Date: 11/09/2023

Virtual Meeting

RECEIVERS' HANDBOOK (E) SUBGROUP
Thursday, November 9, 2023
4:00 – 5:00 p.m. ET / 3:00 – 4:00 p.m. CT / 2:00 p.m. – 3:00 p.m. MT/ 1:00 – 2:00 p.m. PT

ROLL CALL

Kevin Baldwin, Chair	Illinois		
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
		Patrick Zeller	New Mexico
Tom Mitchell	Michigan		

NAIC Support Staff: Sherry Flippo

AGENDA

1. Consider adopting minutes from August 18, 2023, and October 5, 2023—*Kevin Baldwin (IL)* — Attachment A

2. Consider adopting Chapter 6 and Chapter 8 of the *Receivers' Handbook for Insurance Company Insolvencies—Kevin Baldwin (IL)* — Attachment B

3. Consider adopting Chapters 9, 10, 11, and appendix —*Kevin Baldwin (IL)* — Attachment C

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

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Draft: 8/23/23

Receiver's Handbook (E) Subgroup
Virtual Meeting
August 18, 2022

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Aug. 18, 2023. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Miriam Victorian, Vice Chair (FL); Jared Kosky (CT); Tom Mitchell (MI); Leatrice Geckler (NM); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brian Riewe (TX).

1. Adopted Chapter 7 of the Receiver's Handbook

Kosky made a motion, seconded by Mitchell, to adopt Chapter 7 of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook) (Attachment A). The motion passed unanimously.

2. Re-Exposed Chapter 6 and Exposed Chapter 8 of the Receiver's Handbook

The Subgroup considered exposing Chapter 6 and Chapter 8 of the Receiver's Handbook. All comments should be sent to Sherry Flippo (NAIC) at sflippo@naic.org.

Victorian made a motion, seconded by Slaymaker and McDonald, to expose Chapters 6 and Chapter 8 of the Receiver's Handbook (Attachment B) for a 30-day public comment period ending Sept. 18. The motion passed unanimously.

3. Discussed the Drafting Group for Chapters 9, 10, and 11 and Released Current Edits to Chapter 9

In August, the drafting group will have a kickoff meeting. The Subgroup released the current edits to Chapter 9 (Attachment C). Additionally, it was noted that the current Receiver's Handbook version is posted on the Subgroup's website under the documents tab.

Having no further business, the Receiver's Handbook (E) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/RITF/2023 Fall NM/RHS 08182023.docx

Draft: 11/6/23

Receiver's Handbook (E) Subgroup
Virtual Meeting
October 5, 2023

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Oct. 5, 2023. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Miriam Victorian, Vice Chair (FL); Jared Kosky (CT); and Laura Lyon Slaymaker and Crystal McDonald (PA).

There was not a quorum present. Therefore, the Subgroup was only able to do the following:

1. Exposed Chapters 9, 10, 11 and appendix of the Receiver's Handbook

The Subgroup exposed Chapters 9, 10, 11 and appendix for a 30-day period ending Nov. 6, 2023.

Having no further business, the Receiver's Handbook (E) Subgroup adjourned.

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Highlighted references will be confirmed and updated upon adoption of all chapters.

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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, the District of Columbia, Puerto Rico, the United States Virgin Islands[1] have a guaranty mechanism[2] 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, a typical claimant might wait years for payment of a claim 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.[3] 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* (#520) (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/health and property/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 National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), or National Conference of Insurance Guaranty Funds (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 to affected GAs.

[1] U.S. Virgin Islands has one guaranty fund that covers life/health and property/casualty. Oct. 6, 2019, Act No. 8211 was signed into law, and amended 22 V.I.C. § 232 (Scope) to provide that this "chapter shall apply to all kinds of direct insurance, except title, surety, credit, mortgage guaranty and ocean marine insurance."

[2] 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 often 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.

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

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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 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.[4] 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 *Property and Liability Insurance Guaranty Association Model Act* (540) (P/C Model Act). Although the P/C 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 P/C 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 Chapter 2 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.

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

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B. Triggering Fund Liability

See Chapter 1 Section II.G.4

1. General Statutory Activation Requirements

Previously, the P/C 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 P/C Model Act expanded the definition of "insolvent insurer" to read as follows:

> "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 P/C 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.[5]

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.[6] 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

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[5] 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.

[6] 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.

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once put in motion. Judicial review is perceived to be an effective safeguard against arbitrariness and ambiguity.

The current version of the P/C 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 P/C Model Act's current version does not confer jurisdiction on these courts.

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 P/C 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 P/C 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 P/C 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.

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Some guaranty fund statutes provide for a per claim deductible. A majority of guaranty association 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 association'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 association. 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 P/C 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

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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 below for more information in this regard.

2. Proof of Claim

   a. Claims Determination Framework

Nowhere is the interrelationship between the receiver and the guaranty associations more prominent than in the area of claims determination. This relationship is defined in the P/C 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* (#555, commonly known as "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 associations 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 associations 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 association'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.

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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 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 associations 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 IRMA § 405):

- 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
- Such other information as may be needed by the guaranty funds

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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 receiver 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 need 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 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.

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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 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 UDS Technical Support Group (UDSTSD) 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 associations' 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

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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 P/C 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 P/C 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.

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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 associations 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. IRMA Section 706 D 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 associations 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;

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- 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.

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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 IRMA Section 803 F 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 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 IRMA §803 F;
- 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 IRMA §803 B; UDS is the platform commonly utilized 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.

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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 associations concerning the priority of particular guaranty association 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 associations 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 IRMA §803 A(2)(c).

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 IRMA § 803 G.

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.

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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 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.

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 associations, and how the parties might better work together to protect consumers.[7]

III. LIFE AND HEALTH GUARANTY ASSOCIATIONS

A. Introduction

In 1970, the NAIC adopted the *Life and Health Insurance Guaranty Association Model Act* (#520) (Life Model Act). Since 1970, the Life Model Act has undergone several major revisions. The most recent

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[7] 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

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revisions to the Life Model Act were made in 2017.[8] 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 NOLHGA Web site 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 and Puerto Rico, 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 whitepaper on Communication and Coordination Among Regulators, Receivers and Guaranty Associations, cited in Chapter 1 of this handbook, 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

[8] 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.

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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…."[9] Certain types of insurers are excluded from the Life Model Act definition, such as fraternal and mutual assessment companies. Moreover, while a majority of states now include Health Maintenance Organizations ("HMOs") as member insurers, not all states do. State guaranty association laws will govern whether HMOs are member insurers for purposes of guaranty association coverage in a given state.

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. The primary purpose of the guaranty associations is to protect policyholders, however, 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 provide coverage before liquidation.

There are subtle variations among some state guaranty association triggering provisions which could potentially impact uniform triggering of guaranty associations in affected states. Coordination with guaranty association representatives and NOLHGA (if a multistate insolvency), as early as possible 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 triggering. or 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. e Under the Life Model Act, the following coverages are provided:[10]

[9] HMOs were added to the definition of "Member Insurer" as part of the 2017 package of amendments to the Life Model Act. As of this writing, those amendments had been largely adopted in 36 states. However, at least one of those states has continued to exclude HMOs from the definition of Member Insurer.

[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/statinfo) or consult the applicable state guaranty association.

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- 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 to the Life Model Act, replaces the prior reference to basic hospital, medical and surgical insurance and major medical insurance, and includes coverage under health maintenance organization 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 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

[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).

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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. HMOs were added as member insurers under the Model as part of the 2017 amendments. However, these amendments have not yet been adopted in all states. Moreover, a few states may have separate HMO guaranty associations established under state law. Accordingly, it will be important to review state law to determine whether and to what extent a state provides guaranty association coverage for HMO products. 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 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 would 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.

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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)

[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.

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- Rate files/history
- 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 g 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
- Describe the receiver's handling of claims in excess of guaranty association statutory maximums
- 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

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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 IRMA §801), 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 IRMA §803. Early access is typically accomplished by specific agreement, which should include a provision that the guaranty associations will return excess funds.

[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.

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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 IRMA Section§612, 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 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 entering into binding contracts.

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[1] UDS Manual link to be included when published from .ncigf wesite

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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
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 (Model #555, commonly known as 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

[1] 29 U.S.C. Section 1001, *et seq*.
[2] See, for example, Section 626.902, *Florida Statutes*

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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 of this Handbook, section on Liquidation, 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 of this Handbook.

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

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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 of incorporation (i.e., domestic, foreign and alien—see Section III.(C) of this Handbook 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

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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, MODEL #555 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

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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

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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.

[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

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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-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.

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

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IV. 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 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

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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.

> <u>Distressed risk</u> consists of exposures that are characterized by unfavorable underwriting characteristics, such as having sustained frequent losses in recent years.
>
> <u>Unique risk</u> 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.
>
> <u>High-capacity risk</u> 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

[7] Ibid, pg. 6.

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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 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.

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

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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

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

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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.

(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 Associations ("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

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

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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 Section 104(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

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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-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 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.

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

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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.

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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.

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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,

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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.

V. 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.

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

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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.

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.

[13] *Accord* NAIC Protected Cell Company IRLMA § 6.
[14] *Accord* NAIC Protected Cell Company IRLMA § 7.

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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.

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VI. 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 these provisions were adopted because they were incorporated in the Interstate Relations sections of the NAIC's Insurers Rehabilitation and Liquidation Model Act (the IRLMA). The IRLMA 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 IRLMA. 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 (UILA)

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

[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.

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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.

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

[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).

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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

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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 IRLMA.

B. The Insurers Rehabilitation and Liquidation Model Act (IRLMA)

The IRLMA 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 IRLMA 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 IRLMA

Ten sections (54-63) of the IRLMA adopt much of the UILA, as well as its policy objective: centralization of delinquency proceedings in the domiciliary jurisdiction. Unlike the UILA, however, the IRLMA no longer refers to the insolvency proceedings as a "delinquency proceeding." Rather, the IRLMA distinguishes between conservation and "formal proceedings," i.e., rehabilitation and liquidation. States are considered reciprocal under the IRLMA 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 IRLMA parallel those in the UILA, i.e., the same grounds for rehabilitation or liquidation set forth in Section 15 of the IRLMA. 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 IRLMA, 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 IRLMA 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

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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 IRLMA 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 IRLMA 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 IRLMA requires that the receiver provide periodic accountings to the supervising court.

With respect to assets, the IRLMA 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 IRLMA and the UILA treat the filing of claims differently. Under the IRLMA, 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 IRLMA 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 IRLMA, 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 IRLMA also now differs from the UILA in its treatment of controverted claims. Under the IRLMA, 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 IRLMA 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.

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6. Priority of Distribution

Under the IRLMA, general assets are distributed in accordance with the domiciliary state's priority of distribution scheme. The IRLMA was drafted so that the determination of priority by an ancillary liquidator and court is not binding upon the domiciliary liquidator. The IRLMA 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 (#555, IRMA)

The *Insurers Receivership Model Act*, (#555), commonly known as IRMA, was adopted by the NAIC in December 2005 to replace the earlier IRLMA. There are several areas of change between IRMA and the IRLMA, 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 IRLMA. 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 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

[17] IRLMA § 58

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(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.

VII. 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

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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 (e.g., 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 authorised 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.

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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

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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.

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 Own Risk and Solvency Assessment (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 Appendix xxx for a template for development of a resolution plan that describes the U.S. receivership system.

Refer to the NAIC *Financial Analysis Handbook* and the *Troubled Insurance Company Handbook* (regulator only publication) for more details on group-wide supervision, supervisory colleges, CMGs, and recovery and resolution planning.

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[18] A discussion of IAIG criteria and other analysis and regulatory considerations for grup-wide supervision is included in the NAIC *Financial Analysis Handbook* and the *Troubled Insurance Company Handbook* (regulator only publication).

[19] Refer to IAIS Insurance Core Principle (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)

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Highlighted references will be confirmed and updated upon adoption of all chapters.

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I. INTRODUCTION

This chapter of the Receivers' Handbook is intended to provide helpful information about receivership legal matters. Although case law has been cited, this handbook is not intended to be cited as binding legal authority and does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate cases to assist the receiver in targeting useful information. For further details, including any additional adoptions, the statutes and regulations cited should be consulted in each receivership.

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 somewhat 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 the 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.

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[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).

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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~~, commonly 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 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.

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~~commencement of proceedings~~ 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.

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[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].

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

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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 ~~§~~Section 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, ~~§~~Section 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.

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 ~~§~~Section 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

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.

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

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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 ~~§~~Section 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 ~~§~~Section 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 accounting~~s~~ to the court by the conservator at intervals specified by the order, no less frequently than semi-annually. See ~~§~~Section 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 policies (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 ~~§~~Section 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

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liquidation. The motion must be filed within 180 days of the conservation order, unless the court grants a 180-day extension. See IRMA ~~§~~Section 302. The conservator is required to coordinate with guaranty associations to ensure an orderly transition in the event of liquidation. See IRMA ~~§~~Section 303.

2. Conservation of Property of Foreign or Alien Insurers

Most state 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 may not be confidential.

IRMA ~~§~~Section 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 which can be financial such as RBC levels or non-financial grounds. Per ~~§~~Section 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. Examples of the grounds can include by are not limited to certain Risk Based Capital (RBC) level and other non-financial grounds.

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 ~~§~~Section 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, ~~§~~Section 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

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

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rehabilitation. 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 receivership act 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, ~~§~~Section 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 take control of 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; ~~§~~Section 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

[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).

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upon any proposed plan. The court's review of the rehabilitator's proposed plan is generally a limited one, subjecting the rehabilitator's proposal to an abuse of discretion standard.[8]

IRMA ~~§~~Section 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.

Subsection D of ~~§~~Section403 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~~third-party administrators or assuming carriers.

4. Engaging a third-party administrator or guaranty fund (for property/casualty business) 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.

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

4. A marketing plan for the insurer.

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[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).

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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 §Section 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 if required by the state regulator-. 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 claim filing deadline 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

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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 planning, actuarial analyses, fees and expenses, and the rehabilitator's discharge.

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:

- Payment of administrative expenses, including staff salaries,
- Notice to creditors and other interested parties,
- Coordination of data transfer from the insurer's data processing system to the receiver's system,
- 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. ~~§~~Section 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.

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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.

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. IRMA~~§~~ Section 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~~§~~ Section 404B).

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 ~~§~~Section 901, 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.

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

[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).

[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).

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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 ~~§~~Section 501. State statutes describe the effect of the order of liquidation upon contracts of the insolvent insurer, IRMA ~~§~~Section 114, ~~§~~Section 209 B and ~~§~~Section 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, ~~§~~Section 502 makes specific provisions and distinctions as to cancellations of property/casualty coverages and continuations of life and health coverages.

[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).

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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, §Section 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).

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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 associations, 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 ~~§~~Section 208 and ~~§~~Section 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, ~~§~~Section 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, ~~§~~Section 505 D.

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

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in common. In addition, the court must determine whether the intervention will unduly delay or prejudice the adjudication of the rights 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 ~~§~~Section 105 I. All three alternatives prohibit intervention by a person 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 as parties and participate upon application to and approval by the receivership court if the associations are or may become liable to act as a result of the liquidation proceedings. Alternative 2 permits guaranty association intervention as a matter of right. Similarly, the NAIC's Life and Health GA Model Act has, since 1985, recognized the guaranty associations' right to appear or intervene in receivership proceedings involving an impaired or insolvent insurer for which the association is or may become obligated. See Life Model Act ~~§~~Section 8(J). IRMA's 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, ~~§~~Section 701B and ~~§~~Section 801. The liquidator may be permitted to request the court to set a date after which no further claims may be filed. See IRMA, ~~§~~Section 701B. Many receivership acts also contain provisions permitting claimants to file unknown, unliquidated or contingent claims. See IRMA, ~~§~~Section 704 and ~~§~~Section 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

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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 §Section 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.

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 appointment as liquidator, "[I]t is axiomatic … that judicial discretion is not to be substituted for administrative discretion."[15]

[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).

[15] *Foster v. Mutual Fire, Marine & Inland Ins. Co.*, 614 A.2d 1086, 1092 (Pa.1992).

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Under §Section 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. §Section 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 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

[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).

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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 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

[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).

[21] See e.g., In re *Augie/Restivo Baking Co., Ltd*., 860 F.2d 515, 518 (2d Circ. 1988).

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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. 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.

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

[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.*).

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court may decide matters involving the legal rights of the insolvent insurer against 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 insurer owes the reinsurer money, the reinsurer may file the judgment along with a proof of claim in the estate of the insolvent insurer, 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 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

[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.

[29] See *Prentiss v. Allstate Ins. Co.*, 87 F.Supp. 2d 514 (W.D.N.C. 1999).

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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[30]. 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.[31] The court should not permit the action to proceed outside an ancillary receivership proceeding.[32]

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,[33] 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 proceed outside the liquidation court. Some courts have enforced the arbitration clause, saying that federal law favorable to arbitration cannot be ignored.[34] Other courts, particularly in New York,

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[30] For example, six state insurance regulators-initiated court proceedings in their own states seeking to stop implementation of the rehabilitation plan for Senior Health Insurance Company of Pennsylvania, which had been approved by the receivership court in Pennsylvania. The Rehabilitator argued that any disputes regarding the rehabilitation plan must be raised in the receivership court in Pennsylvania; the opposing state regulators argued that the rehabilitation plan violated their state laws and jurisdiction was appropriate in their state courts. As of the date of publication of this update, there has not been a final resolution of these issues.

[31] 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).

[32] 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).

[33] 9 U.S.C. §§ 1-16, 201-208 (West 2001).

[34] 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.

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have said that state insurance liquidation statutes control because of the federal McCarran-Ferguson Act[35] and that a claimant cannot compel arbitration over the liquidator's objection.[36] 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.[37] 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.[38] Other receivership courts, however, have allowed policyholders committees to be appointed so as to provide an additional means of protecting the interests of policyholders.[39]

The Liquidation Model Act was amended to provide that the receiver may, with the approval of the court, appoint an advisory committee of creditors.

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*.

[35] See *McCarran-Ferguson Act*, 15 U.S.C.A. §§ 1011-1012 (West 2000).

[36] *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*.

[37] See e.g, *Washburn v. Societe Commerciale de Reassurance*, 831 F.2d 149 (7th Cir. 1987).

[38] 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).

[39] Policyholder committees have been given standing by courts supervising the insolvencies of Mutual Fire, Marine & Inland Insurance Company (Pa. Court), Constellation Reinsurance Company (N.Y. Court) and Penn Treaty Network America Insurance Company/American Network Insurance Company (Pa. 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).

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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 §Section 504 and to whom notice should be given in §Section 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 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

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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 ~~§~~Section 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.[40] Those 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

[40] 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).

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of adverse domination has also been applied to persons other than corporate officers and directors.[41] Adverse domination is a reliable mechanism for fraud claims. However, some courts have refused to apply the doctrine to negligence claims.[42]

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.[43] 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.[44]

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 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

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[41] 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).

[42] 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).

[43] See 11 U.S.C. § 108; 12 U.S.C. §§ 1821(d)14(A), (B), (C).

[44] 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).

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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.[45] The commissioner's administrative subpoena powers also may be available.[46]

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.[47]

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

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

[45] See e.g., Liquidation Model Act, *supra*, note 3, at Section 24.A.(6) and IRMA §504 A. (1).

[46] See e.g., *Angoff v. M&M Management Corp.,* 897 S.W. 2d 649 (Mo.Ct. App. 1995).

[47] Fed. R. Civ. P. 26(b)(1).

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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[48] 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 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.

[48] See Fed. R. Civ. P. 26(b) (3).

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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.[49]

- 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.

H. Health Insurance and Health Maintenance Organizations (HMOs)

The following legal issues are relevant with respect to health insurers and where noted health maintenance organization (HMO) insolvencies.

1. Hold-Harmless Clause (HMO only)

There are two distinct types of hold-harmless clauses that can apply to providers that contract with HMOs. The first, which is discussed in detail in this section, is the hold-harmless clause that is contained in the contract between an HMO 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 copayments, 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

[49] See *United States of America v. American Telephone and Telegraph Co.,* 86 F.R.D. 603 (D.D.C. 1979).

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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 enrollees have been inappropriately billed, efforts should be made to intercede on behalf of the enrollee and require the return of monies collected by the contracted provider. The receiver should note that claims by an enrollee that represent amounts the enrollee 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 Health Insurers and HMO plans has added new elements to the overall receivership picture. Medicare and Medicaid Health Insurers and HMOs offer eligible enrollees services similar to those of a conventional Health Insurers and HMO rather than the benefits set out by statute or regulation in the fee-for-service programs. Health Insurers and 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 Health Insurer and 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,[50] 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 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.

[50] The Centers for Medicare & Medicaid Services' Web site is www.cms.gov ~~v/medlearn~~.

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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.

Note that the life and health guaranty associations do not provide coverage for Medicare or Medicaid enrollees of insolvent Health Insurers and HMOs.

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 Health Insurer or 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 health 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 Health Insurers and 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 Health Insurer and 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.[51] As with group coverage, nonrenewal is allowed for specified reasons, including carrier market exit.

b. Guaranteed Issue of Coverage by Other Plans

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 Health Insurer or 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

[51] 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).

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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 Health Insurer and 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 Health Insurer or -HMO subscribers under the ACA as outlined above for HIPAA.

I. 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

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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 ~~§~~Section 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 ~~§~~Section 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 ~~§~~Section 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 ~~§~~Section 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

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sometimes referred to as a dispute over multiple contract setoff.[52] 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.[53]

- 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 must 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.[54]

- 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

[52] 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.*

[53] *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).

[54] *Stamp v. Ins. Co. of N. America, supra*.

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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 §Section 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.[55] 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.[56] 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.

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,

[55] 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).

[56] 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).

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there is an open issue of the extent to which setoffs may be taken regarding claims against the company by the federal government.

J. Recoupment

The equitable doctrine of recoupment has been recognized in insurance and other types of insolvency cases.[57] 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.

K. 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.[58] 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.[59] 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;[60] and 2) such application is not inconsistent 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.[61]

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[57] 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).

[58] 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).

[59] 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).

[60] 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).

[61] 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).

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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. 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.

~~§~~Section 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. 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.

~~§~~Section 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. 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.

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. Any remaining assets would be used to pay claims of policyholder, guaranty associations or other creditors that had not yet been paid in full. If assets are remaining after all policyholders, guaranty associations and other creditors have been paid in full, the receiver should consider applicable escheat laws.

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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.

~~§~~Section 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 - 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[62] to insurance liquidation proceedings are discussed in detail below.

B. Notice Issues

Notice issues are discussed in section on Section II.F.2.

[62] 31 U.S.C. § 3713.

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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.

Policyholders who are covered by guaranty associations generally are not required to submit proofs of claim. Any discussion of policyholder claims in this section relates to policyholders who are not covered by a guaranty association. Guaranty association claims are handled separately and often are coordinated by NOLHGA or NCIGF.

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.

Section 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

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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 §Section 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 §Section705 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, §Section 39 of the Liquidation Model Act and §Section 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

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date in the statute. IRMA ~~§~~Section 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.[63]

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~~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~~third-party claimants.

[63] 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).

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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.

§Section 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 property and casualty 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.) In life and health cases, policies may be continued by the covering guaranty associations for many years, and premium reconciliation for the period after the liquidation date will typically be handled by the guaranty associations.

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.

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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 §Section 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.[64]

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

[64] *Underwriters National Assurance Company (UNAC),* 102 S. Ct. 1357 (1982), 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.

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law under which the deposit was placed and to make sure that the foreign jurisdiction is not obligated to return the deposit.

IRMA §Section104 CC, defines "special deposit" as "…a deposit established pursuant to statutes for the security or benefit of a limited class or classes of persons." §Section 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 §Section 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 §Section 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.[65] –(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

<u>Securities Act of 1933 (1933 Act)</u>

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.

[65] See, e.g., *Rohm & Haas Co. v. Continental Assurance Company,* 58 Ill. App. 3d 378, 374 N.E.2d 727 (1978)

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Investment Company Act of 1940 ("1940 Act")

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[66], 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

[66] 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).

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contracts that is next computed after the insurer receives the purchase, withdrawal, or transfer request in good order.

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.

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- 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), ~~§~~Section 3 (K):

"General assets" includes all property, real, personal or otherwise which is not:

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(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.

<u>Separate Account Exclusion in Distribution Scheme</u>

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

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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.

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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.

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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 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[67] 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,

[67] Under Section 4 (2) (b) of the 1940 Act, a UIT may not have a board of directors.

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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 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)[68], except in limited circumstances[69]. 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~~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.

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[68] 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.

[69] 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.

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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 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.[70]

- 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.

[70] But see footnote 65.

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- 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:
        - 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~~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

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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.

- o 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.

- <u>Cash Out Offer with Waiver of Remaining Surrender Charges?</u>

  - o 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.

  - o 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.

  - o Should explore possible 1035 exchange options with other insurers to minimize possible adverse tax impact on owners.

  - o 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.

- <u>What Guaranty Association coverage for the Variable Products might be available?</u>

  - o 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 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.

- <u>Are TIC's Separate Accounts UITs or Managed Separate Accounts or Exempt SAs?</u> 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.

  - o What, if any, authority does the TIC have over the Separate Account Directors or their election or appointment?

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- 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 https://www.sec.gov/investment-management ~~*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

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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[71]. 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

[71] See also footnote 64.

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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 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.[72]

[72] Unregistered fixed account options are frequently included as an option in registered Variable Products.

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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 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,[73] 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[74]; 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.

[73] But see footnote 65.

[74] 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.

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- 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.
- 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.

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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

An order of 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 continuing 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[75] that are issued by a properly licensed life insurer and owned by residents of their state. Guaranty association statutes generally exclude coverage for that

[75] Coverage for unallocated annuities varies in accordance with the type of arrangement involved. Unallocated annuities are beyond the scope of this Chapter.

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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.

(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. In many cases, the guaranty associations (with respect to the covered policies) have looked 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 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.

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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

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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.

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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

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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. (See below for the most recent guidance from the NAIC indicating that the reimbursements should be refunded in full to the guaranty associations to the extent of their claim payments and not be treated as general assets of the estates. All enacted state laws on this point conform with this view. See also Chapter 6 of this handbook and *Guideline for Administration of Large Deductible Policies in Receivership* (Guideline #1980).

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.

- ~~§~~Section 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. ~~§~~Section 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.

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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 to 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.[76] 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.[77] 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.[78] The Court found that the preference given by the Ohio statute to administrative expenses and policyholder claims was

[76] *U.S. Dept. of Treasury v. Fabe,* 113 S.Ct. 2202 (1993).

[77] *Id.*

[78] 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.G of this chapter on Priority of Claims.

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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.[79] State 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.[80]

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.[81] 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.[82]

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 ~~§~~Section 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.[83] (A related remedy is to reclassify debt owed to a shareholder as equity. Reclassification is based on the grounds that the shareholder inequitably

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[79] 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.

[80] 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).

[81] *North Carolina, ex. rel. Long as Liquidator of Northwestern Security Life Insurance Co. v. United States*, 139 F.3d 892 (4th Cir. 1998).

[82] *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).

[83] See generally *4 Collier on Bankruptcy* 510.05 (15 ed. rev. 1997).

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substituted debt for equity capital.)[84] 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.

The doctrine of equitable subordination has long existed as a matter of general equity under the federal bankruptcy laws.[85] 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."[86] On the other hand, to subordinate the claim of a non-fiduciary, the plaintiff must prove egregious misconduct.[87]

Equitable subordination may be useful as an alternative remedy for fraud, fraudulent transfer, breach of fiduciary duty or the like.[88] 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 §Section 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 §Section 47] through the use of equitable remedies," or by §Section 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 Agreements[89]

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

[84] 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).

[85] See e.g., *Pepper v. Litton*, 308 U.S. 295 (1939); *Taylor v. Standard Gas & Elec. Co*., 306 U.S. 307 (1938).

[86] *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).

[87] *In re Giorgio*, 862 F.2d 933 (1st Cir. 1988).

[88] 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).

[89] 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).

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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 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* (#440) (Holding Company Act), a pooling transaction cannot be implemented unless the relevant insurance commissioners have determined that the proposed agreement is fair and reasonable.[90] 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.[91] 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.[92]

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

[90] See NAIC Insurance Holding Company System Regulatory Act §§5A(1), 5A(4), 5 (A)(6)

~~91 Holding5(A)(6).~~

[91] See e.g., *Rubin v. Manufacturers Hanover Trust Co*., 661 F.2d 979 (2d Cir. 1981).

[92] See e.g., Uniform Fraudulent Transfer Act §6(5).

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solvent. However, if the subsidiary is insolvent, generally there is a contrary result.[93] 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.[94] Thus, benefit directly received by one affiliate may produce an indirect benefit or value to other members of the group. 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.[95] 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.[96] 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.[97]

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.[98]

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.

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[93] 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).

[94] 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).

[95] 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).

[96] 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).

[97] 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).

[98] See *Banco de Desarrollo Agropecuario, S.A. v. Gibbs*, 709 F. Supp. 1302 (S.D.N.Y. 1989).

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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.

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.

On Aug. 17, 2021, the NAIC adopted a new provision, Section 5A(6), of the *Insurance Holding Company System Regulatory Act* (#440), which provides that the affiliated entity whose sole business purpose is to provide services to the insurance company is subject to the jurisdiction of the receivership court. This applies to affiliates performing services for the insurers that are an integral part of the insurer's operations or are essential to the insurer's ability to fulfil its obligations. See Section VIII.G.5 below for additional explanation of the Model amendments related to affiliated transactions.[99]

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 associations 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 licensed to do business in that state. Thus, claims against nonadmitted insurers or excess

[99] The full text of Section 5A(6) of the *Insurance Holding Company System Model Act* (#440) is available at *https://content.naic.org/sites/default/files/MO440_0.pdf*. The 2021 NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

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and surplus lines carriers generally are not covered claims. (See Model #540 §Sections 5G(1), 5G(2), optional 5G(3) define covered claims, and section 5H definition of insolvent insurerH[100], which limits coverage to "an insurer licensed to transact insurance.")

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. [101]

    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.[102] 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 claims varyies from state to state. ModelThe #540 §Section 5GH 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

[100] The definitions of covered claims in section 5G and insolvent insurer in section 5H of Model #540 were amended in December 2023. Note the definition of covered claims includes three sections, including one optional section. As these amendments are recent, not all states may have adopted them yet, therefore the receiver should refer to the applicable state's law.

[101] *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).

[102] See *Rhulen Agency Inc. v. Alabama Ins. Guar. Ass'n,* 896 F.2d 674 (2d Cir. 1990).

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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."

To be insolvent for guaranty fund purposes, the insurer must have been declared insolvent by a court of competent jurisdiction and, typically, have an order of liquidation rendered against it. A small minority of states trigger upon a finding of insolvency only. Liquidation and rehabilitation orders should be crafted such that all guaranty funds involved are triggered simultaneously. (See Chapter 6 of this handbook for more information.)

1. ~~1.~~ Court of Competent Jurisdiction

Ordinarily the court of competent jurisdiction does not necessarily mean that only a court in the insurer's domiciliary state may issue the order of liquidation with a finding of insolvency. Generally, any court in any state may issue the order so long as certain requirements are met.[103] 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. ~~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 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.[104]

c. ~~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

[103] 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).

[104] See *New Jersey Property,* 137 N.J. Super. at 345, 349 A.2d at 92.

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Guaranty association coverage under Model #540 definition is not triggered unless there is final order of liquidation with a finding of insolvency.[105] 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.[106] However, if an order of liquidation is not appealed, it is final on the date issued.[107]

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.

1. Model #540—~~§~~Section 5G~~H~~[108]

Section 5~~H~~G- ~~o~~f Model #540 defines a "covered claim" as follows:

d. 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 policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and:

e. 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) Covered claim includes claim obligations that arose through the issuance of an insurance

[105] 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).

[106] *Id.*

[107] *Id.*

[108] The definitions of covered claims in section 5G and insolvent insurer in section 5H of Model #540 were amended in December 2023. Note the definition of covered claims includes three sections, including one optional section. As these amendments are recent, not all states may have adopted them yet, therefore the receiver should refer to the applicable state's law.

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policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:

f. The original member insurer has no remaining obligations on the policy after the transfer;

(b) A final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member's coverage obligations by a court of competent jurisdiction in the insurer's State of domicile;

(c) The claim would have been a covered claim, as defined in Section 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and

(d) In cases where the member's coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.

[Optional:

(3) Covered claim includes claim obligations that were originally covered by a non-member insurer, including but not limited to a self-insurer, non-admitted insurer or risk retention group, but subsequently became the sole direct obligation of a member insurer before the entry of a final order of liquidation with a finding of insolvency against the member insurer by a court of competent jurisdiction in its State of domicile, if the claim obligations were assumed by the member insurer in a transaction of one of the following types:

g. A merger in which the surviving company was a member insurer immediately after the merger;

(b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or

(c) A transaction entered into pursuant to a plan approved by the member insurer's domiciliary regulator.]

~~(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~~3) 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;

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(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.[109] This requirement is primarily to prevent excessive or duplicative claim payments.[110] 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.[111]

i. ~~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.[112] 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

[109] 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).

[110] 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).

[111] *Betancourt v. Ariz. Prop. & Cas. Fund,* 823 P.2d 1304 (Ariz. Ct. App. 1991).

[112] See *Florida Ins. Guar. Ass'n,* 355 So. 2d at 141.

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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.[113]

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.[114] 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.[115] Whether the insured later satisfied the judgment creditors with the insurance policy proceeds was outside the guaranty association's scope.

b. Within the Coverage

All guaranty association acts require that to be covered, a claim must "arise out of and be within the coverage."[116] This provision requires that a claim meet a policy's coverage requirements before it will be paid.[117]

i. ~~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:

[113] *P.I.E. Mutual Ins. Co. v. Ohio Guar. Ass'n,* 66 Ohio St. 3d 209, 611 N.E.2d 313 (Ohio 1993).

[114] *Qualls v. Missouri Ins. Guar. Ass'n,* 714 S.W.2d 732 (Mo. Ct. App. 1986).

[115] *Id.*

[116] Model #540, *supra* note 96, at section 5F.

[117] 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).

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(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.

(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.[118] 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.[119]

However, the insured's legal obligation to the ~~third party~~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.[120]

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

[118] See *King Louie Bowling v. Missouri Ins. Guar. Ass'n,* 735 S.W.2d 35 (Mo. Ct. App. 1987).

[119] *Id.* at 38.

[120] *Id.*

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case, a corporation's subsidiary was found liable for wrongful death.[121] 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.[122]

Generally, "[a] corporation is an entity separate and distinct from its stockholders and from other corporations with which it may be connected."[123] 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.[124]

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."[125] 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). (Michigan is a notable exception where the claim limit of $5 million is tied to a cost of living adjustment (COLA) adjustment.[126][) This graph should be amended when cyber provisions adopted by NAIC.It should also be noted that the 2023 amendments to Model #540 add a statutory cap for cybersecurity insurance coverage of $500,000.[127]

[1] Covered claims shall not include that portion of a claim, other than a worker''s compensation claim or a claim for personal protection insurance benefits under section 3107, that is in excess of $5,000,000.00. The $5,000,000.00 claim cap shall be adjusted annually to reflect the aggregate annual percentage change in the consumer price index since the previous adjustment, rounded to the nearest $10,000.00. MI ST §500.7925.

d. 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.[128] 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.

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[121] 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).

[122] *Id.* at 910.

[123] *Id.*

[124] *Id.*

[125] Model #540, at Section 5H.

[126] Covered claims shall not include that portion of a claim, other than a worker's compensation claim or a claim for personal protection insurance benefits under section 3107, that is in excess of $5,000,000.00. The $5,000,000.00 claim cap shall be adjusted annually to reflect the aggregate annual percentage change in the consumer price index since the previous adjustment, rounded to the nearest $10,000.00. MI ST §500.7925.

[127] As these 2023 Model #540 amendments are recent, not all states may yet have adopted them, therefore the receiver should refer to the applicable state's law.

[128] See *Vaughn v. Vaughn,* 23 Wash. App. 527 (Wash. Ct. App. 1979), 597 P.2d 932, review denied, 92 Wash. 2d 1023 (1979).

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The court found that bad faith claims are not covered claims.[129] 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.[130]

e. ~~D.~~ Unearned Premiums

Most guaranty association acts and the Model #540 specifically allow claims for unearned premiums.[131] 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.

i. Assignments Allowed

In a New Jersey action, a claimant bank had financed insurance premiums.[132] 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.[133] 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.[134]

ii. ~~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.[135] 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.

iii. ~~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.[136] 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.

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[129] *Id.*

[130] *Id.* at 528.

[131] Model #540, at § 5H.

[132] See *Broadway Bank & Trust Co. v. New Jersey Ins. Ass'n,* 146 N.J. Super. 80, 368 A.2d 983 (1976).

[133] *Id.*

[134] *Id.* at 986.

[135] See also *Kroblin Refrig. Express v. Iowa Ins. Guar. Ass'n.,* 461 N.W.2d 175 (Iowa 1990).

[136] See Model #540, at § 5H(1)(a).

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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.[137] 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 anothe~~571nother 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.

iv. ~~ii.~~ Location of Property

Guaranty association acts generally require that the property from which the claim arises must be permanently located in the state.[138] 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.[139] 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 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.~~ 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

[137] 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).

[138] *Id.* at Section 5G(1)(b)

[139] See *Eastern Seaboard,* 175 N.J. Super. at 589.

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rating plan; or due any reinsurer, insurer, insurance pool or underwriting fund as subrogation recoveries, reinsurance recoveries, contribution, indemnity or otherwise.[140]

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. Other than coverages that may be set forth in a cybersecurity insurance policy, iInsurance 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;

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.[141]

[140] See Model #540, at § 5H(2)(c).
[141] 1990 Ga. Laws Section 33-36-3(2)(g).

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Michigan also has a net worth exclusion. The U.S. Court of Appeals has addressed the constitutionality of Michigan's net worth exclusion.[142] 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."[143] 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,"[144] 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 claim for the return of unearned insurance premiums on policies canceled due to an insurer's insolvency.[145]

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.[146] 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

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[142] 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).

[143] 1983 Mich. Pub. Acts Section 500.7925(3). Michigan's current statute has a $25 million net worth exclusion for first and ~~third party~~third-party claimants which is subject to annual increases based on the consumer price index.

[144] *Borman's,* 925 F.2d at 163.

[145] See *United Budget Co. v. Georgia Insurer's Insolvency Pool,* 253 Ga. 435, 321 S.E.2d 333 (Ga. 1984).

[146] *Id.* at 337.

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to recover from the insured proceeds paid on behalf of those insureds that exceed a statutorily provided net worth amount (see Model #540 §Section 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 §Section 14B of Model #540 as follows:

> Any person having a claim which may be recovered under more than one insurance guaranty associationassociation, 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.[147]

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 be entitled to file a claim after the deadline has passed and may be entitled to benefits from the guaranty association.

Jurisdictions may vary on specifics of claim notice requirements. The local guaranty association should be consulted.

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.[148]

In several state guaranty fund acts there is a "separate" bar date for claims against the fund. State law should be consulted in this regard. 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

[147] Model #540, at Section 14B.

[148] Post-Assessment Model Act, *supra* note 91, at Section 8A(1)(b).

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precluded from filing a claim against the guaranty association.[149] 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.[150] 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 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.[151]

- 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. Section§ 704 A of IRMA allows the filing of policyholder protection claims.

  In an Illinois case,[152] 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

[149] 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).

[150] 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).

[151] *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).

[152] 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).

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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.[153]

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.[154] In a Massachusetts action,[155] 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 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.[156]

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.[157]

4. ~~NAIC Proposed~~ Reporting Guidelines

[153] 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).

[154] See *Massachusetts Motor Vehicle Reinsurance Facility v. Commissioner of Insurance,* 379 Mass. 527 (Mass. 1980).

[155] *Id.*

[156] See *Excess and Casualty Reinsurance, 656 F.2d at 495; American Reinsurance,* 527 F. Supp. at 457.

[157] *Id.*

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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~~refer to Exhibit 9-1 – ~~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 somewhat 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;

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;[158]

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;

[158] 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).

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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 of IRMA 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 claims and the return of unearned premiums. In addition to having its own statutory priority to the insolvent insurer's assets, a guaranty fund also is subrogated to the rights of the covered 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. §Section 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.[159]

North Carolina has addressed the question of which associations will be subject to the early access statute.[160] 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.

[159] Liquidation Model Act, at Section 38; IRMA §803 B.

[160] See *State of North Carolina v. Reserve Ins. Co.,* 303 N.C. 623 (1981).

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In another case,[161] 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 §Section 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.[162] Model #540 Section 8A(2) provides:

- The association shall…
    - 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.[163]

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: for various options for treating claims of high net worth insureds. One option is for the guaranty fund to pay the claim and recover the payment from the high net worth insured. In another option the guaranty fund declines the claim in the first instance with an exception for cases of insureds in bankruptcy proceedings.[164]

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 to impact life and health guaranty associations and receivers. Because guaranty association statutes may vary from jurisdiction to jurisdiction, the information contained here is necessarily general in nature. The NAIC Life and Health Insurance Guaranty Association Model

[161] *North Carolina Reinsurance Facility v. North Carolina Ins. Guar. Ass'n,* 67 N.C. App. 359, 313 S.E.2d 253 (1984).

[162] 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).

[163] See generally *Doan Reid Ford, Inc. v. Feldman,* 421 So. 2d 184 (Fla. App. 5th Dist. 1982).

[164] See NAIC Model 540 at Section 13.

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Act (#520) is used as a basis for this discussion, and factual examples are drawn from cases.[165] 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 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, guaranty associations may exercise the right to determine these legal issues locally through declaratory judgment actions.[166]

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.[167]

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.[168]

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.[169] 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.[170] This provision also specifies that the guaranty association "shall also have the right to appear or intervene before a court or agency in another State with jursidiction over an impaired or insolvent insurer for which the Association is or may become obligated..." See 8(J).

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.[171] 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

[165] See NAIC Life and Health Insurance Guaranty Association Model Act [hereinafter Model #520].

[166] ~~See *New Mexico Life Insurance Guaranty Assoc. v. Moore,* 93 N.M. 47, 596 P.2d 260 (1979).~~

[167] *Pennsylvania Life & Health Ins. Guaranty Ass'n. v. Superior Court,* 22 Cal. App. 4th 477, 27 Cal. Rptr. 2d 507 (Ct. App. 1994).

[168] *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).

[169] ~~See *Maryland Life and Health Insurance Guaranty Association v. Perrott,* 301 Md. 78, 482 A.2d 9 (1984).~~

[170] See Model #520, at Section 8J.

[171] ~~*In the Matter of the Liquidation of American Mutual Liability Insurance Co.,* 417 Mass. 724, 632 N.E.2d 1209 (Mass. 1994).~~

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invalid because the fiduciary breach claims were not expressly and knowingly assigned to the guaranty association.[172]

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.[173]

D. Triggering of Guaranty Associations

Guaranty associations primarily act after the entry of an order of liquidation with a finding of insolvency. Some statutes give guaranty associations discretion to act in cases of an impaired insurer. However, this authority has never been exercised in the case of a multistate insolvency and rarely has been exercised in single-state insolvencies. (As noted earlier in this Chapter, IRMA 901 requires that guaranty associations be repaid in full for all amounts expended before a company can be released from a proceeding and allowed to continue as a going concern.) Some statutes empower guaranty associations to act only after the liquidation order becomes final.[174] 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 the continued 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."[175] Similarly, the continuation of coverage is necessary in health and long-term care liquidations to avoid disruption in medical care, treatment and pharmacy services, and insureds may be unable to replace long term care coverage or certain limited or specialty health insurance products. Some guaranty associations may offer substitute coverage either by reissuing terminated coverage or issuing alternative policies.

F. Assumption Reinsurance

Whenever feasible, guaranty associations will attempt to find a company that will guarantee, assume or reinsure the covered policies and contracts of the insolvent insurer. Through early planning and coordination, the guaranty associations can evaluate options for transferring blocks of covered business and, in some cases, have one or more assumption reinsurance agreements in place to transfer blocks of business as of the effective date of liquidation. Life insurance insolvencies often involve many states because most life companies offer their products in multiple states. Coordination among the affected guaranty associations will be facilitated by NOLHGA. –(See Chapter 6(III)(A).) In some cases, the liquidator may pursue a transfer of uncovered liabilities as well, to the extent the estate has assets sufficient

[172] *Texas Life, Accident, Health & Hospital Service Insurance Guaranty Association v. Gaylord Entertainment Co.,* 105 F.3d 210 (5th Cir. 1997).

[173] 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).

[174] See Model #520, *supra* note 147, at Section 8A.

[175] See Model #520, *supra* note 147, at, Section 2 8L.

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to support the transfer of those liabilities. In that event, the liquidator and guaranty associations/NOLHGA will work closely together to coordinate the transfer.

Transferring guaranty association covered policy obligations to a solvent insurer, particularly when timed for the seamless transfer to be effective as of the liquidation date, requires negotiation and execution of assumption reinsurance documents and cooperation between the guaranty associations and the receiver on data and information transfer. The assuming carrier may be required to obtain approval of assumption certificates in the states where the insurer did business. NOLHGA may also need to consider a number of particular legal issues including policyholder notice, policyholder consent (if required), contingent liability accounting and preservation of tax losses or other tax benefits.

G. Residency

Following Model #520, all guaranty association laws limit their protection generally to policyholders who reside in the state.[176] However, 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 due to the insurer not being licensed in the state are usually covered by the guaranty association of the domiciliary state of the insolvent insurer.[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]

~~K~~H. 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 associations. 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 resolution of the issue to date.[181] This preservation of statutory priority to guaranty association claims over those of the federal government was confirmed in *Ruthardt v. United States of America*.[182] 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' claims.[183]

[176] See Model #520, at Section 3A.

[177] See Model #520, at Section 3A(2)(b).

[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 *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.

[182] *Ruthardt v. United States of America*, 303 F.3d 375 (1st Cir. 2002).

[183] "[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.*

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I. Enhancement Plans

In certain life insurer insolvencies, receivers working in cooperation with NOLHGA, affected guaranty associations, and in some cases the insurance industry, developed or supported innovative plans to protect 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 significant coordination with the insurance industry to protect the account values of uncovered policyholders in some circumstances and even the creation of a new insurance company by NOLHGA and the affected guaranty associations to assume the business of the failed insurer.[184]

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.[185] 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.[186]

~~N~~J. 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.[187]

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.[188]

K. Other Guaranty Association Topics

Refer to Chapter 6—Guaranty Funds/Associations for other topics such as:

- Eligibility of Insurer
- Exclusions from Coverage
- Benefit Limitations
- Early Access

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~~third-party administrator agreements), transfers and conveyances so that the receiver

[184] See e.g., the Rehabilitation Plans for Executive Life Insurance Company, Mutual Benefit Life Insurance Company, and Guaranty Security Life Insurance Company, and the Agreement of Restructuring for the liquidation of ~~the Agreement of Restructuring for the liquidation of~~ Executive Life Insurance Company of New York.

[185] ~~*Lawrence v. Illinois Life & Health Guar. Assn.,* 688 N.E.2d 675 (Ill. App. Ct. 1997).~~

[186] ~~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.~~

[187] ~~*Aetna Life Ins. Co. v. Washington Life & Dis. I.G. Ass'n.,* 83 Wash. 2d 523, 520 P.2d 162 (1974).~~

[188] ~~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.~~

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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).[189] 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 is critically important for orderly receivership proceedings. Data can also constitute important evidence in legal proceedings. Typically, claims data is retained in electronic format and relevant records must be available to the guaranty funds at the point where they are obligated to pay covered claims. Chapter 2 of this Handbook provides more detailed information regarding use, handling, and control of electronic data.

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.

[189] 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.

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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."[190] In ~~§~~Section 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 ~~§~~Section 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

[190] Fed. R. Civ. P. 34(a).

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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. ~~Recent amendments~~The 2021 amendments to the ~~NAIC Model~~ Holding Company ~~a~~Act ~~(#440)~~ also address this issue, calling for the data held by third parties to be considered the property of the receiver. More information about pertinent provisions of the ~~current Model~~ Holding Company Act is available in Chapter 2, Section IV. ~~Recent~~The *Financial Condition Examiners Handbook*~~ation~~ outlines procedures ~~Guidelines also~~that address data segregation and convertibility to UDS for troubled companies.[191]

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 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

[191] NAIC Holding Company Act, See also General Examination Guidance, Chapter 3, General Examination Considerations of the *Financial Condition Examiners Handbook*.

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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.

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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

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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 §Section 402 and §Section 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.[192] 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.[193]

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 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.[194]

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.[195]

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

[192] E.g., *Schacht v. Brown,* 711 F.2d 1343, 1346 n.3, (7th Cir.), *cert. denied,* 464 U.S. 1002 (1983).

[193] 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."

[194] 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).

[195] 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).

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right must be paramount and exclusive so as to avoid disorder and confusion in the administration of the insolvent insurer's affairs. §Section 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 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 without 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.

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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.[196]

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 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

[196] 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).

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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

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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 ~~§~~Section 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.

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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.[197]

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 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.

[197] See *Wilcox c. CSX Corp*, *70 P.3d 85*, *473* Utah Adv. Rep. 25, 2003 UT 21(2003*).*

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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. ~~§~~Section 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

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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

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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. Insurance Holding Company System Regulatory Act (#440)

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.[198] 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

[198] *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).

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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.[199]

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 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

[199] E.g., *Omaha Indemnity Company v. Royal American Managers,* 777 F. Supp. 1488 (W.D. Mo. 1991).

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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.

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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.)

5. Transactions Between Affiliates

Sections 5A(1)(g) and (h) of the NAIC Model *Insurance Holding Company Systems Act* (Model #440) and Section 19B(7) of its companion ~~model~~ ~~*regulation*~~*Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (Model #450) were amended in 2021 to clarify the rights of a receiver to the data of an insurer managed or held by an affiliate. The amendments provide that: (i) books and records of an insurer maintained by affiliates are property of the insurer, (ii) that data and records should be identifiable and capable of segregation, (iii) that if a Commissioner deems an insurer to be in a statutorily defined Hazardous Financial Condition, he or she may: require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party's ability to fulfill the contract in the event of a liquidation, (iv) premiums are the property of the insurer with any right of offset subject to receivership law, (v) affiliates are subject to the jurisdiction of the receivership court and the Commissioner may require the affiliate to agree to this in its written agreements with the insurer, (vi) and includes provisions relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate. In the event of a receivership, including supervision and conservatorship, (i) the rights of the insurer extend to the receiver or guaranty fund, (ii) the affiliate will make essential personnel available to the receiver, and must continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work, and (iii) requires affiliates to maintain necessary systems, programs or infrastructure and make them available to the receiver for as long as the affiliate receives timely post-receivership payment unless released by the receiver or receivership court.

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

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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 Atc~~t;~~
- 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~~

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- 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.[200] RICO claims against the insurer's attorneys, solicitors, reinsurers, agents, brokers and shareholders have also been sustained.[201]

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.[202] 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.[203]

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.

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[200] 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).

[201] 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).

[202] *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.

[203] See *Reeves v. Ernst & Young,* 507 U.S. 170 (1993).

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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.

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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.[204] IRMA ~~§~~Section 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.[205]

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 have ~~currently~~ responded to this defense by attempting to distinguish between conduct that injures the corporation and conduct that benefits it.[206]

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.[207] 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.[208]

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.

[204] 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).

[205] *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).

[206] 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.

[207] E.g., *FDIC. v. Ernst & Young,* 967 F.2d 166 (5th Cir. 1992).

[208] 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).

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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.[209]

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.[210]

Preliminarily, it should be noted that an affirmative claim against the receiver may be barred by the liquidation order.[211] There is also a recognized distinction between the regulator and the receiver.[212] 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.[213]

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~~.~~[214]

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[209] E.g., *Rollins v. Ellwood,* 141 Ill.2d 244, 565 N.E.2d 1302 (1990).

[210] 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.*

[211] *Id.*

[212] *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.)

[213] *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).

[214] 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.

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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. which may or may not be necessary depending on the circumstances presented. [215]

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.[216]

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).

[215] https://ujs.sd.gov/uploads/sc/opinions/29663371697e.pdf. The case holds that the statutory extension on time for the Liquidator to make a claim nullifies an E&O/D&O carrier's claims made deadline.

[216] 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).

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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.[217] IRMA ~~§~~Section 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.

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

[217] 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).

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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.[218] 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.[219]

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 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.

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[218] 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*.

[219] 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.").

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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, ceded and assumed, 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.~~

B. 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.[220] Receivers should be aware of case law regarding the legal effect of providing late notice of claims to reinsurers .[221]A

[220] See *Christiana General Insurance Co. v. Great American Insurance Co.,* 745 F.Supp. 150, 161 (S.D.N.Y. 1990).

[221] Certain Underwriters at Lloyd's of London v. Home Ins. Co., 783 A.2d 238 (N.H. 2001); Unigard Sec. Ins. Co., Inc. v. North River Ins. Co., 4 F.3d 1049 (2nd Cir. 1993); and North River Ins. Co. v. CIGNA Reinsurance Co., 52 F.3d 1194 (3d Cir. 1995) evaluated whether the ceding insurers' failure to provide notice of the reinsured claims warranted denial of reinsurance coverage for such claims. The courts concluded that if the reinsurer denies reinsurance coverage based on a reinsured's failure to provide timely notice of reinsured claims, the

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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 breach.[222] 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.[223] 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.

C. 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.

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reinsurer must prove that it was prejudiced by the reinsured's lack of notice, or that the ceding insurer acted in bad faith, meaning that the reinsured acted with gross negligence or recklessness in not providing proper notice of the reinsured claims.

[222] *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).

[223] *Liberty Mutual Ins. Co. v. Gibbs,* 773 F. 2d 15 (1st Cir. Mass. 1985).

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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 (often referred to as "reinsurance collateral") 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 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.

The United States reinsurance regulatory framework has undergone significant changes in the last decade, first in 2011 when reinsurance collateral requirements were reduced for certified reinsurers domiciled in qualified jurisdictions, and then again in 2019 when collateral requirements were eliminated altogether for certain reinsurers that are licensed and have their head offices in reciprocal jurisdictions. If an unauthorized reinsurer is neither a certified reinsurer nor a reciprocal jurisdiction reinsurer, then it must continue to post 100 percent collateral on all U.S. reinsurance assumed. These changes affected the amount of reinsurance collateral readily available with respect to non-U.S. domiciled reinsurers and reduced it from the previous 100 percent requirements for all unauthorized reinsurers.

Alternatively, if the insolvent insurer was a reinsurer, assets of the insolvent insurer may be 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.

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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

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cover the reinsurer's U.S. liabilities.[224] 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.

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.

D. 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.

E. 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 §Section 114 and §Section 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

[224] 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.

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provide guaranty associations with valuable financial support in transferring policy obligations to an assuming insurer. Model #520 and IRMA §Section612 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.[225]

F. 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.

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.[226] 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."[227] 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.

[225] Model #520, at Section 8.N.

[226] 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).

[227] *Id.*

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G. 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.

§Section 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. The receiver may pursue the transfer of a book of business during rehabilitation or a transfer of liabilities not covered by the guaranty associations in liquidation. The receiver should coordinate with the guaranty associations on any reinsurance transaction pursued in liquidation, as the guaranty associations also have the authority to reinsure their obligations.

- 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.

H. 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

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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.

I. 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.[228] 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

[228] See e.g., *Selcke v. New England Ins. Co.* 995 F.2d 688, 689, 690 (7th Cir. 1993).

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otherwise.[229] 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 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.

J. 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.[230]

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.[231]

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.[232] Some cases have noted, however, that the Foreign Sovereign Immunities

[229] 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.).

[230] See e.g., *Morgan v. American Risk Management, Inc.*, 1990 WL 106837 (SDNY July 20, 1990).

[231] *Morgan v. American Risk Management, Inc.,* 1990 WL 106837 (SDNY July 20, 1990);

[232] *John Hancock Property & Casualty Insurance Co. v. Universale Reinsurance Co.,* 1993 U.S. Dist. LEXIS 9411 (SDNY July 12, 1993).

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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.[233]

Additionally, some courts have held that arbitrators have broad authority to require pre-hearing security.[234] 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.

K. 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.[235] Insurers and reinsurers have also contested production on the basis that the information was proprietary and confidential.[236]

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 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.[237]

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.

L. ~~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 ~~§~~Section 801 C(1) of IRMA and ~~§~~Section 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).

[233] See e.g., *Stephens v. National Distillers and Chemical Corp.,* 69 F.3d 1226 (2d Cir. 1995).

[234] *Pacific Reinsurance Management Corp., v. Ohio Reinsurance Corp.,* 935 F.2d. 1019 (11th Cir. 1991).

[235] See e.g., *Leski, Inc. v. Federal Ins. Co.,* 129 F.R.D. 99, 106 (D.N.J. 1989).

[236] See e.g., *National Union Fire Ins. Co. v. Stauffer Chemical Co.,* 558 A.2d 1091, 1097 (Del. Super. Ct. 1989).

[237] *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).

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I. INTRODUCTION

The closure of a receivership—i.e., the termination of the receivership proceeding in the supervisory court—represents the culmination of the efforts of the receiver to complete those duties and wind up the insolvent insurer's affairs as quickly and efficiently as possible. This applies whether the receivership proceeding is one of rehabilitation or liquidation, domiciliary or ancillary.

The conclusion of the affairs of the insurer, both from an asset and a liability standpoint, has to be accomplished in such a way that each of the statutory responsibilities of the receiver has been fully, fairly and promptly addressed. Planning for the closure of the estate should begin at the outset of the receivership proceeding. The receiver must establish and coordinate the legal, administrative, claims handling and accounting functions and set up the related reporting systems to facilitate the closure process. For a discussion of these functions, see Chapter 1—Commencement of the Proceedings~~Takeover and Administration~~. A review of Chapter 5—section on Governmental Agencies, is also advised.

Guidelines within this chapter are based largely upon the NAIC Insurers Receivership Model Act (Model #555, commonly known as IRMA).

II. CLOSING REHABILITATION PROCEEDINGS

A. General

Rehabilitations usually become liquidations or, less frequently, come to a point where control over the insurer is turned back to original or successor management. In a successful rehabilitation, there is a transition to normal operations that evolves from negotiation with former or proposed management and other constituencies. That negotiation is so unique to a particular rehabilitation effort that there is little in the way of guidelines to offer. There will generally be a final accounting and reporting process to the rehabilitation court and an application for termination of the formal proceeding. Accordingly, the receiver should lay the groundwork early for the timely discharge of the receiver, as rehabilitator, and the termination of the rehabilitation proceedings.

B. Closing the Rehabilitation Proceeding

Anytime the rehabilitator or the former directors of the insurer believe the purposes of the rehabilitation have been accomplished, a petition may be filed in the receivership court for an order terminating the rehabilitation, discharging the rehabilitator and restoring the company to private management. The court is also permitted to issue a termination order on its own motion. Before the company can be released from rehabilitation, Section 901 of IRMA requires that any funds paid by the guaranty associations must be repaid or the associations must have agreed to a repayment plan.

The order of discharge should include a release of the rehabilitator, agents, successors and assigns from all claims that may be asserted by creditors of the estate.

The rehabilitator and new management will want to determine and reach agreement on entitlement to and the value of the net operating losses pertaining to insurers which are part of holding company systems which have filed consolidated tax returns and consider other tax ramifications of the transactions.

The preparation of a final accounting by the rehabilitator and new management is necessary. The accounting will include what was originally agreed to between the parties as of the date of disposition to closing.

Under Section 404 of IRMA, the rehabilitator is allowed to file a petition to liquidate the insurer if the rehabilitator determines that further rehabilitation efforts would be futile or would increase the risk of financial loss to policyholders, creditors or the public. If the rehabilitator imposes a moratorium on the

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payment of policy benefits for six months without filing a rehabilitation plan, IRMA requires the rehabilitator to file a liquidation petition.

Section 405 of IRMA further requires the rehabilitator to reserve assets so that the estate can continue claims payments for a short time after liquidation while the guaranty associations prepare. This is particularly true for workers compensation indemnity and medical payments and first party medical benefits under no-fault automobile insurance.

Coordination and reporting by and between the liquidator and the affected guaranty funds are critical. The Uniform Data Standard (UDS) was designed to facilitate this reporting. Prior to filing the petition to liquidate, the rehabilitator should ensure that the estate will have the ability to transmit claims and premium data via UDS to the impacted guaranty funds that will be triggered by liquidation. For further discussion of UDS and the coordination and function of guaranty associations, refer to Chapter 6—Guaranty Associations.

III. CONSIDERATIONS PRIOR TO CLOSURE OF A LIQUIDATION

A. Legal

1. Illiquid Assets and Causes of Action

There may be both assets and causes of action that may not be cost beneficial for the liquidator to pursue. Since the duties of the liquidator include marshaling and liquidating assets for the benefit of the creditors of the insolvent insurer, it is advisable for the liquidator to obtain court approval of any decisions regarding abandonment of assets where marshaling or liquidating is not possible. The liquidator may also wish to consider negotiating with guaranty associations for the transfer of assets and causes of action to the guaranty associations as distributions in-kind. See IRMA Section 802C.

2. Termination of Proceedings

Pursuant to Section 902 of IRMA, when the liquidator has liquidated and distributed all assets that can be economically justified, the liquidator shall apply to the liquidation court for an order approving a final distribution of assets, closing the estate and discharging the liquidator. The order may set aside funds for post-closing administrative costs and provide for in-kind distribution of assets, if appropriate. The liquidator should consider formal corporate dissolution in the application unless the domiciliary state receivership statute dissolves the corporate entity by operation of law.

3. Record Retention

The liquidator should identify the various types of documents in his/her possession and determine the appropriate length of time that the documents should be preserved. In many cases, it may be appropriate to review and deal separately with the documents in different categories, e.g., the insurer's pre-receivership records, the insurer's post-receivership records, the records of the liquidator, etc.

Counsel should determine whether the destruction of these categories of documents is governed by the state law concerning the destruction of public or governmental documents, or by state law concerning business documents generally. In certain situations, state law and/or the Internal Revenue Service (IRS) may require that records be maintained for a specific period of time. Ethical standards for attorneys, as well as others may require retention periods. Federal regulation for record retention, if applicable, may also affect certain retention periods, e.g., Medicare health insurance records. Certain documents may need to be permanently preserved, perhaps through the state archival process.

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Once the legal requirements of the domiciliary state and any other states where the insurer did business have been reviewed, the liquidator should recommend to the court specific retention periods and procedures.

The receiver should reserve funds from the estate for the maintenance of records after the discharge of the receiver. Once the receiver is discharged, the entity assuming maintenance of necessary records of the estate, if any, must be established.

B. Tax Issues to be Considered Prior to Closure

1. General

Generally, federal and state tax returns should be filed by the liquidator throughout the liquidation. The final returns will be filed as of December 31 of the year during which final distributions are paid. As set forth above, the expenses that will be incurred to prepare the returns should be prepaid, as the actual filings will occur in the year subsequent to closure.

With each of the federal tax returns filed during the liquidation, the liquidator may consider the submission of a writ application requesting a Prompt Audit and Determination under Revenue Procedure 2006-24 to the IRS. Generally, this will expedite the entire process and end the statute of limitations for the returns. Technically, this procedure only applies to companies in a bankruptcy proceeding (Title 11), but in the past the IRS has extended it to insurers in receivership. If this procedure is not extended to an insurer in receivership, insurance company receivers are required to file federal income tax returns in the normal course of business as if the insolvent insurer were a perpetual concern, with no mechanism to sever the statute of limitations period. This is an impediment to closure of an estate that must be dealt with by receivers on a case by case basis through closing agreements with the IRS.

For more information regarding tax issues, refer to Chapter 3—Accounting and Financial Analysis. **It is strongly recommended that the receiver consult and retain a tax expert for all tax related issues.**

2. Internal Revenue Codes Relative to Insurance Contracts and Distributions

Tax implications and/or consequences of assumption transactions, 1035 exchanges or other such transfer of policyholder liabilities or payout of policyholder benefits is also an area of concern and consideration by the receiver. In response to insurer insolvencies, the IRS has addressed several issues affecting such taxation and tax implications. Such rulings have addressed issues such as funding in

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"steps,"[1] tax free exchanges,[2] multiple contract issues[3] and contract dates and testing for compliance,[4] to name a few, and specifically relate to Internal Revenue Codes 72 and 7702.

Section 72 of the IRC, "Annuities; Certain Proceeds of endowment and life insurance contracts," specifically subsection (s), references required distributions where the holder of an annuity dies before the entire interest is distributed. The rules in Section 72 govern the income taxation of all amounts received under annuity contracts and living proceeds from life insurance policies and endowment contracts. Section 72 also covers the tax treatment of policy dividends and forms of premium returns.

IRC Section 7702 relates to the definition of a life insurance contract. For purposes of this section, the term "life insurance contract" means any contract that is a life insurance contract under the applicable law, but only if such contract meets the cash value accumulation test as defined in Section 7702(b), or meets the guideline premium requirements of Section 7702(c) and falls within the cash value corridor of Section 7702(d).

a. Cash Value Accumulation Test

Generally, a contract meets the cash value accumulation test if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract.

b. Guideline Premium Requirement and Cash Value Corridor

With respect to the guideline premium, a contract generally meets this requirement if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of such time. Guideline premium limitation means, as of any date, the greater of the guideline single premium or the sum of the guideline level premiums to such date. Guideline single premium means the premium at issue with respect to future benefits under the contract. Guideline level premium means the level annual amount, payable over a period not ending before the insured attains age 95, computed on the same basis as the guideline single premium.

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[1] (Rev. Rul.) 92-43, 1992-1 CB 288. The IRS will allow a valid exchange where funds come into the contract or policy in a series of transactions if the insurer issuing the contract or policy to be exchanged is subject to a "rehabilitation, conservatorship or similar state proceeding." Funds may be transferred in this "serial" manner if: (1) the old policy or contract is issued by an insurer subject to a "rehabilitation, conservatorship, insolvency or similar state proceeding" at the time of the cash distribution; (2) the policy owner withdraws the full amount of the cash distribution to which he is entitled under the terms of the state proceeding; (3) the exchange would otherwise qualify for Section 1035 treatment; and (4) the policy owner transfers the funds received from the old contract to a single new contract issued by another insurer not later than 60 days after receipt or, if later, September 13, 1992. If the amount transferred is not the full amount to which the policy owner is ultimately entitled, the policy owner must assign his right to any subsequent distributions to the issuer of the new contract for investment in that contract. Revenue Proc. (Rev. Proc.) 92-44, 1922-1 CB 875, as modified by Rev. Proc. 92-44A, 1992-1 CB 876; (Let. Rul.) 9335054.

[2] If a non-qualified annuity contract is exchanged under Section 1035 within the scope of Rev. Rul. 92-43 (i.e., as part of a rehabilitation proceeding), the annuity received will retain the attributes of the annuity for which it was exchanged for purposes of determining when amounts are to be considered invested and for computing the taxability of any withdrawals.

[3] An annuity that is received as part of a Section 1035 exchange that was undertaken as part of a troubled insurer's rehabilitation process under Rev. Rul. 92-43 is considered to have been entered into for purposes of the multiple contract rule on the date that the new contract is issued. The newly-received contract is not "grandfathered" back to the issue date of the original annuity for this purpose. Let. Rul. 9442030.

[4] The IRS, in response to insurer insolvency proceedings, stated that modification of an annuity, life insurance, or endowment contract after Dec. 31, 1990, that is necessitated by the insurer's insolvency will not affect the date on which such contract was issued, entered into or purchased for purposes of IRC Section 72, 101(f) 264, 7702 and 7702A and also as not resulting in retesting or the start of a new test period under §§7702(f)(7)(B)-(E) and 7702A(c). Rev. Proc. 92-57, 1992-2 CB 410; Let. Rul. 9239026. See also Let. Rul. 9305013. The date is not affected by assumption reinsurance transactions entered into by the insurer provided that the terms and conditions of the policies, other than the insurer, do not change. Let. Ruls. 9323022, 9305013. The IRS also concluded that where a nonqualified annuity is exchanged for another via Section 1035 as part of a troubled insurer's rehabilitation process under Rev. Rul. 92-43, the annuity received in the exchange will be treated as issued, entered into, or purchased as of the date of the exchange except as provided in IRC Sections 72(e)(5) and 72(q)(2)(F). Let. Rul. 9442030.

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A contract generally falls within the cash value corridor if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value.

As with any tax issue, the implications of all Internal Revenue Codes to a particular liquidation proceeding and that proceeding's specific transactions should be explored with tax counsel.

3. Collection of Tax

Under Section 801 of IRMA, claims of the federal government are assigned a Class 5 priority and claims of state or local government are assigned a Class 8 priority, unless the claims represent losses incurred under policies of insurance (Class 3 or 4 claims). Thus, tax liabilities not properly characterized as an expense of receivership administration (Class 1) rank behind any claims for guaranty fund administrative expenses (Class 2) and all claims of policyholders (Class 3 or 4), including guaranty funds. Conversely, under the federal "super-priority" statute, 31 U.S.C. § 3713, claims of the federal government (in cases not covered by the bankruptcy code) are given first priority. The Supreme Court of the United States has resolved this conflict in *United States Department of the Treasury, et al v. Fabe*, 508 U.S., 491, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993). The Court held that the Ohio priority of distribution statute was not pre-empted by the federal statute to the extent that the Ohio law protects policyholders, because to that extent it constitutes a law enacted "for the purpose of regulating the business of insurance." Since the court also viewed administrative expenses as incurred in the process of protecting policyholders, administrative expenses also were ranked ahead of federal claims.

More recently, the 1st U.S. Circuit Court of Appeals has ruled that the federal government does not automatically have priority over other creditors, including state guaranty funds, in insurer liquidations. The 1st Circuit panel's ruling in *Ruthardt vs. United States of America* (see Chapter 9—Legal Considerations, section on Federal Government Claims) affirmed a Massachusetts district court's decision. In this litigation, the federal government challenged two aspects of the Massachusetts liquidation statute. First, the government argued that the liquidation priority provision in the statute is preempted by federal law to the extent it provides for payment of guaranty association claims ahead of claims of the federal government. The federal government also argued that the state's statutory bar date for filing claims against the insolvent insurer's estate does not apply to claims of the federal government. The federal district court ruled that the provision affording priority to guaranty association claims under the Massachusetts statute is a provision enacted for the purpose of regulating the business of insurance and is therefore shielded from federal pre-emption in accordance with the McCarran-Ferguson Act. With respect to the claims bar date, the district court concluded that it was bound by a controlling 1993 First Circuit decision finding that the benefits provided to policyholders by a state's claim bar date were too tenuous for that provision to constitute the regulation of the business of insurance subject to the McCarran-Ferguson protections. The Court of Appeals affirmed on both issues.

Generally, taxes are, at most, an expense of administration if the taxes arise during the period of administration (as distinguished from unpaid taxes for periods ending before commencement of liquidation) and are incurred by the estate, i.e., imposed on income from which the estate derived some benefit. Decisions regarding the payment of computed taxes should only be made after consultation with legal counsel.

4. Filing of Tax Returns

The entry of an order of liquidation does not terminate the existence of the insurer for tax purposes, regardless of the impact the order may have under state law. The taxable entity remains in existence until the liquidation is complete, i.e., all the assets have been distributed. Accordingly, the liquidator must attend to the continued filing of tax returns during the liquidation proceeding, which may include several taxable years. Therefore, the liquidator should recognize the need to undertake tax planning.

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As set forth above, it is possible that over the period of administration, an insolvent insurer may lose its status as an insurance company or become exempt from taxation altogether. Since these classifications are based on a testing of the company's activities and reserve characteristics, as activities cease, premium diminishes and insurance obligations are ceded under assumption reinsurance arrangements, the company may begin to fail these tests. The liquidator should anticipate the occurrence of this, and plan for the attendant consequences (e.g., reserve restoration, etc.).

If the insurance company placed in liquidation is the common parent of a group that has been filing consolidated returns, the receiver may have to continue filing on that basis. If the company was a subsidiary in a consolidated group, it is arguable that an order of liquidation should cause a termination of membership in the group. It should be noted that the only apparent pronouncement in this area is a 1985 private ruling (LTR 8544018) in which the IRS held that continued inclusion in a consolidated group is required of an insurer throughout the period of administration. However, among the consequences of entering an order of liquidation are the facts that the liquidator is given the power to exercise all shareholder rights (Section 504A(16) of IRMA), the receiver may contemporaneously dissolve the corporate existence under state law (Section 503 of IRMA) and the shareholders, in their capacity as owners, become creditors of the estate (Section 501 of IRMA). Any one of these conditions, and certainly all of them in combination, would seem to indicate that the parent company no longer has any stock ownership interest in the insurer, much less any voting rights. Furthermore, considering that this is a permanent stockholder displacement rather than a mere suspension of rights, the ruling seems rather questionable. In this situation, tax counsel should be consulted. When dealing with tax sharing agreements and consolidated tax returns, the need for termination of any prior agreements should quickly be assessed. Termination of these agreements could prevent a parent of a subsidiary insurance company from taking away tax benefits that rightfully belong to the estate.

The liquidator needs to also be aware of the tax consequences for a member of a consolidated group upon its ceasing to be a member. It will have two short-period years, one ending on the day it leaves the group that will be included in the group's consolidated return, and one beginning on the next day and ending at the insurer's normal year-end that will require a separate return. Even though the insurer might be included in the group's consolidated return for a small portion of the year, it will be jointly and severally exposed to the group's consolidated tax for the entire year, which tax could be increased by the recognition of an excess loss account (i.e., negative basis) that the group might have in the stock of the insurer. If gains of the insurer on prior transactions with other members were deferred, the gains must be recognized in the consolidated return upon the member's departure. The tax thereon can come back to the insurer, either through joint and several liability or under a tax allocation agreement of the group. Any estimated tax payments made by the group during the year must be allocated. Operating losses sustained by the insurer in subsequent periods that can be carried back to prior consolidated returns will produce refunds that will be made to the common parent of the group.

Affiliates' use of losses within a consolidated return presents a difficult issue regarding the estate's ability to recover any portion of the benefit. If the group had entered into a tax allocation agreement, the estate's benefit would be determined pursuant to that agreement. However, absent a written agreement, as a matter of equity, courts seem to allocate tax benefits according to which entities paid the tax being recovered, or whose income is being offset, (thus giving value to the loss). Note that the rules contained in the Department of the Treasury's regulations regarding allocations of consolidated tax are effective only for determining income tax consequences and do not, in and of themselves, create a contractual right of any member to receive any tax payments from another member.

Accordingly, a loss of the insurer, which can only be used against income of other members in the current year or another year and producing a refund of consolidated tax paid in by other members, is not likely to provide a material benefit for the insurer. If a refund potential exists, the liquidator might consider taking the position that inclusion in a consolidated return by a subsidiary insurer is no longer permitted or required, (pursuant to the discussion above), thereby perhaps developing some leverage in negotiating a tax allocation agreement.

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5. Net Operating Losses

An insurer placed under a liquidation order will ordinarily have incurred large operating losses, some of which may have been realized prior to the receivership and remain eligible for carryover to periods ending after the receivership began, and some of which may be realized during the receivership and may be carried back to earlier periods. Operating losses incurred by life insurers may no longer be carried back for taxable years beginning after December 31, 2017. Net operating loss deductions ("NOLs") are limited to 80 percent of taxable income, ~~(~~without regard to the deduction,~~)~~ for losses arising in taxable years beginning after December 31, 2017. Carryovers to other years are adjusted to take accounting of this limitation and may be carried forward indefinitely. Property and casualty insurers may carry back losses 2 years and forward 20 years. The 80 percent limitation on use of NOLs does not apply to a property and casualty insurance company.

It may be necessary for the liquidator to project the probable timing of income realization, particularly for property and casualty insurers where loss carryovers expire if not used within a certain period of time. The major item of income realization may be debt cancellation income when advances from guaranty funds, for example, are forgiven at closing.

The general rules for carryback and carryover of losses are modified if there is a change in the status of the insurer before January 1, 2018. A loss of a life insurance company may only be carried back to a year in which it qualified as a life insurance company if the loss occurs prior to January 1, 2018. For years beginning after December 31, 2017, life insurance companies are allowed the NOL deduction under section 172. A similar rule exists for property and casualty companies. As to loss carryovers, a change in character does not result in denial of the carryover, but the amount of loss from the earlier year may not exceed the amount it would have been if the insurer had the same character in all relevant years as it has in the year to which the loss is carried.

Loss carryforwards generally become severely restricted upon a substantial change in the ownership of the stock of a corporation. However, the rules requiring this result should not apply in these cases. If the IRS takes the position that the entry of an order of liquidation does not affect stock ownership (as, for example, in LTR 8544018), then the rules are not invoked. Conversely, if the entry of the order, in fact, does represent a complete change in ownership, then the exception for "Title 11 or similar case," e.g., bankruptcy or receivership, should be available (see 26 U.S.C. § 382(l)(5)).

The liquidator should consider techniques having the effect of accelerating income, such as the sale of appreciated property, reserve adjustments or reinsurance transactions. If the insurer can remain in a profitable consolidated group with which it has a tax allocation agreement, benefits can be realized without regard to extraordinary transactions.

6. Federal Claims and Releases

   a. Communicating with the Department of Justice.

Contact with the Department of Justice ("DOJ") at the inception of a receivership estate is critical to obtaining a prompt release of personal liability of the Receiver under 31. U.S.C. 3713(b) (the "3713 Release") to facilitate estate distributions to policyholders, claimants against policyholders, guaranty associations and other creditors. DOJ has historically identified a single Assistant U.S. Attorney as gatekeeper between the receiver and all federal agencies, except for the Internal Revenue Service, that may have claims against the receivership estate. Receivers may want to limit the number of people communicating with the DOJ to reduce the possibility of mixed messages, or messages going to the wrong person. Additionally it is recommended that Receivers follow the checklist provided by the DOJ when submitting documents. Contact the NAIC's office in DC if you need assistance to identify the current DOJ receivership contact

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b. Identifying potential federal claims, particularly long tail claims.

The Receiver's initial goal should be to identify potential federal claims from the insurer's claim and corporate files. Federal claims that are classified at the policyholder priority level as claims under an insurance policy or against an insured under an insurance policy should be reviewed and adjusted as soon as possible and their resolution and adjudication should be summarized for the DOJ in connection with the 3713 Release request. In addition to potential federal claims identified by the receiver, DOJ will typically request the receiver to identify all former policyholders of the insurer, including policy periods and limits of coverage so that federal agencies can perform their own search of potential claims against the insurer. An example of claims with a federal agency as a claimant are claims identified as having an environmental exposure.

c. Classification and handling of federal claims.

Pursuant to *United States Dept. of Treas. v. Fabe, 508 U.S. 491 (1993)*, state law may prioritize payment of administrative expenses and policyholder claims, including claims by third parties against policyholders and claims by guaranty associations, ahead of claims of all other general unsecured creditors, provided that the priority of federal claims immediately follows that of policyholders and precedes all other creditor classes. Claims of federal agencies under a policy of insurance or against a policyholder, however, are entitled to policyholder priority treatment.

d. Facilitating the process of obtaining a federal release.

All federal claims that are prioritized at the policyholder priority level should be identified and resolved before applying to the DOJ for a 3713 Release. The process of interacting with the DOJ, including the DOJ's survey of federal agencies for potential federal claims can take several years. Long-tail claims, such as claims involving environmental liability and coverage, as well as the number of policy years that the insurer provided coverage for long-tail exposures, is likely to increase the amount of time needed to resolve the potential federal claims and obtain the 3713 Release.

A best practice is to provide the DOJ with very detailed information on policies and claim information in order to avoid prolonging the process unnecessarily and lead to a long series of back-and-forth requests and production of additional data. For example, include a list of all policyholders unless the lines of business were limited to medical insurance. It may be helpful to segregate the various lines of business as the Environmental Protection Agency (EPA) is more interested in general liability lines as opposed to workers compensation exposures. If the company uses specific policy prefixes for different lines of business, a listing of the policy prefix definitions should be submitted with the list of policies. DOJ resource are usually limited, so key to successfully receiving the Release, it is helpful to keep the lines of communication open, not press for immediate results, consider routine follow-ups with the DOJ such as scheduled monthly status calls.

e. Impact of federal release on receivership closure.

Obtaining the 3713 Release is essential to protecting the receiver against the personal liability imposed under 31 U.S.C. s.3713, and accordingly impacts the receiver's ability to make final distributions of estate assets and close the estate. The foregoing practices should be commenced at the outset of the receivership and pursued with diligence throughout the life of the estate to ensure that the ultimate discharge of the estate is not prolonged.

7. Closing Agreement

The liquidator may want to consider utilizing a closing agreement pursuant to Revenue Procedure 2019-1, IRS Procedures for providing advice to taxpayers in the form of letter rulings, closing agreements, determination letters and information letters, and orally on issues under the jurisdiction of the Associate

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Chief Counsels (Corporate), (Financial Institutions & Products), (Income Tax & Accounting), (International), (Passthroughs & Special Industries), (Procedure and Administration) and Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). The closing agreement is a final agreement between the IRS and the taxpayer on a specific issue or liability and is entered into under the authority in §7121. The closing agreement would provide for a final determination to be made by the IRS with respect to tax returns filed on behalf of the insolvent company for specific years and would be final and conclusive except in the event of fraud, malfeasance or misrepresentation of material fact.

Additionally, retaining a Taxpayer Advocate's opinion is a possible best practice to address potential tax liability after receivership closure. Because the Taxpayer Advocate is associated with the IRS, this type of opinion could create an obstacle for tax authorities if they decide to revisit a tax return.

IV. CLOSING LIQUIDATON PROCEEDINGS

A. General

As the liquidator focuses on the steps necessary to conclude the four primary obligations of a receiver—marshaling the assets, liquidating the assets, adjudicating claims and making distributions to creditors—the liquidator should use some form of task list or project management software in the planning process to keep track of the objectives necessary to satisfy those obligations. The liquidator should allocate resources and determine a critical path indicating when tasks must be started to accomplish closure of the estate in the shortest time.

Timing of the closure process required careful planning and calculation. Utilizing a critical path methodology should assist in assuring that tasks are completed in their proper order.

B. Objectives to be Accomplished Prior to Closure of Liquidation Proceedings

Before the liquidator can be discharged and the estate closed:

1. Assets

All estate assets, both balance sheet and off balance sheet, must be marshaled and liquidated, when possible. After most of the estate assets are liquidated, the liquidator typically is left with certain assets that cannot be readily converted to cash for a considerable period of time or at all. Rather than hold the estate open pending the disposition of these illiquid assets, the liquidator should consider placing the assets in a liquidating trust, or, alternatively, negotiating with guaranty associations for the transfer of assets to guaranty associations as distribution in kind. As discussed in Subsection C.3. below, the distribution must be allocated in a manner that will afford equal treatment to guaranty funds and other priority claimants. In transferring the asset, all records necessary for the guaranty fund to ultimately convert the asset to cash must be transferred, including proper assignments and all other supporting documentation. A value for the asset should be agreed upon and the agreed upon value and transfer must be approved by the court (~~IRMA §~~Section 802 C of IRMA).

Reinsurance recoverables will have been commuted or otherwise collected prior to closure, including the resolution of disputes or arbitration proceedings.

2. Liabilities

All liabilities, through the proof of claim process, must be quantified and either allowed or disallowed by the supervising court.

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a. Claim Filing and Adjudication

The proof of claim and claim adjudication processes are complete as mandated in Article VII of IRMA, and the liquidation court has entered appropriate claim determination orders. The liquidator may want to consider the procurement of a formal written release from the federal government as a part of the claim adjudication process.

b. Classification of Claims

The liquidator has grouped claims by priority class pursuant to Section 801 of IRMA and has calculated the asset distribution percentage by class of creditor. With regard to partial and final distributions, the liquidator will want to make sure that policy claimants not covered by guaranty associations are afforded equal treatment with claims of guaranty associations.

c. Claim Adjudication Process

Claims adjudication and administration procedures are discussed in detail in Chapter 5—Claims. An important objective that will facilitate closure is for the liquidator to establish a tracking system to capture proof of claim adjudication results. The tracking system information should include:

- Name and address of claimant, organized by class~~;~~
- Claim number~~;~~
- Claim amount and priority classification~~;~~
- Statu~~s~~;
  - Allowed~~;~~
  - Denied~~;~~
  - partially allowed~~; and~~
  - determination~~;~~
- Liquidator's recommendation~~;~~
- Court determination~~; and~~
- Results of objections~~.~~

The tracking system should be continually updated as contingent claims mature and as the liquidator and the liquidation court deal with contested claims. The system tracking proof of claim amounts should reconcile with respective balance sheet amounts at any point in time. In short, the system should allow data to be kept current going forward so that reporting is fast and the calculation of amounts for claim recommendations to the court is simplified. The NAIC has developed ClaimNet, an on-line proof of claim submission system, which can be used by receivership offices.

The Uniform Data Standard (UDS) reporting system is discussed in detail in Chapter 6—Guaranty Association and Chapter 2—Information Systems. UDS provides for the reporting of policy and claim information between guaranty funds and receivers. The data provided by UDS may be integrated with the liquidator's claim tracking system to maintain current guaranty fund claim

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amounts. Again, these amounts should reconcile with the respective balance sheet amounts at any point in time.

Depending on the size of the liquidation and available assets, it may be economically preferable to petition the liquidation court to dispense with the claims adjudication process for certain classes if distributions to such classes are unlikely. Keep in mind, however, that the claimant's right to object to the classification of his claim would not be affected.

Ongoing litigation of excess or non-covered claims may impede closure. Moreover, with regard to third party claims against insureds to which the typical insolvency injunction does not extend, the liquidator must determine, based on the nature and size of the litigation, whether to defend. The risk of potential diluted distributions to other Class 3 creditors should be considered by the liquidator.

The insured or the third party may file a claim in the liquidation. The claims must be resolved and included as components of the liquidator's recommendations prior to closure. See Sections 801 and 802 of IRMA.

Pursuant to Section 705 of IRMA, claims that are contingent, unliquidated or immature may be allowed and may participate in all distributions declared subject to the criteria set forth in Section 705. The liquidator should consider commuting remaining treaties and facultative certificates on existing reserves with the assistance and approval of the liquidation court. Contingent claims must be resolved and included as components of the liquidator's recommendations under Section 802 of IRMA prior to closure.

An alternative to the traditional approaches of quantifying long tail Incurred But Not Reported (IBNR) claims to facilitate interim and final distributions and thereby expedite closing, is a process commonly known as "claims estimation." For a more detailed discussion of the claims estimation concept, see IRMA Section 705. Claim estimation can raise issues when seeking to collect reinsurance covering those claims. Procedures for settling reinsurance through commutation based in part on estimated claims are described in detail in IRMA Sections 614 and 615.

Pursuant to Subsection 701B of IRMA, late claims may be allowed and may participate in distributions declared to the extent that the orderly administration of the liquidation is not prejudiced provided stated criteria are met. Late filed claims that do not meet the criteria are placed into priority class.

3. Litigation

All litigation must be concluded. In the event litigation has resulted in the liquidator receiving a judgment against a party or if the liquidator is collecting restitution payments from any party, the liquidator may also consider placing such assets in a liquidating trust or negotiating with guaranty associations for the transfer of assets to the guaranty associations as distributions in kind. As discussed in Subsection C.3. below, the distribution must be allocated in a manner that will afford equal treatment to guaranty funds and other priority claimants.

4. Ancillary Proceedings

Ancillary proceedings must be closed or to a point where there is no continuing financial or legal impact on the domiciliary proceeding. All general and special deposits held by the ancillary receiver should be accounted for, i.e., transferred to its state's guaranty fund, returned to the liquidator, or otherwise appropriately disbursed.

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C. Administration of the Closing Process

1. Order Approving Termination of Proceeding

As discussed herein, and as specified in Section 902 of IRMA, the liquidator should apply to the liquidation court for an order approving a final distribution of assets, closing the estate and discharging the liquidator.

Specific issues to be addressed in the order may include:

- All major transactions, procedures and expenditures of the estate which were not previously approved by the court;
- The expense reserve set for final and post-closure expenses;
- Amounts to be paid in final distribution to claimants;
- Arrangements for storage or destruction of records and the reservation of funds to pay these expenses;
- Assignment of and the valuation of any distributions of assets in-kind to any claimants;
- Release of the receiver and his agents from further liability; and
- Provision that the proceeding will automatically terminate upon the completion of the above issues with the liquidator's filing of a "Closing Statement." The closing statement is simply a statement advising the court that all of the issues have indeed been resolved.

2. Final Expenses

The liquidator has made provision for the final expenses necessary to close the estate. To the extent possible, these Class 1 and Class 2 expenses should be paid in advance of closure. Examples of expenses to be estimated, agreed to and paid in advance are as follows:

- Legal fees and professional fees pertaining to the preparation of the final accounting to the liquidation court;
- Fees pertaining to the preparation of federal and state tax returns, and possibly final audit, pursuant to Section 905 of IRMA;
- Expenses pertaining to the storage and destruction/disposition of records after the termination of the liquidation;
- Legal fees pertaining to the termination of the liquidation proceeding and dissolution of the corporate entity;
- Final salaries and other administrative expenses necessary to wind up the affairs of the estate including but not limited to:
    - Final inventory preparation;
    - Interfacing with tax advisors on final tax preparation;
    - Oversight of records destruction;

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- Final distributions—cutting and processing checks;
- Responding to inquiries relative to final distribution;
- Final bank fees; and
- Unclaimed property report generation; and

- Administrative expenses of guaranty funds (Class 2 claims under IRMA).

3. Calculation of and Final Distribution

A date must be selected upon which the liquidator will make a final distribution to creditors. The date of final distribution is important because the liquidator usually attempts to assure that no additional transactions, such as cash receipts and disbursements, will occur subsequent to that date, and no additional expenses will be incurred, thus avoiding the preparation and filing of additional federal and state income tax returns. In effect, every task should be completed and every open issue resolved, except for the distribution of remaining monies. Alternatively, remaining cash assets can be transferred to a liquidating trust.

A good deal of planning must precede the preparation of final distribution amounts to creditors. Since Class 1 and Class 2 creditors can generally be satisfied in full, the final distribution percentage is calculated by dividing total assets available for distribution for a particular class (typically Class 3 policyholders for direct insurance writers or Class 4 for mortgage or financial guaranty insurers) by the amount of claims in a particular class as approved by the liquidation court. Generally, the distribution percentage for Class 3 claimants is less than 100%, but if Class 3 claims can be paid in full, then the calculation is applied to the next lower priority class that cannot be paid in full. Also, the calculation is complicated by the need to reserve sufficiently for administrative expenses to close the estate and expenses incurred after the distribution is made, if any.

A useful internal tool to provide a snapshot of asset distribution by creditor class at any time during the receivership is the interim Liquidating Balance Sheet (LBS). See Exhibit 10-1 for an example.

The interim LBS allows the receiver to periodically adjust assets to liquidated values based on the best and latest information available, and apply the liquidated asset values to liabilities by creditor class, thereby projecting distribution percentages at each balance sheet date.

There may have been previous interim or partial distributions from the estate that will need to be taken into account when calculating the final distribution percentage. Early access advances may have been made directly or indirectly to guaranty funds and directly to non-covered or excess claimants by order of the liquidation court and should be accounted for at or before final distribution is made. If partial distributions were made to guaranty funds, but not to non-covered/excess policyholder claimants, the final distribution calculations must take this into consideration so that all Class 3 creditors are treated equally.

In the event guaranty funds received early access distributions of funds or other assets in excess of the final distribution percentages to which they are entitled, the early access assets must be returned to the liquidator prior to the payment of a final distribution. The return of early access amounts by the guaranty fund is mandated by Section 803 of IRMA and typically by the Early Access Agreement executed pursuant to other early access laws. The fact that distributions made to non-covered/excess policyholders may not be collectible later if those policyholders received too much, is probably a good reason to take special care in calculating the amounts of any distributions to claimants other than guaranty funds.

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It should not be necessary to hold up the closure of the estate simply because certain assets have not been reduced to cash. Section 802C of IRMA allows distributing assets in-kind provided the creditor and liquidator agree on the value and the receivership court approves the distribution.

Once the final distribution amount has been determined, the funds to be distributed should be aggregated into a single checking account. The bank must be consulted in advance to provide final service charges and other debit amounts to enable the liquidator to determine the exact amount of remaining funds to be distributed. The bank should be provided with a listing of final distribution payees and amounts. Once all checks clear, the account should be closed. Checks for final distribution amounts that do not clear will need to be reported as Unclaimed Property (see subsection C6 of this section). In preparation for a final distribution, the final LBS will set forth distribution percentages by creditor class. Note the accrual for estimated expenses necessary to close the estate. These estimated expenses are detailed in subsection C2 of this section.

4. Reporting to the Liquidation Court

Throughout the liquidation process, financial reporting to the liquidation court is important, but it becomes more so as the liquidator starts to plan for closure. Many liquidators file quarterly or semi-annual status reports with the liquidation court, including a balance sheet, summary of cash receipts and disbursements, income statement and narrative report on liquidation activities. The narrative report usually contains a general overview/background of receivership activities, including details on the insurance business by line, a discussion and status of the assets, the proof of claim and claim adjudication processes, tax returns and litigation. Financial repo~~s~~rting requirements ~~under IRMA~~ are set out in Section ~~§~~117 of IRMA.

This reporting process enables the liquidation court and creditors to keep abreast of the proceeding and its major issues, and simplifies the ultimate final accounting to the liquidation court prior to closure.

5. Final Accounting

As part of the termination proceedings, the liquidator will file with the liquidation court a final accounting that discusses the disposition of major issues during the liquidation and has a summary of significant events, key orders entered by the liquidation court, pending issues, if any, and distribution percentages to remaining creditor classes, along with detailed schedules reflecting creditors, early access and partial distribution amounts previously paid, if any, and final distribution amounts. The liquidator should consider filing basic financial statements with the court (e.g., balance sheet and income statement) as well as an inception to date summary of cash receipts and disbursements. The distribution plan should be pursuant to the liquidation court's orders regarding the liquidator's claim recommendations. The filing of the final accounting will have been preceded by requisite notice to the appropriate parties.

6. Unclaimed and Withheld Funds (Escheat Items)

Uncashed checks or drafts that have not been negotiated prior to a final distribution should be handled in accordance with the applicable state unclaimed property laws or Section 804 of IRMA, as appropriate.

7. Other Required Reporting

Final distributions may require reporting to the IRS as 1099 Miscellaneous Income to the recipient or as other reportable income as determined by tax counsel.

In the event the liquidated company continued to have employees through its final year, certain employer reporting such as W-2 forms, quarterly wage and tax forms, etc. must be completed post-closure. If there were employees retained by the insolvent company, health insurance and any other

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such benefits must be terminated prior to closure. If a 401k plan was in existence prior to liquidation, closure of the plan may require a letter of determination from the IRS for plan termination.

8. Final Tax Returns

The liquidator will make arrangements with its tax advisors to complete and file the final tax return subsequent to the closure of the estate. A final expense for tax preparation should be included as part of the expense reserve.

Records must be accessibly maintained during the preparation of the returns.

9. Corporate Dissolution

The liquidator will comply with any statutory provisions and file any necessary documents to permanently delete the company from applicable agencies. This may include other jurisdictions in which the company maintained a license to operate. The order terminating the liquidation and discharging the liquidator should be provided to the agencies in order for them to close their files.

10. Record Retention

The liquidator will identify the various types of documents in his/her possession and determine, with counsel, the appropriate length of time that the documents should be preserved. The petition for termination and discharge should include a recommendation to the court on retention periods based on type of documents.

Whether records are placed in an off-site storage facility for the retention period or transferred to a state agency for archiving, records should be inventoried for ease in retrieval in the event questions arise in the future.

If an off-site storage facility is utilized, the facility should be prepaid through the final expense distribution as per subsection C2 of this section. Records should be identified with destruction dates, if applicable.

11. Destruction of Records

A part of the final petition and court's order discharging the liquidator, an order authorizing the destruction of the mass of company records should also be included. Those items that have been identified with specific retention periods, of course, will be excluded from this process. Typically, the vendor handling the destruction will provide a certification of destruction and such certification will become part of the retained records.

12. Closure of Office

The actual physical plant will need to be closed, if not already closed. Proper notice to vendors such as utilities must be given prior to closure, as well as terminating any contracts or leases entered into by the liquidator during the liquidation proceeding.

13. Post Closure

Subsequent to the closure of the liquidation, there may be inquiries for records and information made by former business associates of the company and/or policyholders. Arrangements should be made to ensure proper handling of such inquires.

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I. INTRODUCTION

As extraordinarily remote a set of circumstances necessitating it may be, under § 203(e) of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, 18 USC § 5383(e) (Dodd-Frank Act), state insurance Commissioners, their designated deputy receivers and Guaranty Funds are charged with the enormous responsibility of resolving a systemically important insurance company. Those circumstances by definition would be unique and extraordinary. The circumstances also by definition would bring enormous time pressure with high stakes for the U.S. economy and the policyholders and creditors of the particular insurance company in receivership. Responding to those unique challenges would require advanced planning and analysis, which this Chapter addresses, by describing four baseline implementation areas for Commissioners, deputy receivers and guaranty funds to consider.

After a general introduction to the Dodd-Frank insurance receivership framework, the analysis in this chapter focuses on the following considerations:

1) Establishing processes at the state level to ensure the state receivership mechanism will respond effectively to a Dodd-Frank receivership.

2) Analyzing and preparing for the situation in which an insurance company is a subsidiary or affiliate of a covered financial company.

3) Describing national coordination initiatives to ensure the national state-based systems provide further support to administering a Dodd-Frank receivership.

4) Developing state laws that will ensure that state mechanisms can effectively initiate and administer a Dodd-Frank receivership.

II. OVERVIEW OF DODD-FRANK INSURANCE RECEIVERSHIP FRAMEWORK

The Dodd-Frank Act was enacted on July 21, 2010. [1] Title II of the Dodd-Frank Act[2] creates a new orderly liquidation authority (OLA) for the dissolution of failing systemically important financial companies and certain of their subsidiaries when certain conditions are found to exist. In addition to the overview below, the federal and state processes are summarized in flowcharts attached as Exhibits 11-A and 11-B.

The Dodd-Frank Act defines the term "financial company"[3] as any company incorporated or organized under federal or state law that is a bank holding company as defined in the federal Bank Holding Company Act of 1956 (BHCA)[4]; a nonbank financial company supervised by the Federal Reserve Board of Governors (Board); any company (other than an insured depository institution or a nonbank financial company supervised by the Board) that is predominantly engaged in activities that the Board has determined are financial in nature or incidental thereto for purposes of Section 4 (k) of the BHCA (which includes an insurance company)[5]; or any subsidiary of the

---

[1] Public Law 111-203, 12 U.S.C. 5301 *et seq.*

[2] §§ 201 to 217, 12 U.S.C. 5381 *et seq.*

[3] § 201(a)(11); 12 U.S.C. 5381(a)(11).

[4] 12 U.S.C. 1841(a).

[5] 12 U.S.C. 1843(k). Section 4(k)(4) of the BHCA (12 U.S.C. 1843(k)(4)) provides: "For purposes of this subsection, the following activities shall be considered to be financial in nature: …(B) Insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death, or providing and issuing annuities, and acting as principal, agent, or broker for purposes of the foregoing, in any State…."

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foregoing that is "predominantly engaged" in activities that are financial in nature or incidental thereto for purposes of the BHCA, other than a subsidiary that is an insured depository institution or an insurance company.[6]

Under the OLA, the Federal Deposit Insurance Corporation (FDIC) may be appointed as receiver of a "covered financial company" for purposes of liquidating the company.[7] The Dodd-Frank Act defines the term "covered financial company"[8] as a financial company for which the Secretary of the Treasury (Secretary) in consultation with the President has made a determination under § 203(b).[9] However, if the financial company is an insurance

---

[6] § 201(b) provides that no company may be deemed to be predominantly engaged in activities that are financial in nature or incidental to a financial activity unless the consolidated revenues of such company from such activities constitute at least 85% of the total consolidated revenues of such company, including any revenues attributable to a depository institution investment or subsidiary.

[7] Subject to certain exceptions (notably for insurance companies), the Dodd-Frank Act does not contemplate a receivership for the purpose of rehabilitation or reorganization. § 204(a) provides:

It is the purpose of this title to provide the necessary authority to liquidate failing financial companies that pose a significant risk to the financial stability of the United States in a manner that mitigates such risk and minimizes moral hazard. The authority provided in this title shall be exercised in the manner that best fulfills such purpose, so that—

> (1) creditors and shareholders will bear the losses of the financial company;
>
> (2) management responsible for the condition of the financial company will not be retained; and
>
> (3) the Corporation and other appropriate agencies will take all steps necessary and appropriate to assure that all parties, including management, directors, and third parties, having responsibility for the condition of the financial company bear losses consistent with their responsibility, including actions for damages, restitution, and recoupment of compensation and other gains not compatible with such responsibility.

[8] § 201(a)(8).

[9] § 203(b) (12 U.S.C. 5383(b)) provides:

> (b) DETERMINATION BY THE SECRETARY.—Notwithstanding any other provision of Federal or State law, the Secretary shall take action in accordance with section 202(a)(1)(A), if, upon the written recommendation under subsection (a), the Secretary (in consultation with the President) determines that—
>
> (1) the financial company is in default or in danger of default [see footnote 10];
>
> (2) the failure of the financial company and its resolution under otherwise applicable Federal or State law would have serious adverse effects on financial stability in the United States;
>
> (3) no viable private sector alternative is available to prevent the default of the financial company;
>
> (4) any effect on the claims or interests of creditors, counterparties, and shareholders of the financial company and other market participants as a result of actions to be taken under this title is appropriate, given the impact that any action taken under this title would have on financial stability in the United States;
>
> (5) any action under section 204 would avoid or mitigate such adverse effects, taking into consideration the effectiveness of the action in mitigating potential adverse effects on the financial system, the cost to the general fund of the Treasury, and the potential to increase excessive risk taking on the part of creditors, counterparties, and shareholders in the financial company;
>
> (6) a Federal regulatory agency has ordered the financial company to convert all of its convertible debt instruments that are subject to the regulatory order; and
>
> (7) the company satisfies the definition of a financial company under section 201.

§ 203(c)(4) (12 U.S.C. 5383(c)(4)) provides:

> (4) DEFAULT OR IN DANGER OF DEFAULT.—For purposes of this title, a financial company shall be considered to be in default or in danger of default if, as determined in accordance with subsection (b)—
>
> (A) a case has been, or likely will promptly be, commenced with respect to the financial company under the Bankruptcy Code;
>
> (B) the financial company has incurred, or is likely to incur, losses that will deplete all or substantially all of its capital, and there is no reasonable prospect for the company to avoid such depletion;
>
> (C) the assets of the financial company are, or are likely to be, less than its obligations to creditors and others; or
>
> (D) the financial company is, or is likely to be, unable to pay its obligations (other than those subject to a bona fide dispute) in the normal course of business.

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company[10] or its largest U.S. subsidiary (measured by total assets) is an insurance company, the director of the Federal Insurance Office (FIO) and the Board, at the request of the Secretary or on their own initiative, will make a written recommendation, by two-thirds vote of the Board and the affirmative approval of the Director of the FIO in consultation with the FDIC, to the Secretary on whether the Secretary should make a determination to invoke the OLA with respect to the financial company.[11]

The Secretary is required to notify the FDIC and the covered financial company subsequent to any determination under § 203. If the company's board of directors acquiesces or consents to the appointment of the FDIC, the Secretary must then appoint the FDIC as receiver. If the board of directors of the financial company does not acquiesce or consent to the appointment of the FDIC as receiver, then the Treasury Secretary must petition the U.S. District Court for the District of Columbia for an order before appointing the FDIC as receiver of any covered financial company.[12] The Court's review is limited to determining whether the Secretary's determination that the covered financial company is in default or in danger of default and satisfies the definition of a financial company under the Dodd-Frank Act is arbitrary and capricious.

This review is made on a confidential basis and without any public disclosure, but with notice by the court to the company and a hearing in which the company may oppose the petition. If the court determines that the Secretary's determination is not arbitrary and capricious, the U.S. District Court is required to issue an order immediately authorizing the Secretary to appoint the FDIC as receiver of the covered financial company. The court is required to make its ruling within 24 hours of receiving the petition of the Secretary; otherwise, the petition will be deemed granted by operation of law. Either party may appeal the decision to the U.S. Court of Appeals for the D.C. Circuit and then to the U.S. Supreme Court (which is given discretionary jurisdiction to review the Court of Appeals decision on an expedited basis), but the decision may not be stayed or enjoined pending appeal.

Notwithstanding Section 203(b) of the Dodd-Frank Act, if an insurance company is a covered financial company or a subsidiary or affiliate of a covered financial company, then the liquidation or rehabilitation of such insurer and any insurance company subsidiary or insurance company affiliate of the covered financial company would be conducted as provided under applicable state law (by the appropriate state insurance regulator).[13]

However, with respect to such state-based receiverships, if within 60 days after a determination has been made to subject such entity to the OLA the appropriate state insurance regulator has not filed the appropriate judicial action in the appropriate state court to place such insurance company into "orderly liquidation" under the laws and requirements of the state, the FDIC is given the authority "to stand in the place of appropriate regulatory agency and file the appropriate judicial action in the appropriate State court to place such company into orderly liquidation under the laws and requirements of the State."[14]

If the covered financial company in receivership is an insurance company (or its largest U.S. subsidiary is an insurance company), the Dodd-Frank Act authorizes the FDIC to be appointed as receiver of an insurance company subsidiary which itself is not an insurance company (such as third-party administrators, brokerages, managing general agents and any entities that are not "subject to regulation"), even though the FDIC is not the receiver of the insurance company and the insurance company may not be insolvent or in receivership proceedings in state court.[15]

---

[10] Defined as "…any entity that is (A) engaged in the business of insurance; (B) subject to regulation by a State insurance regulator; and (C) covered by a State law that is designed to specifically deal with the rehabilitation, liquidation or insolvency of an insurance company." § 201(a)(13); 12 U.S.C. 5381(a)(13).

[11] § 203(a)(1)(C); 12 U.S.C. 5383(a)(1)(C).

[12] § 202(a)(1); 12 U.S.C. 5382(a)(1).

[13] § 203(e); 12 U.S.C. 5383(e).

[14] § 203(e)(3); 12 U.S.C. 5383(e)(3).

[15] § 210(a)(1)(E)(i); 12 U.S.C. 5390(a)(1)(E)(i) provides:

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Upon the appointment of the FDIC as receiver over such subsidiary, the subsidiary itself will be considered a financial company subject to the OLA, and the FDIC will have all of the powers and rights with respect to that covered subsidiary as it has with respect to a covered financial company.[16]

The Dodd-Frank Act requires the FDIC as receiver to consult with the primary financial regulatory agency or agencies of any subsidiaries of the covered financial company that are not covered subsidiaries (such as state insurance regulatory officials), and coordinate with such regulators regarding the treatment of such solvent subsidiaries and the separate resolution of any such insolvent subsidiaries under other governmental authority.[17] The statute does not provide precise guidance as to how the FDIC would coordinate with the state insurance receiver of the insurance company if the subsidiaries or affiliates' operations are integral to the operation of the insurance company. Examples are management or service companies, (when the insurer has no employees of its own), or third-party administrators, (if the subsidiary has contracts with the insurance company,), or if the insurance company and the subsidiary are jointly obligated to third parties, (such as under a lease). In such instances, it is unclear how the state insurance receiver would protect the interests of the insurer. The appointment of the FDIC as receiver of an insurance company subsidiary may leave the insurance company parent in a weaker financial condition. To protect these operations, the states, through NAIC, must implement procedures for immediate initiation and administration of state insurance receiverships with a high degree of coordination with the FDIC, applicable guaranty funds and others.

III. STATE LEVEL PROCESS FOR IMMEDIATE INITIATION OF STATE INSURANCE RECEIVERSHIP

A. Rapid Response Protocol

Most states have enacted statutes governing the conservation, rehabilitation and liquidation of insurance companies that are patterned after one of three model acts that have been adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) or by the NAIC over the years: the Uniform Insurers Liquidation Act (Uniform Act); the Insurers Rehabilitation and Liquidation Model Act; and the Insurer Receivership Model Act (#245555, commonly known as) (IRMA). NAIC Model Acts uniformly require that the chief insurance regulator of the insurer's domiciliary state (Regulator) be appointed receiver of the insurer to administer the receivership under court supervision.

Title II of the Dodd-Frank Act does not change state liquidation statutes. Nevertheless, the state Dodd-Frank responsibilities require state statutes that assure immediate execution of state receiverships necessary to effectively respond to a national crisis. If there is a federal determination that an insurance company meets the § 203(b) standards codified in 12 U.S.C. § 5383(b), then the Dodd-Frank Act anticipates that the insurance company would be placed immediately into receivership pursuant to state law, 12 U.S.C. § 5383(e). Subject to certain exceptions (notably for insurance companies), the Dodd-Frank Act does not contemplate a receivership for the purpose of rehabilitation or reorganization. See footnote 7, supra. Under state law, the form of receivership is not limited to liquidation. And Section 203(e)(1) of the Dodd-Frank

---

(i) IN GENERAL.—In any case in which a receiver is appointed for a covered financial company under section 202, the Corporation may appoint itself as receiver of any covered subsidiary of the covered financial company that is organized under Federal law or the laws of any State, if the Corporation and the Secretary jointly determine that—

(I) the covered subsidiary is in default or in danger of default;

(II) such action would avoid or mitigate serious adverse effects on the financial stability or economic conditions of the United States; and

(III) such action would facilitate the orderly liquidation of the covered financial company.

[16] § 210(a)(1)(E)(ii); 12 U.S.C. 5390(a)(1)(E)(ii).

[17] § 204(c); 12 U.S.C. 5384(c).

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Act, 12 U.S.C. § 5383(e)(1), explicitly refers to both rehabilitation and liquidation of insurance companies in the insurance company context.

If state regulators do not file the appropriate action within 60 days of the federal determination, then the FDIC has the authority to stand in the place of the state regulator for purposes of initiating the appropriate action under and pursuant to state law, § 203(e)(3), 12 U.S.C. § 5383(e)(3). Regulators, receivers, the courts and other interested persons should not plan to rely on the 60-day window. Immediate state action will be required in most Dodd-Frank insurance company receivership scenarios. Even in the unlikely event that the FDIC filed the state court action due to the passage of 60 days, state laws continue to require that the Regulator be appointed as receiver of an insurance company and that the receivership be conducted under state law.

This section outlines the steps individual states should take to create a rapid response protocol, organizational structure and coordinated interagency effort to immediately initiate a Dodd-Frank receivership and, in any event, meet the 60-day requirement under Title II of Dodd-Frank. The steps include:

- Advanced planning
- Coordination with the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and National Conference of Insurance Guaranty Funds (NCIGF)
- State-federal coordination with proper deference to state insurance regulators and receivers in the orderly liquidation of any insurance company
- Creation of a contact list and executive committee to coordinate receivership implementation
- Formal communication protocols
- Procedures for immediate initiation of receivership and contacting attorneys general
- Procedures or rules for expedited judicial review

B. Advanced Planning

State regulators have long recognized that state receivers who expect to successfully administer a receivership must become familiar with the insurer's operations, business and structure as soon as possible. See Chapter. 1, ~~§~~Section IV~~-~~(A) of this Handbook~~, NAIC *Receivers Handbook for Insurance Company Insolvencies* (2009) (Receivers Handbook)~~. The FDIC recognizes that advanced communication and planning is critical to a resolution that mitigates significant risk and minimizes moral hazard in a Dodd-Frank scenario. If there are multiple proceedings, coordination of those proceedings is essential to resolution of a Dodd-Frank scenario as much or more than in a traditional dual liquidation/bankruptcy scenario.

There are both existing and developing mechanisms in place for both state and federal regulators to consider the impact of the Dodd-Frank Act in the course of regulation. These mechanisms also assist regulators, the NAIC and, at the appropriate time, receivers to have advance (even if separate) direction and warning of the potential for a Dodd-Frank receivership affecting an insurance company. Beginning with the designation of companies as Federal Reserve Board-supervised nonbank financial companies under § 113(a) and spanning all the way to determinations of the Secretary under 12 U.S.C. § 5383(b), and encompassing all regulation in between, both state and federal regulators ideally will be provided with information sufficient to take some pre-receivership regulatory protective action, when necessary, and also engage in some level of advance receivership planning.

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Indeed, state regulators may know in advance of federal regulators that significant financial problems exist in an insurance company. State regulators, therefore, may have opportunity for advance receivership planning and/or independent grounds prior to a 12 U.S.C. § 5383(b) determination to trigger state regulatory action, including:

- A confidential order of supervision by the state insurance regulator.
- Other heightened regulation/prudential standards by the state regulator, including but not limited to, examination, watch list or other restrictions limiting the insurer's issuance of new business.

Thus, there may be a platform in the current state regulatory structure for advance notice and planning by state regulators and receivers in advance of the notice of a federal determination under 12 U.S.C. § 5383(b).

Ideally, the Regulator's advance planning for a Dodd-Frank scenario involving a state-regulated insurer should be highly coordinated with the NAIC and the Receivership Financial Analysis (E) Working Group; other affected state regulators; NOLHGA and NCIGF; and federal regulators and receivers, including the FDIC and the affected insurance company. The insurance company or its parent/affiliate may be required to submit a confidential federal resolution plan providing for rapid and orderly resolution in the event of a future material financial distress or failure, Section 165(d), 12 U.S.C. § 5365(d). That plan should be provided to and reviewed by the Regulator as part of the Regulator's work to broadly pre-identify theoretical scenarios and responses, and certainly as part of the planning to implement an actual Dodd-Frank referral under 12 U.S.C. § 5383(b). The confidentiality provisions under the Dodd-Frank Act, as well as the federal and state confidentially restrictions, must be respected and addressed up front in memorandum of understanding (MOU) or other protections in formulating all pre-planning and communication plans. Alternatively, confidential state-based plans, such as ~~Contagion Reports~~enterprise risk reporting,[18] ~~(~~where applicable, ~~)~~ or confidential Corrective Action Plans, can be used confidentially by state regulators as early planning tools.

Although the Dodd-Frank Act does not expressly require that a determination made under § 203(b) with regard to an insurance company be communicated to the Regulator (the determination is expressly required to be communicated to the FIO, FDIC, Federal Reserve and the covered financial company, and that information is confidential), that basic communication is implied as part of the FDIC's consultation obligations under § 204(c), 12 U.S.C. § 5384(c), and is obviously necessary to the orderly initiation of a Dodd-Frank receivership. Procedures should establish, at a minimum, that the recommendation and determination is immediately communicated in all cases to the NAIC as a central coordination point for state regulators and receiver, and also directly to the domestic Regulator when the company is itself an insurance company and the insurance regulators when there is an insurance company subsidiary or affiliate of a covered financial company. Discussions with the relevant federal actors should focus on state receivership planning and advance warning under the confidentiality constraints of the Dodd-Frank Act.

C. Internal Procedure for Presenting Federal Determination to Commissioner and for Immediately Initiating Receivership

Whether a receivership is expected, preplanned or arises unexpectedly, state insurance regulators and receivers must be prepared internally for the immediate initiation of a receivership well before the expiration of 60 days where there is a federal systemic risk determination as to an insurance company.

[18] The NAIC ~~Model~~ *Insurance Holding Company* *Regultory Model* *Act* (#440) requires that annual enterprise risk reports to the regulator identify material risk within the holding company systems that could pose a financial or reputational contagion to the insurer. The NAIC *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) requires the filing of annual reports for certain large insurers and insurance groups on the insurer or insurance group's assessment of risks.

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In general, as discussed above, under 12 U.S.C. § 5383(a), the FDIC and the Board of Governors of the Federal Reserve System (Federal Reserve), on their own initiative or at the request of the Secretary, recommend that the Secretary appoint the FDIC as receiver for a covered financial company. The recommendation to place an insurance company or a financial company of which the largest domestic subsidiary is an insurance company into receivership is made by the Federal Reserve and the director of the FIO in consultation with the FDIC, 12 U.S.C. § 5383(a)(1)(C). The Secretary, in consultation with the President, determines whether the covered financial company satisfies the criteria in 12 U.S.C. § 5383(b). If such a determination is made, the Secretary notifies the covered financial company of the determination pursuant to 12 U.S.C. § 5383(c) and 12 U.S.C. § 5382(a)(1)(A)(i). There is no exact time limit for the notice, but the expectation is that the notice will be immediate.

Once the determination is made, if the company consents to the determination, the FDIC's appointment as receiver is immediate., 12 U.S.C. § 5382(a)(1)(A)(i). If there is no consent, then the Secretary, upon notice to the covered financial company, shall petition the U.S. District Court for the District of Columbia under seal for an order authorizing the Secretary to appoint the FDIC as Receiver, 12 U.S.C. §§ 5382(a)(1)(A)(i), (ii). The Court has 24 hours to determine whether the Secretary's determination that the covered financial company is in danger of default and satisfies the definition of a financial company is arbitrary and capricious, 12 U.S.C. § 5382(1)(A)(iv). If the Court determines the Secretary's findings are not arbitrary and capricious and that the company is a covered financial company, then the Court shall enter an order immediately authorizing the Secretary to appoint the FDIC as Receiver, Id. If the Court fails to make a determination within 24 hours, the petition is granted by operation of law, and the Secretary shall appoint the FDIC as receiver, 12 U.S.C. §§ 5382(a)(1)(A)(v)(I), (II). The Court's determination is subject to a limited scope and expedited appeal process, but not to stay or injunction, 12 U.S.C. §§ 5382(a)(1)(B), (a)(2). See Flowcharts, (Exhibit 11-A and 11-B).

One exception is that if the covered financial company is an insurance company or an insurance company subsidiary or affiliate of a covered financial company, the rehabilitation or liquidation of such company, and any insurance company subsidiary or affiliate of such company, shall be conducted as provided under state law, 12 U.S.C. §§ 5383(e)(1), (2). In that case, the Regulator has 60 days from the date on which the 12 U.S.C. § 5383(a) determination is made—not communicated—to file the appropriate judicial action in state court to place the insurance company into orderly liquidation under state law, or else the FDIC shall have the authority to make the filing. 12 U.S.C. § 5383(e)(3). The Dodd-Frank Act does not expressly require entry of a liquidation order in 60 days (or ever for that matter), but entry of a receivership order well in advance of the 60-day expiration must be the Regulator's goal in order to be consistent with the federal framework seeking to swiftly resolve company failure that threatens the national economy.

1. Internal Discussions

   As referenced above, the first discussion that must occur is, minimally, notice of the federal determination from the Secretary or other federal representative to the state Regulator. That notice should be immediate.

   However best interlocking with federal processes, discussions must occur as to how the federal government prefers to coordinate and plan for notice. For example, regulators may pre-identify themselves and other persons to be notified. NAIC mechanisms may also be useful to effect fast multi-state notice. Once the state regulator receives notice of the federal determination, the Internal Procedures in the domiciliary state, discussed more specifically below, are triggered if those procedures have not already been triggered as the result of advanced planning. There will be a critical need to respect statutes requiring confidentiality of non-public information in the hands of regulators in this and other preplanning processes. The notice will also likely trigger formal discussions and procedures with stakeholders outside the domiciliary state, but those procedures are not discussed at length in this section.

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2. Key Elements of Initial Due Diligence

As in all receiverships, the Regulator who expects to successfully prosecute a receivership action must become familiar as soon as possible with the insurer's overall operations and business, as must any potential special deputy receivers and staff. See Chapter.1, Section VI(A) of this Handbook. ~~Ch. 1, § V(A), Receivers Handbook.~~ This cooperation and advance planning among the Regulator, the receiver and ideally also the company itself is especially imperative in a systemically important Dodd-Frank scenario. Indeed, the FDIC cites Lehman Brothers' lack of such a plan as a factor that contributed to the chaos of its bankruptcy. See FDIC Report, *The Orderly Liquidation of Lehman Brothers Holdings Under the Dodd-Frank Act*, April 18, 2011.[19]

The circumstances of a Dodd-Frank receivership will dictate the priorities in the initial response once the significant risk to the financial stability of the U.S. is identified. Coordination and information sharing with the federal government, needless to say, will drive much of the early activity and due diligence. Beyond those initial priorities, a number of items will inevitably be a part of any initial due diligence process. Among priority due diligence items in a Dodd-Frank receivership will be for the receiver to meet with the Regulator's staff and possibly also key company personnel as soon as possible to discuss Resolution Plans to the extent they are available, as well as the perceived causes of the insurer's difficulties, the insurer's "place" in the overall corporate structure and its relationship to the systemically important company, and receivership options best suited to accomplish an orderly resolution and liquidation. See Chapter.1, ~~§~~Section VI(A) ~~Receivers~~of this Handbook.

In the Dodd-Frank scenarios, as in all receiverships, the Receiver must be able to readily assess which assets are the insurer's assets. There must be a prompt review and analysis of the interaction and agreements between the insurer and its affiliates and vendors—service agreements, management agreements, key employment agreements, pooling agreements and other similar arrangements. See Chapters. 8~~,~~ and 9 ~~Receivers~~ of this Handbook. In particular, identification and analysis of qualified financial contracts and the impact of any termination and netting rights must be conducted. There must be a prompt assessment by the Receiver of the potential for a successful rehabilitation of the insurance company prior to or in connection with liquidation. Information from state and federal regulators can greatly assist the Receiver. It is also important for the Receiver to meet with the insurer's officers and/or directors, when possible. While these are elements of nearly all insurance receiverships, the receiver should plan for a faster and more focused analysis under the urgent circumstances a Dodd-Frank receivership of an insurance entity presents.

3. Attempt to Broadly Pre-Identify Theoretical Scenarios and Responses

As referenced above, Resolution Plans, Contagion Reports or other regulatory mechanisms exist by which companies confidentially file with the Regulator their plans in the event of a § 203(b) determination as to the failure of an insurer or related entity. Using these or other regulatory mechanisms, such as financial examination, the Regulator can broadly pre-identify theoretical scenarios and responses for actual or potential systemically important companies in the state.

4. Internal Procedure for Initiating State Receivership, Including Procedure for Early Consultation with the State Attorney General or Other Stakeholders

   a. Assuming there is an external procedure for communicating the federal determinations and/or prior proceedings to the domestic Regulator, the Regulator must, in turn, trigger internal procedures for filing the appropriate judicial action seeking liquidation or rehabilitation within 60 days of the determination.

[19] *www.fdic.gov/analysis/quarterly-banking-profile/fdic-quarterly/2011-vol5-2/lehman.pdf*

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b. Most Regulators and Receivers have established internal procedures for contacting the chief liquidation officer, consulting with the attorney general or others needed to file a state receivership action and for notifying the Court once the action is filed. These internal procedures should be adapted, strengthened and memorialized for Dodd-Frank scenarios to provide for heightened and expedited notice and court action. In some states, statutory or rule change will be required to adapt to a Dodd-Frank scenario. For example, if the state requires a public or non-public bidding process for the appointment of a Receiver, that process must be expedited or eliminated in the unique Dodd-Frank scenarios in order to assure federal statutory compliance and expedited appointment of a state receiver.

c. Each Regulator should, as an initial matter, establish an inter-agency Dodd-Frank Executive Committee (Committee) in advance of a Dodd-Frank insurance receivership. The Committee is a working group for preplanning functions and a resource for confidential coordination of a complex and urgent Dodd-Frank receivership. The Committee does not have independent powers, nor can the Commissioner delegate his or her authority to the Committee. The Committee would initially be charged with pre-identifying expedited procedures and pre-identifying contact points (Contact List) unique to each state in the event of a Dodd-Frank insurance company receivership. This would include the development of state-specific, formal communication protocols based on NAIC models and similar to state disaster and recovery plans. This would also include the adaptation of NAIC-based, or development of state-specific, pre-screened and/or outlined court or administrative documents for receiverships prompted by systemic risk determinations.

   In an actual Dodd-Frank scenario, the Committee could act as a group of multidisciplinary experts who are particularly tasked with assisting the Commissioner in the planning for and executing of the orderly resolution and liquidation of particular systemically risky insurance companies.

d. The mission of the Committee is to:

   - Plan in advance (pre-identify contact points and pre-identify expedited procedures that are annually reviewed) for a Dodd-Frank insurance receivership.

   - Assist the Commissioner in the assessment of alternatives for cost-effective resolution or receivership while maximizing protection of policyholders, creditors and the public. Accurate and timely information is critical to perform these functions.

   - Assist the Commissioner in assessing and rapidly responding to federal determinations in a manner that complies with Dodd-Frank and meets the goals of Dodd-Frank Title II.

   - Assure through preplanning or otherwise that adequate assets of any designated systemically important insurance company exist, or that other lending/funding exists, to pay for the receivership of an insurance company receivership arising under Dodd-Frank.

   - Assess early on the severity of potential obligations of guaranty funds resulting from liquidation of a systemically important insurer.

   - Work with the state Receiver to coordinate, implement and resolve the receivership.

e. Depending on the state, the Committee and the Contact List may be comprised of the same or different people. The Contact List is a list of key stakeholders who must be notified by the Regulator immediately in the event of a § 203(b) determination, certainly as to a domestic company, and also possibly in relation to a foreign company with business in that Regulator's

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state. A communication protocol similar to that in place under most states' disaster plans in general must be implemented.

The Committee and/or the Contact List should include:

- Regulator (Chair of Committee) and/or Chief Financial Regulator/Key Department of Insurance Personnel (Committee and Contact List). The Regulator is charged with immediately notifying the members of the Committee and the Contact List upon notification of the federal determination. This notification may occur outside of normal business hours. Therefore, the communication procedures and protocols must anticipate a need to contact key stakeholders at any time of any day.

- Governor or appointed representative (Contact List)

- Chief Liquidation Officer, or Special Deputy Receiver (Committee and Contact List)

- Chief Legal Counsels of Regulator/Receiver (Committee and Contact List)

- Other agencies. It should be noted that some entities (for example. health maintenance organizations and other managed care organizations) may be regulated primarily or jointly by other state agencies, such as the department of health or specialized agencies.

- Attorney General or designated Assistant Attorney General (Committee and Contact List) and/or contracted outside counsel

- If state law and process allow, Chief or Administrative Judge of the receivership court (Contact List)

- Depending on state structure, Contracted Receivers (may need pre-approved short list for magnitude of a Dodd-Frank receivership; consider training core group of current state receivers who can be loaned to other states in the systemically significant circumstances) (Committee and Contact List). Commissioners may in their discretion consider sources of previously identified receivership expertise in assembling resources for the administration of a Dodd-Frank receivership. The NAIC *Directory of Receivership and Run-Off Resources to Assist State Insurance Regulators* provides commissioners, in their capacity as receiver, a list of professional resources. Examples of other sources of expertise may include the ABA Tort & Insurance Practice Section; the Association of Insurance & Reinsurance Run-Off Companies (AIRROC); the International Association of Insurance Receivers, which also accredits insurance receivers; and the International Association of Restructuring, Insolvency & Bankruptcy Professionals.

- NOLHGA and NCIGF, and specialized guaranty funds, such as title and managed care, where appropriate. (Committee and Contact List)

    - Additional Potential Parties for Active Receivership:

        - NAIC, including the Receivership Financial Analysis (E) Working Group. The NAIC can particularly assist with the notification to all affected state Regulators in the event that ancillary receiverships must be rapidly initiated.

        - FIO.

        - Ancillary receivers, if any.

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- FDIC to coordinate treatment of solvent and insolvent insurance company subsidiaries and affiliates and other issues.

- Other state agencies that also regulate the insurance company.

D. Procedure for Rapid Consultation with the State Attorney General or Other Counsel Required to Prepare and Make the Initial Filing

1. In most states, the State Attorney General represents the Regulator. In many states, the State Attorney General also represents the Receiver. Therefore, early consultation and coordination with the State Attorney General in those states where they represent the Regulator and Receiver, or the retained legal staff who represents the Regulator and Receiver is required to swiftly transition a systemically risky insurance company to receivership under state law.

2. In some cases, national coordination with Attorneys General and others who represent the Regulator and Receiver will be required to promptly and cost-effectively domesticate the receivership order in all or the majority of states.

3. States should plan for expedited and/or flexible procedures for the appointment of outside counsel, if required by the Regulator or Receiver. There will be a need for rapid conflicts checking and immediate retention.

4. Depending on state structure, states should consider development of a pre-approved short list of Attorneys General, internal counsel, ~~-~~and/or qualified outside counsel who can respond to the magnitude of a Dodd-Frank receivership. This could ensure immediate consultation with attorneys needed to prepare and make the required filing in state court and execute the receivership under the urgent circumstances presented by a Dodd-Frank receivership.

5. Special attention should be devoted to those special cases in which the federal courts may also be involved, such as the insolvency of a risk retention group or the resort to Chapter 11 of the bankruptcy code by the parent or an affiliate of the troubled insurer that could result in the Section 362 automatic stay impeding accelerated proceedings.

E. Other Considerations

1. States and the NAIC should develop pre-screened/outlined court documents.

2. In some states, statutory amendments may be required or favored to assure that a federal determination under § 203(b) or consent at the federal level is grounds for liquidation. Potential changes are discussed below in section VI. Notwithstanding that, there are provisions in the NAIC models and Model #~~24~~555 that can be incorporated into pre-screened court administrative documents for receiverships prompted by systemic risk determinations, such as:

   a. Rehabilitation may be the best first step for all or part of an insurance company subject to a Dodd-Frank receivership, especially if there is a filed resolution plan providing for the orderly transfer, reinsurability, ~~-~~or runoff of policyholder liabilities. Liquidation may be required if there is a critical need to trigger guaranty funds and an order of liquidation. Plus, a finding of insolvency is required by state law for that trigger. All receivership mechanisms should be considered in consultation with any applicable guaranty funds. In any case, rapid but sophisticated analysis of how a state receiver is going to close or resolve the insurance company must occur. This includes what liquid assets exist to run the receivership; what assets are (un)encumbered, including what liens have been taken by the FDIC; how assets can be sold or liquidated; how claims are going to be filed, determined and paid; and what is the effect of qualified financial contracts.

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b. The following grounds for receivership or liquidation in most current state codes could provide grounds for an insurance company receivership order in the event of a federal determination and can be incorporated into a consent, model complaint and order along with other grounds that may exist (i.e., insolvency):

- The insurer is in such hazardous condition that the further transaction of its business would be hazardous financially to its policyholders, creditors, and the public. Compare § 203(b)(4).

- The board of directors or the holders of the majority of voting shares request or consent to state receivership.

F. Timeline for Prompt Consideration by State Trial Court

Once a petition for receivership is filed, the company will have an opportunity to defend itself, which can result in a trial or an evidentiary hearing. Some states may require or favor a statutory rule change to assure that a Dodd-Frank insurance company receivership complaint (where there is no consent) is fully litigated through appeal on an emergency track analogous to that set forth in § 202(b). All states will, at a minimum, require procedures for emergency intake and consideration of the complaint and any pro hac vice motions by the trial court. When possible, Regulators and Receivers should meet in advance with the Chief Administrative Judge or other appropriate official in the Receivership Court to discuss (i) the new requirements under Dodd-Frank; (ii) how the Court prefers to manage such complaints and cases, in particular if all or part of the initial complaint must be filed in person or heard outside of normal business hours; and (iii) what likely questions the Court would have in the event of a Dodd-Frank filing. Reference can be made to the U.S. District Court for the District of D.C. rules promulgated to implement the federal determination process.

While these court processes will not be entirely in the control of the Regulator and may potentially require legal changes, ideally the procedures would provide for:

1. Intake and administration protocol that results in automatic assignment to a particular judge (such as the chief administrative judge or duty judge) and that avoids jurisdictional disputes (e.g., whether the complaint and case is or is not assigned or transferred to a specialized court or docket).

2. Filing the complaint under seal where appropriate.

3. Intake and administration protocols that provide for expedited processes and orders, ideally hearing and determination of the complaint within 24 hours of filing. This may be accomplished pursuant to a court scheduling order or other order, or existing rules in some states.

   Separately, many, if not all, states have adopted special statutes or rules for expedited litigation and appeal of particular classes of cases. Although those classes of cases are more frequent than insurance receiverships in general, and Dodd-Frank receiverships in particular, state courts should give consideration now to the issue whether new rules or statutes are warranted to provide for immediate and expedited litigation of a Dodd-Frank insurance receivership on an analogous track as is set forth in § 203(b).

4. Limited or no intervention by third parties. To the extent existing state law in a particular state permits third parties (other than the company) to intervene as parties at the outset of an insurance company receivership, consider limiting the right to seek intervention in a Dodd-Frank receivership to ancillary proceeding that occur after entry and appeal of the receivership order. This will assure that states can meet the Dodd-Frank Act's need for immediate entry of a rehabilitation or liquidation order in response to a federal determination and that interventions do not interfere with the emergency activities of the court and the regulator. In states where statutes or case law do not

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presently grant third parties intervention and appeal rights in receivership cases, that law should be preserved in a Dodd-Frank receivership.

5. Domestication of the receivership order and/or initiation of ancillary receivership proceedings.

6. Limited appeal, both in terms of standing and scope of review, analogous to that set forth in Dodd-Frank, Title II, Section § 202. Conversely, only the insurance company, as represented by its board, should have standing to defend against a complaint for receivership as provided for in existing statutes. Affiliates, subsidiaries, and creditors should not be permitted to participated in the litigation of the discreet issue whether a liquidation order should be entered because of the existence of a federal determination under § 203(b).

IV. SUBSIDIARY AND AFFILIATE ISSUES

A. Overview

Subsidiary and affiliate issues require that Commissioners and deputy receivers expand their scenario analysis and planning beyond situations in which an insurance company would be the covered financial company. As described below, several scenarios can emerge whereby the insurance company is affected by a Dodd-Frank receivership, although not as the covered financial company. In particular, issues emerge where the insurance company is an asset, direct or indirect, of a covered financial company, or where the FDIC's lien authority is brought to bear.

Section 2(1) of the Dodd-Frank Act defines "affiliate" as having the meaning set forth in 12 U.S.C. 1813[20], which defines the term as having the meaning set forth in 12 U.S.C. 1841(k), as follows: " ... any company that controls, is controlled by, or is under common control with another company."

Section (2)(18)(A) of the Dodd-Frank Act—Other Incorporated Definitions—provides that "subsidiary" has the meaning set forth in 12 U.S.C. 1813, where is it defined as follows:

(w) Definitions relating to affiliates of depositary institutions

(4) Subsidiary. The term 'subsidiary'

(A) means any company which is owned or controlled directly or indirectly by another company; and

(B) includes any service corporation owned in whole or in part by an insured depository institution or any subsidiary of such a service corporation.

Section 2(18)(A) of the Dodd-Frank Act also provides that the term "control" has the meaning set forth in 12 U.S.C. 1813,[21] where the term is defined as having the meaning set forth in 12 U.S.C. 1841, as follows:

(a)(2) Any company has control over a bank or any company if -

(A) the company directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote 25 per centum or more of any class of voting securities of the bank or company;

[20] 12 U.S.C. 1813(w)(6).

[21] 12 U.S.C. 1813(w)(5).

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(B) the company controls in any manner the election of a majority of the directors or trustees of the bank or company; or

(C) the Board determines, after notice and an opportunity for hearing, that the company directly or indirectly exercises controlling influence over the management or policies of the bank or company.

Determination of an entity's status as an affiliate or subsidiary may vary under the Dodd-Frank Act from that under holding company or state law.

B. Advanced Planning

Section 210(a)(1)(G) of the Dodd-Frank Act provides broad power to the FDIC, as the receiver of a covered financial company, to transfer the company's assets without obtaining approval from any other entity.[22] If an insurance company is owned by a covered financial company, it is, therefore, an asset of the covered financial company, and the FDIC can transfer its ownership. The Dodd-Frank Act does not specify any conditions or limitations on the FDIC's power to transfer ownership, such as obtaining the approval of the domiciliary regulator. Thus, it appears that compliance with NAIC *Insurance Holding Company System Regulatory ~~a~~Act~~s~~* is not contemplated, nor is compliance with other state laws governing ownership (for example, limitations on foreign ownership). It is possible that § 210(a)(1)(G) preserves state authority because comparable authority allowing the FDIC to transfer assets to a "bridge financial company" specifically excludes state approval. Whereas § 210(a)(1)(G) provides that the FDIC can make a transfer "without obtaining any approval, assignment or consent. …," § 210(h)(5)(D), governing transfers by the FDIC to a bridge financial company, provides that a transfer is effective " ... *without any further approval under Federal or State law*, assignment, or consent with respect thereto."[23] The express exemption from obtaining "Federal or State law" approval is not contained in § 210(a)(1)(G), which, therefore, might be interpreted as simply exempting the FDIC from obtaining approval from shareholders, lien holders or other private parties.[24]

An insurance company's assets would not appear to be subject to transfer by the FDIC because § 210(a)(1)(G) only authorizes the transfer of assets of the "covered financial company" for which the FDIC

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[22] § 210(a) - Powers and Authorities.

(1) General Powers

(G) Merger; Transfer of Assets and Liabilities. –

(i) In General. Subject to clauses (ii) and (iii), the Corporation [FDIC], as receiver for a covered financial company, may –

(I) ...

(II) transfer any asset or liability of the covered financial company (including any assets and liabilities held by the covered financial company for security entitlement holders, any customer property, or any assets and liabilities associated with any trust or custody business) without obtaining any approval, assignment, or consent with respect to such transfer.

[23] § 210(h) - Bridge Financial Companies

(5) Transfer of Assets and Liabilities.

(A) Authority of Corporation. The Corporation [FDIC], as receiver for a covered financial company, may transfer any assets and liabilities of a covered financial company (including any assets or liabilities associated with any trust or custody business) to one or more bridge financial companies, in accordance with and subject to the restrictions of paragraph (1).

(D) Effective Without Approval. The transfer of any assets or liabilities, including

those associated with any trust or custody business of a covered financial company, to a bridge financial company shall be effective without any further approval under Federal or State law, assignment, or consent with respect thereto.

[24] § 210(h)(5) is ambiguous in its reference to exemption from "further" approval under Federal or State law. § 210 does not specify *any* State approval requirements, hence exemption from "further" approval is without an antecedent reference.

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is the receiver. The section does not appear to authorize the FDIC to "transfer" the insurer's business through reinsurance or other arrangements. It also, therefore, does not appear to give the FDIC authority to transfer a wholly owned subsidiary of an insurer. The subsidiary is an asset of the insurer, not the covered financial company. But authority granted to the FDIC to impose liens (discussed below) is analogous, and that authority is interpreted as extending to an insurer's subsidiaries.

Under its authority to transfer assets of a covered financial company, the FDIC could transfer ownership of an insurer's affiliates. Transferring an affiliate (or a subsidiary) could be highly problematic for an insurer in numerous situations, such as transfer of an affiliated management company that runs the insurer's operations (the insurer itself may have no employees), transfer of an affiliate or subsidiary that generates profits recirculated by the parent company (or dividend by the subsidiary) to provide capital to the insurer, or transfer of an affiliate or subsidiary whose operations are essential to or interwoven with the operation of the insurer.

The Dodd-Frank Act also provides that the FDIC may transfer the assets of a covered financial company for which it has been appointed as receiver to a "bridge financial company." As noted above, the transfer may be made without approval under "State Law." Again, the FDIC does not appear to be bound by any provisions of the *Insurance Holding Company System Regulatory ~~a~~Model Act~~s~~* or other state laws. Transfer of an insurer or its affiliates to a bridge financial company raises the same issues regarding ownership and operation as are raised by the FDIC's power to otherwise transfer ownership. Transfer to a bridge financial company contemplates a further transfer or other disposition of assets when the status of the bridge financial company terminates.[25] Hence, a further transfer of ownership of an insurer could occur.

C. Lien and Funding Issues

Section 204(d) of the Dodd-Frank Act provides that when the FDIC is appointed as receiver of a covered financial company, it can "make available ... funds" to the receivership. and it can use those funds for a number of purposes[26]. The contemplated purposes include: making loans to the covered financial company

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[25] Section 210(h)(13) - Termination of Bridge Financial Company Status. -- The status of any bridge financial company as such shall terminate upon the earliest of --

(A) the date of the merger or consolidation of the bridge financial company with a company that is not a bridge financial company;

(B) at the election of the Corporation, the sale of a majority of the capital stock of the bridge financial company to a company other than the Corporation and other than another bridge financial company;

(C) the sale of 80 percent , or more, of the capital stock of the bridge financial company to a person other than the Corporation and other than another bridge financial company;

(D) at the election of the Corporation, either the assumption of all or substantially all of the liabilities of the bridge financial company by a company that is not a bridge financial company, or the acquisition of all or substantially all of the assets of the bridge financial company by a company that is not a bridge financial company, or other entity as permitted under applicable law; and

(E) the expiration of the period provided in paragraph (12), or the earlier dissolution of the bridge financial company, as provided in paragraph (15).

[26] § 204 - Orderly Liquidation of Covered Financial Companies.

(d) Funding for Orderly Liquidation. - Upon its appointment as receiver for a covered financial company, and thereafter as the Corporation [FDIC] may, in its discretion, determine to be necessary or appropriate, the Corporation may make available to the receivership, subject to the conditions set forth in section 206 and subject to the plan described in section 210(n)(9), funds for the orderly liquidation of the covered financial company. All funds provided by the Corporation under this subsection shall have a priority of claim under subparagraph (A) or (B) of section 210(b)(a), as applicable [administrative expenses or amounts owed to the United States, respectively], including funds used for --

(1) making loans to, or purchasing any debt obligation of, the covered financial company or any covered subsidiary;

(2) purchasing or guaranteeing against loss the assets of the covered financial company or any covered subsidiary, directly or through an entity established by the Corporation for such purpose;

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or any "covered subsidiary[27]"; purchasing assets of a covered financial company or covered subsidiary[28]; selling or transferring all or any part of "such acquired assets, liabilities or obligations" of a covered financial company or covered subsidiary[29]; and making payments to certain creditors[30]. Section (d) also provides that the FDIC may take a lien on property of a covered financial company or a covered subsidiary, as follows:

[I]ncluding funds used for --

(4) taking a lien on any or all assets of the covered financial company or any covered subsidiary, including a first priority lien on all unencumbered assets of the covered financial company or any covered subsidiary to secure repayment of any transactions conducted under this subsection.

Unlike the term "covered financial company," which is defined in relation to systemic risk[31], a "covered subsidiary" is defined as *any* "subsidiary" of a covered financial company, other than an insured depository institution, an insurance company, or a covered broker or dealer.[32] Further, the term has been interpreted as meaning a subsidiary at any level in the corporate organization; thus, the term appears to include the subsidiary of an insurance company.

For example, in the hypothetical illustration below, a covered financial company owns an insurance company, a federally insured depository, and several other direct and indirect subsidiaries. Under the Dodd-Frank Act, each of the subsidiaries will also be deemed to be a "covered subsidiary," except for the insurance company and the federally insured depository.

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(3) assuming or guaranteeing the obligations of the covered financial company or any covered subsidiary to 1 or more third parties;

(4) taking a lien on any or all assets of the covered financial company or any covered subsidiary, including a first priority lien on all unencumbered assets of the covered financial company or any covered subsidiary to secure repayment of any transactions conducted under this subsection;

(5) selling or transferring all, or any part, of such acquired assets, liabilities or obligations of the covered financial company or any covered subsidiary; and

(6) making payments pursuant to subsections (b)(4), (d)(4), and (h)(5)(E) of section 210.

[27] Subsection (d)(1), *supra*.

[28] Subsection (d)(2), *supra*.

[29] Subsection (d)(5), *supra*.

[30] Sections 210(b)(4), 210(d)(4) and 210(H)(5)(E).

[31] *See* § 203(b).

[32] § 201(a)(9) - Covered Subsidiary. -- The term "covered subsidiary" means a subsidiary of a covered financial company, other than ---

(A) an insured depository institution;

(B) an insurance company; or

(C) a covered broker or dealer.

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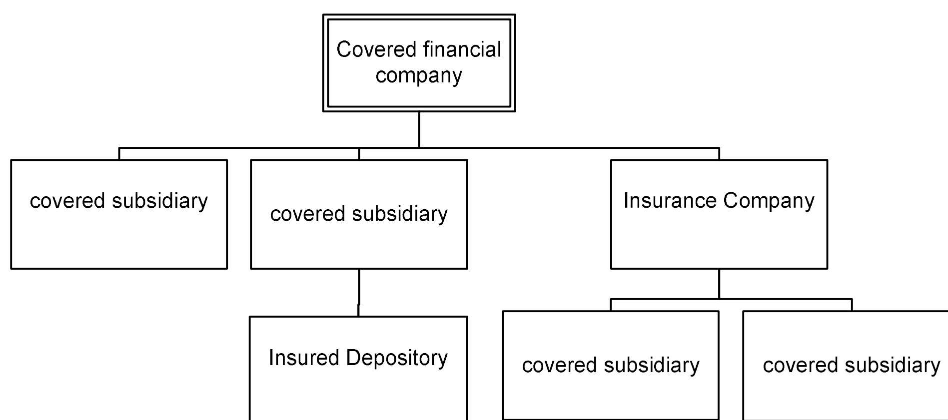

The FDIC adopted Regulation § 380.6[33] regarding its lien authority under § 204(d) as applied to insurance companies and their subsidiaries. The Regulation was amended from its original proposed form, in response to comments by the NAIC, NOLHGA/NCIGF and others, to provide that liens would only be imposed, generally, on the assets of the entity that actually received funds pursuant to § 204(d). The Regulation provides as follows:

Limitation on liens on assets of covered financial companies that are insurance companies or covered subsidiaries of insurance companies.

a) In the event that the Corporation [FDIC] makes funds available to a covered financial company that is an insurance company or to any covered subsidiary of an insurance company or enters into any other transaction with respect to such covered entity under 12 U.S.C. 5384(d), the Corporation will exercise its right to take liens on any or all assets of the covered entities receiving such funds to secure repayment of any such transactions only when the Corporation, in its sole discretion, determines that:

   1. Taking such lien is necessary for the orderly liquidation of the entity; and

   2. Taking such lien will not either unduly impede or delay the liquidation or rehabilitation of such insurance company, or the recovery by its policyholders.

b) This section shall not be construed to restrict or impair the ability of the Corporation to take a lien on any or all of the assets of any covered financial company or covered subsidiary in order to secure financing provided by the Corporation or the receiver in connection with the sale or transfer of the covered financial company or covered subsidiary or any or all of the assets of such covered entity.

Regulation 380.6, subsection (a) limits the FDIC to obtaining liens only on the entity that receives a loan from the FDIC and only if the lien will not unduly interfere with the liquidation or rehabilitation of the parent or affiliate insurer. Generally, this limitation would prevent liens on the assets of an insurance company that is a subsidiary of a covered financial company that received FDIC funding. Subsection (b), however, is a reservation of rights as to subsection (a) that may apply when the FDIC intends to place a lien on an insurer's assets in connection with obtaining financing or in connection with the sale or transfer of the covered financial company, a subsidiary or an affiliate.

The FDIC's lien authority could conflict with the authority of the receiver or the receivership court as to imposition of liens on an insurer's assets. Imposing liens on subsidiaries' assets could negatively affect the

[33] 12 C.F.R. § 380.6

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operations of an insurer when a subsidiary's operations are interwoven with or integral to the operation of the insurer.

V. NATIONAL COORDINATION

In the event of a Dodd-Frank receivership, national coordination between state insurance departments may require use of multiple resources, distribution lists and tools currently in place and available to state insurance departments/receivers. These include, though are not limited to, relying on the expertise of NAIC committees, such as the Receivership Financial Analysis (E) Working Group and the Financial Analysis (E) Working Group. The Receivership Financial Analysis (E) Working Group was established to monitor nationally significant insurers/groups within receivership to support, encourage, promote and coordinate multi-state efforts in addressing problems. This will include interacting with the Financial Analysis (E) Working Group, domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s) with regard to the receiverships. The Financial Analysis (E) Working Group was established to analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled and determine if appropriate action is being taken, as well as to interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s).

It is likely that coordination between state insurance departments and federal bodies may include providing and receiving contact information with various parties (e.g., FDIC, FIO, and the U.S. Department of the Treasury). Thus, it is important to remember that the NAIC maintains distribution lists for various state insurance department parties, including primary receivership contacts, general counsel, chief financial regulator, etc. The NAIC also maintains contact information for federal bodies.

National coordination efforts may also need to involve the expertise of the state guaranty fund system and its existing national framework, if applicable. Thus, please refer to the NAIC's white paper *Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System*. Prepared by the Receivership and Insolvency (E) Task Force, the white paper describes these communication and coordination considerations. Highlights from the publication include the following:

> Guaranty association involvement should be early enough that the guaranty associations can immediately undertake their statutory duties upon liquidation. As a practical matter, this calls for involvement as soon as it appears that there is a significant possibility of liquidation. This point may be reached even before the insurer is under administrative supervision or in conservation or rehabilitation. Assuming that the size, complexity and type of business of any given company has a direct bearing on how much lead-time is needed by the guaranty associations, there is a minimum amount of time, prior to being triggered, in which guaranty associations need to receive information, including quantification of covered liabilities by state, claims system information, lines of business and product specifics, third party agreements, as well as any other arrangements. If adequate information is not gathered pre-liquidation, delays in payments to claimants will result. Guaranty associations can often assist a regulator with formulating a plan for liquidation. Associations are frequently able to devote valuable resources, including legal, financial, actuarial, and other consulting services, in the design of a plan in circumstances in which budgetary or staffing constraints may pose challenges for regulators.

VI. POTENTIAL CHANGES TO STATE LAW

Receivership and the call for orderly liquidation under Title II of Dodd-Frank may be triggered well before the existence of insolvency, impairment or other hazardous conditions have traditionally been established with respect to domestic companies. A Dodd-Frank orderly liquidation will also require a rapid response, as discussed fully in section III above. Accordingly, states should review and consider whether their existing state laws, including the grounds for rehabilitation or liquidation of a domestic company and related procedural rules for obtaining receivership orders, are sufficient to respond to federal determinations that domestic insurers meet the standards codified in Title II of Dodd-Frank, 12 U.S.C. § 5383(b), and the receivership processes established under 12 U.S.C. § 5382(a) and § 5383(e).

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In order to assist the states in this review, the Dodd-Frank Receivership Implementation (E) Working Group prepared the *Guideline for Implementation of State Orderly Liquidation Authority* (#1700) ("Guideline"). See (Exhibit 11-C.) The Guideline is intended to provide guidance and serve as a template for potential state law drafting revisions. The Guideline provides that any of the triggers for a Dodd-Frank receivership under 12 U.S.C. § 5382(a), either consent by the company, entry of an order by U.S. District Court for the District of Columbia, or by operation of law under 12 U.S.C. § 5382(a)(1)(A)(v), see flowchart (Exhibit 11-A), constitute automatic grounds for rehabilitation or liquidation under state law. The Guideline also mirrors the Dodd-Frank Act by establishing timing and procedural rules for the expeditious entry and implementation of receivership orders that support both the policy goals of the Dodd-Frank Act and federal regulators, as well as the extraordinary responsibilities of state regulators for ensuring policyholder protection while resolving a systemically important insurance receivership.

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Exhibits and Checklists from the Receivership Handbook

Chapter 1	**Exhibit 1-1:** Model Language for Selected Provisions of Liquidation Orders for Property and Casualty Insurers **Exhibit 1-2:** Model Language for Selected Provisions of Liquidation Orders for Life and Health Insurers **Exhibit 1-3:** Insurer Insolvency Questionnaire	**CHECKLIST 1**—Pre-Commencement~~Takeover~~ **CHECKLIST 2**—Commencement~~Takeover~~ **CHECKLIST 3**—Human Resources and Payroll **CHECKLIST 4**—Property, Real Estate, Records and Facilities Control **CHECKLIST 5**—Customer Service **CHECKLIST 6**—Underwriting **CHECKLIST 7**—Information Systems **CHECKLIST 8**—Accounting **CHECKLIST 9**—Tax and Compliance **CHECKLIST 10**—Claims **CHECKLIST 11**—Large Deductible Policies **CHECKLIST 12**—Reinsurance **CHECKLIST 13**—Legal
Chapter 3	**Exhibit 3-1:** Example of Financial Reporting Format **Exhibit 3-2:** Example of Daily Cash Flow **Exhibit 3-3:** Example of Budget-Projected Liquidation Expenses	
Chapter 4	**Exhibit 4-1:** Potential Recovery from Unrelated Third Parties Matrix of Relationships	
Chapter 5	**Exhibit 5-1:** Linear Summary of Claims Administration **Exhibit 5-2:** Claimant Notice via Postcard **Exhibit 5-3:** Assignment of Claims Issues Guidance	
Chapter 6	~~**Exhibit 6-1:** NOLHGA Sample Early Access Agreement~~ ~~**Exhibit 6-2:** NCIGF Sample Liquidators Proposal to Disburse Assets~~ ~~**Exhibit 6-3:** NCIGF Sample Refunding Agreement~~ ~~**Exhibit 6-4:** Large Deductible State Code Examples~~	
Chapter 7	**Exhibit 7-1:** Treaty Master Abstract **Exhibit 7-2:** Reinsurance Matrix	
Chapter 9	**Exhibit 9-1:** NAIC Proposed Guidelines Relating to the Reporting of Loss Information to Reinsurers **Exhibit 9-2:** Considerations for Separate Accounts – Receivers' Checklist	
Chapter 10	**Exhibit 10-1:** Interim Liquidating Balance Sheet **Exhibit 10-2:** Closing Liquidating Balance Sheet	
Chapter 11	**Exhibit 11-A:** Initiation of Orderly Liquidation of Insurance Company Under Dodd-Frank **Exhibit 11-B:** State Receivership Initiation Process **Exhibit 11-C:** Guideline for Implementation of State Orderly Liquidation Authority	

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The following are appendices revised by staff. See highlighted and track changes portion of the tables below.

Checklist 1—Pre-Commencement	Project Assigned To	Date Completed	Completed By	Notes
Obtain from the Department of Insurance • Its most recent examination work papers, • The insurer's most recent annual and quarterly statements, • Audited financial statements with auditor's opinion, • Actuarial certifications, • Any SEC filings, • Tax returns and any other financial statements, • Group Profile Summary (i.e., Holding Company Analysis), • Most recent Insurer Profile Summary, • Most recent Holding Company Registration Statement and related filing (Form B, Form F, etc.)				
Obtain copies of any other insurer documents held by the Department such as insurer charter, by-laws, Form As, Form Ds and other applications, etc.				
Obtain list of management, including officers and directors, along with biographical affidavits on file with the Department.				

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Checklist 4—Property, Real Estate, Records and Facilities Control	**Project Assigned To**	**Date Completed**	**Completed By**	**Notes**
Identify, secure and inventory all records located at off-site storage areas.				
Furniture and Fixtures				
Review insurer inventory listings and reconcile to general ledger.				
Conduct physical inventory of furniture and fixtures at all locations.				
Identify leased furniture and fixtures.				
Obtain copies of leases and determine appropriate action.				
List insurer-owned furniture and fixtures (assets).				
Record valuation of assets at receivership date.				
Equipment				
Conduct physical inventory and determine ownership of data processing equipment, hardware, software, copiers, etc.				
Identify leased equipment, obtain copies of leases and determine appropriate action.				
List insurer-owned equipment (assets).				
Record valuation of assets at receivership date.				
If appropriate, discontinue or retrieve: • Cell phones • ~~Pagers~~ • ~~PDAx~~ • ~~Blackberries~~ ▪ Laptops and Tablets ▪ Flash drives ▪ Vehicles ▪ Security ▪ Maintenance agreements ▪ Copiers ▪ Office equipment				

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