advisers. Types of investment companies include mutual funds, closed-end funds, unit investment trusts, and exchange-traded funds. Information regarding the Division of Investment Management and how to contact them may be located on the SEC's website at *www.sec.gov/investment*.

ii. SEC's Role

Investor protection is central to the federal securities laws and the rules applicable to securities products, which includes insurance products that have been registered with the SEC as securities. A receiver benefits from understanding the SEC's possible role if the insurer enters receivership with registered insurance products in its product portfolio. The SEC is not a solvency regulator for insurance companies and, of course, is not a receiver. While the state insurance receivership laws of the state where the insurer is domiciled primarily govern the receiver's duties and obligations, any federal securities laws applicable because of the insurer's registered products would impact the receiver. The federal securities laws may require receivers to do certain things in terms of disclosure and compliance with federal securities laws, which may vary depending on the insurance product that is registered.

In addition to insurance products that are registered as securities, there are certain types of insurance products that are securities but are exempt and therefore not registered with the SEC.

iii. Insurer Receivership

In any receivership, it is important for the receiver to understand the nature of the insurer's business and how the insurer's products are administered. The receivership will be very fact specific and circumstance driven, given the particular contracts, the market at the time and the insurer's assets. What securities laws that might apply are based on the products the insurer issued (e.g., variable, fixed, indexed, etc.).

The receiver's team should include legal counsel qualified to provide advice on the federal securities laws the rules under those laws and compliance issues, and on how state receivership laws and federal securities laws might interact in a receivership. The receiver needs to ensure that communication channels are open with the SEC staff and needs to ensure that the

requirements imposed by the federal securities laws and the rules under those laws are met. The receiver will communicate with the SEC staff during receivership. During rehabilitation and liquidation, the receiver stands in the shoes of the insurer and thus may have responsibility to comply with the federal securities laws applicable to the insurer and its separate accounts. In connection with the liquidation of the insurer, the extent of the guaranty associations' role and responsibilities would need to be analyzed based upon guaranty association triggering and the structure used by the guaranty associations in meeting their statutory obligations. As a practical matter, the structure could be that the guaranty association assumes or guarantees the contracts or transfers the contracts to another commercial insurer or a special purpose vehicle (SPV).

iv. Federal Securities Laws and Considerations Overview

The rules under the federal securities laws require that audited generally accepted accounting principles (GAAP) financial statements for the separate account (GAAP-basis) and the insurance company (GAAP, or statutory accounting principles [SAP], if permitted) be included in registration statements that are filed with the SEC[70]. There are also periodic reporting obligations under the 1934 Act that have to be complied with as well. The federal securities laws and the rules under those laws regulate registered Variable Products by requiring insurance companies to conduct operations in a certain way. The 1933 and 1934 Acts impose disclosure obligations with regard to registered Variable Products and the 1940 Act imposes disclosure and operating requirements on the registered separate accounts that issue those products. The Variable Products that must be registered with the SEC under both the 1933 Act and the 1940 Act are variable annuity (VA) contracts and variable life insurance (VLI) policies (unless there is an applicable exemption). These products must be registered because they are securities and the policy owner receives a pass through of the investment performance of the assets that are held in the separate accounts. The 1933 Act is a disclosure regime that requires a prospectus to be included as a part of the registration statement. The 1940 Act classifies separate accounts that insurance companies create to fund variable products as investment companies and generally requires that they be registered. A separate account is essentially a pool of assets under the control of the insurance company but where policy owners have a beneficial interest in the assets in that pool and in the financial performance of those assets. For that reason, the 1940 Act and the rules under that Act place stringent regulatory requirements on separate accounts. These requirements are similar to the requirements for mutual funds.

There are two types of insulated separate accounts that are used to fund VA and VLI products: 1) the managed separate account; and 2) the unit investment trust. Under a managed separate account, the separate account must have an investment advisor and a board of directors. See Section C (1), above. Under a unit investment trust, the insurer acts as a depositor, and the separate account has no board of directors. The managed separate account was the original VA and VLI funding vehicle; however, registered managed separate accounts are currently out of practice and rare.

In order to sell registered VA and VLI products, the insurer must file a registration statement under both the 1933 Act and the 1940 Act with the SEC. This registration statement includes a prospectus, statement of additional information, audited financial statements for the separate account and the insurer, and other exhibits. Top executives and directors of the depositor insurance company must sign it. The executives and directors who are required to sign the registration statement can be held personally liable for material misstatements or omissions in the registration statement. The statement must be refiled with the SEC at least annually to update the financial statements and any other changes in disclosure. A receiver of the issuer in a receivership would become liable for material misstatements or omissions in the registration

[70] See also footnote 64.

statement. In a provision of a federal law passed in 1996, states are prohibited from requiring more or different disclosures in the prospectus for registered products than are required under the federal securities laws. The intent was to have uniform disclosure for nationally offered products.

Under the 1940 Act, Variable Products funded by a unit investment trust type of separate account are two-tiered products. The assets of a unit investment trust are unitized, are invested in shares of the underlying insurance-dedicated mutual funds offered in the prospectus for the variable product, and must be valued daily. The separate account is the top-tier investment company and the mutual funds are the bottom-tier investment company. Rule 22c-1 under the 1940 Act requires that daily valuation of the separate account units be done using forward pricing, meaning that the units of the separate account will not be priced until the close of business on the day when a contract owner makes a premium payment or requests a transaction involving separate account assets, or separate account assets are otherwise involved in a permitted transaction. A mortality and expense risk charge is deducted from the daily unit value of the separate account assets. Similar to the daily valuation of units, the 1940 Act has a daily redeemability requirement, which requires that units of the separate account must be redeemed at their value computed at the close of business on the day during which the units are tendered for redemption. Payout must occur within seven days. There is also a requirement for the daily pass-through of the investment performance of the underlying funds in which separate account invests such that each contract owner has a right to their proportional share of the monetized value of the separate account assets. A chief compliance officer must be appointed to ensure adherence to written compliance policies and procedures and to conduct an annual review of these policies and procedures. The SEC has multiple enforcement powers available to it, and a receiver of the issuer in a receivership is included within the purview of the 1940 Act. The separate account assets are recorded in book-entry form and there is no physical separation of assets.

There are other types of registered insurance products, such as: certain fixed annuities (and, potentially, life products) with market value adjustments (MVAs) and certain index-linked variable annuities (ILVAs) that must be registered under the 1933 Act. 1933 Act registration means that the insurance company must file a registration statement with the SEC to register the insurance product; the registration statement includes a prospectus that contains extensive disclosures and the signatures of the executives and directors of the insurance company, subjecting them to anti-fraud liability. The registration statement must contain the audited financial statements for the insurance company (as well as any third party guarantor or credit support provider) and be updated regularly. Registered MVAs, indexed life and annuities products and ILVAs may or may not be funded through a separate account; for these types of products there is no requirement that any separate account be insulated. In order for the separate account not to be registered under the 1940 Act, the separate account's investment experience cannot pass directly through to the contract owners. The separate account's insulation alone does not trigger 1940 Act registration. It is also possible to have aspects of both registered fixed and variable annuities in a single product.[71]

Securities that are exempted from the 1933 and 1940 Acts include certain Variable Products sold in the pension market (qualified products) and certain corporate owned life insurance (COLI) and bank owned life insurance (BOLI) products that otherwise might be deemed to be securities. Private placement VA and VLI products are also exempted, as it is assumed that the owners are highly sophisticated or have the financial wherewithal to sustain losses and retain consultants and/or representatives to help assure that they fully understand the investments. In addition, there is an exclusion in Section 3(a) (8) of the 1933 Act for traditional insurance products under which contract owners do not bear significant investment risk and which are

[71] Unregistered fixed account options are frequently included as an option in registered Variable Products.

not regarded as securities. It is possible to have combined contracts, which includes annuity or life insurance products that are partially registered and partially excluded.

In regard to receiverships, the federal securities laws provide the SEC staff with several legal tools to protect the insulation of separate accounts. In a receivership situation, a receiver has a responsibility to comply with the requirements of the 1940 Act and 1933 Act. Under the 1940 Act, the receiver should preserve separate account insulation. A receiver should contact the SEC staff prior to seeking any order from the receivership court restricting withdrawals funded from a 1940 Act registered separate account. See Section C (3). If the product is SEC registered, the receiver generally must maintain the registration statement. The receiver generally must update and send prospectuses to investors at least annually,[72] and file updated registration statements meeting the requirements of the 1933 Act, which would include updated audited financial statements (including the consent of the auditing firm), and updated disclosures about a receivership and any contract changes.

An SEC order would be required to de-register a separate account. There can be a provision in the contracts, which reserves the right for the insurer to deregister a separate account, but there is usually nothing beyond that.

v. Rehabilitation

In rehabilitation, the receiver attempts to stabilize and improve the insurer's financial status while the insurer continues to operate. The receiver manages all aspects of insurer's operations and takes action necessary to remedy insurer's financial problems, to protect its assets and to run off its liabilities to avoid liquidation, while protecting its policyholders. Rehabilitation may be used to implement: 1) sale of the insurer; 2) runoff of claims, including a reduction in benefits due, including ratable payments on claims as they come due[73]; and/or 3) a transition to liquidation.

Upon assuming the insurer's management, the receiver will:

- Identify the types of insurance products to be administered during rehabilitation.
- Determine whether or not the products are registered with SEC.
    - Variable Products and Other SEC Registered Products: Receivers need to be aware that there may be products other than Variable Products registered with the SEC on the insurer's books. These other products may present different federal securities law compliance issues and different communications with the SEC
- Determine types of separate accounts supporting the products.
- Obtain copies of all reports filed with the SEC for the separate account and/or insurance products.
- Obtain registration statements and prospectuses, and all current agreements with reinsurers, distributors, credit support providers, guarantors, custodians and other service providers, and investment advisors/managers that are listed as exhibits in the registration statements.

[72] But see footnote 65.

[73] IRMA Section 403 provides that in the case of a life insurer, the rehabilitation plan may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for a period not to exceed one year from the date of entry of the order approving the rehabilitation plan, unless the receivership court, for good cause shown, shall extend the moratorium. As discussed above, a moratorium may not be feasible for variable products supported by a separate account registered under the 1940 Act.

- Obtain Rule 38a-1 compliance policies and procedures and annual compliance reports for registered separate accounts.

- Obtain copies of any significant SEC orders or other relief applicable to the separate account that modifies the regulatory regime governing the account.

- Determine all guarantees provided with the products, and the standards governing those guarantees.

- Determine amount of the insurer's financial exposure not supported by separate accounts.

- Determine what laws (state, federal, and securities) apply to the SEC registered products and separate accounts, and evaluate options for proceeding in the rehabilitation.

- Review and evaluate the impact of and compliance with the applicable state receivership laws and federal securities laws applicable to the insurer and its registered products and any separate accounts, and evaluate options for proceeding in the rehabilitation.

Once the insurer enters rehabilitation, from an operations standpoint, the receiver should consider maintaining the insurer's infrastructure, compliance program, technology, fund managers, etc., unless there are credibility issues with them. Keeping the existing infrastructure, provided there are no inherent problems in it, is the least disruptive for the policyholders and should assist the receiver with complying with the requirements of the federal securities laws. The receiver will also need to make sure to retain the right people to manage the separate account assets and the SEC filings.

Receivership statutes permit use of a rehabilitation plan excusing certain of the insurer's obligations in order to address causes of the insurer's financial difficulties, but only under certain circumstances consistent with the primary goal of protecting policyholder interests.

- The insurer continues to operate and to pay claims in the ordinary course of business, subject to the possible imposition of a moratorium on policy surrenders and withdrawals and in rare cases on benefit payments (subject to any requirements applicable under the federal securities laws).

- The insurer's contract obligations and assets, and the market at the time, will all bear upon the viability of a rehabilitation plan.

It is envisioned that some of the actions a receiver might take in aid of insurer's rehabilitation—or in liquidation—could include: 1) imposing a moratoriums on contract owner's right to redemption to stabilize the block of business; 2) suspending owners' right of redemption; or 3) transferring the registered product business via an assumption reinsurance transaction. General guidance for receivers regarding these actions is covered in the discussion regarding Redeemability in Section G (4), below, and Possible Resolution of Blocks of Business in Section G (5), below.

vi. Liquidation

In liquidation, the insurer is no longer in business. The receiver will handle the registered products differently as the receiver must liquidate or otherwise dispose of all of the insurer's assets in the liquidation process. In liquidation, there will be no further sales of registered products.

Receivership statutes provide for termination of the insolvent insurer's contracts in liquidation (subject to continuation of the covered portion of contracts by the guaranty

associations) and for all parties' rights and liabilities to be "fixed" as of a specific date (date of the insurer's liquidation order). Distributions are made according to a priority scheme, and policyholders are paid before other unsecured creditors.

There may be direct tension between the liquidation statutes' termination of the insolvent insurers' contracts and rights fixing, and the ongoing obligations of the receiver under the federal securities laws.

(a) Life Guaranty System Triggered

Liquidation with a finding of insolvency triggers protection from the life and health guaranty associations, assuring that at a minimum, covered policies will be honored to guaranty association levels of statutory benefits. National responses to multi-state insolvencies are closely coordinated between the receiver and NOLHGA. The receiver and the guaranty associations will collaborate on issues relating to the registered products business, including the assessment of what securities laws might apply because of registered products and any separate accounts, and evaluate options for proceeding in the liquidation.

Covered policyholders are protected in insurance liquidations: 1) by guaranty associations, discussed more below; 2) by special deposits that are held separately (not as general assets) for the policyholders in states requiring such deposits; and 3) by having an absolute priority status over general and other lower level creditors under the statutory priority scheme for the distribution of general assets contained in all state receivership statutes. Covered policyholders who hold policies that, among other things, required the insurer to hold assets backing some portion of the insurer's policy obligations in a separate account are further protected because the assets in the separate account can be used only to satisfy those insurer obligations under such policies that are supported by the separate account.

Once the guaranty association obligations are "triggered", the guaranty association becomes responsible for covering insurance contracts and paying claims at least to the lower of: 1) the contract's limit of coverage; or 2) the guaranty association's statutory benefit level set forth in the guaranty association statutes. In the life and health insurance context, guaranty association statutes generally require that guaranty associations "guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured the covered policies of covered persons of the insolvent insurer," or issue substitute or alternative policies to replace the insolvent insurer's covered policies or contracts.

As a general matter, guaranty association statutes cover, subject to applicable maximum statutory benefit levels and other limitations/exclusions, life insurance policies and allocated annuity contracts[74] that are issued by a properly licensed life insurer and owned by residents of their state. Guaranty association statutes generally exclude coverage for that portion of a product not guaranteed by the insurer or where the risk is borne by the contract owner.

Even if a policy or annuity is not covered, either in whole or in part by a guaranty association, the policyholder or contract holder may be protected by the policyholder-level priority status in the liquidation.

[74] Coverage for unallocated annuities varies in accordance with the type of arrangement involved. Unallocated annuities are beyond the scope of this Chapter.

(b) Assumption Reinsurance Transaction with Solvent Insurer

The existence of the guaranty association safety net and regulatory reforms since the 1990s generally has lessened risks for many policyholders in life insolvencies, including those with an interest in a separate account registered under the 1940 Act. The receiver and the guaranty associations (with respect to the covered policies) will most likely look for a buyer for the book of business. This would be structured as a sale of the book of business to a solvent insurer through an assumption reinsurance transaction funded by the insurer's estate and/or the guaranty associations. No-action letter relief would likely be sought from the SEC staff in connection with a transfer of the Variable Products backed by separate accounts registered under the 1940 Act, and also in connection with change in control issues arising from the liquidation.

In some of these transactions, contracts are restructured. Historically, separate accounts registered under the 1940 Act have not presented unique issues in these transactions, either because there were no such accounts or because the products relating to the separate account did not contain substantial general account guarantees, which helped facilitate selling the book of business (including the separate account) to a solvent insurer. This may not be the case in future insolvencies.

Where the insolvency is not entirely resolved through a transaction with a solvent insurer, the guaranty associations (with respect to covered contracts) and the insolvent insurer's estate will fund coverage and/or payments to policyholders through enhancement plans or through the traditional liquidation claims process.

vii. Securities Laws Considerations Post-Receivership

(a) Separate Accounts and General Account Guarantees

Receivers recognize that a properly established, insulated separate account supporting Variable and Other SEC Registered Products must be preserved and that the assets in the separate account are insulated and ear-marked and are thus protected from the claims of general creditors in the insurer's receivership. This is the same in both rehabilitation and liquidation.

There is a distinction between the variable contract holders' entitlement to separate account values (right to the monetized value of their proportionate share of the assets in the separate account) and insurer general account guarantees, which are subject to claims paying ability of the insurer. These guarantees include GMWBs, GMABs, GMIBs and GMDBs.

- Prospectuses should contain disclosure that general account guarantees are subject to the insurer's claims paying ability.

Claims associated with the insurer's guarantee of the Variable Product are claims against the general assets of the insurer. To the extent these claims are not covered/paid by a guaranty association, the claim would be treated as a policyholder-level priority status claim in the insurer liquidation proceeding. State receivership law would control the guarantees.

General guidance: In summary, the receiver needs to identify the types of insurance products to be administered during receivership, and review and evaluate the impact of and compliance with the applicable state receivership laws and federal securities laws applicable to the insurer and its registered products and any separate accounts. The receiver must administer the separate account in the same manner as the insurer pre-receivership, and must preserve the separate account insulation.

(b) Securities laws require material information that might affect an investor's view of a company to be disclosed. The SEC staff's position has always been that it is up to the issuer to determine what is material and requires disclosure. It is likely that SEC staff would view entering into receivership (rehabilitation or liquidation) as a fact that would be material and require disclosure. Even prior to the state insurance commissioner's action against the insurer, the insurer would normally be in communications with the SEC staff about disclosure requirements.

General guidance: Initiation of receivership proceedings necessitates filings with the SEC and disclosure to owners of the registered products. Specifically:

- Receiver should be in communication with SEC about the receivership.
- Receiver will need to file updated disclosures regarding the receivership.
- Receiver will need to disclose the receivership to owners of the registered products.

In general, other stages of receivership that might be material and require disclosure include: 1) the rehabilitation plan filing; 2) variable contract changes; 3) liquidation; and 4) transfer of book of business to solvent insurer. There may be other points that are material and thus require disclosure.

(c) Registration Statements and Prospectus Disclosure – Supplementation Requirements

Receivers may seek guidance from SEC staff and experienced legal counsel on the need to keep current the Variable Product and Other SEC Registered Product registration statements, prospectuses and 1934 Act reports (if any) at different stages of rehabilitation. It is the responsibility of the receiver to make the determination as to what information is material (e.g., filing rehabilitation plan, etc.) and requires disclosure and a supplement of the prospectus. It is likely that SEC staff would view this information as material and that the supplement is required to be filed with the SEC and mailed to contract owners in order to put the investor on notice of the facts, including the fact that at some point, the reasonable investor needs to make a decision about further investment (premiums), transfers or withdrawals.

(1) Suspension of Sales

In liquidation, the insurer ceases selling and stops accepting premium on all policies and contracts. The SEC staff has previously issued no-action letters in connection with the rehabilitations of Confederation Life and Mutual Benefit Life confirming it would not pursue an enforcement action for violation of the federal securities laws where, among other things, the receiver stopped accepting any new premium under existing Variable Products and stopped filing amendments to the registration statements governing the Variable Products and separate account (e.g., filing updated prospectus) with the SEC after the Rehabilitation Order had been entered in reliance on the prior SEC no-action letter in Great–West Life and Annuity Insurance Company (avail. Oct. 23, 1990). See Aetna Life Insurance and Annuity Company, Confederation Life Insurance and Annuity Company in Rehabilitation (avail. Sept. 15, 1995). A receiver would be well-advised to consult with experienced legal counsel to determine whether the circumstances they face permit reliance on these letters or other applicable relief already provided by SEC staff. If the receiver decides it cannot comply with any federal securities law requirements because any Variable Products and/or Other SEC Registered Products remain registered securities under the 1933 Act and the separate account, if registered, remains registered as an "investment company" under the 1940 Act, the receiver should consult with experienced legal counsel and then SEC staff.

Note that suspending acceptance of premiums under Variable and other SEC Registered Products raises disclosure issues under the federal securities laws, that is whether the insurer had adequately disclosed previously to those considering purchasing the contract that it had reserved the right to take that action in the future.

General guidance: If the insurer suspends sales, receivers should consult with experienced legal counsel regarding the need to obtain a no action letter from SEC staff regarding not filing updated registration statements and issuing updated prospectuses.

(2) Transferring the Registered Variable Product Business

General guidance: The receiver should be in communication with the SEC staff regarding plans to transfer a book of business to an assuming solvent insurer or plans to restructure the insurer's registered Variable Products, and should seek necessary approvals from the SEC. No action and/or exemptive relief under the 1940 Act should be considered in connection with such a transfer and change in control issues arising from the liquidation.

(3) Continuing to "Evergreen" Prospectuses and File Required Reports

Registration statements and other required reports generally would need to be kept up to date and filed in a timely manner with the SEC if the insurer continues to sell registered products in rehabilitation. Prospectuses would need to be kept up to date and mailed to existing contract owners.

(d) Redeemability

The 1940 Act requirement of redeemability is a primary concern of the SEC for Registered Variable Products. Receivers may potentially request the SEC to grant an exceptive order permitting the receiver to temporarily suspend the daily redeemability requirement and defer the variable contract owners' ability to redeem their contracts using separate account assets. Administrative, technical and/or operational issues preventing the receiver from processing redemptions may necessitate a moratorium on rights of redemption.

Exemptions from the redeemability requirement are rarely granted and are narrowly tailored to address the circumstances presented. Receivers need to be aware that:

- It would be necessary to communicate with the SEC staff and experienced legal counsel regarding potential delays in payments and request an exemptive order.
- Communications with the SEC staff and experienced legal counsel about what is happening and about how it is communicated to contract owners would be required.
- Further, the disclosure requirement may be triggered prior to the event that results in the above issue arising.

General guidance: The receiver should be in communication with the SEC staff and experienced legal counsel about any anticipated disruptions in payments or processing redemptions.

(e) Possible Resolution of Blocks of Business

It may not be possible to arrange a "pre-packaged receivership" that results in the immediate sale/transfer of the registered product business at the time of the insurer's

liquidation order, due to the nature of products in the marketplace at the time (including guarantees provided with Variable Products). There may be a need to restructure the registered product contracts and cease accepting premiums. Note that ceasing to accept premiums on variable annuities with living benefit guarantees and on variable life insurance policies present challenging issues that are of concern to the SEC (e.g., new premiums may be necessary to achieve the policy owner's expected benefits under living benefit guarantees or to keep variable life policies in force).

Consideration also should be given to offering an exchange of the insurer's registered product contract, or offering to buy back the insurer's registered product contracts (e.g., offer more than the contract holder would get if they surrender but less than they would get if they died).

Determining how to proceed would depend upon the specific facts and circumstances of the company and its risk management policies, and the market at the time.

General guidance: The receiver should be in communication with the SEC staff and experienced legal counsel about any plans to restructure, transfer or exchange the insurer's registered product contracts.

I. Large Deductibles

The purpose of these large deductible amounts is to reduce premiums for the insured while permitting the insured to meet statutory or regulatory insurance requirements. Large deductible policies are most common in the workers compensation area but may be found in other types of liability insurance.

Typically, a large deductible policy provides that the insurer will pay claims in full and then collect the deductible amount from the insured. Conversely, first party claims against an auto policy with a deductible are paid minus the amount of the deductible. To ensure that the deductible will be paid, most insurers that write this type of policy will require the insured to post some form of security. This can be a letter of credit, securities placed in a trust or escrow account for the benefit of the insurer, or some other form of a third-party commitment to reimburse for claims within the large deductible, such as a bond or large deductible reimbursement insurance policy. When the insurer pays a claim, depending on the agreement with the insured, the insurer may either submit a bill to the insured for the amount of the claim paid within the deductible or collect directly from the collateral.

As long as the insurer and the insured remain solvent, there are seldom any difficulties with large deductible arrangements. If the insured becomes insolvent and stops paying the deductible billings and if the collateral held is insufficient to pay current and future billings, the insurer's ability to collect the amounts due will be adversely affected.

If the insurer becomes insolvent and is placed into liquidation, the property and casualty and workers compensation guaranty associations will be triggered to begin paying claims. Just like the insurer, the guaranty association will be responsible for first dollar coverage of the claims. After the guaranty association pays the claim, the liquidator can then collect the amount of the claim within the deductible from the insured or the collateral. Historically, receivers and the guaranty associations disagreed on the disposition of these proceeds. Some receivers believe that the proceeds are claims based assets, similar to reinsurance recoverables, which should go into the general assets of the estates and be distributed *pro rata* to all claimants. The guaranty associations believe that, to the extent that the claim payment is within the deductible, they are not paying a claim on behalf of the insolvent insurer but rather on behalf of the insured and therefore, they should receive the reimbursement directly.

The first significant incidence of large deductible policies in a receivership occurred in the administration of the Reliance Insurance Co. Estate. During the early years of this receivership, the guaranty associations paid several hundred million dollars of claims within large deductible limits. After extensive unsuccessful

negotiations between the Pennsylvania liquidator and the guaranty associations, a suit was filed in the Commonwealth Court of Pennsylvania asking the Court to determine entitlement to the large deductible recoveries. The suit was rendered moot by passage of Act 46 of 2004 by the Pennsylvania General Assembly. Act 46 provided that the liquidator would collect the deductible reimbursements and deliver them to the guaranty associations that had paid the claims. The Act allows the liquidator to retain part of the reimbursements to offset the expense of collection.

Subsequently, several other states have enacted legislation addressing this issue modeled after the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act (NCIGF Model). On April 14, 2021, the NAIC adopted *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980) that also addresses this issue Statutes vary by state, therefore, the receiver for a large deductible insolvency should review the applicable statutes of the domiciliary state and states where the claims will be processed.

- § 712 of IRMA requires the receiver to collect the deductible reimbursements as a general asset of the estate, but the amount collected is to be distributed to the guaranty associations that have paid claims within the deductible amount as early access subject to claw-back if the amount distributed ultimately exceeds the amount to which the receiving guaranty association would be entitled from the final estate distribution.

- Under Guideline #1980 subsection B, "Unless otherwise agreed by the responsible guaranty association, all large deductible claims that are also "covered claims" as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling." Refer to the Guideline subsection B for further discussion of deductible claims paid.

J. Federal Government Claims

The federal superpriority statute (31 U.S.C. § 3713) provides:

A claim of the United States Government shall be paid first when:

A. person indebted to the government is insolvent; and

   i. the debtor without enough property to pay all debts makes a voluntary assignment of property;

   ii. the property of the debtor, if absent, is attached; or

   iii. an act of bankruptcy is committed, or

B. the estate of a deceased debtor, in the custody of the executor or administrator, is not enough to pay all debts of the debtor.

This subsection does not apply to a case under Title 11:

- A representative of a person or an estate (except a trustee acting under Title 11) paying any part of a debt of the person or estate before paying a claim of the government is liable to the extent of the payment for unpaid claims of the government."

The statute has been on the books substantially in the above-referenced form since 1789.

The last 100 years have produced much case law on the meaning of each key phrase in subsection (A) of the statute: how to define insolvent, whether one of the three triggering events has occurred and whether there is a claim owed the federal government.

Similarly, there are many court decisions dealing with the meaning of subsection (B) which imposes personal liability upon a fiduciary who pays other creditors ahead of the federal government. The courts have adopted a broad definition of those subject to § 3713(b) liability, and a receiver of an insolvent insurer is certainly within the established meaning of the word representative. However, a fiduciary will not be liable under § 3713(b) for ignoring claims of the government unless he or she has actual knowledge of facts as would lead a prudent person to inquire about the existence of such claims. Where a receiver has actual knowledge of facts that indicate the existence of a possible liability to the U.S., the receiver may have sufficient knowledge of possible liabilities to be subject to the provisions of § 3713(b).

It should be noted that tax claims, including interest and penalties, are included in the meaning of debt under § 3713. Thus, a receiver should be aware that such tax claims could present complex questions and would require the assistance of a tax specialist.

As can be seen from the words of § 3713 itself, there is no express exception to the superpriority granted to the U.S. under § 3713. However, the Supreme Court has held that state liquidation priority statutes may give administrative expense priority over a debt due to the U.S.[75] There do not appear to be any reported cases inconsistent with that holding. Obviously, aside from the priority statutes and its effect on estate assets, a receiver has to be able to administer the receivership and bring assets into the estate for the benefit of the federal government and all other creditors. Similarly, the courts have created an exception for prior security interests, saying that the statute grants the federal government superpriority in the sharing of assets held by a debtor at the time that the insolvency described by the statute occurred; property (i.e., a specific perfected lien) transferred by the debtor prior to that time is beyond the reach of the statute.

Until 1993, courts were split on the issue of whether to follow the federal superpriority statute or individual state liquidation statutes which set forth distribution priorities. At issue was whether the federal statute preempted the state priority statutes, or whether the state priority statutes fell within the provisions of the McCarran-Ferguson Act, which provides, inter alia, that "[n]o Act of Congress shall be construed to … supersede any law enacted by any state for the purpose of regulating the business of insurance." In 1993, the U.S. Supreme Court settled the question by ruling that the federal priority statute must yield to a conflicting state statute to the extent the state statute furthers policyholders' interests.[76] However, the Court also held that the state statute was not a law enacted for the purpose of regulating the business of insurance to the extent it was designed to further the interests of creditors other than policyholders.[77] The Court found that the preference given by the Ohio statute to administrative expenses and policyholder claims was reasonably necessary to further the goal of protecting policyholders. The preferences given by the Ohio statute to employees and other general creditors, however, were found to be too tenuously connected to the regulation of insurance, and thus, these claims were held to be preempted by the federal statute.[78] State

[75] *U.S. Dept. of Treasury v. Fabe,* 113 S.Ct. 2202 (1993).

[76] *Id.*

[77] But see, *Ruthardt v. United States of America*, 303 F.3d 375 (1st Cir. 2002) where the court interpreted *Fabe* in deciding whether the federal claim priority statute preempted a state liquidation priority statute giving guaranty fund claims priority over federal claims. The First Circuit Court of Appeals stated, "*Fabe*'s premise was not that priority (over the United States) for policyholders is all right and priority for anyone else is not; *Fabe* itself upheld a priority for administrative expenses of liquidation (and apparently for administrative expenses of guaranty funds, too…) because these reimbursements facilitated payment to policyholders. …the question is one of degree not of kind." *Id. at 382.* See also Section IV of this chapter on Priority of Claims.

[78] In 1995, on remand, the District Court ruled that the Ohio priority statute was not severable and that, therefore, the entire priority statute was invalid because it gave priority to general creditors' claims over claims of the federal government. *Duryee v. U.S. Dept. of Treasury,* 6 F.Supp.2d 700 (1995). Soon after the District Court's decision, the Ohio Legislature enacted a new liquidation priority statute revised to comply with *Fabe*. Pursuant to the new statute, federal government claims have third priority to the assets of an insolvent insurer behind administrative expenses and policyholder claims. The statute was passed as emergency legislation and is intended to apply retroactively to pending insolvencies as well as prospectively.

insurance liquidation priority statutes that put administrative expenses and policyholder claims ahead of federal government claims should be valid in light of the Supreme Court's ruling.[79]

However, the federal government may attempt to characterize some of its claims as post-receivership administrative expenses. Certain federal taxes, such as those incurred as a result of wages paid by a receiver to receivership employees or on interest income earned post-receivership, are easily seen as administrative expenses. The difficult cases are when income is the result of pre-receivership activity, but is considered to be earned post-receivership. For example, one court has held that although premiums may be paid up front, income resulting from the premiums is considered earned, for tax purposes, over the life of the policy.[80] Thus, although the estate did not receive cash, income was earned on a book basis, and the tax on the income was treated as a post-receivership administrative expense.

There is also case law to support the notion that the federal government is not subject to a state's claim filing deadline for proofs of claim in a liquidation.[81]

K. Cut-Through Endorsements

A cut-through endorsement is a contractual exception to the general principal of the reinsurance insolvency clause. It is an endorsement to the reinsurance agreement that redirects proceeds otherwise payable to the cedent's liquidator to the insured or mortgagee, pursuant to the reinsurance agreement's insolvency clause, in the event of the insolvency of the ceding company.

Cut-through endorsements are authorized by statute in many states. IRMA § 611H recognizes cut-throughs under very limited circumstances. Cut-throughs are narrowly construed by most receivers and are limited to situations where there is an express written provision and statutory reinsurance credit has not been taken on the cedent's financial statements. The policy rationale for this position is that it gives a preference in liquidation to such insureds or mortgagees and is thus unfair to other claimants who will receive a lesser portion of their claims when the assets of the estate are distributed. One court has termed the cut-through endorsement an improper preference and held that a reinsurer may not pay losses pursuant to a cut-through endorsement, but must instead pay the reinsurance recoverables to the liquidator.

L. Equitable Subordination

The theory of equitable subordination may be available to the receiver. Equitable subordination is a theory whereby the claims of one creditor are subordinated to the claims of other creditors to the extent necessary to redress harm caused by such creditor's inequitable conduct.[82] (A related remedy is to reclassify debt owed to a shareholder as equity. Reclassification is based on the grounds that the shareholder inequitably substituted debt for equity capital.)[83] The effect of equitably subordinating a claim is to postpone distribution on the subordinated claim until all claims in the same class (and higher priority classes) have been paid in full. Accordingly, recovery on the subordinated claim is eliminated or substantially diminished, thus increasing the recovery for other claims in the relevant class or classes.

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[79] Indeed, a state priority statute giving state guaranty associations the same priority as policyholders was also found to further the interests of policyholders. *Boozell v. United States,* 979 F. Supp. 670 (N.D. Ill. 1997). Applying the principles of *Fabe*, the Illinois District Court held that the Illinois priority statute's preference of guaranty association claims over federal claims is not preempted by the federal superpriority statute under the McCarran-Ferguson Act. The United States' appeal of this case was withdrawn. See also *State ex rel. Clark v. Blue Cross Blue Shield, Inc.,* 203 W.Va. 690, 510 S.E. 2d 764 (1998).

[80] *North Carolina, ex. rel. Long as Liquidator of Northwestern Security Life Insurance Co. v. United States*, 139 F.3d 892 (4th Cir. 1998).

[81] *Ruthardt v. United States of America*, 303 F.3d 375, 384 (1st Cir. 2002); *Garcia v. Island Program Designer, Inc.*, 4 F.3d 57 (1st Cir. 1993).

[82] See generally *4 Collier on Bankruptcy* 510.05 (15 ed. rev. 1997).

[83] See e.g., *In re Hyperion Enterprises, Inc*., 158 B.R. 555 (D.R.I. 1993); *In re Diasonics, Inc*., 121 B.R. 626 (Bankr. N.D. Fla. 1990). See also *In re Herby's Foods, Inc*., 2 F.3d 128 (5th Cir. 1993) (equitable subordination on similar theory).

The doctrine of equitable subordination has long existed as a matter of general equity under the federal bankruptcy laws.[84] Accordingly, the remedy ought to be available in insurance insolvency cases. The standards to obtain equitable subordination differ depending on whether the holder of the claim was a fiduciary with respect to the insolvent company. When the defendant is a fiduciary for the debtor, "the burden is on the [fiduciary] … not only to prove the good faith of the transaction but also to show its inherent fairness from the viewpoint of the corporation and those interested therein."[85] On the other hand, to subordinate the claim of a non-fiduciary, the plaintiff must prove egregious misconduct.[86]

Equitable subordination may be useful as an alternative remedy for fraud, fraudulent transfer, breach of fiduciary duty or the like.[87] In fact, it may be the only remedy available as a practical matter when the target is another insolvent insurance company (or a debtor in a bankruptcy case). In that situation, an action against the target would be subject to the anti-litigation injunction in the target's proceedings. However, unlike other actions, equitable subordination should not be held to violate that injunction because equitable subordination addresses the treatment of a claim filed by the target in the insolvent insurance company's proceedings. The filing of such a claim subjects the target to the jurisdiction of the receivership court and should be held to waive any stay as to the filed claim.

It might be argued that equitable subordination is precluded by § 47 of the Liquidation Model Act which provides: "No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes [of § 47] through the use of equitable remedies," or by § 801 of IRMA which has the same language. That argument should fail. Equitable subordination (as proposed to be used here) is a collective remedy for the insolvent insurer's receiver, not a remedy for a specific shareholder, policyholder or other creditor of such insurer. Prohibiting individual creditors and shareholders from seeking subordination as to one another prevents individuals from delaying a receivership case with inter-creditor or inter-shareholder litigation. The same considerations do not apply to a collective remedy. Moreover, this language does not refer to the insolvent insurer's receiver at all but, rather, its prohibition is limited to certain persons other than the receiver. Accordingly, that provision should not be construed to prohibit the receiver from seeking subordination for the benefit of an entire class (or classes) of creditors.

M. Inter-Affiliate Pooling Agreements88

In a typical pooling transaction, companies cede all of their premiums and losses to a single member of the group. In return, each of the ceding companies receives a designated percentage of the combined underwriting profits or losses of the group. A pooling agreement that has not been terminated is an executory contract that the receiver may either adopt for the benefit of the insolvency estate (if it is profitable) or abandon (if it is not profitable). When a group of companies have become insolvent, at least one receiver is likely to abandon the pooling agreement, thereby effectively discontinuing the agreement on a prospective basis for all participants.

Such abandonment would constitute a breach of the pooling agreement and would give rise to claims against the abandoning company's estate. These claims would have the same status and priority as general claims such as claims under abandoned reinsurance treaties. Thus, the claims would be junior to administrative expenses and the claims of policyholders. However, the claims may be subject to rights of setoff depending

[84] See e.g., *Pepper v. Litton*, 308 U.S. 295 (1939); *Taylor v. Standard Gas & Elec. Co*., 306 U.S. 307 (1938).

[85] *In re Mobile Steel Co*., 563 F.2d 692, 701 (5th Cir. 1977). 11 USCS 510(c) may have rendered this requirement moot, see *In re Felt Manufacturing Co.,* 371 B.R. 589 (Bank. D.N.H. 2007).

[86] *In re Giorgio*, 862 F.2d 933 (1st Cir. 1988).

[87] See e.g., *In re Osborne*, 42 B.R. 988 (W.D. Wis. 1984) (remedy for misrepresentation); *In re Crowthers McCall Patterns, Inc*., 120 B.R. 279 (Bankr. S.D.N.Y. 1990) (remedy for fraudulent transfer).

[88] See generally H.S. Horwich and L.M. Weil, *Regulation of Inter-Company Pooling Agreements: An Insolvency Practitioner's Perspective*, Journal of Insurance Regulation, Vol. 16, No. 5 (Fall 1998).

on state law. As such, if the receiver had a claim against another member of the pool arising under another agreement, that claim may be used to set off against the claim under the pooling agreement.

In cases where the pooling arrangement significantly contributed to the insolvency of the company, abandonment of the agreement could give rise to significant claims by other members of the pool. In such cases, the receiver will look for ways to avoid these claims, and, more importantly, to recover some of the losses that were paid prior to the commencement of insolvency proceedings. There are several remedies that may be available to the receiver: fraudulent transfer; breach of fiduciary duty; substantive consolidation; and equitable subordination. Each of these remedies involves proof that the pooling transaction was unfair to the insolvent company.

Under the Insurance Holding Company System Regulatory Act (Holding Company Act), a pooling transaction cannot be implemented unless the relevant insurance commissioners have determined that the proposed agreement is fair and reasonable.[89] Thus, in an insolvency situation, other members of a pooling group may argue that a receiver is precluded from attacking the fairness of the pooling transaction due to the insurance commissioner's prior determination of fairness as to the insolvent insurer under the Holding Company Act. That contention should fail.

In order for an issue to be precluded in litigation based on a prior determination, the parties to the litigation must be the same. The insurance commissioner acting as regulator is a different party from the insurance commissioner acting as receiver. Thus, one of the requisites for issue preclusion is missing. In addition, for an issue to be precluded in litigation based upon a determination in prior proceedings, the issue decided in the prior proceedings must be the same as the issue to be precluded. A determination of fairness under the Holding Company Act is based on facts and circumstances existing at the inception of the pooling transaction. The losses resulting from a pooling transaction may have been caused by materially different circumstances than those considered at the inception of the transaction. Thus, an after-the-fact fairness determination in insolvency proceedings is not precluded.

Fraudulent transfer law may be available to recover amounts paid under the pooling agreement or to avoid obligations incurred pursuant to the pooling agreement on the basis that the relevant insurer did not receive reasonably equivalent value, fair consideration or the like in exchange for the payment made or obligation incurred and either was insolvent or became insolvent as a result. Fraudulent transfer statutes define a period in which transactions are subject to avoidance. Transactions that occurred prior to that period are not subject to avoidance. Thus, it is critical to determine when the transaction is deemed to have occurred. With respect to transactions under pooling agreements, the outcome of this issue varies by statute and also by jurisdiction. There are cases that hold that each segment of the transaction is to be evaluated separately as it occurs.[90] On the other hand, there are cases that hold that the fairness of an ongoing transaction is to be measured at the time of its inception and not thereafter.[91]

Fraudulent transfer law has special rules for inter-affiliate transfers. First, payments by a parent corporation for the benefit of its subsidiary generally are not deemed to be a fraudulent transfer if the subsidiary is solvent. However, if the subsidiary is insolvent, generally there is a contrary result.[92] Second, when corporate affiliates are operated as if they constitute a single business enterprise, courts recognize that, in certain circumstances, all affiliates benefit from the synergistic effort of the grouping.[93] Thus, benefit directly received by one affiliate may produce an indirect benefit or value to other members of the group.

[89] See NAIC Insurance Holding Company System Regulatory Act §§5A(1), 5A(4).

[90] See e.g., *Rubin v. Manufacturers Hanover Trust Co*., 661 F.2d 979 (2d Cir. 1981).

[91] See e.g., Uniform Fraudulent Transfer Act §6(5).

[92] Compare *Branch v. F.D.I.C*., 825 F. Supp. 384 (D. Mass. 1993) (solvent subsidiary) with *In re Duque Rodrigue*, 77 B.R. 937 (Bankr. S.D. Fla. 1987) (insolvent subsidiary).

[93] See e.g., *Mann v. Hanil Bank*, 920 F. Supp. 944, 953-954 (E.D. Wis. 1996); *In re Miami General Hospital, Inc*. 124 B.R. 383 (Bankr. S.D. Fla. 1991).

Arguably, a pooling arrangement benefits all of the members of the group because it gives them access to the combined financial strength of the group. However, where the pool's performance is poor, that defense is correspondingly weaker. Also, the indirect benefit defense may be unavailable if the insolvent insurer consistently suffered losses that it would not have suffered in the absence of its pool participation.

The law of breach of fiduciary duty also may provide a basis for another claim available to the receiver. Under this theory the receiver may obtain affirmative recoveries and may also avoid claims. The receiver would allege that a member of a pooling group or inter-locking management owed the insolvent company fiduciary duties with respect to the pooling arrangement. The receiver would further allege that those duties had been breached by causing the insolvent insurer to enter into, or remain subject to, the pooling arrangement.

In order to maintain a claim under this theory, the receiver must first establish the existence of a fiduciary duty. Directors of the insolvent company clearly owed fiduciary duties to the company; however, the duties of the pooling companies to each other are less clear. Generally, a parent company owes no fiduciary duty to its wholly-owned subsidiary, and affiliates owe no fiduciary duties to one another.[94] However, courts generally make an exception to that rule that imposes a duty on a parent company to a subsidiary when the subsidiary is insolvent or in a vulnerable financial condition.[95] In that situation, courts generally recognize the existence of a fiduciary duty running from the parent (or controlling affiliate) to the subsidiary and its creditors. Moreover, in some states, when a subsidiary becomes insolvent, its assets are deemed to be a trust fund for its creditors, and its parent owes a fiduciary duty to the insolvent subsidiary's creditors.[96]

Once a fiduciary duty has been established, there are questions as to the applicable level of scrutiny. Self-interested transactions are subject to closer scrutiny than other transactions. A pooling transaction involving a parent company and subsidiaries is a self-interested transaction for the parent. It may not be a self-interested transaction for officers and directors. In order to impose liability on inter-locking officers and directors, it may be necessary to show more than their concurrent presence on the boards of directors of the companies involved. It may be necessary to show that the individual benefited from the transaction personally. A better argument with respect to officers and directors may be that they aided and abetted a breach of the controlling company's fiduciary duties to the insolvent company.[97]

It may also be argued that members of a holding company group should be deemed to be fiduciaries for each other by virtue of the Holding Company Act. As noted above, under the Holding Company Act, all transactions within an insurance holding company system must be fair to the regulated company. As discussed below, that is the obligation that fiduciaries have to their charges. Accordingly, it may be argued that the Holding Company Act imposes liability in the event that the transaction was unfair.

The theory of equitable subordination may be used to subordinate pooling agreement claims of affiliates of the relevant insurers to the claims of general creditors of the insurer such as reinsurers. Equitable subordination may be useful as an alternative remedy to actions for affirmative recovery such as fraud, fraudulent transfer or breach of fiduciary duty. In fact, it may be the only remedy available to the receiver if the target affiliate is also in insolvency proceedings. That is so because, unlike suits seeking affirmative recovery, equitable subordination should not be held subject to the anti-litigation injunction in the target company's insolvency proceedings.

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[94] See *Anadarko Petroleum Corp. v. Panhandle Eastern Corp*., 545 A.2d 1171 (Del. 1988). It is reasonably well settled that a parent corporation does owe a fiduciary duty to a corporation when less than all of the subsidiary's stock is owned by the parent. See 18A Am. Jr. 2d *Corporations* § 773 (1985).

[95] See *Pioneer Annuity Life Ins. Co. v. National Equity Life Ins. Co*., 765 P.2d 550 (Az. Ct. App. 1988); see also *F.D.I.C. v. Sea Pines Co*., 692 F.2d 973 (4th Cir. 1982). cert. denied, 461 U.S. 928 (1983).

[96] See e.g., *Abraham v. Lake Forest, Inc*. 377 So.2d 465 (La. Ct. App. 1979), writ denied, 380 So.2d 100, writ denied, 380 So.2d 99 (La. 1980).

[97] See *Banco de Desarrollo Agropecuario, S.A. v. Gibbs*, 709 F. Supp. 1302 (S.D.N.Y. 1989).

Equitable subordination may also be useful in cases where fraudulent transfer is unavailable because of limitations inherent in the statute or case law. For example, an obligation under a pooling agreement may not be avoidable under fraudulent transfer law because the obligation was deemed to be incurred at the time of the agreement and, as a consequence, occurred outside the look-back period. In that situation, an equitable subordination claim may be available based on the creditor company's failure to terminate the agreement once it became unfair to the insolvent company.

A receiver may also consider the use of the doctrine of substantive consolidation. When insolvency proceedings are substantively consolidated, inter-company obligations between the relevant insurers are eliminated. Accordingly, a receiver may consider substantive consolidation of insurers that are parties to a pooling agreement in order to effectuate the pooling of their assets and liabilities without the complexities of the pooling agreement.

IV. PROPERTY/CASUALTY GUARANTY ASSOCIATIONS

A. Introduction

This section addresses general legal concepts, highlights, points to be aware of and pitfalls to watch out for when dealing with state guaranty associations. Because guaranty association statutes will vary from jurisdiction to jurisdiction, the information contained here is necessarily general in nature. The NAIC *Property and Casualty Insurance Guaranty Association Model Act* (#540) is used as a base for this analysis as it typifies most guaranty association acts. Factual examples are drawn from cases that have decided important issues in the receiver/guaranty association relationship. When analyzing a specific problem, of course, the law of the jurisdiction should be consulted.

While most state guaranty association statutes essentially parallel the Model #540, there are notable exceptions. To the extent guaranty association do not cover an insured or third party claimant, the claimant may have a claim against the assets of the insolvent estate. Consequently, it is important for receivers to understand what issues arise in determining the extent of coverage, if any, by the state guaranty association system.

It is also important to be aware that a particular state's guaranty association only covers claims against insolvent insurers admitted to do business in that state. Thus, claims against nonadmitted insurers or excess and surplus lines carriers are not covered claims. (See Model #540 § 5H, which limits coverage to "an insurer licensed to transact insurance.") New Jersey, however, does have a separate guaranty fund to cover nonadmitted insurers.

Legal Status of Guaranty Associations

- Jurisdiction

  Jurisdictional issues often arise when a claimant files a lawsuit against a non-resident guaranty association and that court asserts jurisdiction over the non-resident association. An insured with liability coverage seeking indemnification or defense costs in a suit brought against it in one state may hope to obtain coverage from multiple state guaranty associations or from a foreign guaranty association that provides higher limits by bringing one or more foreign guaranty funds into the lawsuit. In this context, the issue is whether a particular state court can exercise jurisdiction over a foreign guaranty association.

  - In Personam Jurisdiction

    In a Florida case, an appellate court found that the trial court was not justified in asserting personal jurisdiction over a South Carolina insurer or the South Carolina Insurance Guaranty Association. The court based its decision on the minimum contacts test that requires that the defendant's contacts with a foreign state be such that the defendant could reasonably expect to be summoned into that

state's court. Further, the defendant must purposely avail itself of the privilege of conducting activities within the state.[98]

Jurisdiction also becomes an issue when a suit against a guaranty association is filed in federal court and the court determines the citizenship of the guaranty fund for purposes of diversity jurisdiction. A plaintiff that files a diversity lawsuit in federal court must show that all plaintiffs have a different citizenship from all defendants. Some cases hold that a guaranty association is a citizen of each state in which one of its member insurers is a citizen. Therefore, federal diversity jurisdiction is often defeated and the suit must be dismissed.

Similarly, an unincorporated guaranty fund does not have its own citizenship.[99] Guaranty associations are comprised of all the insurers authorized to write policies in a particular state, and their citizenship is deemed to be the same as that of their members.

B. Legal Disputes Over Triggering of Guaranty Associations

An analysis of when guaranty association coverage is triggered should begin by assessing the purpose for which guaranty associations exist.

Generally, guaranty associations exist to protect the insurance consumer from harm caused by an insolvent insurer. The trigger for a guaranty association obligation regarding covered claims varies from state to state. The #540 § 5G states:

> "Insolvent insurer" means an insurer that is licensed to transact insurance in this state, either at the time the policy was issued , when the obligation with respect to the covered claim was assumed under an assumed claims transactions or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile."

Simply, to be insolvent for guaranty fund purposes, the insurer must have been declared insolvent by a court of competent jurisdiction.

1. Court of Competent Jurisdiction

The phrase court of competent jurisdiction does not mean that only a court in the insurer's domiciliary state may issue the order of insolvency. Generally, any court in any state may issue the order so long as certain requirements are met.[100] Usually, these requirements are: 1) the state has sufficient minimum contacts with the parties or the property to make exercise of its authority reasonable; 2) the state has entrusted exercise of that authority to the court in question; and 3) the state has provided the parties adequate notice and an opportunity to be heard. However, if the order is entered in any state other than the insurer's state of domicile, it will not trigger any guaranty association that has Model #540 language cited above other than the guaranty association in the state where the order is entered and only if there is specific statutory language authorizing the regulator to seek such an order.

a. Minimum Contacts

An insurer may satisfy the minimum contacts test in a number of ways. Some examples are: the insurer is authorized to do business in the forum state; the insurer maintains assets within the borders of the forum state; or the company maintains offices and transacts business within the

[98] *South Carolina Ins. Guar. Ass'n v. Underwood,* 527 So. 2d 931 (Fla. Dist. Ct. App. 1988); *contra Ruetgers-Neas-Chemical Co. v. Friemers Ins.,* 236 N.J. Super. 473, 566 A.2d. 227 (N.J. App. 1989).

[99] See *Rhulen Agency Inc. v. Alabama Ins. Guar. Ass'n,* 896 F.2d 674 (2d Cir. 1990).

[100] See e.g., *New Jersey Property - Liability Ins. Guar. Ass'n v. Sherran,* 137 N.J. Super. 345, 349 A.2d 92 (1975), cert. denied, 70 N.J. 143, 358 A.2d 190 (1976); *contra Fla. Ins. Guar. Ass'n. v. State,* 400 So.2d 813 (Fla. Ct. App. 1981).

forum state. Basically, if an insurer derives any benefits from a state or solicits business in that state, the insurer will likely satisfy a minimum contacts test for that state. A court in that state will then have competent jurisdiction over the insurer to declare the insurer insolvent, but not to commence a delinquency proceeding.

b. Exercise of Authority Entrusted to the Court in Question

The issue of whether a state has given a court authority to exercise its jurisdiction in an insolvency is readily answered. If a state statute authorizes the court to determine an insurer's insolvency, the court has been properly authorized.[101]

c. Parties Provided with Adequate Notice and Opportunity to be Heard

State court rules will dictate the requisite notice necessary to apprise an insurer of an insolvency hearing. Court rules also provide the hearing's procedural requirements. Such procedural safeguards rarely are breached and do not commonly affect a receiver's relationship with a guaranty association.

2. Order of Liquidation with a Finding of Insolvency

Guaranty association coverage under Model #540 definition is not triggered unless there is final order of liquidation with a finding of insolvency.[102] A finding of insolvency in a rehabilitation order is not sufficient to trigger guaranty association coverage in most states. However, since there are some states whose guaranty associations are triggered by the finding of insolvency alone, care should be exercised in the preparation of conservation and rehabilitation orders.

Problems may arise in determining when an order of liquidation is final. Generally, an order of liquidation does not become final until all possible appeals have been exhausted.[103] However, if an order of liquidation is not appealed, it is final on the date issued.[104]

3. Timing

Another issue may arise when determining the date of an insurer's insolvency and what obligations are triggered upon a determination of insolvency. Section 8A(1)(a) of Model #540 provides:

The Association shall:

- Be obligated to pay covered claims existing prior to the order of liquidation, arising within 30 days after the order of liquidation, or before the policy expiration date if less than 30 days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within 30 days of the order of liquidation.

C. Extent of Coverage of Guaranty Associations

Guaranty associations exist for the protection of first- and third-party covered claimants. This section addresses issues that may arise when determining whether a guaranty association is obligated by law to cover a particular claim. This analysis establishes some working guidelines for receivers to use when interacting with guaranty associations.

[101] See *New Jersey Property,* 137 N.J. Super. at 345, 349 A.2d at 92.

[102] See *Young v. Shull,* 149 Mich. App. 367, 385 N.W.2d 789 (1986). See also *In Re Oil & Gas Ins. Co.,* 9 F.3d 771 (CA 1991) a bankruptcy order is not sufficient to trigger guaranty associations).

[103] Id.

[104] *Id.*

1. Model #540—§ 5H

Section 5H-of Model #540 defines a "covered claim" as follows:

(1) 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 an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and:

(a) The claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the state in which its principal place of business is located at the time of the insured event; or

(b) The claim is a first party claim for damage to property with a permanent location in this state.

(2) Except as provided elsewhere in this section "covered claim" shall not include;

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

(i) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred-but-not-reported losses.

2. Covered Claims

a. Unpaid Claims

Under most guaranty association acts, to recover for a claim from a guaranty association the claim must be unpaid.[105] This requirement is primarily to prevent excessive or duplicative claim payments.[106] Though it may seem apparent whether a claim is unpaid, courts have addressed a variety of situations in determining this issue. For example, a claim draft issued by the insolvent insurer which is not honored because of the liquidation order is an unpaid claim and is the obligation of the guaranty association to the extent of the guaranty association's statutory limits.[107]

i. Insured Already Compensated

If a claimant has entered into an agreement with an insolvent insurer's policyholder not to levy execution on the insured's property in return for a guaranty of the unconditional receipt of the judgment amount, the claim may not be unpaid.[108] The agreement may render the claim unrecoverable against a guaranty association because the unconditional receipt effectively pays the claim.

Under the agreement, any amount the plaintiff recovered would benefit the insurer. The statutory scheme which established the guaranty association seeks to avoid shuffling of funds among insurers. Therefore, the association is excused from paying claims if the ultimate beneficiary would be an insurer.

Where other solvent insurers paid the claim and then sought recovery from the guaranty association, the court held the claim was not unpaid.[109]

ii. Insured versus Guaranty Association where Insured has not Satisfied Judgment

A guaranty association may have to indemnify an insured even where the insolvent insurer did not defend its insured's claim and the insured has paid nothing on an adverse judgment. In Missouri, an insurer refused to defend its insured and a judgment was then rendered against the insured.[110] Subsequently, the insurer became insolvent. Though the insured had not paid the judgment, the court granted the insured's indemnity claim against the guaranty association after it found that the judgment was a covered claim.[111] Whether the insured later satisfied the judgment creditors with the insurance policy proceeds was outside the guaranty association's scope.

[105] See *Florida Ins. Guar. Ass'n v. Dolan,* 355 So. 2d 141, 142 (Fla. Ct. App. 1st Dist.), cert. denied*, Dolan v. Florida Ins. Guar. Ass'n,* 361 So. 2d 831 (Fla. 1978).

[106] See *Ferrari v. Toto,* 9 Mass. App. Ct. 483, 402 N.E.2d 107 (1980); aff'd*,* 383 Mass. 36, 417 N.E.2d 427 (1981).

[107] *Betancourt v. Ariz. Prop. & Cas. Fund,* 823 P.2d 1304 (Ariz. Ct. App. 1991).

[108] See *Florida Ins. Guar. Ass'n,* 355 So. 2d at 141.

[109] *P.I.E. Mutual Ins. Co. v. Ohio Guar. Ass'n,* 66 Ohio St. 3d 209, 611 N.E.2d 313 (Ohio 1993).

[110] *Qualls v. Missouri Ins. Guar. Ass'n,* 714 S.W.2d 732 (Mo. Ct. App. 1986).

[111] Id.

b. Within the Coverage

All guaranty association acts require that to be covered, a claim must "arise out of and be within the coverage."[112] This provision requires that a claim meet a policy's coverage requirements before it will be paid.[113]

i. Claims Where Liability is to a Third Party

Generally, liabilities to third parties are considered covered claims. In the Missouri case described above, the guaranty association argued that because an insured had not paid the judgment against him, the insured's claim did not arise out of and was not within the coverage of the insurance policy. The court disagreed and held that the action arose out of the policy because the insured was liable to third parties. The exposure to liability amounted to the insured's suffering a loss arising out of the policy. Thus, covered claims may include an insured's action against a guaranty association for liability to a third-party.

ii. Settlements

Section 8A(6) of Model #540 provides:

The association shall:

(a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insured were parties prior to the entry of the order of liquidation, the association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:

(i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:

(I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or

(II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.

(ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on its merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.

[112] Model #540, *supra* note 96, at section 5F.

[113] See *Indiana Ins. Guar. Ass'n v. Kiner,* 503 N.E.2d 923 (Ind. Ct. App. 1987); see also *Treffenger v. Ariz. Ins. Guar. Ass'n,* 22 Ariz. App. 153, 524 P.2d 1326 (1974).

(iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.

(b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.

In another Missouri case, an insured settled a claim with a third-party, and then sought reimbursement from the Missouri Insurance Guaranty Association.[114] The insured argued that the settlement payment constituted a covered claim. The court held that as a general proposition, a third-party claimant's decision to bypass a fund's claim procedure should not deny the insured otherwise available protection.[115]

However, the insured's legal obligation to the third party claimant was never adjudicated because the suit was voluntarily settled. The court reasoned that if the insurer had not become insolvent and since coverage was not an issue, the insured could not have successfully pursued reimbursement claims for settlements the insured voluntarily made. The insured was similarly barred from recovering from the guaranty association. Generally, a guaranty association statute gives an insured no broader rights against the guaranty association than those previously existing against the insurer.[116]

iii. Corporation Satisfies Third-Party Claim against Subsidiary

If a corporation voluntarily satisfies a judgment against its subsidiary where the subsidiary's insurer is insolvent, a guaranty association may not cover the corporation's claim. In an Illinois case, a corporation's subsidiary was found liable for wrongful death.[117] The corporation owned an excess general liability and automobile insurance policy which covered it and its subsidiaries. When the excess insurer became insolvent, the corporation itself satisfied the judgment against its subsidiary. However, because the subsidiary only, and not the parent corporation, was liable for wrongful death, the corporation's satisfaction of the judgment was not a loss arising out of and within the coverage of the insolvent insurer policy.[118]

Generally, "[a] corporation is an entity separate and distinct from its stockholders and from other corporations with which it may be connected."[119] Since shareholders of a corporation that includes other corporations will not ordinarily be liable for the debt and obligations of the corporation, satisfaction of the judgment was voluntary. The party making the claim under the guaranty association's act must be the same entity which suffered the loss arising out of and within the coverage. Thus, the corporation could not recover from the guaranty association.[120]

[114] See *King Louie Bowling v. Missouri Ins. Guar. Ass'n,* 735 S.W.2d 35 (Mo. Ct. App. 1987).

[115] *Id.* at 38.

[116] *Id.*

[117] See *Beatrice Foods Co. v. Illinois Ins. Guar. Fund,* 122 Ill. App. 3d 172, 77 Ill. Dec. 604, 460 N.E.2d 908 (1st Dist. 1984).

[118] *Id.* at 910.

[119] *Id.*

[120] *Id.*

c. Subject to the Applicable Limits

Like the Model Act, each state provides that the guaranty association's liability shall be "subject to the applicable limits of an insurance policy to which this Act applies."[121] This language explicitly limits a guaranty association's liability to the limits of the policy in question. Most states also have a statutory cap, which ranges from a low of $100,000 to as high as $1 million. The policy limit or the statutory cap, whichever is lower, will apply to each covered claim (see Exhibit 6-1).

- Recovery of Excess Denied

  In a Washington case, a claimant appealed a judgment which denied her a recovery against the guaranty association in excess of policy limits.[122] The claimant alleged that because of the bad faith of her insolvent insurer, she should be able to recover the full amount of the bad faith award. The trial court denied the portion of the claim which exceeded the insured's policy limits.

  The court found that bad faith claims are not covered claims.[123] The court also discussed the significance of the insured's policy limits. Because Washington's guaranty association statute stated that in no event shall the association pay a claimant an amount in excess of the policy's face amount, as a matter of law the claimant was not entitled to recovery above the policy limits.[124]

d. Unearned Premiums

Most guaranty association acts and the Model #540 specifically allow claims for unearned premiums.[125] Generally, there is a cap and deductible that will apply, and unearned premium recovery is limited to the extent that the insurer would have had to reimburse the insured.

- Assignments Allowed

  In a New Jersey action, a claimant bank had financed insurance premiums.[126] The bank's customers had assigned to the bank all rights by which they might recover any unearned premiums from their insurer. After the insurer became insolvent, the bank sought to recover from the guaranty association unearned insurance premiums it had paid the insolvent insurer. The court held that, under certain circumstances, a claim for unearned premiums is a covered claim.[127] While the applicable act distinguished reinsurers' claims from others, it did not distinguish between individual and corporate claimants. Had the legislature intended to differentiate between individuals and commercial assignees, it would have expressly done so.[128]

[121] Model #540, at Section 5H.

[122] See *Vaughn v. Vaughn,* 23 Wash. App. 527 (Wash. Ct. App. 1979), 597 P.2d 932, review denied, 92 Wash. 2d 1023 (1979).

[123] *Id.*

[124] *Id.* at 528.

[125] Model #540, at § 5H.

[126] See *Broadway Bank & Trust Co. v. New Jersey Ins. Ass'n,* 146 N.J. Super. 80, 368 A.2d 983 (1976).

[127] *Id.*

[128] *Id.* at 986.

e. Residency and Location of Property

Generally, a guaranty association will limit coverage only to those insureds and third-party claimants who can meet certain residency and property location requirements. The Model #540 provides coverage to insureds or claimants who reside, at the time of the insured event, in the state where the individual seeks guaranty association coverage. If the insured or claimant is an entity other than an individual, the applicable residence is the state where its principal place of business is located at the time of the insured event.[129] A first -party claim for property damage is also covered if the property from which the claim arises is permanently located in the guaranty association's state.

i. Residence of Claimant

An individual, or other entity, must be a resident of the guaranty association's state at the time of the insured event to support a covered claim.[130] Therefore, the claimant must establish that it was a resident when the loss occurred, otherwise the guaranty association will not cover the claim. Disputes have arisen in attempting to determine the parameters of the residency requirements in a particular state.

In a New Jersey case, the court addressed whether a Delaware corporation was a resident for guaranty association purposes when it was authorized to do business in New Jersey and maintained its principal offices in New Jersey.[131] The court held that a corporate claimant need not be a domestic corporation to seek recovery from a guaranty association. Whether a corporation has established residence in a foreign jurisdiction for guaranty association purposes depends upon the aim and context of the statute containing the residency requirement.

The court noted that another important element in deciding residency was the extent and character of the business transacted in the state. The guaranty association act involved did not require the claimant to make contributions, direct or indirect, to the guaranty association. The critical issues were whether the insolvent insurer was licensed to transact insurance business in the state either when the policy was issued or when the insured event occurred. Because the claimant conducted substantially all of its business in New Jersey, the court found it was a New Jersey resident even though domiciled in Delaware.

ii. Location of Property

Guaranty association acts generally require that the property from which the claim arises must be permanently located in the state.[132] The New Jersey case described above also discussed the permanently located requirement. In that case, a sea-going dredge sustained damage covered by the policy.[133] Subsequently, the insurer became insolvent and the insured submitted a claim to the New Jersey Guaranty Association. The guaranty association argued that the dredge did not satisfy the permanently located requirement of the guaranty act. The court disagreed.

The court held that property is permanently located in a state when it has significant and continuing contacts with the state and no significant and continuing contacts with any other state. Because property can only have one permanent location under the guaranty association

[129] See also *Kroblin Refrig. Express v. Iowa Ins. Guar. Ass'n.,* 461 N.W.2d 175 (Iowa 1990).

[130] See Model #540, at § 5H(1)(a).

[131] See *Eastern Seaboard Pile Driving Corp. v. New Jersey Property and Liability Guar. Ass'n,* 175 N.J. Super. 589, 421 A.2d 597 (1980).

[132] *Id.* at Section 5G(1)(b)

[133] See *Eastern Seaboard,* 175 N.J. Super. at 589.

act, if it has significant and continuing contacts with more than one state, it will be deemed to have no permanent location.

The property's contact with New Jersey was found to be more significant. New Jersey was the home base of the dredge. The property was retained in New Jersey whenever it was not on a job. All repairs and refitting of the property were performed in New Jersey. Therefore, the property was permanently located in New Jersey within the meaning of the guaranty association act.

3. Non-Covered Claims

Guaranty associations do not cover all claims made against an insolvent insurer. In addition to the restrictions placed on a claimant by the definition of covered claims, are those claims which are specifically excluded by or are outside the scope of a guaranty association act.

a. Excluded Claims

Jurisdictions may differ as to which claims are specifically excluded from guaranty association coverage. Model #540 paraphrased, specifies that covered claims shall not include amounts awarded as punitive or exemplary damages; sought as return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool or underwriting fund as subrogation recoveries, reinsurance recoveries, contribution, indemnity or otherwise.[134]

b. Outside the Scope of Guaranty Association

Also not covered by guaranty associations are those claims that arise from areas deemed to be outside the scope of a guaranty association's obligations. Jurisdictions use different terms when describing which transactions are not covered by a guaranty association. Generally, however, these exclusions are similar. The Model #540, Section 3, provides:

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

A. Life, annuity, health or disability insurance;

B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;

C. Fidelity or surety bonds, or any other bonding obligations;

D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

E. Insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

F. Title insurance;

[134] See Model #540, at § 5H(2)(c).

G. Ocean marine insurance;

H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insured) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

I. Any insurance provided by or guaranteed by government.

c. Net Worth Exclusions

Some state guaranty associations exclude coverage for claims made by those who have a net worth greater than a statutorily provided limit. In Georgia, for example, the guaranty association will reject a first party claim if the insured had a net worth in excess of $10 million on Dec. 31 of the year preceding the date the insurer becomes an insolvent insurer; a third-party claim is excluded if the insured had a net worth in excess of $25 million on Dec. 31 of the year preceding the date the insurer becomes an insolvent insurer. However, the exclusion as to the third-party claimant will not apply where the insured is in bankruptcy.[135]

Michigan also has a net worth exclusion. The U.S. Court of Appeals has addressed the constitutionality of Michigan's net worth exclusion.[136] In that case, a plaintiff obtained a personal injury judgment in excess of $1 million against Borman's, a supermarket chain's corporate parent. Because Borman's insurer was insolvent, Borman's had to pay the judgment itself. Borman's then filed a claim against the Michigan Guaranty Association for money it would have received from its insurer.

The association rejected the claim because Borman's net worth exceeded Michigan's statutory limit. At that time, the Michigan Property & Casualty Guaranty Act excluded from its definition of a covered claim, "obligations to ... a person who has a net worth greater than 1/10 of one percent of the aggregate premiums written by member insurers in this state in the preceding calendar year."[137] After Borman's claim was denied, Borman's brought suit in the U.S. District Court seeking declaratory and injunctive relief and challenging the constitutionality of the Michigan statute.

The trial court found that net worth was not rationally related to a company's ability to absorb loss. Therefore, exclusion of certain insureds from guaranty association coverage violated the equal protection clauses of the U.S. and Michigan Constitutions. The court of appeals reversed. On appeal, the insured introduced testimony which suggested that net worth is not a reliable measure of a company's ability to absorb loss. However, because the constitutional test is "not whether the legislative scheme is imperfect, but whether it is wholly irrational,"[138] the court upheld the net worth exclusion.

- Assigned Rights Treated as Separate Claims

A premium financing company may stand in the shoes of a policyholder if there is a valid assignment of rights. In a Georgia case, an insurance premium finance company submitted a

[135] 1990 Ga. Laws Section 33-36-3(2)(g).

[136] See *Borman's, Inc. v. Michigan Property and Casualty Guar. Ass'n,* 925 F.2d 160 (6th Cir. 1991), *reh'g, en banc,* denied*,* 1991 U.S. App. LEXIS 5159 (6th Cir. 1991).

[137] 1983 Mich. Pub. Acts Section 500.7925(3). Michigan's current statute has a $25 million net worth exclusion for first and third party claimants which is subject to annual increases based on the consumer price index.

[138] *Borman's,* 925 F.2d at 163.

claim for the return of unearned insurance premiums on policies canceled due to an insurer's insolvency.[139]

The court reasoned that if each of the 3,127 individual Georgia policyholders had submitted a claim to the guaranty association, the unearned premiums would have been paid to them provided they had a net worth of less than, at that time, $1 million. Because the premium financing company asserted the claim for return of the unearned premiums as the policyholders' assignee and attorney-in-fact, the company stands in the shoes of the insureds.[140] The company was, therefore, entitled to all unearned premiums on the canceled policies to which the policyholders would have been entitled but for the assignments.

The court held that under these circumstances the limitation on net worth did not apply. The premium financing company's claims made pursuant to an assignment of policyholders' rights to recover unearned premiums are treated as separate claims not subject to an aggregate statutory claim recovery limit.

In addition to those states that exclude outright coverage of claims based on net worth are those states that have adopted the Model #540 provision that grants the guaranty association a right to recover from the insured proceeds paid on behalf of those insureds that exceed a statutorily provided net worth amount (see Model #540 § 13B). This type of net worth exclusion sometimes referred to as pay and recover is discussed below in the subrogation section.

D. Primary Responsibility for Handling a Claim

Coverage Under More Than One Guaranty Association

In certain circumstances, more than one guaranty association may be obligated to cover a claim. Since coordination between state guaranty associations and the receiver is essential, receivers should understand the issues which arise in determining when dual liability attaches. The order of recovery is set forth in § 14B of Model #540as follows:

> Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.[141]

E. Late Claim Filing

Most guaranty association acts mandate that all persons known or reasonably expected to have claims against the insolvent insurer, receive adequate notice of the insolvency. Model #540 Section 8A(5), however, requires notice be sent only upon the Commissioner's request. The primary purpose of the notice requirement is to advise insureds of the claim filing deadline and to provide them with adequate time to file a claim. The insured's claim may be rejected by the guaranty association if it is filed after the deadline. Even though the insured may still seek recovery from the receiver, if no timely proof of claim form has been filed, the claim may be denied or designated to a lower distribution priority. However, if the insured is not provided with adequate notice of the insolvency and the procedure for filing a claim, the insured may

[139] See *United Budget Co. v. Georgia Insurer's Insolvency Pool,* 253 Ga. 435, 321 S.E.2d 333 (Ga. 1984).

[140] *Id.* at 337.

[141] Model #540, at Section 14B.

be entitled to file a claim after the deadline has passed and may be entitled to benefits from the guaranty association.

In a California case,[142] the claimants were an anesthesiologist and a nurse-anesthesiologist insured for malpractice from 1971 to 1973. In 1978, their insurer became insolvent and the California State Insurance Commissioner was appointed receiver of the insurer. The receiver sent notice that claims must be filed within six months to all insureds under professional liability policies since 1974. The claimants were therefore not notified.

In 1980, two years after the claim deadline, claimants were sued for malpractice and submitted claims to the California Insurance Guarantee Association (CIGA). CIGA rejected the claims and the superior court denied the claimants' petition to allow the claims.

On appeal, the court held that claimants were entitled to relief because a California statute required the receiver to give written notice to persons known or reasonably expected to have or be interested in claims against the insurer.[143] Thus, CIGA was estopped from asserting the time limits and denying the claim.

The filing deadline, or bar date, is one of the most important dates in guaranty association law. The Model #540 prohibits guaranty associations from handling any claims filed under the bar date.

Section 8A(1)(b) of the Model #540 sets forth this limitation:

> … Notwithstanding any other provisions of this Act, a covered claim shall not include any claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.[144]

Courts have also addressed guaranty associations' obligation to cover late-filed claims. Most courts strictly uphold filing requirements. An Ohio court held that insureds who brought a claim against an insurance guaranty association after the expiration of the filing deadline were precluded from filing a claim against the guaranty association.[145] The court based its decision on an Ohio statute that permitted the court to set discretionary final dates for the filing of claims in liquidation proceedings.

The court found that the statute served a valid legislative purpose by allowing the early liquidation of insolvent insurers. Early liquidation benefited policyholders who would otherwise have to wait until all potential statutes of limitation had run before recovering from the estate. Further, the court reasoned that, even though their claims against the insurance guaranty association were precluded, insureds who brought late claims were still entitled to bring their claims against the estate of the insolvent insurer.

A similar decision was reached in a Michigan case.[146] An insured's untimely claim was accepted by the receiver in the insolvency proceeding. However, the court held that the insured's untimely claim was not a "covered claim" within the meaning of the statute because it was filed after the deadline. The court commented that the trend in other jurisdictions was to strictly preclude recovery for late claims. The allowance of delinquent claims prolonged distribution of an insolvent insurer's assets to the detriment of other claimants and adversely affected guaranty associations.

Conversely, a minority of states will allow a late claim upon a showing of good cause. Florida and Wisconsin may allow late claims where the insured was not aware of the claim's existence and filed it as

[142] See *Middleton v. Imperial Ins. Co.,* 34 Cal.3d 134, 193 Cal. Rptr. 144, 666 P.2d 1 (1983).

[143] Cal. Ins. Code, Section 1063.7 (West 2000).

[144] Post-Assessment Model Act, *supra* note 91, at Section 8A(1)(b).

[145] See *Ohio Ins. Guar. Ass'n v. Berea Roll & Bowl, Inc.,* 19 Ohio Misc. 2d 3, 482 N.E.2d 995, 15 Ohio G. 167 (1984).

[146] See *Satellite Bowl v. Michigan Property and Casualty Guar. Ass'n,* 165 Mich. App. 768, 419 N.W.2d 460 (1988), appeal denied, 430 Mich. 888 (1988); *In re Ideal Mutual, Midwest Steel Erection v. Ill. Ins. Guar. Assn.,* 578 N.E.2d 1235 (Ill. Ct. App. 1991).

soon as reasonably possible. California may allow a late claim upon a showing that the receiver was responsible for the late filing.

In some instances, the receiver may accept a late-filed claim as timely filed or as an excused late-filed claim. This determination is not binding and the guaranty association may still properly reject the claim as not timely filed.[147]

- Contingent and Policyholder Protection Claims

Some jurisdictions permit an insured to file a contingent claim in order to protect the right to bring a claim against the guaranty association. Other jurisdictions, however, prohibit policyholder protection claims and require specific claim information in the proof of claim forms. § 704 A of IRMA allows the filing of policyholder protection claims.

In an Illinois case,[148] an insured filed a policyholder protection claim prior to the deadline for filing claims but the insured's actual claims were not filed until after the deadline. The court held that the guaranty association was not obligated to cover the claims, regardless of the insured's ignorance of the loss prior to the deadline. The court reasoned that the statute's requirement that claims be filed on or before the last date fixed for filing of proofs of claim demonstrated a legislative intent to provide a cutoff date after which an insurance guaranty association would not be liable. The court found that the policyholder protection claim did not constitute a valid proof of claim. Thus, the claims brought after the cutoff date were not entitled to guaranty association coverage.

F. Reinsurance Proceeds

1. Awarded to Receiver

In the past, some guaranty associations have challenged a receiver's right to reinsurance proceeds. However, courts invariably award reinsurance proceeds to the receiver of the insolvent insurer.[149]

2. State-Created Reinsurance Fund Distinguished

A guaranty association may be entitled to reinsurance proceeds if the proceeds come from a state-created reinsurance fund and not a private reinsurer.[150] In a Massachusetts action,[151] a state-created reinsurance fund was set up to cover high risk policies. Under this scheme, insurers ceded high risk policies to a state-created reinsurer. After a ceding insurer became insolvent, a dispute arose between

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[147] *In re Ideal Mutual, Midwest Steel Erection v. Ill. Ins. Guar. Fund,* 578 N.E.2d 1235 (Ill. App. Ct. 1991); *Monical Mach. Co. v. Mich. Prop. & Cas. Guar. Ass'n.,* 473 N.W.2d 808 (Mich. Ct. App. 1991).

[148] See *Union Gesellschaft Fur Metal Industrie Co. dba Union Frondenberg USA Co. v. Illinois Ins. Guar. Fund,* 190 Ill. App. 3d 696, 158 Ill. Dec. 21, 546 N.E.2d 1076 (5th Dist. 1989*); In Re Liquidations of Reserve Ins. Co., et al.,* 524 N.E.2d 555, 122 Ill. 2d 555 (1988) (claims of ceding insurers entitled to general creditor status, below claims of policyholders); *In Re Liquidation of Security Cas. Co.,* 537 N.E.2d 775, 127 Ill. 2d 434 (1989) (constructive trust and rescission claims of defrauded shareholders denied in view of statutory priority scheme, which provides exclusive remedy thus precluding use of inconsistent equitable remedies); *Morris v. Jones,* 545 U.S. 539 (1947) (full faith and credit clause required Illinois liquidator to recognize judgment entered post-liquidation by Missouri court against insolvent Illinois insurer); *Matter of Ideal Mutual Ins. Co. (Midwest Steel) v. Ill. Ins. Guar. Fund,* 218 Ill. App. 3d 1039, 578 N.E.2d 1235 (1st Dist. 1991) (policyholder protection claim not covered by Ill. Guaranty Fund because claim did not satisfy statutory requirement for timely proof of claim in the estate); *Kent County Mental Health Center v. Cavanaugh,*659 A.2d 120 (R.I. 1995); *A.O. Smith Corp. v. Wisc. Security Fund,* 217 Wis.2d 252, 580 N.W.2d 348 (Wis. Ct. App. 1998).

[149] See *Excess and Casualty Reinsurance Ass'n v. Insurance Comm'r of Cal.,* 656 F.2d 491 (9th Cir. 1981); *American Reinsurance Co. v. Insurance Comm'r of Cal.,* 527 F. Supp. 444 (C.D. Cal. 1981); *Skandia American Reinsurance Corp. v. Barnes,* 458 F. Supp. 13 (D. Colo. 1978*); Skandia American Reinsurance Corp. v. Schenck,* 441 F. Supp. 715 (S.D.N.Y. 1977).

[150] See *Massachusetts Motor Vehicle Reinsurance Facility v. Commissioner of Insurance,* 379 Mass. 527 (Mass. 1980).

[151] *Id.*

the insurer's receiver and the state guaranty association as to which was entitled to the reinsurance proceeds.

The court held that the guaranty association had a direct right to the proceeds the state-created reinsurance facility owed the insolvent insurer. The court reasoned that the reinsurance fund was created to benefit the public. To remit these proceeds to the receiver would give the estate, along with preferred creditors, a legislatively unintended windfall. The court held that it was the intent of the legislature for the association to recover the reinsurance proceeds.

3. Subrogation

Guaranty associations have also attempted to collect reinsurance proceeds from a reinsurer through the equitable doctrine of subrogation. Subrogation is the right of a party who has paid an obligation to collect money from another party who should have paid the obligation. In the reinsurance proceeds context, subrogation allows a guaranty association to step into the shoes of the insolvent insurer and acquire any right to reinsurance proceeds. However, just as a guaranty association has no right to direct payment of reinsurance proceeds, a guaranty association cannot obtain reinsurance proceeds by way of subrogation.[152]

A guaranty association will not have a right to reinsurance proceeds through subrogation due to the association's position after it pays a claim. A reinsurance contract is between the ceding company and the reinsurer. Courts have uniformly held that individual policyholders have no right to reinsurance proceeds because they are not parties to, or third-party beneficiaries of, the reinsurance contract. After a guaranty association pays a claimant, it is subrogated to the claimant's rights against the estate but not against the reinsurer of the estate. Therefore, because a claimant has no rights against the reinsurer, the guaranty association has no right to reinsurance proceeds.[153]

4. NAIC Proposed Reporting Guidelines

The domiciliary receiver has an important relationship with the reinsurer of an insolvent insurer, which may be complicated by the involvement of one or more guaranty associations. Reinsurers request loss reporting information from receivers, and guaranty associations often are the only repositories for this information. It is the receiver's responsibility to establish requirements for guaranty association reporting to the receiver.

The NAIC strongly encourages receivers to consult with guaranty associations and other receivers when creating reporting requirements. To enhance these relationships and the efficient administration of insolvent estates, the NAIC publishes Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers by Insolvent Property and Casualty Insurers. (See Exhibit 9-1.)

G. Priority of Claims

Order of Distribution

The Liquidation Model Act sets forth the priority of distribution of claims from the insolvent insurer's estate. However, statutory priorities differ substantially from state to state. The Liquidation Model Act requires that every claim in a class be paid in full before members of the next class receive any payment on their claims. It also prohibits the establishment of subclasses. Paraphrased, the order of distribution found in the Liquidation Model Act is:

Class 1. Costs of administration;

[152] See *Excess and Casualty Reinsurance, 656 F.2d at 495; American Reinsurance,* 527 F. Supp. at 457.

[153] *Id.*

Class 2. Administrative expenses of guaranty associations;

Class 3. Policyholder, third-party claims and guaranty association claims under policies;

Class 4. Claims of the federal government other than under policies;

Class 5. Limited compensation for employee services;

Class 6. General creditor claims;[154]

Class 7. Claims of a state or local government for a penalty or forfeiture;

Class 8. Surplus notes or similar obligations;

Class 9. Claims of shareholders or other owners in their capacity as shareholders;

In IRMA, the order of distribution under Alternative 1 is:

Class 1. Costs of administration;

Class 2. Expenses of guaranty associations;

Class 3. Policyholder, third-party claims and guaranty association claims under policies;

Class 4. Claims under financial guaranty and mortgage guaranty insurance policies;

Class 5. Claims of the federal government other than under policies;

Class 6. Limited compensation for employee services;

Class 7. General creditor claims;

Class 8. Claims of a state or local governments, and claims for services and expenses in opposing the delinquency proceeding;

Class 9. Claims for penalties, forfeitures and punitive damages;

Class 10. Late filed claims;

Class 11. Surplus notes or similar obligations;

Class 12. Interest on allowed claims if approved by receivership court;

Class 13. Claims of shareholders or other owners in their capacity as shareholders.

Alternative 2 places defense and cost containment expenses of guaranty funds in Class 3, while remaining expenses of guaranty funds are in Class 2.

Realistically, administrative expenses and guaranty association expenses may exhaust the estate's assets. Therefore, policyholders must rely upon state insurance guaranty funds for the payment of

[154] Most states do not expressly refer to cedent's claims. *See In re Liquidation of Security Casualty Co.,* 127 Ill. 2d 434, 537 N.E.2d 775, 130 Ill. Dec. 446 (1989); *Foremost Life Insurance Co. v. Indiana Department of Insurance as Liquidator for Keystone Life Insurance Co.,* 274 Ind. 181, 409 N.E.2d 1092, 78 Ind. Dec. 346 (1980); *Neff v. Cherokee Insurance Co., in Receivership,* 704 S.W.2d 1 (Sup. Ct. Tenn. 1986); *Covington v. Ohio General Ins. Co.,* 99 Ohio St.3d 117, 789 N.E.2d 213 (2003).

claims and the return of unearned premiums. Once a guaranty fund pays a claim, it is subrogated to the rights of the claimant against the insolvent insurer's estate.

H. Early Access

Many states have adopted the early access provision in the Liquidation Model Act. An early access statute enables a guaranty association to obtain liquid assets from an insolvent insurer's estate prior to a final order of distribution. The purpose of the statute is to add to the guaranty association's capacity to pay policyholder claims and expenses as well as reduce the necessity for assessments against solvent member insurers. § 38 of the Liquidation Model Act requires a receiver to submit to the court a proposal to distribute assets to guaranty associations:

> Within 120 days of a final determination of insolvency of an insurer by a state court of competent jurisdiction, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshaled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency.[155]

North Carolina has addressed the question of which associations will be subject to the early access statute.[156] The court held that the guaranty association was entitled to use funds from a special deposit. Pursuant to state statute, an insurer deposited funds with the state treasurer as a condition of doing business in North Carolina. After the insurer's insolvency, the guaranty association asserted a right to the deposit to cover claims and expenses. A "quick access" statute authorized the guaranty association to expend any insurer deposits. The court reasoned that these deposits were placed in trust for the protection and benefit of policyholders. Therefore, the guaranty association was authorized to expend the deposits to pay covered claims and all its expenses relating to the insolvent insurer.

In another case,[157] the court held that a guaranty fund was entitled to a credit balance held by a reinsurance facility. The court rejected the argument that the credit balance was an asset that the receiver could recover. The guaranty fund was perceived as standing in the shoes of the insolvent insurer since it paid all claims against the insurer. The court reasoned that by giving the money to the guaranty fund, it placed more money in the hands of the member insurers, thus lowering the fund's costs and policyholders' premiums.

IRMA's early access provision is at § 803, and its intent is to spell out all aspects of an early access plan thereby eliminating the need for an early access agreement.

I. Guaranty Association's Right to Subrogation and Salvage on Claims Paid

1. Subrogation

When a guaranty association pays a claim on behalf of an insolvent insurer, the guaranty association is generally considered to step into the shoes of that insurer. Then, through subrogation, a guaranty association may seek indemnity from a third party as if it were the insolvent insurer.[158] Model #540 Section 8A(2) provides:

- The association shall…

[155] Liquidation Model Act, at Section 38; IRMA §803 B.

[156] See *State of North Carolina v. Reserve Ins. Co.,* 303 N.C. 623 (1981).

[157] *North Carolina Reinsurance Facility v. North Carolina Ins. Guar. Ass'n,* 67 N.C. App. 359, 313 S.E.2d 253 (1984).

[158] See Model 540 at Section 8A(2). However, while the guaranty association does provide insolvency insurance, it does not "stand in the shoes" of the insolvent insurer for all purposes. See also *Biggs v. California Ins. Guar. Ass'n,* 126 Cal. App. 3d 641, 179 Cal. Rptr. 16 (2d Dist. 1981).

- be deemed the insurer to the extent of its obligation on the covered claims and to that extent shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association.

Courts usually permit a guaranty association to seek subrogation.[159]

2. Subrogation Based on "Net Worth" or "Affiliation"

Similar to a net worth exclusion, some states statutorily provide the guaranty association the right to recover funds paid on behalf of persons who have a certain net worth or affiliation. Model #540 provides:

- The Association shall have the right to recover from the following persons the amount of any "covered claim" paid on behalf of such person pursuant to the Act:
  - Any insured whose net worth on Dec. 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds $50 million and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act; and
  - Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act.

Thus, a guaranty association may effectively seek reimbursement for claims paid on behalf of parties whose assets exceed a statutorily given threshold.[160] State net worth provisions vary widely, so it is critical to consult a particular state's law when confronting a possible net worth issue.

V. LIFE & HEALTH GUARANTY ASSOCIATIONS

This section addresses legal issues that have the potential for significant impact on the relationship between life and health guaranty associations and receivers. Because guaranty association statutes vary from jurisdiction to jurisdiction, the information contained here is necessarily general in nature. The NAIC Life and Health Insurance Guaranty Association Model Act (#520) is used as a basis for this discussion, and factual examples are drawn from cases.[161] When analyzing a specific problem, the law of the subject jurisdiction should be consulted.

A. Jurisdiction

Documents executed jointly by receivers and guaranty associations including Early Access Agreements typically will contain provisions that expressly address jurisdictional issues and often provide that the domiciliary liquidation court has limited jurisdiction over the guaranty association solely for the purpose of resolving disputes under the agreement. When the size of the liquidation or other factors require an enhancement agreement (enhancement of a deficient liquidation estate by means of a multi-state implementation of guaranty association statutory obligations, negotiated in concert through the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA)), typically the documents establish that jurisdiction regarding the powers and duties of the guaranty associations and the interpretation of their governing statutes is reserved to the state courts of each participating association. In addition,

[159] See generally *Dan Reid Ford, Inc. v. Feldman,* 421 So. 2d 184 (Fla. App. 5th Dist. 1982).

[160] But see *North Carolina Ins. Guar. Ass'n. v.Guilford Tech*, 648 S.E.2d 859 (2007) (Sovereign immunity prevents Association from recovering payments made on behalf of high net worth insured)

[161] See NAIC Life and Health Insurance Guaranty Association Model Act [hereinafter Model #520].

guaranty associations may exercise the right to determine these legal issues locally through declaratory judgment actions.[162]

Similarly, it has been held that personal jurisdiction over a foreign guaranty association could not be successfully asserted by a beneficiary who filed suit in the state of the policyholder's residence.[163]

In addition, attempts to have federal bankruptcy courts assert jurisdiction over insolvent insurers have failed, thus preserving the relationships between receivers and guaranty associations as established under state statutes.[164]

B. Standing

Courts have held that guaranty associations have standing to appear in any court with jurisdiction over the impaired insurer in order to enable the guaranty association to protect its interests and to address the best interests of the policyholders.[165] Model #520 contains similar language, although it recognizes that guaranty associations have the standing to intervene as well. Under Model #520, a guaranty association's standing to appear or intervene extends to all matters germane to the powers and duties of guaranty associations, including the determination of the policies or contracts and contractual obligations.[166] In the context of a court proceeding to approve the settlement of a receiver's recoupment action, it has been held that guaranty associations should have access to the underlying records and should be afforded an opportunity to be heard, although without granting the formal status of standing.[167] A guaranty association that receives a valid assignment of an ERISA fiduciary breach claim can have derivative standing to bring such a claim. But on the facts of the case, the court held that ERISA preempts a state statute purporting to assign such claims by operation of law. Applying federal law, the court determined that the assignment was invalid because the fiduciary breach claims were not expressly and knowingly assigned to the guaranty association.[168]

C. Abstention

Some federal courts have declined to exercise jurisdiction over guaranty associations for the purpose of interpreting the provisions of the state guaranty association act, citing the principles of the Burford abstention doctrine.[169]

D. Triggering of Guaranty Associations

Guaranty associations primarily act after the entry of an order of liquidation upon the finding of insolvency. However, some statutes give guaranty associations discretion to act in cases of an impaired insurer to guarantee, assume or reinsure any or all policies or otherwise provide money to the insurer. Some statutes

[162] See *New Mexico Life Insurance Guaranty Assoc. v. Moore,* 93 N.M. 47, 596 P.2d 260 (1979).

[163] *Pennsylvania Life & Health Ins. Guaranty Ass'n. v. Superior Court,* 22 Cal. App. 4th 477, 27 Cal. Rptr. 2d 507 (Ct. App. 1994).

[164] *In the Matter of Estate of Medcare HMO,* 998 F.2d 436 (7th Cir. 1993); *In re Family Health Services, Inc.,* 143 B.R. 232 (C.D. Cal. 1992); *In re Master Health Plan*, 1997 U.S. Dist. Lexis 22880 (S.D. Ga. 1997).

[165] See *Maryland Life and Health Insurance Guaranty Association v. Perrott,* 301 Md. 78, 482 A.2d 9 (1984).

[166] See Model #520, at Section 8J.

[167] *In the Matter of the Liquidation of American Mutual Liability Insurance Co.,* 417 Mass. 724, 632 N.E.2d 1209 (Mass. 1994).

[168] *Texas Life, Accident, Health & Hospital Service Insurance Guaranty Association v. Gaylord Entertainment Co.,* 105 F.3d 210 (5th Cir. 1997).

[169] See *Metropolitan Life Insurance Co., et al. v. Wisconsin Insurance Security Fund,* 572 F. Supp. 460 (W.D. Wis. 1983); *Clark v. Fitzgibbons,* 105 F.3d 1049 (5th Cir. 1997), and *Feige v. Sechrest,* 90 F.3d 846 (3rd Cir. 1996). See also *Quackenbush v. Allstate,* 517 U.S. 706 (1996).

empower guaranty associations to act only after the liquidation order becomes final.[170] In order to facilitate this, it is important that the receiver work with the guaranty associations at the earliest possible moment.

E. Continuation of Coverage

A primary concern with life insurance companies is continuance of a company's contractual obligations, which are generally long-term in nature. The state guaranty associations are required by the life and health insurance guaranty association acts (many of which are patterned on Model #520) to ensure payment of benefits similar to the benefits that would have been payable under the policies of the insolvent insurer subject to statutory limits. The basic purpose of this approach is stated in a comment to the Model #520, "Unlike the property and liability lines of business, life and annuity contracts in particular are long term arrangements for security. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar coverage from other insurers. The payment of cash values alone does not adequately meet such needs. Thus, it is essential that coverage be continued. In like manner, an insured may be unable to obtain new health insurance or, at least, he may lose protection for prior illness."[171] Some guaranty associations may offer substitute coverage either by reissuing terminated coverage or issuing alternative policies.

Often, an attempt will be made to rehabilitate the company. This is particularly appropriate if the reason for the company's troubles is investments, such as real estate, that have not increased in value as expected. By restructuring the policyholders' contracts and prohibiting policyholders from withdrawing money for a period of time, it may be possible to allow the investments to realize their full potential.

If rehabilitation is not possible, attempts will likely be made to find a company that will guarantee, assume or reinsure the life policies and annuity contracts of the insolvent insurer. The receiver and the guaranty associations will generally cooperate closely in this effort. Life insurance insolvencies often involve many states because most life companies offer their products in multiple states. Therefore, the receiver may have to work with many guaranty associations. This effort can be facilitated and coordinated by NOLHGA (See Chapter 6(III)(A).)

F. Assumption Reinsurance

Whenever possible, NOLHGA will assist the receiver in transferring future policy obligations to a solvent insurer.[172] This may require executing numerous assumption reinsurance documents and extensive cooperation between the guaranty associations and the receiver. The assuming carrier may be required to obtain approval of assumption certificates in the states where the insurer did business. The NOLHGA may also assist the receiver in resolving a number of particular legal issues including policyholder notice, policyholder consent, contingent liability accounting and preservation of tax losses or other tax benefits. Whether the receiver or the guaranty associations are entitled to the ceding commission is subject to debate.[173]

G. Residency

Following Model #520, all guaranty association laws limit their protection generally to policyholders who reside in the state.[174] There are exceptions to the resident-only coverage rules. For example, persons who are not eligible for coverage by the guaranty association in their state of residence are usually covered by

[170] See Model #520, *supra* note 147, at Section 8A.

[171] See Model #520, *supra* note 147, at, Section 8L.

[172] See Model #520, at Section 8M.

[173] For one of the few disputes which has led to completed litigation, see *Continental Security Life v. Missouri Life and Health Ins. Guar. Assn.,* Cole County Cr. Ct., Case No. CV189-546CC 12-16-94, holding that ceding commissions are assets of the estate; however, insolvency plans in other cases have been structured and approved by courts on a different basis.

[174] See Model #520, at Section 3A.

the guaranty association of the domiciliary state of the insolvent insurer.[175] A related issue is whether the guaranty association laws of the other state provides substantially similar coverage for residents of the domiciliary state. This issue has been addressed by two states.[176] Another related issue that Idaho has addressed is how the obligations of relevant guaranty associations are affected by the residency of a certificate holder under a group policy.[177] Finally, an emerging legal issue is the coverage eligibility of residents who are not citizens of the U.S.[178] Under Model #520, the situs of coverage for unallocated annuities is the state of the principal place of business of the plan sponsor.[179] The situs of coverage for structured settlement annuities is the residency of the payee.[180]

H. Eligibility of Insurer

A guaranty association is obligated to provide benefits to those persons who are covered under contracts issued by a "member insurer."[181] The definition of "member insurer" varies from state to state. For example, one case discussed whether certain group health insurance for a self-funded trust constituted "direct disability insurance" under the state's guaranty association act.[182] Similar disputes have generated litigation over whether health maintenance organizations are to be included under a non-model act.[183] The courts have not yet addressed a number of legal issues regarding the eligibility of an insolvent insurer in instances involving mergers or assumptions occurring between various combinations of licensed and unlicensed companies.[184] Under the Model #520, a health maintenance organization is excluded from the definition of "member insurer."[185]

I. Exclusions from Coverage

There are specific exclusions from guaranty association coverage,[186] including reinsurance unless assumption certificates have been issued[187] and any portion of a contract under which the risk is borne by the contract holder.[188] Local variances in statutory language may lead to legal disputes. In one case decided under New Mexico's guaranty association act, the court found that the insurer's single premium deferred annuity contracts were not included among the covered contracts.[189] Other states have specific exclusions

[175] See Model #520, at Section 3A(2)(b).

[176] See Idaho Attorney General Opinion No. 78-35, 1978 Op. Atty. Gen'l. 140 (8-24-78).

[177] See Idaho Attorney General Opinion No. 78-35, 1978 Op. Atty. Gen'l. 140 (8-24-78).

[178] See Texas Attorney General Opinion No. JM-1223, which determined that an individual need not be a U.S. citizen or a legal alien to qualify as a resident for purposes of guaranty fund protection.

[179] See Model #520, Section 3A(3)(a).

[180] See Model #520, at Section 3A(4)(a).

[181] See Model #520, at Section 5L.

[182] See *SouthTrust Bank of Alabama v. Alabama Life and Disability Ins. Guaranty Assn.,* 578 So. 2d 1302 (Ala. 1991). See also *Intervenor Policyholders of American Indemnity Trust v. Oklahoma Life and Health Ins. Guar. Assn.,* 825 P.2d 1341 (Okla. 1992).

[183] See *New Mexico Life Ins. Guaranty Assn. v. Moore,* 93 N.M. 47, 596 P.2d 260 (1979).

[184] Model #520, at Section 3B(2)(f).

[185] See Model #520, at Section 5L(2).

[186] See Model #520, at Section 3B(2).

[187] See Model #520, at Section 3B(2)(b).

[188] See Model #520at Section 3B(2)(a).

[189] See *New Mexico Life Ins. Guar. Assn. v. Quinn & Co,* 111 N.M 750, 809 P.2d 1278 (1991).

for municipal guaranteed interest contracts, unallocated funding obligations or structured settlements.[190]/[191] Also, Minnesota held that certain unallocated funding obligations must be included in the "annuity" assessment base. This issue directly affected the capacity of the guaranty fund to pay the outstanding claims.[192] Guaranty association statutory coverage for guaranteed investment contracts varies across the country with approximately 26 guaranty associations covering them to some extent, 25 excluding coverage and one silent on the subject. Arizona, Maryland and Pennsylvania held that certain guaranteed investment contracts were covered contracts.[193] Courts in California, Michigan, New Mexico, Oklahoma, South Carolina, Texas and Virginia have reached opposite conclusions.[194]

J. Benefit Limitations

An Illinois court held that a guaranty association's liability to annuitants was limited only as to the annuitants' rights to withdraw part or all of the immediate value of the contract before maturity.[195] The guaranty association argued that the law limited their obligation to $100,000 because annuity payouts were based on cash value. The Illinois Director of Insurance argued that the $100,000 limit referred only to the right to withdraw part of the cash value prior to maturity and that the general $300,000 limitation should apply. The court held that the guaranty association law should be construed liberally to effect its purpose in protecting policyholders and ruled in favor of the higher limitation.[196]

There is some variation from state to state in the dollar limits of specific benefits by guaranty associations. In addition, life and annuity contracts may be subject to interest limitations as set forth in the Model #520.[197] And finally, at least one state's guaranty association applies a deductible to certain life and health claims.[198]

K. Priority of Claims

The priority of distribution from an insolvent insurer's estate may become the subject of differing legal interpretations, such as in the context of the appropriate priority for life and health administrative claims of various sorts submitted by guaranty funds. This issue also is addressed by the Liquidation Model Act and by IRMA. However, care must be taken to determine which version of the model has been enacted in the domiciliary state. With regard to the relative priority between claims of the federal government and guaranty association claims for both benefits paid and administrative expenses, recent cases appear to have preserved the statutory priority of the guaranty association claims, although there has been no final

[190] See Model #520, *supra* note 147, at Section 3B(2)(g) and (h). California is one of over a dozen jurisdictions whose guaranty fund statutes have for certain periods specifically excluded unallocated funding obligations from coverage. New York is one of the jurisdictions that specifically covers such obligations.

[191] The Iowa Life and Health Guaranty Association for certain periods has not covered structured settlement annuities.

[192] See *Minnesota Life and Health Ins. Guaranty Assn. v. Dept. of Commerce,* 400 N.W.2d 769 (Minn. Ct. App. 1987).

[193] *Arizona Life & Disability Ins. Guar. Fund v. Honeywell, Inc*., 190 Ariz. 84, 945 P.2d 805 (Ariz. 1997); *Board of Trustees of the Maryland Teachers & State Employees Supplemental Retirement Plans v. Life and Health Ins. Guar. Corp.,* 335 Md. 176, 642 A.2d 856 (1994); *UNISYS Corp. v. Pennsylvania Life and Health Ins. Guar. Ass'n.,* 667 A.2d 1199 (Pa. Cmwlth. 1995), *aff'd,* 684 A.2d 546 (1996).

[194] *UNISYS Corp. v. California Life and Health Ins. Guar. Ass'n.,* 63 Cal. App. 4th 634, 74 Cal. Rptr. 2d 106 (Ct. App., 1998); *Henry L. Meyers v. Michigan Life & Health Ins. Guar. Ass'n*., 222 Mich. App. 675, 566 N.W. 2d 632 (1997); *Krahling v. First Trust National Assoc*., 944 P.2d 914 (N.M. Ct. App. 1997); *Oklahoma Life & Health Ins. Guar. Ass'n*. v. *Hilti Retirement Sav. Plan*, 939 P.2d 1110 (Okla. 1997); *South Carolina Life and Accident and Health Ins. Guar. Ass'n*. v. *Liberty Life Ins. Co*., 500 S.E.2d 193 (S.C. Ct. App. 1998), *aff'd,* 2001 S.C. Lexis 63 (S.C. April 2, 2001); *Unisys Corp. v. Texas Life, Accident, Health & Hospital Serv. Ins. Guar. Ass'n*., 943 S.W.2d 133 (Tex. Ct. App. 1997); and *Bennet v. Virginia Life, Accident and Sickness Ins. Guar. Ass'n*., 251 Va. 382, 468 S.E.2d 910 (1996).

[195] See *Matter of Georgetown Life Ins. Co.,* 148 Ill. App. 3d 360, 102 Ill. Dec. 204, 499 N.E. 2d 984 (1st Dist. 1986), appeal denied*,* 106 Ill. Dec. 46, 506 N.E. 2d 352 (1987).

[196] *Id.*

[197] See Model #520, *supra* note 147, at Section 3B(2)(c).

[198] See e.g., Wis. Stat. Ann. Section 646.31(3) (West 2000).

resolution of the issue to date.[199] This preservation of statutory priority to guaranty association claims over those of the federal government was confirmed recently in *Ruthardt v. United States of America*.[200] In Ruthardt, the United States Court of Appeals for the 1st Circuit reviewed the holding in Fabe and concluded that when the issue is the payment of promised benefits to policyholders or, as here, the funding of such payments, Fabe places the priority within the protection of McCarran-Ferguson. The court held that the federal claim priority statute did not preempt the priority accorded to guaranty associations' reimbursement claims.[201]

Litigation has arisen concerning the status of various claims under pertinent state liquidation statutes. In a major liquidation proceeding, the California Insurance Commissioner, acting as conservator, determined that owners of Municipal Bond Guaranteed Investment Contracts (Muni-GICs) would not be given claims priority status as "policyholders" but would be given lower priority status (all other claims). In reversing this determination, a California appellate court examined California's liquidation statute and the historical treatment of annuities-certain, and ruled that Muni-GICs are entitled to liquidation priority as "policyholder claims."[202]

L. Early Access

1. General

For a discussion of the general legal issues surrounding early access distributions to guaranty associations, see above (refer to specific section for P&C). The availability of early access is important in life and health insurer insolvencies, which often involve the transferring policy obligations through assumption reinsurance. Guaranty associations typically incur significant up-front costs in those transactions. Early access distributions are an effective way of defraying those costs, thereby lessening the need for assessments on member insurers.

2. Security Deposits

Early Access agreements between receivers and guaranty associations often provide that any security deposit obtained by the guaranty association will be treated as an early access distribution. However, in a U.S. Supreme Court decision, it was decided that the guaranty association could not claim the sole right to a local deposit when the Indiana domiciliary rehabilitation court previously had approved a plan that included the deposit.[203]

M. Enhancement Plans

In recent life insurer insolvencies, receivers working in cooperation with NOLHGA, affected guaranty associations, and in some cases the insurance industry, developed innovative plans to remedy the insolvency and benefit policyholders. The most common arrangement involves a healthy company assuming the business of the insolvent insurer, with financial support from the receivership estate and guaranty associations. Other plans have included contributions from the insurance industry to protect the account

[199] See *United States Dept. of Treasury v. Fabe,* 508 U.S. 491, 113 S. Ct. 2202 (1993); *Kachanis v. United States, et al.,* 844 F. Supp. 877 (D.C. R.I. 1994); *Boozell v. United States,* 979 F. Supp. 670 (N.D. Ill. 1997); *but see Garcia v. Island Program Designer, Inc.,* 4 F.3d 57 (1st Cir. 1993). Regarding priority in general, see also the Ohio *Duryee* decision discussed in Chapter 5.

[200] *Ruthardt v. United States of America*, 303 F.3d 375 (1st Cir. 2002).

[201] "[P]riorities that indirectly assure that policyholders get what they were promised can also trigger McCarran-Ferguson protection; the question is one of degree, not of kind." *Id. at382.*

[202] *Texas Commerce Bank v. Garamendi,* 11 Cal. App. 4th 460 (Ct. App. 1992).

[203] See *North Carolina Life and Accident and Health Insurance Guaranty Association v. Underwriters National Assurance Co.,* 48 N.C. App. 508, 269 S.E.2d 688 (1980), *rev'd,* 455 U.S. 691 (1982).

values of uncovered policyholders and the creation of a new insurance company by NOLHGA and the affected guaranty associations to assume the business of the failed insurer.[204]

Courts have held that these plans are sufficient to discharge the statutory obligations of individual guaranty associations and operate to bind individual policyholders who participate in the plans.[205] Guaranty associations take the position that policyholders who opt out of enhancement plans waive their rights to object to the method chosen by the association to discharge its obligations and have no further rights against the association. Courts accept this position with mixed results.[206]

N. Constitutional Issues

The constitutionality of the general guaranty association mechanism and assessment process was established by the Supreme Court of the State of Washington in a 1974 decision.[207]

A number of specific constitutional issues have been addressed by decisions involving property and casualty guaranty associations, some of which may be applicable to all guaranty funds. Virtually all courts addressing the issue have found that the application of a guaranty association statutory amendment to pre-existing claims does not violate constitutional standards.[208]

VI. ACCOUNTING AND FINANCIAL ANALYSIS

The goal of the receiver should be directed toward making sure that accountants identify insurer and HMO assets, liabilities, operational needs, obligations (including, but not limited to, reinsurance treaties, excess of loss or stop loss policies and third party administrator agreements), transfers and conveyances so that the receiver can comply with the restrictions, limitations and requirements imposed upon the estate. It is important to identify, as early as possible, accounting issues that may require the employment of outside consultants (e.g., valuation of derivatives, swap agreements and retrospectively rated premiums).[209] The accountants play an integral role in the valuation of assets and liabilities, the determination of operational needs and the implementation or structuring of receivership plans. It is also important that books and records are organized so accounting objectives can be coordinated with the objectives of other sections including claims, auditing, legal and administration. Coordination is designed to preserve the insurer's assets, enhance asset recovery and to limit liability to the greatest extent possible. Tax issues are considered in detail in Chapter 3—Accounting and Financial Analysis, section on Tax Issues.

VII. DATA PROCESSING

Data regarding an insurer that has been put into receivership may be important to orderly receivership proceedings. Data can also constitute important evidence in legal proceedings. Electronically stored data is no exception.

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[204] See e.g., the Rehabilitation Plans for Executive Life Insurance Company, Mutual Benefit Life Insurance Company, and Guaranty Security Life Insurance Company.

[205] *Lawrence v. Illinois Life & Health Guar. Assn.,* 688 N.E.2d 675 (Ill. App. Ct. 1997).

[206] Ruling for the association was *McCulloch v. Washington Life & Disability Ins. Guar. Assn.,* King County Super. Ct., Washington, Aug. 4, 1995; ruling the other way was a decision in an Illinois administrative ruling, *BW/IP International v. Illinois Life & Health Guar. Assn.,* Jan. 18, 1996.

[207] *Aetna Life Ins. Co. v. Washington Life & Dis. I.G. Ass'n.,* 83 Wash. 2d 523, 520 P.2d 162 (1974).

[208] See e.g., *Honeywell, Inc. et al. v. Minnesota Life and Health Ins. Guar. Ass'n.,* 110 F. 3d 547 (8th Cir. 1997), and *Reinsurance Association of Minn. v. Dunbar Kapple,* Minn. Ct. App. Aug. 1, 1989.

[209] The Insurers Rehabilitation and Liquidation Model Act and IRMA clarify the treatment of swaps and derivatives when an insolvent insurance company has been a party to one of these agreements (see Section 46 and Section 711 respectively). The general intent was to make the insolvency treatment of these instruments, for a failed insurance company, the same as for other financial services institutions.

Electronically stored information presents a number of practical problems which may have important ramifications for the receiver's legal position. These practical problems include the following:

- Specialized skills. Retrieving the electronically stored information and presenting it in a meaningful fashion often requires specialized skills.

- Easily altered. The stored information can be modified, manipulated, copied or deleted easily and quickly.

- Portability. Because a large volume of information can be stored electronically in a small space, electronic information is more portable than a comparable volume of hard copy records.

The types of information the insurer may maintain in electronic form is as varied as the information used by the insurer. Often, the term "data processing" is assumed to refer only to the insurer's large system for keeping detailed data on policies, premiums, claims and other high volume transactions. However, other information, such as reinsurance transactions, agency information, accounting information, correspondence, customer lists, telephone logs and even notes maintained by individuals may be maintained in electronic form. As used herein, the term "data" refers to any information maintained in electronic form.

Data will also be generated by the receiver after taking over the insurer. If the insurer is being rehabilitated, the type of data the receiver inputs and maintains will be substantially similar to the insurer's data, though it may be maintained in a different manner. If the insurer is being liquidated, the receiver's data will include additional and different data. Such data could include a claims tracking system to monitor the sending of notices and communications to potential claimants.

This subchapter will examine some of the ways in which electronically stored information may present unique legal issues for the receiver. This subchapter examines how to: 1) take control of data so as to minimize data loss; 2) secure the insurer's data that may be in the possession of uncooperative third parties; 3) examine any evidentiary problems that may arise from the loss of data maintained in a data processing system; and 4) examine the issues surrounding the discovery of data maintained by the insurer or imputed by the receiver.

A. Taking Control of the Data

Seldom is all of the insurer's data stored in one integrated computer system. Typically, the insurer will have a large system that maintains detailed information, such as policies and claims, while other information, such as reinsurance recoverables, agent balances, investment portfolio and accounting information is maintained on other systems—most frequently personal computers (PCs). PCs are often used for word processing, spreadsheet and small database applications.

Data may not be located on the premises of the insurer. Some insurers still use off-site mainframe computer services on a time-sharing basis. Also, increasingly, the data processing functions for certain books of business are performed by managing general agents (MGAs), third-party administrators (TPAs), or other businesses associated with the insurer. In addition, even if the computer equipment itself is located at the offices of the insurer, persons outside of the insurer may have access to those computers. Information may also be maintained on portable laptop computers that officers of the insurer may easily carry away with them.

Because the data may be located off premises, the court order should direct the receiver to take control of all documents and records of the insurer, wherever situated, including insurer records maintained by agents, brokers, management contractors and third-party administrators with whom the insurer does business. The order should further enjoin any disposition or modification to those documents and records. In this regard, it should be noted that the Federal Rules of Civil Procedure, and state rules that are typically patterned after the Federal Rules, define documents as including "data compilations from which information can be obtained, translated, if necessary, by the respondent through detection devices into reasonably usable

form."[210] In § 104V(3) of IRMA, the definition of "property of the insurer" or "property of the estate," includes:

> All records and data that are otherwise the property of the insurer, in whatever form maintained … within the possession, custody or control of a managing general agent, third-party administrator, management company, data processing company, accountant, attorney, affiliate or other person.

See also § 118 A. of IRMA, which requires TPAs, MGAs, agents, attorneys and other representatives of the insurer to release records to the receiver.

Once the order is obtained, the seizure must be executed in such a way as to minimize the likelihood that any valuable information will be inadvertently or deliberately lost. Typically, immediately preceding the seizure, the state's examiners will be focusing on the insurer. During this time, the examiners will obtain an understanding as to how the insurer maintains its data, where such data is located and who has access to modify the data. When fraud by officers or others with access to data is suspected, special efforts should be made to execute the seizure in such a way as to preserve that data, especially private notes and communications that may be found on personal computers.

The decision as to whether a computer contains useful data should be made only by a data processing expert. Often, data that would appear to a novice to have been deleted from a computer can in fact be retrieved by a person who is knowledgeable about the computer system. This is especially true of personal computers. When a file is deleted from a personal computer, the file actually remains on the disk, but the computer designates the space occupied by those files as available to be overwritten with new information. A knowledgeable data processing person can recover the original file, which may contain valuable information.

B. Legal Action Against Others to Obtain Data

While a court order will permit a receiver to assert control over records of the insurer that are in the hands of third parties, it may be necessary to enforce the order against those parties. If the receiver believes that a third party will not voluntarily comply with the order, or does not trust the third party to properly comply with the order, it may be necessary to enlist the assistance of courts and law enforcement to obtain compliance.

The initial question is whether data in possession of a third party really is a record of the insurer. This question is typically answered by applying state law to the relationship between the third party and the insurer. Agreements between the insurer and agents, especially MGAs, may provide that the records of the agent, including not only policy and claims information, but also customer lists, are the property of the insurer. These agreements may also give the insurer the right to audit the third party and obtain copies of data in possession of that third party. Even without an agreement specifically designating the third party's records as the property of the insurer, applicable state law may impose trust or fiduciary obligations upon the third party deeming the third party's data as records of the insurer.

Under these circumstances, the court order gives the receiver authority to take control of the records in possession of a third party. If the receiver expects an agent to be uncooperative, the receiver should make arrangements with local law enforcement officers in order to aid the receiver's representatives when executing the seizure order.

If the third party is located outside of the domiciliary state, the receiver will have to determine how to execute the seizure order in a foreign jurisdiction. If possible, the receiver should obtain the cooperation of regulators in the foreign jurisdiction. It may also be necessary to begin legal action in the foreign jurisdiction

[210] Fed. R. Civ. P. 34(a).

in order to seek enforcement of the seizure order entered by the court in the domiciliary state. If so, it may be preferable to initiate an ancillary receivership.

Such an order from the foreign jurisdiction's court may be sought *ex parte*, without notice to the third party. The order sought should allow the receiver to take immediate possession of the data processing equipment believed to contain the insurer's information, with adequate provision for safeguarding information that may belong solely to the third party or others. The order should direct that before control of the equipment is returned to the third party, a full back-up of all information in the computers should be made and maintained under the control of the receiver subject to further order from the court.

The receiver's ability to obtain such an order from the court in another state is subject to many variables. For example, the likelihood of success in obtaining the order of the foreign court depends on how clearly state law recognizes the insurer's property interest in the data.

If the foreign court refuses to issue an order *ex parte*, then receiver's counsel should send the third party a letter. Notice of the suit and a request for a temporary injunction should accompany this letter. The letter should set forth the insurer's position that it has a property right in the data, should demand that the insurer not destroy any back-up copies of the data and should state that the receiver will hold the agency fully accountable for any information that is lost. To the extent that the insurer's contact with the third party gives the insurer the right to audit the third party, that right should immediately be asserted and an audit should immediately follow.

Once the receiver obtains access to the data, persons knowledgeable about the type of equipment and software utilized by the third party should retrieve the data. For customized systems, this may require the assistance of one or more employees of the third party. The receiver should make efforts to recover information which may have been recently modified or deleted by the third party's personnel.

C. Potential Problems Arising from Loss of Data

Problems that can arise from loss of data are as varied as the types of data used by the insurer or the receiver. The discussion to this point has focused on how the receiver can minimize the loss of data used by the insurer at the time the receiver takes control of the insurer. This section will examine some typical problems which may result from the loss of insurer data. It will also examine problems which may arise from loss of data the receiver inputs after the takeover.

In any action brought by the receiver to recover assets of the insurer, the receiver, as plaintiff, will typically bear the burden of proving that the defendant is liable and the amount for which the defendant is liable. Once liability is established, most states require that the amount of damages need not be proven with mathematical precision, but can be based upon a reasonable estimate. Speculative damages, however, may not be recoverable.

Data typically relates most directly to the amount of damages recoverable in an action by the receiver. What data relates to those damages will depend upon the nature of the action and the receiver's theory of damages. In some cases, the amount recoverable will be calculated in a straight-forward manner from a limited amount of data. For example, a claim for unpaid premiums against an agent requires that the receiver know the amount of premiums due from an agent and the amount actually received. In other cases, including cases against the insurer's directors and officers or outside accountants, the damage theory may base the amount of damages upon the insurer's financial status at different times.

Regardless of the type of case, the amount of damages will be calculated from the data maintained by the insurer. To the extent that the data is impaired, estimates will need to be used. As the need for estimation increases, so does the likelihood that the court may find the ultimate damage figure too speculative to use for an award to the receiver.

The loss of data by the insurer also impairs the receiver's ability to challenge information offered by the opponent. In the minds of most lay people, detailed computer output carries a great aura of accuracy. However, computer data may easily be manipulated. Furthermore, in the final analysis, the computer output is no more accurate than the information that was put into the computer (garbage in, garbage out). To the extent that the insurer lacks its own independent data from which it can assess the amount owed, the receiver's ability to challenge the data provided by the opponent will be impaired.

In certain cases, the availability of detailed data may influence the basis for the damage calculations. For example, when pursuing the directors and officers on claims of mismanagement or misconduct, counsel typically has a choice of damage theories available. Under one damage theory, the amount of damages may be arrived at by adding up losses sustained on a number of individual transactions or programs claimed to have resulted from mismanagement or misconduct. These damages are not easily calculated, however, if the data regarding these transactions or programs has been lost. This may force counsel to select an alternative damage theory, premised on the net shortfall of the insurer at the time it was put in receivership or the net shortfall in satisfying claims during liquidation. Such theories present difficult legal issues, but the amount of damages arrived at under such theories can often be determined from overall financial statement information which is sometimes available without the detailed data.

Data also can be important evidence of liability. If the officers are suspected of fraud, a possible suit by the receiver against them should be anticipated. Such a suit may involve claims under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 USCS §§ 1961, et seq. Those claims may be predicated, in part, upon telephone calls made to further the fraud. Most telephone systems frequently maintain a record of all calls made by the insurer. This data may be important evidence of wire fraud.

Accidental loss of data put into the system by the receiver may also have adverse legal consequences. For example, a claimant may file a claim after the deadline for filing claims has expired, arguing that the receiver never gave proper notice of a claims deadline. Typically, the receiver would rebut such an argument by producing to the court claims tracking data which establishes that the claimant was properly sent a notice of the deadline. Accidental loss of data from the claims tracking system may expose the receiver to a reopening of claims by a claimant who asserts lack of proper notice.

These examples present only some of the potential legal ramifications of data loss. Before destroying data, the receiver should consult with counsel to minimize the risk that any data destroyed will have adverse legal impacts.

D. Discoverability of Data

The Federal Rules of Civil Procedure, and the rules of most states which were patterned after the Federal Rules, make clear that the same rules regarding discovery apply to information stored electronically as to any other information maintained by a party to litigation. Rule 34 of the Federal Rules of Civil Procedure permits any party in litigation to request the inspection and copying of any designated documents, and specifically defines "documents" as including "other data compilations from which information can be obtained, translated, if necessary, by the respondent through detection devices into reasonably usable form."

The Advisory Committee Note of 1970 comments on this definition as follows:

> The inclusive description of "documents" is revised to accord with changing technology. It makes clear that Rule 34 applies to electronic data compilations from which information can be obtained only with the use of detection devices, and that when the data can, as a practical matter, be made usable by the discovering party only through respondent's devices, respondent may be required to use his devices to translate the data into usable form. In many instances, this means that respondent will have to supply a printout of computer data. The burden thus placed on respondent will vary from case to case and the courts have ample power under Rule 26(c) to protect respondent against undue burden or expense, either by restricting discovery or requiring that the discovering party pay costs. Similarly, if the

discovering party needs to check the electronic source itself, the court may protect respondent with respect to preservation of his records, confidentiality of nondiscoverable matter and costs.

Analysis of whether data is discoverable is analytically the same as discovery of other documents or tangible items. The Discovery section of this chapter discusses, in detail, general issues with respect to discovery.

When discovery of data is sought, the respondent must provide that data in reasonably usable form. What that means will depend upon the nature of the data sought. Typically, it is interpreted as requiring the respondent to produce computer printouts. Such printouts may not disclose tampering with the data before it is printed out. Printouts may also provide parties seeking discovery with less information than a copy of the computer data in computer readable form. For example, a computerized printout of accounting information may not communicate underlying relationships between the data which would be disclosed by viewing the underlying formulas. If the information is provided in computer readable form, the underlying formulas may also be disclosed, unless the respondent copying the data takes certain precautions. The medium in which the information will be provided should be considered whenever data is requested from the receiver or by the receiver in litigation.

VIII. INVESTIGATION AND ASSET RECOVERY

A. Introduction

The purpose of this section is to introduce and discuss various fundamental legal issues that have been or may be raised in receiver lawsuits seeking recovery from those who may be liable to the insolvent insurer's estate in connection with an insurer's insolvency. The legal matters reviewed herein are by no means conclusively established; consultation with counsel is essential.

Jurisdictional issues discussed in detail in this chapter in section II(H)—Important Legal Procedural Issues, should be considered in connection with matters discussed in this section.

1. Receiver's Authority to Sue

The authority of the receiver to assert a cause of action is established by relevant state statute and the receivership court's order, see also § 402 and § 504 of IRMA.

2. Receiver's Standing

It is now well established throughout the U.S. that the breadth of a receiver's standing is defined by the language of its statutory authorization. Statutes that vest the receiver with "title to all property, contracts and rights of action of the company" are typically construed to authorize the receiver to bring any suit the company could have brought, but no others.[211] One state has held that only a statute that specifically authorizes the receiver to sue on behalf of third persons creates standing for the receiver to sue on claims that the company could not itself have pursued.[212]

Even where a receiver's authorization is limited to suits on behalf of the company, there are many types of claims that may be pursued. For example, various courts have upheld a receiver's standing to assert claims against an insurer's shareholders, directors and officers for breaches of fiduciary duty and corporate waste, against a controlling stockholder of the insurer for federal securities fraud and breach of fiduciary duties, to enforce an insolvent insurer's creditors' rights against a title company, to set

[211] E.g., *Schacht v. Brown,* 711 F.2d 1343, 1346 n.3, (7th Cir.), *cert. denied,* 464 U.S. 1002 (1983).

[212] See *Frank J. Delmont Agency, Inc. v. Graff,* 55 F.R.D. 266 (D. Minn. 1972) for a discussion of such a statute. The Minnesota statute construed as authorizing the receiver to assert a creditor's claim, is Minn. Statutes § 60B.25, which provides: "Subject to the court's control, the liquidator may… (13) Prosecute any action which may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer, or any other person."

aside fraudulent transfers and to bring an action on behalf of the insurer's policyholders and creditors against a director-majority shareholder for mismanagement and breach of fiduciary duties. Courts have found that both rehabilitators and liquidators enjoy this standing.[213]

One important potential limitation on the standing of a receiver to assert a claim on behalf of the insolvent insurer's creditors may arise from the nature of the creditors' claim. If the claim is one in favor of creditors, in general, arising out of injury to the insolvent insurer and, therefore, injury to creditors of the insurer, the receiver will ordinarily have standing to assert the claim. If, however, the claim is one for special damage done to one group of creditors not common to other creditors, then the action may be found to be personal to the injured creditors and the receiver may not have standing to bring the action.[214]

While it is well established that the receiver has standing to bring suit, states are divided on the question of whether that standing is exclusive. That is whether the fact that the receiver had standing to assert a claim on behalf of a creditor or policyholder of the insolvent insurer precludes that creditor or policyholder from asserting that same claim on his or her own. Some states have said that the receiver's right must be paramount and exclusive so as to avoid disorder and confusion in the administration of the insolvent insurer's affairs. § 504 A(10) of IRMA provides in relevant part:

> The liquidator shall have the power: …. To prosecute or assert with exclusive standing any action that may exist on behalf of creditors, members, policyholders or shareholders of the insurer or the public against any person, except to the extent that the claim is personal to a specific creditor, member, policyholder or shareholder and recovery on the claim would not inure to the benefit of the estate…

Courts in other states have ruled, however, that while the receiver clearly has standing to represent injured policyholders and creditors of an insolvent insurer, standing is non-exclusive. The receiver should consult counsel to determine whether the receiver's standing is exclusive or non-exclusive in the applicable jurisdiction.

B. Audit/Investigation of Financial Statements

The question of the accurate preparation of financial statements is at the core of the management's duty to the insurer, and thus, at the heart of the receiver's analysis of the insolvent estate. The following is a discussion of potential claims against third parties for their willful and/or negligent damage to the insurer through their acts leading to the misrepresentation of the insurer's financial condition. It must be stressed, however, that any potential claim and/or suit must be evaluated by the receiver's attorneys to determine the utility and the cost-effectiveness of bringing the claim and/or suit.

1. Claims Against Accountants and Actuaries

   a. Misrepresentation of Solvency

   The outside accountants of an insurer owe a duty to the insurer to perform their audits in adherence with professional standards required by the American Institute of Certified Public Accountants (AICPA), applicable state statutes and common law. The outside accountants may be liable for failure to adhere to these standards. Increasingly, insurers employ actuaries to certify loss reserves. Those actuaries are also held to a standard of professionalism when they render a loss reserve

[213] See, e.g., *University of Maryland v. Peat Marwick Main & Co.,* 923 F.2d 265 (3d Cir. 1991); *Grode v. The Mutual Fire, Marine and Inland Ins. Co.,* 1991 U.S. Dist. LEXIS 16850 (E.D. Pa. 1991); *Commissioner of Ins. v. Arcilio,* 221 Mich. App. 54, 65-66, 561 N.W. 2d 412 (Mich. App. Ct. 1997); *Foster v. Peat Marwick Main & Co.,* 587 A.2d 382 (Pa. Commw. 1991).

[214] See e.g., *In Re Liquidation of Integrity Insurance Company,* 240 N.J. Super. 480, 573 A.2d 928 (1990); *Selcke v. Hartford Fire Ins. Co.,* 238 Ill.App.3d 292, 606 N.E.2d 291 (1992), aff'd, sub. nom. *In Re Rehabilitation of Centaur Ins. Co.*, 158 Ill. 2d 166, 632 N.E.2d 1015 (1994).

certification. A serious deviation from good accounting and/or actuarial practices may render the actuaries and accountants liable for damages. If the accountants and/or actuaries fail to fulfill their duties with respect to an insurer which subsequently is discovered to be insolvent, such failure may give rise to liability to the estate, as well as to policyholders, cedents, reinsurers and other interested third parties.

Accountants render opinions when they audit financial statements. An unconditional opinion is generally considered to be a sign of good financial health by industry, investors and the public. The refusal to render an audit opinion or an audit opinion with conditions is an indication that the accountants have reservations about the financial condition of the insurer. Actuaries certify the adequacy of loss reserves.

b. Malpractice

Accountants may be found liable for failing to adhere to professional standards with respect to detecting errors or otherwise failing to adhere to professional standards. Accountants remain responsible for errors when preparing financial statements and performing audits. However, to be responsible for the errors, the accountant must truly be the source of the errors and not the recipient of erroneous information passed on by management. Therefore, the receiver should know the scope of the engagement of the accountant and the quality of management's records.

c. Statute of Limitations

Statutes of limitations are discussed in detail in Section IIH2. In considering action against an accountant or actuary, the receiver should note that in many states, a separate statute of limitations applies to professional liability actions. This statute of limitations is often shorter than that for actions on contracts. The receiver should exercise care and consult with counsel to verify that a statute of limitations will not bar the receiver's contemplated action.

d. Damages

The degree of an insurer's insolvency and damages suffered by those who dealt with the insurer may have been substantially increased over the years if the delayed reporting of the insurer's poor financial position caused the insurer to continue to operate for a period of years before it was placed in receivership. Policyholders and ceding insurers may have renewed coverage and other parties may have dealt with the insurer based on the lack of indication of the insurer's true financial position. This in turn, may give rise to claims that would not have otherwise arisen.[215]

2. Claims Against Former Management

Potential claims against former management may be based upon many theories and fact patterns. Management may have been inexperienced, unprofessional, unwise or dishonest. If it becomes apparent that former management failed to fulfill its obligations to the insurer, the receiver should consult legal counsel to ascertain whether a cause of action is available.

a. Misrepresentation of Solvency

Management, like accountants, has a clear duty to accurately report the financial condition of the insurer to the public, to policyholders, to shareholders and to insurance regulators. For example, annual statements are required to be certified by management, under oath, as representing an accurate presentation of the finances of the insurer. If management had reason to know that the

[215] An appellate court reinstated a jury verdict that held the company's auditors liable for damages occasioned by the 13-month delay in instituting rehabilitation proceedings where the auditor's malpractice induced the insurance department to settle with management. *Curiale v. Peat, Marwick, Mitchell & Co.,* 630 N.Y.S. 2d 996 (N.Y. App. 1995).

annual statement did not accurately reflect the true financial condition of the insurer but nevertheless certified the statement, a cause of action may be available to the receiver acting as the insurer's representative. The receiver should also check whether there had been a recent change in management. This may be an indication that prior management was not effective.

b. Loss Reserve Certification

Qualified actuaries are employed to certify loss reserves. Presumably, there is a right to rely on the loss reserve certification by an expert. If this certification is in error, then the receiver may have a cause of action against the actuary. Obviously, this is a question of expert opinion and besides conferring with an attorney, the receiver must also seek the opinion of an independent qualified actuary. Generally speaking, management is also required to have sound reserves based on its sworn oath in the jurat of the annual statement. It may be prudent to ask whether adequate controls were installed to ensure that reserving and other financial practices were sound.

c. Insurance Law Violations

Management may have violated insurance laws in a variety of ways to deplete the assets of the insurer before insolvency. There is no exhaustive list of violations, but the following is typical. For example, management may have inadequately supervised MGAs to verify that they kept trust funds or remitted funds to the insurer. The insurer may have charged inadequate rates, which could make their business unprofitable. The management may have demanded insufficient LOCs or used unsuitable reinsurers. The insurer might have engaged in unusual reinsurance transactions where transfer of risk is questionable. Unless the contract contains this essential element of risk transfer, the ceding company may not account for it as reinsurance recoverable. Investments may have been made as a result of self-dealing and conflict of interest and not for their investment value. Holding company transactions may have been entered into, which favored non-insurer members of the holding company over the insurer. All the above transactions have the same characteristic. They were not made in the best interests of the insurer, its shareholders and policyholders.

d. Business Judgment Rule

The business judgment rule has different formulations in different states. Generally, the rule holds that if management or directors acted in an informed basis in good faith and in the honest belief that they were acting in the best interest of the company, they may not be held liable for their actions unless it can be demonstrated objectively that they had reason to know of the detrimental impact of their actions on the insurer. The business judgment rule upholds the subjective view of the intent of the board of directors and the management, and allows the court to presume their good faith. This presumption is subject to rebuttal if the receiver shows that there is persuasive evidence that the best interests of the insurer were not pursued or that the board of directors and management did not act in good faith. Obviously, with the benefit the business judgment rule defense provides the directors and management, the receiver must seek to develop evidence of the intent of their actions in order to rebut the presumption.

3. Discovery

The best advice for a receiver taking over an insolvent insurer is to review every material transaction and every party's involvement in it in order to determine the bona fides of the transaction. The following is a list of the primary sources of that information:

- Audit review
    - The work papers of the accounting firm and the work papers of the insurer relating to internal audits of the insurer's operations are invaluable. The work papers of the loss reserve certification specialist should also be examined.

- Management's reports
    - Board of directors committee meetings reports and board of directors reviews should be examined. Claims and underwriting audits should be reviewed. Personnel files are also helpful.
- Reinsurance audits
    - Some reinsurers audit the books of businesses that they reinsure and their examination may be invaluable. It may be troublesome to obtain copies from the reinsurers, but it is probably well worth the effort.
- Other sources
    - Prospective purchasers of the insurer may have performed surveys and studies which will illuminate the problems the insurer encountered. State insurance departments' market conduct and financial examinations are invaluable. The U.S. Treasury Department (Treasury) certifies certain insurers for writing surety bonds for the federal government. The Treasury's examination is valuable. Security analysts may also have written on the insurer and its prospects. In addition, the receiver may review the files of the insurer's attorneys, its internal audit reports, its bankers' loan files, its consultants, 'managing general agents' and reinsurance intermediaries' files, as well as the file of Insurance Department officials who regulated or examined the company prior to insolvency.

C. Voidable Preferences

1. Terms of Specific Statute Govern

A receiver is authorized to reclaim property transferred by the insolvent insurer to another party if the transaction constituted a "voidable preference" as defined by statute. In general, these statutes permit the receiver to recover certain assets which were transferred by the insurer in order to satisfy prior debts and which result in some creditors receiving a greater share of the insurer's assets than other creditors similarly situated. A preferential transfer under IRMA § 604 may be to or for the benefit of a creditor. The statutes in place in various states differ significantly in substance, scope and form. Some states, in fact, do not have a voidable preference statute. A receiver should consult the applicable statutes in the receiver's state to ascertain if there is a voidable preference rule and, if so, to learn the particular requirements of that statute.

2. General Elements of Voidable Preferences

Generally, voidable preference statutes authorize receivers to avoid transactions meeting all of the following requirements:

a. Transfer of Property of the Insurer

The transaction must involve a transfer of the insolvent insurer's property before the receiver may have a right to reclaim the transferred assets. Transfers by third parties, such as bank payments on a letter of credit which was issued at the request of the insolvent insurer, are not voidable by a receiver as a preference. The issuance of collateralized letters of credit, however, may constitute indirect transfers, which may be voidable.

Similarly, receivers cannot recover property held in trust by the insolvent insurer that is transferred to its beneficial owner because the insurer does not hold this property for its own use, but only for the use of the beneficial owner. However, if the insurer's property is transferred into the trust during the preference period, the transaction may be voidable.

b. Transfer During Specified Time Period

Voidable preference statutes only permit receivers to recover transfers which occur within a particular time period immediately preceding the receivership proceedings. This period of time is frequently referred to as the "preference period." Property transferred before the preference period generally is not recoverable under voidable preference statutes (although the property may be recoverable under other theories). While this is generally true, some statutes contain an exception to this rule. (See below.)

The preference period may vary from four months to two years depending upon the particular state's law. In addition, many statutes provide longer preference periods for transfers involving directors, officers, substantial shareholders or other persons with significant influence over the affairs of the insolvent insurer than they do for transfers to parties totally unrelated to the insurer. Depending upon the state, the preference period may be measured from the date of the liquidation order, the rehabilitation order, the order declaring the insurer insolvent, or the filing of the liquidation, rehabilitation or conservation proceeding. Again, the receiver must consult state law on this issue.

Receivers should be aware that controversies may arise over the exact timing of a particular transfer if the transfer involves anything more complex than a cash payment. Courts are divided evenly on relatively common transactions, such as check payments. Some courts have ruled that the transfer occurred upon delivery of the check, while others have ruled that the transfer occurred when the bank honored the check.

As an alternative to proving that the transfer occurred during the preference period, some statutes provide that the receiver may void a transaction if the receiver establishes that the insurer was insolvent at the time of the transfer, even though the transfer occurred before the preference period.

c. Transfer Must be Made in Order to Satisfy an Antecedent Debt

Most voidable preference statutes authorize receivers to avoid transactions only when the transactions involve transfers to creditors in satisfaction of an "antecedent debt," that is, transactions which do not constitute substantially contemporaneous exchange. Payments in exchange for contemporaneous transfers of goods or services are generally not voidable by the receiver under these statutes.

Sophisticated and complex transactions may involve controversial determinations of exactly when the insurer incurred the debt (that is, whether the debt is an antecedent debt). Transactions involving contingent liabilities may also be controversial because they involve uncertain liabilities which will be incurred by the insolvent insurer in certain circumstances. It is not clear in what circumstances these contingent liabilities may constitute an antecedent debt. These determinations are highly fact-dependent, and the conclusions may vary from jurisdiction to jurisdiction.[216]

d. Transaction Must Result in Preference

To avoid a transfer, the receiver must also demonstrate that the transfer resulted in a "preference" to the creditor receiving the property. The law of the particular jurisdiction must be consulted. In general, the receiver needs to show that, as a result of the transfer, the creditor obtained payment of a greater percentage of the debt owed that creditor by the insolvent insurer than another creditor of the same class would receive from the estate.

Transfers of property to fully secured creditors do not generally constitute preferences because secured creditors would ordinarily receive the value of the collateral even in the context of a

[216] See Wilcox c. CSX Corp, *70 P.3d 85*, *473 Utah Adv. Rep. 25, 2003 UT 21(2003).*

receivership proceeding, and therefore the secured creditors do not receive a disproportionate benefit as a result of the transfer. If, however, the security interest was created during the preference period (for example, by providing collateral for a previously existing debt), then a voidable preference may have occurred. Similarly, payments to some creditors may not result in a preference if the creditors would be entitled (even without the transfer) to set off the payments of the insolvent insurer against debts owed by the creditors to the insurer. In these cases, the creditor can either accept the property and later pay the amount owed by the creditor to the insurer's estate or not accept the property and, instead, reduce the amount it pays to the estate by the amount owed to it by the insurer. The creditor is in essentially the same position either way. A receiver should be aware, however, that some courts have suggested that the mere timing of a particular transfer can constitute a preference because of the time value of money, even in cases where the creditor receives the same dollar amount the creditor would have received from the insolvent insurer's estate. In short, this question comes down to whether extra interest earned by the creditor as a result of having the money sooner rather than later constitutes a preference.

e. Intent Requirement

Many voidable preference statutes require the receiver to establish that the creditor receiving the transfer had reasonable cause at the time to believe that the insurer was insolvent or was about to become insolvent. Other statutes may require the receiver to prove that the creditor had reasonable cause to believe that the transfer would result in a preference. Establishing this subjective requirement may prove to be a significant hurdle for the receiver. Not all states, however, require the receiver to show these facts in all cases. Some states only require proof of intent if the receiver is seeking to recover assets transferred before the preference period or if the receiver is seeking to prove that the transfer occurred at a time when the insurer was insolvent.

3. From Whom Can the Receiver Recover the Amount of the Preference?

The most obvious target of a receiver's voidable preference claim is the creditor who receives the preferential transfer. A receiver may also be able to assert a claim against additional parties. Many statutes provide that officers, employees or other "insiders" who participated in granting the preference can be held responsible for return or repayment of the transferred property under the doctrine of joint and several liability. The receiver, therefore, may be able to recover the amount of the preference from the "insider" who authorized the transfer if the insider had reasonable cause to believe that the insurer was or was about to become insolvent. In some cases, this approach may be more efficient than pursuing the creditor, particularly if the creditor is located in another jurisdiction.

Although the law is unsettled, receivers may be able to recover the amount of the transfer from certain "non-insiders" who assisted in the transfer and received a benefit from the transaction. For example, a receiver may wish to consider the role of agents or brokers in the transaction. In addition, a receiver may be able to recover from persons who subsequently purchase the transferred property from the creditor to the extent that these purchasers do not in good faith provide full equivalent value for the property. Local counsel should be consulted as to these issues.

4. Mechanics of Recovery of Preference

The receiver must ordinarily commence suit before the applicable statute of limitations has run in order to recover assets conveyed in a transaction that meets all of the requirements of the applicable voidable preference statute. The receiver should also consult local counsel for all procedural rules.

The receiver can void the entire range of transactions meeting the statute's requirements even if the transaction is otherwise innocent. The applicable voidable preference statute, therefore, can be a valuable tool for augmenting the assets of the estate and assuring that all creditors are treated equally.

D. Fraudulent Transfers

1. Authority

Receivers typically have the authority to recover assets conveyed by the insurer in transactions that constitute fraudulent transfers. The receiver's authority to recover fraudulent transfers may stem from a specific statute, the Uniform Fraudulent Conveyance Act, to the extent adopted in the particular state, or the common law of fraud. The receiver should consult counsel to ascertain which theories concerning recovery of fraudulent transfers are available to the receiver. § 605 of IRMA addresses fraudulent transfers.

2. Elements of Fraudulent Transfer

The fraudulent transfer laws perform a function similar to the purpose of voidable preference statutes. Both laws authorize the receiver to rescind certain transactions and bring previously transferred assets back into the insolvent insurer's estate. The voidable preference statutes, however, address transfers made to satisfy antecedent debts which result in some creditors receiving a greater percentage of their debt than other creditors in the same class (see previous discussion). The fraudulent transfer laws deal with transfers for inadequate consideration and with transfers aimed at obstructing or defrauding other creditors.

Fraudulent transfer laws vary from state to state, but most laws permit the receiver to avoid transactions which meet the following requirements:

a. Transfer for Unfair Consideration or with Fraudulent Intent

Many fraudulent transfer laws require the receiver either to demonstrate that the insolvent insurer did not receive "fair consideration" for the transfer or to establish that the transaction was made with the intent to hinder, delay or defraud other creditors in order for the receiver to rescind the transaction as a fraudulent transfer and thereby recover the transferred assets.

b. Transfer During Specified Time Period

Fraudulent transfer statutes typically apply only to transfers made within one year prior to a particular stage of the receivership proceedings, such as the filing of a successful petition for receivership. The particular time period, however, varies in different states, and the receiver should consult counsel to determine the rule in the particular jurisdiction. Issues addressed in the voidable preferences section concerning potential disputes as to the timing of a particular transaction are equally relevant in the context of fraudulent transfers. The receiver should consult the previous discussion of voidable preferences for further information on this issue. Simply stated, the exact timing of a particular transfer (and especially a transfer involving a complex commercial transaction) is not always clear and can cause disputes as to the applicability of a fraudulent transfer law to the particular transaction.

c. Status of Insurer

Some states may require the receiver to show that the insurer was insolvent or otherwise financially impaired at the time of the transaction (or became insolvent because of the transaction) in order to attempt to recover a fraudulent transfer.

d. Distinct Rules for Reinsurance Transactions

Many states impose different standards on reinsurance commutations occurring within the fraudulent transfer period. The receiver may be able to rescind a commutation with a reinsurer if the receiver can prove that the insolvent insurer did not receive the present fair equivalent value of

its release of the reinsurer from liability. The receiver should consult Chapter 7—Reinsurance for further information on this subject.

3. From Whom Can the Receiver Recover the Amount of the Transfer?

Receivers may recover the value of the fraudulent transfer from the person who received the transfer from the insurer. Receivers also may be able to recover the value of the transfer from other persons who are subsequent holders of the transferred property, although many statutes do not permit recovery from such persons if they provided present fair equivalent value for the property when they procured it. In addition, the receiver may be able to assert a claim against persons who participated in the transfer, such as directors, officers, employees or other "insiders" of the insolvent insurer. The potential liability of such persons is discussed in greater detail under a separate heading in this chapter.

4. Mechanics of Recovery of Fraudulent Transfers

To recover assets conveyed in transactions which constitute fraudulent transfers, the receiver needs to commence suit within the period of the applicable statute of limitations. Counsel should be consulted as to procedural requirements.

5. Typical "Red Flag" Transactions

To the degree practicable, the receiver should examine all transactions which occur during the fraudulent transfer period to see if the transfers may be rescinded. Receivers should pay special attention to extraordinary dividend payments to stockholders, commutation agreements with reinsurers, related party transactions, portfolio transfers, surplus relief reinsurance treaties and any unusual disbursements. While all of these transactions may be entirely innocent, they can also be tainted by fraudulent intent or by unfair consideration which may enable the receiver to rescind the transactions.

E. Related-Party Transactions

A common "target" of receivers involves improper or questionable transactions between the insurer and those "related" to it, including parent corporations and shareholders, prior to insolvency.

1. Holding Company Act

The Insurance Holding Company System Regulatory Act (the Holding Company Act) constitutes an extensive statutory scheme regulating among other things, the registration, reporting, examination, acquisition and control by holding companies of an authorized insurer. By statute, "control" is presumed if the holding company owns 10% or more of the voting shares of an insurer. Furthermore, the Holding Company Act requires that all material transactions must first obtain regulatory approval, and that in any event, all transactions between the holding company and the "held" insurer must be "fair and equitable." As such, any transactions between the now insolvent insurer and the controlling party which do not meet the standard (preferences, non-arms-length transactions) may be attacked by the receiver under those statutes.

2. Piercing the Corporate Veil

The ability of a receiver to assert a successful "piercing the corporate veil" claim against the former parent or shareholder of an insolvent insurer will necessarily depend upon the elements of such a claim under the relevant state's laws. Defendants, however, have often attacked such a claim as a matter of law in arguments that closely relate to standing arguments. In essence, defendants have argued that receivers only have standing to sue on behalf of the fallen insurer and, therefore, argue that a corporation

may never pierce its own veil.[217] Nevertheless, it can be argued that the receiver also represents creditors and policyholders who can clearly assert alter ego claims or piercing the corporate veil claims. In addition, there is a fundamental difference between an "alter-ego" action brought by a receiver and that brought by a viable corporation. When a viable corporate entity sues on its own behalf, it is in essence suing for the benefit of its shareholders. Thus, a suit by a viable corporate entity seeking to pierce its own veil is the equivalent of a suit by a corporation (for the benefit of its shareholders) against its shareholders. As such, many courts have found that such an action must fail. Where, however, the corporate entity is in receivership, the receiver's suit is for the benefit of the insurer's creditors. In such a setting, the interests of the party plaintiff (i.e., the receiver on behalf of the estate, representing among others, the creditors) differs from the defendants (the shareholders).

In addition, the Holding Company Act expressly contemplates actions against holding company systems which own and control an insurer. In fact, one of the provisions typically found in these statutes mandates that officers and directors of a controlled insurer manage the insurer so as to assure its separate operating identity. Violation of that statute, coupled with the express right of action under a separate provision, clearly contemplates an alter ego or piercing the corporate veil claim under insurance laws.

F. Other Suspect Transactions

Besides the above enumerated transactions which are not exhaustive, it is possible that aspects of or the intent of any transaction may be fraudulent. Therefore, all material transactions should be investigated to see if they indicate fraud, self-dealing, violation of law, conflict of interest, etc. Insolvency may be accompanied by acts which render the management, board of directors or vendors of services liable for damages. Recovery of these damages will increase the assets of the estate and, thus, the amount available for distribution.

G. Potential Actions Against Unrelated Third Parties

In the examination of the insolvent insurer, the receiver may come across possible causes of action to bring against third parties and present all such findings to counsel. The rights to bring a suit and/or make a claim must be evaluated in terms of the relevant statutes and case law.

1. MGA/Agent/Broker

Although producers share certain characteristics, only agents (including MGAs) represent the insurer and ordinarily owe a duty to the insurer. Nevertheless, in certain states, brokers may owe a duty to the insurer. There are states in which all producers are deemed agents. Consult an attorney to determine the duty owed by the producer. Under the insurance laws, almost all states require producers to maintain trust funds which are held to pay premiums to insurers and for other purposes. MGAs who underwrite business must comply with the legal requirements of the rating law and may not underprice the business so as to make it unprofitable. MGAs may have violated underwriting guidelines or made claim payments in violation of guidelines set up by the insurer. This may make them liable under a breach of contract theory if their agency agreement required adherence to insurer guidelines. In particular, a MGA may have had binding reinsurance authority. Breaches of authority, lack of good faith or other acts may make the MGA liable under a contract or tort theory depending on the acts committed.[218]

It may also be possible to bring an action based upon a tort theory. A common example of facts creating tort liability is where the MGA violated its trust and wrote business solely to earn commissions rather than to obtain a profitable return for the insurer. The MGA may have committed breaches of

[217] *Selcke v. Hartford Fire Ins. Co.,* 238 Ill. App. 3d 292, 606 N.E.2d 291 (1992), aff'd, sub. nom., *In re Rehabilitation of Centaur Ins. Co.*, 158 Ill. 2d 166, 632 N.E.2d 1015 (1994).

[218] E.g., *Omaha Indemnity Company v. Royal American Managers,* 777 F. Supp. 1488 (W.D. Mo. 1991).

underwriting or claims authority or failed to document business written so as to render the insurer unable to assemble its records.

A broker owes a duty to the insured. A broker who owns and controls an insurer also owes a fiduciary duty to that insurer. If the broker has failed to fulfill its obligations to the insurer by knowingly placing substandard or underpriced risks with the insurer so as to generate additional commission income for the broker, the receiver may have a cause of action against the broker for the resulting damage to the insolvent insurer.

Many states have statutes that are directed at managing general agents and define these as property and casualty agents with expanded responsibilities that may include underwriting, policy issuance, claims payment and continued policy owner services, as well as the marketing of the insurance products. Life insurers also have marketing contracts that may be labeled "Managing General Agent" (MGA) or "Brokerage General Agent" (BGA) contracts. These contracts, however, pertain to the acquisition of new business and retention of existing policies.

A BGA can differ from a MGA in that a BGA, through special contracts with a number of life insurance companies, provides a variety of products and solutions to an agent that is seeking to solve a client's unique needs. A MGA for a life insurer normally will distribute for a single insurer (or a very limited number of insurance companies) through a group of agents recruited by the MGA, who will focus their selling activity on the products of that insurer.

Some life insurers have attempted to streamline internal operations by sharing their home office functions with large MGA and BGA operations. Because of this, both electronic data as well as physical files are kept by the MGA or BGA for some blocks of business. The MGA or BGA serves as the administrator, while the life company serves as the insurer. Care should be taken not to disenfranchise the field agents when the retention of their services and equipment may be important to the discovery, communication and rehabilitation process.

2. Reinsurance Intermediaries

Reinsurance intermediaries must now be licensed in most states. Under the laws, an intermediary generally must have clear written authorization from its principal and must notify its principal when it has bound reinsurance. If the assuming reinsurer is unauthorized, the reinsurance intermediary must exercise due diligence in researching the financial condition of the unauthorized reinsurer. The intermediary must maintain records for a number of years and maintain a premium trust fund in a fiduciary capacity. These laws generally also require disclosure whether the intermediary controls the ceding insurer or reinsurer, or the ceding insurer or reinsurer controls the intermediary.

It may be possible to base a claim on breach of contract. The reinsurance intermediary may have an engagement or contract with the party it serves and, therefore, if this contract is breached by the reinsurance intermediary, the estate may have a contract claim against the intermediary.

It may also be possible to base a claim on a tort theory. The reinsurance intermediary may be alleged to have violated its duty of reasonable care to the party it represented. It may have encouraged or encountered a conflict of interest or it may have misrepresented the underwriting posture of the ceding insurer or the financial capability of the assuming insurer.

In both the contract and tort actions, one must be aware of the applicable statute of limitations.

3. Attorneys

Attorneys perform various functions for insurers. Principally, they advise the board of directors and management as to transactions and agreements and the interpretation of insurance law. They also defend claims and may prepare reinsurance agreements. If attorneys have given faulty, negligent or fraudulent advice, the attorneys may be liable to the estate. As stated above, refer such questions to counsel. The receiver should also evaluate current or prior representations of attorneys for conflicts of interest.

4. Recovery from Other Sources

In collecting the assets of the estate, the receiver should remember that other parties may owe the estate reimbursement for their acts, such as ownership of salvage, receipt of the fruits of fraudulent transfers, etc. The following is not an exhaustive list, but an illustrative list of parties which may owe proceeds to the estate.

a. Subrogation and Salvage

Subrogation is an equitable principal by which the wrong-doer who has caused a compensated insurance loss owes indemnity to the insurer. Alternatively, a party may hold property on which the insurer has paid a loss and which thus belongs to the insurer. The property is called salvage. As part of the review of claims procedures, the receiver should check to see that subrogation and salvage were routinely investigated in losses.

Close attention should be paid to the security provided to the company by its reinsurers, including letters of credit and trust accounts. These should be reviewed early to determine whether there is compliance with the obligations under the reinsurance treaties. To assure the reinsurer does nothing to diminish the security as a result of the receivership, it is essential for the receiver to provide notice of the insurer's receivership to all institutions that have issued letters of credit or are acting as the escrow agents. The same parties should also be advised that the receiver must be notified of any transaction that may affect the security. Once it is determined that the security is in place, it is still necessary to continue to monitor the security during the receivership to ensure that it remains in place, including seeing that letters of credit are renewed and that security is increased pursuant to the reinsurance agreement, if appropriate.

b. Fraudulent Transactions

The beneficiary of a fraudulent transaction may, under many state fraud statutes, owe the proceeds back to the insurer. (See the section on Investigation and Asset Recovery in this chapter.)

H. Dividends and Intercompany Transactions

State insurance codes have strict limitations on how much money can be paid as dividends by insurance companies to their shareholders. All dividends paid by the company should be reviewed to determine compliance with these limitations. The receiver should also examine whether the financial statements were manipulated to make otherwise impermissible dividends appear valid.

As part of this process, intercompany transactions should be reviewed to look for disguised dividends. The company may have entered into cost sharing agreements, tax sharing agreements, marketing agreements and other such transactions with affiliates. These transactions should be reviewed closely. When a company is foreclosed from issuing dividends, it may try to disguise dividends as transactions pursuant to these agreements.

Illegal dividends may be recovered in actions for fraud or breach of fiduciary duty. Additionally, some insurance codes allow the receiver to recover all dividends, whether lawful or unlawful, that were made

during a stated time period prior to the receivership. Furthermore, the failure of the company's auditors and external accountants to detect unlawful dividends may form the basis of a negligence action.

I. Directors, Officers and Shareholders

1. Mismanagement/Negligence

Numerous actions have been filed by receivers throughout the country against former directors and officers of now insolvent insurers for gross negligence and mismanagement that caused the insurers' insolvency. Prior to instituting action, corporate bylaws should be reviewed to determine whether corporate officers will be indemnified for defense costs for actions against them arising from the performance of their corporate duties.

Examples of mismanagement and negligence claims asserted in these actions are failure to exercise due care, breach of fiduciary duties owed by the defendant officers and directors to the corporation and its shareholders, self-dealing and the filing of false and misleading financial reports.

In addition, many of these actions have also alleged fraud and breach of fiduciary duties against an insurer's former directors and officers and the corporation's parent. Possible bases for legal action against an insurer's management or ownership are:

- Operating the insurer as a "loss leader" to enhance other elements of the controlling parties' business at the expense of the insurer;
- Failing to operate the insurer as an independent profit-making corporation;
- Permitting the insurer to violate the insurance laws;
- Managing and operating the insurer without regard to its profitability or solvency and in a manner inconsistent with prudent business practices;
- Operating the insurer to serve the interests of the controlling parties in contravention to the insurer's own interests;
- Forcing the insurer to pay monies to one or more members of the insurer's holding company system when such members performed no services for the insurer;
- Binding the insurer to extremely unprofitable policies;
- Binding the insurer to, or forcing the insurer into, highly disadvantageous arrangements with other members of the holding company system, their clients or others;
- Causing the insurer to make preferential transfers to members of the holding company system and others;
- Causing the insurer to enter into transactions with affiliates that were unfair to the insurer and in violation of the Holding Company Act;
- Failing to investigate, review, scrutinize, monitor, supervise and manage the financial affairs of the insurer to prevent its insolvency;
- Allowing the insurer to maintain inadequate books and records;
- Failing to establish and apply reasonable and prudent underwriting guidelines; or

- Concealing the insurer's insolvency and misrepresenting the insurer's financial condition through the preparation and issuance of materially false and misleading financial statements filed with regulatory authorities;

2. RICO

Claims under the federal Racketeer Influenced and Corrupt Organizations Act (RICO) 18 USC 1961 et. seq., against former directors and officers of a failed insurer have been sustained against dismissal motions by some courts.[219] RICO claims against the insurer's attorneys, solicitors, reinsurers, agents, brokers and shareholders have also been sustained.[220]

RICO provides remedies, including treble damages and attorneys fees, for activity that meets the following criteria:

- The defendants were "persons" employed by or associated with an "enterprise" (usually, but not always, the insolvent insurer or a related entity);

- The affairs of the enterprise affected interstate commerce;

- The defendants engaged in a "pattern of racketeering activity" (defined in the statute as violations of certain federal and state criminal laws); and

- The defendants conducted or participated, directly or indirectly, in the conduct of the enterprise's affairs through this pattern of racketeering activity.

- The insolvent insurer was injured in its business or property and that the injury was proximately caused by the racketeering activity.[221] In order for a receiver to recover under Section 1962 of RICO, the receiver must show that the defendant participated in the operation or management of the insurance company itself. This "operation or management" test arises from the statute's requirement that a defendant "conduct or participate, directly or indirectly in the conduct of such enterprise's affairs." See Section 1962(c) The U.S. Supreme Court affirmed the dismissal of a RICO claim brought by a bankruptcy trustee against an outside accounting firm on the basis that the accounting firm had not participated in the management of the defunct company.[222]

3. Breach of Fiduciary Duty

It is clear that directors and officers of an insurer owe a fiduciary duty to the corporation. In addition, there is a well-established line of cases holding that dominant or controlling stockholders or a sole shareholder has a fiduciary relationship to the corporation. The same is true of directors and officers of the corporation. In the event of insolvency, the corporation's right to sue for breach of fiduciary duty rests with the receiver.

[219] However, some courts have held that the RICO claims must be brought on behalf of the insolvent insurer, and have dismissed them when brought on behalf of the insurer's policyholders and creditors. See e.g. *Shapo v. Engle,* 1999 U.S. Dist. Lexis 11231 (N.D.Ill. July 12, 1999), dismissed in part, 1999 U.S. Dist. LEXIS 17966 (N.D. Ill. Nov. 10, 1999).

[220] E.g., *Schacht v. Brown,* 711 F.2d 1343, (7th Cir.), cert. denied*,* 464 U.S. 1002 (1983); *State of North Carolina ex rel. Long v. Alexander & Alexander,* 680 F. Supp. 746 (E.D.N.C. 1988); *Durish v. Uselton,* 763 F. Supp. 192 (N.D. Texas 1990); *Department of Ins. v. Blackburn*, 633 So. 2d 521 (Fla. Dist. Ct. App. 1994).

[221] *Sedima, S.P.R.L. v. Imrex Co.,* 473 U.S. 479, 495 (1985). Some states have enacted parallel state legislation. Local counsel should be consulted.

[222] See *Reeves v. Ernst & Young,* 507 U.S. 170 (1993).

It is fundamental that damages resulting from a neglect of fiduciary duty are recoverable by the insurer, and this right passes to the receiver.

4. Presumption of Fraud

A severe problem facing all receivers is the frequently disorganized situation the receiver often confronts when first reviewing and investigating the history and cause of a failed insurer. It is not uncommon to find the books and records of the insurer in complete disarray caused by the mismanagement, negligence and sometimes intentional misconduct of former management. Yet, under normal circumstances, the burden of proof is on the receiver to establish his or her claims despite the fact that former management may have intentionally made that burden impossible.

However, there are statutes in some states which, along with the existence of the fiduciary relationships between directors and officers and the corporation (represented by the receiver), provide assistance in shifting that burden. For example, New York Insurance Law Section 1219(b) states:

"The insolvency of an insurance corporation is deemed fraudulent unless its affairs appear upon investigation to have been administered fairly, legally and with the same care and diligence that agents receiving a compensation for their services are bound, by law, to observe."

Hence, upon insolvency and a finding that no investigation has shown that the defunct carrier was administered fairly, legally or competently, it can be argued that director and officer defendants have the burden of disproving the fraudulent insolvency of a carrier.

5. Shareholders

- Holding Company Act

As discussed previously, the Holding Company Act constitutes an extensive statutory scheme regulating, among other things, the registration, reporting, examination, acquisition and control by holding companies of an authorized insurer.

The Holding Company Act expressly contemplates actions against holding company systems and persons that abuse the statutory provisions.

J. Common Defenses to Receiver Lawsuits

As previously discussed, while it is clear that a receiver has standing to sue on behalf of the defunct insurer, many defendants claim that the receiver has no right to assert claims on behalf of creditors and policyholders. The defendants then argue that because the principal claims asserted in the receiver's complaint against the defendants do not belong to the defunct insurer (but to its creditors and policyholders), the complaint must be dismissed.

As previously noted, the receiver in some states may have, and pursuant to IRMA does have, standing to sue on behalf of policyholders and creditors. In any event, the claims most commonly asserted by a receiver belong to the insurer. For example, a corporation may sue shareholders and directors and officers for breaches of fiduciary duty or corporate waste. Such claims also pass to the receivers of insolvent insurers and may be made against the shareholders of such companies.

The purpose of the liquidation scheme is to preserve and enhance the assets of the insolvent insurer for the benefit of all creditors, policyholders and shareholders. A receiver for an insolvent insurer has a right to maintain the corporation's assets and to recover assets of which the corporation has been wrongfully deprived through fraud. In such a suit, the receiver may be said to sue as the representative of the corporation and its creditors, policyholders and stockholders.

The one exception noted by any court and contained in IRMA is that the receiver may not have standing to pursue claims that are personal to any one or group of policyholders or creditors and uncommon to all other policyholders, creditors and claimants.[223] IRMA § 112 addresses the issue of defenses, which may be asserted against the receiver.

1. Ratification

Defendants have asserted the defense that no viable action can be brought against them since the Board of Directors ratified the complained of conduct. This defense is generally unsuccessful and considered contrary to public policy.[224]

Only disinterested directors and shareholders can ratify transactions. However, acts which are fraudulent, prohibited by statute or violate public policy cannot be ratified. Such acts are void rather than merely voidable.

Moreover, creditors are not prejudiced by the corporation's acts of ratification. Any ratification, even if effective, would therefore not preclude a receiver's action on behalf of the creditors.

2. Misconduct "Aided" Insurer

Defendants have also asserted the defense that if any misconduct occurred, it only served to place more money in the insurer's coffers by encouraging outsiders to continue doing business with the insurer and/or prolonging the insurer's existence. Courts currently respond to this defense by attempting to distinguish between conduct that injures the corporation and conduct that benefits it.[225]

In a similar line of cases, courts have held that where the insurer is wholly owned by the persons responsible for negligent operation or fraud against outsiders, the misconduct should be "imputed" to the insurer, which defeats a receiver's claim on behalf of the insurer.[226] This defense is inapplicable, however, where the alleged misconduct involves looting from the insurer for the benefit of the owner/director and contrary to the interest of the insurer.[227]

3. Fiduciary Shield Doctrine

The fiduciary shield doctrine holds that the acts of an agent performed in-state for an out-of-state corporation will not form the basis for exercising jurisdiction against the agent as an individual, but may be used to subject the corporation to jurisdiction.

Courts in some states have limited the doctrine, theorizing that it would be inequitable to allow a corporate agent to assert the doctrine where the agent has committed a tort in the state.

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[223] See *Caplin v. Marine Midland Grace Trust Co. of New York,* 406 U.S. 416 (1972); *State of Arizona v. Arizona Pension Planning,* 154 Ariz. 56, 739 P.2d 1373 (1987).

[224] *William M. Fletcher, Fletcher Cyclopedia of the Law of Private Corporations* § 998 (perm. ed. rev. vol. 1994); *Neese v. Brown,* 218 Tenn. 686, 405 S.W.2d 577 (1964); *Coddington v. Canaday,* 157 Ind. 243, 61 N.E. 567 (1901); see also *Foster v. Monsour Medical Found.,* 667 A.2d 18 (Pa. Commw. Ct. 1995) (Defendants unsuccessfully claimed that Insurance Commissioner and Department ratified actions of insolvent insurer through knowledge of, and supervision over insurer's operations).

[225] Compare e.g., *Schacht v. Brown,* 711 F.2d 1343 (7th Cir.), cert. denied, 464 U.S. 1002 (1983), holding that fraudulently prolonging an insolvent insurer's existence "ineluctably" injures the corporation with *Seidman & Seidman v. Gee,* 625 So. 2d 1 (1992), rehearing denied, 1993 Fla. App. LEXIS 8483, holding that prolonging an insolvent insurer's existence allows the insured to be used as an "engine of theft" against outsiders, which benefits the corporation.

[226] E.g., *FDIC. v. Ernst & Young,* 967 F.2d 166 (5th Cir. 1992).

[227] E.g., *Schacht v. Brown, supra* 711 F.2d 1343 (7th Cir.) Other recent decisions applying or rejecting versions of this defense include *FDIC v.O' Melveny & Meyers,* 969 F.2d 744 (9th Cir. 1992), reversed and remanded, 114 S.Ct. 2048 (1994); and *In Re Integrity Insurance Co.,* 573 A.2d 928 (N.J. Super. 1990).

The doctrine does not generally apply to corporate officers or directors who reside or have offices in the state where the offending acts took place. It should also be pointed out that courts have viewed fairness and equity as the paramount tests of the fiduciary shield's applicability.[228]

4. Counterclaims Against Regulator

A common defense asserted by defendants in receiver lawsuits is a counterclaim alleging that the insurance commissioner as regulator improperly or negligently interfered with the operations of the insurer or negligently failed to place the insurer in receivership sooner.[229]

Preliminarily, it should be noted that an affirmative claim against the receiver may be barred by the liquidation order.[230] There is also a recognized distinction between the regulator and the receiver.[231] Claims (including affirmative defenses) brought against the former cannot be asserted in a receivership action except as to affirmative defenses which assert that the regulator's misconduct constituted an intervening and superseding cause of the insolvency. In other words, the defendants must plead and prove that the conduct of the regulator interrupted the causal nexus between the defendants' negligence and mismanagement and the insolvency, thereby relieving defendants of their liability.[232]

5. Statutes of Limitations

Receivers must be mindful of the relevant state statutes of limitations, particularly regarding negligence and fraud claims. While comfort may be taken in that most states' limitation periods for fraud commence upon discovery (presumptively by the receiver), negligence claims may not have such a savings provision.

In actions against accountants for malpractice, the defendants often claim that such actions are time barred under the relevant state limitation period, which is often three years from the date of issuance of their audit reports. Even if the receiver's action is brought after the three-year period, the receiver may have defenses to a motion to dismiss founded upon:

- A longer statute of limitations period provided for contract actions;
- The Continuous Treatment doctrine which may toll any period of limitations for the entire period that the accountant defendants served as the insurer's certified public accountants; or
- The Adverse Domination doctrine, under which all statutes of limitation are tolled during the period in which persons and entities alleged to have harmed the insurer are in control of its operations.[233]

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[228] E.g., *Rollins v. Ellwood,* 141 Ill.2d 244, 565 N.E.2d 1302 (1990).

[229] See e.g., *Williams v. Standard Chartered Bank*, No. 96-220-CV-ORL-22 (M.D. Fla.), 9-10 *Mealey's Litig. Rep. Ins. Insolv. 6 (1997)s.*

[230] *Id.*

[231] *Foster v. Monsour Medical Found.,* 667 A.2d 18 (Pa. Commw. Ct. 1995) (pre-liquidation regulatory conduct of Insurance Commissioner cannot be raised where commissioner brings actions as statutory liquidator, rather than in regulatory capacity.)

[232] *Meyers v. Moody,* 693 F.2d 1196 (5th Cir. 1982), reh'g denied, 701 F.2d 173 (5th Cir.), cert. denied, 464 U.S. 920, 104 S.Ct. 287, 78 L.Ed. 2d 264 (1983); *Schacht v. Brown,* 711 F.2d 1343 (7th Cir.), cert. denied, 464 U.S. 1002 (1983); *In Re Ideal Mutual Insurance Company,* 140 A.D.2d 62, 532 (N.Y. App. Div. 1988); *Corcoran National Union Fire Insurance Company,* 143 A.D.2d 309 (N.Y. App. Div. 1988); *North Carolina v. Alexander & Alexander,* 711 F. Supp. 257 (E.D.N.C. 1989); *FDIC v. Renda,* 692 F. Supp. 128 (D. Kansas 1988); *FSLIC v. Burdette,* 696 F. Supp. 1183 (E.D. Tenn. 1988); *FDIC v. Niver,* 685 F. Supp. 766 (D. Kansas 1987); *FDIC v. Coble,* 720 F. Supp. 748 (E.D. Mo. 1989); *FDIC v. Glickman,* 450 F.2d 416 (9th Cir. 1971); *Clark v. Milam,* 891 F.Supp 268 (S.D.W.Va. 1995).

[233] E.g., *Clark v. Milam,* 872 F. Supp. 307 (S.D.W.Va. 1994); *Washburn v. Brown,* 1987 U.S. Dist. LEXIS 495, (N.D. Ill. January 23, 1987); *Durish v. Uselton,* 763 F. Supp. 192 (N.D. Texas 1990); *RTC v. Interstate Federal Corp.,* 762 F. Supp. 905 (D. Kan. 1991); *FDIC v. Greenwood,* 739 F. Supp. 450 (D.C. Ill. 1989); *FDIC v. Paul,* 735 F. Supp. 375 (D. Utah 1990); *FDIC v. Howse,* 736 F. Supp. 1437 (S.D.

6. E&O and D&O Insurance

Many companies purchase Errors and Omissions (E&O) and Directors and Officers (D&O) policies, which may provide coverage for certain types of conduct described above. As part of the investigative examination, all E&O and D&O policies should be found and examined. These policies will almost certainly be claims made policies and should be reviewed to determine the deadline for notifying the carrier concerning possible claims. Additionally, the policies may provide for the purchase of tail coverage to extend the time to file a claim. The presence of insurance can determine which causes of action against officers and directors should be brought. Certain causes of action may be excluded by the language of the policy; it is, therefore, important for counsel to thoroughly review the policies before any suits are filed. One common exclusion that should be considered is a regulatory exclusion, which will likely be present in the policy under review.

7. Failure to Mitigate Damages

Defendants may allege that the receiver has not done everything possible to reduce the damages to the estate. For instance, the defendants may claim that the receiver pursued certain actions, such as entering into reinsurance commutations, that did not benefit the estate or failed to pursue other reinsurance commutations that might have prevented further deterioration of the insurer's financial position.

As a litigation tactic, defendants may attempt to use such a defense to convert the litigation into an examination of the receiver's conduct, rather than a review of defendants' conduct contributing to the insurer's insolvency.

8. Public Policy

Another litigation tactic, particularly where the receiver is suing former officers and directors, is to argue that since the receiver represents the defunct insurer's policyholders and creditors, which may include the officers and directors, a claim against them should not, for public policy reasons, be funded by those policyholders and creditors. Where this tactic has been attempted, the attempt has been universally unsuccessful.[234]

K. Discovery Issues

1. Receiver's Right to Preliquidation Documents

As the statutory successor to the insurer, the receiver owns the preliquidation documents of the insurer. If this is challenged, legal counsel should be consulted.

Texas 1990); *FDIC v. Farris,* 738 F. Supp. 444 (W.D. Okla. 1989); *FDIC v. Carlson,* 698 F. Supp. 178 (D. Minn. 1988); *FDIC v. Butcher,* 660 F. Supp. 1274 (E.D. Tenn. 1987); *FDIC v. Buttram,* 590 F. Supp. 251 (N.D. Ala. 1984); *FSLIC v. Williams*, 599 F. Supp. 1184 (D. Md. 1984); *FDIC v. Bird,* 516 F. Supp. 647 (D.P.R. 1981). But see *Mutual Sec. Life Ins. Co. v. Fidelity & Deposit Co.,* 659 N.E.2d 1096 (Ind. Ct. App. 1995) (In action for coverage under fidelity bond issued to insolvent insurer limiting coverage to losses discovered by insurer during bond period, liquidator could not use "adverse domination" to toll discovery period, despite allegation that discovery delay was caused by insurer's officer).

[234] The defense has been routinely disapproved in cases brought on behalf of failed financial institutions. E.g., *FDIC v. Crosby,* 774 F. Supp. 584 (W.D. Wash. 1991); *FDIC v. Stanley,* 770 F. Supp. 1281 (N.D. Ind. 1991), *aff'd,* 2 F.3d 1424; *FDIC v. Stuart,* 761 F. Supp. 31 (W.D. La. 1991); *FDIC v. Ekert Seamans Cherin & Mellot,* 754 F. Supp. 22 (E.D.N.Y. 1990); *FDIC v. Baker,* 739 F. Supp. 1401 (C.D. Cal. 1990). The few courts considering the defense in cases involving insolvent insurance companies have also disapproved it. See e.g., *Meyers v. Moody,* 475 F. Supp. 232 (N.D. Tex. 1979) *aff'd,* 693 F.2d 1196 (5th Cir. 1982), cert. denied, 464 U.S. 920 (1983); and *Bonhiver v. Graff,* 248 N.W.2d 291 (Minn. 1976).

2. Attorney-Client Privilege

The attorney-client privilege may be asserted against the receiver's request to examine documents in the possession of third parties. However, in light of the fact that the receiver becomes the client as successor to the insurer, it is uncertain whether the attorney-client privilege can be asserted against the receiver.

3. Discovery of Regulator for use Against Receiver

This refers to the fact that private third parties may subpoena the domiciliary insurance department in an attempt to discover the regulator's evaluations of the insurer over the years in question in order to use those evaluations as defenses in receiver's actions against the third party. Such requests for information may be controlled by the state's Freedom of Information Act (FOIA) and, where the FOIA controls, these evaluations have generally been found to be subject to discovery by third parties. However, requests for specific documents may not be subject to disclosure, as the documents may be protected by the insurance department laws. Insurance department counsel and receivership counsel should work together in responding to requests for pre-receivership information as to the insurer.

4. Disclosure by Receiver

Forcing disclosure of the receiver's papers has been less successful than forcing disclosure by the regulator. The theory is that the receiver serves in a private capacity and is not subject to FOIA. Be careful to note whether a regulator holds papers in a regulatory or receivership capacity, as the receiver's authority is separate and distinct from the authority of the regulator.

5. Shifting of Burden of Proof

New York Insurance Law Section 1219(b) deems an insurer insolvency to have resulted from fraud. Under a similar statute, it may be possible to argue that the burden of proving that the directors of the insolvent insurer did not engage in fraud is borne by the directors. If such an argument were to succeed, the directors would essentially be required to prove that their actions were not fraudulent or at least culpable. This theory would greatly aid discovery and proof of their acts and is an argument which should be discussed with counsel regarding pursuit of a claim/suit against the directors.

L. Other Issues

1. Effect of Receiver's Fraud Action Against Directors and Officers Upon Reinsurance Recoverables

Before initiating a fraud action against the management or directors of the insolvent insurer, the receiver should consider possible unintended consequences of the suit. It is possible that the assertion of fraud will provide a basis for the insurer's reinsurers to seek rescission of their reinsurance obligations based upon the same fraud. If so, the receiver may sacrifice the largest asset (reinsurance recoverables) in the estate. This, in fact, happened in a 1996 New York insolvency.[235] IRMA § 112A provides that an allegation of improper or fraudulent conduct by management is not a defense to the receiver's action to enforce a contract unless the other party can prove that the fraud was "materially and substantially related" to the creation of the contract.

The ramifications of such a rescission would be far-reaching and dire. The effect would be to deprive the estate of substantial assets, reinsurance recoverables amounting to millions of dollars in most cases, and could severely undermine the receivership proceedings.

[235] See *Matter of Liquidation of Union Indemnity Insurance Co. of New York,* 89 N.Y.2d 94, 674 N.E.2d 313 (N.Y. 1996).

A receiver faced with such a demand for rescission may wish to argue that granting rescission fails to take into account the governing principles of law and public policy. Further, rescission contravenes the fundamental purpose of the insurance laws throughout the country, because it would result in a significant preference to reinsurers, as compared to other creditors against the estate, many of whom are innocent policyholders.[236] Under this argument, reinsurers should be accorded the same status as any other creditor and permitted to file a proof of claim in the liquidation proceeding (for fraud) and should not be allowed to absolve themselves of obligations owed to the estate via rescission.

While there is not a great deal of established precedent directly on point, courts have, in some cases, declined to allow rescission based on fraud where to do so would contravene established public policy reflected in a statute. These cases have involved an insolvent health maintenance organization, stockholders' subscriptions, the Federal Deposit Insurance Act, the Security Investor Protection Act (SIPA) and other banking statutes.[237]

Depending upon relevant state statutes, particularly in the area of credit for reinsurance, it may also be possible to construct an argument that allowing rescission in the context of an insurer insolvency is contrary to the legislative purpose and public policy. Such an argument might run as follows: the insurance laws require insurers to satisfy specific capital and surplus requirements. If the capital and surplus requirements are not met, the regulator may revoke the insurer's license to sell insurance in the state. In computing an insurer's capital and surplus requirements, an insurer under certain circumstances is entitled to a credit as an admitted asset (or a deduction from liability) for the amount of its risks and policy liabilities which it has reinsured.

Reinsurance may not be carried as an admitted asset unless the reinsurance proceeds are payable directly either to the insurer, or to the receiver, in the event of the insurer's insolvency, without diminution because of the insolvency of the ceding insurer. These requirements make it clear that the purpose of the regulatory scheme is to protect policyholders and other creditors in the event of an insolvency. The receiver could argue that this legislative purpose cannot be effectuated, however, and will be abrogated, if reinsurers are permitted to rescind ab initio their reinsurance contracts.

Another argument which may be available to the receiver based upon statute and public policy is that the loss of funds coming into the estate as a result of rescission could interfere with the administration of the estate.

Finally, it should be noted that rescission is an equitable remedy and is normally used to restore the parties to a previously existing condition. Some courts have suggested that, when a party enters into a contract with one person knowing that other persons will be affected, such party should not be allowed rescission as to one party without consideration of the consequence to others. Thus, the receiver may wish to argue that rescission ought not be allowed where the reinsurer knew or should have known that the cedent's policyholders would be affected by the reinsurance transaction.

Reinsurers may be expected to counter these arguments by noting that the insolvency clause is designed to prevent refusal of a reinsurer to pay based upon the cedent's insolvency and is not relevant to the separate and distinct question of rescission based upon fraud. Similarly, while state statutes limit preferences, preferences are not prohibited. For example, secured creditors are ordinarily allowed to convert secured property even though this effectively results in a preference. Further, there is an

[236] See *Garamendi v. Abeille-Paix Reassurances,* No. C-683-233, slip. op. (Cal. Super. Ct. L.A. Co. June 25, 1991); but see *Prudential Reinsurance Co. v. Superior Court of Los Angeles County,* 3 Cal. 4th 1118, 842 P. 2d 48 (1996) which arguably rejects the approach taken in *Garamendi*.

[237] See e.g., *Union Indemnity Co. v. Home Trust Co.,* 64 F.2d 906 (8th Cir. 1933); *In re Liquidation of Security Casualty Co.,* 127 Ill. 2d 434, 537 N.E.2d 775 (Ill. 1989) (refused to allow defrauded shareholders to rescind, and thereby increase their priority from Class "F" to constructive trust "super priority.").

established body of case law which suggests that parties such as reinsurers who are induced to enter into an agreement by fraud are entitled to attempt to rescind the agreement.

In summary, allegations of fraud could trigger efforts by reinsurers to rescind their reinsurance agreements with the insolvent insurer. While the receiver has available arguments against rescission, the receiver should be aware that the consequences to the estate are potentially severe. Counsel must be consulted and all potential ramifications explored before allegations of fraud are asserted.

2. Receiver's Claim of Proceeds of Directors and Officers Policy

The receiver is the successor in interest to the insurer. Therefore, the receiver has a right to claim against the directors' and officers' liability policy previously provided by the insurer. However, be advised that a claim based on fraud or intentional misrepresentation might provoke a reaction by vendors such as MGAs and reinsurers. They may argue the fraud allegedly prohibited them from rendering proper services to the insurer and, therefore, they are immune from suits and claims as described above. The directors and officers liability insurance policy, if any, may also exclude coverage of claims based upon fraud. The tension and conflict in these two positions should be noted and discussed with the estate's attorney.

IX. REINSURANCE

A. Introduction and Goal

The concept of reinsurance is discussed in detail in Chapter 7—Reinsurance. In this section, we will discuss the various legal issues and concepts that may arise in the course of the receivership, both where the insurer was the ceding insurer and where the insurer was the reinsurer.

This is an important area of law as reinsurance recoveries will often be the largest asset of the estate.

B. Reinsurance Ceded and Assumed

Chapter 7—Reinsurance sets forth a detailed discussion of ceded and assumed reinsurance.

C. Reinsurance Accounting and Collection Procedures

1. Loss Notifications

Agreements between primary insurers and reinsurers generally contain a provision requiring the insurer to give prompt and adequate notice to the reinsurer in the event of a loss which may trigger the indemnity required under the agreement. Chapter 7—Reinsurance includes a discussion of notice requirements.

- Timeliness

A legal issue often encountered is whether failure to give timely notice of a claim to a reinsurer relieves the reinsurer of the obligation to make a payment based upon the claim.

Case law in this area is far from settled. Some federal and state courts have determined that before a reinsurer can avoid liability due to late notice of loss, the reinsurer must be able to show that it has been prejudiced or suffered damage as a result of the lack of notice.[238] A small number of courts even require that an insurer seeking relief from its obligations based on breach of a notice clause must show "substantial prejudice" to its position in the underlying action resulting from the

[238] See *Christiana General Insurance Co. v. Great American Insurance Co.,* 745 F.Supp. 150, 161 (S.D.N.Y. 1990).

breach.[239] This is frequently a difficult burden for a reinsurer to meet, but the prudent receiver should expect contentions that late notice has prejudiced reinsurers. Further, other courts have recognized that if a reinsurance contract makes notice a "condition precedent" to payment, then failure to provide this required notice obviates the reinsurer's obligations under the reinsurance agreement regardless of whether prejudice can be demonstrated.[240] The receiver should consult counsel to ascertain the applicable rule in the local jurisdiction.

2. Defenses to Collection Based on Contract

a. Contract Limitations

In addition to the "late notice" defense, several other defenses to payment under reinsurance agreements may emerge. Depending upon the particular facts, reinsurers may assert that a claim arose after the expiration of either the primary coverage or the reinsurance coverage or is otherwise beyond the scope of coverage provided by the underlying insurance or the reinsurance agreement.

b. Exclusions

Both the underlying insurance policies and the reinsurance agreement will typically include descriptions of excluded risks. Before billing reinsurers, the receiver should verify that the loss is within the covered terms of the reinsurance agreement.

D. Secured Reinsurance

At the present time, the NAIC is considering the design of a revised United States reinsurance regulatory framework. This revised framework would establish a Reinsurance Evaluation Office. Among other things, this office would determine which other foreign countries have equivalent regulatory systems as the U.S. Reinsurers from those countries would be certified to access the United States market through a port of entry similar to foreign direct insurers. Additionally, collateral requirements would be set based on the nature of the reinsurance exposure, rather than on reserves. For a summary of the NAIC's work on this, see *NAIC Reinsurance Collateral Update*, Brian Fuller NAIC Senior Reinsurance Manager, Sept. 27, 2007.

1. Credit for Reinsurance in General

U.S. licensed reinsurers are regulated in essentially the same manner as primary insurers, except for rate and form regulation. Because U.S. insurance regulators have no, or limited jurisdiction over non-U.S. reinsurers, the reinsurance transaction (as opposed to the reinsurer) is regulated through the cedent by prescribing the terms under which the cedent can take financial statement credit for reinsurance recoverables.

While an insurer can opt to obtain reinsurance that does not qualify for financial statement credit, in most circumstances, it will be very important to a ceding insurer that it be allowed to take credit on its financial statements for reinsurance which it procures. However, there is no regulatory requirement that reinsurance meet this standard.

All U.S. jurisdictions have developed standards prescribing the circumstances in which a ceding insurer is allowed to take credit for reinsurance. The credit for reinsurance laws are important to a receiver for several reasons. If a reinsurer is licensed or authorized in a state, no security is typically required. However, if a reinsurer is not licensed or authorized, it is important for a receiver to know that there may be security posted in favor of the insolvent insurer securing obligations owed to that insurer by reinsurers. Alternatively, if the insolvent insurer was a reinsurer, assets of the insolvent insurer may be

[239] *GTM, Inc. v. Transcontinental Ins. Co.*, 5 F.Supp.2d 219 (D.Vt. 1998); *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715 (Cal. Ct. App. 1993).

[240] *Liberty Mutual Ins. Co. v. Gibbs,* 773 F. 2d 15 (1st Cir. Mass. 1985).

encumbered elsewhere to provide security necessary for credit for reinsurance purposes. This security usually takes one of three forms: letters of credit, trust funds and funds withheld.

2. Letters of Credit (LOC)

Situations where letters of credit are used for credit for reinsurance purposes involve three separate and distinct contractual arrangements. First, the reinsurance agreement itself usually will expressly require the reinsurer to provide security necessary for credit for reinsurance purposes. Second, there will be a contract between the reinsurer and the issuer of the letter of credit (LOC) (almost always a bank) pursuant to which the issuer agrees to issue the LOC in return for compensation. This agreement is sometimes referred to as an "account agreement." The account agreement usually requires the reinsurer to post collateral with the issuer to protect the issuer in the event that the issuer is compelled to make payment under the LOC. The third contract is the LOC itself, which is a separate and distinct contract entered into between the issuer of the LOC and the ceding insurer as the beneficiary of the LOC.

a. Maintenance

The mechanics involved in maintaining letters of credit are discussed in Chapter 7. The receiver should bear in mind two legal issues in connection with maintenance of LOCs. First, in most cases, the reinsurance agreement will expressly impose a contractual obligation upon the reinsurer to maintain the LOC for as long as the reinsurer has outstanding obligations under the agreement. If the receiver of an insolvent ceding insurer receives notice that a LOC will not be renewed while a reinsurer's obligations are still outstanding, the receiver should consult counsel immediately. The reinsurer's actions may give the receiver a contractual right to draw on the LOC. Such failure may also provide the receiver with a basis to charge the reinsurer with breach of the reinsurance contract.

Second, all LOCs posted for credit for reinsurance purposes are required to include an "evergreen clause" under which the issuer of the LOC agrees to give the beneficiary advance written notice prior to termination of the LOC. If appropriate notice is not provided, the LOC automatically renews. If the issuer allows termination without providing the receiver with requisite advance notice, there may be a cause of action available against the issuer for breach of the terms of the LOC and possibly for failure to fulfill the issuer's fiduciary responsibility to the ceding insurer as beneficiary.

b. Draw Down on LOC

The key legal issue for the receiver to remember in connection with a draw down on a LOC is the fact that the LOC and the reinsurance contract are separate and distinct contracts. A commercial dispute as to whether a particular obligation is due under the reinsurance agreement should not form a basis for a court to prevent a draw under the LOC. Letters of credit established for credit for reinsurance purposes are generally "clean" and "unconditional," meaning that all that is necessary for a draw to take place is for the ceding insurer to make a proper demand upon the issuer. It is generally well established that courts will not interfere with such a draw except in two cases: first, where the attempted draw is fraudulent; and, second, where the underlying transaction is so tainted with fraud that the draw should not be allowed (called "fraud in the transaction"). Of course, a draw that is appropriate under the terms of the LOC may ultimately be found to have constituted a breach of the underlying reinsurance agreement if the obligation is not actually due.

c. Right to Collateral

Once an issuer pays on a letter of credit, it will most certainly apply the collateral posted as security for the LOC by the reinsurer under the account agreement against the outstanding balance due from the reinsurer. Thus, wrongful or premature draws on LOCs may damage the estate of an insolvent reinsurer. The damages may be based not only on the loss of collateral, but also on the loss of interest income which would have been earned by the reinsurer had a premature draw not taken

place. Consequently, wrongful or premature draws may provide a basis for the receiver to bring suit against the cedent for breach of the underlying reinsurance agreement and consequent damages. The receiver of an insolvent cedent which draws down an LOC wrongfully or prematurely may also face a claim by the reinsurer.

3. Trust Funds

An alternative security device to letters of credit is trust funds. Trust fund arrangements involve two separate contracts. The first is the reinsurance agreement itself. The second is the trust agreement pursuant to which the reinsurer, as grantor, places assets in trust under the control of the trustee (again, usually a bank) with the ceding insurer named as beneficiary of the trust. See the NAIC Credit for Reinsurance Model Act (#785), Section 2D.

a. Maintenance

Unlike clean, irrevocable LOCs, trust agreements are fairly detailed and spell out the respective rights and duties of the parties. The receiver and his attorney should review the text of trust agreements to ascertain the rights and duties of the insolvent insurer. Failure of the trustee or the insurer who is a party to the agreement to comply with the agreement's terms and conditions may form a basis for a breach of contract action in favor of the estate.

b. Access to Trust Assets

This is largely spelled out by the terms and conditions of the trust agreement. General principles of contract law are applicable.

c. Chapter 15—Proceedings Under the United States Bankruptcy Code

An insurer will frequently cede business to a non-U.S. reinsurance company that is not licensed or authorized to do business in any state. In order for the insurer to take credit for the reinsurance it procures from such insurer, most states require the insurer to provide collateral to secure its U.S. obligations, in case the reinsurer becomes unable to fulfill those obligations for any reason. The reinsurer may provide this collateral in the form of a trust. The trust must contain enough funds to cover the reinsurer's U.S. liabilities.[241] The reinsurer can set up the trust for the benefit of a single ceding insurer, or for the benefit of all the ceding insurers with which it does business in the U.S. In the case of these latter trusts, known as multiple-beneficiary trusts, there must be a trusteed surplus in addition to the funds covering the reinsurer's liabilities, e.g., $20 million for most reinsurers, and $100 million for Lloyd's.

If the reinsurer becomes insolvent and fails to pay U.S. claims, state laws intend that the U.S. claimants may then turn to the trust for payment. In order to receive payment, claimants must follow the steps set forth in the trust instrument. These steps usually include acquisition of a judgment, exhaustion of appeals of the judgment, filing of the judgment with the trustee, and a 30-day notice to the reinsurer (or its receiver) that the cedent will obtain payment of its claim from the trust unless the reinsurer pays the claim itself.

Chapter 15 of the Bankruptcy Code states that a court may not grant relief under Chapter 15 with respect to any deposit, escrow, trust fund or other security which is required or permitted by any applicable state insurance law or regulation for the benefit of claim holders in the U.S. The purpose of this language is to make certain that bankruptcy courts have no power over U.S.-based reinsurance collateral posted for the benefits of U.S. claimants.

[241] For single beneficiary trusts the amount of the trust cannot be more than the amount of financial credit that the cedent has taken on its financial statements. This might be less than the reinsurer's total liabilities to the ceding insurer.

Additionally, states which have adopted the most current version of the NAIC model law and regulation on credit for reinsurance have addressed the problems which used to be posed by 18 U.S.C § 304. A U.S. receiver with trust claims should determine whether the state where the trust is located has adopted the most current version of the NAIC model law and regulation on credit for reinsurance. If the state has enacted those provisions, the U.S. receiver should consult an attorney to determine whether the provisions are applicable to the trust and claims in question.

4. Funds Withheld

A third alternative is for the reinsurance agreement to provide that the ceding insurer will hold funds belonging to the reinsurer in a separate account to secure the reinsurer's duties and obligations to the cedent. Again, general principles of contract law control the parties' respective duties and obligations with respect to funds withheld.

E. Setoff

While the concept of setoff can involve fairly complex computations, it contemplates that funds owed by an entity to an insolvent insurer's estate will be set-off against funds owed by the insolvent insurer to that entity, so that only the net will be collected or paid. The mechanics and potential financial ramifications of setoffs for an estate are discussed in detail in the reinsurance and accounting chapters of this handbook.

F. Cancellation of Reinsurance Agreements

A receiver should have staff review all agreements to determine what, if any, provisions are included regarding cancellation in the event of insolvency. Generally, absent such a provision (and frequently even if present) a receiver is empowered by the relevant state statute to cancel any contracts including reinsurance agreements, see § 114 and § 504A(8) of IRMA. Whether representing an insolvent reinsurer, primary insurer, or an insurer with both ceded and assumed reinsurance, notice to the opposite contracting party is essential. This is so that ceding insurers can replace their coverage and reinsurers can be aware of the date when their liabilities are cut off.

In the context of a life and health insurer insolvency, guaranty associations should be consulted before the company's ceded reinsurance agreements are canceled or otherwise terminated. Indemnity reinsurance may provide guaranty associations with valuable financial support in transferring policy obligations to an assuming insurer. Model #520 and IRMA §612 recognize this by providing guaranty associations with the right to assume the insolvent company's indemnity reinsurance agreements for the purpose of meeting coverage obligations.[242]

G. Rescission

1. Rescission Defined

Black's Law Dictionary (8th ed. 2004) defines rescission of contract as follows:

A party's unilateral unmaking of a contract for a legally sufficient reason, such as the other party's material breach, or a judgment rescinding the contract; VOIDANCE. • Rescission is generally available as a remedy or defense for a nondefaulting party and is accompanied by restitution of any partial performance, thus restoring the parties to their precontractual positions.

[242] Model #520, at Section 8.N.

2. Legal Ramifications

Alabama maintains that a reinsurance contract cannot be rescinded absent fraud or collusion. Nebraska law permits rescission of a reinsurance agreement if the ceding insurer has failed to perform its duties respecting reserving, reporting and other aspects of administration so totally as to constitute a material breach of the reinsurance agreement. In either circumstance, if the jurisdiction supports the grounds, the reinsurer may be entitled to rescind the contract from its inception.

A leading case describes the essential elements necessary to maintain an action for rescission because of false representations.[243] The party seeking rescission must allege and prove: 1) that representations were made; 2) that they were false and so known to be by the party charged with making them; 3) that without knowledge as to their truth or falsity they were made as a positive statement of known fact by the party charged with making them; 4) that the party seeking rescission believed the representations to be true; and 5) that the party relied and acted upon them and was injured thereby.

This case also discusses rescission based on non-performance of contract. Not every breach of contract or failure to perform entitles the other party to rescind. A rescission is warranted only by a breach of contract "so material and substantial as to defeat the objectives of the parties in making the contract."[244] Whether a breach qualifies as material or substantial enough to serve as grounds for rescission is a question of fact which depends on the circumstances of each case.

A party's right to rescind a reinsurance treaty is not absolute. If a party knows of facts giving rise to the right of rescission and fails to declare a rescission and disclaim the benefits of the contract within a reasonable time, the right to rescind may be barred. Also related to an insurer's right to rescind a reinsurance treaty are the questions of whether voluntary rescission may constitute a preference under existing statutes, the Liquidation Model Act and/or IRMA and, if a preference is created, whether it is a voidable preference. For example, if a ceding insurer, immediately before being declared insolvent, agrees to rescind from inception a ceded treaty where reinsurance recoverables exceed ceded premiums, the receiver may attempt to void the transaction. Each transaction should be analyzed in terms of the elements of a voidable preference discussed earlier in this chapter.

H. Use of Reinsurance to Wind Up the Affairs of an Insolvent Insurer

There are several reinsurance transactions available which may serve as tools for winding up the affairs of the insolvent insurer. These are briefly described below.

1. Commutations

A commutation agreement is one pursuant to which a reinsurer and a ceding insurer agree to terminate all obligations under a reinsurance agreement, accompanied by a final cash settlement. Commutations are discussed in detail in Chapter 7—Reinsurance.

There may be a commutation clause in the relevant reinsurance agreement. Alternatively, the parties may simply agree to the commutation based upon negotiations. The end product of the negotiations will be the reinsurer making a one-time cash payment into the estate in return for a full release from all future liability.

Given the material nature of the transaction, approval of the transaction should be obtained from the receivership court.

[243] See *Stone v. Walker,* 201 Ala. 130, 77 So. 554 (1917), cited with approval in *Johnson v. Jagermoore-Estes Properties,* 456 So.2d 1072 (Ala. 1984).

[244] *Id.*

§ 614 of IRMA authorizes commutation agreements and requires court approval where the gross consideration for the agreement is in excess of $250,000. This section also authorizes the receiver to have competing commutation proposals submitted to an arbitration panel and outlines the process to be used and the possible outcomes.

2. Assumption Reinsurance

Assumption reinsurance is a misnomer. It is an agreement whereby one insurer transfers to another insurer its contractual relationship and obligations to its insured. Thus, the purpose of the transaction is to bring about a novation. Assumption reinsurance can be a means for a receiver to transfer books of business away from the insolvent ceding insurer to another, solvent insurer, thereby reducing strain on the estate and alleviating one of the hardships otherwise caused by the insolvency. If guaranty fund assets will be needed to fund reserves when transferring a book of business, the receiver should work with the NOLHGA or the affected guaranty association during rehabilitation to locate a solvent carrier and to coordinate the transfer with the entry of a liquidation order.

- Mechanics

Notification to policyholders is essential if the agreement is to have the desired effect of precluding future claims by the policyholders against the ceding insurer's estate. In some states, notice alone may not be sufficient to achieve a novation; e.g., the policyholders' written agreement may be required. In some instances, both the transferring insurer and the assuming insurer have been found to have a continuing obligation to the insured where notice was not given and consent was not obtained. Applicable state law should be consulted to determine what law is followed in each jurisdiction. Mechanically, the assuming reinsurer issues what are called "assumption certificates" to the policyholders notifying them of the change in insurer. Given the material nature of the transaction, approval of the receivership Court should be obtained.

I. Portfolio Transfers and Financial Reinsurance

The various types and effects of financial reinsurance are discussed in detail in Chapter 7—Reinsurance.

1. Regulation of Financial Reinsurance

General Transfer of Risk Provisions

To receive accounting treatment as a reinsurance transaction, a transfer of risk is required. NAIC Statement of *Statutory Accounting Principles 62—Property and Casualty Reinsurance* (SSAP No. 62) requires the transfer of insurance risk for the ceding company to be granted accounting credit for the transaction. SSAP No. 62 states that the reinsurer must indemnify the reinsured entity, not only in form but in fact, against loss or liability by reason of the original reinsurance. Receivers should consult SSAP No. 62 if there are questions surrounding the accounting treatment of a particular reinsurance transaction. See Chapter 7—Reinsurance for a more detailed statement.

2. Financial Reinsurance in the Insolvency Context

Receivers of insolvent insurers which have engaged in financial reinsurance transactions should examine carefully the insurer's reinsurance agreements, giving careful consideration to the nature and purpose of the agreements. Among the factors that a receiver must weigh in evaluating whether a financial reinsurance agreement occurred between the insolvent ceding insurer and a reinsurer(s) are:

- Whether the transaction was accomplished solely to prolong the life of the ceding insurer;

- Whether a financial reinsurance transaction occurred between affiliates;

- Whether the transaction was close to the date of the declaration of insolvency;
- Whether the transaction was negotiated by officers or directors of an insurer who might have had a personal interest in the transaction;
- Whether accountants who prepared the ceding insurer's annual statement appear to have correctly reflected the transaction; and
- Whether there were any possible affiliations between the reinsurance intermediary and the parties to the financial reinsurance transaction.

If the receiver has reason to believe upon examining all facts that a financial reinsurance transaction did not meet the risk transfer requirements of SSAP No. 62, the receiver should consult with counsel to ascertain whether there are any viable causes of action arising out of the activities of the parties to the financial reinsurance transaction.

J. Dispute Resolution

There is no question that an insolvent insurer will have many disputes to resolve. There will be looming questions, however, of how the resolutions will occur, how long they will take and how much they will cost. These are questions a receiver will face on a regular basis and they are virtually always about collecting or paying money. More often than not, they involve reinsurance proceeds.

The insolvent insurer has various options in settling disputes: negotiation; mediation; arbitration; and litigation. As a general rule, negotiation is the fastest and least expensive option and litigation is the most costly and time consuming.

Arbitration has many advantages in the dispute resolution process. A majority of reinsurance agreements provide for it as the sole means of resolving conflict.[245] Most courts, including the U.S. Supreme Court, favor enforcing agreements to arbitrate, but a small number of New York and Ohio cases have held otherwise.[246] Historically, arbitration awards were forthcoming much sooner than a similar decision from a court of law. The result was usually less expensive than litigation and had other advantages such as: confidentiality of process; expert triers of fact; broad ranges of relief; and other procedural and substantive benefits.

The confidentiality aspect has been criticized because it prevents the award from having any precedential effect. However, the agreements which are generally the subject of arbitration proceedings are complex reinsurance agreements with multiple parties. In addition, the industry has such arcane, esoteric language and customs that it is unlikely a court decision as to the interpretation of a particular agreement would have precedential effect in any event.

One reason a receiver may want to resolve disputes through litigation is because of the cases being heard in a perceived "friendly forum." Since insolvent insurers are liquidated by virtue of the statutes of the state of domicile, the receivership court has broad powers to wield in protecting the estate. It may restore a spirit of cooperation and settlement, giving the insolvent insurer back some of the leverage it lost with the

[245] See e.g., *Selcke v. New England Ins. Co.* 995 F.2d 688, 689, 690 (7th Cir. 1993).

[246] See e.g., *Quackenbush (as Liquidator of Mission) v. Allstate* 517 U.S. 706 (1996) (U.S. Supreme Court ruled that receiver may be required to arbitrate); *Foster v. Philadelphia Manufacturers,* 592 A.2d 131 (Pa. Commw. Ct. 1991) (Court ruled that arbitration clause was enforceable against receiver under Pennsylvania state law), contra *Koken v. Reliance Ins. Co.*, 846 A. 2d 778 (Pa. Comm. Ct. 2004) which held that arbitration could not be compelled where receivership was liquidation rather than rehabilitation as in *Foster*, there was a court order which prohibited bringing actions against the Liquidator, and the Liquidator did not initiate the lawsuit where arbitration was in issue; *Benjamin v. Pipoly,* 155 Ohio App. 3d 171, 800 N.E. 2d 50 (2003 Ohio App.) and *Hudson v. John Hancock Fin. Serv. ,*2007 Ohio App. LEXIS 6137 (Enforcing arbitration clause is against Ohio public policy in insurance receiverships); *Washburn v. Corcoran,* 643 F.Supp. 554 (S.D.N.Y. 1968) (Court ruled that arbitration clause was unenforceable against receiver under New York law.).

reinsurers when it ceased to be a potential source of future business. Reinsurers will typically resist litigation. Each receiver must determine in each case when arbitration would be advantageous to the estate.

K. Pre-Answer Security

Courts may require certain insurers to post security when sued in U.S. jurisdictions in which they are not licensed. Thirty-eight states have adopted the Uniform Unauthorized Insurers Act. For example, New York Insurance Law Section 1213(c) requires a foreign or alien (nonadmitted) insurer to post "pre-answer security" before it files any pleadings in the court. The security must be sufficient to guarantee the payment of a final judgment that may be issued against the insurer. In New York, a failure to post the required security may result in a default judgment.

The law was originally enacted to protect policyholders who experienced difficulty executing judgments against unauthorized foreign and aliens insurers with insufficient assets in the state in question to satisfy the judgment. Although reinsurers have argued that the statute was not intended to apply to them, courts consistently have applied the statute to reinsurers being sued by ceding insurers or their receivers.[247]

Courts have addressed several other issues in recent decisions, such as the amount of security that is required, or the circumstances, under which an insurer is "doing business" in a state, that are sufficient to invoke the pre-answer security requirement.

In reinsurance disputes, courts often require an amount of security equal to the plaintiff's alleged damages. In a New York case, however, the required amount of security was limited to paid losses, excluding case reserves and IBNR.[248]

In at least one case, a ceding insurer licensed in New York invoked the pre-answer security requirement against an alien reinsurer even though no policy was delivered in New York and the reinsurance transaction took place through the mail.[249] Some cases have noted, however, that the Foreign Sovereign Immunities Act 28 USCA § 1602, et. seq. may preempt state security statutes if the foreign insurer or reinsurer is an agency or instrumentality of a foreign state.[250]

Additionally, some courts have held that arbitrators have broad authority to require pre-hearing security.[251] Arbitration panels also are increasingly requiring the posting of security. Reinsurers may be subject to posting security in actions seeking to compel arbitration or to confirm arbitration awards.

L. Discovery of Reinsurers

Reinsurance information has been generally undiscoverable to policyholders. In those instances where policyholders have tried to obtain information regarding their insurer's reinsurance, the release of the information has been denied on the basis of relevancy since the policyholder had no contractual right to the reinsurance proceeds.[252] Insurers and reinsurers have also contested production on the basis that the information was proprietary and confidential.[253]

Increasingly, policyholders in large coverage disputes are pressing for reinsurance information and courts are allowing production based on the typical analyses applied to other industries and litigants, e.g., whether

[247] See e.g., *Morgan v. American Risk Management, Inc.*, 1990 WL 106837 (SDNY July 20, 1990).

[248] *Morgan v. American Risk Management, Inc.,* 1990 WL 106837 (SDNY July 20, 1990);

[249] *John Hancock Property & Casualty Insurance Co. v. Universale Reinsurance Co.,* 1993 U.S. Dist. LEXIS 9411 (SDNY July 12, 1993).

[250] See e.g., *Stephens v. National Distillers and Chemical Corp.,* 69 F.3d 1226 (2d Cir. 1995).

[251] *Pacific Reinsurance Management Corp., v. Ohio Reinsurance Corp.,* 935 F.2d. 1019 (11th Cir. 1991).

[252] See e.g., *Leski, Inc. v. Federal Ins. Co.,* 129 F.R.D. 99, 106 (D.N.J. 1989).

[253] See e.g., *National Union Fire Ins. Co. v. Stauffer Chemical Co.,* 558 A.2d 1091, 1097 (Del. Super. Ct. 1989).

the communications were protected by the attorney-client privilege or work-product doctrine, and whether the communications between a lawyer and his client constituted legal or business information.[254]

If discovery of reinsurance information is being sought by the receiver or discovery demands are being made on the receiver, counsel should consult local law to determine the extent to which such information is discoverable.

M. Priority of Claims for Payment of Reinsurance

Both the Liquidation Model Act and IRMA exclude from the policyholder level distribution class "obligations of the insolvent insurer arising out of reinsurance contracts," see § 801 C(1) of IRMA and § 47C(1) of Liquidation Model Act. Those claims are subordinated to the unsecured claim distribution class. States without this exclusion that have considered the issue have reached the same conclusion, See *Covington v. Ohio General Insurance Co*, 99 Ohio St.3d 117, 789 N.E.2d 213 (2003); *Neff v. Cherokee Insurance Co.*, 704 S.W.2d 1 (Tenn. 1986); *In re Liquidation of Reserve Insurance Co.*, 122 Ill.2d 555,524 N.E.2d 538 (1988); *Foremost Life Insurance Co. v. Indiana Dept. of Ins.*, 274 Ind. 181, 409 N.E.2d 1092 (1980).

X. EXHIBITS

Exhibit 9-1: NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers

Exhibit 9-2: Considerations for Separate Accounts – Receivers' Checklist

[254] *Lipton v. Superior Court,* 56 Cal. Rptr. 2d 341 (Cal. Ct. App. 1996); and *Allendale Mutual Insurance Co. v. Bull Data Systems,* 152 F.R.D. 132 (N.D. Ill. 1993).

Exhibit 9-1: NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers

NAIC PROPOSED GUIDELINES
RELATING TO THE REPORTING OF LOSS INFORMATION TO REINSURERS

- The parties to reinsurance agreements involving a U.S. ceding insurance company are presumed to know the role of guaranty associations in a domestic liquidation.

- Liquidators have the obligation for loss reporting to reinsurers in accordance with the terms of the insolvent insurance company's reinsurance agreements.

- Liquidators should promptly advise the guaranty associations of the loss reporting requirements of applicable reinsurance agreements and what additional information is needed from the guaranty associations.

- Guaranty associations should acknowledge the responsibility to furnish timely and adequate information to liquidators so that the liquidators may meet their loss reporting obligations to reinsurers.

- Reinsurers should request from liquidators only that information to which the reinsurers are entitled under the reinsurance agreement.

- Reinsurers should not contact guaranty associations directly. Upon consultation with each guaranty association, liquidators should permit and initiate arrangements for reinsurers to review the claims handling practices of guaranty associations and to examine claim files in which reinsurers have an interest. Guaranty associations should acknowledge their obligation to permit such reasonable review by representatives of liquidators or reinsurers; liquidators should acknowledge their obligation to timely advise guaranty associations of such requests of reinsurers to examine claim files and to verify the scope of such review. Reinsurers are encouraged to provide a summary of their findings to liquidators, who will then provide a copy to the appropriate guaranty association.

- Unless otherwise determined by the liquidator, guaranty associations should promptly report the following loss information to liquidators; liquidators should promptly provide this information to reinsurers to, among other things, provide reinsurers an opportunity to elect to participate in the defense and to establish the reinsurers' own reserves:

    - Initial reports on each claim arising after liquidation.

    - Narrative description of each claim arising after liquidation.

    - Regular reporting of payments and notification of closing, updated at least on a quarterly basis.

    - Regular reporting of reserve information, including reports of changes in reserves, updated at least on a quarterly basis; also included with such reports should be projected loss exposures regardless of the guaranty association's maximum statutory liability (cap), or in the alternative immediate notification of any claim that is reserved at or near the cap.

- Interim reporting of information to liquidators with respect to bodily injury, personal injury and/or property damage claims of a catastrophic nature as well as environmental, toxic pollution, hazardous waste, des, asbestos-related, agent orange and other product liability claims and major losses; major losses should be defined in each insolvency by agreement between the liquidator and the guaranty associations.

- Interim reporting of known trial dates and settlement conferences on specified types of claims as agreed between liquidators and guaranty associations.

- Interim reporting of significant changes in the status of claims, reserve changes and loss or expense payments; the liquidators should promptly advise the guaranty associations of the reporting requirements with respect to each book of business.

Provision by guaranty associations of the above-listed information in a sufficiently detailed, uniform format utilizing electronic data processing capabilities is desired.

- In claims arising out of policies with aggregate coverage limits, it is the responsibility of liquidators to monitor the cumulative payments and/or allowances (pre- and post-liquidation) and to promptly advise guaranty associations of policies having aggregate limits and the amount remaining available under each such limit. Guaranty associations should consult with the liquidator on all claims involving an aggregate limit prior to entering into any settlement or issuing any payment. Liquidators should furnish such aggregate status information to reinsurers upon request.

- Liquidators and reinsurers should accept determinations of "covered claims," as defined under the applicable guaranty association statutes, and the amount of "covered claim" payments made by guaranty associations unless an extraordinary fact situation exists, or an applicable law justifies a challenge.

- Under reinsurance agreements, salvage and subrogation recoveries may belong to the reinsurers rather than liquidators; thus, the guaranty associations and liquidators should consult and cooperate with each other concerning the handling and disposition of salvage and subrogation recoveries.

- In the absence of prejudice, the payment of loss due under a reinsurance agreement by a reinsurer should not be withheld solely on the basis of time limits of the liquidator's reporting of that loss where the liquidator can show reasonable compliance with the applicable loss reporting requirements under the agreement.

- Guaranty associations should recognize liquidators' requirements to receive original closed claims files. Liquidators should recognize guaranty associations' requirements to retain closed claim files through an audit cycle. Liquidators should consult with the reinsurers and guaranty associations concerning the establishment of appropriate document retention/destruction procedures, subject to the liquidation court's approval.

- Guaranty associations should recognize liquidators' requirements, from time to time, to have reproduced some or all open and closed claim files; liquidators will be reasonable in such requests and shall consult with guaranty associations regarding the manner and timing of payment of reproduction costs.

- Liquidators and reinsurers should transmit information through reinsurance intermediaries when provided for in the applicable reinsurance agreements, unless there has been agreement by all concerned that the information should be transmitted directly between the reinsurers and the liquidator.

- Numerous reinsurers may have an interest in an individual claim. It is incumbent upon the liquidators and reinsurance intermediaries to develop procedures to efficiently match and respond to reinsurers' inquiries in a reasonable and practicable manner and to avoid requesting duplicate data from guaranty associations.

Considerations for Separate Accounts – Receivers' Checklist

This receiver's checklist accompanies Chapter 9: Legal Considerations – III. H. General Guidance for Receivers in a Future Receivership of a Troubled Insurer that Issued SEC Registered Products. The checklist is intended to assist with issue spotting and identifying areas where receivers should be in communications with the U.S. Securities and Exchange Commission (SEC). Receivers should be aware that insurers' registered products are constantly evolving, and that the issues that might be encountered in a receivership of an insurer that issued registered products are likely to be different than those in prior receiverships due to the different product mixes. Receivers encountering SEC registered products in a receivership should early in the proceedings retain experienced legal counsel qualified to provide advice on the federal securities laws the rules under those laws and compliance issues, and on how state receivership laws and federal securities laws might interact in a receivership.

1. Immediately identify the types of insurance products to be administered during receivership.
2. Immediately determine whether or not products are registered with the SEC. Registered products include:
    - Variable Products (variable annuities or variable life insurance policies).
        - If there are registered variable products, then any separate account supporting those Variable Products will also be subject to registration under the Investment Company Act of 1940 (1940 Act) and be subject to additional compliance requirements under the 1940 Act.
    - Other SEC Registered Products (e.g., certain fixed annuities with market value adjustments or index-based adjustments to value).
3. Receivers should identify other interested federal regulators and establish lines of communication with them.
4. Receivers of an insurer with Managed Separate Accounts should communicate with the board of directors of that Managed Separate Account since any action taken may require board approval.

    If the insurer has registered products, immediately contact SEC staff to establish lines of communication and identify contact points for coordination.

    - The SEC's website contains contact numbers for SEC offices in Washington and for SEC's regional offices: *www.sec.gov*.
    - Information regarding the SEC Division of Investment Management and how to contact these SEC staff may be located at: *www.sec.gov/investment*.
5. Immediately focus on SEC registered products. The federal securities laws applicable because of the insurer's registered products vary depending on the type of product.
    - Review and evaluate the impact of and compliance with the applicable state receivership laws and the federal securities laws applicable to the insurer and its registered products, in particular if the registered products are variable products with separate accounts.

    For variable products,

    - Determine types of separate accounts supporting the variable products and whether any existing separate account was, or was required to be, registered under the 1940 Act as either:
        - Unit Investment Trust (UIT).
        - Managed Separate Account.

- Determine if variable product is backed by insulated separate account not registered under the 1940 Act (Exempt SAs).

- Obtain and review available 1933 Act and 1940 Act registration statements and other filings.
  - Obtain complete set of all SEC filings, looking for:
    - Insurer's "Plan of Operations" or similar documentation for operation of separate account (may not be filed with the SEC).
    - Obtain all agreements with reinsurers, distributors, third-party credit support providers, guarantors, administrative service providers, custodians and investment advisors/managers involved with insurer's maintenance of separate accounts
- Obtain and review Rule 38a-1 written compliance policies and procedures and annual compliance reports.
- Obtain copies of any significant SEC orders or other relief applicable to the separate account that modifies the regulatory regime governing the account.
- Determine the types of variable products and amount of the insurer's net financial exposure.
  - Locate and review all prospectuses filed with SEC and all variable product forms insurer issued.
- Determine all guarantees provided with registered products, such as:
  - Expense charge guarantees.
  - Mortality guarantees.
  - Optional guaranteed benefits, such as guaranteed death benefits (GMDBs), and guaranteed living benefits such as guaranteed minimum withdrawal benefits (GMWBs), guaranteed minimum accumulation benefits (GMABs) and guaranteed minimum income benefits (GMIBs).
- Determine the standards governing the guarantees.
  - Based upon or determined from guaranteed return of premium, guaranteed annual interest rate return, or highest anniversary value.
- Determine insurer's financial risk not supported by separate accounts.
  - Review all actuarial memoranda and analysis.
- Determine insurer's financial hedging transactions to support obligations under variable products.
  - Evaluate whether hedging programs are adequate.

<u>For other SEC Registered products</u>,

- Determine if SEC registered product is backed by an insulated separate account that is not registered under the 1940 Act (such as registered MVA, and registered index-linked variable annuities).
- Obtain and review available 1933 Act registration statements and other filings and all 1934 Act reports (Form 10-K, 10-Q and 8-K), if applicable.
  - Obtain complete set of all SEC filings, looking for:
    - Insurer's "plan of operations" or similar documentation for operation of separate account (may not be filed with the SEC).
    - Obtain all agreements with reinsurers, distributors, third-party credit support providers, guarantors, administrative service providers, custodians, and investment advisors/managers involved with insurer's maintenance of separate accounts
  - Determine the types of other SEC registered products and amount of the insurer's net financial exposure.
    - Locate and review all prospectuses filed with SEC and all product forms insurer issued.

- Determine all guarantees provided with other SEC registered products, such as:
    - Expense charge guarantees.
    - Mortality guarantees.
    - Optional guaranteed benefits, such as guaranteed death benefits (GMDBs), and guaranteed living benefits such as guaranteed minimum withdrawal benefits (GMWBs), guaranteed minimum accumulation benefits (GMABs) and guaranteed minimum income benefits (GMIBs).
- Determine the standards governing the guarantees.
    - Based upon or determined from guaranteed return of premium, guaranteed annual interest rate return, or highest anniversary value.
- Determine insurer's financial risk not supported by separate accounts.
    - Review all actuarial memoranda and analysis.
- Determine insurer's financial hedging transactions to support obligations under variable products.
    - Evaluate whether hedging programs are adequate.

6. Determine whether from an operations standpoint the receiver should maintain the insurer's infrastructure, compliance procedures, administrative procedures, technology, fund managers, etc.
    - Obtain and review all documentation, contracts, licenses, etc., pertaining to these matters.
7. Life Guaranty System
    - Collaborate with guaranty associations (through the NOLHGA in multi-state insolvency) as soon as practical regarding registered products that may be eligible for guaranty association coverage, including the assessment of (i) what securities laws might apply to covered registered products and any related separate accounts and (ii) compliance and operational issues with respect to the possible continuation of covered registered products, including whether the receiver should maintain the insurer's infrastructure, technology, product administration, fund managers and other relevant operational mechanisms
8. Explore sale of insurer's book of business (assumption reinsurance transaction)
    - Communicate with SEC staff and legal counsel regarding plans to transfer registered products book of business.
9. Securities Laws Compliance Considerations
    - Separate accounts supporting variable products
        - Properly established, insulated separate accounts supporting registered products must be preserved.
        - Assets in the separate account are insulated and ear-marked and are thus protected from the claims of general creditors in the insurer's receivership.

- General Account Guarantees regarding SEC Registered and variable products.
    - Insurer's general account guarantees are subject to claims paying ability of the insurer.
    - Claims associated with the insurer's guarantee of the variable product are claims against the general assets of the insurer.
- SEC Registered Products with Guarantees.
    - Guarantees are subject to claims paying ability of the insurer.

- Disclosure Requirements.
    - Initiation of receivership proceedings and other actions taken during receivership will likely necessitate filings with the SEC and disclosure to owners of the registered products. The receiver should seek advice from legal counsel regarding what events need to be disclosed under the federal securities laws and the manner and timing of such disclosures.
- Registration Statements and Prospectus Disclosure Requirements – Supplementation Requirements.
    - Receivers may seek guidance from SEC staff and legal counsel on the need to keep product registration statements and prospectuses current at different stages of receivership.
    - Suspension of Sales & New Premium.
        - Consult with SEC staff and legal counsel as soon as possible in the receivership process if receiver decides it cannot comply with any federal securities law requirements, since commencement of a receivership does not terminate the registration of any contracts registered as securities under the 1933 Act or of any separate account registered as an "investment company" under the 1940 Act.
        - Consult with legal counsel regarding the need to obtain a no action letter from SEC staff regarding not issuing updated prospectuses.
        - Suspending new premiums on in-force SEC Registered Products could be problematic and should be discussed with SEC staff before implementation.
    - Transferring Registered Variable Product Business.
        - Communicate with SEC staff and legal counsel regarding plans to transfer a book of business to an assuming solvent insurer.
        - No Action relief should be sought in connection with such a transfer and change in control issues arising from the liquidation.
    - Restructuring Registered Product Contracts.
        - Communicate with SEC staff and legal counsel regarding plans to restructure insurer's registered product contacts, and should seek necessary approvals from SEC staff.
    - Continuing to "Evergreen" Prospectuses and File Required Reports.
        - Keep prospectuses up to date if the insurer continues to sell registered products or receive premiums in receivership.
    - Continue to comply with periodic reporting obligations of the 1934 Act.
- Redeemability
    - Communicate with SEC staff and legal counsel about any anticipated disruptions in payments or processing redemptions funded by any separate account registered under the 1940 Act.
    - Resolutions of Blocks of Business.
        - Where a "pre-packaged receivership" that results in the immediate sale/transfer of the registered product business is not possible, consideration should be given to:
            - Restructuring the registered product contracts and cease accepting premiums.
            - Offering an exchange of the insurer's registered product contract.
            - Offering to buy back the insurer's registered product contracts.
        - Consult with SEC staff and legal counsel regarding above implementation of above considerations.

