NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 07/10/23

Virtual Meeting

RECEIVERSHIP LAW (E) WORKING GROUP
Monday, July 24, 2023
2:00 – 3:00 pm Eastern; 1:00 – 2:00 pm Central; 12:00 – 1:00 pm Mountain; 11:00 am – 12:00 pm Pacific

ROLL CALL

Kevin Baldwin, Co-Chair	Illinois	Robert Wake	Maine
Laura Lyon Slaymaker, Co-Chair	Pennsylvania	Christopher Joyce	Massachusetts
Michael E. Surguine	Arkansas	Tom Mitchell	Michigan
Joe Holloway / Jack Hom	California	Shelly Forrest	Missouri
Rolf Kaumann	Colorado	Lindsay Crawford	Nebraska
Jane Callanan	Connecticut	Alexander S. Adams Vega	Puerto Rico
Lorrie Arterburn	Florida	Brian Riewe	Texas
Kim Cross	Iowa	Charles Malone	Washington
Tom Travis	Louisiana		

NAIC Support Staff: Jane Koenigsman

AGENDA

1. Consider Adoption of its May 23, 2023, Meeting Minutes — Attachment A
   —*Laura Slaymaker (PA)*

2. Discuss the Comments Received on Proposed Amendments to Model #540—
   Laura Slaymaker (PA)
   a. Comment Letters: — Attachment B
      i. Cantilo & Bennett, L.L.P.
      ii. Fairfax (US) Inc.
      iii. National Conference of Insurance Guaranty Funds (NCIGF)
   b. Exposure Draft, including reference and format edits — Attachment C

3. Consider Adoption of Proposed Amendments to Model #540
   —*Laura Slaymaker (PA)*

4. Hear a Request regarding Receivership Estate Records Retention — Attachment D
   —*Kevin Baldwin (IL) and Richard Janisch (Arcina Risk Group)*

5. Discuss Any Other Matters Brought Before the Working Group
   —*Kevin Baldwin (IL)*

5. Adjournment

Draft: 6/20/23

Receivership Law (E) Working Group
Virtual Meeting
May 23, 2023

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force met May 23, 2023. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Michael Surguine (AR); Joe Holloway (CA); Jack Broccoli (CT); Miriam Victorian (FL); Kim Cross (IA); Tom Travis (LA); Christopher Joyce (MA); Robert Wake (ME); Tom Mitchell (MI); Shelley Forrest (MO); Lindsay Crawford (NE); Shawn Martin (TX); and Charles Malone (WA).

1. Exposed Amendments to Model #540

A. ITBs and CDs Amendments

Baldwin said the Working Group met Nov. 7, 2022, to discuss comments from Maine on the original exposure of proposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540). The purpose of the amendments is to address guaranty fund coverage for policies that are included in insurance business transfers (IBTs) and corporate divisions (CDs). The Working Group formed a drafting group that met four times, had many email exchanges, and went through several drafts. The drafting group has two new versions of the amendments to present to the Working Group and seeks feedback on each version to settle on a single version.

Wake summarized the proposed amendments in version one (Attachment Two-A) and the document describing the amendments (Attachment Two-B). He said the drafting group considered four different points of entry. There are various ways to get to the results, such as by amending the definitions of covered claim, insolvent insurer, or assumed claims transaction, or by expanding membership. The National Conference of Insurance Guaranty Funds (NCIGF) showed him a definition of a New Hampshire law that was simple and clean. After some technical work, proposed paragraph 5G(2) could be added to the definition of covered claim. He said he did not distinguish between other types of transactions because, with few exceptions, there was not any point in choosing which would get coverage preserved and which would not. He said the mandate was to start with IBTs and CDs, but he feels there is strong public policy consensus that the same thing is wanted for transactions like mergers and common law novation, except transactions where policies are commuted into a captive and still have guaranty fund coverage. Wake said the one complexity with version one is that he was asked to consider other transactions where a member insurer did not write the original coverage. Either it was self-insured or written in surplus lines or by a captive. He has not seen any real-life examples of such a transaction. Generally speaking, if an insurer wanted to bring something into the admitted market, it would write a substitute policy. Because some asked for language that did not take away anything, optional language was added with a long drafting note in paragraph 5G(3). He said version one is simpler because it gets rid of some definitions, but it does make a lot of changes to the existing model by deleting verbiage. He said his summary document includes a comparison matrix like the matrix provided for version two. He said he disagrees with what transactions in version two are covered.

Barbara F. Cox (Barbara F. Cox LLC) summarized the NCIGF comments on version one (Attachment Two-E). She said NCIGF supports a stand-alone paragraph 5G(2) in the first paragraph of version one to the covered claim definition. She said NCIGF does not support 5G(3). She said NCIGF feels it goes beyond the charge. She said version two allows coverage for an IBT started with a nonmember insurer to a member. That is not consistent with the charge that says guaranty fund coverage should be unchanged or retained, nor is it consistent with the Restructuring Mechanisms (E) Working Group's latest drafts, which it has not finalized. She said every discussion and document she has reviewed calls for guaranty fund coverage to remain unchanged. In the context of IBTs and

CDs, version two goes beyond that. It is more than what is needed. NCIGF's support is for a stand-alone paragraph 5G(2). NCIGF does not support paragraph 5G(3). NCIGF is neutral on any idea of assessing a nonmember that becomes a member in a post-insolvency assessment context. That does not make sense. If the claim started in a member insurer, they would pay the assessment if any was due in the year the policy was issued. Version one includes an optional concept to look at the claim volume that is transferred and assess based on some percentage of that amount if it is unclear whether there was an assessment and the percentage the assessment should have been.. NCIGF is neutral on that idea and observes that it adds some complexity that would be cleaner with just a stand-alone 5G(2). Wake added that the optional assessment language was added as part of the request to keep the substance of everything in the existing model. He does not feel it is needed since few states have adopted that language.

Patrick Cantilo (Cantilo and Bennett LLP) summarized the proposed amendments in version two (Attachment Two-C) and the document describing the amendments (Attachment Two-D). He said version two entails only changing paragraph 5H(1). It adds the language required to include IBTs and CDs so that claims arising under a policy assumed by doing IBTs or CDs would be covered. He said version two offers alternative language that works the same way in that they amend the same section. He said the reason for the alternatives in version two is that most states have not adopted the assumed claims language. He said if a state wants to have a version of the statute that does not refer to assumed claims language, then alternatives one and two accomplish that. Alternatives also address if the transferee is a nonmember and the transferor is a nonmember. Each alternative only amends paragraph 5H(1). He said he also offers a definition for IBT and CD that may or may not be necessary. Cantilo said the main difference between his version two and Wake's version one, aside from whether one is viewed as simpler, is that version two does not overtly eliminate the possibility of coverage that arose from a non-member to within guaranty association coverage once a member assumes it. Those transactions may be rare. It was an issue for the Reciprocal of America situation in which half of the workers' compensation business had been assumed from a self-insured trust. Reciprocal of America became insolvent before replacement policies were issued for much of that business. In that case, it eventually became a covered business and was treated like any other business. That situation may or may not happen again. Cantilo said if the Working Group only wants to ensure that Model #540 preserves coverage for IBTs and CDs, version two accomplishes that. If the Working Group wants to go further and eliminate the possibility of having assumed claim language, then additional amendments would be required. He said he does not believe that is part of the charge.

Cox asked if version two carves out guaranty fund coverage for an IBT or CD originating with a nonmember going to a member. Cox said the matrix in Cantilo's explanation document shows nonmember to member would be guaranty fund covered, so she said it does include that. Cantilo said he did not think it was part of the charge, but it would be a simple change to make if the Receivership and Insolvency (E) Task Force wants to take that track.

Wake said his understanding of alternatives two and three in version two address member-to-nonmember transactions because otherwise, the insurer must be an insolvent insurer to have coverage, which means the transferee must be a member insurer to become an insolvent insurer. Cantilo said the question is if there are states that do not want to cover member-to-nonmember. The other three alternatives allow states to adopt such language consistent with their views. The first alternative for a member-to-nonmember transfer is covered. Wake said that regarding Reciprocal of America, he received from Cantilo a Virginia opinion where the insurer had issued replacement policies even if the document did not say it was a replacement policy.

Wake made a motion, seconded by Mitchell, to expose version one without the optional language for a 30-day comment period ending June 23. The motion passed with Massachusetts opposing. Joyce said he understands Cantilo's position and has concerns about exposing version one without the optional language. Wake said he could expose it either way. Mitchell said he echoes Cox's comments referring to the scope of the original request to modify the law. It seems outside the scope to create coverage rather than retain and continue coverage. However, if it is the will of the Working Group, he does not oppose exposing the optional language. Surguine said he liked

the procedure under the assumption of reinsurance laws where policyholders get notice. A transaction does not bind policyholders unless they get notice and opt-in. He does not like the part of IBT laws that can force policyholders into a transaction. However, Arkansas has already enacted an IBT statute. Wake said he is sympathetic to Surguine. He said that even if a state has not passed an IBT statute, other states have adopted such statutes. He said policyholders should not be penalized.

Wake made a motion, seconded by Joyce, to expose version one with the optional language for a 30-day comment period ending June 23. The motion passed unanimously.

B. Cybersecurity Insurance Amendments

Baldwin said the Request for NAIC Model Law Development to amend Model #540 to clarify guaranty fund coverage of cybersecurity insurance was approved by the Executive (EX) Committee at the 2023 Spring National Meeting.

Cox summarized the NCIGF's proposed amendments to Model #540 for cybersecurity insurance (Attachment Two-F). She said cybersecurity insurance is different from what has been dealt with before in insolvencies. Along with indemnity coverage, cybersecurity insurance also includes various services such as mitigation of losses, notices to potential persons whose data have been breached, and even ransom negotiations and payments. One of the characteristics is the immediacy of the insurance company to respond. A member insurer presented to NCIGF and said the insurer is the firehouse, not the clean-up crew. If a breach occurs, the insurer needs to be prepared to respond immediately. The proposed amendments include:

- Clarification of coverage. Some may conclude that cyber may not be covered.
- A definition of cybersecurity insurance.
- Powers and duties to tie all losses paid by the guaranty funds triggered by the cyber event not to exceed $500,000. There was no claim loss volume reporting to use. NCIGF had to use other sources to determine whether this covered claim cap would cover a small to medium size business.
- Clarification that the guaranty funds have the right to appoint and direct other services providers, such as legal, notice, mitigation, forensics, etc.
- Provides that coverage may be paid for high-net-worth insureds even if the state has high-net-worth exclusion due to the immediacy of the need to address claims. If the insured is later determined to exceed the net worth limitation, that loss could be addressed later.

Wake asked if a definition of covered services is needed and how that affects the claim limit. Cox said NCIGF would not object to further clarification on covered services. She said the $500,000 limit is intended to be all-inclusive. Any residual amount is turned over to the estate and settled in due course. Wake said there are services under other policies, so it may not be an issue. Cox said some states have limits on defense costs.

Wake made a motion, seconded by Kaumann, to expose the proposed amendments for cybersecurity insurance for a 30-day comment period ending June 23. The motion passed unanimously.

Having no further business, the Receivership Law (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 NAIC Meetings/Summer National Meeting/E Committee/RITF/052323_RLWGmin.docx

CANTILO & BENNETT, L.L.P.

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June 2, 2023

Ms. Laura Lyon Slaymaker Co-Chair
Mr. Kevin Baldwin, Co-Chair
Receivership Model Law (E) Working Group
C/O Jane Koenigsman
Sr. Manager - Life/Health Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street
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BY ELECTRONIC MAIL

RE: MODEL 540 COMMENTS

Dear Ms. Lyon Slaymaker and Mr. Baldwin:

Please accept this letter as my comments in response the May 24 Model 540 Exposure Draft. I address only the proposed amendments regarding IBT/CD transactions. I offer no comment on those related to cybersecurity insurance. This letter is not a request that you reverse the May 23 decision of the Receivership Law (E) Working Group (RLWG) to adopt the proposal submitted by Ms. Cox and Messrs. Wake and Snider (Version 1). I understand that the RLWG has already considered my comments and my proposal (Version 2). Instead, I submit this letter so that it may be included when the RLWG forwards its recommendation to the Receivership and Insolvency (E) Task Force (RITF) or the Restructuring Mechanisms (E) Working Group (RMWG).

The charge to the RLWG was to propose amendments to Model 540, the Property and Casualty Insurance Guaranty Association Model Act (the Act), to assure that implementation of Insurance Business Transfers (IBT) and Corporate Division (CD) transactions, will not result in loss by policyholders of guaranty association protection.

After extensive discussion and analysis, I proposed a straightforward amendment as follows:

H. "Covered claim" means the following:

(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 the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and …

No other change to the Act would be needed to fulfill the goal of the referral to the RLWG. The NAIC could adopt this simple amendment thereby assuring that IBT and CD transactions would not result in the loss of guaranty association coverage.

Recognizing that some may conclude that a definition of IBT and CD should be included, I proposed the following:

(c) For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.

To be clear, however, this definition is an optional suggestion, not necessary to achieve the stipulated purpose.

During the discussions it emerged that, since many states have not adopted the assumed claims provisions added to the Act in 2009, an alternative should be offered that would accomplish the same goal in those states. That is true because the current Act's assumed claims provisions assure coverage even if the transferee insurer (even in an IBT or CD transaction) is not a member insurer. My initial "Default" provision (quoted above) accomplishes only the goal of assuring that IBT and CD transactions do not eliminate guaranty association coverage under the Act as it exists currently. That was the goal articulated in the referral to the RLWG. Under this provision, transactions (including IBT or CD) would be covered in most cases: member to member and non member to member, but would not be covered in IBT and CD transactions in which the transferee insurer is unlicensed (highly improbable in my view).

Although I would not recommend it, it is possible that some states may want to provide guaranty association coverage even if the transferee insurer is unlicensed. The discussions also resulted in suggestions that some states may not want to provide coverage in all the other cases encompassed within my proposal, for example when the transferee insurer is not a member insurer. While this went beyond the RLWG's charge, to address these permutations, I offered three alternatives (SEE Exhibit 1) included in the exposure draft. They would permit a state to select an option that, both, addresses the goal of the referral, and limits coverage as follows:

ALTERNATIVE 1: Does not provide coverage for assumed claims transactions or transfers to non-member insurers;

ALTERNATIVE 2: Does not provide coverage for assumed claims transactions but retains it for transfers to non-member insurers; and
ALTERNATIVE 3: Provides coverage for assumed claims transactions and transfers to non-member insurers.

All of the alternatives have the same virtue as the default proposal: they only envision limited edits to Section H(1). Thus, no matter what its preference, under my proposal a state could accomplish the referral's goal of preserving coverage in the case of IBTs or CDs, AND also limit coverage as summarized above.

This contrasts with the very extensive and complicated edits of the Act (including extensive deletions of current provisions) required to implement Version 1, the one selected by the RLWG. The simple explanation for the difference is that, unlike my proposal, Version 1 is structured to permit the NAIC to remove now the assumed claims coverage added in 2009. If it were not for that new goal, there would be no reason to prefer Version 1. That new goal, of course, was not part of the charge to this Working Group.

This point merits a bit further explanation. My proposal DOES enable an individual state to provide guaranty association coverage for IBT and CD transactions WITHOUT assumed claims coverage. Where it differs from that adopted by the Working Group is that the latter enables amendment of the Act to ELIMINATE EVEN THE POSSIBILITY of assumed claims coverage. I submit respectfully that there is no public policy justification for this *sotto voce volte-face.*

My purpose here is simply to highlight that my proposal would enable RITF to accomplish the referral's goal with a simple amendment of the Act. I respectfully reserve further explanation as to why I think the new goal served by Version 1 is inappropriate, and other concerns I have articulated already as to Version 1, pending further deliberations following referral of the proposed amendments by the RLWG to RITF.

I thank you for your kindness in adding my comments to your referral.

Very truly yours,

Patrick H. Cantilo

Patrick H. Cantilo

EXHBIT 1

PATRICK CANTILO'S PROPOSED REVISION TO THE DEFINITION OF COVERED CLAIM IN MODEL 5401-1 SECTION 5.

H. "Covered claim" means the following:

(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 the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and …

[OPTIONAL – to define IBT and CD if deemed necessary]

(c) For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.

EXPLANATION

Versions of this language can be adopted whether or not the Assumed Claim language has been adopted. The proposal deliberately doesn't remove the "assumed claims" language. However, a state that wants to adopt this remedial provision without adopting the assumed claims language can do so easily enough just by making this change to the definition:

(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 the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an ~~assumed claims transaction or in an~~ Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and …

Similarly, if a state wants to add coverage when the transferee is a non-member insurer, the following edits accomplish this.

(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 (A) the insurer becomes an insolvent insurer after the effective date of this Act, and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy

was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) 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, and

Here's how the final would look:

WITH ASSUMED CLAIMS LANGUAGE AND WITHOUT NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

(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 the policy was issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and

ALTERNATIVE 1: WITHOUT ASSUMED CLAIMS LANGUAGE AND NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

(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 the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and

ALTERNATIVE 2: WITHOUT ASSUMED CLAIMS LANGUAGE BUT WITH NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

(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 (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) 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, and

ALTERNATIVE 3: WITH ASSUMED CLAIMS LANGUAGE AND NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

(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 (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and in such a transaction subsequently assumed by, or allocated to, another insurer (other than a risk retention group) 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, 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.

OPTIONAL

(c) *For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.*

FAIRFAX
FAIRFAX (US) Inc.

2850 LAKE VISTA DRIVE, SUITE 150
LEWISVILLE TX 75067

Kevin Baldwin and Laura Slaymaker
Co- Chairmen, Model Law Working Group

RE: Exposure Draft on Restructuring Transactions and Cyber Security-Comments due June 23

Dear Kevin and Laura:

I am writing to offer comments on the aforementioned exposure draft, specifically regarding guaranty fund coverage for restructured business. As you may know, I have been a supporter at the NAIC of the concept of business restructuring. Additionally, I have served as an insurance regulator in Rhode Island for over 30 years and have been active in many NAIC initiatives. Currently I am employed by the Fairfax US Inc. as Vice President – Regulatory Affairs. Coincidentally, I also serve as the Chairman of the NCIGF Board of Directors. In this capacity I have a keen interest in supporting the protection the guaranty fund system affords to covered policyholders.

I offer a few observations that I hope will move the Working Group towards a solution that includes only 5(g)(2) of the exposure draft. First, restructuring transactions, while a useful business tool, were never intended to afford coverage on policy claims that were, before the transaction, not covered by guaranty funds. The current drafts being circulated by the Restructuring Working Group support the idea that guaranty coverage not be "changed" by the transaction. G(2) as a standalone is consistent with this approach. Second, regarding the assumption reinsurance provisions that were adopted by the NAIC in 2009, I understand that the drafting group has determined that, in current form, those provisions would not deal with IBTs and CDs – the most recent iterations of restructured business. Moreover, the 2009 amendments have only been adopted in three states – Rhode Island- the state I regulated - among them. It is appropriate to strike these provisions in the way that the current exposure draft indicates. Third, and probably most important, IBT and CD statutes continue to be enacted in the states and have already been used on several occasions in various jurisdictions. It is important to have a legislative remedy on the books to protect policyholders soon to address situations where the transferee company, despite all efforts to prevent this, becomes insolvent.

I understand that 5(g)(3) provides for an optional remedy for states to cover some transactions that did not originate from guaranty fund covered business. This, in my view, is contrary to the intent of the transactions. Further, as I understand it, there is additional "optional" language throughout the draft to clarify and permit some recoupment of guaranty fund assessments that may have been collected had the business originally been guaranty fund covered, a concept NCIGF has not put forward. This additional language adds a layer of complexity that would not be necessary if g(3) were not enacted and, sadly, has the potential to complicate legislative efforts to protect covered policyholders.

E-mail: jtorti@fairfaxinc.com Landline: 401.231.3195 Mobile: 401.209.4538

Thank you for your attention to my comments.

Sincerely yours,

Joseph Torti III

Cc: Roger Schmelzer, NCIGF
Rowe Snider, Locke Lord
Barbara Cox, Barbara F. Cox, LLC

June 20, 2023

Kevin Baldwin and Laura Slaymaker
Co-Chairmen of the Receivership Law (E) Working Group

Subject: May 23 Exposure Draft on Guaranty Fund Coverage for Restructured Business

Dear Kevin and Laura:

We appreciate the Receivership Law Working Group's consideration of our proposed guaranty fund model law amendment to address restructuring transactions. As you know, NCIGF's policy is coverage neutrality – that is, if there was guaranty fund coverage before the transaction the coverage should remain in place after the transaction. Conversely, coverage that did not exist prior to the transaction should not be created by the transaction. We believe this position aligns with the charge to the Model Law Working Group and the most recent drafts circulated by the Restructuring Working Group. [1]

We feel that the proposed amendment to the covered claim definition at 5G(2), as a standalone revision, is consistent with the NCIGF policy. We would be comfortable recommending it to our members and others who may be involved in addressing restructured business guaranty fund coverage in the various states.

Further, we believe that the strike through of the 2009 amendments (including the adjustment to 5G(1)) intended to address assumption transactions is appropriate given that 1) as adopted in 2009 the language does not address IBTs and CDs and 2) the amendments have only been adopted in three states.

The optional paragraph 5G(3) in the exposure draft goes beyond the NCIGF coverage neutrality position and is not supported by the NCIGF. Likewise, the additional language which we understand is intended to offer options to support G(3) (such as additional definitions and options to provide for a look back to recover guaranty fund assessments that may have been collected had the business originally been covered business) is not necessary without G(3). It also may unduly complicate state efforts to amend their guaranty fund acts because of its complexity.

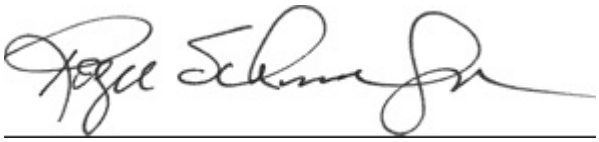
Note that NCIGF is not commenting on the cyber security amendments included in the exposure draft at this time. However, we do look forward to continued discussion of these amendments.

[1] See the Request for NAIC Model Law Development adopted by the E Committee 7/21/22 – "The scope of the request is limited to addressing the issue of continuity of guaranty fund coverage when a policy is transferred from one insurer to another." See also Best Practices Procedures for IBT/Corporate Divisions discussion draft dated 4-4-23 – "For corporate divisions involving property and casualty insurance, the applicant's representation that that the laws of each U.S. jurisdiction where any such policies issued by the dividing insurer are allocated address restructuring transactions such that rights to guaranty fund coverage are not reduced, eliminated, or ***otherwise*** ***changed*** as a result of the transaction. Emphasis added. We are not aware of any objections expressed on this portion of the discussion draft.

National Conference of Insurance Guaranty Funds
300 North Meridian Street, Suite 1020
Indianapolis, IN 46204
Phone 317.464.8199 | Fax 317.464.8180
www.ncigf.org

Many thanks for considering our comments. Please feel free to contact me or Barbara Cox for additional information.

Very truly yours,



President & CEO
National Conference of Insurance Guaranty Funds

[1] See the Request for NAIC Model Law Development adopted by the E Committee 7/21/22 – "The scope of the request is limited to addressing the issue of continuity of guaranty fund coverage when a policy is transferred from one insurer to another." See also Best Practices Procedures for IBT/Corporate Divisions discussion draft dated 4-4-23 – "For corporate divisions involving property and casualty insurance, the applicant's representation that that the laws of each U.S. jurisdiction where any such policies issued by the dividing insurer are allocated address restructuring transactions such that rights to guaranty fund coverage are not reduced, eliminated, or ***otherwise changed*** as a result of the transaction. Emphasis added. We are not aware of any objections expressed on this portion of the discussion draft.

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PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

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, insurance ~~I~~insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

F. Title insurance;

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 insurer) 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.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some, of the lines excluded by this provision.

For purposes of this section, "Financial guaranty insurance" includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;

2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;

3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;

4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, "credit insurance" means insurance on accounts receivable.

The terms "disability insurance" and "accident and health insurance," and "health insurance" are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: "Ocean marine insurance" means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

A. "Account" means any one of the three accounts created by Section 6.]

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

A. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.

B. "Association" means the [State] Insurance Guaranty Association created under Section 6.

C. "Association similar to the association" means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

~~**Drafting Note:** There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and Q and Alternative 1b or 2b in Section 8A(3).~~

~~D. **[Alternative 1]** "Assumed claims transaction" means the following:~~

~~(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or~~

~~(2) An assumption reinsurance transaction in which all of the following has occurred:~~

~~(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies: and~~

~~(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and~~

~~(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies~~

~~**[Alternative 2]** "Assumed claims transaction" means the following:~~

~~(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or~~

~~(2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:~~

~~(a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and~~

~~(b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.~~

~~(c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or~~

~~(3) An assumption reinsurance transaction in which all of the following has occurred:~~

~~(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;~~

~~(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; andAs a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.~~

~~(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.~~

D~~E~~. "Claimant" means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

E~~F~~. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term "commissioner" appears.

F~~G~~. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

G~~H~~. "Covered claim" means the following:

(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 policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and: ~~the policy was either issued by the insurer or assumed by the insurer in an assumed claims transaction; 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) "Covered claim" includes claim obligations that arose through the issuance of an insurance 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:

(a) 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~~Paragraph~~ 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 ~~Section 5G(3)~~:

(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:

(a) 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.]

Drafting Note: Optional –Section 5G(3) provides coverage for certain claims that are not within the scope of ~~Paragraphs~~ Subsections (1) or (2) because the original coverage was not provided by a member insurer. Subsections~~paragraphs~~ (a) and (b) are based on Alternative 1 of the former definition of "assumed claims transaction," (below) and Subsection~~paragraph~~ (c) is based on the additional scenario included in Alternative 2 of the former definition of assumed claims transaction (below).

Former Definition of "Assumed Claims Transaction" for Optional Section 5G(3): There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 below provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 below provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1 below, it must select Alternative 1 below and Alternative 1 or 1a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 below, the former definitions of Assumption Consideration and Novation (below) and Alternative 2 or 2a in Section 8A(3).

[Assumed Claims Transaction Definition Alternative 1] "Assumed claims transaction" means the following:

(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or

(2) An assumption reinsurance transaction in which all of the following has occurred:

(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies: and

(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

[Assumed Claims Transaction Definition Alternative 2] "Assumed claims transaction" means the following:

(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or

(2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:

(a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and

(b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.

(c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or

(3) An assumption reinsurance transaction in which all of the following has occurred:

(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;

(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

Former Definition for Assumption Consideration: "Assumption Consideration" shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.

The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.

Former Definition of Novation: "Novation" means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.

(32) Except as provided elsewhere in this section, "covered claim" shall not include:

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

(i) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred-but-not-reported losses.

Drafting Note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that "policyholder protection" proofs of claim, while valid to preserve rights against the ~~State~~ estate of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

[Optional ~~Section 5H~~:

H. "Cybersecurity insurance", for purposes of this Act, includes first and third party coverage, in a policy or endorsement, written on a direct, admitted basis for losses and loss mitigation arising out of or relating to data privacy breaches, unauthorized information network security intrusions, computer viruses, ransomware, cyber extortion, identity theft, and similar exposures.]

H~~I~~. "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 transaction,~~ 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.

Drafting Note: "Final order" as used in this section means an order which has not been stayed. States in which the "final order" language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

I~~J~~. "Insured" means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

J~~K~~. (1) "Member insurer" means any person who:

(a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and

(b) Is licensed to transact insurance in this State (except at the option of the State).

(2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer's license.

K~~L~~. "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

[Optional ~~Section 5K~~:

K. "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees and including all premiums and other compensation collected by a member insurer for obligations assumed under a transaction described in Optional Section 5G(3), less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers, other than compensation received for entering into a transaction described in Optional Section 5G(3).]

Drafting Note: ~~The~~ Optional Section 5K is for states that have adopted Optional Section 5G(3).

~~M. "Novation" means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations.~~

~~Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.~~

K~~N~~. "Person" means any individual, aggregation of individuals, corporation, partnership or other entity.

L~~O~~. "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of "receiver" to the definition used in the State's insurer receivership act.

M~~P~~. "Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

~~Q. **[Alternative 2b]** "Assumption Consideration" shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.~~

~~In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.~~

~~The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.~~

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K~~J~~ shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

A. The workers' compensation insurance account;

B. The automobile insurance account; and

C. The account for all other insurance to which this Act applies.]

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term "director" shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of "the business of insurance" similar to that found in the NAIC Insurer Receivership Model Act.

B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.

D. Any board member who is an insurer in receivership shall be terminated as a boar*d member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.

E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

A. The association shall:

(1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy

or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(ii) An amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium;

(iii) An amount not exceeding $500,000 per claimant for all other covered claims.

(iv) In no event shall the Association be obligated to pay an amount in excess of $500,000 for all first- and third-party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of claimants.

(b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a 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.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

(c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to $10,000, against the association. The maximums ($10,000 for the return of unearned premium; $500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, 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. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.

(3) **[Alternative 1~~a~~]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

Drafting Note: -Alternative 1 for S~~ubs~~ection 8A(3) above or the Alternative 1a for S~~ubs~~ection 8A(2)(3) included in this drafting note ~~as follows~~ -should be used in conjunction with Assumed Claims Transaction Definition Alternative 1 as described in the drafting note for Optional Section 5G(3).

(3) **[Alternative 1a for S~~ubs~~ection 8A(3)]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments

shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

~~[[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.~~

(3) **[Alternative ~~1b~~2]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the

payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

Drafting Note: -Alternative 2 to S~~ubs~~ection 8A(3) above and the Alternative 2a to Section 8A~~(2)~~(3) included in this drafting note ~~as follows~~ should be used in conjunction with Assumed Claims Transaction Definition Alternative 2 as described in the drafting note for Optional Section 5G(3).

(3) [Alternative 2a for Section 8A(3)] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.

~~(3) *[Alternate 2b] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date~~

~~*of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]*~~

[Optional:

(4) Assess member insurers that have entered into transactions described in Optional Section 5G(3), in addition to the assessment levied under ~~Paragraph~~Section 8A(3), an amount reflecting liabilities that may have arisen before the date of the transaction. The assessment under this ~~paragraph~~subsection is not subject to the annual percentage limitation under Paragraph (3) and shall be the amount that would have been paid by the assuming insurer under Paragraph (3) during the three calendar years preceding the effective date of the transaction if the business had been written directly by the assuming insurer. If the amount of the applicable premiums for the three year period cannot be determined, the assessment shall be 130% of the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the assumed claims transaction, multiplied by the applicable guaranty association assessment percentage for the calendar year of the transaction.]

Drafting Note: Optional ~~Paragraph~~Section 8A(4) is for states that have adopted Optional Section 5G(3) and choose to require an additional "assumption consideration" assessment when claim obligations are assumed from an entity other than a member insurer.

(4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims and to appoint and direct other service providers for covered services.

(5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

(6) (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 insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the

following defenses, in addition to the defenses available to the insurer:

(i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:

(I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or

(II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.

(ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the 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.

(7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.

(8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.

(9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

(1) Employ or retain persons as are necessary to handle claims, provide covered policy benefits and services, and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;

(5) Perform other acts necessary or proper to effectuate the purpose of this Act;

(6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

(6) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

(1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.

(2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional: ~~Section 8D~~

D. (1) The legislature finds:

(a) The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;

(b) The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;

(c) The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;

(d) The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and

(e) In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the

association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.

(2) In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.

(3) In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.

(4) Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.

(5) In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].

Drafting Note: This provision should only be considered by those States that haveserious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association

can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

Section 9. Plan of Operation

A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.

(2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

(1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;

(2) Establish procedures for handling assets of the association;

(3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;

(4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;

(5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;

(6) Establish regular places and times for meetings of the board of directors;

(7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;

(8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;

(9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;

(10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other

organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;

(2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

B. The commissioner may:

(1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than $100 per month;

(2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.

B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.

B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.

C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to Statepriority of distribution in liquidation act].

D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines "high net worth insured," has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States' net worth restrictions pursuant to those States' guaranty association laws.

A. For purposes of this section "high net worth insured" shall mean any insured whose net worth exceeds $50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

[Alternate Section 13A

A. (1) For the purposes of Subsection B(1), "high net worth insured" shall mean any insured whose net worth exceeds $25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]

(2) For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] "high net worth insured" shall mean any insured whose net worth exceeds $50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of "covered claim." The Michigan Supreme Court, in interpreting a "net worth" provision in the Michigan guaranty association statute, held that governmental entities possess a "net worth" for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

(2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.~~]~~

i. The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(1). In that case, the Association shall recover from the high net worth insured under this s~~S~~ection all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this s~~S~~ection.]

Drafting Note: -Alternative 1 for Section 13B ~~paragraph~~ (3), would only be a consideration in states with a net worth exclusion.

[Alternative 2 for Section 13B

B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

(2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:

(a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;

(b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or

(c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

(3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.

(4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.~~]~~

(5) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this s~~S~~ection all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's

fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this ~~s~~Section.]

Drafting Note: Alternative 2 to Section 13B ~~paragraph~~ (5) would only be a consideration in states with a net worth exclusion.

[Alternative 3 for Section 13B

B. The association shall not be obligated to pay any first party claims by a high net worth insured.*]*

C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.

D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.

E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.

(2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)

(a) The credit shall be deducted from the lesser of:
(i) The association's covered claim limit;
(ii) The amount of the judgment or settlement of the claim; or
(iii) The policy limits of the policy of the insolvent insurer.*]*

[Alternative 2 for Section 14A(2)(a)

The credit shall be deducted from the lesser of:

(i) The amount of the judgment or settlement of the claim; or

(ii) The policy limits of the policy of the insolvent insurer.*]*

(b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.

(3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.

(4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.

(5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:

(a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and

(b) Any amount payable by or on behalf of a self-insurer.

(6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.

B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.

C. Reports and recommendations provided under this section shall not be considered public documents.

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[*Alternative 1 for Section 17*

A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.

B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.

D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:

(1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and

(2) The last sentence in Subsection C above shall not apply.

E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.*]*

[*Alternative 2 for Section 17*

A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.

C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.

D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.*]*

[*Alternative 3 for Section 17*
The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.*]*

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. I 218, 252, 253-262, 298 (adopted).
1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. I 44, 46, 126, 217 (amended).
1981 Proc. I 47, 50, 175, 225 (amended).
1984 Proc. I 6, 31, 196, 326, 352 (amended).
1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
1986 Proc. II 410-411 (amendments adopted later printed here).
1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

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Preservation of Records Post-Closure of Insolvent Estate

July 24, 2023

1

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Next Steps

- Stop the Destruction of Any Estate Records that are nearing Closure
- Determine documents within Estate Records to retain for Public Purpose
- Determine Authority and Duties bestowed on Libraries
- Determine if evidentiary standard for Estate Records must be changed
- Determine ability to restore any recently destroyed Estate Records

3

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NAIC Receivership Law Working Group **July 24, 2023 Meeting**

Topic: Preservation of Records Post-Closure of Insolvent Estate

Objective: Consider that Commissioner/Receiver has broad authority to provide Estate Records to Libraries instead of destroying them at Closure of an Insolvent Estate; aiding in resolution of Future Claims and otherwise benefiting the Public.

Need for Records after Closure of Insolvent Estate

- **Occurrence Basis**- Insurance policies are often written on an occurrence basis and thus, when Post-Closure Claims arise, while the Insolvent Estate is no longer able to contribute to any costs or judgments, the policies themselves speak toward the rights and duties of the Parties. By providing their Estate Records, Insolvent Estates can help Insureds understand the nuances of their legacy insurance programs.
- **Follow the Forms**- When dealing with insolvent carriers in primarily liability insurance layers, we're encountering excess coverage with "follow the form" language which is hindered by not having the records of the insolvent primary carrier. The insured will then incur additional costs to recoup defense costs or coverage itself depending on the nature of the drop-down clause at-issue. Thus, without the verbiage of the primary policies, it would be difficult or impossible to understand the obligations of excess policies.
- **Disservice to the Public**
    - Operational records are no longer primarily stored in physical formats, so the cost of ongoing storage and maintenance is greatly reduced than before.
    - Innovations in Data Analytics and Artificial Intelligence permit better cataloging as well as skimming of information to draw useful information from the clutter to aid the Public.
- **Emerging Risks**: Opioids; PFAS; Acetaminophen (APAP); Zantac, Sexual Abuse & Misconduct (SAM)
    - KCIC Asbestos Review 2022 advises an average of ~3,885 NEW filings annually from 2018 to 2022 alleging **asbestos** exposure
    - Claims originating from **talc** use allege an asbestos cross-contamination aspect which is actively being litigated and for which the scope of asbestos exclusions are being tested.
    - Perfluoroalkyl & Polyfluoroalkyl Substances (**PFAS**) aka "Forever Chemicals"- Found in many consumer and industrial products such as firefighting foam, these chemicals are known to seep into groundwater resulting in environmental contamination, such as around airports.
    - On February 6, 2023, the *Justice for Survivors Act* (AB 452) was introduced which seeks to end the civil statute of limitations for minors who have experienced **sexual abuse** and removes barriers that prevent survivors from seeking justice against their abusers.
    - On September 16, 2022, President Biden signed the *Eliminating Limits to Justice for Child Sex Abuse Victims Act*, which removed statute of limitations for people who were **sexually abused** as minors to file civil claims in federal courts.

NAIC Receivership Law Working Group
July 24, 2023 Meeting
Topic: Preservation of Records Post-Closure of Insolvent Estate

Sources:

- Asbestos Litigation: 2022 Year In Review, KCIC Industry Report
- https://sd09.senate.ca.gov/news/20230206-addis-and-skinner-introduce-bill-end-civil-statute-limitations-child-sexual-abuse
- https://thehill.com/homenews/administration/3647958-biden-signs-bill-eliminating-civil-statute-of-limitations-for-child-sex-abuse-victims/
- May 28, 1978, Los Angeles Times Article

Relevant Statutes:

- **Insolvency Model Act- Section 118(A)**- “Upon entry of an order of conservation, rehabilitation or liquidation, the receiver shall be vested with title to all of the books, documents, papers, policy information, claim files and all other records of the insurer”
- **Texas- Sect. 443.017**- "Receiver is vested with title"
- **California- Sect. 1011-** "...[V]esting title to all of the assets of that person... in the commissioner or [their] successor in office"
- **Pennsylvania- Sect. 221.6(2)-** "...make available and deliver to the commissioner any...records...pertaining to the insurer and in [their] control"